

At the Front Door
Child Protection Reporting in a Changing Policy and Legislative Context

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Declaration

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work.

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Summary

Irish child protection and welfare services have been subject to a range of recent policy and legislative change underpinned by a significant increase in reporting rates over the last ten years. This study set out to explore a sample of current child protection and welfare reports made to statutory services and provide important insights within this context of change and increased pressure. In doing so, it has filled a gap in empirical research by providing a robust and detailed analysis of the types of concern reported, the source of reports and the initial responses made.

A case study methodology was utilised and focused on the intake system, the ‘Front Door’, of one administrative area of Tusla, the Child and Family Agency, during Q1 2015. A mixed methods design was used and quantitative and qualitative methods employed to gather and analyse data on all reports received during the time period under study. To supplement this data a focus group and in depth qualitative interviews were carried out with eight practitioners from the area.

By providing comprehensive statistical data and the perspectives of those who operate the system, the study shows how far reform in Ireland has synchronised with current international models of service delivery. To this end, the findings are discussed in the context of Irish and international literature on child protection systems, referral and re-referral, reporting trends, decision making, filtering and thresholds. This study argues that while Irish child protection and welfare services strive to foster a ‘welfarist’ and children’s rights approach, the ‘forensic paradigm’, endemic within many Anglophone countries, continues to endure; evidenced by an aversion to risk and increasing proceduralisation within the system.

Key findings from the study showed how practitioners behind the Front Door struggle to address the range of need evidenced in reports. The data demonstrate that the largest proportion of reports are made by lay referrers. Yet, the way that the intake system is formalised ultimately privileges professional reporters and could be seen to deter families and members of the public from seeking the assistance they require. The findings also illustrate that, while a significant proportion of reports are referred forward to the next stage of an initial assessment, a high rate of attrition ultimately prevails. Analysis of the types of reports that are re-referred within a relatively short period indicates that certain difficulties, for example, children’s mental health and behavioural problems, fall between service gaps. Paradoxically, reports made by ‘protective’ parents about their children appear less likely to receive an assertive response than those made by others.

The child protection intake system operates according to a set of standard business processes which were developed to structure service delivery and promote a consistent response. The current study shows that it responds effectively to reports representing clearly defined ‘abuse’ cases amenable to a straightforward classification of ‘child protection’. However, a substantial proportion of the

difficulties being reported, classified as ‘welfare issues’, relate to parental capacity and family functioning. The latter are more likely to be complex and multi-faceted and require case by case deliberations in order to make a decision about the next step to be taken. The research illustrates the challenges involved in achieving this in an environment characterised by high levels of demand, low resources, time constraints and limited information.

Decision making at the Front Door, both in terms of the categorisation and outcome in cases was revealed in this study to be a very subjective task, guided more by ‘sense making’ strategies than by any official guidance or policy afforded by the statutory agency. Localised practice norms were also found to influence thresholds in a context of high pressure and varying levels of service availability.

By revealing, through the statistical analysis of intake records, the full extent of concerns reported to services, the links between the nature of child harm and vulnerability, the sources of reports and the likely early decisions made, this research should enable policy makers and service planners to make evidence based projections. This will be particularly important in the context of upcoming legislation on mandatory reporting. The study has also illustrated some weaknesses behind the Front Door, particularly in its apparent capacity to respond to certain difficulties that present repeatedly. It suggests that some reappraisal of the agency's skill mix could usefully take place, but also recommends deeper consideration of the purpose and function of the intake system.

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Glossary of Terms

ACPC	Area Child Protection Committee
CAMHS	Child and adolescent mental health services
CFSN	Child and family support networks
CPC	Child protection conference
CPNS	Child protection notification system
CPT	Child protection team
CSC	Children's social care
CWT	Child welfare team
DPC	Data Protection Commissioner
DSW	Duty social worker
HSE	Health Service Executive
IA	Initial assessment
ICS	Integrated children's system
ICT	Information communications technology
IS	Information systems
ISW	Intake social worker
IT	Information technology
LAP	Local area pathways
NCCIS	National child care information system
NFA	No further action
NI	Northern Ireland
OOHS	Out of hours social work service
PE	Preliminary enquiry
PHN	Public health nurse
PPFS	Partnership, prevention and family support programme
ROI	Republic of Ireland
SBP	Standard business process
SCR	Serious case review
SCRA	Scottish Children's Reporter Administrator
SDM	Structured decision making
SNBI	Safeguarding Board of Northern Ireland
SRF	Standard reporting form

SWD	Social work department
SWTL	Social work team leader
TL	Team leader
UNCRC	United Nation's Convention on the Rights of the Child
UNOCINI	Understanding needs of children in Northern Ireland

Chapter 1: Introduction

The purpose of the current study is to examine in some depth the reports that are made to statutory child protection and welfare services in Ireland. These services are provided by Tusla, the Child and Family Agency (hereafter Tusla) which came into being in January 2014 following the enactment of the Child and Family Agency Act, 2013. The establishment of Tusla brought together child and family services, family support services, education and welfare services, some psychological services and a range of services responding to domestic, sexual and gender based violence. Up to then child and family services had been part of the Health Service Executive (HSE), the state's provider of public health and social care services. Tusla has statutory responsibility, under the Child Care Act 1991, to promote the welfare of children not receiving adequate care and protection.

This study, entitled 'At the Front Door', borrows a concept which is common in child protection parlance, and was mooted in September 2014 by the then Chief Executive of Tusla (Jeyes, 2014). The Front Door represents the single point of entry for referrals, and is intended to provide easy access and a consistent response to professionals and members of the public who want to bring their concerns to official attention. It is a key element of the relatively newly established service, and one which has a unique facility to 'tell the temperature' of the agency. However, although Tusla publishes a certain amount of administrative data in monthly and quarterly reports (Tusla.ie), it is quite limited in the degree to which it reports on the circumstances of vulnerable children and families whose stories come through the Front Door. Apart from classifications of the four universally recognised abuse categories, and the ubiquitous 'welfare' category, which encompasses reports not reaching the 'abuse' threshold, it provides no information about the social problems or difficulties that lead to children being referred, their social circumstances, their gender or their ages, who identifies their problems or any linkages between these factors. Tusla publishes some fairly crude information about the early disposal of reports that it receives, but it provides insufficient information to indicate the processes used to make decisions, and provides no insight into which cohorts of children are more likely to receive child protection interventions and which are closed with no further action, referred elsewhere or find their way back through the Front Door within a short period.

The dearth of information becomes more significant at a time when Irish child protection and welfare services, in common with other Anglophone countries, are in the process of reform. One of the goals of reform is to provide a proportionate response to children and families' difficulties. Without detailed information on the type of difficulty presenting, the capacity of service planners and policy makers is compromised. An impending issue for Irish child protection and welfare services is the implementation of the Children First Act, 2015, which aims to increase awareness of child protection in organisations and includes mandatory reporting for certain professional groups. Without information on the current reporting behaviours of these groups, it will not be possible for relevant

government departments to anticipate future reporting levels and place training and other resources appropriately. It is therefore intended that the analysis of reporting trends provided by this thesis will provide important information for the future planning of Irish child protection and welfare services.

There are other, more philosophical, reasons underpinning this choice of topic. As the following chapters will show, child protection systems internationally have grappled over many years with competing ideologies related to what Parton (1991) first referred to as ‘governing the family’, encapsulated in the perceived conflict between children’s rights to protection versus families’ rights to bring up their children as they see fit. Irish services have also been through a unique journey where the protection of state institutions was seen to take priority over the welfare of children to a point where the issue became highly politicised (Buckley and Buckley 2015). Interrogation of the rate and types of child protection reports should give an indication of how far the State has acted on the reassurances of the State, expressed in the words of the then Taoiseach, Enda Kenny, that:

‘Through our legislation, through our Government’s action to put children first, those who have been abused can take some small comfort in knowing that they belong to a nation — to a democracy — where humanity, power, rights and responsibilities are enshrined and enacted always for their good’ (Houses of the Oireachtas, 2011).

Six research questions were posed in this study to elucidate what is happening at the Front Door. These questions address: what matters are being reported; who is making the reports; how are these reports being categorised; what outcomes are reached and how well the systems that have been established are working. Recognition of the Front Door as an integral element of Irish child protection and welfare services is postulated by this study, given its influence on the future trajectory of cases. As the concept of the Front Door is the main focus of this thesis, it will be referred to in capital letters throughout and the research on which this thesis is based will be referred to as ‘the current study’. The following sections will describe the particular context in which the current study was situated.

Social work services in Ireland are provided by Tusla, through a number of service delivery arrangements. The four regions of Dublin Mid Leinster, Dublin North East, South and West cover, between them, 17 administrative areas. The social work departments in each area have a number of teams, including an intake team, which normally consists of two or more social workers whose sole task is to receive and process reports. This research represents a case study of one such area (hereafter Oaktown) over a three-month period. The current study comprised a quantitative and qualitative analysis of the 794 child protection and welfare reports received during Q1 2015 and 8 interviews held with key practitioners involved in the provision and management of the intake system in Oaktown.

Chapter 2 provides a comprehensive description and discussion of the evolution of child protection and welfare services in Ireland. The remainder of this chapter provides a detailed overview of the

‘intake’ system, i.e. the Front Door: how professionals and lay people make reports; and the actions required by an intake social worker (ISW) once a report is received. To conclude, it will anticipate the contribution to knowledge to be made by this thesis and provide an overview of its layout.

Making a report to the intake system

Guidance for reporters, both lay and professional, on how to make a report is set out on the website of Tusla (<http://www.tusla.ie/children-first/report-a-concern/>). Guidance is also available in *Children First: National Guidance for the Protection and Welfare of Children* (Department of Children and Youth Affairs, 2011) and in the *Child Protection and Welfare Practice Handbook* (HSE, 2011b), both of which are available online (Tusla.ie).

Advice is also provided on the Tusla website for organisations and professionals working with children who may be concerned about the welfare and protection of a child (<http://www.tusla.ie/children-first/roles-and-responsibilities/organisations/report-a-concern>). In the first instance, reporters are encouraged to discuss their concerns with a designated person within their organisation or to seek advice from their local Tusla social work department (SWD). Following on from this if they wish to make a formal report, referrers are encouraged to use the standardised report form (SRF) which is also available online (<http://www.tusla.ie/children-first/publications-and-forms>).

Separate advice is provided on the Tusla website for parents, guardians, young people and the general public who are advised to contact their local social work office if they wish to report a concern (<http://www.tusla.ie/children-first/how-do-i-report-abuse>). While members of the public will be met by a social worker if they present at an office, contact by the general public is encouraged by phone or letter. Reporters are advised to contact An Garda Síochána (the Irish police force, also referred to as the Gardaí) if their concern is urgent and requires a response out of office hours.

Standard procedures for receiving reports are detailed in the *Child Welfare and Protection Social Work Departments Business Processes* (HSE, 2009) (hereafter SBP guidance document). Decision making about the disposal of reports is guided by the *Threshold of Need Guidance for Practitioners in Tusla Social Work Services* (Tusla, 2014c) (hereafter threshold guidance document).

Once a referral is received the reporting process is instigated, consisting of two phases: screening and preliminary enquiry.

The screening step

The screening step, as its title suggests, is concerned with screening out enquiries, reports and requests for services which do not fall within the remit of child protection and welfare services. The process is officially described as informal, and unless the reports are considered *bona fide*, they will not be included in official data returned on a monthly basis to the national office, nor counted as referrals in the national data sets. An informal enquiry may also consist, for example, of a query from a professional seeking advice on whether or not their concern is reportable. In Oaktown telephone reports are received, in the first instance, by administrative staff who record the initial details of the referral and then pass it on to the intake social worker (ISW). Calls that are deemed inappropriate, such as requests for monetary assistance, will be screened out by administrative staff at this stage. All other calls are transferred to the ISW on duty. During the study period, 326 informal enquiries, received by the administrative staff in Oaktown, were ultimately deemed ineligible to move to the next stage of preliminary enquiry.

The preliminary enquiry (PE) stage

Once a referral is considered to be within the remit of child protection and welfare services, a standardised intake record form is completed by the intake social worker (see Appendix 1). The details gathered and entered on this document inform the preliminary enquiry (PE) stage. The tasks to be carried out during the PE stage are detailed in the SBP guidance document, which allows 24 hours for the following tasks:

- Receive the referral;
- Fill in the intake record form;
- Screen out inappropriate referrals using the threshold guidance document;
- Carry out relevant checks with colleagues and records held within Tusla regarding the child and family. This is not mandatory and is carried out at the discretion of the ISW depending on the concern reported;
- Consult with the referrer;
- Discuss the referral with the team leader (TL);
- Make a decision regarding the outcome of the referral;
- Sign off on the decided outcome (both the ISW and the TL);
- Provide feedback to the referrer.

(Adapted from HSE, 2009)

Carrying out checks

‘Carrying out relevant checks’ appeared in the current study to be a task that is interpreted at times with considerable flexibility by the ISW and will be discussed in more detail in this thesis. As outlined above, the SBP guidance document states that ‘other checks’ are not mandatory and are ‘carried out at the social workers’ discretion (depends on the nature of the concern reported)’ (HSE, 2009: p.20). This guidance advises that sufficient ‘checks, verifications and consultations’ will have been completed when the social worker is ‘able to determine or is satisfied that the nature of the concern reported continues to constitute a report and is satisfied that he or she has enough information to make a recommendation on the action to take’ (*ibid*, p.14).

Checking with colleagues external to Tusla during the PE stage, according to the guidance, constitutes the instigation of an initial assessment, a stage beyond the preliminary enquiry, and requires parental consent. The guidance also states that ‘this includes any communication where parental consent is required such as contact with teachers, Gardaí and others outside of the HSE (now Tusla) and the social work department’ (*ibid*, p.20). However, overarching this guidance on procuring parental consent is the direction from *Children First* that in the instance of a child protection concern and where it is considered that contacting parents would increase the risk to children information may be sought from relevant professionals outside of Tusla (*Children First*, 2011 Section 5.2.6).

A practice note was produced by Tusla in May 2016 following a complaint made to the Children’s Ombudsman, which adds further clarity to this issue:

The primary issue for the social worker to consider is the immediate safety of a child and to gather necessary and relevant information to protect that child. If parents refuse consent and the Agency believes that the child is, or is likely to be, at immediate and serious risk of significant harm then they should proceed to conduct the necessary network checks in the best interests of the child’s safety (Tusla, 2016h: p.1).

In the matter of contacting children and families at the stage of a preliminary enquiry, the guidance also states the ‘rule of thumb is that any decision to contact a parent or child constitutes a decision to begin an initial assessment’ (HSE, 2009: p.20). It also points out that ‘a balance always needs to be struck between protecting the child and avoiding unnecessary and distressing interventions’. The one instance in which it is clear is when the child and / or family have instigated the referral themselves.

A clear delineation exists in the guidance between a preliminary enquiry and an initial assessment (*ibid*, p.14) and it is pointed out that:

‘A preliminary enquiry is not an assessment. The aim of the preliminary enquiry process is to support and help the user (the social worker) to make a decision on the action to take in response

to the information reported, that will result in the best outcome for the child who is the subject of the referral. Normally that decision or action will be an assessment or assessment and another action' (*ibid*, p.10).

The standardisation of child protection and welfare services in Ireland

Over ten years ago, the process of standardising practice in Irish child protection and welfare services was initiated with the establishment of the National Child Care Information System Business Process Standardisation Project (hereafter the NCCIS Project). At that time, child protection and welfare services were still part of HSE.

The aim of the NCCIS Project was to develop and improve child care information management and within this there were two interrelated elements: business process standardisation and an information and communication technology (ICT) project. The overall goal of the project was 'to create an integrated child welfare and protection system to look after every child and manage every case from first contact with the HSE social work department through to case closure' (HSE, 2009: p.5). It was decided to develop and implement the business processes in advance of the ICT system (*ibid*).

To this end standard business processes were developed for each stage of the child protection and welfare system and the deliverables for each were: standard operating procedures; accompanying forms; guidance for forms and detailed process maps (HSE, 2009). The forms that were issued to practitioners were devised to ultimately synchronise with the ICT system once it was operational. The project began with the intake and referral stage and in 2007 the intake record form, mentioned above, was piloted. In due course, forms and guidance for all stages, processes, sub-processes and services in the child protection and welfare system were included and timescales for each were proposed and ultimately became the timeframes for the system as it operates today. The report of the NCCIS Project (HSE, 2009), became, by default, the guidance by which practitioners implemented new business processes in their practice. The chart in Appendix 2 depicts the initial tasks to be carried out and decisions to be made once a referral is received by an intake social worker.

Research on child protection in Ireland and the contribution of this thesis

My previous career as a child protection social worker and my more recent involvement in research provided the inspiration for undertaking a PhD in this field. A dearth of robust and good quality Irish child protection research was identified by an audit completed by Buckley et al. (2010), which also noted that the body of existing studies lacked primary or empirical research and some were very small scale with unclear methodologies. In addition, the authors made the point that 'available

statistical data on child protection, which are vital for planning services and allocating resources, require further development and analysis to improve accuracy and to provide a more comprehensive picture of child protection issues and activities' (p.41). In a similar vein, Jones et al. (2016), conducted a review of child protection research in the UK between 2010 and 2014, and found a three-fold dominance of academic publications based on non-empirical research over those reporting on empirical research. The literature search conducted for the current study, detailed below, demonstrated that the imbalance identified in the 2010 audit still prevails in Ireland.

Predominance of qualitative over quantitative methodologies in studies on social work practice is not unique to Ireland and has also been reported on in the UK (Sheppard et al. 2015). While this trend is being redressed to some extent, for example Guo (2015) reviewed journal articles submitted to five peer reviewed social work journals from the beginning of 2012 to the end of 2013, and reported that over four-fifths (81%) used quantitative methods, it still prevails and the dearth of quantitative research leaves the knowledge base deficient in important aspects. Quantitative research complements the perspective provided by qualitative research and can 'illuminate the scale, scope and impact of social issues and inform how we respond in ways that are ethical, empowering and effective' (Teater et al., 2017: p.27). This study is the first in depth quantitative analysis of child protection and welfare data in Ireland.

Review of the literature

The collection and review of literature relevant to this dissertation was constant throughout the three years of this study, to shape the research design and to help understand and contextualise the findings after the data analysis was complete. The literature review commenced at the beginning of this PhD, slowed down somewhat during the data collection phases and resumed during the data analysis and write up phases.

Searching for relevant articles to inform the literature review for this study was carried out using bibliographic databases and also by directly searching the archives of relevant journals. Bibliographic databases, which were extensively searched to access literature for the current study were: Academic Search Complete; ERIC; Psychinfo; PUBMED; Science Direct; Scopus; Social Science Index; Sociological Abstracts and Web of Science. Alerts were set up for pertinent journals and extensive searching was carried out in the archives of relevant journals such as: *British Journal of Social Work*; *Child Abuse and Neglect*; *Child Abuse Review*; *Child and Adolescent Mental Health*; *Child and Family Social Work*; *Children and Society*; *Children and Youth Services Review*; *Child Care in Practice*; *Child Maltreatment*; *Child Welfare*; *European Sociological Review*; *International Social Work*; *Journal of Family Studies*; *Qualitative Social Work*; *Research on Social Work Practice*; *Social Work* and *Social Work Research*. An alert was also set up for the *Community Care Daily*

Bulletin (<http://www.communitycare.co.uk/>) which provided an interesting insight into topical issues within English child protection services and notification of recently published relevant research. Particular attention was also given to three relevant Irish journals and searches were carried out to seek out any articles or research studies of relevance to this PhD. These were: *Irish Journal of Applied Social Studies*; *Irish Social Worker* and *Administration*.

A lot of consideration was given to the search terms used within these databases and journals. These were modified and renewed during the duration of the study. Search terms and search strategies were applied consistently across all databases, although some variation was required at times due to the functionality of the different databases. When available the ‘advanced search’ option was always used. Various combinations of the following search terms were used, separated by Boolean operators where applicable, and truncated to increase the search results: refer*; report*; child welfare, child abuse, child maltreatment, child protection, child protect*, social work, child protection services, intake, child protective services, child welfare services, social services, re-report, re-referral, decision-making, filter* and thresholds. Inverted commas were also applied at times around certain phrases to enable more precise searching.

The literature search generated a wide range of articles on the operation of child protection systems and the debates about the future development of such systems. It also yielded a substantial number of articles on re-referral. Articles and empirical research carried out on intake systems and the reasons why children and families are reported to child protection services were more difficult to access. Shaw and Holland (2014) provide a useful guide for the appraisal of quantitative and qualitative studies, and the establishment of inclusion and exclusion criteria. Included in these criteria are a number of considerations to be applied to the process of comparing one piece of empirical research with another. These criteria were used as a template for deciding which studies to include and reference in the literature review.

Inclusion of ‘grey literature’ in the review, that is governmental and organisational policy documents, and in particular administrative data figures, was considered very important given the nature of the current study. Reports and data figures from government departments and research repositories and hubs were also accessed. These included: *Childlink* (<http://www.childlink.ie.elib.tcd.ie/>); *North South Child Protection Hub* (<http://members.nscph.com.elib.tcd.ie/>) and *Children’s Research Network for Ireland and Northern Ireland* (<http://www.childrensresearchnetwork.org>) as well as research repositories particular to Ireland and Irish research such as *Tara* (<http://www.tara.tcd.ie/>), *Rian* (<http://www.rian.ie>) and *Lenus* (<http://www.lenus.ie>). Given the policy and legislative context of the current study, it was of crucial importance to keep abreast of any significant developments in this regard and to this end contact was made and maintained with key stakeholders in the area and conferences, launches and briefings of relevance were attended.

Layout of the thesis

Chapters 2 to 5 of this thesis provide a review of relevant literature. Chapter 2 provides an overview of the evolution of child protection services in Ireland to their current iteration and considers the degree to which they synchronise with the contemporary aspiration to establish a new paradigm and the impact on this of the imposition of a technical rational mode of operation. It thus provides a conceptual context for considering the findings of the current study. Chapter 3 discusses findings from empirical research and the implications of administrative data from different jurisdictions. It focuses specifically on the source and type of reports made to child protection systems in a number of Anglophone countries and thus provides a template for comparing the findings from the current study. Chapter 3 also signals international concern about the issue of underreporting which is drawn out in greater detail in Chapter 4. Chapter 4 provides a comparison between overall reporting trends in Ireland and other Anglophone countries. Particular attention is given in Chapter 4 to a comparison of child protection systems north and south of the border between Ireland and Northern Ireland. Chapter 5 reviews available literature on decision making, thresholds and filtering in child protection settings and illustrates the complexity of these tasks and the uncertain environments within which intake systems operate.

Chapter 6 outlines the methodological approach taken in the current study and in doing so discusses how the research was carried out, the limitations of the study and the impact of an ethical issue.

Chapters 7, the first of the findings chapters, details the information gathered on the children, the perpetrators and the difficulties reported. Chapters 8 and 9 interrogate in more detail the difficulties reported for the children and for the parents and families respectively. Chapter 10 provides the findings on the source of the reports made during the study period and the type of difficulties reported. Chapter 11 considers the checks that were carried out by the intake social workers and the impact these checks had on the outcome in a case. The focus of Chapters 12 and 13 is on decision making during the preliminary enquiry and Chapter 14 considers the rate of re-referral to Oaktown and identifies the characteristics and situations of the children and families who were re-referred. The final chapter synthesises the findings from the current study, integrating them with existing research to further elucidate what happens at the Front Door.

Chapter 2 The Child Protection System in Ireland – Evolution and Change

Introduction

The central challenge facing children's services is how best to protect and simultaneously meet the welfare needs of an ever increasing number of children and families. Different jurisdictions have travelled on their own trajectories of service development in pursuit of meeting these two challenges in a context where resources are usually outstripped by demand. In the meantime, Ireland has its own unique tale to tell. As Mc Gregor and Quin (2015: p.2) point out, consideration of 'the history of the present' serves as a conceptual device to emphasise how the present and the past cannot be separated, one being a product of the other.

This chapter first outlines current child protection discourses, using international literature to illustrate the diversity of systems but also the way in which different approaches are tending to merge in their aspiration to create a new paradigm. It will then analyse the development of the Irish child protection system to illustrate how it has evolved into the context in which the current study is situated. It will go on to consider international research on the quest for a new paradigm of child wellbeing, and finally, it will consider the unintended consequences of policy development, specifically in relation to increasing bureaucratisation of systems.

Classification of child welfare systems and the search for a new paradigm

Over twenty-years ago Fox Harding (1997) presented a four-fold typology to understand the continuum of services provided to children and families. At the two extremes of this typology are the paradigms of laissez-faire / patriarchy which encompasses the view that the family should not be interfered with except in the most extreme situations and at the other end state paternalism and child protection, associated with the growth of state interventions in matters of child welfare and protection in the late nineteenth and early twentieth centuries. More recently, in an attempt to classify child welfare systems operating in different countries, the terms 'welfarist' and 'child protection' are commonly cited by commentators and social policy analysts to describe the type of orientation adopted (Gilbert et al. 1997; Spratt, 2001). Gilbert (1997), for example, examined child welfare systems in nine countries in the mid 1990's and found two principal orientations to practice: child protection and family services. Distinguishing these approaches was the former's emphasis on an investigative and regulated approach whilst the latter emphasised early intervention and family support. Gilbert (2012) addresses the salient issue of how abuse was characterised along the continuum spanning the two approaches:

‘The child protection approach framed abuse as the harmful behaviour of malevolent parents, which called for legal investigation and public measures to control deviant, if not outright criminal, behaviour. In contrast the family service orientation perceived the problem as a manifestation of family dysfunction stemming from psychological difficulties, marital troubles and socio-economic stress, which are amenable to therapeutic interventions’ (p.532).

By 2010, however, in a follow up study in the same nine countries Gilbert (2012) notes the beginnings of a convergence with the ‘child protection’ approach moving more towards family support and prevention and countries which had favoured a more ‘welfarist’ approach beginning to introduce more forensic elements, for example formalising and regulating their intake system and introducing mandatory reporting. Gilbert (2012) also notes the emergence of a third approach around this time which stressed the importance of considering child development, seen to be broadly influenced by the United Nations Convention on the Rights of the Child and its emphasis on children’s social, political and legal rights.

Ireland’s position within this evolutionary trajectory is somewhat fluid. As in many other jurisdictions, at the time of the foundation of the State, in 1922, the most common approach used to address the care and welfare needs of the children of the nation was placement in institutional care (Buckley et al., 1997). The Children Act 1908, originally enacted by the British government prior to Irish independence, provided the legislative basis for children’s services until it was replaced by the 1991 Child Care Act. In addition, the Irish constitution provided an important ideological context with its enshrinement of the primacy of the married family as the ‘primary and fundamental unit of society’ (Article 42, Irish Constitution, 1937).

The Health Act 1970 provided for the first time a role for the Irish state in the provision of social services which had previously been carried out by voluntary and religious organisations. As Buckley and Burns (2015) have pointed out, under this Act the profession of social work was provided with new opportunities to undertake community as opposed to institutionally based work. This was affirmed by the recommendation of the *Task Force on Child Care Services* (Department of Health 1980) for community based interventions to prevent the removal of children into alternative care. Responsibility for child protection, Skehill (2004) argues, was willingly accepted by the profession which, she claims, was ‘desperately seeking to find legitimate space to occupy within the professional sphere of social service provision’ (p.124).

Policy documents illustrate how, during the 1970s in Ireland, child harm was largely constructed in terms of physical injury to a child (Buckley et al, 1997). As such, the lead responsibility for assessing and confirming such abuse rested primarily with the medical profession. In keeping with this approach, the first set of guidelines for detecting and responding to child abuse, produced by the Department of Health four decades ago in 1977, identified child harm in terms of ‘non-accidental

injury to children' and focused almost exclusively on physical abuse, citing hospitals or GP surgeries as the key identifiers (Buckley and O'Nolan, 2013).

As Ferguson and O'Reilly (2001) have pointed out, definitions of what constituted child harm began to reflect a broader perspective during the 1980s and by 1987 included neglect, sexual and emotional abuse as well as physical abuse. By the mid 1990's, medical leadership had been replaced by a new social work management structure. At the same time, awareness of the extent and impact of child sexual abuse and its impact on children had grown and was reflected in the numbers of cases being reported. The publication of an investigation into interfamilial child sexual abuse, known colloquially as the '*Kilkenny Report*' (Mc Guinness, 1993), created what Buckley and Burns (2015) term a 'watershed' in the development of child protection services. It highlighted not only inadequacies in the system, but the need for a cultural change in relation to matters such as domestic violence and children's rights and the sharing between professions of information which had previously been considered private. The full implementation of the Child Care Act 1991 quickly followed, funding for services increased exponentially and a number of the recommended policy initiatives were implemented, all of which gave a higher profile to the problem of child abuse. These included the establishment of a dedicated child care unit within the Department of Health, a specialised unit for dealing with family violence in the police force and the appointment of a Minister of State with specific responsibilities for child and youth policies (Buckley et al., 1997; Buckley and O'Nolan, 2013; Mc Gregor, 2014a; Buckley and Burns, 2015).

The Child Care Act 1991 transformed child protection services in Ireland and, importantly, it firmly established a statutory role for social workers in child protection, obliging them on behalf of the state to 'take such steps as it considers requisite to identify children who are not receiving adequate care and protection and coordinate information from all relevant sources relating to children in its area' (Department of Health, 1991 Section 3 (2) (a)).

Added to this, as pointed out by Mc Gregor (2014a), the legislation represented a move away from a 'residual, reactive child protection system' (p.773) towards one concerned with early interventions and an emphasis on the best interests of the child. However, despite the proactive philosophy underpinning the Act, concerns emerged on the part of a number of commentators (Buckley et al., 1997; Eastern Health Board, 1997) who identified an enduring emphasis in, what was then called 'community care', (statutory) social work on the investigation of reports with less activity in family support services. The need was identified for 'a refocusing towards a supportive and preventive response to children and families in need' (Buckley and Burns, 2015: p.55).

The current child protection and welfare system

Changes in the orientation of the Irish child protection system were reflected in a new iteration of procedures published in 1999 and named *Children First, National Guidelines for the Protection and Welfare of Children*. This document, known colloquially as ‘*Children First*’, reflected the recommendations of the *Kilkenny Report* and other recent child abuse inquiries (Ferguson and O’Reilly, 2001). It was based on a number of key principles which included: ‘the paramount concern of child welfare, the importance of child welfare, the importance of early intervention, the importance of parental participation in the child protection process, inclusiveness and the necessity of interagency collaboration’ (Buckley and O’Nolan, 2013: p.42). The guidelines laid significant emphasis on joint working and cooperation between personnel and services working with children, with a specific section on liaison with the Gardaí. There was a strong focus on family support and the inclusion of the word ‘welfare’ in the title of the guidelines was seen by some to reflect the government’s intention to increase its investment in family support (Buckley and Burns, 2015).

In keeping with McGregor’s (2014a) observations, echoes of the past began to bring positive changes, not least with regard to the promotion of children’s rights both in socio-political terms and also specifically in relation to child protection policy. Ireland became a signatory to the United Nations Convention on the Rights of the Child (UNCRC) in 1992, and in 1995 The Children’s Rights Alliance was established, whose key purpose was the implementation of the UNCRC. This was followed by a ten year plan known as the *National Children’s Strategy, Our Children – Their Lives* (2000) which was pivotal in the procurement of individual rights for children, the development of the Ombudsman’s Act in 2004 and establishing an Ombudsman for Children Office. These initiatives, according to Mc Gregor and Quin (2015), highlight ‘the explicit move from a residual, reactive discourse of child welfare to a proactive, children’s right orientation’ (p.6).

However, concern remained about the focus on ‘investigation’ in statutory social work practice and annual statistics continued to demonstrate that most social work activity was concerned with screening and investigating reports, with a high attrition rate. The data also indicated that child welfare and neglect reports dominated, with the majority being either screened out or receiving short term responses (Buckley and Burns, 2015: p.56).

Pressure on child protection social work services continued following the reforms of the 1990s and as McGregor (2014a) argues, practice remained ‘focused on [the] high end reactive level in a stressful and resource constrained environment despite the discursive commitment to prevention’ (p.774). Yet, as Buckley and O’Nolan (2013) point out, administrative data from this time (see HSE, 2011a: p.11) showed that larger proportions of the reports being made to child protection and welfare services were being classified as ‘child welfare’ rather than ‘child protection’, illustrating that the

majority of reports did not meet the threshold for coercive action and further affirming the need for greater investment in and development of early intervention and supportive services.

The publication in 2009 of the Report of the Commission to Inquire into Child Abuse (Office of the Minister of Children and Youth Affairs, 2009), colloquially known as the Ryan Report, heralded the most significant transformation to occur in relation to child protection services. This was an investigation of the abuse of children in schools run by the Catholic Church, and it became, as described by McGregor (2014a: p.774), ‘a major driver’ in the reform of services, specifically the establishment of a stand-alone child protection agency, separate from the wider Health Service Executive. As previously outlined the new Child and Family Agency, also known as Tusla, brought together child and family service with a range of other related services. The agency was generally welcomed by commentators and seen as ‘an attempt by the government to ring-fence and raise the profile of child protection’ (Buckley and Burns, 2015: p.60) and ‘the embracing of a children’s rights ethos across the whole service to shift Ireland from a family-model to one where children’s as well as parental rights are operationalised’ (*ibid*: p.63).

The establishment of Tusla was guided by three core principles: an emphasis on family support, prevention and early intervention; integration of services from the community and the provision of seamless and unified services (Mc Gregor, 2014a). For the first time it brought a formality and structure to family support services which previously were left without any attempt to quantify its operation or outcomes. These principles formed the basis of a service delivery framework known as Prevention, Partnership and Family Support Programme (PPFS), which is intended to be operationalised through Local Area Pathways (LAP) and Child and Family Support Networks (CFSN). A core element of the PPFS is a practice model called Meitheal¹. A Meitheal is defined as a coming together of the family and professionals involved in a child’s life to share knowledge, expertise and concerns about the child with the ultimate goal of all concerned working together to achieve a better life for the child (Tusla, 2015g).

The key underlying message behind this practice framework is the sharing of responsibility between key services. It also aims to spare families the rigour of a child protection investigation if it is not strictly necessary. This vision of service delivery is an ambitious one and it necessitates professionals across services and sectors working together, communicating well with each other and trusting each other and each other’s judgement. Thus, the viability of these is heavily dependent on collaboration, communication and trust.

¹ ‘Meitheal is an old Irish term that describes how neighbours would come together to assist in the saving or harvesting of crops or other tasks’ (Tusla, 2015g: p.15).

Conflicting discourses in Irish child protection work

A parallel development to the welfarist approach underpinning the reformed service delivery framework is the planned implementation of what amounts to mandatory reporting of suspected child abuse, an issue that had originally been mooted in the Kilkenny Report but had gained currency in the meantime following a series of scandals relating to the Church's response to alleged child abuse (Buckley and Buckley, 2015). The Children First Act 2015, enacted but not yet commenced, puts *Children First* on a statutory footing. The main elements of the Act are aimed at raising awareness of child abuse and neglect; providing for the mandatory reporting of child abuse by key professionals; improving child protection arrangements in organisations providing services to children and providing for inter-agency working and information-sharing in relation to assessments by Tusla. Once fully commenced, the Act will place a statutory obligation on persons working with children to keep them safe and will require defined categories of staff (mandated persons) to report child protection concerns over a defined threshold to Tusla and it will require these mandated persons to assist Tusla in the assessment of child protection risk.

The above developments could be seen to operate in conflict with each other and as Buckley and Burns (2015) have commented, up to recently '(t)he Irish child protection system never consciously adopted a strong or polarised orientation on which to develop' (p.278). Mc Gregor (2014a) argues that Irish child protection and welfare services for children are now influenced by three core and inter-related discourses: a need to purge past shames, a need to purge past systemic failures and a need to re-conceptualise child protection services towards child-centred and children's rights orientation. She comments that 'this discourse can be readily identified in institutional (new agency); intellectual (children's rights and child-centeredness); social and cultural (media attention) and political (the creation of separate Department and Minister) contexts' (p.776).

The degree to which the new legislation will challenge the capacity of Tusla to meet its aspiration to be a supportive, proactive service is yet unknown. Evidence from other jurisdictions indicates that the instigation of mandatory reporting has led to an increase in reporting rates (Ainsworth, 2002; Buckley, 2008) and provides reason for practitioners and managers to fear a similar impact in Ireland. However, as R. Buckley (2013) points out, it can be difficult to attribute increased reporting rates to mandatory reporting only as there is a need to consider its impact within the socio-political context to which it is introduced as well as the fact that reporting rates were already increasing before its introduction.

The search for a universal child protection paradigm

As the earlier sections have illustrated, approaches to children and youth services internationally have demonstrated a sort of ‘family focused child protection’ (Connolly 2007) orientation, with less sharp divisions between the welfarist and child protection orientations. However, despite what appears to be a rational trajectory of service development, there is still a great deal of unease expressed in the literature about the approach adopted in many jurisdictions. Also, there appears to be a consistent aspiration for a new paradigm for social work and a more ‘developmental approach’ that promotes cohesion in communities and works to alleviate poverty and deprivation (see for example Lonne et al., 2009; Gilbert et al., 2011; Parton, 2014a; Featherstone et al., 2014; Bilson and Martin, 2016). This section will consider some of the elements that have been suggested for a new approach, which include attention to structural factors, community cohesion, promotion of children’s rights and a more child focused approach.

It is argued that the prevailing discourse, which includes investigating large numbers of ultimately unfounded reports (Bywaters, 2015), registering vast numbers of families (Bilson and Martin, 2016) and taking many children into long term care (Gilbert, 2012; Bilson and Martin, 2016) is allowed to prevail without any evidence that it is preventing further harm. Indeed Hood et al. (2016), in their examination of the long term trends of the demand and provision of English child protection services, found that the forensic paradigm is still very robust. They revealed an increased use of investigative child protection procedures such as section 47 investigations, child protection conferences and child protection plans, which is steadily overtaking the growth in referrals to child protection services and the numbers of children meeting the children in need threshold. They further remark that ‘this trend has led to concerns about the way in which poor communities are subject to statutory surveillance and control, about the stigmatisation of families who may not be abusing their children but are nonetheless drawn into the child protection process’ (Hood et al., 2016: p.938).

It is also claimed that this approach draws much needed funds away from early intervention (Bywaters et al., 2015) and pays insufficient attention to factors such as poverty and deprivation. Bilson and Martin (2016) describe ‘developmental social work’ as an approach which focuses on advocacy, alleviating poverty and the development of family and community strengths. It aims to create ‘tangible improvements in standards of living, health and education and a concomitant reduction in poverty, malnutrition and illiteracy’ (Midgley and Conley, 2010: p.13).

Structural factors and their links to child harm have been the subject of research in the US (see for example Gil, 1970; Pelton, 1978, 1981, 1994) but as Winter and Connolly (2015) claim, they have received less attention on this side of the world. To address this gap in evidence, the latter authors carried out research in Northern Ireland examining 342 referrals to children’s services. They found a ‘strong association’ between levels of deprivation and the rate of referrals and made a case for the

consideration of issues such as support and social capital when planning for children in need (Winter and Connolly, 2015: p.945). Bilson et al. (2015) also identify the paucity of evidence that current approaches effectively reduce overall levels of physical abuse or neglect. Rather they highlight the need to ‘genuinely engage with socially excluded communities (and) stand alongside them in combating poverty and social exclusion through taking a developmental approach to social work’ (p.787).

There are debates evident in the literature about the association between different types of service provision and the economic prosperity or otherwise of a district or area. Bywaters et al. (2015), on the basis of a study conducted in 13 UK local authorities, reveal that the connection between the rates of intervention and level of deprivation is complex. They found that areas with high deprivation indices had lower intervention rates. Explanations for what they term an ‘inverse intervention law’ include the possibility that informal support networks may be stronger in disadvantaged communities thus reducing the need for the intervention of services or, conversely, that reporters in disadvantaged communities become desensitised to family problems and are less likely to make reports to the authorities. Either way, they suggest that their ‘provisional explanation for the inverse intervention law reinforces rather than undermines the importance of structural factors on child welfare intervention rates’ (p.104). In some contrast, Hood et al. (2016), found higher levels of referral and higher levels of intervention rates in areas where there are higher levels of deprivation than their more affluent counterparts. Thus, they questioned whether child protection work is carried out differently depending on the socio-economic profile of children and families. They found significant differences in how the work is managed which was correlated with the level of deprivation and affluence in a particular area. They also found that statutory services in deprived local authorities rely more heavily on non-statutory services to meet demand and cuts to these services at times of austerity led to increased child protection referrals with a higher level of need. A point agreed on by both sets of authors is that statutory services in affluent local authorities had the capacity to meet more of the overall demand.

The need for a new and more humane paradigm which promotes community cohesion is promoted by Bilson and Martin (2016). Lonne et al. (2009) agree and assert ‘[f]ragmented remedies based on one-dimensional revisions will not alter the system failures’ (p.101), rather they propose ‘a comprehensive revision of principles, policies and practices ... that values the lived experience of children, their families and their communities must be developed’ (*ibid*).

The promotion of children’s rights has also been identified as an important facet to the provision of child protection services according to Parton (2014a), who comments about the patchy adherence to this issue in the UK thus far. He argues that while there is an acknowledgement of the need to move beyond the protection of children from adult perpetrators there is reluctance on the part of

government to look at institutions, harmful policies and laws, conflicts, failure of governance and social disruption which can detract from children's rights. There is a need, Parton (2014a) argues, to adopt a public health approach to child maltreatment, pointing out that it has 'cultural, institutional and structural dimensions as well as individual ones' (p.192).

The 'child focused orientation' identified by Gilbert et al. (2011) 'concentrates on the child as an individual with an independent relationship to the state [and] with a child-focused orientation, the state takes on a growing role for itself in terms of providing a wide range of early intervention and preventive services' (p.252). Gilbert et al. (2011) caution, however, that such an approach with its focus on the individual is 'potentially opposed to the family' (*ibid*). They suggest that rather than be seen as a discrete model for intervention, it should be viewed as an 'orientation' from which elements could be used. Featherstone et al. (2014: p.152) issue even stronger warnings about the child-focused approach, cautioning against 'defamilialisation' which may, they argue, feed into a 'child rescue project'.

Recent commentary from the newly appointed chief executive of Tusla provides an interesting perspective on this debate and shows the current thinking within the agency regarding the responsibility of parents to seek solutions to the difficulties that they and their children are experiencing:

'Certainly part of my approach is getting families to own the problem, because unless they own the problem we're not going to be able to work with them to move it on, and of course if they don't own the problem then the State's intervention increases accordingly It's not the State's problem, it's the family's problem, but our job is to try to support them to come up with solutions to their problem' (Available at: <http://www.thejournal.ie/tusla-chief-executive-3046658-Oct2016/>)

Featherstone et al. (2014) drawing on the work of Cottam (2011) agree with Bilson and Martin (2015) that approaches to working with children and families need to adopt a developmental approach. However, they also add that such approaches need: to be realistic about risk and acknowledge the importance of resilience; focus less on infrastructure and more on relationships; be concerned about the context in which families live; learn from models that are not focused exclusively on child protection and develop rigorous research and awareness of 'the consequences of inequalities for children and parents' mental health and physical, self-harming behaviour and abuse' (Featherstone et al., 2014: p.154).

Gilbert et al. (2011) conclude their study with the observation that the three dominant orientations in contemporary work with children and families, which they term child focus; family service and child protection, 'can be seen to range along a continuum from a more laissez-faire neo-liberal approach that emphasises the watchdog functions of government to the more social democratic approach that

advances policies associated with defamilialisation’ (p.255). Most countries, they assert, contain a mix of some of these orientations and they suggest that instead of trying to place countries somewhere along a continuum from child focus to family service to child protection it is more useful to consider where they might fall within a three-dimensional framework.

Managerialism, bureaucratisation and proceduralisation

A further important facet to modern day child welfare systems is the neo liberal pre-occupation with risk that has emerged in the wake of child abuse scandals together with a demand for value for taxpayers money. These factors have contributed to the increase in bureaucratisation, proceduralisation and managerialism in social work in Ireland and elsewhere (Parton, 1998; Kemp, 2008; Buckley, 2008). Efficiency and transparency have become important goals in child protection systems as in other areas of work. The fiscal crisis, Kemp (2008) contends, has meant that all public services, including welfare services, are now looking more towards the ‘three E’s’ of economics, efficiency and effectiveness as well as value for money. Buckley (2008) observed that ‘new public service management’ has increasingly become part of the provision of statutory social work services in Ireland, its aim being to streamline and make accountable the provision of services. However commentators have cautioned that this drive towards increased bureaucratisation, can stifle the ‘helping relationship’ that is seen as central to the very essence of social work (Howe, 1992; Munro, 2011; Buckley, 2012). Concepts such as key performance indicators, which are central to such managerialism, demand the measurement of output and imply that child protection work can be quantifiable and good practice and good outcomes for children and families measurable. Buckley (2008) also points out how performance indicators prioritise the use of very concrete and visible approaches to intervention, thereby limiting the use of less formal and resourceful methods of working. She also suggests that they imply that child abuse and neglect are easy to identify and address and that failure to do so is the fault of the worker rather than due to the complex nature of the many different scenarios that unfold. McGhee and Waterhouse (2007) also caution that the over proceduralisation of social work can mean that the wider contextual concerns families face are ignored in favour of those that can be easily classified by the agency and the systems it has established. Added to this ‘are the inherent conflicts and unintended consequences of trying to streamline such an unwieldy and uncertain area of work, and at the same time, prevent it from alienating the children and families whom it is intended to serve’ (Buckley, 2008: p.9). This is despite numerous claims in research about the crucial importance of the relationship that is formed between social worker and client, albeit difficult to measure or quantify, (Spratt, 2001; Trotter, 2002; Dale, 2004; Buckley, 2008; Buckley et al., 2008).

While guidelines and procedures have underpinned Irish child protection since 1977, Ireland has, by international standards, been slower to implement regulation compared with other jurisdictions. Consistency has been difficult to achieve in Irish child protection work, and while standardisation has been attempted in a material way, a lot of variation has endured. Kemp (2008), for example, has noted the irony that the more attempts that are made with statutory social work services in Ireland to homogenise practice, the more divergent the practice has become at local level. He cites the example of *Children First* which was shown to have been interpreted and implemented in diverse ways across the regions (Office of the Minister for Children and Youth Affairs, 2008). The establishment of a national computer based information system has been slow in Ireland, reflecting a national ambivalence towards the sensitive business of regulating families, as noted by Buckley (2003) who pointed out that:

‘The backdrop of constitutional and ideological reverence for the family has made it less politically possible to acknowledge and own responsibility for a social problem such as child abuse, let alone set up complex administrative and managerial systems to address it’ (p.10).

Yet despite a slow start, and concern from commentators regarding the misfit between social work and proceduralisation, with the advent of the NCCIS project in 2007, such a system has arrived in Ireland. However, as highlighted in Chapter 1, the introduction of forms, such as the intake record form, in advance of the ICT project being ready has led, in keeping with Kemp’s (2008) assertion, to some variation in practice rather than the standardisation that the NCCIS Project set out to achieve.

Howe’s (1992) paper on the bureaucratisation of social work is an oft quoted seminal work on the topic. Using Callon’s (1986) concept of ‘translation’ as a backdrop he shows how the shift away from helping parents to change towards one of protecting children necessitated the development of guidelines and procedures to improve social work assessments and management structures to address the criticisms that were being levelled at the profession. Howe warned, however, that adding new procedures to social work in the wake of tragedies would only serve to compound the problem and would push the social worker into what he termed ‘defensive practice’ and will leave her more concerned with the procedures she must follow and less sensitive to the needs of the children and families she is working with. These were prophetic words indeed when one looks at how child protection practice has evolved since Howe wrote that article twenty five years ago and the impact child deaths have had on the drive towards proceduralisation.

The Integrated Children’s System (ICS) in England, described as ‘a centrally prescribed practice and performance management model, configured and embedded through information technology (IT)’ (White et al., 2010: p.406), was first mooted in 2000 and gained momentum following the death of Victoria Climbié and the key finding in the resultant Laming Report (2003) regarding deficits in information sharing amongst professionals:

‘Such appalling incidents periodically punctuate the conscience of the nation, evoking moral panic, political embarrassment and inevitably, the clamour for “something to be done”’ (Wastell, 2010: p.423).

However, the downsides to this development were soon recognised, and it has been claimed that the time spent by social workers entering information detracts from their availability to directly engage with children and families (Munro, 2011: p.137) and that ‘far from increasing child safety, the ICS paradoxically put children at greater risk’ (Wastell, 2010: p.424). Featherstone et al. (2012) add that information sharing in child protection is not straight forward and is influenced by a range of human, social and interactional factors and ‘not readily responsive to exhortations to “share information”’ (p.52). White et al. (2010) carried out extensive ethnographic research with social work referral and assessment teams amongst others in England and Wales and found that not one social work practitioner or manager was happy with the system. White et al. (2010) also describe how the performance management timescales inherent were, in the practitioners view, stifling their practice and importantly, the use of their own professional judgement:

‘A familiar concern across our sites was the omnipresence of performance management timescales and targets. ICS serves to further instantiate these in day-to-day practice, providing little scope for workers to exercise intelligent discretion. For example, worries about timescales for initial and core assessments came to dominate practitioners’ worlds’ (p.412).

The research carried out by White et al. (2010) led them to conclude that information systems (IS) don’t enhance social work practice, their findings show that the electronic methods don’t necessarily make the related tasks any easier but they contend this supposition has never been interrogated or explored by those who are making the decisions to instigate such systems:

‘The re-configuration of professional work into formalized ‘business processes’ [had] an affecting but troubling faith in the power of information and communication technologies (ICTs)’ (p.407).

The ICS came to be considered as a ‘foundering project’ to which the stakeholders were seen to be overly attached and unable to see the faults (*ibid*). Deficiencies in the system came increasingly under the spotlight following the conclusion of the trial into the death of Baby Peter Connelly in 2008 and a social work task force set up to examine all aspects of social work included a comprehensive review of the ICS (Wastell and White, 2014).

In Ireland little or no empirical or ethnographic research has been carried out into the operation of NCCIS project to date and given that the ICT aspect of the project is at the piloting stage there is little of that to evaluate as of yet. Featherstone et al. (2012) carried out a small empirical study with a team involved in the NCCIS project, which at that time was at an early stage of implementing the standard business processes described in Chapter 1. While they found that that the processes did

seem to be impacting positively on auditing the service there were some reservations expressed about the precedence of time frames over professional judgement. The introduction to Irish child protection services a version of a system that has been critiqued in other jurisdictions has been considered paradoxical by Featherstone and her colleagues, who note that ‘at time where developments such as standardisation are under serious scrutiny in England, they are being embraced in Ireland’ (p.49).

While in the recent past commentary in the literature has tended to focus on a critique of the shortcomings of information systems (IS) within social work and its negative impact on practice, Gillingham (2016) suggests that while the drawbacks need to be understood, lest the same mistakes be made again, they also need to be overcome given how ubiquitous IS is in modern society. Attention, he contends, is and should now be on how the systems can be re-designed to support rather than hinder practice. Wastell and White (2014) agree and suggest that ‘there is an alternative to the incumbent paradigm and the socio-technical approach to the design of systems for social care’ (p.218).

Gillingham (2016) goes on to list the reasons why problems and drawbacks have arisen such as: IS developers lacking in knowledge about front line social work practice and frontline practitioners being unable to define their needs; the needs of managers taking precedence over those of frontline practitioners and social workers not being involved at the early design stage or design process. Involvement of staff in development of the ICS was espoused from the outset according to Wastell (2010) however the research by White et al. (2010) revealed that in reality ‘its design had been highly centralised, led by a small cadre of senior civil servants and expert advisers. Input from social work practitioners has been very limited, and feedback from the field has had minimal impact on design; oft heard are tales of requests to simplify the exemplars, for instance, going routinely ignored’ (Wastell, 2010: p.423).

Munro (2012) and Wastell and White (2014) chart new innovative developments in social care informatics in England which strive to overcome the deficits of the ICS and better meet the IS needs within social work. For example *E-Table* strives to better mimic the sensory and visual experience of spreading out files and reports on families when trying to make sense of a family’s history and produce chronologies which to date is difficult to replicate on small 2D screens.

At the heart of the critiques of the ICS and suggestions for future development of IS in social work is ‘the need to involve users in the design process and to base design on careful ethnographic observation in the workplace [and] the need to prioritise practice over process, seeking solutions that augment autonomy, retaining the local flexibility ... which is essential to getting the job done’ (Wastell and White, 2014: p.218). Gillingham (2016) echoes this when he recommends that participatory design needs to be central to the redesign of IS with ‘the functionality matched to practice initiatives and with practitioners directing technologists, rather than the other way around’

(p.333). Gillingham (2016) highlights the paradox of how social work activities are modelled procedurally in current IS designs as if all variables can be predicted and planned whereas in reality social workers are constantly reacting to information and situations within very different contexts.

In Ireland consultation regarding the development of the NCCIS Project was carried out over a number of years in advance of it being introduced and ‘the detailed processes were designed by way of extensive consultation with stakeholders throughout the country’ (HSE, 2009: Appendix C). These stakeholders who formed ‘expert teams’ were nominated by the Children and Family Services, National Steering Committee and were familiar or had practical experience of child care processes. They also had the ‘experience and authority to make changes (where required) to procedures and information issues that affect the management of child care services nationally (and) to the tasks, case management, information and definitional issues that affect the practice of social work nationally’ (p.7). Notably there is no mention of consultation or evaluation of the business processes with the front-line practitioners operationalising the forms and processes.

There are many lessons that the NCCIS Project can take from the experience of the ICS in England as it begins to be rolled out and in time is evaluated. Featherstone et al. (2012) recommend that Ireland learns from England’s mistakes and avoids prioritising the management of ‘institutional risk’ over improvements to practice. Kemp (2008) agrees, arguing that risk and the management of risk is becoming a predominant focus in Irish social work which he contends ‘has created an atmosphere of defensive practice, where doing the thing right is far more important than doing the right thing’ (p.106). Proceduralisation and the IS which accompanies it can, it would seem from the English experience, stifle a practitioner’s professional judgement and creativity when responding to the needs of families and deflect them away from the time needed to invest in developing meaningful and trusting relationships. As Munro (2005a) puts it ‘which matters most – the child or the performance indicator?’ (p.398). Featherstone et al. (2012) conclude ‘Ireland should grasp the opportunity to embrace principles of system design which aim at building trust and supporting the front-line professional task, guarding against the seductive proxies for quality that timescales and targets produce. These create new arenas for blame and tend to spawn more of themselves in response’ (p.60).

Conclusion

Like the development of child welfare systems elsewhere the foundations of the system in Ireland are embedded in the history of its evolution. The system, and the principles upon which it is based, are broadly similar to Gilbert’s (2012) summary of a modern day ‘child protection’ approach where the identification and investigation of abuse remains centrally important largely due to high profile child abuse inquires and scandals but simultaneously there is a more recent identifiable shift towards

family support, prevention and early intervention. The importance of child welfare and early intervention was formally acknowledged towards the end of the last century with the publication of *Children First* and in a more structured way with the advent of a new service delivery framework for the newly established Child and Family Agency. However, then and now, concern continues to be expressed about an over emphasis on child abuse investigation within the system, the focus on blaming parents and the high levels of attrition as children and families move between each stage of the child protection and welfare process. Added to this, it is anticipated that the impending introduction of mandatory reporting will lead to a sharp increase in reporting rates to child protection services which could divert even more attention and resources away from preventative services and more towards investigation. In preparation for this, and consistent with modern day demands for increased accountability in the public sector, Irish child protection systems are now structured by a suite of standard business processes and performance indicators and the IS to accompany these processes. Against a backdrop of compelling calls from our nearest neighbours to learn lessons from their experience of the ICS, the NCCIS is about to be launched.

Ireland has made some meaningful strides in acknowledging children's rights in recent policy and legislative developments and this emphasis on children's political, social and legal rights is seen as a key consideration in the search for a new paradigm for social work. While there is disagreement in the literature on whether an over emphasis on a child focussed approach will lead to a dereliction of the importance of a child's relationship with his or her family and a reduction in parental responsibility, there is broad agreement that any new paradigm must meaningfully consider and address the structural issues, which massively impact children's lives, and a need to focus on the development of family and community strengths. The formalisation of links between statutory social work services and the community and voluntary sector within the new service delivery framework go some way towards meeting these goals but the need for meaningful efforts to acknowledge and address the impact of poverty and deprivation on the needs of children and families within child protection services remain.

It is suggested by Gilbert et al. (2011) that most countries contain a mix of orientations in their provision of child protection and welfare services and certainly this is the case in Ireland. They also make the pertinent point that 'the fragile and uncertain nature' of child protection and welfare work should never be underestimated and that a sudden crisis can easily change the focus or orientation of a system in a country such as happened in the UK in the aftermath of the deaths of Victoria Climbié and Baby P. Significant change in service provision in Ireland has also come following high profile child abuse inquiries most notably the Kilkenny Incest Investigation and the Ryan Report. Only time will tell whether the provision of child protection and welfare services in Ireland will continue along the same trajectory or what change lies ahead. This thesis will, by explicating the processes involved in responding to children and families and, in the process, detailing for the first time the nature of

concerns experienced by service users of the system, indicate how far services have come along the continuum of reform, and the lengths to which they will have to go in order to meet the aspirations so zealously expressed by our legislators and policy makers. The following chapter will continue to review research on child protection, focusing in particular on the way that reports come to the attention of statutory child protection and welfare services.

Chapter 3 Referrals and Re-Referrals

Introduction

The majority of child protection systems in Anglophone countries are experiencing a particular type of referral activity, that is, while the number of reports rises each year, there is a parallel increase in the numbers of cases filtered out, or unconfirmed by preliminary screening and assessment. In the meantime, the ability of the system to capture genuine maltreatment reports is subject to challenge, illustrated by Jenkins et al.'s (2017, p163) depiction of child protection services as receptacles for both under and over-reporting, the former concerned with serious incidents of child abuse and the latter with cases which mostly do not require 'significant intervention'. The proportion of cases that are re-referred also raises questions about the accuracy of preliminary judgements. This section will examine data sets from different jurisdictions and draw on empirical research findings to elucidate the process of referring and re-referring suspected child harm to statutory services and demonstrate commonalities and differences.

Definitions of referral and methodological challenges

An obvious starting point for a study of child protection intake systems is to define what is meant by the action of 'making a referral'. In Ireland, official guidance for statutory practitioners defines a referral as 'the first point of engagement/contact between a social work department and a referrer or reporter (i.e. the general public and others)' (Tusla, 2014d: p.25). It goes on to note that '[t]he social work department has no control over the nature, volume, frequency, timing or indeed any other feature of a contact. Like any referral process, the duty social worker must first decide if a contact is in fact a "referral"' (*ibid*).

The NSPCC, presenting reporting data for the United Kingdom, define referral in a similar way:

'A referral is the first stage of the child protection process in all four nations. A referral will be made about children because some aspect of their life is giving cause for concern. It is worth noting that some referrals are for services (e.g. disabled children) so not every referral is the first stage of the child protection process. It is also worth noting that an initial contact is not a referral. A referral is a referral when the local authority accepts it as such' (Jutte et al., 2014: p.52).

The two definitions make the same pertinent point: that a reported concern is only construed as a referral when the person or authority receiving it accepts it to be so. Accepted referrals, also termed 'reports', represent the concerns which meet the criteria for action from the statutory child protection

and welfare services provided by that jurisdiction. Bilson and Martin (2016), writing in a UK context, elaborate further:

‘The statutory child protection process starts with a referral to children’s social care (CSC). Anyone with a concern about a child’s well-being can make a referral. Some referrals do not meet the statutory threshold for assessment by CSC and are directed into universal services or Early Help’ (p.3).

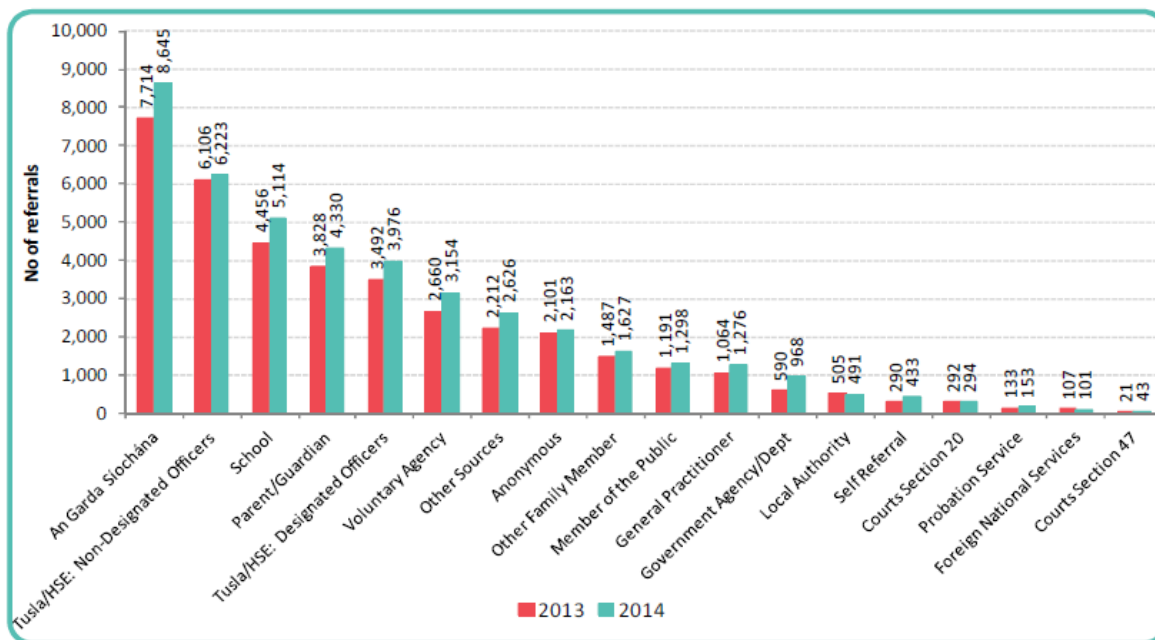
Inter jurisdictional and even inter-regional comparisons may not always be methodologically valid, a point made by Cleaver et al. (2004) and also by Forrester (2007) who observes that categories may not always be consistent or conceptually clear. These methodological considerations notwithstanding, comparisons still offer important insights into the reporting patterns within the area researched for the current study.

Who is referring to child protection services?

Empirical research and available administrative data from different jurisdictions together indicate a general trend, whereby the most frequent referrers to child protection services are police, educators, health and social services and friends, family and neighbours. There is some disparity regarding which group makes the most referrals, and thus it is difficult to make generalisations or draw comparisons. The breakdown of the referrers to child protection services in a particular area seems to be influenced by factors such as the structure of local service provision and whether certain or all professionals in contact with children are mandated to report suspected child harm.

The most recently published Irish data that identify reporters to child protection services were published in 2014 (see Figure 3.1 below) and shows An Garda Síochána (the Irish police) as the most frequent referrers in 2013 and 2014, followed by Tusla (previously HSE) staff, then schools followed by parents and guardians. In 2014 the referral source was provided in 98% of the administrative data pertaining to referrals returned to Tusla headquarters for analysis, and of those 20% came from An Garda Síochána, 15% from Tusla staff, 12% from schools and 10% from parents and guardians (Tusla, 2014b).

Figure 3.1 Source of referrals to child protection services in Ireland 2013-2014



Source: Tusla Quarterly Data Returns

Source: Tusla (2014b: p.63)

Up to date data on referral source are available from all four countries of the United Kingdom. In Northern Ireland figures from 2015/2016 show that for the year ending 31st March 2016 police were the more frequent referrers (26%), followed by social services (21%), hospitals (8%), school/educational welfare officer (6%) and relatives (6%) (Information Analysis Directorate, 2016: p.12).

In England, figures for the year ending 31st March 2016 also show the police as the main referrers (28%), followed by schools (17%) (with a further 3% referred by ‘education services’), health services (14%), local authority services (13%) and individuals (9%) (Department for Education, 2016: p.6).

In Scotland, reports to Scottish Children’s Reporter Administration (SCRA) show that 64% of the reports came from the police for the year ending 31st March 2016, the next most frequent reporters were social work services (26%), schools (8%) and Courts (2%) (Scottish Children’s Reporter Administrator, 2016a: p.17).

Data regarding referral source in Wales are presented for the children who became ‘a child in need’ for the year ending 31st March 2016 and these data shows a fairly even spread of referrals across the four main referrers: other departments of own or other local authority (19%); local authority’s own social services department (19%); police (18%) and primary health/community health (17%). The next most frequent referrer was family, friend or neighbour 9% (Welsh Government, 2016).

Looking internationally to other Anglophone countries, where similar data are available, latest statistics from the U.S. Department of Health and Human Services show that in 2015 the largest percentage of referrals across the U.S. came from education personnel (18.4%) followed closely by legal and law enforcement personnel (18.2%), social services personnel accounted for over a tenth (10.9%) of all referrals received and a slightly smaller proportion (9%) came from medical personnel. Taken together non-professionals, which included parents, other relatives, friends and neighbours, alleged victims and alleged perpetrators, accounted for 18.3% of the referrals received in 2015 (US Department of Health and Human Services, 2015: p.8).

National figures published in Canada in 2010 reveal the main sources of referral to child welfare services were schools (24%), followed by the police at 22% and community, health or social services at 12%. Non-professional reporters taken together accounted for 27% which included: custodial or non-custodial parent (11%); relative (7%); neighbour/friend (7%) and child (subject of referral) (2%) (Public Health Agency of Canada, 2010: p.26).

Data from Australia, regarding the source of referral to child protection services, are presented as the number of investigations by source of notification and this shows the main sources of such notifications as the police (22%), school personnel (17%), social worker (12%), family (11%) and medical/health personnel (11%) (Australian Institute of Health and Welfare, 2016: p.73).

As evidenced above, the police are active reporters to child protection services and represent the largest proportion of reports in five of the child protection systems cited above. Schools and education services feature in the top three reporters of six of the countries, the only exceptions being Wales and Northern Ireland, and social services feature in the top three of six of the countries detailed.

Of course it should be noted that the foregoing figures are national averages and studies which concentrate on particular areas can and do identify very different trends. For example, Forrester (2007) found that in a study conducted in 2000 of 400 closed referrals to three London local authorities, that referrals were received from a very wide variety of sources with parents and the police accounting for more than 50% of the total. Only three other referral sources individually accounted for more than 5% (schools, housing and hospitals). Winter and Connolly (2005) examined all referrals received by two family and child care teams in Northern Ireland during a three year period and found that referrals came most commonly from professionals such as health visitors and teachers, family members and neighbours.

In 2002, Mc Daniel reporting on statistics from the US Department of Health and Human-Services Administration on Children, Youth and Families (2002) detailed that 'a little more than half of the reports that led to investigation in the US were made by professionals such as doctors, teachers, police officers and social workers who are mandated by law to report suspected child maltreatment

and the remaining reports (43.6%) were initiated by non-professionals (i.e. family members, friends, neighbours, alleged victims, and anonymous sources)' (p.308). However, in her own study of 1260 low income families in Illinois considered at risk of a child maltreatment report, mandated reporters had made the reports in the majority of cases (64%), while neighbours, friends, family members and anonymous sources reported the remaining 36%.

Wattam (2002) in a review of research of referral rates to English local authorities drew attention to the low numbers of self-referring children. A review of the statistics presented above from Ireland and elsewhere also reveals very low levels of self-referral across all countries where this information is provided for the year 2015/2016: Ireland (1%); Northern Ireland (2%); Wales (0.6%); US (0.4%); Canada (2%) and Australia (0.3%). This could infer either that children and young people lack confidence in the ability of the service to meet their needs or that they lack information about sources of help for themselves or their siblings or peers.

Reason for referral

The process of measuring reasons for referral is subject to a number of methodological challenges. For example, datasets and research findings on the reasons for referral need to be treated with some caution. Forrester et al. (2007) points out that authors who report only the main presenting problem may omit the prevalence of other issues, deemed secondary, thereby limiting the usefulness of their findings. They go on to highlight the need for a reliable and valid typology of need to facilitate accurate descriptions and overall they conclude that 'descriptions of "main" need did not appear to be reliable for either allocated cases or closed referrals [as] crucially decisions about "main" need often involve implicit or explicit ideas about chains of responsibility' (Forrester et al., 2007: p.57).

Most contemporary research studies detail the steps taken to ensure inter-coder reliability which typically include content and code development by a number of people (see for example Manion and Renwick, 2008) and also present findings on the multitude of issues in the lives of the children and families researched. Some older studies omitted this detail, for example Cleaver et al. (2004) conducted one of the first British studies which looked at a large sample of referrals to social service departments. They reviewed 2248 referrals from 24 local authorities and provided information on the main presenting concerns. These comprised: child protection concerns (30%), 'other parenting issues' (15%), a child or young person being beyond parental control (11%) and those which had domestic violence as its main concern (10%). Almost a fifth (23%) of the referrals related to other issues including parental mental illness, parental alcohol and drug misuse, disabled children and asylum seeking. The remaining 11% were categorised as 'other' and referred to by the authors as 'a rag-bag of reasons' (p.171). While these findings are noteworthy, Forrester (2007) has criticised their

applicability because the categories used are not conceptually clear and the authors reported only on the main presenting problem.

Gibbons et al. (1995) completed a seminal study of 1,888 cases referred to eight English local authorities. The largest proportion of those referred (44%) was for suspected physical abuse, next was suspected sexual abuse (28%) and just over a fifth (21%) were referred for neglect. Only a very small proportion (3%) concerned emotional abuse without any of the other forms of maltreatment. They also looked for evidence of characteristics common to the children's parents which have been identified by the literature as risk factors in child abuse. While there was variation across the eight authorities, overall they found violence to a partner in 27% of cases, substance abuse in 20% of cases, mental illness and criminal records in 13% of cases and a parent who was themselves abused in childhood in 12.5% of cases. This study, however, is 22 years old and it could be claimed that understanding of different types of abuse has modified in the interim, as well as guidance on what types of child harm may be reportable.

More recent studies show a different pattern. Manion and Renwick (2008) in a review of 988 cases which proceeded from intake to an investigation, found that neglect was reported in 44% of cases, emotional abuse in 32%, physical abuse in 36% and child sexual abuse in 13%. Where physical abuse was reported they found an over-representation of violent care-givers and cases where domestic violence was present in the family. Overall 36% of cases demonstrated issues of domestic violence and 33% demonstrated issues of care givers with violent behaviour. Care-givers' substance abuse was suspected in 23% of cases and care-giver mental health issues in 13%. Custody disputes were recorded in only 7% of cases and the researchers comment that this could have been under-reported in case notes. Manion and Renwick (2008) also found that young people between the ages of 13 and 17 years had the highest rate of behavioural difficulties and they highlighted a particular gap in services for caregivers managing these behaviours.

Parental substance misuse has, over the years, been identified as a recurring parenting issue by studies on referral to child protection services (Gibbons et al., 1995; Mc Ghee and Waterhouse, 2007; Manion and Renwick, 2008, King and Scott, 2014). Mc Ghee and Waterhouse (2007) also cited parental substance misuse as a crucial feature in the lives of the children referred to the Scottish children hearing system and they also identified domestic violence as a contributor to the rise in referrals.

Forrester's (2007) study identified the most common reason for referral as concern about abuse or neglect (one third of cases) though there was only evidence of maltreatment having occurred in 11% of the sample. Other common reasons comprised concerns about parental capacity (e.g. mental illness, alcohol or drug misuse or violence in the home), which accounted for nearly a third (30%) of referrals. Social problems (housing or financial) were cited as reasons for referral in 34% of cases

and a quarter of the reports (25%) identified parent /child relationship difficulties (generally teenagers with accompanying requests for the child to come into care).

As previously mentioned, there is a dearth of Irish empirical research on child protection and welfare services and prior to the current study no empirical research had been carried out on referral and reporting trends to these services.

Characteristics of the children reported

In general, administrative data are available from most jurisdictions on the age, gender and ethnic backgrounds of the children considered to be in need of a service. However, it is notable that Irish administrative data on reports to child protection and welfare services do not detail such demographic information. Information on the demographic profile of children reported is also provided in some research studies. While there is some disparity in the available information, some discernible trends are evident, as detailed below.

Age

While statistical data showing age breakdown of children referred are not routinely published in Ireland such data on children in need (England, Scotland, Wales and Northern Ireland), ‘investigated’ children (Canada), child victims (U.S.) and children receiving child protection services (Australia) are available. While it cannot be assumed that this data is representative of the age profile of all the children reported in these countries, they do provide an interesting insight into the ages of children who are receiving child protection services. In detailing the age profile of these children, most jurisdictions group them into age bands. As these groupings are not uniform, data linkage becomes difficult but summary reports provide some useful information. For example, the Department for Education made the following observation in relation to children classified as in need in England for 2015-2016:

‘The age split of children in need at 31st March 2016 also remains similar to previous years. The largest age group is those aged 10-15 years accounting for 30.6% of children in need; 23.6% are under 5 years of age’ (Department for Education, 2016: p.4).

Published data show that in Northern Ireland children in need had a slightly older age profile with ‘36% aged 12 and over compared with 32% of the overall child population’ (Information Analysis Directorate, 2016: p.10). Scottish figures are provided for the number of children reported to the SCRA (see Table 3.1 below) and this figure also shows a predominance of older children with

the largest proportion (37%) in the 13 to 17 year old age category (Scottish Children's Reporter Administration, 2016b: p.8).

While older children are the largest group receiving services in the UK, the age profile in Canada, the U.S. and Australia is lower. The highest rate of investigated maltreatment in Canada relates to infants (Public Health Agency of Canada, 2010: p.36) with similar data in the US² and Australia³.

Disparities notwithstanding, available administrative data indicate that young children and teenagers are the age groups most likely to be reported and involved in child protection services and this finding is also replicated in empirical research outlined in the literature. Forrester's (2007) study, for example, reports that out of a total of 770 children in the 400 families studied, young children, particularly children 2 years old or less (23%) and teenagers (16% were 15-17 years) dominated the sample.

Table 3.1 Age profile of children reported to the SCRA 2015/2016

Age profile of children reported to the SCRA 2015/2016		
	Frequency	Valid percent
Less than 1 year	1240	7.5
1 – 4 years	2918	17.6
5 - 8 years	3024	18.2
9 - 12 years	3251	19.6
13 – 17 years	6,144	37.0
Total	16,577	100.0

Source: Adapted from Scottish Children's Reporter Administration (SCRA) (2016b) p.8

Gender

In general there are no substantial differences in the number of boys and the number of girls reported to child protection services (Forrester, 2007). Parton (2014a) points out that the relationship between

² '52 states reported that more than one-quarter (27.7%) of victims were younger than 3 years. The victimization rate was highest for children younger than 1 year (24.2 per 1,000 children in the population of the same age)' (US Department of Health & Human Services, 2017: p.20).

³ 'Across Australia in 2014–15, infants (children aged under 1) were most likely (35.1 per 1,000 children) to be receiving child protection services and those aged 15–17 were least likely (19.4 per 1,000 children). This pattern was consistent across all jurisdictions except New South Wales, where children aged 5–9 were most likely to be receiving child protection services' (Australian Institute of Health and Welfare, 2016: p.15).

child maltreatment and gender is far from straightforward however, in terms of both perpetrator and victim. In the UK, two large scale studies were carried out by the NSPCC looking at the prevalence rates of all forms of child abuse in 2000 (Cawson et al.) and later in 2011 (Radford et al.). The second study drew its findings from over 6,000 interviews carried out with randomly selected parents/guardians, children and young adults. This research found that mothers and mother figures were responsible for marginally more abuse to under 11s, while fathers and father figures were reported to be slightly more responsible for abuse to 11-17 year olds and domestic violence against another parent. For specific types of abuse, there were also notable gender differences with significantly more males responsible for severe physical abuse by a parent or guardian and contact sexual abuse in childhood. In terms of the gender of the children maltreated, females aged 18-24 reported significantly higher levels of severe maltreatment during childhood than males.

Bilson et al. (2015) found, in a longitudinal study, that females tend to be more involved with child protection services than males and are much more likely to be the subject of child sexual abuse reports. Mannion and Renwick (2008) also found that child sexual abuse was most commonly reported for female children between the ages of 9 and 12 years and that self-harm, where reported, was more common amongst girls (85% of all reported cases).

Ethnicity

Chand and Thoburn (2006) observed a paucity of information on the ethnic profile of children reported to child protection services. It is notable that in Ireland, despite evidence of a growing multi ethnic population (Central Statistics Office, 2017: p.60), the standard intake record form, used by statutory services, does not provide for the recording of a child's ethnicity and therefore no administrative data are collected on this topic. Chand and Thoburn (2006) further observed that even in jurisdictions where such data are collected, different ethnic groups are often combined into one therefore making it difficult to draw out the issues specific to individual ethnic groups. It is almost universally evident, however, that children from ethnic minorities are disproportionately represented in child protection statistics. For example, in the UK in March 2002 17% of all children who received a formal child protection service were of minority ethnic origin compared to 13% ethnic minority children recorded in the UK Census (*ibid*). Drake et al. (2011) noted that reports about black children in the US were made and substantiated twice as often as white children. Forrester (2007) also reported a wide range of ethnicities in referrals received, continuing a trend noted back in 1995 by Gibbons et al. where 25% of the children reported were from a minority ethnic group. More recently, Bilson et al. (2015) found 'worryingly high and accelerating rates' of Aboriginal children involved in child protection services in Australia, estimating that they were nearly four times more likely to be referred and one and a half times more likely to be re-reported' (p.781).

Debates within the literature and research about the reason for this over-representation offer differing explanations: whether the children are subject to greater risk, or whether they are the subject of bias in particular communities (Jonson-Reid et al., 2009; Drake et al., 2011; King and Scott, 2014). Drake et al. (2011) opt for the former explanation, finding that the overrepresentation of black children over white in reports made to child protection services is 'attributable to higher risk than reporting bias' (p.471). Somewhat conversely, Klein and Merritt (2014) found that for Black, Hispanic or White children under the age of 18 years living in racially/ethnically diverse communities rather than racially/ethnically homogeneous communities 'is a clear risk factor for child welfare system involvement' (p.101). This finding, the authors assert, is consistent with social disorganisation theory which shows that racially/ethnically homogeneous communities tend to be more cohesive as neighbours share and promote community values, such as those linked to appropriate parenting and child safety.

Drake et al. (2011) also reported on what they termed the 'Hispanic paradox' where Hispanic children benefit from the presence of protective moderating factors such as strong maternal support networks, healthy dietary practices and women's devotion to the maternal role which offset the relationship between poverty and poor outcomes for these children. As outlined in Chapter 2, Bywaters et al. (2015) term the explanation for such occurrences as an inverse intervention law of demand, where, for example, communities such as those referenced above have good support networks thereby lessening the demand for services, and supply whereby reporters in such communities become desensitised to the existence of difficulties amongst families or have higher thresholds and therefore there is an underreporting of concerns. What is agreed upon in the literature is that more research and attention is needed to better understand ethnicity and referral to child protection services and certainly a good starting point for Ireland would be for the collection of such administrative data.

Structural and economic issues

Research has inevitably established links between deprivation and child vulnerability. Parenting alone, family size, lack of a wage earner, unstable living conditions, poverty and general deprivation are all identified as factors associated with referrals to child protection and welfare services (Thorpe 1994, 1997; Gibbons et al., 1995; McDaniel, 2006; McGhee and Waterhouse, 2007 and King and Scott, 2014). However, this connection has not always received the level of attention that is warranted. Over twenty years ago Stevenson (1996) cautioned social workers not to become immune to families 'bumping along the bottom' and ten years ago McGhee and Waterhouse (2007) wondered why 'despite the consistent pattern of social adversity found in the backgrounds of children caught up in welfare provision, the significance attributed to this dimension of their lives remains ambiguous' (p.153). Consideration of such environmental factors is strongly advocated by Winter

and Connolly (2005) and more recently by Garrow and Hasenfeld (2017) who argue that social researchers have a responsibility to ‘interrogate the structural determinants of the oppressed and marginalized’ (p.494).

Hood et al. (2016) demonstrated, using correlation and factor analysis, how the level of deprivation in an area impacted on the service provided in response to the referrals received. Unsurprisingly local authorities in more deprived areas showed, amongst other factors, higher levels of demand in terms of the rates of referral, more screening out of referrals, a tendency to step down statutory plans quickly, a lessened likeliness to work longer term with families and higher levels of re-referral rates. Winter and Connolly (2005) went so far as to claim that it was possible to predict the number of child protection referrals (81.5% accuracy) and the number of child care concern referrals (91.4% accuracy) on the basis of deprivation measures in relation to health and employment.

The visibility of the children who are referred

The data referenced above makes a persuasive case about the link between deprivation and higher levels of reporting. However, this topic requires further probing to establish whether less well-off children are subject to biased judgements in the community in respect of working class child rearing norms, or subject to increased risk due to the co-existence of poverty and need. Nearly four decades ago, Pelton (1978) proposed that poorer people were subject to higher levels of public scrutiny with the corollary of greater involvement with social and law enforcement services. However, in a later work, Jonson-Reid et al. (2009) considered the question of bias and need using a range of data from different sources and offered a contrary view, concluding that ‘the overrepresentation of poor children is driven largely by the presence of increased risk among the poor children that come to the attention of child welfare rather than high levels of systemic class bias’ (p.422).

Other commentators have offered a slightly more refined analysis, theorising a link between the identification of child harm with the level of access that potential reporters have to children. Giovannoni (1995), for example, suggested that neighbours and non-mandated referrers report difficulties which are visible ‘through the window’ and may reflect concerns such as a lack of supervision and a failure to meet a child’s basic needs. Mc Daniel (2006) building on the earlier work by Giovannoni (1995) carried out research among 1260 low-income families at risk of child protective services involvement and found that professionals and non-professionals are privy to different aspects of people’s lives, as evidenced in their reports. King and Scott (2014) contend that services with a ‘vantage point’, such as schools, will observe more difficulties and may be sensitive to parental difficulties which are chronic in nature.

It is also suggested that the location and relationship of reporters with children might affect the way they rate the severity of the maltreatment. Mc Daniel (2006) hypothesises that ‘particular risk factors may be more salient to certain reporters’ (p.310) and that different groups of reporters place different significance on parenting and family characteristics. For example, she found that reporting patterns differed between community members and professionals, with the former reporting more large families with young children and lower incomes as well as families experiencing domestic violence, compared with mandated professionals who reported parenting stress and caregivers with learning disability.

Manion and Renwick (2008) looked retrospectively at cases which proceeded to the investigation stage and highlighted some fairly predictable trends in relation to the age of children referred by different professions, finding that health staff report more preschool children, education staff report primary school age children and police report more cases where there were ‘formal’ findings of abuse (p.79).

This point is further exemplified in King and Scott’s (2014) study where reports tended to be linked with issues that directly affected the setting in which the children were observed, e.g. schools were more likely to report mental health or behaviour problems than family difficulties, a finding echoed by Jonson-Reid et al. (2007) and Walsh et al. (2006) who also found that teachers in their research were better at reporting physical abuse over neglect or emotional abuse.

Links between the reporter and the outcome of the report

Research identifies an association between the source of a report and its disposal (Drake, 1995; Mc Daniel, 2006; Manion and Renwick, 2008; King and Scott, 2014). It is also evident that reports from mandated professionals or professionals generally are more likely to be substantiated than those from lay people or anonymous sources (Mc Daniel, 2005; Manion and Renwick, 2008). One exception to this trend was found by King and Scott (2014) whose research showed that reports from educators were more than twice (2.09) as likely to have an outcome of unsubstantiated as reports from other professionals. They also reported that educators were the profession most likely to report physical abuse with approximately two-thirds (61.6%) of all referrals from professionals coming from school staff.

King and Scott (2014) raise important questions about how child protective and education services interact in the pursuit of protecting children. They question whether the low substantiation levels mean that more emphasis is being placed on the parents’ capacity to avoid maltreatment than the problems exhibited by the child. They also raise the question of whether educators are in some way considered less than credible reporters of child protection concerns even though their concerns are

often predicated on a disclosure from a child. Teachers, they contend, in a large proportion of situations become concerned about the safety of a child because of a disclosure from a child and this they believe is unique to this professional group. Yet research (Youngstrom et al., 2011) has shown that children are often considered less credible reporters of their experiences than the professionals they come in contact with and King and Scott (2014) wonder is the reliance on the word of a child in the reports made by teachers a reason why these reports are often unsubstantiated.

However, other studies supported the notion that reports from professionals carry more weight. Manion and Renwick (2008) observed that notifications that were received from police, education and health professionals were more likely to have a 'critical status' (p.78) and a formal positive finding and speculated that notifications from professionals may be more descriptive and specific than those offered by lay reporters. Mc Daniel (2006) also found that referrals received by mandated reporters, for example police or professionals from health or education sectors were considerably more likely to be substantiated than reports received from non-mandated sources.

In a similar vein, Drake (1995) analysed 42,679 reports to Child Protective Services in the state of Missouri in the US and found that anonymous reports were the least likely to be substantiated while those from law enforcement agencies were the most likely to be substantiated.

Such findings, as King and Scott (2014) suggest, could imply that professionals are more discriminating than community members in terms of what they consider reportable, and may be 'predisposed to report maltreatment that is considered severe and indicative of an immediate child safety concern' (p.2).

Impacts on rates of reporting, rising rates and barriers

'Underreporting has been a continuing problem for social policy involving child abuse. Thus, abused children fail to receive protection and treatment' (Webster et al., 2005: p.1294).

While reporting rates are rising internationally, simultaneously concern exists about underreporting. These two factors are discussed below, starting with the steady rise in reporting rates.

Increased reporting rates

In their commentary on the varying reporting rates within the United Kingdom, the NSPCC point out that an increase in rates may indicate greater awareness or an increase in concern about child safety, or even changes in legislation and as such, cannot be considered either good or bad in terms of overall child welfare (Jutte et al., 2014: p.52). Lonne et al. (2009) had previously suggested that a

variety of complex and interrelated reasons underpin a rise in reporting. The impact of child abuse inquiries and professional anxiety is one such reason, compounded by resultant public concern (Mansell, 2006; Mc Ghee and Waterhouse, 2007; Saint-Jacques et al., 2012). For example, Mansell (2006) analysed the impact of media attention to child abuse, child deaths and perceived failures of the system and found a clear connection between it and weekly spikes in notification rates. He also observed that the establishment of a centralised intake centre in New Zealand in 2001 resulted in an acceleration of client notifications.

Pelton (2008) and Lonne et al. (2009) have offered additional perspectives, pointing out that for some families in need of welfare assistance, the only way to access services is through statutory child protection services, a factor which inevitably impacts the number of families reported. Lonne et al. (2009) also identified an increased awareness amongst the general public as a reason for increased reporting levels and others relate it to key changes to child protection policy such as the introduction of mandatory reporting (Bilson et al., 2015; Pelton, 2008). Trocmé et al. (2014) suggest that the increase in reporting rates in Canada have been driven by ‘a broadening of child welfare mandates’ (p.484) and within this the inclusion of emotional maltreatment, exposure to intimate partner violence, a concern amongst professionals about the risk of future maltreatment and greater awareness amongst professionals about the emotional and cognitive impact of child maltreatment.

Underreporting

While it is beyond doubt that reporting levels are rising in many jurisdictions, concern continues to be expressed with regard to children at risk whose situations are not reported (Webster et al., 2005; Finkelhor, 2017). Findings from serious case reviews in the UK and child death reviews in Ireland have both, at times, identified a failure to report as a factor in tragic outcomes for some children, for example:

‘(A) number of Serious Case Reviews (SCRs) have identified failures to report. This may be due to the difficulty in identifying signs of need or harm (such as neglect), to a lack of clear referral procedures, or to cultural and institutional factors in specific regulated settings. We need to know more about these barriers and how to address them to ensure consistently high quality and timely referrals in all cases’ (Department for Education, 2014: p.7).

Parton (2014a) is also concerned with the problem of underreporting of abuse in the UK and comments ‘both the scope and complexity of the problem of child abuse and neglect (are) underestimated’ (p.179). Gilbert et al. (2012) similarly point out that a reliance on reported or substantiated cases of child abuse to denote levels of abuse in a country measure only a small part of the bigger picture.

The most contemporary piece of empirical research which attempted to address this topic in Ireland was the SAVI Report, produced in 2002 (Mc Gee et al., 2002), which gathered data on participants' experience of sexual abuse during childhood. No research to date has looked at the prevalence of physical abuse, emotional abuse or neglect in Ireland. The findings in the SAVI Report were derived from 3,118 telephone interviews with adults who were randomly selected to participate. They show high prevalence rates of child sexual abuse for example: 'one in five women (20.4%) reported experiencing contact sexual abuse in childhood with a further one in ten (10.0%) reporting non-contact sexual abuse [and] one in six men (16.2%) reported experiencing contact sexual abuse in childhood with a further one in fourteen (7.4%) reporting non-contact sexual abuse' (McGee et al., 2002: p.xxxiii). The research further revealed a 'strikingly low' level of reporting of child sexual abuse to professionals with very small proportions of those abused in childhood reporting that abuse to the Gardai (8%) or medical professionals (4%). While the applicability of these findings to contemporary society have limitations given, for example, the retrospective nature of the data gathered and the changes that have occurred to service availability and awareness of child sexual abuse, it still provides an interesting insight into the levels of abuse that remain undisclosed.

The larger scale and more recent study carried out by Radford et al. (2011) in the UK showed severe child maltreatment experienced by substantial minority of children and young people: 5.9% of under 11s, 18.6% of 11-17 year olds and 25.3% of 18-24 year olds. The findings also show that 0.5% of under 11s, 4.8% of 11-17 year olds and 11.3% of 18-24 year olds had experienced contact sexual abuse at some point in their childhood.

Gilbert et al. (2009) conducted a review of research into the prevalence of child abuse in high-income countries and while they found indications of a decrease in overall levels they also found significant disparity between reported and actual rates of child abuse leading them to conclude that official rates for substantiated child maltreatment represent less than a tenth of the actual level. Parton (2014a), commenting on this reported decline, argued that while there may have been improvements to public health measures, such as early intervention and overall positive change in parental attitudes towards the use of physical punishment, there has also been a sharp economic decline in the last decade since the time of Gilbert et al.'s (2009) research and a curtailment of public expenditure which may have reversed the decrease.

Obstacles to reporting

Buckley and Buckley (2015) argue that, for reporting to be effective, certain barriers must first be addressed. Bunting et al. (2010) go some way towards this, in their international literature review, by elucidating a number of perceived obstacles. In the first instance they uncovered a reluctance on the part of professionals, related to the quality of evidence available to support their suspicions; a

hierarchy of abuse type whereby those that are more easily identifiable or are likely to be subject to public concern are more commonly reported; the occupational group of the professional concerned; concern about causing damage to their relationship with their client; a lack of faith in the child protection system to adequately respond; an ambivalence with regard to physical punishment and a fear of being wrong. Adding to these reasons, Gilbert et al. (2012) suggest that child abuse is often hidden and therefore not recognised by the health professionals with whom children come into contact. They also assert that 'health, education and other community professionals in contact with children consistently report to child protection agencies only a proportion of children whom they recognise as being maltreated' (p.759).

R. Buckley (2013) carried out a significant piece of empirical research in Ireland with 156 professionals from health, education, sport, youth and youth justice sectors as part of a doctoral study. This research sought the views of these professionals on the potential impact of the introduction of mandatory reporting and asked them about their current reporting practices. Like Bunting et al. (2010), she found that when the physical manifestations of abuse are clear, practitioners tend to respond and report quickly, she found, however that responses to more complex matters such as neglect or emotional abuse were slower due to the 'multiplicity of anticipated positive and negative outcomes including adverse consequences' (Buckley and Buckley, 2015: p.287). Other impediments cited in that study included a fear of getting it wrong, a fear of retaliation from parents and a lack of confidence in the child protection system compounded by a lack of feedback from social workers when reports were made.

To overcome obstacles, Bunting et al. (2010) suggest training that is targeted at overcoming barriers by clarifying the limits of confidentiality and client relationships as well as highlighting the impact of neglect and abuse and the complexities of disclosure. They also suggest that education on the work of social services would enhance understanding. Buckley and Buckley (2015) add that doubts and personal challenges experienced by reporters and the level of knowledge and expertise that reporters have in relation to child harm need to be addressed and assuaged in order to increase reporter confidence.

The education sector and child protection reporting

The education sector has been identified in the literature as a significant resource for children needing child protection interventions, and as such, warrants particular attention. The key role that teachers play in recognising and responding to child abuse is set out in *Children First* (2011):

'Teachers are particularly well placed to observe and monitor children for signs of abuse and neglect. They are the main care-givers to children outside the family context and have regular

contact with children in the school setting. Teachers have a general duty of care to ensure that arrangements are in place to protect children and young people from harm' (p.23).

The unique role of educators has been highlighted in the literature (Giovannoni, 1995; Mc Daniel, 2006; Walsh et al., 2006; King and Scott, 2014). Bourke and Maunsell (2015) point out how teachers have a particularly important role to play in identifying and reporting neglect as some indicators, such as inadequate clothing, poor food and nutrition, excessive tiredness, failure to thrive, lack of concentration and poor social skills, may be directly observable.

The role of education staff as referrers to child protection services also receives a lot of attention in the literature (Crenshaw et al., 1995; Hawkins and McCallum 2001; Kenny 2001; Webster et al. 2005; Buckley and Mc Garry, 2011; Mc Garry and Buckley, 2013; King and Scott, 2014; Bourke and Maunsell, 2015) and concern has been expressed that despite a legal mandate in some countries, there is a level of underreporting in this sector (Kenny, 2001). Crenshaw et al. (1995) surmised two decades ago that 'schools are both the largest reporting source and the largest underreporting source' (p.1095) and empirical data have continued to reflect this paradox.

Mc Garry and Buckley (2013) on the basis of their survey of 103 newly qualified primary teachers found that the rhetoric on the standardisation of child protection reporting procedures in schools in Ireland is not the lived reality. Only 48% of respondents reported that they received child protection training during their teacher training; 57% said they were either not confident or were uncertain of their ability to identify abuse and 83% reported that they did not receive any child protection training as part of their induction into their current school. In a separate US study Kenny (2004) also found that only 66% of teachers in her sample had received child protection training during their college education.

The literature demonstrates a number of particularities to the reporting practices of teachers. They are reportedly better at referring particular types of abuse (Crenshaw et al., 1995; Kenny et al.; Walsh et al., 2006), for example empirical research has shown them to consider physical abuse easier to report (Walsh et al., 2006). Barriers to their reporting include the fear of making an inaccurate report (Kenny, 2001), the view that child protection services will not offer any help to the child (Kenny, 2001), a lack of confidence in identifying child abuse (Crenshaw et al., 1995; Kenny, 2001; Mc Garry and Buckley, 2013) and fear regarding the impact on the teacher-child and teacher-parent relationship (Bourke and Maunsell, 2015). Webster et al. (2005) detail how the underreporting they uncovered in their factorial survey of 480 teachers was linked to particular characteristics of those teachers such as less education, being in an administrative position, concern that making a report would cause problems for themselves and/or the child and never having made a report before.

Proposals to improve reporting by teachers focus on the interrelated issues of detection and reporting. In many respects, teachers are the first line of defence and training which focuses only on improving

understanding of child protection procedures is insufficient (Mc Garry and Buckley, 2013). Rather teachers need regular child protection training, during and after qualification and the importance of their roles within a child's life needs to be acknowledged in such training. Bourke and Maunsell (2015) advocate that teachers' belief systems and attitudes to child abuse also need to be addressed and challenged for training to be effective.

Families and their experience of being reported to child protection services

Parents and family members are also an important source of reports to child protection services and have a unique status as carers, referrers and recipients of the services provided. A substantial body of recent empirical research describes and analyses families' experiences of child protection services (Spratt and Callan, 2004; Dumbrill, 2006; Palmer et al., 2006; Buckley et al., 2008; Schreiber et al., 2013; Hollinshead et al., 2017; Smithson and Gibson, 2017). These studies tended to be small in scale and usually are based on in depth qualitative interviews with services users. However, they are generalisable to the extent that all report similar findings.

Families tend to approach their interactions with child protection services with apprehension and trepidation (Spratt and Callan, 2004; Scheiber et al., 2013). Such apprehension and trepidation is rooted in their perceptions that statutory child protection services are very powerful (Spratt and Callan, 2004; Dumbrill, 2006; Scheiber et al., 2013) and often in the stereotypical view of social workers 'as people that "take your kids"' (Buckley et al., 2008). Research has also shown that families experience strong negative emotions such as 'fear, anger or shame' (Schreiber et al., 2013: p.713) when visited by a child protection social worker, and parents are left feeling 'vulnerable, fragile, frightened and utterly powerless' (Davies, 2011: p.203). Feelings of anxiety are reportedly intensified when the family were unaware of or unsupportive of the referral which was made by a source other than themselves (Spratt and Callan, 2004; Buckley et al, 2008).

Negative experiences of child protection services can be mitigated by the development of good trusting and supportive relationships with practitioners (Palmer et al., 2006; de Boer and Coady, 2007; Buckley et al, 2011; Schreiber et al., 2013; Jackson et al, 2016), empathy on the part of the social worker (Forrester et al., 2008), a system which is prompt in its response and accessible and when service users perceive that they are receiving a good quality and well informed response to their needs (Buckley et al, 2008; Buckley et al, 2011). It is also considered important for practitioners to acknowledge and address the power imbalance and fear that families inevitably feel (Dumbrill, 2006).

While modern child protection systems aspire to child centeredness, family participation and positive relationships with families, the concurrent development of managerial systems that are risk averse is detracting from this goal. As Buckley (2017) points out 'attempts to moderate the system and promote family participation and engagement have been losing the battle with simultaneous efforts

to streamline' (p.77). Increased reporting rates, coupled with high thresholds and pressure to meet case closure deadlines can mean that families, and in particular those who themselves instigate contact with child protection services are left waiting for long periods sometimes until the risk threshold is reached (Buckley, 2017). In the research carried out by Buckley et al., (2008) one service user, whose daughter was engaging in serious self-harm, 'used the metaphor of needing "a knife in your child's back" to get attention' (p.65). Also evident in this research was a tendency for child protection practitioners to withdraw services on the basis that the 'non-abusing parent's awareness of the abuse is sufficient to protect their children' (Buckley et al, 2008: p.21).

Empirical research also evidences that service users who instigate contact with child protection services are more willing to engage with practitioners (Buckley, 2003; Spratt and Callan, 2004; Buckley et al, 2008) and that if parents are actively involved in interventions this leads to better outcomes for children at risk of maltreatment (Saint-Jacques et al., 2006; Jackson, 2016).

Re-referral to child protection services and methodological challenges

Findings from both research and administrative datasets indicate substantial levels of re-referral and re-reporting, suggesting that children who are reported and quickly screened out of the system often 'bounce' back into child protection services. Re-referrals are defined in Irish guidance as 'new referrals or reports on cases closed in the last 12 months' (HSE, 2009: Appendix A) and in the UK 'a re-referral is where a child has been referred within 12 months of a previous referral' (Department for Education, 2016: p.5).

A high rate of re-referral could be explained as inevitable, given the instability in the lives of some services users, but it can also signify that available services are not suitable or sufficiently resourced to meet the needs of the children and families referred to them (Connell et al., 2007; Manion and Renwick, 2008; Bae et al., 2010; Hélie et al., 2013; Jenkins et al., 2017). As researchers have argued, examination of this trend is critically important for policy-makers, as identification of case characteristics that lead to re-referral can assist service planning (Forrester, 2007; Connell et al., 2007; Jedwab et al., 2017).

As Palusci (2011) points out, rates of re-referral can vary greatly between different studies, depending on the methods and definitions used thus making the comparison of results challenging. Some do not differentiate between first and subsequent referrals, others only count 'active' cases and timelines can also differ (Hélie et al., 2013). Nevertheless Hélie et al. (2013) concede that some observations can be made with respect to factors associated with recurrence. Jenkins et al. (2017), on the other hand, caution that while a number of factors common to repeated reporting can be identified, understanding about why it occurs is more challenging. They challenge the idea that rates of re-

referral indicate more chronic levels of abuse and assert that figures which conflate recurrence and rates of maltreatment may incorrectly assume that repeated allegations are always valid. Indeed Bilson et al. (2015) also argue that, given the rate at which repeat reports are screened out, multiple reports do not necessarily indicate maltreatment. A number of commentators put it more simply and have pointed out that children and families who receive services are more likely to be re-reported to services than those that do not (Connell et al., 2007; Jenkins et al., 2017), leaving Fuller and Nieto (2014) posing the question whether this implies that the services families are receiving are simply ineffective in reducing risk. Jedwab et al. (2017) add that the belief that substantiated cases represent children who have been maltreated and unsubstantiated cases represent children who have not is misplaced, as studies have indicated that the presence of risk factors, outcome and future risk are often the same for the two groups (Drake et al., 2003) and thus unsubstantiated cases may well indicate child maltreatment (Connell et al., 2007). Child protection services, Jenkins et al. (2017) conclude, are complex systems and recurrence involves a series of interactions between the children and families concerned and those making the decisions and must be understood as ‘an emergent property of a complex system’ (p.167). Bae et al. (2010) also endorse an ecological model for understanding child maltreatment re-reporting in which they include child protection system factors and Héile and Bouchard (2010) stress that future studies should employ a ‘multivariate, ecological perspective that integrates factors associated with the various ‘systems’ within which children develop’ (p.421).

Risk factors associated with re-referral

While taking the foregoing methodological challenges into consideration, research has raised a number of observations and proposed different understandings of re-reporting trends, or what has been termed ‘re-cycling’ of child abuse reports (Mc Ghee and Waterhouse, 2007).

The theory of previous involvement as a predictor of future involvement is endorsed in numerous studies (English et al., 1999; Fluke et al., 1999; Forrester, 2008; Bae et al., 2010; Heile et al., 2013; Fuller and Nieto, 2014; Casaneuva et al., 2015; Eastman et al., 2016). Heile et al. (2013) concur with other research which has described the effect of more reports on a child on the likelihood of recurrence as a ‘snowball effect’ and McGhee and Waterhouse (2007) contend ‘(t)he most likely explanation for “recycling” is the longstanding nature and complexity of the problems facing the children and their families. A lack of preventive services at an early stage in the genesis of the problems may be a further factor’ (p.155). In particular, children whose initial report was substantiated or confirmed are more likely to be re-referred, as observed by Putman-Hornstein et al., 2015. Forrester (2008) comments that this finding on its own is too common to be useful but points

out its potential usefulness when considered alongside physical abuse and / or parental alcohol misuse.

A number of the studies reviewed demonstrated the short time period that elapses prior to re-referral (Defanilis and Zuravin, 1999a; English et al., 1999; Forrester, 2007; Connell et al., 2007; Jedwab et al., 2017) leading to a view, voiced by several commentators (McGhee and Waterhouse, 2007 and Jedwab et al., 2017) that all first time reports should receive targeted and preventive services, regardless of the outcome.

Where age is concerned, most studies reviewed found that younger children are likely to be re-reported (Fuller and Nieto, 2004; Jedwab et al., 2017) and that the likelihood of a re-referral decreases with age (Connell et al., 2007; Héile et al., 2013), with some attributing this to children aging out of the system, i.e. reaching official adulthood at 18 years of age (Fluke et al., 1999).

Héile et al. (2013) are particularly interested in the impact of age on the predictability of re-referral and found that children in the 6-11 age group had the highest likelihood of recurrence in the five years following their initial contact, while those aged 12-17 had the lowest. This contravenes findings in other studies, as reported above, which conclude that age protects children against recurrence. Héile et al. (2013) point out that the risks of recurrence are not the same for children of all ages and therefore advocate the use of a developmental approach in service planning.

Findings with regard to ethnicity and re-referral are also somewhat mixed (Jedwab et al., 2017). Membership of a minority ethnic group was significantly related to re-referral rates in a number of studies (Connell et al., 2007; Héile et al., 2013; Jedwab et al., 2017) however Fuller and Nieto (2014) found that Hispanic and black children were less likely to be re-referred than white children.

Many studies have reported a link between neglect and re-referral (DePanfilis and Zuravin, 1999a; Connell et al., 2007; Manion and Renwick, 2008; Héile et al., 2013; Fuller and Nieto, 2014; Eastman et al., 2016; Jedwab et al., 2017) possibly due to an under-reaction to the initial referral. Connell et al. (2007) reported that substantiated cases of physical abuse had a higher likelihood of being re-referred than cases that were not substantiated or those involving neglect.

It is suggested by Manion and Renwick (2008) that children who are subjected to neglect, emotional abuse and behavioural and relationship difficulties present with issues that are difficult to effectively assess and address, resulting in multiple presentations to child protection services before a specific incident is identified that can be addressed.

Substance misuse (English et al., 1999; Forrester, 2007; Connell et al., 2007; Fluke et al., 2008; Jedwab et al., 2017) mental health (Jedwab et al., 2017) and domestic violence (DePanalis and Zuravin, 1999b; Jedwab et al., 2017) are frequently identified in empirical research as significant reasons for re-referral. However Connell et al. (2007) found no likelihood of re-referral for cases

which involved domestic violence and Jedwab et al. (2017) also found that cases which involved issues such as domestic violence or parental substance abuse were not found to be significantly correlated with a substantiated re-report and they speculate that this may be the case because families where these issues prevail are likely to have either had the child removed or to have received sufficient services following the initial report.

Some studies also found that a family's socio-economic status had a significant effect on the rate of re-referral to child protection services (Connell et al., 2007; Drake et al., 2003) and Connell et al. (2007) reported that disability status (33% increase) was also associated with increased rates of re-referral.

When Forrester (2007) reviewed 400 closed cases, he found there was a re-referral rate of 75% within the first year. However, only 18 re-referrals related to 'significant harm' in 11 families. In a slightly later paper based on this research Forrester (2008) concludes that practitioners were 'relatively good' at avoiding closing cases that were likely to be re-referred for serious abuse or maltreatment and found little evidence of poor decision making at the initial stages.

Conclusion

Research reviewed in this chapter has demonstrated that police, the education sector, health and social services, friends, family and neighbours are consistently the most significant referrers. Notably few children self-refer despite being the primary focus of child protection and welfare services.

Reasons for referral differ between studies, whose comparability is limited by methodological considerations. However, as may be predicted, parental substance abuse is a frequently cited reason, while the cohorts most frequently reported comprise younger children and teenagers.

The relationship between certain issues, ethnicity and poverty for example, and referral to child protection services and the response received are currently being debated in the literature. The issue of whether poorer families are subject to more reports to child protection agencies because of class bias regarding working class child rearing norms or because of increased risk due to poverty is considered with more contemporary explanations focusing on systemic class bias. Other analysis looks at the visibility of the those reported and the relationship that certain reporters have with those they report as influencing factors on who and what is referred to child protection services. The source of a report is shown by empirical research to have an impact on the outcome of a referral and overall reports from professional or mandated reporters are shown to be more likely to be substantiated than those from lay people or anonymous.

Reporting levels in most Anglophone countries are steadily increasing, an issue which will be explored in more detail in the next chapter, however, concern continues to be expressed about underreporting. It is suggested that the scope and complexity of child maltreatment is underestimated (Parton, 2014a) and that obstacles to reporting by professionals should be tackled.

The education sector and families are important sources of referrals but further work is required by child protection services to capitalise more on this. Teachers are shown by research to be underreporting and the need for training which focuses on the identification of child maltreatment and which challenges their belief systems and attitudes to child abuse is ongoing. Families' experiences of child protection services tend to be negative yet families continue to self-report and when they do so research has shown that they are more willing to engage with practitioners, which leads to better outcomes for children. While research points to the fact that self-referral by families should be encouraged, paradoxically increased proceduralisation and high thresholds can mean those who instigate contact are considered lower risk than those who do not and are slow to receive a service.

Re-referral is a complex phenomenon but a very important consideration for child protection systems and one which receives a lot of attention in the literature. It is convincingly argued in the literature that re-referral cannot be correlated with maltreatment rates as these reports may not be substantiated and children who are never referred may be the victims of abuse. It is not unexpected that previous involvement, younger children and particular child and family difficulties such as neglect, physical abuse, emotional abuse, behavioural difficulties amongst children and parental substance misuse feature most frequently in re-referral trends. Nonetheless, the pattern of re-referral in an area is a topic worthy of further exploration, given the potential insight it may provide into not only the prevalence of certain risk factors, but the appropriateness of the services to meet the needs that are referred to it, and this topic will be a focus of investigation in the current study.

The next chapter looks in detail at child protection and welfare reporting rates in Ireland and compares and contrasts these figures with data on the four countries in the UK and other Anglophone countries. Particular attention is given to a comparison between the intake systems in the Republic of Ireland and Northern Ireland.

Chapter 4 Child Protection Reporting and Trends

Introduction

This chapter examines child protection and welfare in Ireland using available national administrative data. These statistics reveal interesting insights into the reporting trends in Ireland and, when interrogated closely, reveal variances from one area to the next, challenging the aspiration of the newly formed Child and Family Agency towards consistency in all its business processes. National averages are useful, however, when comparing and contrasting reporting trends in Ireland with analyses of similar data from other countries as well as emerging international trends. Particular attention is given to administrative data from the UK and comparisons are made between the child protection systems in Northern Ireland and the Republic of Ireland.

Child protection and welfare reporting in Ireland and internationally

The number of children and families reported to child protection and welfare services in Ireland is increasing every year. The most recent national figures available show that between 2007 and 2016 reports more than doubled, increasing from 23,268 in 2006 to 47,399 in 2016, see Table 4.1 below (HSE, 2011a and Tusla, 2017b).

A steep increase is observable between 2011 and 2012, due in part to a change in the way that referrals were counted, from ‘cases’, which may have comprised several children, to individual children, and the inclusion of multiple referrals about the same child concerning the same incident from different sources (Tusla, 2015h).

Table 4.1 below details the proportion of children in the population that was reported to child protection and welfare services between 2007 and 2016. It could be inferred that the increase reflects recent changes in policy and legislation.

Table 4.1 Number of referrals received annually and population size 2007 - 2016

Number of referrals received annually and population size 2007-2016										
Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Referrals	23,268	24,668	26,888	29,277	31,626	40,187	41,599	43,630	43,596	47,399
Population	1,056,947	1,085,258	1,107,034	1,127,672	1,144,513	1,165,382	1,181,499	1,194,462	1,208,917	1,220,907
% Referred	2.2	2.3	2.4	2.6	2.8	3.4	3.5	3.6	3.6	3.9

(Source of Figures Department of Children and Youth Affairs 2008; 2010; 2012; 2014; 2016 and Tusla 2012; Tusla 2013; 2014b; Tusla 2015a; Tusla 2016e and Tusla 2017b).

An overall rapid increase in referral rates is not unique to Ireland and it actually replicates recent international trends over the past two decades. McGhee and Waterhouse (2007) reported that care and protection referrals in Scotland had increased by 69% in the ten years to 2000/01 (p.145). Trocmé et al. (2005) reported that investigated reports in Canada increased from 135,000 in 1998 to 235,000 in 2008; in New Zealand between 2001 and 2006 notifications to the statutory child protection agency doubled (Mansell, 2006) and in Australia child protection notification rates more than doubled during the seven year period 1999/2000 (107,134) to 2005/2006 (266,745) (Humphreys, 2008). Gilbert et al. (2012) carried out extensive research into child maltreatment trends and policies in Sweden, USA, Canada, Western Australia, England and New Zealand and came to the pessimistic conclusion that there exists ‘no clear evidence for an overall decrease in child maltreatment despite decades of policies designed to achieve such reductions’ (p.770).

Contemporary research reflects Gilbert et al.’s (2012) assertion, showing a continuing increase in levels of reporting. For example, Bilson et al. (2015) carried out a longitudinal study of reports to the statutory child protection service in Western Australia focusing on all children born there in 1990 and 1991. They found that more than one in eight (13.3%) were reported to child protection services before their 18th birthday. Bilson and Martin (2016), using data obtained by a freedom of information request, also provide some significant longitudinal findings with regard to the number of child protection referrals for a specific cohort of children in England. They analysed data gathered from 75% of all English children’s services, which cover half a million children, and found that ‘22.5% of children that were born in the financial year 2009-2010 were reported to children’s social care before they were five (Bilson and Martin, 2015: p.1).

Reporting rates in Ireland and the UK: Comparing and contrasting figures

Looking to the statistics for the four countries of the United Kingdom, our nearest neighbours, shows a mixed picture in contrast to the trend outlined above, whereby, as will be detailed presently, levels in some countries are beginning to plateau or even decrease. It is, however, important to bear in mind that comparisons are compromised by the different procedures operating in individual countries.

Although Mc Ghee and Waterhouse (2007) had demonstrated an increase in reporting in Scotland ten years ago, current data for this country indicates a reduction. Child protection reports to the Scottish Children's Reporter Administration (SCRA) have decreased for the ninth consecutive year and levels are at their lowest since 1982 (SCRA, 2016b: p.22). However, while other countries publish figures on the total number of reports to social services, Scotland ceased doing so in 2010 due to 'concerns about inconsistency of definitions used to record data with local authorities' (Bentley et al., 2016: p.46), which makes it difficult to compare it with the other UK jurisdictions. The SCRA attribute the decrease to a recently introduced programme of sophisticated pre-referral screening whereby referrals are screened out unless early assessment indicates a child protection concern. In the year 2015/2016, 13,688 children and young people were referred on non-offence (care and protection) grounds which represented 1.5% of all children and young people 16 years of age and under in Scotland (*ibid*).

For the three other countries in the UK, figures are published on the total number of reports received by social services and in some instances further information is provided to indicate whether they had been subject to initial assessment.

In Wales, rates of reporting to social services have decreased year on year since 2009/10 (Jutte et al., 2014: p.52) and while figures showed a slight increase in 2014/2015 with 35,423 referrals for the year ended 31st March 2015 (Bentley et al., 2016: p.47), figures for 2015/2016 have again decreased to 33,536 (Department for Education and Skills, 2016: p.3). With a child population of approximately 620,000 (Source: <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/wales/statistics/>) this represents 5.4% of all children under 18 years of age in Wales.

In England, 621,470 referrals were made to social services and for the year ending 31st March 2016 (Department for Education, 2016: p.5). With 11 million children in England (Source: <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/england/statistics/>) this represents 5.6% of all children under the age of 18 years. While this indicates a slowdown in the numbers reported following the sharp increase noted in 2013/14, overall numbers of referrals have remained higher than those received in the previous twelve years (Bentley et al., 2016: p.47).

In Northern Ireland, the number of referrals to social services increased steadily from 2007/08 until 2013/2014 at which point a decrease became evident. During the year ending 31st March 2015,

38,418 children were reported. Although this represented an increase, comparisons with previous years are not possible due to changes in the way the data are collected (Bentley et al., 2016). However, during the year ending 31st March 2016, 34,124 children were referred, representing a decrease from the previous year (Information Analysis Directorate, 2016: p.8). With approximately 430,000 children in Northern Ireland (Source: <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/northern-ireland/statistics/>) this represents a reporting rate of 7.9% of all children under the age of 18 years of age for 2015/2016.

To summarise, even with the challenges to data linkage, a comparison of the proportion of children reported to social services for child protection or welfare concerns across Ireland and the UK demonstrates the following: in Ireland in 2015 3.6% of children under the age of 18 years were reported; in England for the year 2015/2016 5.6% of children under the age of 18 years were reported; in Wales for the year 2015/2016 5.4% of children under the age of 18 were reported; in Northern Ireland 7.9% of children under the age of 18 years were reported and in Scotland the figure for child protection reports only indicates that 1.5% of children under the age of 16 years were reported for the year 2015/2106. Overall this analysis shows that Irish services experience relatively low levels of reporting by comparison with our UK neighbours. The area in which this research was based (Oaktown) received reports on 3%⁴ of the child population living there, which is a little below the national average.

Outcome and categorisation of reports at national and local level in Ireland

Information provided by Tusla regarding the referrals received by its social work departments is published quarterly in arrears in two reports entitled *Integrated Performance and Activity Reports* and *Quarterly Management Data Activity Report* (available online at: <http://www.tusla.ie/data-figures>). The data displayed in these reports provide a breakdown of the outcome of cases reported in terms of overall outcome of a report, the proportion which were deemed ‘child welfare’ and the proportion which were deemed ‘child protection’ and the categorisation of abuse type within the child protection referrals. Data are available for both national averages and at local level. Prior to 2014, data on the categorisation of abuse types were available in reports colloquially known as the ‘*Review of Adequacy Reports*’.

⁴ (102,800 was the 0-18 years population reported for 2015 in Oaktown, reporting rate of 3,129 for 2015 = 3% reporting rate)

Overall outcome in cases reported

Data published by Tusla regarding the overall outcome in referrals focus on the number of reports which received a preliminary enquiry and were subsequently put forward for an initial assessment. Available data show that in 2014 51% of all reports received an initial assessment; in 2015 this figure had reduced to 48% and in 2016 it reduced again to 43% (Tusla 2015j; Tusla 2016e; Tusla 2017c). Data for Q1 2015, the time period on which this research was based, show that on average, 49% of reports on children were put forward for an initial assessment (Tusla, 2015b: p.4). This is somewhat lower than the figure of 62% reported for Oaktown, which will be discussed in more detail in a subsequent chapter. However, an examination of the proportions requiring initial assessment across the 17 areas of Tusla during 2015 reveals substantial variation. As shown in Table 4.2 below proportions ranged from 25% in one area to 67% in another.

Table 4.2 Proportion of referrals which had an outcome of initial assessment in 2015

Proportion of referrals which had an outcome of initial Assessment in 2015	
Area ⁵	Initial assessment ⁶ %
Area 1	67
Area 2	65
Area 3	64
Area 4	62
Area 5	58
Area 6	58
Area 7	44
Area 8	43
Area 9	42
Area 10	41
Area 11	41
Area 12	40
Area 13	40
Area 14	32
Area 15	32
Area 16	31
Area 17	25

(Source: Tusla 2016e)

Categorisation of the reports received

The categorisation of all reports received nationally between 2007 and 2016 is presented in Table 4.3 below. This statistical information charts the breakdown of child welfare and child protection referrals received between 2007 and 2016. The pattern of just over half the reports received being categorised as ‘welfare’, i.e. not reaching the threshold for a child protection intervention, and just under half being classified as ‘child protection’ has been consistent throughout the last decade (Buckley and Burns, 2015). However, it is notable that the gap has been widening slightly over the last three years with progressively more referrals received being categorised as ‘child welfare’

⁵ Area names have been anonymised to protect the identity of the area where this study took place.

⁶ Percentages are rounded in administrative data

concerns than ‘child protection’ concerns. Tusla has acknowledged that this fact requires further examination, and speculates that it may reflect not only socio economic factors but also a growing awareness of children’s needs by educators and others (Tusla, 2014b). In the same report, Tusla also notes a trend whereby neglect cases are often categorised as ‘welfare’ rather than ‘abuse’. The current study, by including the perspectives of staff managing intake teams, should also help elucidate the reasons for this.

Table 4.3 Breakdown of referrals received nationally 2007-2016

Breakdown of referrals received nationally 2007-2016										
Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Welfare	12,715	12,932	14,875	16,452	15,808	21,143	22,192	24,954	25,361	28,312
% Welfare	54.6	52.4	55.3	56.2	50.0	52.6	53.3	57.2	58.2	59.7
Abuse	10,553	11,736	12,013	12,825	15,818	19,044	19,407	18,676	18,235	19,087
% Abuse	45.4	47.6	44.7	43.8	50.0	47.4	46.7	42.8	41.8	40.3
National	23,268	24,668	26,888	29,277	31,626	40,187	41,599	43,630	43,596	47,399

(Source: Adapted from HSE, 2011a; Tusla, 2014b; Tusla, 2015a,b,c,d; Tusla, 2016a; Tusla 2016e, Tusla 2017b).

Categorisation of reports at area level

It is interesting to review the figures with regard to the categorisation of reports across the 17 areas of Tusla for the year 2015. As shown in Table 4.4, the proportion of referrals categorised as ‘child welfare’ range from 34% to 84% and those categorised as ‘child protection’ range from 16% to 66%. This significant variation across the 17 sites again shows that the national averages are not representative of the referrals received and categorisations given at local level. As previously outlined, variations in local patterns have been noted by Kemp (2008) whose earlier research highlighted inconsistency in the way that local policies have been implemented. It could also be inferred that local managers and practitioners not only have implemented policies differently, but also interpreted them according to a different set of operational norms. The current study will address this topic in the following chapters.

Figures for the area in which the current study is situated are also not representative of the national trend. As previously reported, 794 reports were made to the child protection and welfare services during Q1 2015 in Oaktown, and, of those, 86% were categorised as ‘child welfare’ at intake and 14% were categorised as ‘child protection’. This is in some contrast to the 58% ‘welfare concerns’

and 42% ‘child protection’ indicated for the year 2015 in Table 4.3 above. Similarly the breakdown reported nationally for Q1, 2015 was 57% ‘welfare concerns’ and 43% ‘child protection’ concerns. (Tusla, 2016e). It could, in fact, be inferred that the figures for Oaktown are more closely aligned with the reporting patterns in England, Wales and Northern Ireland.

In England if the local authority to whom the child was referred considers that ‘reasonable ground to suspect that the child is suffering, or is likely to suffer significant harm’ exist, it will conduct an assessment (Department for Education, 2016: p.8). Therefore the number of children who were referred on for such an assessment are assumed here to be the children about whom there were child protection concerns. The number of such reports totalled 172,290 in the year ending March 2016 or 28% of all reports received (*ibid*), which also equates to 1.6% of all children under 18 years of age in England. This figure also represented a 7.6% increase of such reports from 2015 when there were 160,200 child protection reports (*ibid*).

In Wales available statistics do not provide a breakdown of the proportion of reports deemed to be ‘child protection’ but do show that of the 35,423 reports received in 2015/2106, 26,393 (75%) initial assessments were completed (Department of Education and Skills, 2016: p.4). In England, as previously mentioned, 28% of all reports received by social services for the year ended 2016 were deemed child protection and, in Northern Ireland, child protection referrals accounted for 7% of the reports received.

Table 4.4 Proportionate breakdown of welfare and protection referrals across the 17 Areas in 2015

Proportionate breakdown of welfare and protection referrals across the 17 Areas in 2015			
Area	Welfare %	Protection %	Total (no.)
Area 1	39.5	60.5	1,753
Area 2	65.1	34.9	2,145
Area 3	83.6	16.4	3,129
Area 4	63.6	36.4	4,495
Area 5	69.1	30.9	2,457
Area 6	55.4	44.6	3,853
Area 7	34.3	65.7	2,371
Area 8	43.6	56.4	938
Area 9	46.8	53.2	5,160
Area 10	54.7	45.3	997
Area 11	56.4	43.6	2,638
Area 12	53.8	46.2	3,462
Area 13	56.9	43.1	4,079
Area 14	71.0	29.0	3,179
Area 15	50.5	49.5	884
Area 16	66.5	33.5	1,007
Area 17	70.2	29.8	1,049

Source Tusla, Child and Family Agency (2016e)

Categorisation of abuse type nationally

The national breakdown of abuse type in reports that are categorised as ‘child protection’ was also examined for any obvious patterns. Table 4.5 presents all available information on referrals regarding the four categories of physical, sexual and emotional abuse and neglect from 2007-2016.

Table 4.5 Breakdown of abuse type for all referrals received nationally 2007-2016

Breakdown of abuse type for all referrals received nationally 2007-2016										
Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Welfare	12,715	12,932	14,875	16,452	15,808	21,143	22,192	24,954	25,361	28,312
% Welfare	54.6	52.4	55.3	56.2	50.0	52.6	53.3	57.2	58.2	59.7
Abuse	10,553	11,736	12,013	12,825	15,818	19,044	19,407	18,676	18,235	19,087
% Abuse	45.4	47.6	44.7	43.8	50.0	47.4	46.7	42.8	41.8	40.3
Physical Abuse	20.4	20.4	21.8	20.3	19.2	*	22.3	21.8	21.9	23.3
Sexual Abuse	21.9	20.3	21.6	23.1	21.0	*	27.2	33.4	35.8	15.9
Emotional Abuse	18.8	18.7	17.7	19.5	25.3	*	17.4	16.7	16.1	36.0
Neglect	39.0	40.6	38.9	37.1	34.5	*	33.1	28.2	26.2	24.7
Totals	100.0	100.0	100.0	100.0	100.0	*	100.0	100.0	100.0	100.0
National	23,268	24,668	26,888	29,277	31,626	40,187	41,599	43,630	43,596	47,399

(Source: Adapted from HSE, 2011a; Tusla, 2014b; Tusla, 2015a,b,c; Tusla, 2016a; Tusla 2016e.

*Breakdown of abuse type not available in national figures).

Table 4.5 shows that from 2007 until 2013, neglect was proportionately the largest category of reported abuse. From 2014, alleged sexual abuse began to dominate the statistics. Added to this, is the conjecture from a recent annual review, as previously mentioned, that some referrals have been mistakenly categorised as ‘welfare’ instead of neglect, which implies that the actual figure for neglect referrals would be even higher (Tusla, 2014b).

The number of reports regarding physical abuse remained fairly constant between 2007 and 2016 and while reports regarding sexual abuse also remained relatively constant until 2011 they showed substantial signs of increase in 2013, 2014 and again in 2015, however, in 2016 such reports have dropped significantly. Reports of emotional abuse have fluctuated, from the lowest category over a ten year span, to a substantial proportion (36%) in 2016.

Categorisation of abuse type at area level

It is of interest to compare these figures with the breakdown of abuse referrals in the area in which this research was based. As previously reported, in Q1 2015 86% of the reports received in Oaktown were categorised as ‘welfare’ while the remaining 14% were categorised as ‘abuse’. The latter consisted of physical abuse (51%), child sexual abuse (27%), neglect (18%) and emotional abuse (4%) which is at variance with the national averages. However, the figures for Q1 2016 in Oaktown are more closely aligned with the national averages (physical abuse (39%), neglect (26%), child sexual abuse (25%) and emotional abuse (11%)) and the increased reporting of neglect and emotional abuse and concurrent decreases in physical and child sexual abuse reports. Table 4.6 shows the proportionate breakdown of child protection referrals across the 17 areas for the year 2015, which again demonstrates a lot of variation at local level (Tusla, 2016e). In all but two areas the combined proportions of emotional abuse and neglect referrals are larger than the combined proportions of physical abuse and child sexual abuse referrals (*ibid*).

Table 4.6 Proportionate breakdown of protection referrals across the 17 areas in 2015

Proportionate breakdown of protection referrals across the 17 areas in 2015					
Area	PA%	SA%	EA%	Neglect%	Total (no.)
Area 1	22	12	23	42	1,060
Area 2	23	17	37	24	748
Area 3	42	23	16	19	512
Area 4	21	14	33	32	1,638
Area 5	28	16	33	24	760
Area 6	36	15	28	22	1,717
Area 7	18	12	34	36	1,557
Area 8	22	20	20	38	529
Area 9	18	12	48	23	2,746
Area 10	15	13	35	37	452
Area 11	18	15	43	24	1,151
Area 12	20	18	46	16	1,598
Area 13	17	24	36	23	1,757
Area 14	22	18	39	20	922
Area 15	16	16	34	35	438
Area 16	17	21	35	27	337
Area 17	31	29	22	18	313

(Source: Tusla, 2016e)

This trend has been reported in other jurisdictions (Trocmé et al., 2014; Bilson and Martin, 2016). For example, on the basis of their analysis of data from the 1998, 2003 and 2008 Canadian incidence studies of reported child abuse and neglect, Trocmé et al. (2014) showed that while the number of investigations of physical abuse and physical injuries in children under four years have not changed significantly, the number of sexual abuse investigations has decreased and those concerning neglect have increased. Bilson and Martin (2016) report how ‘a similar pattern is seen in England where, between 2009-10 and 2014-15 (DfE, 2015a), the numbers on child protection plans because of neglect (+28 per cent) and emotional abuse (+54 per cent) grew sharply whilst physical abuse fell and sexual abuse changed little’ (p.6).

Hart and Glaser (2011) identify a reduction in the levels of physical and sexual abuse in Australia, the US and the UK between 1993 and 2004 and note that the rates of neglect and psychological or emotional abuse remain unchanged or may be increasing. Gilbert et al. (2011) also echo these

findings and report that ‘in the United States, Canada and England, neglect has become the predominant child maltreatment category, with considerable declines in cases categorised as physical or sexual abuse’ (p.246). Finkelhor et al. (2017) report how overall substantiated cases of sexual abuse in the US have declined by 65% between 1992 and 2015 and substantiated cases of physical abuse have also declined by 56% since 1992. They also report an 11% decline in neglect cases since 1992 within a context of an overall decrease of child maltreatment for the first time since 2011. However, despite the reductions in 2015, neglect continues to be reported in much higher numbers than the other two maltreatment types in 2015 (sexual abuse: 58,500 -2%; physical abuse: 118,700 -1%; neglect: 548,200 -3%) (*ibid*; p.1).

Manion and Renwick (2008) reviewed cases reported to Child, Youth and Family in New Zealand which proceeded to an investigation phase and found a positive correlation between neglect and emotional abuse. They reported that, when combined, ‘emotional abuse and neglect constituted the most commonly found and suspected category of maltreatment’ (p.84) in their sample.

Overall, general agreement exists amongst commentators (Trocmé et al., 2014; Gilbert, 2012; Humphreys, 2008) that the expansion of the categories of child abuse or child maltreatment to include emotional abuse and the exposure of children to intimate partner violence has contributed to the increase in these figures. It is interesting to compare these more contemporary findings with the findings from the study carried out by Gibbons et al. in 1995. They reviewed 1,888 cases referred to eight English local authorities and found that the largest proportion of those referred was for suspected physical abuse (44%), next was suspected sexual abuse (28%) and just over a fifth (21%) were referred for neglect. Only a very small proportion (3%) concerned emotional abuse without any of the other forms of maltreatment.

Child Protection Reporting in Ireland North and South

Northern Ireland (NI) provides an interesting point of comparison in terms of child protection reporting given its closeness and comparability with the Republic of Ireland (ROI). Indeed, in recent research carried out by thedetail (<http://www.thedetail.tv/>) on child protection reporting rates in the two jurisdictions it was stated:

‘Experts, north and south, ... said that while there are some differences, child protection services in both jurisdictions are more similar than not’ (<http://www.thedetail.tv/articles/gap-in-children-at-risk-figures-north-and-south-raises-questions>).

There were two key findings in the above research. Firstly, it showed that four times as many children were placed on the child protection register in NI as in the ROI and secondly, there were three times as many social workers per head in Northern Ireland than in the south. Added to this, the research

provided a comparative analysis of child protection referrals across the two jurisdictions for the twelve month period ending in March 2016 (NI) and for the year 2015 (ROI).

As outlined above, the overall reporting rates for Ireland north and south illustrate quite a disparity with more than twice as many children being reported in NI (7.9% of all children under the age of 18 years reported in the year 2015/2016) than in the ROI (3.6% of all children under the age of 18 years reported in 2015). Commenting on the figures, Koulla Yiasouma, Northern Ireland's Children Commissioner, commented:

‘What I do very strongly believe that the figures don't say is that we have higher levels of child abuse in Northern Ireland, what I think they say is that our system is more mature and therefore responding to children and young people. What I will say is that in the north we can't be complacent just because we seem to have a system that is better able to respond to children and young people's needs, that doesn't mean we've got it cracked. Possibly the people of Northern Ireland, the people who are going to refer into systems may have more confidence in our systems and therefore are more likely to refer to them which is what should be happening’ (<http://www.thedetail.tv/articles/gap-in-children-at-risk-figures-north-and-south-raises-questions>).

Looking in more detail at the numbers of child protection reports in each jurisdiction, the research produced by thedetail shows a stark contrast between the child protection referrals received in the ROI and those received in NI. As reported above for the year ending 31st March 2016, 4,279 child protection referrals were received in Northern Ireland or 12.5% of all reports received, while in the Republic of Ireland during 2015, 18,235 referrals were received that were categorised as child protection (Tusla, 2015a,b,c,d and Tusla, 2016a) which accounts for 42% of all reports received. These figures for child protection reporting equate to 0.9% of all children under the age of 18 years in NI and 1.5% of children in the ROI. This implies that twice as many children were reported for child protection concerns in the ROI than in NI. However to recap on the figures cited above for child protection reporting in England (1.6% of all children under 18 years of age) and Scotland (1.5% of all children under 18 years of age) these figures show Ireland's rates of child protection reporting to be very much in line with these two countries.

Closer examination of the two systems reveals that the intake systems are broadly similar. In NI referrals outlining concern for a child are made to the Gateway Single Point of Entry within the local Health and Social Care Trust and the procedure to be followed is outlined in regional policies and procedures (Area Child Protection Committee (ACPC), 2005 and 2008). There is a great deal of emphasis placed on the use of the Understanding Needs of Children in Northern Ireland (UNOCINI) Assessment Framework (Department of Health, Social Services and Public Safety, 2011) by all organisations working with children and families, both to help them identify needs and as a means

for referring children to Gateway services. Urgent referrals can be made by telephone but must be quickly followed up by the provision of a completed UNOCINI A1 preliminary assessment form. As the statement below illustrates, the Department of Health (formerly the Department of Health, Social Services and Public Safety) strongly promote the view that good quality referral information is key to effective assessment:

‘The UNOCINI review in January 2007 concluded that improving the quality of referral information was critical to safe decision making. The quality of referral information has been, and continues to be, stressed as a critical element in improving the quality of assessment. Amongst the products of the UNOCINI Project is guidance on how to make a good referral, to assist the flow of good quality information between stakeholders’ (DHSSPS, 2008: p.6).

Upon receipt of a referral in which the referring person, professional or lay, indicates child protection concerns the relevant guidelines state:

‘After receiving a Child Protection referral the social worker should immediately check:

- the Child Protection Register
- social services’ computerised and manual records
- with all agencies, including their own, that may have information about the child and family.

In the course of these initial enquiries every attempt should be made by the social worker to fill gaps in the referral information, record this fully and pass this to his line manager’ (ACPC, 2005: 5.25).

It is then the role of the social work manager to decide upon appropriate further action. The key notable difference between policies and procedures operating in the ROI and NI lies in the protocols to be followed upon receipt of a child protection referral (as opposed to those which are considered child welfare). In NI, when a referral is categorised as child protection, the social worker is directed to check ‘with all agencies, including their own, that may have information about the child and family’ (ACPC, 2005: 5.24) and it is noted that it may be necessary in some instances to do so without parental consent. These guidelines are currently being re-drafted and this key issue of gathering information without parental consent is being addressed. It is thus stated: ‘[A] decision to discuss the referral with other agencies without parental knowledge or permission should be in accordance with the Safeguarding Board of Northern Ireland (SBNI) Information Sharing Agreement’ (Safeguarding Board of Northern Ireland, 2017a: p.9). These comprehensive draft guidelines from the SBNI offer ‘Seven Golden Rules for Information Sharing’ (Safeguarding Board of Northern Ireland, 2015: p.18) and include advice such as: ‘(S)hare with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case’ (*ibid*).

In the ROI, as outlined in Chapter 1, guidelines to assist the ISW in carrying out their tasks during a preliminary enquiry are available in the *Child Welfare and Protection Social Work Departments Business Processes* (SBP guidance) (HSE, 2009) which is a document that was written to accompany a technological data gathering project which is yet to be launched nationally. The issue of checking with other professionals during the preliminary enquiry stage and the need to procure parental consent is also addressed in this guidance and in *Children First* and the operating principle in both documents is that parental consent must be sought unless ‘the perceived risk to the child is such that it is not deemed desirable to contact the parents/carers’ (*Children First*, 2011: Section 5.2.6). In May 2016, Tusla released a practice note to add further clarity to this issue which clearly was causing difficulty for practitioners. As following chapters will confirm, the difficulties have nonetheless endured.

In terms of the timelines within which initial enquires must take place in NI the guidelines state that:

‘The referral, and action agreed, including categorisation of the referral, should be confirmed in writing by the Social Work Manager to the referrer within **5 working days** of the receipt of the referral’ (Area Child Protection Committee, 2005: 5.21).

Thus more time is allowed for decision making at this initial stage in NI than in the ROI where the time line for a preliminary enquiry and a referral’s first categorisation decision regarding outcome is 24 hours.

To enable a more comprehensive comparison of the two systems, it is instructive to look at further available data from each country regarding the outcomes of referrals that were categorised as child protection.

Of the 4,279 child protection referrals received in NI in 2015/2016 3,470 required child protection investigations, 2,317 were subject to initial case conferences and ultimately 2,040 of these children were placed on the Child Protection Register. This registration rate represented a 7% increase on the previous year (Information Analysis Directorate, 2016).

As previously outlined, in 2015 of the 43,596 referrals that were received in the ROI, 18,235 (42%) were classified as ‘child protection’ and the remainder 25,361 (58%) were categorised as ‘child welfare’ (Tusla, 2015a,b,c,d and Tusla, 2016a). The vast majority (98%) received a preliminary enquiry and of those 20,393 (48%) received an initial assessment as recommended by the preliminary enquiry (*ibid*). In Q1 2015 nationally the proportion of cases that were put forward for an initial assessment following the preliminary enquiry was also 48% (Tusla, 2015e). Of those referrals that received an initial assessment, 10,432 were ‘child welfare’ referrals and 9,956 were ‘child protection’ referrals, however, a higher proportion of ‘child protection’ referrals (56%) required an initial assessment than those which related to ‘child welfare’ concerns (42%) (Tusla, 2016e).

Data on the outcome of these initial assessments are limited as not all information returned to Tusla from each of the 17 areas recorded an outcome. This is a big gap in the national child protection and welfare statistics in the ROI. Nevertheless, the figures that are detailed provide an insight into the outcome of the initial assessments completed. Outcome were recorded in 9,680 (47%) of the 20,393 initial assessments that were completed that year (*ibid*).

The highest proportion of recorded outcomes from child protection reports was ‘no further action’ (NFA) (52%), followed by ‘further assessment’ (22%). It is notable that after an initial assessment only 13% of referrals continued with a categorisation of child protection and a tenth (10%) were re-categorised as ‘child welfare’ or ‘family support’ (*ibid*).

In respect of the ‘child welfare’ referrals, the highest proportion of recorded outcome following initial assessment was also NFA (65%) which is notably higher than the same outcome for the ‘child protection’ initial assessments. Further assessment was recommended in 15% of these initial assessments and ‘child welfare’ or ‘family support’ in 14%. An outcome of ‘child protection’ was recorded in 5% of the initial assessments that were originally categorised as a ‘child welfare’ referral at the preliminary enquiry stage (*ibid*).

Of the 13% of child protection referrals which continued to be categorised as ‘child protection’ after the initial assessment, it is likely that all or most went on to a child protection conference (CPC). Unfortunately, these data are not available for 2015. What is available is the number of children listed as ‘active’ on the child protection notification system (CPNS⁷) at the end of 2015 (1,349) and ‘inactive’ (2,407) (Tusla, 2015c). The only information that is provided regarding the number of children that were newly listed in that year relates to Q4 when ‘382 children were listed as “active” on foot of a CPC that took place in the quarter’ and that ‘(f)or the same period, a total of 36 children were reactivated on the CPNS (i.e. their status changed from ‘inactive’ to ‘active’) (Tusla, 2015c: p.18).

In summary, the number of referrals to social services annually in Northern Ireland is more than double those made in the Republic of Ireland, yet almost three times more of these referrals are categorised as ‘child protection’ in the ROI than those in NI. Added to this, in December 2016 there were four times as many children (per 10,000 population) on a child protection register in NI (51) than in the ROI (11) and in NI there is a 1:227 ratio of social workers to children, whereas in the ROI the ratio is 1:714. (Source: <http://www.thedetail.tv/articles/gap-in-children-at-risk-figures-north-and-south-raises-questions>).

⁷ ‘The CPNS is a securely held national list that records the names of children who have been identified as being at ongoing risk of significant harm and are, or have been, subject to a child protection plan agreed at a child protection conference’ (Tusla, 2015i: p.17)

Conclusion

Available administrative data on child protection and welfare referral rates in Ireland confirm assertions made in the literature that child maltreatment reporting in most Anglophone countries continues to rise (Trocmé et al., 2005; Mansell, 2006; Humphreys, 2008; Gilbert et al., 2012; Bilson et al., 2015; Bilson and Martin, 2016). By comparison with our UK neighbours, however, Ireland reports a smaller proportion of the total child population to child protection and welfare services.

In terms of the categorisation of reports received, a persistent pattern has prevailed during the last ten years whereby slightly less than half are categorised as ‘child protection’ and slightly more than half are categorised as ‘child welfare’ (Buckley and Burn, 2015). Over the last three years this has begun to change somewhat with more cases being categorised as ‘child welfare’. However, there is evident variation in practice across the 17 areas of Tusla in terms of the categorisation of cases, indicating a lack of uniformity of practice across the agency. There is also an evident element of variation across the 17 areas with regard to the recording of abuse type with evidence of an overall increase in emotional abuse and neglect cases and a reduction of physical and child sexual abuse cases, which is line with reporting patterns in other countries (Manion and Renwick, 2008; Finkelhor et al., 2017; Hart and Glaser, 2011; Trocmé et al. 2014; Bilson et al., 2016).

As our nearest neighbour and most comparable system, particular attention has been given in this chapter to child protection and welfare systems in the Republic of Ireland and Northern Ireland. Comparisons between the two jurisdictions raises a number of questions, notably whether social services in NI are more efficient at providing services to vulnerable children because of the type of pre-screening carried out. The key differences between policies in the two jurisdictions are firstly, the amount of time allowed for initial enquiries, secondly the detail provided in guidance about information sharing without parental consent and thirdly, the ratio of social workers to children in the population.

While there are gaps in available data for the Republic of Ireland, there is evidence of a high level of filtering as cases make their way through the various phases of screening and enquiries which raises questions about the quality of decision making in a highly pressured context. The next chapter furthers the discussion regarding the filtering out of cases in the Irish system and looks to the international body of literature on decision making, thresholds and filtering to contextualise it.

Chapter 5 Decision Making, Thresholds and Filtering

‘Practitioners are asked to solve problems every day that philosophers have argued about for the last 2,000 years and will probably debate for the next 2,000. Inevitably, arbitrary lines have to be drawn and hard cases decided’ (Dingwall et al., 1983: p.244).

A key aspect of the process of responding to reports about children is decision making. Central to this are the two inter-related judgments: whether a case is classified as ‘child protection’ or ‘child welfare’ and whether it should be closed without further action or put forward for an initial assessment. This chapter presents findings from empirical research to provide perspective on the context in which these decisions are made. Implicit within the process are thresholds, filters and a degree of what is termed ‘moral reasoning’. The literature pertaining to these related issues is reviewed below.

Decision making

There is broad agreement in the literature that social workers have very difficult, complex and challenging decisions to make at the Front Door or the point of referral, often with very little knowledge of context or background of the child and family who are the subjects of the reports. The irony of this was highlighted almost two decades ago by Littlechild (1998) who pointed out that ‘it is not always possible to know what is serious and what is not until some form of investigation takes place’ (p.118). This truism is reiterated in the guidance provided to intake social workers by Tusla which points out that ‘(t)he social worker cannot be expected to confirm the report type at this early stage’ (HSE, 2009: p.21). Yet the intake social worker is expected to provide a categorisation of the cases reported at this preliminary stage and within a restricted time frame.

The business of classifying child protection and welfare reports has been examined by a number of researchers (Spratt, 2001; Hayes, 2006; Hayes and Spratt, 2009; Hayes and Spratt, 2014) and has been shown by empirical research to be a very subjective endeavour. For example, Hayes and Spratt (2014) found in a sample of fifty-five social work practitioners from three Health and Social Care Trusts in Northern Ireland that no agreement existed regarding the categorisation of the twenty case vignettes distributed. As other recent empirical research has shown, factors influencing this level of reasoning may be impacted by external as well as internal factors. For example a recent survey showed that some social workers in England feel pressured into downgrading child protection cases in order to cope with an upsurge in reporting (Stevenson, 2015: p.1).

Since the advice to child protection services to apply a lighter touch to reports about vulnerable children and families outlined in the Department of Health's (1995) *Child Protection: Messages from Research*, an overall reduction in the number of cases being classified as 'child protection' and subject to investigations has been observed in some jurisdictions (Hayes, 2006; Hayes and Spratt, 2014). However, research carried out in the years following the development of child welfare and family support services showed that social workers remain very focused on the management of the risks in the families reported leading to the development of strategies which are 'child protection light' but still somewhat forensic in their orientation (Hayes and Spratt, 2009: p.1593)

As Platt (2006) has pointed out, social workers are under significant pressure to make the right decision as to fail to do so may place a child in the way of harm. Yet, very few of these decisions are straightforward as observed by Benbenishty et al. (2003):

'[T]here are only a few, and extreme objective conditions (physical or interpersonal) that are unanimously recognised as constituting maltreatment or abuse, and which are either self-evident or unequivocally discernible through the application of some systematic or scientific procedure' (p.138).

Rather, the reports received are more likely to be complex and multifaceted and are received into the particular environs of the duty or intake system. A considerable body of contemporary empirical research has been carried out into the operation of these systems (Spratt, 2000; Benbenishty et al., 2003; Buckley, 2003; Platt, 2006; Broadhurst et al., 2010; Gillingham and Humphreys, 2010; Wilkins, 2013; Kirkman and Melrose, 2014; Kettle, 2015; Saltiel, 2015) and there is tacit agreement that decisions made in a context of high demand and heavy workloads, limited resources, limited time, poor supervision, a lack of information and sometimes conflicting information can leave the social worker concerned grappling with a high degree of uncertainty and ambiguity (Mansell, 2006; Platt, 2006; Saltiel, 2015). As Gambrill (2008, p.176) pointed out, lack of information and challenges in distinguishing between 'personal ignorance' and deficient knowledge, client ambivalence and lack of resources all contribute to uncertainty.

A small number of the reports received by intake social workers are easily defined as child maltreatment. For example, research conducted in the 1990s showed that sexual abuse allegations tended to be investigated (Gibbons et al., 1995; Cleaver and Freeman, 1995; Buckley et al., 1997; Buckley, 2003). However, in the main, decisions reached regarding how to proceed necessitate case by case deliberations in line with Benbenishty et al.'s (2003) assertions. Munro (2005a) observed that 'interpreting information becomes particularly problematic when judging whether it reaches the threshold to be considered abuse or neglect' (p.381). This sentiment is reflected in the literature reviewed here (Buckley, 2003; Spratt, 2000; Benbenishty et al., 2003).

Policies, procedures and guidelines have been developed in most jurisdictions to assist workers to process the reports received at intake. Research on the topic looks in particular at the usefulness and applicability of risk assessment tools including structured decision-making (SDM) tools, many of which have been developed to address shortcomings highlighted by child death and serious case reviews over the last number of years (Reder and Duncan, 2004; Gillingham and Humphreys, 2010). Although research carried out into the efficacy of these tools is largely positive (Shlonsky and Wagner, 2005), very little attention has been given to the way in which practitioners put them to use.

To address this gap, Gillingham and Humphreys (2010) carried out an ethnographic study with child protection practitioners in Queensland, Australia which demonstrated how the tools were used as ‘accountability rather than decision making tools’ (p.2609). They found that not only were decisions sometimes made before the tools were used, but that at times participants manipulated the tools to align with the outcome they had predicted. This practice had been observed earlier by English and Pecora (1994) who showed how, at times, risk estimation tools were used after practitioners had decided upon the outcome of a case. In order to combat these tendencies, Gillingham and Humphreys (2010) recommended that risk assessment tools should complement rather than replace practice expertise, and advised caution in their application to human problems. Their research demonstrates that the SDM tool is unable to encompass the complexity of the problems reported as child abuse. They further argued that the inherent risk factors are not linear and static but rather multi-faceted and constantly evolving, often requiring much more than a single solution. Similarly, Wilkins (2013) cautions that, if actuarial or structured decision-making tools are to be used, regard must be given to the ability of child protection social workers to balance positive and negative factors, as well as identifying risks. Munro (2005b) made the pertinent point that child abuse investigations require skill in not only gathering the information but also, crucially, interpreting it.

The matter of interpretation is addressed in great detail in the literature on child protection decision making. Platt and Turney (2014) put forward a conceptual model which challenges the technical-rationality underpinning risk assessment models. They propose a naturalistic decision-making approach and consider the various sense-making strategies through which threshold decisions are mediated at local level. While an over-emphasis on the interplay of intuitive decision making shortcuts (heuristics) and cognitive bias in understanding decision making has been criticised by some, it is suggested by Platt and Turney (2014) that a consideration of both the rational and the intuitive is essential when reviewing real life practice. They further propose that the relatively straight-forward factors which influence decisions such as political, economic and organisational structural factors all interact with each other and with the individual professional factors of the worker. These include their experiences, attitudes and value systems which ‘crucially all are subject to a process of sense-making which leads to the actual decision in the individual case’ (p.1480).

In a similar vein, Munro (1999) drew the distinction between the two major forms of human reasoning that are evident in literature: analytic and intuitive. Hammond (1996) provided a useful definition outlining the difference between the two. He defines analytic reasoning ‘a step-by-step, conscious, logically defensible practice’ (p.60) and intuitive reasoning as ‘a cognitive process that somehow produces an answer, solution or idea without the use of a conscious, logically defensible step-by-step process’ (p.60). Munro (1999) contends that these two forms of human reasoning are easily discernible in child protection work: intuitive reasoning in the form of the reliance by social workers on their intuition in decision-making and analytical reasoning in the availability of policy documents and checklists to guide and improve these decisions.

Practice guidance documents are generally available to guide decision-making at the Front Door. However, their utility in practice is challenged in an Irish study by O’Connell (2014), who questioned whether and how the sixty policies developed by statutory child protection services have been assimilated into everyday practice. She identified ‘policy overload’ and a fear amongst child protection social workers of using too much individual discretion, of making the wrong judgement and of being held accountable for not being familiar with all related policies.

Exploring the lessons from research on decision making Munro (2008) identifies the ‘classic art-science debate’ (p.195). She observes that both technical and intuitive approaches ‘offer valuable lessons for different decision-making scenarios in child welfare’ (*ibid*). She points out that formal decision theory may be lauded for its openness and visibility, which means that the processes used can be clearly understood, challenged and justified. However, she argues for acknowledgment of the countless minor decisions that need to be made urgently and are heavily reliant on a worker’s judgement.

The intuitive reasoning and ‘sense-making’ used in decision making are explored in a number of studies (Buckley, 2003; Munro, 1999; Munro, 2005a; Broadhurst et al., 2010; Platt and Turney, 2014; Kirkman and Melrose; 2014; Saltiel; 2015). It is generally agreed that ‘real world’ child protection work does not readily fit with what Buckley (2003) described as the ‘relatively straightforward framework outlined in the child protection guidelines’ (p.90). In fact Buckley (2003) further argued that ‘the work is shaped by the ‘sense making’ activities of child protection practitioners’ (*ibid*) as did Saltiel (2015) who remarks ‘such reasoning does not figure in official accounts of social work. It takes place locally and informally in emotionally and cognitively demanding contexts and is profoundly shaped by them’ (p.11).

In understanding the process whereby practitioners ‘make sense’ of the information that is presented to them, Buckley (2003) drawing on the work of Thorpe (1994) and Parton (1997) highlighted how the practitioners in her research applied ‘situated moral reasoning’, through a process of negotiation

with their colleagues, to each referral received. For example, she noted a trend whereby families who were re-reported were likely to be considered un-cooperative and tended to be discounted and receive no response. Platt (2006) also found consideration of the culpability of the families reported to be a 'component of social workers' moral reasoning' (p.14). Related to this is the concept of 'cultural relativism' (Dingwall et al., 1983) and its impact on the ability of workers to discriminate between what is child abuse and what is not. Buckley (2003) documented how child abuse, and in particular neglect, was defined with reference to cultural norms. For example, she demonstrated how the practitioners in her study applied different standards of care in respect of children living in settled families to those living in Traveller families. Overall, research and theory on this topic advocates greater awareness on the part of child protection social workers of the value base for their decisions.

There is agreement in the literature that time constraints and workload pressures tend to promote a practitioner's use of intuition (Buckley, 2003; Platt, 2006; Broadhurst et al., 2010; Saltiel, 2015; Kirkman and Melrose, 2014) and that intuition can be prone to biases (Kahneman and Klein, 2009). While it is agreed that skilled and experienced intuition can be honed with time and experience (Saltiel, 2015), it is also noted that intuition is prone to bias or heuristics described by Kirkman and Melrose (2014) as 'mental shortcuts or rules of thumb' (p.18) which can, if not checked, lead to systematic errors in judgment.

Examples of heuristics or biases are provided by Platt and Turney (2014) and include 'confirmation bias' 'where a practitioner selectively gathers evidence to confirm an intended decision' (p.1482) or 'order effects' by which 'information presented later in the development of a case is seen to carry more weight than information obtained earlier' (*ibid*). It is contended by some that processing large amounts of information will lead to errors in judgement (Miller, 1956; Benbenishty et al., 2003). As Munro (1999) pointed out, the first and last piece of information, as well as that which is 'vivid, concrete or arouse emotion' are likely to be remembered and recalled with the greatest ease.

Drawing on literature from the field of behavioural science, Kirkman and Melrose (2014) have also provided examples which they consider relevant to work at the Front Door such as 'availability heuristics' and 'recall biases' in which 'people's perception of the likelihood of things like a specific event occurring are strongly influenced by their ability to recall a similar example or event' (p.22). Media coverage and its influence on decision making is thought to play a significant role here. Kirkman and Melrose (2014) also identify 'group think', a term coined by Janis (1982), and show how social work decisions about how to respond to a particular case or a particular issue may be influenced in a group setting. Farmer and Owen (1995) earlier observed that group decisions are particularly susceptible to bias as individuals may be reluctant to challenge a belief in a group setting and eager to avoid the additional stress of confronting a colleague in a semi-public situation. Other examples, outlined by Kirkman and Melrose (2014), include: when the difficulties in a case are

judged relative to other similar cases that the decision maker has previously encountered; the use of decision avoidance strategies, such as passing responsibility around to adequately define the situation and making a number of smaller decisions first before making the final decision; allowing one's affective or emotional response to influence the decision made; using jargon as a mental shortcut and, drawing on the work of Dijkster and Koomen (1996), how practitioners under pressure rely on their emotional responses.

Kirkman and Melrose (2014) also observed the use of jargon in the local authorities they visited and note its propensity to mask lack of understanding and promote less sophisticated thinking. Jargon and other 'localised practice norms' (Pithouse, 1987: p.24) such as localised guidance, developed separate to centralised policies and procedures (Spratt, 2000), have been remarked upon by a number of commentators in their analysis of decision making at the Front Door:

'To enter the assessment system, a contact or referral must meet local eligibility criteria, that is based not just on the nature and relevance of the concern, but also on team-specific factors reflecting available staffing and resources' (Broadhurst et al., 2010: p.358).

The gruelling impact of decision making in complex and challenging cases is noted in the literature. Kirkman and Melrose (2014) observe that exhaustion experienced by the social workers involved may lead to depletion of mental resources and consequently poor decision making, decision-avoidance or simplification of decisions. As Broadhurst et al. (2010) have argued, the need to make a decision within a time constraint requires workers to make a quick but not necessarily reliable response and may mean that 'speed practices' (p.359) and deflection strategies become normalised and habitual. Deflection or deference may be directed towards a superior, based on the presumption that they have knowledge and experience to hand followed by a reluctance on the social worker's part to challenge the decision made by a superior. Kirkman and Melrose (2014) observe '[t]his may be particularly pertinent in a social work environment as the most common operating structure at the front door is for all decisions to be signed off by a manager before being passed on for assessment or out of the service' (p.30).

Research on decision making found that some of the tools essential to the process, such as rebuttal (consideration of possible alternative scenarios) and qualifiers (degree of confidence and likelihood) were lacking (Benbenishty et al., 2003) and yet essential for good decision making (Buckley, 2003). Failing to rebut or question decisions may mean that intake social workers may fall into the trap of only gathering information that is consistent with their initial hypothesis (*ibid*; Munro, 1999) and can be slow to revise their initial hypothesis even in the face of new evidence (Farmer and Owen, 1995). Buckley (2003) similarly found that the social workers in her study, cautious about 'devastating' families by their intervention, tended to construct whatever evidence was available in a positive light

and became disinclined to search for more information that could potentially discredit that view (p.182).

Empirical research has identified how the quality and quantity of information provided to intake social workers can influence outcomes. For example, Kirkman and Melrose (2014) illustrate the way that poor quality information from the source of the referral can have a negative impact on decision making. Too much information can create what they term 'a dilution effect' (p.32) where important information can be buried in an unnecessarily long referral and, as a result, a high level of comprehension skill is needed to effectively synthesise the information provided. Platt and Turney (2014) also suggest that the specificity of information can have a bearing on the decisions made. Added to this, Saltiel (2015) reported a constant tension between the need to make a quick decision and the time it took to gather the information that was necessary to inform such a decision.

Hayes and Spratt (2014) found that the most frequently provided reason for giving a reported case a categorisation of CCP (child care problem) was that the referral contained insufficient evidence or information to justify a CPI (child protection investigation) and concluded that the former should be regarded as a 'holding category' (p.630) pending the establishment of evidence to elucidate the concern.

In a recent study Saltiel (2015) identified the potential unreliability of information available to intake workers, who are often dealing with incomplete and partial accounts from both professional and lay reporters and reported a tendency to use informal skills in evaluating this information. Indeed, a number of those writing on decision making at the front line have identified how the social worker's perception of the source of information can be a strong determinant of the decision outcome and can impact the decisions that are made.

Differing responses to information can occur. For example, Platt (2006) found, information received from more than one source at around the same time or referrals appearing clusters, thereby corroborating the concern, tilted the balance towards intervention. While Buckley (2003) noted that consideration was given to the reputation of certain reporters and noted an unacknowledged norm that further information would not be pursued from reporters unless they supplied enough detail to compel it.

Referrer credibility and the motive of the referrer have been identified as important factors in decision making about a referral in a number of other studies (Dingwall et al., 1983; Giller et al., 1992; Platt and Turney, 2014) and Buckley (2003) develops this with her assertion that information processing strategies were applied in respect of certain referrers in order to keep the work level manageable and to preserve a spectrum of the seriousness of reports so as not to de-value the system. Broadhurst et al. (2010) also found in their research that failing to provide referrers with feedback, which may

afford the referrer an opportunity to challenge the categorisation of their report, may at times add to the potential for errors. Platt and Turney (2014) identified operational strategies such as deflecting referrals back to another agency or responding to certain referrals with a standardised letter as a means of coping with the pressures affecting their work.

Kirkman and Melrose (2014) mirror Buckley's (2003) findings about the influence of referrer credibility citing the example of police in the UK reporting all incidents of domestic violence witnessed by children regardless of their severity, resulting in a 'crying wolf' effect which may increase the possibility of missing emotional abuse.

Research has noted a trend whereby workers become 'habituated' to rationing. For example, reports from neighbours and relatives were often regarded with suspicion (Broadhurst et al., 2010). Similarly, referrals from unidentified persons tend to be discounted or regarded as malicious, a finding that was earlier identified in a study in Missouri by Drake (1995) who described screening as an unacceptable solution to anonymous reporting.

Filtering

Filtering is an integral part of the intake system and while it is ostensibly an exercise in assessing risk to children, the literature demonstrates that other competing motives may be at play. Buckley (2003), for example, identified the type of reasoning employed in filtering, including reluctance to intrude where not much may be achieved and the determination of intake social workers to share the 'dirty' work of child protection. She described the filtering process as 'sense making' (p.90).

The potential for a case to be filtered out is a constant as a case makes its way through the different phases of referral and assessment. Concern has been expressed on two levels about the number of cases that are eliminated from child protection services at each stage in the system and questions are raised firstly as to why so many 'ineligible' cases are referred inwards, and secondly, about the accuracy and appropriateness of decisions made. These are not new concerns; more than twenty years ago Jane Gibbons and her colleagues (Gibbons et al., 1995) carried out a study, which is considered by some (for example, Lonne et al., 2009) as seminal, into the operation of the English child protection system. As well as conducting a national postal survey of all child protection registers in England, the researchers tracked a sample of 1,888 children who were referred to eight local authorities for suspected abuse or neglect over a 16 week period. They used the now well-known metaphor of a fishing net to illustrate the screening out process within the child protection services they researched:

'The child protection system might be considered as a small-meshed net, in which are caught a large number of minnows as well as a smaller number of marketable fish. The minnows have to

be discarded but no rules exist about the correct size of the mesh. Each fishing fleet may therefore set its own. The ‘meshes’ are the organisational filters operated by local child protection systems’ (p.51).

Their study found high rates of elimination of newly referred cases with little information about the rationale applied each time. It found that reports about neglect and what were regarded as minor physical abuse formed the bulk of the 25% excluded at the outset. At the end of the pathway six out of every seven of the reports about children were filtered out. The process which led to this, they pointed out, represented not only an ‘an enormous burden of work’ for already hard pressed services but also left far too many families feeling “unjustly” accused’ (p.78). The ‘filter-and-funnel’ approach described by Gibbons et al. (1995), also identified in other research (Besharov, 1990; Thorpe, 1994; Buckley, 2003; Cleaver et al. 2004; Manion and Renwick, 2008), is still visible in Anglophone countries, as illustrated by Hood et al. (2016) on the basis of their extensive research in the UK. As they commented, the system appears to be ‘designed to manage rather than meet the needs of families’ (p.937), and they noted the endurance of the ‘fine meshed fishing net’ approach previously identified twenty years ago by Gibbons and her colleagues.

Buckley (2012) notes how, despite high levels of reporting of child abuse in Ireland (29,277 in 2010) only a very small proportion (5%) were ultimately confirmed as child abuse. As previously outlined, outcomes are not consistently and comprehensively reported in national administrative data but it is possible to discern that only 13% of ‘child protection’ referrals in 2015 and also in 2016 retained their original classification following initial assessment (Tusla, 2017b).

Bilson et al. (2015) and Bilson and Martin (2016) have also reported high levels of filtering in Australia and England respectively, noting that while over 13 per cent of all children born in 1990 and 1991 in Western Australia were reported before reaching the age of eighteen, 71 per cent of these reported children were found not to have been maltreated.

Bilson and Martin (2016: p.12) effectively use the metaphor of an average classroom of thirty children in 2014-2015 to show that just under a quarter (7) would have been referred to children’s services by their fifth birthday. Only one of this cohort, they claim, would have been considered as suffering or likely to suffer significant harm, one or two would have been the subject of child protection investigations and four would have been assessed as having complex needs. Commenting on the implications of this level of filtering, Bilson et al. (2015) highlight the futility of expensive and time consuming investigative and blaming approaches and argue for reform which facilitates genuine engagement with socially excluded communities, which will foster ways of supporting children and families. Hood (2016) also comments on the wasteful expenditure of resources in filtering cases, claiming that:

‘(T)oo much time and effort is consumed in navigating thresholds and boundaries between different parts of the system. For managers the incentive is to control workflows (e.g. by closing cases and referring on), rather than meeting need at the point of entry’ (p.3).

Some empirical research yielded positive findings regarding the filtering processes they examined. A key finding of Manion and Renwick’s (2008) research, for example, was that cases that were closed post-investigation did not constitute a waste of effort. Their review indicated that the cases contained sufficient concern to warrant an investigation and a large proportion of them required some form of service to ‘assist the family with the stressors and risk that could otherwise compromise the wellbeing of their children and youth’ (p.72).

Forrester (2008) also offers a slightly different perspective on the process of filtering and provides some empirical evidence from a study of 400 closed cases in the UK which were re-referred. He postulates that, despite high levels of screening, practitioners appear to be ‘relatively good’ at discerning which cases may involve or be at risk of maltreatment and keeping them open whilst closing others (p.296). He also observed that the re-referrals of closed cases often contained new information which could not have been predicted. This finding led Forrester (2008) to conclude that filtering in the 1990s and early 2000s was comparatively accurate and that new systems could be equally good, however he does stress that as yet this remains untested.

No further action and thresholds

In the Anglophone jurisdictions, most operating child protection procedures use the term ‘no further action’ (NFA) to indicate the journey of a case has come to an end. The term itself has quite a final feel to it and it is apparent in the research literature that the application of this determination has certain connotations for the practitioners making that decision. In the ethnographic research carried out by Broadhurst et al. (2010), a decision to give a case an outcome of ‘NFA’ was at times described as a ‘relief’ by the workers but sometimes based on a questionable rationale:

‘We [the researchers] were told that children aged thirteen, fourteen and fifteen were routinely NFA-ed (i.e. no further action was recorded) on the basis that these children and young people “must have lived with these concerns for a long time and be quite resilient”’ (p.360).

In theory, the decision that a case requires no further action is taken on the basis of its ineligibility, or failure to meet the thresholds for services. It can also be made if it is perceived that the needs of the child and family reported have been met. Saltiel’s (2015) research found that cases which had an outcome of ‘no further action’ were those which were considered low priority or those cases where ‘more universal, less stigmatising services’ (p.10), would be willing to work with the child and family

As he puts it ‘NFA decisions are clearly a central element of gate-keeping and threshold management, and some of the most important decisions the team takes’ (*ibid*).

Reports are accepted into the child protection system if they reach a particular ‘threshold’. As Kirk and Duschinsky (2016) argue, within a forensic system, the application of thresholds is based on the idea that they can be determined logically. They go on to point out that the level of clarity and rationality required is not achievable in practice. Rather, as Broadhurst et al. (2010) point out: thresholds ‘shift and flex to fit local conditions’ (p.358). This point was also made by Mansell (2006) who commented that at a local service provision level they are embedded in the time and resources available ‘where workload mediates the threshold for intervention [and] the effect of increasing demand is not an increase in notification rates, but rather an increase in the threshold for intervention’ (p117). Mansell also noted that the multiple stakeholders, including community, media and government ‘set demands for levels of risk assurance and so influence risk-screening thresholds’ (Mansell, 2006: p.101).

Platt (2006) points out the artificiality of applying thresholds to real life where children’s experiences of abuse or neglect are not so neatly ordered. He suggests that ‘a more holistic understanding of the child’s circumstances is required’ (p.16) and surmises that in order to make decisions social workers need to find ‘ways of managing the complexities and uncertainties at the referral stage, albeit through the reduction of those complexities to a set of intuitive steps’ (p.16). The need to move away from a preoccupation with thresholds in decision making is also promoted by Kettle (2015) who examined ‘tipping points’ (p.7), that is when a social worker’s categorisations of a child’s need changes potentially resulting in a very different service response. Kettle (2015), on the basis of 22 in-depth interviews with child protection social workers, found that ‘triggers for, and consequences of, the “tipping point” may be as much to do with the changes in the internal world of the social worker as the changing circumstances of the family’ (p.1). Such changes by the social worker may come about because of deliberate strategies, for example re-reading the chronology of a case or bringing a pair of ‘fresh eyes’ to it but equally they may come about because of intuitive responses.

There are various suggestions in the literature of strategies that could be used to improve decision-making at the Front Door. While Munro (2005a) has contended that the intuition by which decisions are guided may improve with time and experience, Kirkman and Melrose (2014) counter this notion and argue that a very different set of skills is required. Spratt (2000), Wilkins (2013) and later Kirkman and Melrose (2014), as well as Gambrill (2008) suggest that feedback and reflection are integral to the development of intuition at the Front Door, however, they acknowledge that the potential for contemplation is often undermined by pressures of the work. Saltiel (2015) similarly found that the physical presence and availability of a manager helped to keep thresholds lower and ensured that a range of views and options were considered when decisions were being made.

Benbenishty et al. (2003) found that social workers receiving referrals try to make their decisions based on the facts of the case presented to them and try to process these in a deliberate manner. In a similar view, Munro (2005b) wonders whether decision-making would change if the practitioners involved had more information available. However, she refers to what Simon (1996) has termed 'bounded rationality' whereby humans only have a limited ability to process data and increasing the amount can result in a deterioration rather than an improvement in decision-making skills.

Intake work encompasses both 'major-decision points' such as taking a child into care and simultaneous 'less significant, but far more common decisions' (Munro, 2008: p.200). It would be a mistake, Munro (2008) has argued, to focus solely on the 'big' decisions in the development of any formal decision making tools, emphasising the importance of raising 'everyday' decisions to 'a higher critical standard' (*ibid*). Intuition is more likely to guide every day decisions whereas more analytical thinking is needed for the more difficult, all-encompassing ones and it is Hammond's (1996) view that these two types of decision-making styles be viewed on a continuum. Gambrill (2008) takes this further by observing the emergence of an integrative view in which two different processes operate' (p.180).

Research also highlights the need for social workers to reflect on the systems around them, which impact the decisions they make (Wilkins, 2013). Gambrill (2008) goes further, pointing out that 'a systemic view of decision making requires attention to the organisational context in which decisions occur including time pressures and conflicting goals' (p.188). Finally, Munro (2005b) suggests that tools and decision making aids should be developed in accordance with the need identified by those who will be using them.

Conclusion

The decisions made by intake workers are necessarily difficult and complex and happen in time constrained circumstances. As the literature has demonstrated, the categorisation of reports is a very subjective endeavour which can be sensitive to both local pressure and shifts in national policy imperatives.

Some jurisdictions have developed risk assessment tools to help with the ordering and interpretation of information. Evaluations have yielded mixed reviews, the most common message being the limited nature of these mechanised processes and their inability to replace practice expertise.

The process of 'sense making' is given considerable attention in the literature which focuses on systemic influences as well as the interplay of analytic and intuitive reasoning and acknowledges how workload, time pressures and a lack of good quality referral information may lead to an over

reliance on informal reasoning. Studies have also highlighted how time pressures may promote 'speed practices' and deflection strategies. Research on filtering, an integral element of the intake process, illustrates its susceptibility to competing motives. Added empirical evidence points to very high rates of attrition as cases make their way through the intake system and beyond, leading some to conclude that too much time and effort is spent investigating reports that will inevitably be eliminated from the system, while greater effort should be made to constructively engage families and socially excluded communities. Conversely, there is some limited empirical evidence to suggest that social workers are good at discriminating between serious and non-serious reports.

The use of 'no further action' as a case outcome is also reported in the literature to be at times based on localised sense making strategies. Thresholds are also reported to be heavily influenced by local practices and the availability of resources and at a theoretical level, thresholds assume a level of rationality and order that does not exist within children's experiences of abuse and neglect. Rather, it is suggested that it is more useful to think holistically and use innovative ways to manage the inherent complexities and uncertainties that must be dealt with.

Recommendations are made in the literature regarding the future development of any decision making aide and these include: the need to acknowledge the critical role played by feedback and reflection; the need to acknowledge the use of both intuitive and analytical reasoning in decisions made; an appreciation of the systems which surround intake social workers and have a direct impact on their decision making and the involvement of those who will use them in their design. Returning to Dingwall (1983) for the final word, he asserts that the most important decision that must be made is about what constitutes a good society:

'Moral evaluations can and must be made if children's lives and wellbeing are to be secured. What matters is that we should not disguise this and pretend it is all a matter of finding better checklists or new models of psychopathology or technical fixes when the proper decision is a decision about what constitutes a good society (p.244).

Literature review concluding comments and development of research questions

The review of literature in the four preceding chapters has portrayed the evolution of the Irish child protection system as largely determined by government responses to public concerns about the plight of certain children. Combined with growing international knowledge of the effects of child harm, it was also shaped by politics and economics and the aspiration of a new paradigm with an ideology base of early and proportionate intervention, supportive outreach and children's rights. International data on re-referrals and reporting trends, however, reveal some anomalies and ambiguities about the efficacy of reporting and intake systems, and throws some doubt on whether the aspirations towards

reform held in most Anglophone countries are achievable. It has also exposed an enduring focus on the identification and elimination of risk, exemplified both in increased proceduralisation and the implementation of mandatory reporting in a number of jurisdictions. Finally, the literature on decision making and filtering exposes the stark contrast between the assumptions underlying the official rhetoric and the real world operation of intake workers just inside the Front Door in Ireland and elsewhere, who need to make important decisions in a very uncertain environment.

It would seem evident from recent policy and legislative changes that Irish services are following the reformative trend adopted in many Anglophone countries. The Irish and international legislation, policy and protocols described in Chapter 2 outline a technically rational system that purports to make effective and timely decisions at the Front Door. However this study represented an opportunity to look in detail at what is happening at the Front Door of child protection services. It afforded an opportunity to gather the perspectives of those who operate and manage the services provided there on the process of reform that is underway and in particular to review the impact of increased standardisation inherent in the work being carried out. To elucidate this issue within the current study, the following question was posed: Was the new level of policy and standardisation helpful to practitioners at the Front Door and what impact did it have on the processing of reports?

As outlined in Chapter 3 Irish child protection and welfare administrative data does not routinely publish demographic information on the children reported nor does it provide information on the difficulties that these children and their families were experiencing. This gap, which the current study has sought to address, became even more apparent through the review of research and administrative data published by other countries which do detail and offer commentary and analysis on such data. To provide such information in an Irish context, thereby enabling comparison with the data from other Anglophone countries, the following research question was posed: What were the difficulties being experienced by the children and families reported?

While some administrative data is provided by Tusla regarding who makes reports to Irish child protection and welfare services (most recently in 2014) no information is provided regarding the type of difficulties that they report. Yet, as outlined in Chapter 3, there are a number of discernible trends inherent in the type of reports received from different sources and at times in the responses that these reports receive. It was thus considered important to pose the following two questions, which again would enable comparisons between Irish data and that from other countries: Who was making the reports and what difficulties were they reporting? And was there a relationship between the type or origin of reports and later decisions made in respect of the report?

Chapter 3 also presents literature and research findings with regard to re-referral to child protection services and signals it as a methodologically complex but important consideration for service providers. Information is provided with regard to trends in difficulties experienced by children and

their families which can frequently result in re-referral. No empirical information has previously been provided in Ireland regarding the rate of re-referral to child protection and welfare services or the difficulties faced by the children re-referred. To address this gap the following question was posed: What was the rate of re-referral and what were the difficulties being experienced by the children and families re-referred?

The continuing rise of maltreatment reporting in most Anglophone countries, and patterns in how these reports are categorised by the services receiving them, are topics that are explored in Chapter 4. The presentation of administrative data from the last ten years shows how Ireland's particular pattern of categorising slightly less than half of the reports received as 'child protection' and slightly more than half as 'children welfare' has begun to change with increasingly more cases being categorised as 'child welfare'. Within the context of this change it was considered important to pose a question regarding the categorisation of the cases received at the Front Door: What was the outcome of the reports at the end of the preliminary enquiry stage and what criteria were used to decide on categorisation and final outcome of cases?

The broader issue of how decisions are made within the particular environs of the Front Door of child protection services and the influences thereon are explored within available literature and detailed in Chapter 5. This critical issue was addressed in two of the research questions posed in the current study: What was the outcome of the reports at the end of the preliminary enquiry stage and what criteria were used to decide on categorisation and final outcome of cases? And was there a relationship between the type or origin of reports and later decisions made in respect of the report?

The remainder of the thesis will augment the empirical research and theory on the topic of reporting and processing child abuse reports by presenting and analysing the findings from the fieldwork. Ultimately, it will present a new synthesis of information and knowledge about operations at the Front Door. The next chapter outlines the research methodology employed to carry out the empirical research.

Chapter 6 Methodology

Introduction

Six key research questions were posed by the current study, which was based on a case study of a particular service (one area of Tusla) at a particular point in time (Quarter 1, 2015) and to address these a mixed methods research approach was employed. All intake records (IRs) created on receipt of reports of child protection and welfare concerns during this time period were reviewed and analysed and comprised a sample of 794 records. Following this analysis eight practitioners were interviewed, on foot of the preliminary findings from the analysis of the quantitative data on the IRs, to ascertain their views on what had emerged and offer their perspectives on how the intake system is working. This chapter details the methodological approach used and describes how the research was carried out. It also discusses an ethical issue that came to the fore in the course of the research and the impact this had on the study.

Research questions

As outlined in the previous chapter, the review of literature led to the development of the research questions that were posed by the current study. The central focus of the current study was on the processes operated by intake workers at the Front Door within the context of changing policy and legislation and within this six key research questions were posed, each of which were informed by the literature and research presented thus far:

1. What were the difficulties being experienced by the children and families reported?
2. Who was making the reports and what difficulties were they reporting?
3. What was the outcome of the reports at the end of the preliminary enquiry stage and what criteria were used to decide on categorisation and final outcome of cases?
4. Was there a relationship between the type or origin of reports and later decisions made in respect of the report?
5. What was the rate of re-referral and what were the difficulties being experienced by the children and families re-referred?
6. Was the new level of policy and standardisation helpful to practitioners at the Front Door and what impact did it have on the processing of reports?

Selecting the research methodology and methods – epistemology and ontology

Bryman (2016) has pointed out that the research methodology used and the research methods chosen are not neutral but rather are closely linked with a consideration of how social reality should be studied. Thus when carrying out social research attention must be given to the question of paradigm, the worldview entailing fundamental epistemological and ontological assumptions and beliefs, which guide the researcher (Guba and Lincoln, 1994) and impact on the methods chosen. Braun and Clarke (2006) also contend that questions of epistemology will be raised during the analysis phase in a research project.

Epistemology is concerned with the nature of knowledge and how we know what we know, how we get knowledge and how we discover new things. Within this a central question is whether the social world should be studied using the same principles, procedures and ethos as used within natural sciences (Bryman, 2016). Positivism is an epistemological position which advocates that such principles and procedures should be applied to the study of social reality, while interpretivism is an alternative orthodoxy which requires the researcher to grasp the subjective meaning of social action. Ontology is concerned with the nature of social entities and whether they can be considered as objective entities which have a reality external to social actors (objectivism) or rather should they be considered social constructions built upon or up from the perceptions and actions of social actors (constructivism) (ibid). In the research that I carried out for this dissertation and in other research that I have completed in the past I find myself more drawn to a constructionist view: the idea that meaning and experience are socially produced and reproduced and the importance of considering the socio-cultural contexts and structural conditions that influence and facilitate the accounts that are given (Braun and Clarke, 2006).

When it comes to selecting the research method to be used, endemic within social research is the either/or debate of quantitative versus qualitative research methods in terms of which is best placed to help us understand and analyse our social world (Guo, 2014; Sheppard, 2015) with the different approaches at times aligned to opposing epistemological and ontological stances. However, Bryman (2016) has noted that particular epistemological principles and research practices ‘do not necessarily go hand in hand in a neat unambiguous manner’ (p.28) and ‘that the connections that [are] posited between epistemology and ontology on one hand and research method on the other are best thought of as tendencies rather than as definitive connections’ (p.621). Robson and Mc Cartan (2016) demonstrate how when scrutinised many of the distinctions between qualitative and quantitative research break down. For example they discuss how the claim that qualitative research does not use numbers and quantitative research does is simplistic and often not true. Indeed Bryman (2016) details the use of ‘quasi-quantification’ in qualitative research, defined as engaging ‘in a limited amount of quantification when it is appropriate, such as when an expression of quantity can bolster an argument’

(p.631). At a more philosophical level Robson and Mc Cartan (2016) also point out that to claim that qualitative research is concerned more with meanings while quantitative research focuses more on behaviour is not fully supported as both may be concerned with the views and actions of people.

In the past it was postulated that qualitative and quantitative research were ‘incompatible’ due to their association with two distinct paradigms (Guba, 1990). However this claim has been refuted (Howe, 1998; Teddlie and Tashakkori, 2011) and rather the mixing of methods is endorsed by some, which is seen to offer a viable and useful alternative to ‘draw from the strengths and minimise the weakness of both in single research studies’ (Johnson and Onwuegbuzie, 2004: p.14-15). Underlying such an approach is pragmatism, an alternative paradigm, suggested by Howe (1988) and endorsed by many others (Johnson & Onwuegbuzie, 2004; Maxcy, 2003; Tashakkori & Teddlie, 1998). While Johnson and Onwuegbuzie (2004) acknowledge that like all philosophies there are shortcomings and recommend that researchers are reflexive and strategic to avoid such shortcomings or weaknesses in their work, they demonstrate how pragmatism is based on a sound philosophical system systematically developed by classical pragmatists and refined latterly by neo-pragmatists. Many of the key tenets of pragmatism resonated well with my overall approach to social research and the subsequent design of the current study. For example, at a philosophical level the central idea is that ‘the meaning of a concept consists of its practical implications. Hence truth is simply defined as “what works”’ (Robson and Mc Cartan, 2016: p.28). Added to this pragmatism suggests that the ‘research methods should follow research questions in a way that offer the best chance to obtain useful answers’ (Johnson and Onwuegbuzie, 2004: p.17-18).

To address the central focus of the current study, the processes operated by intake workers at the Front Door within the context of changing policy and legislation, six key research questions were posed. As outlined in the previous chapter, these questions were informed by the review of national and international literature and empirical research on child protection systems. It became apparent from the review of literature that there was very little data available on the Irish intake system aside from scant administrative data published by Tusla. Yet it was also apparent that intake represents a key stage in the trajectory of cases reported to child protection and welfare services. I was interested to examine what unfolded when children and families were referred to the service. The detail of who and what was being reported and by whom and outcome could be collected by the analysis of data captured on the IR forms which comprised both quantitative and qualitative data. However, I was also interested in situating the intake system within the broader policy legislative context and looking at how effective or otherwise the policies and procedures in operation were in meeting the needs of those reported. Following on from the collection and analysis of the data recorded on the intake record form, it became evident that to effectively answer all of the research questions posed would necessitate talking to the practitioners who were providing and managing the intake service. To that end both quantitative (analysis of intake records) and qualitative (interviewing of key practitioners)

methodologies were employed and a mixed methods approach used, which will be discussed in more detail below.

A case study of Oaktown child protection and welfare services

To analyse and explore the intake system a case study methodology of one of the 17 administrative areas of Tusla was used. While numerous definitions populate the literature on case study research, Simons (2009) offers a useful one:

‘Case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, program or system in a ‘real life’ context’ (p. 21).

Although a relatively popular form of research design (Bennett et al., 2003), a number of criticisms are levelled at case study as a research methodology, including their limited generalisability (Flyvbjerg, 2006; Thomas, 2010; Holland and Shaw, 2014) and their alleged arbitrary and subjective nature (Flyvbjerg, 2006). The case study has also been called a ‘weak sibling among social science methods’ (Yin, 2003: p.xiii). Flyvbjerg (2006) however refutes these criticisms arguing that a well-chosen research site can significantly contribute to understanding of social phenomenon and scientific development. With regard to generalisability, it is Flyvbjerg’s (2006) contention that case studies strengthen social science and produce exemplars which are essential to the discipline. He argues that findings from a case study add merit to a field of inquiry, not by verification but rather through ‘falsification’ whereby if one observation does not fit with a proposition or hypotheses then they must be either rejected or revised and new theories proposed (p.228). Thomas (2010) adds that reliance on the anatomy of narrative in case study design adds weight to its processes and conclusions. With regard to case studies being arbitrary and subjective, Flyvbjerg (2006) suggests that this is one of the main advantages of the approach as it facilitates a better understanding of the behaviours and perspectives of the actors involved which can result in new insights.

Thomas (2011), cognisant of the criticisms of case study as a form of inquiry, offers a useful typology with classificatory layers to provide a structure to the features of this study. According to Thomas’ (2011) typology the ‘subject’ is the focus of the study, selected because it is an interesting or revealing example and because of local knowledge or familiarity. Flyvbjerg (2006) suggests, as outlined above, that a well-chosen case may ‘greatly add to the generalisability of a case study’ (p.226). In the current study, purposive sampling was used in the choice of research site and steps were taken to make the sample as representative as possible. Key aims in the selection of the research site were to achieve representation of both an urban and rural population, to select an area that has a sizeable population and one which receives a sizeable number of child protection and welfare reports

annually and in particular has a large population of children. Oaktown covers a wide geographical area, has both rural and urban populations and incorporates 8.9% of the country's 0-17 year old population (Central Statistics Office, 2012).

The 'object', the next part of Thomas' (2011) typology, 'constitutes the analytical frame within which the case is viewed and which the case exemplifies' (p.515). In the current study the 'object' is the changing policy and legislative context into which child protection and welfare reports are received in Ireland, the increased drive for standardisation in everyday practice and the impending introduction of mandatory reporting.

Finally, Thomas (2011) suggests that consideration must be given to the approach or methods to be used and the operational processes of the study, that is the boundaries around it such as time and the persons, events or institutions to be included. The approaches used in the current study comprised both quantitative and qualitative methods and this mixed method approach will be discussed in more detail presently. The current study focussed on a three month period in 2015 which Thomas (2011) terms a 'snapshot' whereby 'the case is being examined in one defined period of time' (p.517). Particular consideration was given to the timing of the study to maximise the number of referrals received. For example it is possible that the level of referral might decrease during the summer months as children and young people are not in school and therefore referrals would not be received from the educational sector. For the same reason it is likely that early in the calendar year is a good time frame to choose as it does not incorporate holiday periods such as Easter, summer holidays or Christmas. Thus the period of January to March was purposively selected.

Mixed methods

As outlined above mixed methods offer a bridge between positivist and interpretivist paradigms and an 'opportunity to transform these tensions into new knowledge through a dialectical discovery' (Creswell et al., 2011: p.4). As Flyvbjerg (2006) points out:

'In my interpretation, good social science is opposed to an either/or and stands for a both/and on the question of qualitative versus quantitative methods. More often than not, a combination of qualitative and quantitative methods will do the task best' (p.242).

The mixing of methods is generally considered pragmatic (Holland and Shaw, 2014), whereby the advantages of one approach can be used to offset the weakness of the other (Royce et al., 2010). Johnson et al. (2007) take it one step further and assert that the mixed methods approach should be considered as one of 'the three major research paradigms' (p.112) alongside quantitative and qualitative methods and it is also now increasingly being considered as a research method in its own right (Tashakkori and Teddlie, 2003; Bronstein and Krovacs, 2013).

Many different definitions (Johnson et al., 2007) and formulations of mixed methods research (Holland and Shaw, 2014) are postulated in the literature. Essentially this approach necessitates ‘the intentional collection of both quantitative and qualitative data and the combination of the strengths of each to answer research questions’ (Creswell et al., 2011: p.5). What is important, however, in deciding how and when to mix methods is clarity of purpose, that is what does the research require and how can the choice of method be justified (Creswell et al., 2011; Bronstein and Krovacs, 2013; Holland and Shaw, 2014). A proliferation of mixed method typologies have developed over time (Bryman, 2007), and many are detailed in the literature (Greene et al., 1989; Creswell and Plano-Clark, 2011; Creswell et al., 2011). Teater et al. (2017) encapsulate the four main types of mixed method design as: explanatory mixed-method design; exploratory mixed-method design; embedded design and triangulation. The terms ‘explanatory mixed-method design’ best describes the methodology employed in the current study whereby ‘qualitative methods are used to add depth to the findings of quantitative research’ (Teater et al., 2017: p.224).

Bronstein and Krovacs (2013) affirm the need for thoughtful consideration about ‘what to mix and when and how to mix methods’ (p.355) and advise that these decisions need to be guided by the research question and purposes. As previously stated, the necessity to interview practitioners in the current study about their experience of operating the intake system was apparent from the outset. While it was anticipated that information on the operation of the system would become evident through the analysis of the data on the IR forms, it was also understood that the personal narratives of practitioners would greatly enrich the data. As it turned out, the preliminary analysis of the quantitative data on the IR forms contributed to the formulation of the interview questions and the interviews served as a means to validate, clarify and elaborate on the quantitative findings thus facilitating the ‘recasting ... [of] results from one method with questions or results from the other method’ (Teater et al., 2017: p.233). It is also important to note that the quantitative data collection yielded a substantial amount of qualitative data in the form of notes and comments written by intake social workers on the IR forms.

While the use of mixed methods in the current study was always planned, the manner in which it became operationalised evolved as the study progressed thereby creating an ‘emergent’ mixed method design (Creswell and Plano-Clark, 2011). It was planned from the outset that these two distinct phases of the research process would take place sequentially, starting with the quantitative data collection and analysis, to be followed by the qualitative interviewing. The quantitative component in the current study was more dominant given the amount of data generated. However, despite its ancillary nature, the qualitative phase was critical in elucidating key findings from the first phase and it provided key insights into the operation of the intake system which otherwise would not have been revealed. In particular, the analysis of the qualitative data on the IR forms provided greater detail on the difficulties being experienced by the children and families reported and the decisions

made in each case. The use of the quantitative findings in designing the interview schedule for the qualitative phase greatly helped the integration of both sets of findings in writing this dissertation. Such integration is a feature which is considered essential when writing mixed method reports (Bryman, 2007; Royce et al., 2010; Bronstein and Kovacs, 2013).

Access to the research site

Following a number of meetings with key management personnel during the spring of 2015 Oaktown child protection and welfare services agreed to be the research site for the current study. Management were keen to use the opportunity as a learning exercise and identified the benefit of gaining more insight into the profile and needs of the children and families using their services. Such unobstructed access to a research site and enthusiasm to participate is unusual in research (Taylor et al., 2016) and greatly assisted the research process.

Ethical considerations

Ethical approval for this project was sought from and granted by the Research Ethics Committee in the School of Social Work and Social Policy, Trinity College and the Tusla Research Ethics Committee. The principal ethical issue which arose in relation to the completion of this research project was access to sensitive, identifying information on the intake record forms without the permission of the service users to whom it concerned. As Hayes (2005) points out, 'gaining access to such settings is not a one-off event but a continuing process which is likely to involve negotiation with a series of gate-keepers' (p.1196). Following a number of meetings with key personnel within Tusla, which yielded a variety of different suggestions as to how to overcome this obstacle, and in line with the Data Protection Commissioner's (DPC) data protection guidelines on research in the health sector, it was agreed that all identifying information on the IR forms would be redacted by personnel within Tusla. The DPC guidelines state that 'irrevocable anonymisation of personal data puts it outside data protection requirements as the data can no longer be linked to an individual and therefore cannot be considered to be personal data' (Data Protection Commissioner, 2007: p.7).

It was agreed by the management in Oaktown that the administrative staff there would redact all the IRs from Quarter 1, 2015 and forward them to me. This arrangement brought me in contact with another layer of gate-keepers, albeit at a lower level in the organisation, who also had an impact on access (Mc Gee, 1999). The administrators who were nominated to anonymise the forms understandably found it difficult to prioritise this task over their other work. As a result, receipt of all 794 IRs was a long and drawn out process and necessitated a great deal of patience and perseverance and acknowledgement of the great favour that these administrative staff were doing me

by carrying out this extra work. I, like Hayes (2005), found that expressions of gratitude, and a thank you gift at the end of the process, made a significant impact on the good relations that developed between myself and these gate-keepers.

Quantitative data collection and analysis

The time lapse until full receipt of all relevant intake records amounted to 10 months, however, it was possible to set up the database for data entry, based on the national intake form template, in which to enter the data as the IRs were furnished. SPSS Version 22, a statistical analysis software package, was used to create the database and to analyse the quantitative data on the IR forms.

Variables were created to capture all of the information contained on the IR form and codes were developed to quantitatively record the reason for referral as described by the reporter. Accurately representing the reasons why a child or family is referred is reported as a problematic and subjective endeavour in the literature (Forrester et al., 2007), and often empirical studies on referral will use varying systems of inter coder reliability to give more validity to the coding decisions that are taken. Within the resource constraints of a being a PhD student steps were taken to increase the reliability of the decisions taken and the codes developed. I had regular discussion with my supervisor regarding the appropriateness of the codes, which were intended to make explicit any underlying biases or assumptions (Gillingham and Humphreys, 2010). I also reviewed thresholding and categorisation information available in official Tusla documentation (Tusla 2014c; Tusla 2014d) and *Children First* and drew on my own previous practice experience.

Once the SPSS database was created and all data were entered, a process of data cleaning was undertaken. This incorporated a series of checks to ensure that the data were entered correctly and accurately. Each variable was considered individually and cross checks were carried out with corresponding or related variables to ensure that the figures entered were correct. Further to this, 10% of cases were randomly selected and the data entered checked for accuracy.

As previously mentioned, intake records were created for 794 children between January and March 2015 by Oaktown child protection and welfare services. It is important to note, however, that an IR could have been created for the same child twice during this time period. It was also considered important to analyse and report on the difficulties referred for the parents separately and to facilitate this a second SPSS database was created where siblings were deleted. The data in this database were cleaned to ensure that all issues for the parents of siblings from the same family were consistent.

The analysis of the quantitative data on the IR forms was exploratory and set out to detect patterns of relationships between identified variables and test hypotheses based on referral patterns in existing research. Descriptive statistics, such as frequencies, were used to examine the univariate data

extracted from the IR forms and provide a profile of the children and families reported to Oaktown during the research period. This information included biographical data on the children reported, the relationship of the child to the reporter, the parent's awareness of the report, the mode and source of the report, the relationship of the child to the alleged perpetrator, whether the child was previously known to the social work department, the difficulties reported for the child and the family and the outcome of the report.

Bi-variate analysis was also carried out on the relationships between a number of nominal variables within the quantitative data. To this end, crosstabulations were used to explore the relationships between a number of key variables for example: the age of the child and the type of difficulty reported; the source of the report and the type of difficulty reported; the outcome of the report and the type of difficulty reported and whether the child was already known and the outcome of the report. Chi-square analysis was used to test whether the relationships between variables were statistically significant and not due to chance. To test for significant in these relationships the Alpha level (α) was set at 0.05.

Teater et al. (2017) cite the advantages of using routinely gathered administrative data as the fact that it has already been gathered, it is usually noted for its reliability and validity and its frequent political or policy importance. Disadvantages cited by them include the fact that such data focus less on the overall intended outcome of services, such as improving the welfare and protection of the children reported, and more on the proxies of same within the service, for example numerical measures of outcome. Added to this, Teater et al. (2017) note that 'data collected as a "performance indicator" tend to be shaped by this fact [and] tend to be of more interest when added to' (p.62), which further reinforces the value of the mixed method approach used in the current study.

Qualitative data collection and analysis

As previously outlined the qualitative data generated for the current study were derived from two sources. The qualitative data on the IR forms was a good source of information regarding the detail of the difficulties reported, the checks carried out by the ISW and the decisions made in the cases. Added to that, eight practitioners were interviewed, three as a group and five individually. Three of the interviewees were senior managers within Tusla. Of the remainder, one was a principal social worker, one was a team leader and three were intake social workers in Oaktown for some period of time during the research period. All interviewees agreed to take part in the research and consent forms were signed by all (see Appendix 3). The group interview took place first following my request for feedback from staff in Oaktown on the preliminary findings from the analysis of the quantitative data on the IR forms. The attendance at this group interview was decided upon by the management in the area and access to additional interviewees was negotiated at this interview by means of

‘snowball sampling’ (Atkinson and Flint, 2001), whereby relevant personnel were identified and contact information supplied. These interviewees were duly contacted and each was agreeable to participate in an individual interview.

Drawing on the preliminary findings from the analysis of the quantitative data a semi-structured interview schedule was devised and used for all interviews, although some modification was necessary depending on the interviewee’s role in Tusla (see Appendix 4, for interview schedule). Questions posed also changed in line with Miles et al.’s (2014) suggestions on data analysis which recommend that data analysis is ‘concurrent with data collection’ thus helping the ‘fieldworker cycle back and forth between thinking about existing data and generating strategies for collecting new, often better data’ (p.70).

Each interview began with some ‘grand tour’ questions (Spradley, 1979), for example regarding the practitioner’s role in Tusla and the length of time they had worked there, to make the participants feel more at ease. Questions in the main were open-ended and Kvale’s (1996) nine question types were used to guide the questions posed, keep the interview flowing and to assist in drawing interviewees out further on certain topics of interest. All interviews took place at the participants’ place of work. The individual interviews last approximately one hour, while the group interview lasted approximately two hours. With the consent of the participants, all interviews were recorded.

The use of a focus group in this study happened more as a result of a decision taken by the management in Oaktown than by my instigation. I requested some feedback from the area regarding my preliminary findings and the decision was taken by the area for three practitioners to meet me as a group. Focus groups, originally used to conduct market research, have become a commonly used method in social research. Focus groups enable the research to gather valuable information and insights within a group context. As Morgan (1988) points out, ‘the hallmarks of focus groups is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group’ (p.12).

A focus group allows the researcher to develop an understanding about why people feel a certain way about a topic by facilitating group members to probe one another’s reasons for holding a certain view and it can also provide a greater insight into how individuals make sense of phenomenon and construct meaning around it (Bryman, 2016). However, there are limitations to the use of focus groups such as the dominance of some participants over others or participants being prone to expressing culturally expected views. However, in this instance the participants in the group were well known to each other and the conversation that ensued produced very rich and relevant data.

All qualitative data, from the IR forms and interviews, were transcribed into Word and then imported into NVivo 11 for coding and analysis. The qualitative data was analysed using thematic analysis described by Braun and Clarke (2012) as ‘an accessible, flexible, and increasingly popular method

of qualitative data analysis' (p.57). As previously mentioned this stage of data analysis also necessitates consideration of one's epistemological and ontological position and while thematic analysis can be conducted within both interpretivist and constructionist paradigms (Braun and Clarke, 2006) the constructivist view that meaning and experience are socially produced and reproduced was more influential in my analysis.

Braun and Clarke (2012) provide a very useful six-phase approach to thematic analysis which helps to guide and structure the analysis of qualitative data: 1. Familiarise yourself with the data. 2. Generate initial codes. 3. Search for themes. 4. Review potential themes. 5. Define and name themes. 6. Produce the report.

Phase 1 Familiarity with the data

As I transcribed in full all data contained on the IR forms, each of the five individual interviews and the focus group I became very familiar with the qualitative data I had gathered. Further to this once the transcription process ended I read back over all of the data. Whilst transcribing the data and re-reading the transcripts, I maintained an electronic journal of emerging themes which assisted in the development of codes for analysis.

Phase 2 Generating initial codes

At this point I began to generate some initial codes which seemed of relevance to the research questions posed. Braun and Clarke (2012) point out how at this stage these codes will be a mix of both the descriptive and interpretive. Also useful in this process were the codes developed from the quantitative analysis of the difficulties reported for the children and families. These provided a useful structure for the analysis of the qualitative data on the IR forms, which provided the detail of these difficulties, and an additional opportunity to check the quantitative coding as each IR was re-read to ensure that the correct code was assigned to each in the SPSS database. As each code was developed the qualitative data was re-read to see which excerpts could be assigned to that code and in doing so ideas for other codes emerged. The importance of the development of codes is discussed by Charmaz (2014) as follows:

'Coding means that we attach labels to segments of data to depict what each segment is about. Through coding, we raise analytic questions about our data from the very beginning of data collection. Coding distils data, sorts them, and gives us an analytic handle for making comparisons with other segments of data' (p.4).

Phase 3 Searching for themes

At this point in the analysis codes were created in NVivo and the qualitative data fully coded accordingly. NVivo also provides a hierarchical coding scheme which enables the creation of

categories and sub-categories of codes, which was very useful in bringing the analysis to the next phase in Braun and Clarke's approach: searching for themes. For example, it became apparent that the intake social workers were carrying out checks in relation to the reports that they received (theme) which was of interest but some checks were carried out over the phone (code) and some in person (code). Miles et al. (2014) assert that a good visual 'display' of the data gathered greatly assists the analytical process of formulating explanations for the patterns, categories and relationships evident in the data and the visual presentation of codes and sub codes in NVivo was very useful in this regard.

Braun and Clarke (2012) also stress that at this point it is better to be inclusive in this early stage of coding in terms of the data assigned to each code as it is easier to discard codes than to have to recode data at a later stage. NVivo greatly assists in the coding, recoding and indeed un-coding of data and also displays the data using 'coding stripes' which visually displays the codes to which each segment of data has been coded. NVivo also offers case classification and attributes which can be ascribed to the data imported. These tools permitted the data in each code, where relevant, to be sorted by attributes or characteristics such as gender, age, referral source, case categorisation and outcome and enabled crosstabulation analysis of the codes by these attributes. NVivo also provides annotation and linked memo tools, both of which facilitate the construction of comments on the data entered. This all assisted in bringing the analysis to a more conceptual level and beginning 'to explore the relationship between the themes and to consider how the themes will work together in telling the overall story about the data' (Braun and Clarke, 2012: p.65).

Throughout the analysis stage generally critical questions were asked of the data in order to form concepts around which themes and later codes could be built. Such reflection was greatly helped by regular discussions with my supervisor. Overall, the development of themes was very much an iterative process, going back and forth between the codes and the data and continuously updating and developing new codes. This 'data condensation' is defined by Miles et al. (2014) as 'the process of selecting, focusing, simplifying, abstracting and/or transforming the data' and one which 'occurs continuously throughout the life of any qualitatively oriented project' (p.12).

Phase 4 Reviewing potential themes

This stage in the process is described by Braun and Clarke (2012) as quality checking where the developing themes are considered in relation to the coded data and whether any new ideas or sub-themes emerge. At this point I found myself reading and re-reading the qualitative data gathered at the interviews because as my analysis of the qualitative data on the IR forms progressed new meanings and importance of comments made by the practitioners became apparent.

Phase 5 Defining and naming themes

According to Braun and Clarke (2012) this phase involves the deep analytic work of thematic analysis and where the write up begins. Themes are named but also extracts are chosen which are relevant and accurately represent those themes. To do this it was important to move beyond just relying on what the data says and providing extracts from it but rather to offer an interpretation of it and organise it into a conceptual framework. Also at this stage it became apparent that in order to accurately represent the volume of qualitative data derived from the IR forms and in particular the frequency of the difficulties identified for the children and families, counting techniques (Silverman, 2014; Seale, 1999) needed to be employed to guard against anecdotalism or reporting on only the more interesting or unusual cases. As Seale (1999) points out:

‘Such counting is an important way of showing data to the reader as fully as possible, enabling readers to judge whether the writer has relied excessively on rare events, to the exclusion of more common ones that might contradict the general line of argument. This can help readers to gain a sense of how representative and widespread particular instances are’ (p.128).

Phase 6 Producing the report

By treating the analysis of the data as a continuous and iterative process and using the organisational and visual tools provided by NVivo it was possible to reach representative conclusions about the data and the themes therein and begin the write up.

The role of reflexivity in the research process

Reflexivity in social research is defined by Lynch (2000) as ‘an inward-looking, sometimes confessional and self-critical examination of one’s own beliefs and assumptions’ (p.29). When carrying out social research a researcher inevitably brings their own values, feelings and interests, constructed through their own particular life experiences, to the process. Both the selection of research interests and the analysis of data are inevitably impacted by the particular “lens” of the researcher and as outlined above their epistemological and ontological positionality. Earlier in my professional career I had trained and worked as a frontline practitioner, including eighteen months as a child protection social worker. Added to that I had also carried out a number of research projects on related topics and had gathered a great deal of experience in interviewing both practitioners and service users. Both my practice and research experience were key influencers in the topic I choose for this study. Although my experience of working as a child protection social worker had taken place almost twenty years ago it undoubtedly provided me with useful insights into this type of work, although I was also immediately struck by how much had changed in the intervening years. I believe that my previous work and research experience lent me a level of credibility with the staff in Oaktown

which facilitated the ease with which I was accepted there and my accessibility to the research site. However, it was also important for me to be aware of and to make explicit any underlying biases or assumptions I may have developed from my particular work experiences that could have impacted the execution of the research and in particular the analysis of the data (Gillingham and Humphreys, 2010). Regular discussions with my supervisor were integral in drawing out any such biases or assumptions.

Limitations and generalizability of the study

There are certain limitations inherent within the current study and while they were unavoidable it is important to acknowledge that they may have had some bearing on the findings reported. Data collection and analysis was limited to the information that was recorded on the IR form and it has to be acknowledged that these data may not be fully representative of the difficulties reported and the interventions of the practitioners. The data gathered, as Teater et al. (2017) have pointed out, are recorded to comply with stipulations set down by performance indicators and as such how and what is recorded may be somewhat shaped by this. It is also possible that more information was afforded to the ISW than was recorded and, as will be outlined in the findings chapters, more discussion and thought given to the outcomes decided upon than was written down. A further limitation, as outlined earlier in this chapter, is that children may have been reported more than once during the period under study and therefore may feature more than once in the sample.

Sometimes in social research interest lies in the findings in their own right, at other times however interest lies in the generalizability of the study (Robson and Mc Cartan, 2016). Bryman (2016) points out that when qualitative research is conducted with a small number of participants or in a certain locality or organisation, like the current study was, critics argue that it is impossible to know how the findings from such research can be generalizable to other settings. For quantitative research to be generalizable the sample must be representative of the population from which it was drawn (Teater et al, 2017) and it is not possible to make such a claim regarding this study.

The case study approach used in this current study is subject to criticism in terms of its generalizability. However, it is convincingly argued that such an approach can make a significant contribution to understanding social reality by providing exemplars and challenging hypotheses leading to the development of new theories. As has been demonstrated in the literature, each of the 17 administrative areas within Tusla could be considered an outlier, such is the variation in case disposal from the national average, both in terms of categorisation and outcome. Nevertheless, as has also been discussed in the literature, all child protection and welfare work in Ireland is governed by the same administrative, legislative and policy frameworks and the intake system operated in Ireland bears many similarities to those operated in other Anglophone countries. As such the key findings or

‘lessons learned’ from the current study are likely to be applicable in similar settings (O’Leary, 2005). It is thus suggested that while this a case study of one area during one point in time, it provides findings which are useful and generalizable to other intake systems both in Ireland and other jurisdictions.

Conclusion

This chapter has outlined the methodological approaches which underpinned the current study. A case study design using mixed methods was utilised and this chapter has used the research methodology literature to justify its selection for the current study. In order to answer the research questions posed, a plan was made to gather and review intake record forms generated in one area of Tusla during one quarter of 2015 and also to interview practitioners.

While the data collection comprised two sequential phases, one of which was largely quantitative and the other qualitative, the data gathered in the quantitative phase had a direct influence on the way in which the qualitative interviews were conducted. The analysis of all data gathered was an iterative and ongoing process and reflexive thinking was used the pursuit of a comprehensive and systematic analysis.

As previously outlined in the introductory chapter, there is a need for more empirical research on social work in Ireland, and in particular there is a dearth of quantitative studies on operation of the child protection system. The current study is intended to address that gap.

Chapter 7 The Children, the Alleged Perpetrators and the Difficulties Reported

Introduction

This and the following chapters will report, in turn, on the different elements of data that were examined, starting with findings on the children, the alleged perpetrators and the difficulties that were outlined in the referral information. The children who were reported came from 547 families.

This chapter details findings regarding the gender and age of the children reported, the incidence of sibling reports and the size and composition of the families reported. It also presents the information that was gathered from the intake record (IR) forms on the person who was allegedly causing harm to the child. It provides detail of the three most pressing concerns that were reported for the children and the families in the sample and also a breakdown of the primary issues reported. Significance testing was carried out on the difficulties reported for the children by age and gender and these findings are also presented.

Biographical information on the children in the sample

As shown in Table 7.1 below, slightly more female (52%) than male children (48%) were reported. The age of the children reported varied from infants who were only a day or two old to young people who were almost 18 years of age (see Table 7.2). A small proportion of the children (6%) were less than one year old and a little over a quarter (26%) were under five years of age. The majority of children (65%) reported were under 12 and teenagers accounted for a little over a third (35%) of all reports.

Table 7.1 Gender of the children reported

Gender of children reported		
	Frequency	Valid percent
Male	379	48.4
Female	404	51.6
Total	783	100.0
Missing	5	
Unborn baby	6	
Total	794	

Table 7.2 Age of the children reported

Age of children reported		
	Frequency	Valid percent
Less than 1 year	43	5.6
1 – 4 years	155	20.1
5 – 8 years	154	19.9
9 – 12 years	149	19.3
13 – 17 years	271	35.1
Total	772	100.0
Missing	22	
Total	794	

Sibling reports

As previously mentioned 794 children, from 547 families, were referred to the intake social work service during the period under study. In a quarter of these families (25%) siblings were also referred. A little over a fifth of reports (21%) mentioned other children in the family who were not included in the report. On the basis of these figures, it appears that the intake social worker (ISW) receiving the initial report gave due consideration to whether the child's siblings should be included as part of the IR. Families where siblings were reported varied in size from two children in a family, which was the most common family size (57%), to one with eight children (see Table 7.3).

Table 7.3 Family size when siblings were reported

Family size when siblings were reported		
	Frequency	Valid percent
2 children	77	57.0
3 children	30	22.2
4 children	11	8.1
5 children	12	8.9
6 children	2	1.5
7 children	2	1.5
8 children	1	0.7
Total	135	100.0

Detail of the person allegedly causing harm to the child

When relevant, the ISW is required to complete details of the person allegedly causing harm to the child on the IR form. These include their name, address and date of birth. While this identifying information was redacted, detail was gathered regarding the gender of the alleged perpetrator, the relationship of the alleged perpetrator to the child, contact with the child and the current location of the child.

The largest proportion of the alleged perpetrators was male (46%) while females represented 41% and in the remainder of cases alleged perpetrators were listed jointly as male and female.

The relationship of the alleged perpetrators to the children in the sample is shown in Table 7.4 below. Alleged perpetrators were primarily the child's parent or guardian (81%). An overwhelming majority of alleged perpetrators (89%) were related to the child as either parent/guardian, extended family member or sibling. The child's peers accounted for 4% of the alleged perpetrators, while service providers and strangers each accounted for 1%.

Table 7.4 Relationship of the alleged perpetrator to the child

Relationship of the alleged perpetrator to the child		
	Frequency	Valid percent
Parent / guardian	431	81.2
Extended family member	26	4.9
Peer	20	3.8
Parent's (ex) partner	20	3.8
Sibling	16	3.0
Service provider	7	1.3
Stranger	6	1.1
Neighbour / friend of the family	5	0.9
Total	531	100.0

In the majority of cases (72%) the alleged perpetrator lived with the child. In 13% of cases the perpetrator had no current contact with the child, while 5% of the children saw the alleged perpetrator regularly through access visits or informal family arrangements. A small number of children (3%) had only intermittent contact with the person either through visits to the family home or informal contact in the community. Other avenues for regular contact with this person were at school (2%) and through shared care arrangements (2%) and in a further 2% of cases the child was either in a relationship or was friends with the alleged perpetrator.

In the section on the IR form which requires details of the alleged perpetrator, the ISW is also required to fill in the current location of the child. Almost half (49%) of the children in the sample were at home with their mothers, while a much smaller proportion (5%) lived with their fathers. Taken together with the children who lived with both their parents (18%) and those who lived with a parent and that parent's partner (3%) it was evident that three quarters of the children (75%) were living in their own home with one or both of their parents. Other accommodation types, that the children were living in at the time of the report, included staying in a refuge with their mother (6%), staying with friends or relatives (5%) and in care (4%).

Difficulties reported for the children in the sample

The IR provides details about the concern that was reported to the ISW at the time of the referral. Analysis of the information provided by referrers revealed a wide range of difficulties, which were reported for the children, parents and families in the sample. The difficulties reported for the children are detailed in Table 7.5 below. In the vast majority of cases the referrers gave details of two or more concerns for the children they were reporting and, where applicable, the three most pressing issues identified for the child were considered and analysed.

The most commonly reported difficulty was ‘exposure to domestic violence and parental conflict’. This was reported for 14% of children in the sample or one in every seven children. Approximately one in eight of the children reported (12%) were alleged to have suffered ‘physical abuse’, usually at the hands of a parent or carer. Eleven per cent of reports concerned child ‘behavioural problems’ and there were concerns for the same proportion of children regarding the ‘impact of parental substance abuse’ (11%). A tenth of the children were reported due to issues in their education, primarily because they were out of school, and a further tenth were reported because of sexual abuse or sexualised behaviour that they themselves had engaged in or were exposed to by another, usually a peer. The same proportion of the children (10%) was seen by the reporters to have mental health needs. Referrers reported that 9% of the children in the sample had ‘emotional problems’, while 7% were seen to be victims of ‘emotional / verbal abuse’ from their parent(s). ‘Neglect’ was also reported for 7% of the children, 5% were referred because of ‘learning difficulties or intellectual disabilities’ and a further 5% because they were misusing substances. Other difficulties, reported for smaller proportions of the children, can be seen in the table below. Where a child’s difficulties did not fit into any of the categories listed in the table, they were designated as ‘other’ and these included concerns such as bereavement and bullying.

Table 7.5 Difficulties reported for the children

Difficulties reported for children		
	Frequency	Percent**
Exposure to domestic violence and parental conflict	108	13.6
Physical abuse	97	12.2
Behavioural problems	90	11.3
Impact of parental substance abuse	88	11.1
Educational difficulties / out of school	80	10.1
Sexual abuse and sexualised behaviour	80	10.1
Mental health need	77	9.7
Emotional problems	71	8.9
Emotional / verbal abuse by parent	59	7.4
Neglect	58	7.3
Learning difficulties or intellectual disabilities	41	5.2
Child abusing drugs or alcohol	37	4.7
Difficult child / parent relationships	33	4.2
Homelessness	32	4.0
Negative impact from parental mental health	32	4.0
Lack of appropriate supervision	21	2.6
Sibling violence	20	2.5
Inappropriate use of social media	14	1.8
Child to parent violence	11	1.4
Complex needs or physical disabilities	9	1.1
Teenage pregnancy and parenting	8	1.0
Excessive responsibility in the home	7	0.9
Impact of parental separation	6	0.8
Child involved in crime	6	0.8
Other	38	4.8
Total*	1123	

*Totals do not add up to 794 as referrers could report more than one difficulty for each child.

**Percentages do not total 100 because values were calculated out of the total number of children reported in the study (n=794), rather than the total number of difficulties reported (n=1123).

Referrer's primary concern for the child

As mentioned above, referrers could detail more than one concern in their report so it is interesting to consider what their primary concern was when one was reported (see Table 7.6). At times the primary issue reported concerned the parent and not the child. This analysis revealed that, as well as representing the most commonly reported concern for the children in the sample, 'exposure to domestic violence and parental conflict' was also the most frequently reported primary concern (13%). Almost the same number of reports detailed 'physical abuse' as the most pressing concern (12%) while 'sexual abuse and sexualised behaviour' was considered the primary concern in just over a tenth (11%) of all reports received during the time period. The mental health needs of 8% the children in the sample was the referrer's primary concern while the same proportion were primarily concerned about the 'impact of parental substance abuse' and in a slightly smaller number of cases the primary concern was 'neglect' (7%).

Table 7.6 Primary difficulty reported for the child

Table Primary difficulty reported for the child		
	Frequency	Valid percent
Exposure to domestic violence and parental conflict	81	12.5
Physical abuse	80	12.4
Sexual abuse and sexualised behaviour	68	10.5
Mental health need	52	8.0
Impact of parental substance abuse	49	7.6
Neglect	45	7.0
Behavioural problems	34	5.3
Homelessness	32	4.9
Emotional problems	28	4.3
Negative impact from parental mental health	24	3.7
Emotional / verbal abuse by parent	21	3.2
Educational difficulties / out of school	18	2.8
Lack of appropriate supervision	18	2.8
Learning difficulties or intellectual disabilities	13	2.0
Child who is abusing drugs or alcohol	12	1.9
Child to parent violence	11	1.7
Sibling violence	9	1.4
Complex needs or physical disabilities	9	1.4
Teenage pregnancy and parenting	8	1.2
Inappropriate use of social media	5	0.8
Other	30	4.6
Total	647*	100.0
No information provided	147	
Total	794	

*Number of children for whom a primary issue was reported.

Detailed analysis of the difficulties experienced by children in the sample

A range of cross tabulation analyses were conducted to look at the age and gender of the children experiencing the different difficulties reported in the sample. To test for significant in these relationships the Alpha level (α) was set at 0.05.

Gender and the difficulties reported for the children in the sample

The gender breakdown of the difficulties reported for the children in the sample is provided in Table 7.7. ‘Sexual abuse and sexualised behaviour’ was reported more frequently for girls in the sample (60%), as were ‘emotional problems’ (61%), ‘inappropriate use of social media’ (71%), ‘complex needs or physical disabilities’ (67%) and ‘excessive responsibility in the home’ (86%). However, none of these gender differences were statistically significant, possibly due to the very small numbers reported for some of the concerns⁸ and the very small number reported for some of these concerns has to be borne in mind when reviewing these findings.

The chi square test of association showed a significant relationship between gender of the child and ‘behavioural problems’ with boys more likely than girls to be reported for these difficulties (χ^2 (1, N=783) = 27.6, $p = < .001$). A significant association was also found between gender and being reported for ‘learning difficulties or intellectual disabilities’, again with boys more likely to be reported for these difficulties than girls (χ^2 (1, N=783) = 15.22, $p = < .001$).

⁸ It was not possible to carry out chi square testing on the variables ‘excessive responsibility in the home’, ‘child involved in crime’, ‘complex needs and physical disabilities’, ‘teenage pregnancy & parenting’ and ‘impact of parental separation’ due to the small number in each cell.

Table 7.7 Difficulties reported for the children in the sample by gender

Child difficulties by gender			
	Gender		Total
	Male	Female	%
Domestic violence and parental conflict (n = 105)	51.4	48.6	100.0
Physical abuse (n = 97)	48.5	51.5	100.0
Behavioural problems (n = 90)	74.4	25.6	100.0
Impact of parental substance abuse (n = 87)	52.9	47.1	100.0
Sexual abuse and sexualised behaviour (n = 80)	40.0	60.0	100.0
Educational difficulties / out of school (n = 79)	43.0	57.0	100.0
Mental health need (n = 77)	49.4	50.6	100.0
Emotional problems (n = 67)	38.8	61.2	100.0
Emotional / verbal abuse by parent (n = 59)	47.5	52.5	100.0
Neglect (n = 54)	55.6	44.4	100.0
Learning difficulties or intellectual disabilities (n = 41)	78.0	22.0	100.0
Child abusing drugs or alcohol (n = 37)	59.5	40.5	100.0
Difficult child / parent relationships (n = 33)	54.5	45.5	100.0
Negative impact from parental mental health (n = 32)	46.9	53.1	100.0
Homelessness (n = 32)	46.9	53.1	100.0
Lack of appropriate supervision (n = 20)	60.0	40.0	100.0
Sibling violence (n = 20)	65.0	35.0	100.0
Inappropriate use of social media (n = 14)	28.6	71.4	100.0
Child to parent violence (n = 11)	54.5	45.5	100.0
Complex needs or physical disabilities (n = 9)	33.3	66.7	100.0
Teenage pregnancy and parenting (n = 8)	0.0	100.0	100.0
Excessive responsibility in the home (n = 7)	14.3	85.7	100.0
Impact of parental separation (n = 6)	50.0	50.0	100.0
Child involved in crime (n = 6)	66.7	33.3	100.0
Other (n = 38)	57.9	42.1	100.0

Age and the difficulties reported for the children in the sample

The analysis of age and the difficulties reported for the children in the sample are set out in Table 7.8 below. This provides an insight into the age at which children are more or less impacted by the difficulties they encounter in their environments⁹.

As the table reveals, ‘exposure to domestic violence and parental conflict’ was reported fairly evenly across all age categories for the children in the sample with the exception of children under the age of one, but this pattern was not statistically significant.

‘Physical abuse’ was reported most frequently for the oldest cohort of children in the sample (35%) with five to eight year olds the next age category reported most frequently for this difficulty. However, these differences were not statistically significant.

‘Behavioural problems’, as might be expected, were not reported for children under the age of one year (0%) and very infrequently for children aged 1 to 4 years (6%), whereas the majority of children reported for this reason were in the 13 – 17 year age category (58%). Inspection of the standardised residual revealed this association with age was highly significant (χ^2 (4, N=772) = 33.3, p = <.001).

The ‘impact of parental substance abuse’ on the children in the sample was most heavily concentrated across the ages of 1 to 12 years (89%). Children in the 1 to 4 year age group were statistically more likely to be reported for this difficulty (33%) whereas the teenagers were less likely to be reported for this difficulty (11%) (χ^2 (4, N=772) = 28.75, p = <.001).

Reporting of ‘sexual abuse and sexualised behaviour’ shows a peak from ages 9 to 17 years with almost three quarters (71%) of the children reported in this age cohort. In particular, the prevalence of reports for children aged 13 to 17 years for ‘sexual abuse and sexualised behaviour’ was found to be significantly higher than among the other groups (χ^2 (4, N=772) = 12.85, p = <.05).

A range of difficulties were reported more commonly for older children, particularly in the 13 to 17 year age category, and was found to be statistically significant. For example, ‘educational difficulties’ were reported most (52%) for children in the in the 13 to 17 year age category (χ^2 (4, N=772) = 17.27, p = <.005). The overwhelming majority of children (82%) who were reported for ‘mental health need’ were also within the 13 to 17 year age group and there were very small numbers of younger children reported for this reason (χ^2 (4, N=772) = 87.81, p = <.001).

Other issues which were reported more frequently for older children and were statistically significant included ‘learning difficulties or intellectual disabilities’ (54%) (χ^2 (4, N=772) = 12.7, p = <.05),

⁹ It was not possible to carry out chi square testing on the variables ‘excessive responsibility in the home’, ‘child to parent violence’, ‘child involved in crime’, ‘complex needs and physical disabilities’, ‘teenage pregnancy and parenting’, ‘impact of parental separation’, ‘inappropriate use of social media’ or ‘lack of appropriate supervision’ due to the small number in each cell.

which may indicate that such difficulties become more difficult to manage, for the children themselves and their families, as the child becomes older. Unsurprisingly, alcohol and drug misuse was another issue that was reported most commonly for children between the ages of 13 and 17 years ($\chi^2 (4, N=772) = 58.8, p = <.001$) as were fractious relationships between teenagers and their parents ($\chi^2 (4, N=772) = 37.19, p = <.001$).

Table 7.8 Difficulty reported for the child by age

Child difficulties by age						
	Age (years)					Total
	< 1 Yr %	1 – 4 %	5 – 8 %	9 – 12 %	13 – 17 %	%
DV and parental conflict (n = 107)	5.6	24.3	27.1	21.5	21.5	100.0
Physical abuse (n = 96)	3.1	14.6	27.1	19.8	35.4	100.0
Behavioural problems (n = 89)	0.0	5.6	14.6	21.3	58.4	100.0
Impact of parental sub abuse (n = 85)	8.2	32.9	28.2	20.0	10.6	100.0
SA / sexualised behaviour (n = 79)	1.3	11.4	16.5	20.3	50.6	100.0
Educational difficulties (n= 77)	0.0	9.1	22.1	16.9	51.9	100.0
Mental health (n = 74)	0.0	0.0	1.4	16.2	82.4	100.0
Emotional problems (n = 66)	0.0	13.6	18.2	21.2	47.0	100.0
Emotional / VA by parent (n= 59)	3.4	20.3	25.4	22.0	28.8	100.0
Neglect (n = 52)	1.9	32.7	30.8	19.2	15.4	100.0
Learning difficulties or ID (n = 41)	0.0	7.3	12.2	26.8	53.7	100.0
Child abusing drugs or alcohol (n = 36)	0.0	0.0	0.0	5.6	94.4	100.0
Neg. impact of parent m/health (n = 32)	15.6	34.4	18.8	18.8	12.5	100.0
Difficult child / parent rel. (n = 32)	0.0	0.0	3.1	12.5	84.4	100.0
Homelessness (n = 31)	9.7	12.9	22.6	19.4	35.5	100.0
Lack of appropriate supervision (n = 20)	0.0	25.0	30.0	30.0	15.0	100.0
Sibling Violence (n = 19)	0.0	10.5	0.0	10.5	78.9	100.0
Inappropriate use of social media (n = 14)	0.0	0.0	21.4	28.6	50.0	100.0
Child to parent violence (n = 11)	0.0	0.0	0.0	27.3	72.7	100.0
Complex needs or phys. disability (n = 9)	11.1	33.3	11.1	11.1	33.3	100.0
Teenage pregnancy and parenting (n = 8)	0.0	0.0	0.0	0.0	100.0	100.0
Impact of parental separation (n = 6)	16.7	0.0	33.3	33.3	16.7	100.0
Child involved in crime (n = 6)	0.0	16.7	0.0	16.7	66.7	100.0
Excessive resp. in the home (n = 6)	0.0	0.0	0.0	83.3	16.7	100.0

Difficulties reported in respect of parents and families in the sample

In the majority of instances the reports received also made reference to the difficulties that were being experienced by a child's parent(s) or families. As previously mentioned, the sample consisted of 547 families and a wide range of difficulties were reported. In some reports, issue(s) were identified only for the child. However, in almost three quarters (74%) or 407 of the families, problems were additionally identified in respect of the parent(s) or families. It is also important to signal the possibility that the same family could have been reported more than once during the time period under study.

Common with the children in the sample, most parents and families were reported for more than one difficulty and some had many to contend with and, as with the analysis of the data on the children, where applicable, the three most pressing issues were considered and analysed.

As can be seen from Table 7.9 below, the most commonly reported difficulty in respect of parents and families was a lack of adequate parenting skills which featured in over a quarter of the families in the sample (27%). 'Significant relationship difficulties', including disagreement about custody and access, were reported for one in five of the families in the sample (20%). The 'misuse of drugs and alcohol' was reported for almost one fifth of the families (19%) and 'domestic violence' was recorded as an issue for 14%. A little over an eighth of the parents and families in the sample were 'struggling to manage their child's behaviour' (13%) and a similar proportion of the parents were struggling with 'mental health difficulties' (12%). 'Accommodation issues, including homelessness', was reported for 7% of the parents and families. Other issues, for example 'non-engagement with services' (3%), 'social isolation' (3%), 'financial issues' (2%), 'disabilities / health problems' (1%), were reported for smaller proportions of parents and families in the sample.

Table 7.9 Difficulties reported for parents and families

Difficulties reported for parents and families		
	Frequency	Percent**
Lack of parenting skills	145	26.5
Significant relationship difficulties	110	20.1
Misuse of drugs and alcohol	102	18.6
Domestic violence	79	14.4
Struggling to manage child's behaviour	70	12.8
Mental health difficulties	63	11.5
Accommodation issues, including homelessness	36	6.6
Non-engagement with services	17	3.1
Socially isolated	14	2.6
Financial issues	8	1.5
Disabilities / health problems	7	1.3
Family with someone involved in crime	6	1.1
Adolescent parents	5	0.9
Family under threat	3	0.5
Parent deceased	2	0.4
Learning disability	2	0.4
Other	5	0.9
Total*	674	

*Totals do not add up to 547 as referrers could report more than one difficulty for each child.

**Percentages do not total 100 because values were calculated out of the total number of parents and families reported in the study (n=547), rather than the total number of difficulties reported (n=674).

Primary difficulty reported in respect of parents and families in the sample

As previously mentioned, the three most pressing issues for each parent or family were considered in the analysis completed. Where identified, the most frequently reported primary issue was a 'lack of parenting skills' (24%) (see Table 7.10). The second most commonly reported primary issue was the 'misuse of drugs and alcohol' (17%) and 'domestic violence' was seen as the primary issue in 14% of families. For 13% of families 'significant relationship difficulties' was the primary issue reported while for 11% it was their struggle to manage their child's behaviour. In the same proportion of families the main issue was the 'mental health difficulties' being experienced by the parent(s) (11%).

‘Accommodation issues, including homelessness’, was the primary issue for 4% of the parents and families reported for ‘non-engagement with services’ was the primary issue for 3%. Other issues were considered the main concern in much smaller numbers and are detailed in the table below.

Table 7.10 Primary difficulty reported for parents and families

Primary difficulty reported for parents and families		
	Frequency	Valid percent
Lack of parenting skills	97	23.8
Misuse of drugs and alcohol	70	17.2
Domestic violence	57	14.0
Significant relationship difficulties	51	12.5
Struggling to manage child’s behaviour	44	10.8
Mental health difficulties	43	10.6
Accommodation issues, including homelessness	15	3.7
Non-engagement with services	11	2.7
Disabilities / health problems	3	0.7
Family under threat	3	0.7
Adolescent parents	3	0.7
Family with someone involved in crime	2	0.5
Parents deceased	2	0.5
Parents with learning disability	2	0.5
Other	4	1.0
Total	407*	100.0
No information provided	140	
Total	547	

**Number of parents and families for whom a primary issue was reported.*

Primary report type

Once the ISW has considered the report made by the referrer and carried out whatever checks are necessary or appropriate (s)he must then decide on the ‘primary report type’. In Section C of the IR form the ISW is instructed to ‘tick welfare or one of the abuse categories’ which represents their

‘view’ as to what is the primary report type of the child referred. The standard business process guidance stipulates that at this point (s)he consults with the team leader for approval of the categorisation (HSE, 2009). As Table 7.11 shows, the majority of cases (86%) were judged to fit in the ‘welfare’ category and a much smaller proportion was considered to fit in one of the four ‘abuse’ categories (14%). The largest of the ‘abuse’ categories was physical abuse which was selected for 7% of the reports received followed by sexual abuse (4%), neglect (3%) and emotional abuse (1%).

Table 7.11 Primary report type

Primary report type		
	Frequency	Valid percent
Welfare issues	680	85.6
Physical abuse	58	7.3
Sexual abuse	31	3.9
Neglect	20	2.5
Emotional abuse	5	0.6
Total	794	100.0

Welfare concern categories

Separate to the difficulties referred by the reporters, the ISW, as part of the preliminary enquiry, must make a preliminary determination about the report received. Initially the ISW decides whether the case is ‘welfare’ or ‘abuse’. Once the ISW selects ‘welfare issues’ as the primary report type for the child they are then required to select from a list of factors relevant to the child, parents and family in question and to rank them in order of priority (see Appendix 1). There is also an ‘other’ option available to the ISW to specify an issue which is not listed on the form. This information provides an insight into the judgement made by the ISW, after carrying out some preliminary checks, about the lives of the children and families reported.

Table 7.12 shows the welfare concern categories which were indicated for the children in the sample. These were selected for 215 children in the sample (27%) and in total 322 issues were identified as more than one could be selected for each child.

The most prevalent welfare concern category was ‘behavioural problems’ which was reported for 9% of children in the sample. ‘Mental health need’ and ‘educational problems’, including absenteeism, were reported for the same proportion of children (7%) and children with ‘emotional

problems' accounted for a slightly smaller number (6%). A small proportion (3%) of children was reported to be abusing drugs or alcohol and other issues were identified for a very small proportion of the sample.

Table 7.12 Welfare concern categories identified for children

Welfare concern categories, children		
	Frequency	Percent*
Behavioural problems	69	8.7
Mental health need	54	6.8
Educational difficulties / out of school	52	6.5
Emotional problems	49	6.2
Abusing drugs or alcohol	26	3.3
Learning disabilities	21	2.6
Complex health needs	13	1.6
Intellectual disabilities	11	1.4
Involved in crime	10	1.3
Pregnant	8	1.0
Homeless	5	0.6
Communication problems	5	0.6
Carer	1	0.1
Total	322	

**Percentages do not total 100 because values were calculated out of the total number of children reported in the study (n=794), rather than the total number of difficulties reported (n=322).*

Table 7.13 details the welfare concern categories which were selected in respect of the parents in the sample. It is notable that the frequency of difficulties amongst parents is greater than that amongst children. The most commonly selected welfare concern category in respect of parents was a 'lack of parenting skills' (17%). A slightly smaller proportion (15%) was deemed to be 'misusing drugs or alcohol' and 8% were recorded as having 'mental health difficulties'. A small proportion (6%) had 'unsuitable / unstable accommodation'. This did not include homelessness, which affected only 1% of the sample.

Table 7.13 Welfare concern categories identified for parents

Welfare concern categories, parents		
	Frequency	Percent*
Lack of parenting skills	95	17.4
Misuse of drugs or alcohol	81	14.8
Mental health difficulties	41	7.5
Unsuitable / unstable accommodation	32	5.9
Homeless	7	1.3
Disabilities / health problems	4	0.7
Deceased	3	0.5
Adolescents	3	0.5
Learning disability	2	0.4
Total	268	

**Percentages do not total 100 because values were calculated out of the total number of parents and families reported in the study (n=547), rather than the total number of difficulties reported (n=268).*

Finally, Table 7.14 shows the welfare concern categories which were selected in respect of the families in the sample. The most frequent issue selected ‘families with relationship difficulties’ (19%) and in 12% of the families ‘domestic violence’ was considered an issue. Other difficulties were experienced by only small proportions of families.

Table 7.14 Welfare concern categories identified for families

Welfare concern categories, families		
	Frequency	Percent*
Families with relationship difficulties	101	18.5
Family where domestic violence is a factor	68	12.4
Family which is socially isolated	10	1.8
Family members with a history of causing serious harm to others	8	1.5
Family with someone involved in crime	7	1.3
Family with financial difficulties	6	1.1
Family with a known abuser	5	0.9
Family where substance misuse is an issue	3	0.5
Family where siblings have disabilities or chronic health problems	1	0.2
Total	209	

**Percentages do not total 100 because values were calculated out of the total number of parents and families reported in the study (n=547), rather than the total number of difficulties reported (n=209).*

In a small but significant proportion of intake records (13%, n=103) the ISW selected the option of 'other, please specify' in the welfare concern categories. The most frequently specified 'other' issue was inappropriate sexualised behaviour (n=27, 4% of total sample), other issues specified, in small numbers, included poor supervision of the child, child and/or family under threat and contact with an alleged abuser.

Differing perceptions of reporters and intake social workers

It is evident from the data presented above that substantial differences existed between the type and frequency of difficulties referred by reporters and how these reports were categorised by the ISW. This may be explained in part by the fact that the ISW, by the time the categorisation was made, had access to several sources of information including records held in the social work department and further discussion with the reporter and other key people. This is an issue which will be discussed in more detail in subsequent chapters.

Conclusion

This chapter has presented findings regarding the profile of the children and families who were reported to the child protection and welfare services in Oaktown during Q1 2015, on the basis of age, gender and family composition. Slightly more girls than boys were reported in the current study and this minimal difference in gender breakdown is consistent with findings from child protection administrative data and empirical research (Forrester, 2007). Notwithstanding inter-country and inter-study differences, the age categories reported in this study also align with existing empirical data with proportionally the largest groups of children 4 years and younger and 13 years and older.

The data indicate that the person most likely to be allegedly causing harm to the child was their parent or guardian. Indeed, the majority of alleged perpetrators were related to the child and there were only very small proportions of non-relatives, peers, services providers or strangers. Also notable is the fact that only slightly more of the alleged perpetrators were male than female.

As previously outlined, there is dearth of contemporary empirical studies looking at the difficulties reported to child protection services and a tendency in existing research to focus solely on the main presenting problem which can be difficult to objectively identify (Forrester et al., 2007). Studies reviewed in an earlier chapter highlight a range of difficulties being experienced by children and families referred to child protection services, with parental substance misuse being most commonly identified across all studies reviewed (Gibbons et al., 1995; McGhee and Waterhouse, 2007; Manion and Renwick, 2008, Scott and King, 2014) and this pattern was replicated in the current study with parental substance misuse reported for one in nine of the children referred. Notably, the most frequently referred difficulty was 'exposure to domestic violence and parental conflict', which was reported for one in seven of the children in the sample and was also the most frequently reported primary concern. 'Physical abuse' was reported for one in eight children in the sample while 'behavioural problems' was reported for one in nine. 'Educational difficulties', 'sexual abuse and sexualised behaviour' and 'mental health need' were each reported for approximately one in ten children in the sample.

Data from the current study show that a significant proportion of the children reported for 'behavioural problems' were boys, which is consistent with findings from other research studies (Manion and Renwick, 2008). Also significant in the current study was the proportion of boys reported for 'learning difficulties or intellectual disabilities'. With regard to age, very small numbers of younger children were reported for 'mental health need' and more than expected were reported for the 'impact of parental substance abuse', in contrast fewer older children than expected were reported for this difficulty. However, older children were found to be statistically more likely than the younger groups to be reported for 'behavioural problems', 'educational difficulties', 'sexual

abuse and sexualised behaviour', 'mental health need', 'learning difficulties or intellectual disabilities', 'child abusing drugs and alcohol' and 'difficult child / parent relationships'.

The increased likelihood of girls to be reported for sexual abuse more frequently than boys has also been highlighted in the literature (Mannion and Renwick, 2008; Bilson et al., 2015) and this was replicated in the current study, with two-thirds of the children reported in the sample for 'sexual abuse and sexualised behaviour' being girls, although this was not found to be a significant finding.

The most commonly reported difficulty in relation to the parents and families was a lack of adequate parenting skills to meet or respond to the needs of the children in the family. This was also the most frequently reported primary issue.

This chapter also presented findings on the categorisation of reports on the basis of the information received, subsequent checks made and discussions with frontline managers. The categorisation of cases in terms of 'welfare' and 'abuse' in the study is out of line with the overall national figures for Q1 2015 which show that 57% of all reports concerned 'welfare' issues and the remaining 43% concerned 'abuse'. This is a key finding in the current study and will be discussed in more detail in subsequent chapters.

Attention was drawn to the disparity between the difficulties highlighted by the reporters and those identified by the ISW. This difference illustrates the significance of the checks carried out during the preliminary enquiry stage and will be discussed in detail in a subsequent chapter.

The next two chapters take a closer look at the difficulties reported for the children and the families in the sample using the qualitative data recorded on the IR forms to illustrate them.

Chapter 8 A Closer Look at the Difficulties Reported for the Children

Introduction

The last chapter demonstrated the most frequently reported difficulties for children referred to the intake system. This chapter goes on to examine these in more detail, analysing the information recorded on the intake record forms. It focuses on the difficulties which were most commonly reported or were most frequently cited as the primary concern for the children in the sample. These include: ‘exposure to domestic violence and parental conflict’; ‘physical abuse’; ‘behavioural problems’; ‘impact of parental substance abuse’; ‘educational difficulties’; ‘sexual abuse and sexualised behaviour’ and ‘mental health need’. Building on the overview provided in the previous chapter, each difficulty is considered in relation to the frequency with which it was reported, the age and gender of the children for whom it was reported and the source of the reports. Drawing on the qualitative detail provided on the IR forms, examples will be given of the type and nature of each difficulty reported.

Exposure to domestic violence and parental conflict

As previously outlined, ‘exposure to domestic violence and parental conflict’ was the most commonly reported concern in respect of the children in the sample and was reported for almost one in every seven (14%). It was also the most commonly reported primary concern (13%). This category included children whose parents were living together and separately and were being emotionally and or physically abusive to one another to the extent that reporters were concerned about the negative impact of parental behaviour on the children.

The gender of the children who were reported in this category was almost evenly distributed between boys (51%) and girls (49%). As previously highlighted in Chapter 7, the breakdown of ages also showed an even distribution across all the age categories with the exception of children under the age of one year where the problem was reported with much less frequency (6%). The findings with regard to the age and gender breakdown of this difficulty were not significant.

In the majority of instances, ‘exposure to domestic violence and parental conflict’ was depicted as a father or male partner being physically or verbally violent and abusive towards the child’s mother and, in most cases, concern was expressed in the report about the child’s exposure to this and its subsequent impact. Analysis of the gender of those alleged to be responsible for domestic violence or parental conflict indicated that the majority were male (76%) and the minority female (7%). Both of these findings were found to be statistically significant (χ^2 (2, N=531) = 61.04, $p < .001$). In the

remainder of cases both the mother and father were alleged to be responsible for the harm to the child (17%).

Examples of adult male to female violence included serious physical assaults, resulting in injuries which on occasion necessitated hospitalisation. At times children reportedly became embroiled in these situations and were also subjected to physical assaults:

‘Mother, Child A and Child B came to the refuge following an incident of domestic violence. Mother alleges that Father returned to the house at night and woke herself and Child A. He physically assaulted Mother by holding her arm back and punching her. During this assault, Child A was also struck by her father’ (A021547).

While in a smaller number, there were instances where fathers reported abuse by their female partners and expressed their concern regarding the impact this was having on their children:

‘In his first assessment Father stated that he is being both physically and emotionally abused by his wife. He showed scars and cuts on his left arm, he claimed were made by his wife He said she does not give him money to live, he is unemployed, and she expects him to beg to bring money to the house. Father stated that his wife is abusive to him and hits him, he said she cooks and cleans for the children but not for him. He said that he is not fed. He said that all this happens in front of the two children and that they are witness to the abuse and he stated that they are very distressed by it’ (B011562).

There were also reports of violence and aggression between adult family members, for example grandparents and adult siblings, to which children were also exposed whilst living in the same house:

‘Mother reported that she had to move out of the house following an altercation with her sister. She reported that her sister hit her over the head with a charger and she responded by punching her. Her brother had to physically separate them. Maternal Grandmother reports that Child [aged 1] was sitting on the floor of the room and when she walked into the room Mother had completely lost it and was sitting on top her sister hitting her with Child’s toys’ (A031514).

In some cases, accounts were confined to verbal altercations between the parents, which were considered by the reporter to be having a very negative effect on the child in question:

‘Child [aged 7 months] was exposed to an extremely volatile and verbally aggressive incident between his Mother and Father. Child was observed to be frozen and non-responsive during the incident and when he was removed by staff from the room he clung to the ... worker’ (B031551).

In a substantial proportion of the reports, referrers had described the impact of domestic violence and parental conflict on the child’s emotional wellbeing and, in a smaller number of reports, referrers observed that the issue was having a direct effect on the child’s behaviour.

Reports showed that children had made fairly detailed disclosures about family violence and its impact on them in school:

‘Child presented to school very distressed. He expressed concern that his mother’s partner is controlling and being threatening and verbally abusive to both him and his mother. Child repeatedly expressed that he wished to kill himself. Child stated that he would rather commit suicide than return to the apartment and did not want to leave school’ (A021520).

Most reports concerned current domestic violence and parental conflict but a small number of reports concerned situations that had been resolved by the departure of the perpetrator, where reporters were concerned about the enduring impact of past events on the child or children concerned.

In order to examine the source of professional reporting of family violence, the chi square test of association was carried out and inspection of the standardised residuals revealed that these reports were statistically more likely to come from domestic violence services than any other reporting source: 21% of all reports came from this source (χ^2 (15, N=794) = 49.2, $p = <.001$). In most instances, the women and children concerned were resident in the refuge and had disclosed their children’s exposure to, or an injury from, domestic violence to a worker there.

Schools and Gardaí were the next most frequent reporters of this concern (16%) (see Table 8.1). Schools tended to contact services when a child made a disclosure in school regarding an incident at home between his or her parents. In most cases reports from the Gardaí noted that the child(ren) had witnessed a violent incident between parents. Less frequently, they reported instances where the children were not present in the room at the time of the incident. Family members (normally the victim) reported a tenth (10%) of these domestic violence concerns and were worried about the impact that it was having on their child(ren). However, the findings with regard to reports from these sources were not found to be statistically significant.

Table 8.1 Reporters of exposure to domestic violence and parental conflict

Reporters of exposure to domestic violence and parental conflict		
	Frequency	Valid Percent
Domestic violence services	23	21.3
School personnel	17	15.7
Gardaí and probation	17	15.7
Family member	11	10.2
Medical personnel	13	12.0
Voluntary organisations – children, housing and disability	7	6.5
Health Service Executive staff	4	3.7
Mental health services	3	2.8
Youth services	2	1.9
Local authority staff	1	0.9
Care staff	1	0.9
Tusla staff	1	0.9
Self	1	0.9
Other*	7	6.5
Total	108	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Physical abuse

For one in eight of the children in the sample (12%), the main reported concern was past or current 'physical abuse'. This was also the primary concern in the same proportion (12%) of the reports. Predominantly, the alleged 'physical abuse' was reported to be current and ongoing and only in a small number of cases were the concerns about physical abuse retrospective. The proportion of reports for 'physical abuse' were similar for boys (49%) and girls (51%). Only 3% of the reported children were in the younger than 1 year category, while 35% were in the adolescent category. However, these age and gender patterns were not found to be statistically significant.

Additional detail recorded on the IR forms revealed that the alleged 'physical abuse' had usually taken place in the home, apparently perpetrated by one or both of the child's parents. In fact, 90% of all alleged perpetrators of 'physical abuse' in the sample were the child's parent(s). Analysis of the gender of the alleged perpetrator of the reported 'physical abuse' revealed a breakdown of 54% male,

32% female and 14% male and female together. However, these findings were not statistically significant.

Examination of reporters of 'physical abuse' showed school personnel were significantly more likely to report 'physical abuse' than any other professionals with 31% of referrals coming from this sector ($\chi^2 (15, N=794) = 40.04, p < .001$) (see Table 8.2). Mental health services were responsible for almost a tenth (9%) of the reports and Gardaí and probation and family members both accounted for the same proportion of reports (8%). Medical personnel and Tusla staff each accounted for 7% of the reports. A slightly smaller number of reports were made by youth services (6%) and voluntary organisations reported a slightly smaller proportion (5%).

While a variety of professionals reported 'physical abuse', the IRs indicate that most were made following a disclosure by a child. The most common scenario was disclosure of 'physical abuse' by a child to a professional, most commonly school personnel, who then reported it to Oaktown on their behalf. The qualitative data reveal that children were also likely to confide in youth workers, counsellors and play therapists. For example:

'Child [aged 14 years] reported to the school chaplain that her father often gets extremely angry with her and her siblings. She reports that he loses his temper over minor things such as one of the children spilling something. When he is angry she reports that he shouts at them in what seems to be an abusive manner and she says that he hits her' (A011585).

While 'physical abuse' was cited as a primary difficulty in 12% of reports made, ultimately only 7% of all reports were categorised as 'physical abuse' by the ISW. A review of the qualitative data on the IRs revealed that, in a small number of instances, events which has been reported as 'physical abuse' were ultimately reinterpreted as inappropriate discipline by the ISW. At times there was a cultural element to such cases where parents from different countries appeared to have used a degree of physical discipline that would not be acceptable in Ireland. In such cases the parent(s) were contacted and advised that their mode of discipline was unacceptable and should be abandoned. They were further advised that if the use of such inappropriate discipline were to come to the attention of the SWD again further action may need to be taken.

Table 8.2 Reporters of physical abuse

Reporters of physical abuse		
	Frequency	Valid percent
School personnel	30	30.9
Mental health services	9	9.3
Gardaí and probation	8	8.2
Family member	8	8.2
Medical personnel	7	7.2
Tusla staff	7	7.2
Youth services	6	6.2
Voluntary organisations – children, housing and disability	5	5.2
Health Service Executive staff	4	4.1
Domestic violence services	4	4.1
Care staff	2	2.1
Member of the Public	2	2.1
Self	2	2.1
Drug and alcohol treatment services	1	1.0
Other*	2	2.1
Total	97	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Behavioural problems

‘Behavioural problems’ were reported for 11% of the children in the sample but were the primary concern in a much smaller proportion of the cases (5%) meaning that at times they featured as a secondary or tertiary concern for the child.

As previously outlined in Chapter 7, there was a statistically significant relationship between gender and ‘behavioural problems’ ($\chi^2 (1, N=783) = 27.6, p = <.001$) with 74% of those reported for such difficulties being male and 26% female.

Analysis of the association between age and ‘behavioural problems’ also showed a highly significant pattern ($\chi^2 (4, N = 772) = 33.3, p = <.001$) where the largest proportion of children in the sample with ‘behavioural problems’ were children in the 13 to 17 age group (58%) and children from younger

age groups less likely to be reported (only 20% of the children reported for 'behavioural problems' in the sample were under 8 years or under).

In a small number of the IR forms, the 'behavioural problems' of the child, while referenced, were not elaborated upon and rather the child was described as having 'difficult' or 'challenging' behaviour. However, in the majority of the forms detail was given and terms such as 'violent', 'aggressive', 'destructive' and 'challenging' were commonplace. There were also a number of discernible trends in the behaviours these children were displaying.

Amongst the boys, younger than the age of eight years, the reports detailed concerns about these children showing a lot of anger and at times aggression, in particular towards their mothers. In one incidence, concern for the child centred on the fact that he had killed the family pet.

Amongst the male children in the 9 to 12 year age group who were displaying 'behavioural problems', half were also reported to have a learning or intellectual disability and these children's behaviours were more likely to be described as 'violent' than those in the younger group. Sexualised behaviours constituted another noteworthy trend in this sub-group. In one report, regarding a twelve year old boy, the school principal reported:

'Child is displaying 'dangerous' behaviour, he has outbursts of violence towards other pupils, which are very unpredictable. He flaunts school rules, he had been bringing a phone to school and looking up inappropriate videos on YouTube. He has been stealing items of school property, stationery etc., he has pulled down a fellow pupil's trousers and underpants in the yard' (B021547).

The older male children referred were also reported for engaging in violent and aggressive behaviours. Behavioural issues such as theft, property damage, school refusal, disobeying rules in the home and drug and alcohol use were reported with greater frequency for this older age group.

Whilst 'mental health need' was detailed for some of the younger male children, this featured much more prominently in reports on older children. Similarly, while 'sexual abuse and sexualised behaviour' and children with 'learning difficulties or intellectual disabilities' featured amongst the older male children, they were more prevalent in the 8 to 12 year old group.

Girls in the sample were reported less frequently for 'behavioural problems' and those who were reported tended to be in the older age category. Younger girls in this category displayed behaviours such as hitting other children in school and throwing tantrums, whilst children in the 9 to 12 years age group were reported for more aggressive behaviours including school refusal and property damage:

‘Child [aged 10 years] is refusing to attend school. Mother took Child’s iPad and games off her yesterday and in response Child “trashed the house”, she poured juice and milk on the floor and broke items’ (B0115101).

Similar to the boys, although fewer in number, older girls were more likely to be reported for more violent or threatening behaviours and also for school refusal.

Across both genders, most of the reported aggression and threatening behaviour, particularly amongst the older children, was predominantly directed towards mothers and siblings at home and there were many instances of parents claiming inability to cope with their child’s behaviour, some requesting care placements for their children. Some parents admitted responding to their children’s behaviour with violence or aggression. These themes will be explored in more detail in a later chapter.

Analysis of the data on reporters of ‘behavioural problems’ indicates that while a wide variety of professionals were concerned about this problem, school personnel were the group most likely to report this difficulty (see Table 8.3) and were responsible for almost a third of all the referrals. The second group most likely to report were family members (14%) followed by Tusla staff (11%). Chi square tests of association revealed that school personnel were significantly more likely than other sources to report this difficulty (χ^2 (15, N=794) = 54.05, $p < .001$). In fact, of all reports made by school personnel in the sample almost a quarter (23%) were regarding ‘behavioural problems’ highlighting this as a prominent issue for these professionals.

Table 8.3 Reporters of behavioural problems

Reporters of behavioural problems		
	Frequency	Valid percent
School personnel	29	32.2
Family member	13	14.4
Tusla staff	10	11.1
Gardaí and probation	9	10.0
Mental health services	5	5.6
Care staff	5	5.6
Medical personnel	3	3.3
Health Service Executive staff	3	3.3
Youth services	3	3.3
Drug and alcohol treatment services	3	3.3
Voluntary organisations – children, housing and disability	2	2.2
Member of the public	2	2.2
Local authority	1	1.1
Other*	2	2.2
Total	90	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Impact of parental substance abuse

The 'impact of parental substance abuse' was a reported in relation to 11% of the children in the sample, more than one in ten, and for 8% of children in the sample it was the primary concern.

As outlined in the previous chapter, the children who were allegedly most impacted by this factor were between the ages of 1 and 12 years (89%). In particular children in the 1-4 year age group were significantly more likely to be affected by parental substance misuse (33%) and teenagers significantly less likely to be affected (11%) (χ^2 (4, N=772) = 28.75, p = <.001).

There were no findings of note regarding the gender of the children who were impacted by parental substance abuse with male and female children represented almost equally (male 53%, female 47%). However, analysis of the relationship of the person misusing substances and the reported children reveals that the overwhelming majority (97%) were in a parental or guardianship role. Chi square analysis of the gender of these alleged perpetrators was carried out and inspection of the standardised

residuals yielded statistically significant results which showed 56% were female, 23% were male and 21% were male and female, meaning that both parents were engaged in substance misuse that was impacting on the children in the family (χ^2 (2, N=531) = 24.2, $p < .001$). While this finding may have been skewed by the high proportion of female headed lone parent families, it is still notable that the majority of parents whose substance misuse was considered harmful to children were female.

Examination of the type of substance misuse that negatively impacted on children indicated that drug and alcohol misuse featured in almost equal measure:

‘My Mammy sometimes drinks alcohol but I don’t like it. I don’t like it when my Mammy drinks alcohol. I do not like to see her drunk. One time we are not allowed to tell anyone, Mammy doesn’t let us talk about it my Mammy got drunk and she went to the toilet on the floor. She was all sleepy and went to go to the toilet but didn’t go and she went on the kitchen floor instead, then she went to sleep on the couch’ (Child aged 10) (A011509).

The majority of reporters in this category gave details of the deficits in parenting associated with parental substance misuse, most frequently citing unmet needs. An example of this came from one maternal grandfather who spoke to the ISW about his daughter:

‘There is insufficient food in the house. Grandfather is worried that Mother might be using drugs as he feels she is paranoid and she often cannot explain where her money has gone. Grandfather is concerned about supervision levels, he said he walked into the house one night and observed one of the children asleep on the floor and another child wandering around while Mother was fast asleep on the couch. There is an inappropriate sleep routine where Mother is putting the children to bed very early and then becoming very angry with them when they get up too early’ (B011514).

The next most frequently cited example of harm or potential harm caused by substance misuse related to parents driving their children whilst under the influence of alcohol. Other examples included the use of substances in front of the children, the impact it was having on the children’s attendance at school, children being exposed to the paraphernalia that goes with drug use in particular, drug misuse during pregnancy, children being left unattended and children being given excessive responsibility in the home.

Analysis of the identity of reporters of this factor revealed some interesting findings. As shown in the Table 8.4, almost one third (31%) of all reports came from family members, followed by anonymous persons and voluntary organisations (11%). The next most frequent reporters were school personnel and medical personnel who each reported almost a tenth (9%) of these reports.

A chi square test of association revealed that family members were significantly more likely (31%) to report this difficulty than other reporters (χ^2 (11, N=794) = 87.2, $p < .001$). Indeed, of all reports

made by family members in the sample over a quarter (26%) of them related to the ‘impact of parental substance abuse’ on their children.

Table 8.4 Reporters of the impact of parental substance abuse

Reporters of impact of parental substance abuse		
	Frequency	Valid percent
Family member	27	30.7
Anonymous	10	11.4
Voluntary organisations – children, housing and disability	10	11.4
School personnel	8	9.1
Medical personnel	8	9.1
Tusla staff	6	6.8
Gardaí and probation	6	6.8
Member of the public	5	5.7
Mental health services	3	3.4
Health Service Executive staff	1	1.1
Domestic violence services	1	1.1
Other*	3	3.4
Total	88	100.0

**Reporting sources with very low frequencies were collapsed into ‘other’ to enable chi square analysis.*

Educational difficulties / out of school

‘Educational difficulties’ were reported for a tenth (10%) of the children in the sample, although were cited as a primary concern in only 3% of the reports made during the time period under study. Analysis of the qualitative data from the IR forms confirms that in the vast majority of cases children reported in this category had at least one and sometimes many more difficulties to deal with. The chi square test of association did not indicate any significant association between children experiencing ‘educational difficulties’ and any one particular primary issue, implying that these children were experiencing a wide range of other difficulties:

‘Child started junior infants in September and the school had concerns from early on. Child came to school without a coat on very cold days in November and December and on some days had no lunch at all. The principal said that Mother was wheeling a young baby in a buggy with no blanket

on very cold days. Child's pattern of attendance in school is very poor, she was present for 61 days and missed 31 days. The principal said that overall he is very concerned and believes that Mother may have addiction issues and is neglectful regarding Child's education' (B011557).

The analysis of the gender of the children reported for 'educational difficulties' in the sample showed slightly more females (57%) being reported for this difficulty than males (43%) although this finding was not statistically significant. Analysis of the age of the children showed, as expected, children under the age of five were significantly less likely to be reported for 'educational difficulties' (9%) whereas those in the oldest age category were more likely (52%) (χ^2 (4, N=772) = 17.27, p = <.005). In total 15% of the teenagers in the sample were reported for 'educational difficulties'.

'Educational difficulties' reported for children in the sample mostly pertained to absenteeism from school, school refusal, poor school attendance generally and in some instances being suspended or expelled from school. Analysis of the qualitative information on the IR forms linked school absenteeism with other behavioural difficulties such as substance misuse, violent or aggressive behaviours as well as mental health problems, learning difficulties or intellectual disabilities or a lack of parental supervision:

'Child [aged 16] is refusing to go to school or obey the rules of the house. [He is] verbally and physically abusive towards his Mother. [He] did not attend school for five weeks and returned yesterday for one day. He stays in the shed with his friends and does not listen to anyone' (B021567).

Additional difficulties for children who were reported for poor school attendance related to parenting issues such as substance misuse or domestic violence and parental conflict:

'Maternal Grandmother said that the boys have missed some school and also have been late due to their Mother's drug use. Maternal Grandmother said that their Mother has been a great Mother and loves the boys but that she is incapable of caring for them when she is on drugs' (B011535).

The data on reporters of 'educational difficulties' did not reveal any statistically significant findings. Unsurprisingly educational personnel made the most reports in this category (25%), followed by family members (19%) (see Table 8.5).

Table 8.5 Reporters of educational difficulties

Reporters of educational difficulties		
	Frequency	Valid percent
School personnel	20	25.0
Family member	15	18.8
Voluntary organisations – children, housing and disability	8	10.0
Tusla staff	6	7.5
Medical personnel	5	6.3
Tusla staff	4	5.0
Domestic violence services	4	5.0
Gardaí and probation	3	3.8
Anonymous	3	3.8
Mental health services	3	3.8
Youth services	2	2.5
Care staff	1	1.3
Other*	6	7.5
Total	80	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Sexual abuse and sexualised behaviour

Concerns about 'sexual abuse and sexualised behaviour' were reported for a tenth (10%) or one in ten of all of the children reported in the sample and it was also the primary concern in a little over a tenth of all the reports made (11%). This implies that when this difficulty was reported for a child in the sample in most instances it was considered the most important issue faced by the child.

Sexual abuse and sexualised behaviour were considered together for the purposes of the current study because they are often linked and proved difficult to analyse as distinct issues, particularly given the limited information provided on the IR form. Added to this, it was at times difficult to ascertain from the IR whether the children or young people who were referred had themselves experienced the reported incidents as sexual abuse or as inappropriate sexualised behaviour or interactions. It is also notable that the IR form provides no option for the ISW to select sexualised behaviour as a 'welfare' concern which may instead lead them to categorise the concern as sexual abuse or mention it in the 'other' category.

Reports concerning 'sexual abuse and sexualised behaviour' in the sample detailed a range of different situations and experiences in respect of the children and young people concerned, some of which they engaged in willingly, sometimes unwillingly; sometimes with somebody they knew, sometimes with a stranger and sometimes with someone their own age and sometimes someone older. Reports included: children and young people engaging in inappropriate sexualised behaviour with another child or young person; children and young people who reported that they were sexually assaulted by another which sometimes was an adult or sometimes was a peer; inappropriate sexualised play particularly amongst younger children; concern that a child or young person had been sexually abused although they had not made any disclosure; concern that a known perpetrator was in contact with a child or young person which may make them vulnerable to sexual abuse and a child or young person who was inappropriately exposed to adult sexual behaviours or interactions.

Ultimately, only 4% of the reports in the sample on 'sexual abuse and sexualised behaviour' were classified as sexual abuse which contrasts with the frequency of 10% which was reported by the referrers. However, as the foregoing demonstrates many factors need to be taken into account by ISWs when deciding on the classification of these cases.

Consideration of the gender of the children reported for 'sexual abuse and sexualised behaviour' within the sample showed a greater frequency amongst girls (60%) than the boys (40%) however this finding was not found to be statistically significant. As outlined in Chapter 7, children between the ages of 9 and 17 were more likely to be reported for this concern and almost three quarters (71%) of the children referred were between these ages. The finding that slightly over half (51%) of the children reported for 'sexual abuse and sexualised behaviour' were in oldest age category (13 to 17 years) was found to be statistically significant ($\chi^2 (4, N=772) = 12.85, p = <.05$).

When 'sexual abuse and sexualised behaviour' was reported, information regarding the relationship that the child or young person concerned had with the person who was alleged to have caused them harm was provided in almost three quarters of the reports (74% {59/80}). Given the small numbers involved, it was not possible to carry out a chi square test of association. The largest group, who were alleged to have caused harm, were parents or guardians (32%) followed by peers (25%). Siblings accounted for 12% of the alleged perpetrators and other extended family members accounted for one tenth (10%). Strangers accounted for only 10%.

The nature of sexualised behaviour and interactions between peers was a commonly detailed concern on the IRs. However, the form that it took and the way in which it had been experienced by the child being reported varied greatly in the accounts provided. For example, this child undoubtedly experienced a sexualised interaction with two of her peers as abusive:

'Child A advised that on a Monday two of her friends from school, Child B and Child C came to her home. She stated that they repeatedly asked her to perform oral sex on them. Child A advised

that at one point [Child C] grabbed her head by her hair and forced her head toward his crotch area. She noted that he forced her head and held her until she performed oral sex on him. She stated that then both youths hugged her and left the home' (A011542).

Other incidents reported could be construed as inappropriate sexualised behaviour:

'Child A said Child B came into the toilet when Child A was there, Child B pulled her tights down and asked Child A to 'touch her there' (pointing to her genitalia) and to "stick her finger right up there" pointing to her bum. Child A said she didn't do it' (A011545).

It was notable, that in a small number of cases, the children or young people engaging in sexualised behaviour also had learning or intellectual disabilities.

Data on reporters of 'sexual abuse and sexualised behaviour' were analysed and are detailed in Table 8.6 below. The most frequent reporters were schools (19%), Gardaí and Probation (16%) and family members (15%). No statistically significant patterns were found.

Table 8.6 Reporters of sexual abuse and sexualised behaviour

Reporters of sexual abuse and sexualised behaviour		
	Frequency	Valid percent
School personnel	15	18.8
Gardaí and probation	13	16.3
Family member	12	15.0
Mental health services	11	13.8
Medical personnel	8	10.0
Care staff	6	7.5
Tusla staff	6	7.5
Voluntary organisations – children, housing and disability	2	2.5
Domestic violence services	2	2.5
Other*	5	6.3
Total	80	100.0

**Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.*

Mental health need

‘Mental health need’ was reported for one tenth (10%) of the children in the sample and was considered the primary difficulty for 8% of the children reported.

Reports were almost evenly divided between female (51%) and male (49%) children. As outlined in the previous chapter the overwhelming majority of children (82%) who were reported for ‘mental health need’ were within the 13 to 17 age group, a pattern which was significant (χ^2 (4, N=772) = 87.81, $p = <.001$). It is also interesting to note that only one child under the age of nine was reported for ‘mental health need’.

The mental health difficulties that were reported included self-harm and self-harm ideation, suicide attempts and suicide ideation, low mood and depression and general concerns about a child’s mental health. Self-harm and suicide attempts were by far the most common reasons for referral but there was differentiation evident in the reports between those who were contemplating such behaviours and those who had carried them out. The number of children reported for ‘mental health need’ who had actually self-harmed was greater than the proportion who had only thought about self-harming while the reverse was true for suicidal ideation, those who said they had thought about committing suicide far outnumbered those who had made suicide attempts. Although most of the children who were reported for suicidal and self-harm ideation and attempts were older, there were reports of such difficulties amongst children as young as nine and ten.

Where information was provided, it indicated that children who had self-harmed mostly had engaged in cutting:

‘Mother had noticed Child with cuts on her arms, she was then checking Child’s body and hadn’t noticed anything else for a while She then started to cut her legs. Mother looked into the bathroom the other evening when Child was taking her shower and she then saw cuts on her hips. Mother talked to Child for about two hours and she eventually told her what had happened’ (B031553).

Children and young people who had made attempts on their own lives had done so either by overdose or hanging.

The mental health difficulties being experienced by some children were attributed to a specific event or experience detailed in referral. In other cases children’s ongoing school or family problems appeared to be impacting on their mental health on an ongoing basis.

Specific events in children’s lives which were recorded as causes of distress included the death of a close family member or friend, a sexual assault or sexual abuse, bullying or a physical assault by a parent. Other cited difficulties included: diagnosis of a learning difficulty or intellectual disability; a

poor relationship with their parent(s); parental substance misuse; domestic violence and parental conflict and their parent's own mental health difficulties:

‘Child [aged 16] presents with low mood; his school attendance has dropped greatly; he has become extremely isolated and introverted; he has poor appetite; displays little or no interest in activities, friends etc. and continues to self-harm and speak of suicidal ideations. This is further compounded by a very fractious relationship between Child and his Mother who is his primary carer. The referral comes to the social work department with serious concern for the negative home environment and the real associated risk of the home placement breaking down’ (B031556).

School personnel were the most frequent reporters of this issue (25%), followed by mental health services (20%) (see Table 8.7). When mental health professionals made reports, it was because they believed that a child protection or welfare issue was impacting on a child's mental health.

The chi square test of association was carried out on these findings and inspection of the standardised residuals did not demonstrate significance for the rate of referral from school personnel (standardised residual 1.9) but did for the rate of referral from mental health services (χ^2 (11, N=794) = 61.7, p = <.001).

Table 8.7 Reporters of mental health need

Reporters of mental health need		
	Frequency	Valid Percent
School personnel	19	24.7
Mental health services	15	19.5
Medical personnel	11	14.3
Family member	7	9.1
Youth services	6	7.8
Tusla staff	5	6.5
Gardaí and probation	3	3.9
Care staff	3	3.9
Voluntary organisations – children, housing and disability	3	3.9
Health Service Executive staff	2	2.6
Other*	3	3.9
Total	77	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Conclusion

This chapter used the qualitative data recorded on the IR forms to provide a more in depth perspective on the most frequently reported difficulties for the children in the sample, the age and gender of those children and the source of the reports.

Analysis of this data provides greater clarity as well as insight into the nature of the difficulties reported. For example, while there were variations in the types of domestic violence and parental conflict reported in the sample the most frequent manifestation were of a father or male partner being physically or emotionally violent and abusive towards a child's mother in the presence of the child.

Schools were found to be the most significant reporters of 'physical abuse'. However, the data also provide interesting information about other professionals to whom children open up, for example counsellors and play therapists. It is also interesting to note that reports of 'physical abuse' in the current study were normally a result of a child's disclosure rather than the result of physical abuse being diagnosed by a medical person. This is contrary to the tradition by which doctors and GPs particularly were always seen as pivotal identifiers of physical abuse (Buckley and O'Nolan, 2013). The qualitative data analysed on the IR forms also profile the distinction between 'physical abuse' and 'inappropriate physical discipline' which often presents challenges to the assessing social worker.

A number of discernible trends were evident in relation to reported 'behavioural problems' detailed on the IR forms, most notably how the type and severity of the behaviours described increased with age. Although there were similar patterns to the behaviours reported for girls, they were much less likely to be reported for 'behavioural problems' than the boys in the sample. Schools were again revealed to be significantly more likely to report this difficulty than any other source of reports.

As previously mentioned, parental substance misuse as a common reason for referral to child protection services has been identified in a number of studies (Gibbons et al., 1995; McGhee and Waterhouse, 2007; Manion and Renwick, 2008, Scott and King, 2014). Within the current study, findings with regard to age and the 'impact of parental substance abuse' are particularly noteworthy and indicate that younger children are more likely to be impacted by this issue than older children. The qualitative data presented bear out this finding and show how the care of young children is adversely impacted by substance misuse, such as the upsetting experience of seeing a parent intoxicated or the inability of a parent to establish the routines that are so integral to child well-being and development. There was a particular predominance of female headed households amongst parents whose substance misuse was negatively impacting on the children in the sample.

While 'educational difficulties' were reported for one in ten of every child in the sample, this matter was the primary concern in only a very small proportion of reports and was usually associated with

a range of other difficulties. Most frequently, these included behavioural problems, mental health need, learning difficulties or a lack of parental supervision. Accordingly, the type of difficulties reported related more to attendance at school rather than performance. A significant pattern of association was found between age and ‘educational problems’ with the largest proportion of those reported coming from the oldest age category.

‘Sexual abuse and sexualised behaviour’ was a reported difficulty for one in ten of the children in the sample and was also a primary concern for a similar proportion. This is in contrast with the much smaller proportion of reports (4%) which were categorised as sexual abuse by the ISW as an outcome of their assessment. Significance testing revealed that older children were more likely to be reported for this concern than younger children. This conflicts somewhat with Mannion and Renwick’s (2008) finding in their empirical research, where girls between the ages of 9 and 12 years were most commonly reported. In the current study schools, Gardaí and probation and family members were the most frequent reporters of this difficulty, however no significant patterns of association were found.

‘Mental health need’ was reported for one in ten of the children in the sample and there was a significant association within the sample of older children being reported for this difficulty and of mental health services reporting of this issue.

The next chapter provides a closer look at the difficulties that were reported in respect of the parents and families in the sample.

Chapter 9 A Closer Look at the Difficulties Reported for Parents and Families

Introduction

This chapter again uses the qualitative detail added to the intake record forms by intake social workers as a data source for examining in greater depth the most frequently reported difficulties for parents and families. The matters that were reported most frequently in respect of parents and families included: a 'lack of parenting skills'; 'significant relationship difficulties'; the 'misuse of drugs and alcohol'; 'domestic violence'; 'struggling to manage child's behaviour' and parental 'mental health difficulties'. These difficulties were also most frequently considered the primary concerns for the parent and family. Each issue will be examined in terms of the frequency with which it was reported, the source of the report and the qualitative detail that was recorded on the IR form.

Lack of parenting skills

A 'lack of parenting skills' was reported for over one in four of the families in the sample (27%) and it was the primary issue reported for almost the same proportion (24%). While the family problems reported were varied, their impact on children in terms of unmet need was the most common theme.

Some reporters had made general observations about the impact of problems on parenting capacity, but most identified specific developmental, basic care and emotional needs that were considered to be unmet. For example:

'Child presented to the emergency department following the deliberate ingestion of tablets. Mother was advised to stay with the child over-night, she did not do this. Child has displayed vulnerable coping skills and medical social worker would be concerned that her mother presents as unable to meet her emotional needs as she did not provide adequate supervision and support during child's stay in hospital' (A021525).

The inability of a parent to support a child with mental health difficulties was a common concern and to a lesser extent the inability to provide support to a child who had an adverse experience such as sexual abuse.

Inappropriate parenting practices such as leaving a young child unattended, giving children excessive responsibility in the home and leaving children for excessive periods of time with carers that were sometimes considered unsuitable were also frequently reported. Reporters in some cases had found that parents, when challenged, had little insight into the impact of their behaviour. For example:

‘Garda advised that while on patrol in Area A he observed Child [aged 2] alone in Estate A. She was walking around in her bare feet, was covered in muck and had cuts on her face. Garda notes that Mother reportedly did not see a problem with Child being alone in the field when she was informed of the situation by the Gardaí. Garda noted that she did not accept that she had done anything wrong and appeared to blame Child for the situation’ (A031506).

Other behaviours which were less frequently reported included: exposing the child to risky or inappropriate situations such as drug dealing; sleeping rough; being in a stolen car or being verbally aggressive to other adults in front of the child. In a small number of cases a parent was reported for offering and encouraging their child to partake in drug use.

Reporters were also concerned about the use of physical abuse and, to a lesser extent, verbal abuse as a means of discipline, for example:

‘On Thursday morning Child was being dragged to school by both his parents which is often the case. On this occasion his father grabbed him by the throat and said “go to school” or he would “effing kill him”’ (B0315107).

Deficits in parenting were frequently reported in the context of other difficulties that the parent was experiencing. In these instances, detail was given as to how this particular difficulty was impacting on their ability to parent. Parental substance misuse was the most commonly mentioned difficulty in this regard:

‘Over the past two years the caller [anonymous] has observed many, many times the parents to be in a pub for hours on end with their son in a buggy. The caller reports that the boy [aged 3] sleeps for three and four hours straight despite the noise and she believes he is medicated to sleep. Caller queries use of Phenergan or Dozol to ensure the child sleeps. The child is observed to have extremely poor speech and is still in nappies. He is never observed to be given a bottle or a meal even though they could be in the pub for 6 or 7 hours. He is either left in the buggy or when out is left in the corner of the pub playing with beer mats – he has no stimulation and no one is playing with him’ (B031554).

Mental health difficulties and in particular the impact of medication on parenting or the impact of not taking medication when it was prescribed was also reported:

‘Mother is not currently taking her medication correctly and is physically and verbally abusive towards the children on a daily basis. Mother does not attend to their needs and often during the night leaves the three month old crying for hours. Mother just sleeps on the sofa in the sitting room and does not assist with the household duties, meal preparation or children’s needs’ (B011530).

A small number of parents were considered young and inexperienced and at times lacking in any family support networks which was seen to further compound their lack of parenting skills.

As can be seen in Table 9.1 below, schools were significantly more likely to report this issue than any other source (26%) (χ^2 (12, N=547) = 37.07, p = <.001). Qualitative data on the IR forms indicated that the reporting of this difficulty by schools mostly related to parents who were unwilling or unable to respond to the needs of their child(ren). None of the other sources of reports regarding this issue were found to be significant but it is notable that approximately a tenth of these reports came from family members (12%), mental health services (10%) and Gardaí and probation (9%).

Table 9.1 Reporters of lack of parenting skills

Reporters of lack of parenting skills		
	Frequency	Valid percent
School personnel	37	25.5
Family member	17	11.7
Mental health services	15	10.3
Gardaí and probation	13	9.0
Medical personnel	12	8.3
Health Service Executive staff	11	7.6
Tusla staff	10	6.9
Anonymous	7	4.8
Youth services	6	4.1
Voluntary organisations – children, housing and disability	5	3.4
Member of the public	4	2.8
Other*	8	5.5
Total	145	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Significant relationship difficulties

'Significant relationship difficulties' were reported for one in five families in the sample (20%) and was considered the primary concern in 13% of cases.

The most frequently reported relationship difficulty for parents and families in the sample concerned the custody of, and access to, children where relationships had broken down. At times, court ordered

arrangements were in place and at other times these arrangements were informal. Difficulties regarding these arrangements were mostly reported by parents and included those who wanted more access to their children and those who wanted more help from the other parent in caring for the children. Overwhelmingly, however, the difficulties centred on accusations and counter accusations between the parents regarding how the children were treated or what they were exposed to whilst in the care of the other parent. The most common allegation concerned substance misuse on the part of the estranged partner whilst caring for the child. For example:

‘Mother informed staff in the centre that the children’s father had ‘taken’ the children at the weekend against her will and is refusing to return them. The senior social worker spoke to the father by phone and he said that he is concerned for Mother’s ability to care for the children given that she has been actively using drugs and is drug affected’ (B021533).

A substantial number of parents also expressed concern that their child was being sexually abused either by their estranged partner or whilst in that parent’s care. In some instances, the concerned parent had brought the child for a medical examination to have their suspicions assessed. Other worries on the part of parents included children being physically abused by their other parent, the impact of the mental health of the other parent, concerns about the parent’s new partner’s care of their child and allegations of their children being left unsupervised.

In the vast majority of cases concerning the custody and access of children, poor communication between the parents impeded resolution of the problem. Consequently some reporters looked to the ISW to mediate.

Other reported relationship difficulties included acrimony between parents and adults living in the same household. At times, children spoke to professionals about the ‘tense environment’ they were living in where there were ‘constant arguments’ and ‘parents fighting a lot’. Reports were also made regarding acrimony between adult siblings, parents and other extended family members who lived together, which at times involved violence and aggression:

‘Child lives with her mother, maternal grandfather and maternal uncle. In interviews Father has had with his probation officer he has alluded to violence on Child’s mother by her brother. He stated concern for Mother’s well-being due to assaults by her brother. These were at times of intoxication and drug use’ (B011541).

There were also a number of reports regarding arguments and friction between parents, some of whom were separated but were still living in the same house.

Child to parent violence was also an issue in a small number of the reports and was also considered to be a significant relationship difficulty.

Statistical data on the source of the reports for ‘significant relationship difficulties’ are shown in Table 9.2 below. Consistent with the findings reported above, family members were significantly more likely than any other source to report this difficulty (28%) (χ^2 (9, N=547) = 38.32, p = <.001). None of the other findings regarding the source of the report were found to be significant.

Table 9.2 Reporters of significant relationship difficulties

Reporters of significant relationship difficulties		
	Frequency	Valid percent
Family member	31	28.2
Gardaí and probation	19	17.3
School personnel	13	11.8
Medical personnel	8	7.3
Tusla staff	6	5.5
Mental health services	7	6.4
Domestic violence services	7	6.4
Voluntary organisations – children, housing and disability	5	4.5
Health Service Executive staff	3	2.7
Other*	11	10.0
Total	110	100.0

**Reporting sources with very low frequencies were collapsed into ‘other’ to enable chi square analysis.*

Misuse of drugs and alcohol

The ‘misuse of drugs and alcohol’ was reported for almost a fifth of the parents in the sample (19%) and was considered the primary concern for parents in 17% of reports.

Reports about parental substance misuse described the impact it was having on the child(ren) living with the parent and the detail of these reports was elaborated on in Chapter 8. In the remainder of reports regarding parental substance misuse, the direct impact on the child(ren) in the family was not explicitly named but was implied. In these instances, reports detailed generalised concerns regarding parents who had long histories of substance misuse and were in need of support. At times, the report detailed a particular incident which raised concern:

‘Child was brought to hospital under Section 12 of the Child Care Act. Child was observed by a member of the public in a park in the care of a man who was under the influence. It was reported

to the Gardaí. When the Gardaí arrived the man was unconscious. Baby was in a buggy without a rain cover, soaking wet and her blanket was soaking wet' (A0212558).

Links between substance abuse and subsequent aggression were reported, and the co-occurrence of domestic violence and substance misuse was cited in a number of reports. Concerns were reported about parents who were using drugs while pregnant, for example this referral came from an addiction service:

'Please review this 30 year old lady who remains unstable throughout her current pregnancy. She is approximately 21 weeks pregnant this week and attending for ante natal care. She is engaging with her ante natal care at present. Mother was stable long-term but destabilised when transferred out to her community GP. She returned here to our services but has failed to re-stabilise and regain take-aways. She continues to refuse samples regularly but when she does give them they are benzodiazepine positive' (A031520).

Analysis of reporters of parental substance misuse is presented in Table 9.3 below and while no significant patterns of association were found, families were the most frequent reporters of this difficulty within the sample (19%).

Table 9.3 Reporters of misuse of drugs and alcohol

Reporters of misuse of drugs and alcohol		
	Frequency	Valid percent
Family member	19	18.6
Medical personnel	15	14.7
School personnel	14	13.7
Gardaí and probation	11	10.8
Tusla staff	8	7.8
Voluntary organisations – children, housing and disability	8	7.8
Anonymous	7	6.9
Member of the public	4	3.9
Mental health services	3	2.9
Self	3	2.9
Drug and alcohol treatment services	2	2.0
Other*	8	7.8
Total	102	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Domestic violence

'Domestic violence' was reported for one seventh of the families in the sample (14%) and was considered the primary concern for the same proportion. While concern was expressed in some reports regarding the impact of domestic violence on the children in the family, as outlined in Chapter 8, reporters were also concerned about the impact of this abuse on the alleged victim.

The majority of reports regarding domestic violence related to situations of physical abuse that were happening in people's homes and the most common report type was violence perpetrated by men on their wives and partners. In a small number of cases the domestic violence had happened in the past but in most cases it was ongoing:

'Mother attended PHN with left side of face swollen and a black eye. Mother alleged that her husband hit her with a cup. She alleged that while this is the first time he had hit her with an object, he loses his temper with her about once a week. Mother stated that it is normal for her to have bruises on her arms now' (A011547).

While physical abuse was the most commonly reported form of domestic violence, emotional abuse was also reported and, in a small number of cases, women were also subjected to financial abuse. There were two reports of fathers being subjected to emotional abuse by their partners but otherwise all victims of domestic violence reported in the sample were women.

Examples of emotional abuse included criticism about parenting, threats of harm to a parent and to the children, shouting and being verbally abusive and humiliating the parent in front of the children.

Just under half of the reports on physical abuse had been prompted by a particular incident where the mother was assaulted by her partner which, in a small number of cases, led to the victim being hospitalised:

‘Mother was admitted to hospital with a head injury following an alleged trauma to the head by her husband using a bottle that knocked her unconscious. Mother contacted the Gardaí and the husband was arrested. Mother reports domestic violence ongoing for five years and the incidents are escalating’ (A021552).

In the majority of cases the victim was living at home at the time of the report and the remainder were in a refuge, in hospital or staying with friends.

A number of notifications were received from refuges alerting the child protection and welfare team that the mother and children were living in a refuge, but not expressing any child protection concerns. Two such reports highlighted the number of admissions to the refuge with concern expressed regarding the impact this was having on the children’s school attendance.

Unsurprisingly domestic violence services were significantly more likely to report ‘domestic violence’ than any other source (24%) and schools were found to be significantly less likely to report this difficulty (9%) (χ^2 (8, N=547) = 102.9, $p < .001$) (see Table 9.4).

Table 9.4 Reporters of domestic violence

Reporters of domestic violence		
	Frequency	Valid percent
Domestic violence services	19	24.1
Medical personnel	9	11.4
Gardaí and probation	9	11.4
School personnel	7	8.9
Voluntary organisations – children, housing and disability	7	8.9
Family member	6	7.6
Mental health services	5	6.3
Tusla staff	4	5.1
Other*	13	16.5
Total	79	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Struggling to manage child's behaviour

'Struggling to manage child's behaviour' was reported for 13% of the families in the sample and was reported as a primary concern for 11%. In these reports, the principal concern was the child's behaviour and the parent's ability to manage it. As demonstrated in Table 9.5 below, family members themselves, mainly mothers, were the most frequent reporters of this difficulty, although this pattern was not found to be significant.

The behaviours, which most challenged parents were described as aggressive, destructive or threatening. At times, parents spoke of how they were afraid of their children:

'Mother contacted the social work department to say that her son is "out of control" that he has "smashed up" her house and her car. She said that he is using drugs, he admits to smoking weed but she believes he is using stronger drugs also. She said that she is afraid of him in the house, she fears that she will hit her. She said that he is regularly aggressive and abusive towards her. There is no one else living in the house apart from the two of them (B031545).

Parents also found behaviours associated with their child's mental health difficulties and their learning or intellectual disabilities to be challenging and at times they lacked the skills to deal with their child's indiscipline and disobedience.

In a number of instances a request for help in dealing with a child's behaviour was precipitated by a particular incident which may have involved the Gardaí or the out of hours social work service (OOHS):

‘The out of hours social work services was contacted by the Gardaí. OOHS advised that the Gardaí had been called to Child's home by her mother when Child reportedly threatened to “stab her mother in her sleep”. Mother informed the Gardaí that Child's behaviour has been difficult for quite some time but she has been trying to manage this herself without making contact with social work services’ (B0315108).

As the example above highlights, parents had often sought to find their own solutions before seeking assistance from services. These strategies included sending children to stay with relatives and asking children to leave the family home. In a small number of cases, parents admitted that they had used physical or emotional abuse in an effort to control their child's behaviour.

Table 9.5 Reporters of struggling to manage child's behaviour

Reporters of struggling to manage child's behaviour		
	Frequency	Valid percent
Family member	15	21.4
School personnel	12	17.1
Tusla staff	8	11.4
Gardaí and probation	8	11.4
Mental health services	8	11.4
Medical personnel	6	8.6
Youth services	4	5.7
Drug and alcohol treatment services	3	4.3
Other*	6	8.6
Total	70	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Mental health difficulties

‘Mental health difficulties’ were reported in respect of 12% of the parents in the sample and were considered the primary difficulty for 11% of them. The identified problems included depression, anxiety, suicidal ideation and suicide attempts and also some had specific conditions such as bipolar and personality disorders.

For some parents, mental health difficulties were ongoing but for others they were the consequence of a particular experience, for example post-natal depression, homelessness or bereavement:

‘Mother has left home and left her two children in care of their adult sister. Sister has two children of her own and is pregnant with her third. Mother’s son committed suicide last year and she has not accessed bereavement support. Another son was attending a counsellor in school and the counsellor sent home a note to say that he was expressing suicidal ideation. Mother took this badly, was distressed, and left the family home’ (A031510).

Other personal stressors associated with parental mental illness included addiction, health problems and dealing with children with a high level of physical or psychological need. Domestic violence was also a feature:

‘Mother was admitted to A&E following an overdose that she advised the psychiatric team she thought would kill her. This followed an incident where her husband grabbed her by the throat in the presence of her daughter. Mother described that her husband subjects her to mental torture but that they try to be civil in front of the children. Mother reports feelings of hopelessness and worthlessness’ (A031542).

The principal concern in reports regarding parental ‘mental health difficulties’ was the impact that it was having on the parent’s ability to care for their children and the need for them to access support to be better able to meet their children’s needs.

Unsurprisingly, mental health services were significantly more likely to report ‘mental health difficulties’ amongst parents than any other source (21%). Gardai were significantly less likely to report this difficulty (2%) (χ^2 (8, N=547) = 36.0, $p < .001$) (see Table 9.6).

Table 9.6 Reporters of mental health difficulties

Reporters of mental health difficulties		
	Frequency	Valid percent
Mental health services	13	20.6
Medical personnel	10	15.9
Family member	8	12.7
School personnel	8	12.7
Voluntary organisations – children, housing and disability	7	11.1
Health Service Executive staff	6	9.5
Tusla staff	4	6.3
Gardaí and probation	1	1.6
Other*	6	9.5
Total	63	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Conclusion

By analysing the information that was detailed on the IR forms this chapter has provided a closer look at the difficulties that were reported for the parents and families in the sample.

A 'lack of parenting skills' was the most commonly reported difficulty for the parents within the sample and this included an inability or unwillingness to meet the child's need. Issues relating to parental capacity have been identified as common reasons for referral to child protection and welfare services in other empirical research studies (Forrester, 2007). In keeping with this, a 'lack of parenting skills' was frequently reported in the current study in the context of other difficulties that the parent was experiencing and detail was provided regarding how such difficulties were adversely impacting on their ability to effectively parent. The most frequent of such reports was the negative interaction of substance misuse with parenting capacity. Mental health difficulties and immaturity were also seen by reporters as adverse influences on parenting. Schools were found to be the source most likely to report a 'lack of parenting skills'.

'Significant relationship difficulties' were reported for one in five families in the sample and the most frequently reported of such difficulties concerned the custody of, and access to, children when relationships had ended. In some instances the lack of communication left the ISW mediating

between estranged parents. Family members were significant reporters of this difficulty in the sample.

As previously reported the 'impact of parental substance abuse' was a prominent issue for children in the sample, and particularly young children, so it is no surprise that the 'misuse of drugs and alcohol' was reported for almost one in five parents in the sample and was a primary concern for a similar proportion (17%). This finding again highlights this difficulty as a key issue reported to child protection and welfare services consistent with other research studies (Gibbons et al., 1995; McGhee and Waterhouse, 2007; Manion and Renwick, 2008, Scott and King, 2014).

'Domestic violence' was reported for one in seven of the families in the sample and in the main victims were female and the perpetrators male. While physical abuse was the most commonly reported form of domestic violence there also examples of emotional and financial abuse. Predictably domestic violence services were the most likely source of these reports. In the context of services reporting domestic violence to child protection and welfare services, it is worth noting that recent European empirical research, which looked at the prevalence of domestic violence in Ireland has shown that in 2012 one in three women experienced some form of psychological violence by a partner and one in four reported some form of physical or sexual violence by a partner or non-partner since the age of 15 (FRA European Agency for Fundamental Rights, 2014). The finding in this current study of one in seven raises the question as to whether this issue is being underreported to child protection and welfare services by professionals in contact with children and families. However, other research has indicated 79% of women victims have never reported a serious sexual or physical assault perpetrated by their partner or a non-partner to anyone (Safe Ireland, 2016).

Given the level of behavioural difficulties reported for children in the sample, outlined in Chapter 8, is it unsurprising that some parents would be struggling to manage their children's behaviour and this is a difficulty that was reported for one in seven parents in the sample. While parents themselves were the most frequent reporters of this difficulty in the sample this was not reported as a significant finding.

'Mental health difficulties' were reported for one in eight families in the sample and while some were related to a specific incident, others were ongoing and were associated to other difficulties in the parents' lives such as addiction, health problems, coping with children with high level need and domestic violence. Again the principal concern in these reports was the impact of this difficulty on the parent's ability to meet the child's needs. As one would expect, mental health services were the most likely reporter of this difficulty while the Gardaí were a less likely source of this type of report.

The next chapter takes a more in depth look at each referral source in turn and the difficulties that they reported for the children and families in the sample.

Chapter 10 Who is Reporting and What are they Reporting?

Introduction

This chapter provides findings on the source of reports made on the 794 children reported to Oaktown child protection services during Q1 2015. It presents the quantitative data derived from the IR forms, supplemented, where relevant, with qualitative data derived from discussions with practitioners and managers in Oaktown. While some data have already been provided in Chapters 7 and 8 on the sources of the reports and the difficulties being experienced by the children and families in the sample, this chapter augments these findings and provides a more in-depth perspective by drawing out associations between reporters and the matters reported.

Source of the report

A wide range of professionals and non-professionals reported their child protection and welfare concerns during the period under study. Table 10.1 below shows the source of report for each child reported and Appendix 5 provides a full breakdown of all professionals and non-professionals included in each source of the report. The largest proportion of reports were made by school personnel which included mostly principals but also teachers, home school liaison officers and a school chaplain. Taken together, school personnel made 16% of all reports received.

The second largest group of reports (13%) came from family members, mostly parents (63%) or from within the nuclear family (68%) but also grandparents, aunts, uncles and a cousin. When all non-professional reporters: family members; members of the public; anonymous reporters and self-referrers are considered together they accounted for almost one fifth (19%) of all reports made.

Gardaí and probation services made an eighth of all reports (12%) and a similar proportion (11%) came from medical personnel which included doctors, nurses and medical social workers. Domestic violence services made 7% of the reports received during the three month time frame as did voluntary organisations working with children, homeless people and those with disabilities (7%). A further 6% of reports came from mental health services, HSE staff members and Tusla staff respectively.

Table 10.2 shows the source of reports for the parents and families referred, which differs slightly from the table reported on above, given that there were more than one child reported in some of the families.

Table 10.1 Source of the report for each child reported

Source of the report (child)		
	Frequency	Valid percent
School personnel	126	15.9
Family member	106	13.4
Gardaí and probation	98	12.3
Medical personnel	89	11.2
Domestic violence services	58	7.3
Voluntary organisations – children, housing and disability	55	6.9
Mental health services	49	6.2
Health Service Executive staff	48	6.0
Tusla staff	45	5.7
Care staff	19	2.4
Anonymous	19	2.4
Youth services	17	2.1
Member of the public	15	1.9
Local authority	8	1.0
Drug and alcohol treatment services	8	1.0
Self	5	0.6
Other	29	3.7
Total	794	100.0

Table 10.2 Source of the report for each parent and family reported

Source of the report (parent and family)		
	Frequency	Valid percent
School personnel	101	18.5
Family member	73	13.3
Gardaí and probation	66	12.1
Medical personnel	66	12.1
Mental health services	43	7.9
Tusla staff	37	6.8
Voluntary organisations – children, housing and disability	28	5.1
Health Service Executive staff	25	4.6
Domestic violence services	22	4.0
Care staff	19	3.5
Youth services	15	2.7
Anonymous	11	2.0
Member of the public	10	1.8
Drug and alcohol treatment services	6	1.1
Self	5	0.9
Local authority	4	0.7
Other	16	2.9
Total	547	100.0

Source of the report – perspective of the interviewees

In order to elucidate some of the statistical data gathered in the first phase of the fieldwork, the findings on the source of reports was presented to interviewees, all of whom were Tusla staff members. Interviewees were asked for their perspectives on the findings and the most frequent reporters and the sectors who make the fewest reports. Interviewees, on the basis of their personal experiences, were in agreement that schools are the biggest source of the reports they receive. They believed that this trend reflected the considerable effort made in their area to raise awareness with schools of their child protection role and clarify the role of the social work department. One interviewee (IP5), describing schools as ‘big referrers’ noted how overall referral rates would decrease during school holidays.

Family members were also perceived by the practitioners interviewed as frequent reporters and differences between urban and rural contexts were highlighted. It was suggested that a culture existed in urban areas whereby families would make reports but would simultaneously source formal and informal services for children about whom they were worried, by means of mechanisms such as ‘mini family welfare conferences’ (IP2). In contrast the lack of services in rural areas, according to interviewees, meant that families were more dependent on the SWD. This view is, in fact, upheld in the quantitative analysis which showed a higher proportion (72%) of reports made by families came from those resident in the rural setting of Oaktown.

When discussing reports from medical personnel, interviewees distinguished between medical social workers, who were considered to be excellent reporters and medical practitioners such as GPs and consultants who were considered to be not only very poor reporters but to be reluctant or slow to provide written reports regarding their concerns. Their perception was again affirmed by the quantitative data, which showed that the largest proportion of reports from medical personnel in the current study came from medical social workers (67% / 60 reports), while GPs accounted for less than a fifth of these reports (17% / 15 reports) and consultants made only 3 reports (3%) during the time period.

GPs, in particular, were objects of criticism by the interviewees, for example:

‘When I was training as a social worker GPs were seen as one of those critical professionals but ... I think there is a reluctance to get involved. I think they just don’t see it as their job They are not engaged in it [child protection] at all to be honest. There are some excellent ones but they would be an exception. [They are] very anxious about it, very, very anxious that is my experience, very anxious about litigation’ (IP1).

Another interviewee took a less critical approach and suggested that awareness of the waiting list in the SWD might actually deter GPs from reporting:

‘I have noticed that if the GP experiences our response as timely and helpful then we would get more referrals from them’ (IP7).

She also identified the dilemmas faced by doctors and saw a need to offer more support:

‘I also think that GPs feel that they are in a very difficult position and it can sometimes be very difficult given the relationship that they have with their clients and timing it when they do refer and possibly I think that it is a reflection on ourselves as an agency and needing to do a lot more education with GPs’ (IP7).

Interviewees concurred with the finding from the quantitative data regarding the level of reporting from HSE staff and expressed anxiety about its low level, describing it as ‘worrying’. It was

suggested that HSE staff may be frightened to have the ‘difficult’ conversations with parents about how they are caring for their children. While public health nurses were generally considered good reporters, speech and language therapists, psychology and primary care were not:

‘I mean when you think of speech and language therapists and how many children they must be meeting with language delay when potentially the language delay is down to parenting issues and potentially domestic violence and all that. Look, I mean there is loads of other reasons for language delay but I have only got one report from them in my whole time [as a social worker]’ (IP1).

The findings from the study, regarding the breakdown of reporters from health services, supported the views of the interview participants. Within this sector by far the largest proportion of reports came from public health nurses PHNs (83% or 40 reports). Speech and language therapists and psychologists had made only 2% of the reports (2 reports) from this group with 4% (8 reports) made by other health workers. Reports from PHNs accounted for 5% of the reports in the overall sample and reports from speech and language therapists and psychologists accounted for only 0.2%.

Source of the report and difficulties reported

Chapters 8 and 9 outlined the difficulties most commonly faced by the children and families in the sample. This chapter takes a closer look at the difficulties reported by each different source and considers the difficulties they observed most frequently and indeed what difficulties did not come to their attention. As has been previously outlined, most referrals identified more than one difficulty and so analysis was carried out on the three most pressing concerns. Findings of statistical significance are reported on.

School personnel

School personnel, as previously mentioned, were the most frequent single category of referrers to child protection and welfare services in the current study (16%) and a number of statistically significant patterns were found in the reports that they made. The breakdown of difficulties reported by school personnel are detailed in Appendix 6. With regard to the children in the sample, significant patterns were evident in the reports of ‘physical abuse’, ‘behavioural problems’ and ‘emotional problems’ signifying that these were more likely to be identified and reported by this source. ‘Physical abuse’ was the difficulty referred most frequently by school personnel; it was detailed in almost a quarter (24%) of all reports from this source (χ^2 (15, N=794) = 42.0, p = <.001). A slightly smaller proportion of reports from schools (23%) described children with ‘behavioural problems’

(χ^2 (15, N=794) = 54.05, p = <.001) and ‘emotional problems’ were detailed in a fifth (20%) of their reports (χ^2 (7, N=794) = 37.34, p = <.001).

With regard to the parents and the families in the sample, significance testing revealed a pattern of association between school personnel and their reporting of a ‘lack of parenting skills’, which featured in 37% of their referrals (χ^2 (11, N=547) = 35.1, p = <.001). School personnel were also found to be less likely to report ‘domestic violence’ as an issue for parents and families than other difficulties (7%) (χ^2 (8, N=547) = 102.9, p = <.001).

Family members

Family members were the second largest source of reports in the current study (13%). They were significantly more likely to report on the ‘impact of parental substance abuse’ on the children in the family than other issues (26%) (χ^2 (15, N=794) = 68.45, p = <.001) and 31% of all reports on this issue came from family members. All of the difficulties reported for the children in the sample by family members are detailed in Appendix 7 and this shows that, as well as the foregoing, the difficulties most frequently reported by family members included: ‘emotional / verbal abuse by parent’ (14%); ‘educational difficulties’ (14%) and ‘behavioural problems’ (12%) amongst children, although these were not statistically significant findings.

With regard to parent and family difficulties, the number of reports from family members about entrenched relationship difficulties was found to be significant (χ^2 (9, N=547) = 38.32, p = <.001) with this issue mentioned in 43% of all reports made by this source, which accounted for 28% of all reports received on this matter.

Gardaí and probation services

Gardaí and probation services accounted for 12% of all the reports received in the study and the analysis of the reports made by this group of professionals shows some interesting findings in terms of difficulties that Gardaí and probation services were significantly less likely to report. ‘Mental health need’ amongst children was mentioned in only 4% of reports (χ^2 (10, N=794) = 61.21, p = <.001) and with regard to parent and family difficulties parental ‘mental health difficulties’ were mentioned in only 2% of reports from this sector (χ^2 (8, N=547) = 36.02, p = <.001).

Medical personnel

Medical personnel reported just over a tenth (11%) of the children in the sample. The majority of reports relating to 'teenage pregnancy and parenting' (75%) came from this source. These reports accounted for 7% of all reports from medical personnel and these findings were found to be significant (χ^2 (10, N=794) = 33.04, p = <.001). The only other significant finding with regard to reports made by medical personnel concerning the children in the sample was the very low level of reporting of 'behavioural problems' (3%) (χ^2 (15, N=794) = 54.06, p = <.001) and 'neglect' (1%) (χ^2 (6, N=794) = 132.65, p = <.001).

Domestic violence services

Domestic violence service (DVS) were the next most frequent reporters in the sample, reporting 7% of the children, and there were a number of significant patterns in the reporting and non-reporting of concerns by this source. In terms of matters reported, unsurprisingly DVS were responsible for the largest proportion of reports regarding the 'exposure of children to domestic violence and parental conflict' (21%) and this featured in two fifths (40%) of their reports (χ^2 (15, N=794) = 49.16, p = <.001). Similarly, reports from DVS regarding 'domestic violence' as an issue for the parents and families accounted for almost a quarter (24%) of all reports received and was mentioned in the majority (86%) of reports from this source (χ^2 (8, N=547) = 102.9, p = <.001). There were also a number of difficulties that DVS were less likely to report than other issues. In relation to the children and young people with whom they were in contact, DVS made no reports about 'mental health need' (χ^2 (11, N=794) = 61.71, p = <.001), 'behavioural problems' (χ^2 (15, N=794) = 54.06, p = <.001) and 'neglect' (χ^2 (6, N=794) = 132.64, p = <.001) and they made only one report regarding the 'impact of parental substance abuse' (χ^2 (15, N=794) = 68.45, p = <.001). Regarding the parents and families with whom they were in contact, DVS made no reports regarding a 'lack of parenting skills' (χ^2 (12, N=547) = 37.07, p = <.001).

Voluntary organisations¹⁰

Reports from voluntary organisations accounted for 7% of the reports received during the time period under study. Voluntary organisations comprised of services for children, including children with disabilities and services for families with housing needs. However, cognisant of the fact that these services are concerned with different issues it is of interest to consider the difficulties that each of

¹⁰ Voluntary organisations, in the current study, refer to not-for-profit organisations which provide services to children, including children with disabilities and services for families with housing needs.

the different services were reporting. The largest number of reports from voluntary organisations were from children's services (n=30), followed by housing services (n=18) and then disability services (n=7). Children's services most frequently reported the 'impact of parental substance abuse' (n=7) and 'educational difficulties' (n=7) for the children they referred; disability services most frequently reported the 'impact of domestic violence and parental conflict' (n=5) and housing services unsurprisingly most frequently reported 'homelessness' (n=6). Chi square analysis was carried out but none of these findings were found to be statistically significant.

Mental health services

Mental health services, which accounted for 6% of the reports in the study, were the source most likely to report 'mental health need' amongst children in the sample (20%) and this issue was detailed in almost a third (31%) of their reports (χ^2 (16, N=794) = 64.59, $p = <.001$). Similarly mental health services were significantly more likely to report 'mental health difficulties' amongst the parents than other difficulties (21%) and this issue was cited in 30% of reports made by this source (χ^2 (8, N=547) = 36.02, $p = <.001$).

Health Service Executive staff

HSE Staff reported 6% of the children in the sample but there were no significant patterns discernible in those reports.

Tusla staff

Tusla staff also reported 6% of the children in the sample. 'Behavioural problems' were more likely to be reported by Tusla staff than other difficulties (22%) (χ^2 (15, N=794) = 54.05, $p = <.001$) and these reports accounted for 11% of all the reports on this difficulty. It is interesting to note that Tusla made only one report regarding the exposure of a child to domestic violence and parental conflict and this finding was reported as significant (χ^2 (15, N=794) = 49.16, $p = <.001$) implying that they were significantly less likely to report this difficulty than other difficulties.

Care staff

Care Staff reported only a small proportion of the children in the sample (2%) and were significantly more likely to report 'sexual abuse and sexualised behaviour' than other issues (χ^2 (9, N=794) = 33.12, $p = <.001$). It was detailed in almost a third (32%) of their reports

Anonymous reporters

Anonymous reports accounted for 2% of the reports in the sample and there were some significant patterns to the anonymous reports received. Anonymous reporters were significantly more likely to report on the 'impact of parental substance abuse' on children (53%) (χ^2 (11, N=794) = 87.19, p = <.001) and 'emotional / verbal abuse by parent' (32%) (χ^2 (9, N=794) = 37.71, p = <.001) than any other issues. In terms of parent and family issues anonymous reporters were more likely to report a 'lack of parenting skills' (64%) (χ^2 (12, N=547) = 37.07, p = <.001) and parents' alcohol and drug misuse (64%) (χ^2 (11, N=547) = 42.77, p = <.001) than other difficulties.

Youth services

Youth services also referred 2% of the children in the sample; significant patterns were found in their reporting of 'physical abuse' which was detailed in 35% of their reports (χ^2 (15, N=794) = 42.04, p = <.001) and 'mental health need' which was also detailed in 35% of their reports (χ^2 (11, N=794) = 61.71, p = <.001).

Members of the public

Members of the public reported 2% of the children in the sample. These reporters were significantly more likely to report on the 'impact of parental substance abuse' on children than other issues; this was detailed in 33% of their reports (χ^2 (11, N=794) = 87.12, p = <.001).

Local authorities

Local authorities reported 1% of the children in the sample and there were no significant patterns of reporting in the referrals received from local authorities in the study.

Drug and alcohol treatment services

Drug and alcohol treatment services reported 1% of the children in the sample. This source was more likely to report children's 'behavioural problems' than other issues (38%) (χ^2 (15, N=794) = 54.06, p = <.001). In terms of the parent and family difficulties this source was more likely to report how parents were struggling to manage their children's behaviour than any other issue (50%) (χ^2 (8, N=547) = 27.84, p = <.05).

Self-referral

Five reports in the sample were received when children self-referred by either telephoning or presenting in person. Three of these children spoke of their parents' misuse of substances and two detailed their own emotional problems.

All non-professional reporters

Attention was given to whether there were any significant reporting patterns when all non-professional reporters are considered together, these comprised: family members; anonymous reporters; members of the public and children who self-referred. There were three issues that this group of referrers were more likely to report than other issues: the 'impact of parental substance abuse' was detailed in 29% of all reports made by this group and accounted for 48% of all reports on this issue in the sample ($\chi^2 (13, N=794) = 72.63, p = <.001$); 'neglect' featured in 19% of the reports by this group and accounted for 50% of all reports regarding neglect in the sample ($\chi^2 (5, N=794) = 48.36, p = <.001$); and 'emotional / verbal abuse by parent' was mentioned in 17% of their reports and accounted for 42% of all reports regarding this issue in the sample ($\chi^2 (5, N=794) = 32.46, p = <.001$).

In terms of parent and family difficulties reported by non-professionals, there were two issues that this group of referrers were more likely to report than other issues: 'significant relationship difficulties' were mentioned in 34% of their referrals, which accounted for 30% of all reports of this issue ($\chi^2 (9, N=547) = 26.94, p = <.05$) and the 'misuse of drugs and alcohol' by parents was detailed in 33% of reports and accounted for 32% of all reports of this issue ($\chi^2 (8, N=547) = 30.90, p = <.001$).

Perspectives of interviewees

Interviewees offered their perceptions, based on their practice experience, about which concerns are most frequently reported by the different groups of reporters, with a particular focus on schools, family members and GPs.

In keeping with the quantitative data, interviewees agreed that schools were good at reporting concerns regarding physical abuse, behavioural difficulties and emotional problems among the children they were teaching. However, interviewees noted their failure to report other matters of importance. They pointed out that *Children First* training has assisted teachers to identify 'tangible' matters such as physical abuse, but believed them to be less sensitive to more complex matters:

‘I really do worry that we are not hearing about the neglect cases from schools and we are not hearing about the domestic violence cases from schools. And of course those kids who are crying and have behavioural difficulties in school could be the ones where there could be domestic violence, could be, I’m not saying there is in all of them’ (IP1).

Similar concerns were also expressed by another interviewee:

‘[A]re they picking up on the child in the class who is neglected? Poor hygiene, head lice all that kind of stuff, it’s not being picked up by school, but they freak out about the physical abuse, because it is straightforward’ (IP2).

As the current study has demonstrated children’s ‘exposure to domestic violence and parental conflict’ featured in only 14% and ‘neglect’ in 10% of the reports received from schools. These findings were not statistically significant. Also, as previously outlined, the current study found that schools were less likely to report ‘domestic violence’ as an issue for parents and families and this supports the perception of the interviewees that this issue is not being picked up on by schools. However, schools were considered to be a unique position, given the extensive periods of time that they are in contact with children and young people and the opportunities that they have to develop trusting relationships, to pick up on difficulties that may exist in the children and young people’s lives.

Family members were perceived by interviewees as most likely to report the neglect of their young relatives and parents were considered likely to seek help dealing with the behavioural difficulties and self-harm of their children:

‘When we looked at that it was actually family members or parents saying I need help with my teenager who is self-harming’ (IP1).

While ‘neglect’, ‘behavioural problems’ and ‘mental health need’ were all reported for the children in the sample by family members, there was no statistical significance to these findings. However, as reported in the previous chapter, referrals that were received regarding parents who were struggling to manage their children’s behaviour mostly came from the parents themselves, mirroring the perceptions of the interviewees. However, this also was not a statistically significant finding.

Reports by family members, according to interviewees, frequently consisted of counter allegations made between separated couples in the context of custody and access disputes. As outlined above families were more likely to report ‘significant relationship difficulties’ than other issues, wherein custody and access problems featured prominently. For example:

‘You can get both sides ringing in and saying something and sometimes it is malicious and you need to be aware of that as well, unfortunately sometimes it is “well I am going to ring the social

workers and say you did this” and then they will go “well I am going to ring and say you did that”. We have had malicious complaints like that and the child, you know it is just not a nice place for the child to be, in between the two parents’ (IP5).

GPs, who made only 1% of the neglect reports in the sample, were considered by interviewees as more likely to report straightforward child protection concerns such as a disclosure from a child regarding sexual abuse or physical abuse than complex issues.

Interviewees felt strongly that all professionals who are in regular contact with parents need to constantly consider the possibility that their children could be open to child abuse either by omission or commission:

‘[E]ven if you don’t work with children if there is something going on in the adult’s life you have to ask yourself how that could impact the children if there is children in the house you have to ask yourself the question ‘how are the children’ and ‘is there a risk potentially’ (IP1).

Such professionals, it was asserted, need to have an inquiring mind, ‘be a nosey busy body’ and ask pertinent questions about whether life at home may be adversely affecting the children living there:

‘Do you have kids, I actually think that is how basic you have to go? Do you have any children or are they in school or how are you managing or how are you coping, or do you need a bit of support?’ (IP2).

Source of the report and the gender of the children reported

The gender of the children reported by each referral source was analysed and the results are set out in Appendix 8. This analysis revealed an even distribution of male and females being referred by most sources and the chi square test of association did not reveal any statistically significant findings.

Source of the report and the age of the children reported

The age of the children reported by each referral source was also analysed and using the age groupings of under 5, 5-12 years and 13-17 years and some statistically significant patterns of reporting were found¹¹ (χ^2 (30, N=772) = 155.4, p < .001). As shown in Table 10.3 schools were more likely to report children 5-12 age category (58%) and as might be expected unlikely to report children in the under 5 category (10%). The biggest proportion of children reported by voluntary organisations were in the under 5 category (44%) and most of these reports came from organisations

¹¹ To carry out the chi square test of association it was necessary to decrease the number of age categories and also to merge the source ‘local authority’ with ‘other’.

working directly with children. High proportions of children in the oldest age categories were reported by care staff (84%), youth services (77%) and mental health services (62%) and the largest proportion of children reported by HSE staff were under 5 (53%) which would be consistent with the finding reported above that the majority of these reports came from PHNs.

Table 10.3 Source of the report by age

Source of the report by age				
	Age (years)			Total
	Under 5	5-12	13-17	%
School personnel	10.4	58.4	31.2	100.0
Family member	26.9	42.3	30.8	100.0
Gardaí and probation	28.6	30.6	40.8	100.0
Medical personnel	34.9	26.5	38.6	100.0
Domestic violence services	29.3	48.3	22.4	100.0
Voluntary organisations	44.0	38.0	18.0	100.0
Mental health services	14.9	23.4	61.7	100.0
Health Service Executive staff	53.2	34.0	12.8	100.0
Tusla staff	20.5	31.8	47.7	100.0
Care staff	15.8	0.0	84.2	100.0
Anonymous	44.4	44.4	11.1	100.0
Youth services	5.9	17.6	76.5	100.0
Member of the public	33.3	60.0	6.7	100.0
Drug and alcohol treatment services	14.3	14.3	71.4	100.0
Self	0.0	20.0	80.0	100.0
Other*	5.7	68.6	25.7	100.0

*Reporting sources with very low frequencies were collapsed into 'other' to enable chi square analysis.

Mode of the report

Reports were received by the ISWs in a variety of different ways and in a small number of instances reporters used two modes of contact to make their report. Table 10.4 shows the breakdown of frequencies of the different modes of report used for all reports received during the time period under study. The three most popular methods for making contact with the ISW were phone (32%), letter

(29%) or fax (19%). Taken together these three methods of contact accounted for over three quarters (80%) of all reports made. It is notable that standard report form (SRF), which is the means of contact suggested by Tusla on its website and in *Children First* was only used in initial contact in less than a tenth of instances (9%).

Consideration of which reporters communicated their concerns in writing revealed that the highest proportion of written correspondence within the sample came from schools (20%), medical personnel (15%) and mental health services (15%).

Some significant findings were made regarding the modes of a report used. Family members were more likely to use the phone to make a report (35%) and Gardaí were significantly less likely to use the phone (2%) than other reporting sources (χ^2 (16, N=786) = 269.1, p = <.001). Faxes were significantly more likely to be used by domestic violence services (27%), medical personnel (25%) and Tusla staff (14%) (χ^2 (16, N=786) = 230.7, p = <.001). Schools were significantly more likely than other sources to use a standard report form to make a report (22%) (χ^2 (7, N=786) = 49.5, p = <.001).

The majority of reporters calling in person to the SWD to make a report were family members (65%). Due to the small number of cases (n=20) it was not possible to run a chi square analysis.

SRF and the perspective of the interviewees

As outlined in Chapter 1, the standard report form (SRF) is the official document recommended for use when making a report to Tusla. However, the data from the current study has shown that it was utilised in less than a tenth of reports. Interviewees were asked for their view on its low usage. Some reported that they normally requested reporters to complete the SRF following a phone report, but many of them were critical of the form itself, claiming it was too restrictive in terms of the information a reporter may wish to provide:

‘When I speak to professionals and they are going to make a report ... I request that they put it in a SRF, I think it is quite limiting in terms of what you can put, physically the space, what exactly you might want to share so I would always say send additional information so what a lot of them would do is put the name of the child on the SRF and then say “see report”. They find it too restrictive or there might end up being an awful lot of blanks on it because they may not have enough information about additional siblings or a Dad or whatever it might be. The SRF could probably be revisited’ (IP4).

Some also commented that the necessity for reporters to photocopy the SRF multiple times diminished its physical quality.

Table 10.4 Mode of the report

Mode of the report		
	Frequency	Percent**
Phone	254	32.0
Letter	226	28.5
Fax	148	18.6
SRF	71	8.9
Garda notification	65	8.2
Email	26	3.3
In person	20	2.5
Total	810*	

*At times reporters used more than one source.

**Percentages do not total 100 because values were calculated out of the total number of reports (n=794) rather than the total number of modes used (n=810).

Parents' awareness of the report and reporter anonymity

The IR form that is completed by the ISW requires information about whether or not parents of the child are aware that a report is being made to Tusla. The forms which showed this information indicated that over two-thirds of (both) parents (69%) had been made aware that a report was being made and in 7% of cases one parent was aware while the other parent was not. Apart from telling the parent that they were going to make a report to Tusla, most reporters (76%) had discussed their concerns about the child with the parent and in vast majority of cases (95%) the reporter was prepared to be identified to the parents.

Quantitative analysis showed that family members (30%), members of the public (16%) and reporters who did not give their names (50%) were, in the main, those who sought anonymity. It was not possible to carry out significance testing due to the small numbers involved.

Conclusion

This chapter has provided both quantitative and qualitative data regarding the source of reports to Oaktown child protection and welfare services during Q1 2015 and the difficulties that were reported. The quantitative data was augmented with the perceptions of a number of staff who were interviewed following a discussion of the quantitative results. Associations between the reporters and the matters reported were drawn out. While many of the links identified were logical and predictable, the findings

also illustrated gaps, whereby certain types of child harm are rarely reported by particular professions or organisations, potentially indicating a lack of awareness about certain types of abuse or possibly an unwillingness to report it.

The current study has shown schools to be the largest single source of referrals. This is an important finding as it emphasises the important role of schools in children's lives and the significance of the relationship between child protection and welfare services and education services. However, the finding, frequently highlighted by empirical research that schools tend to underreport (Kenny et al., 2001; Webster et al., 2005) suggests that further resources may need to be committed to this sector. A lot of attention is given in the literature to the role of teachers and educators in detecting and reporting child abuse (Crenshaw et al., 1995; Kenny 2001; Webster et al. 2005; Buckley and Mc Garry, 2011; Mc Garry and Buckley, 2013; King and Scott, 2014; Bourke and Maunsell, 2015) and empirical research has pointed to some shortcoming in the carrying out of this role and deficits in the type of difficulties commonly identified (Kenny, 2001; Mc Daniel, 2006; Buckley and Mc Garry, 2011; Mc Garry and Buckley, 2013). Interviewees pointed out that while schools were good for reporting tangible issues like physical abuse they questioned why they do not report issues like neglect or domestic violence. Schools in this current study significantly reported 'physical abuse', 'behavioural problems' and 'emotional problems' amongst the children they were teaching. While school personnel included a 'lack of parenting skills' as a difficulty in 37% of their reports they were also found to be less likely to report 'domestic violence'. These findings, along with the perception of the interviewees, suggest that consistent with conclusion in the literature, schools are more likely to identify suspected or confirmed child problems and less likely to cite family problems (Walsh et al., 2006; Jonson-Reid, 2007; King and Scott, 2014).

Schreiber et al (2013) contend that 'child protection services are typically not initiated by parental requests for assistance' (p.707) and yet, in the current study, families reported difficulties in substantial numbers. What is unclear though, is whether they did so because of a belief that the child protection system would be able to help them with their concerns or whether they did so because there was little else on offer. In support of the latter explanation, the quantitative analysis revealed that a higher proportion of reports from families came from the more rural part of the catchment area, where there was a reported lack of service available to meet need. Whatever the motivation, however, research has shown that while families have predominantly negative experiences when referred to child protection services (Spratt and Callan, 2004; Dumbrill, 2006; Palmer et al., 2006; Buckley et al., 2008b; Schreiber et al., 2013; Hollinshead et al., 2017; Smithson and Gibson, 2017), those who self-refer experience less apprehension (Spratt and Callan, 2004; Buckley et al, 2008b) and are more willing to engage with practitioners (Buckley, 2003; Spratt and Callan, 2004; Buckley et al, 2008b). Added to this, it is pointed out that more active involvement of parents this will lead to better outcomes for their children (Saint-Jacques et al., 2006; Jackson, 2016). Thus the self-referral of

families is something which should be encouraged. Family members were found to be significantly more likely to report the 'impact of parental substance abuse' on children and 'significant relationship difficulties' than any other issues. Difficulties which could be categorised as those which are 'visible through the window' (Giovannoni, 1995).

National and international administrative data on the source of reports, detailed in an earlier chapter, generally show police, educators, health professionals, social services and friends and families as the main sources of report and this was more or less replicated in the findings of the current study. The perceptions of the interviewees in the current study were also aligned with these trends. The interviewees added their insights which go some way to explaining some of the patterns observed. They particularly highlighted the low levels of reports from professionals such as GPs and some HSE staff such as psychologists and speech and language therapists, which were also reflected in the quantitative findings.

The findings in the current study on self-referral by children indicate a particularly low level, an issue that has already been identified by Wattam (2002) who highlights the negative impact this can have on assessment. Despite their rhetoric about the 'Front Door', Irish child protection services, by officially restricting contact from the public to phone or letter may inadvertently deter young people who are in need of help.

Discussion with interviewees on the links between reports and reporters reveals the disparity of issues reported by all the different sources. Such disparity is perhaps reflective of McDaniel's (2006) contention that different reporters report different issues and identify different families and King and Scott's (2014) assertion that the 'vantage point' a reporter has of a family they are in contact with heavily impacts what they in turn report.

A number of significant findings from the current study regarding the issues reported by the different referral sources are of interest. Gardaí were found to be less likely to report mental health difficulties both amongst children and amongst parents than other difficulties. Medical personnel were responsible for three quarters of all reports made with regard to 'teenage pregnancy and parenting' and were also less likely to report 'behavioural problems' and 'neglect' than other difficulties. Unsurprisingly domestic violence services made the largest proportion of reports regarding the 'exposure of children to domestic violence and parental conflict' and 'domestic violence' as an issue for parents and families. Interestingly, however, there were a number of significant patterns with regard to difficulties that this sector did not report, which were: 'mental health need' amongst children, 'behavioural problems', 'neglect' and a 'lack of parenting skills'. Predictably mental health services were the source most likely to report 'mental health need' amongst children and were more likely to report 'mental health difficulties' amongst parents than any other difficulty. Tusla staff were more likely to report 'behavioural problems' than anything else and notably they only made one

report regarding the exposure of children to domestic violence and parental conflict. Care staff were significantly more likely to report 'sexual abuse and sexualised behaviour' amongst the children they were in contact with than other issues. Anonymous reporters were found to be significantly more likely to report the 'impact of parental substance abuse' on children, 'emotional / verbal abuse by parent', a 'lack of parenting skills' and parents' alcohol and drug misuse than any other difficulties. Youth services detailed both 'physical abuse' and 'mental health need' in significant proportions of their reports. Members of the public were more likely to report the 'impact of parental substance abuse' on children than other difficulties. Drug and alcohol treatment services were more likely to report children's 'behavioural problems' and parent's struggling to manage their children's behaviour than any other issue.

Children who self-referred tended to focus on their parent's misuse of substances and their own emotional problems.

As all non-professional reporters accounted for the largest referral source in the current study, particular attention was given to the issues that they reported. Findings of this analysis revealed that this group were more likely to make reports with regard to the 'impact parental substance abuse' on children, 'neglect', 'emotional / verbal abuse by parent', 'significant relationship difficulties' amongst families and the 'misuse of drugs and alcohol' by parents.

Findings from the qualitative interviews regarding the sources and content of reports broadly endorsed the quantitative findings. However, interviewees also expressed concern about what they considered to be underreporting by particular professional groups. As mentioned above, interviewees had concerns about the reports made by schools in this regard and concern was also expressed regarding the lack of reports made by GP's.

Findings are also presented in this chapter regarding the gender and age of the children reported by the different referral sources. While analysis of gender related patterns did not reveal any findings of note, analysis of the age of the children reported showed schools primarily reporting children in the 5-12 age group, while reports for younger children tend to come from voluntary organisations and health staff (mostly from public health nurses). For older children the main sources were care staff, youth services and mental health services.

Findings concerning the mode of reports used by reporters revealed phone, letter and fax are still the most popular means used to make a referral to child protection and welfare services. Notably, the standard report form issued by Tusla was used in less than a tenth of instances, and most commonly by schools.

Data derived from the IR forms showed that in the majority of cases (76%) one or both parents were aware of the report being made to Tusla and in the vast majority of cases reporters did not wish to

remain anonymous. When anonymity was sought it was most likely to be sought by non-professionals.

The next chapter looks at the checks that were carried out during the preliminary enquiry stage when deciding on outcome.

Chapter 11 Carrying out checks

Introduction

This chapter continues the trajectory of reports through the various phases stipulated in Tusla guidance, following the standard business processes, which aim to provide consistency of services as well as a level of transparency and accountability of child protection work. As previously outlined, the intake social worker (ISW) is required, as part of the preliminary enquiry (PE) stage, to check any relevant records held by Tusla about the child and family concerned, as well as make enquiries of relevant professionals and agencies (HSE, 2009). ‘Checking’ means gathering further information about the reported child and reason for referral, establishing whether the child is already known and if relevant, the nature of any previous involvement. Detail on the prevalence and nature of re-referral to Oaktown child protection and welfare services during Q1 2015 will be provided in a subsequent chapter. The focus of this chapter is on the process of ‘checking’, the persons or agencies requested to provide information and the impact of carrying out checks on the outcome in a case. It also addresses the question of whether more extensive checking at the preliminary enquiry stage might reduce the number of cases retained in the system and referred onwards, and demonstrates the way that standard business processes and data protection regulations shape practice in ways that sometimes defy intuition or common sense. It also illustrates the thin line treaded by social workers in balancing the perceived safety and welfare needs of children against the protection of families from the trauma of investigation by child protection services, a task that was noted three decades ago by Corby (1987) that still influences social work judgement today.

Finding from the current study regarding ‘other checks’ carried out

As previously outlined, Section 13 on the intake record (IR) form requires the ISW to detail any ‘other checks’ they carried out in relation to the child who has been reported. The ‘other’ refers to carrying out checks additional to ascertaining whether the child and family are already known to Tusla. The form states: ‘This information is recorded in case notes but it may be appropriate to highlight particular details here’.

Bearing in mind that the data available to the current study are limited to the notes made by the ISW on the IR form, it appears that ‘other checks’ were carried out in 44% of cases (n=346) and were not carried out in 56% of cases (n=448).

As shown in Table 11.1 below, the data reveal that the people most likely to be contacted following a report were family members (32%). School personnel were the next most frequently contacted at

22%, while similar proportions of HSE personnel (13%) Tusla Personnel (12%), Gardaí and JLO's (12%) and Medical Personnel (12%) were contacted. It is notable that only two children were contacted with regard to the report made about them.

Table 11.1 Who was checked with?

Who was checked with?		
	Frequency	Percent**
Family members	111	32.1
School personnel	77	22.3
Health Service Executive personnel	45	13.0
Tusla personnel	43	12.4
Gardaí and probation	43	12.4
Medical personnel	42	12.1
Voluntary organisations – children, housing and disability	36	10.4
Domestic violence services	24	6.9
Mental health services	18	5.2
The child	2	0.6
Total	441*	

*Total do not add up to 346 as more than one source could have been consulted regarding each child.

**Percentages do not total 100 because values were calculated out of the total number of reports where checks were conducted (n=346) rather than the total number of sources consulted (n=441).

Reporters and other persons or services contacted

Further analysis of persons or services contacted shows that in 43% of instances, the reporter was the only person with whom the ISW communicated. This communication generally consisted of a phone call following the initial report made by the referrer to seek further clarification. In the other 57% of reports, further checks were carried out with someone other than the reporter. Table 11.2 shows, for each source of the report checked with, the proportion who were reporters and the proportion who were non-reporters. A number of significant patterns of association were found. The vast majority of health (HSE) personnel (91%) who were contacted had not reported the child in question (χ^2 (1, N=346) = 24.27, p = <.001), similarly 91% of Tusla staff contacted had not made the report (χ^2 (1, N=346) = 22.48, p = <.001), the same was true for 81% of the Gardaí and probation contacted (χ^2 (1, N=346) = 11.71, p = <.001) and 80% of the families contacted had not reported the concern about their child (χ^2 (1, N=346) = 35.18, p = <.001). The majority of HSE personnel checked

with were PHNs (76%) and they were statistically more likely to have not reported the child (97%) (χ^2 (1, N=346) = 24.44, p = <.001).

Table 11.2 Reporters and who was checked with

Reporters and who was checked with			
	Reporter		Total
	Yes	No	
Family members (n=111)	19.8	80.2	100.0
School personnel (n=77)	55.8	44.2	100.0
Health service executive personnel (n=45)	8.9	91.1	100.0
Tusla personnel (n=43)	9.3	90.7	100.0
Gardaí and probation (n=43)	18.6	81.4	100.0
Medical personnel (n=42)	59.5	40.5	100.0
Voluntary organisations (n=36)	47.2	52.8	100.0
Domestic violence services (n=24)	70.8	29.2	100.0
Mental health services (n=18)	38.9	61.1	100.0
The child (n=2)	50.0	50.0	100.0

Checks carried out – rural / urban context

Consideration was given to whether more or less checks were carried out in urban or rural settings and a significant disparity was revealed: checks were more likely to take place in the urban setting (54%) than in the rural setting (34%) (χ^2 (1, N=794) = 23.81, p = <.001).

Checks and outcome

Table 11.3 displays the proportionate outcome in cases when checks were or were not carried out¹². The results of this analysis, all of which were found to be statistically significant (χ^2 (1, N=787) = 91.19 p = <.001), show that where the outcome was no further action (56%) checks were more likely to have been carried out. Similarly, in cases where no checks were conducted, reports were more likely to go forward for an initial assessment (77%). This fairly self-explanatory finding indicates a

¹² As will be detailed in a subsequent chapter a small number of reports had an outcome of ‘ongoing social work involvement’. These cases had to be excluded to enable chi square analysis.

higher level of decision making confidence when workers had corroborated information. It may also indicate that the ISWs saw little point in carrying out further checks if initial information had immediately signalled the requirement for an initial assessment, as indicated by one interviewee:

‘Well our rule of thumb was once you have identified that it needed to go on for an initial assessment [IA] then it goes on, so there is no point in you ringing because you are basically doing a mini IA then and it is duplication of work and your colleague who is doing the IA is going to have to do that piece anyway and you are going to piss off the professionals because they are going to have to talk to two different social workers’ (IP6).

Table 11.3 Checks carried out and outcome

Checks and outcome			
Were checks carried out?	Outcome		Total
	NFA	IA	
Yes	56.1	43.9	100.0
No	22.9	77.1	100.0

Carrying out checks – perspective of the interviewees

Interviewees were asked to reflect on the finding that checks were not carried out in relation to the majority of reports:

‘That is actually probably the hardest question, how much checking do we do, and you know what’s enough? What’s too much? Have we got enough information to ensure that we are responding in a way that is going to be helpful to families and it is a really difficult question’ (IP7).

Interviewees spoke at length about their efforts to balance the need for more information with respect for the privacy of families and the need to adhere to data protection regulations.

It became apparent from the discussions that the process of gathering information during the preliminary enquiry stage presents challenges for practitioners on the front line and that guidance on the matter was somewhat ambiguous. While the flexibility in the guidance was viewed positively by some, others expressed a wish for more specificity, as explained by a frontline manager:

‘They are coming to me and saying we need guidelines on that, they want something in writing and you are like ‘there is nothing’’ (IP2).

And another colleague added:

‘I keep saying we need guidance at the Front Door of who we can and who we can’t contact without telling parents, cause at the moment we are separate agencies and what we would have found is that people were probably massively breaking the rules in contacting the county council, schools ... technically I don’t think we are meant to do that but we need guidance’ (IP1).

Interviewees spoke of how local and somewhat flexible practices were developed. This provided practitioners with a way of diverting some cases away from needless assessment and protecting families from unnecessary stress, particularly when it was suspected that referrals were malicious. Prior to the establishment of Tusla, public health nurses and social workers were employed by the Health Service Executive. However, the separation of the statutory agencies has given rise to some as yet unresolved data protection issues which have caused confusion to practitioners, as depicted by this interviewee:

‘Well I sought direction from on high on that because it was a thing that basically if I wasn’t able to contact the PHN or the Gardaí it was really crippling the intake process and I got an email back and I was advised that I could contact the PHN in certain circumstances ... So that was a bit of leeway and I could do that without parental consent and I wouldn’t have to notify the parents that I had done it And Guards as well, you could ring them as well, you know if someone is making an allegation and the Guards had been up then we could ring the Guards and just check if there was any substance to it And like we wouldn’t notify the families in those instances that a referral had been received cause it is not in anyone’s interest to open up that can of worms, you are actually just playing into the hands of the malicious referrer’ (IP5).

While it was not always obvious from the IR whether or not parental consent had been sought, there was evidence from the quantitative data that numerous health and social care personnel, as well as police, were frequently contacted for information, regardless of whether or not they had made the report about the child in question.

Interviewees also revealed a level of uncertainty about the lengths to which a preliminary enquiry should go:

‘What we have learnt over time is that people have interpreted the process slightly differently so what one person interprets as preliminary enquiry, which would include simply some initial phone work and checking internal records, other people have progressed into nearly home visits on preliminary enquiry and have gone after a lot more information earlier to make a better decision about whether to accept the report or referral or not. So we have seen quite a bit of variation around the country’ (IP8).

Interviewees were clear, however, that professionals could be contacted without parental consent if there were indications of a serious child protection concern:

‘I would say if someone rang in today to say they are really concerned, there is a baby in the house who is crying repeatedly, I would have no problem picking up the phone to the PHN and asking them. I think the key piece is that we can stand over what we did and what our rationale was’ (IP1).

They were also clear that there was no prohibition against talking without parental consent to any service that had made a referral. However, seeking information from non-referring sources gave rise to uncertainty as well as anxiety about breaching data protection regulations:

‘[If] we do an assessment and in that the parents make an FOI [Freedom of Information] request and in that they see on file that someone contacted another professional without telling them and without getting their consent So part of it is that we are tied in knots and to me there is national guidance needed to overcome the knots’ (IP1).

There was a prevailing view that information gathering should be restricted to a ‘need to know’ basis in order to respect children’s and families’ right to privacy:

‘Like I kind of believe in the minimalist intervention as well as much as is needed and once I have reached that point I would stop because it is important to me that families are protected there is a massive stigma attached to our involvement’ (IP6).

Could more checking result in fewer assessments? The perspective of the interviewees

As earlier sections have shown, large numbers of reports are referred onwards for initial assessment and subsequently closed with no further action. As interviewees pointed out, assessments were sometimes delayed because of work pressures in Oaktown. It could be argued that resources would be more efficiently used if the reports were more thoroughly investigated and further checks carried out at an earlier stage. This question was put to interviewees and elicited differing opinions. Some interviewees believed that a more ‘robust’ Front Door’ would reduce the numbers going forward to IA:

‘If we got the Front Door robust enough you would be getting children and families to the right services as opposed to putting them forward for an IA when that is not actually required especially with mandatory reporting coming in’ (IP2).

Others were of the view that bottle necks in one part of the system or another will continue to pose obstacles to good practice until the service is properly resourced. For example, it was suggested that

carrying out more checks is tantamount to conducting assessments on all referrals, which would be needlessly time consuming. At the same time, however, practitioners acknowledged that initial assessments are often delayed, which undermines their efficacy, and that earlier intervention at the preliminary enquiry stage could be more constructive:

‘[M]yself and my Team Leader – we would be like “ring Mam and talk to her and see what you can do” and so we did a good bit of that but we might have sent it on [for an IA] without that piece if we thought that it was going to get a timely response’ (IP6).

There was also an awareness of what it must be like for a parent to have to wait lengthy periods before finding out why a social worker wants to meet them:

‘It must be pretty horrific to get this letter and to sit with that for two weeks going what is this about. You can imagine as a parent yourself the first thing you would want to do is get to the bottom of it. So I might be better to have a conversation and call Mum on the phone and say “look we have had a report and I am not sure if it is right or wrong but it would be really helpful to me if I could speak to one or two people even over the phone to clarify some information as that would help me to decide [or] maybe offer you a different type of support here”’ (IP8).

Overall, the majority view was that more checking done at an earlier stage could often bring more clarity to the issue being reported and negate the need for an initial assessment. Interviewees identified the time constraint imposed by the standard business processes on the preliminary enquiry stage as the main cause of limited or incomplete information gathering at this point. A decision had been made at local level that any case remaining for longer than three days at preliminary enquiry stage would be put forward for an initial assessment:

‘To my IR team I have said after three days if we can’t make a decision put it out to patch. So a preliminary enquiry is nearly three days rather than the 24 hour timeframe’ (IP2).

So while there were some recommendations that the timing of a preliminary enquiry needed revision and that the consent issue needed clarification, it was also suggested that a ‘common sense’ approach should prevail over and above strict adherence to procedures:

‘Actually what is needed is for people to think about what is the concern, what is the harm for this child, are they in immediate danger at the moment do I need to make this information vital or critical to my understandings around protecting this child and if I do then I am going to proceed on that basis and get that information and I will make that call but I will tell Mum and Dad as soon as is practical’ (IP8).

Conclusion

This chapter has examined the quality and quantity of ‘checks’ carried out on the children and families reported during Q1 2015 to see whether the practice norms currently in use were effective in terms of correctly identifying reports that required further assessment.

Analysis of the data has established that, at the preliminary enquiry stage, checks were less likely to be carried out than carried out. In a majority of instances when checks were conducted they were with someone other than the referrer. It is notable that children themselves were rarely checked with.

In terms of outcome, analysis revealed that carrying out checks at an early stage was more likely to lead to a case being closed. On balance, interviewees believed that more checking should take place during the preliminary enquiry stage and that doing so could, at times, negate the need for an initial assessment.

Although it was generally agreed that more information gathering at an early stage could also obviate the need for unnecessary initial assessments, interviewees identified a number of dilemmas. In particular, the desire to achieve a balance between having enough and having too much information; both in terms of staying within the boundaries of a preliminary enquiry and the need to respect a family’s right to privacy. Within such contexts practitioners worried about doing the wrong thing and acknowledged that they erred on the side of caution by desisting from further checking, reminiscent of Kemp’s (2008) adage ‘where doing the thing right is far more important than doing the right thing’ (p.106).

Paradoxically, despite the fact that standardisation and regulation had caused many of the dilemmas experienced by practitioners, the solution proposed by them was even more standardisation in the form of guidance. In the interim, they had mediated their dilemmas by developing localised practices, following a tendency frequently reported on in empirical studies carried out on child protection decision making (Pithouse, 1987; Spratt, 2000; Kirkman and Melrose, 2014; Platt and Turney, 2014; Saltiel, 2016).

Overall, examination of the nature and type of checks conducted by ISWs revealed a high level of selectivity, whereby the majority of reports did not elicit further checks to substantiate or elaborate on the concerns reported. This restrictive practice appeared to be underpinned by the multiple drivers of compliance, albeit flexibly, with standard business process, protection of resources and safeguarding the privacy of families.

The next chapter looks in more depth at the perspectives of the practitioners interviewed regarding the influences on the key decisions they make during a preliminary enquiry and issues they grapple with as they decide on the categorisation and outcome in the cases reported.

Chapter 12 Decisions Making at the Coalface

Introduction

Decisions made during the preliminary enquiry stage dictate the future pathway of all cases reported. Referrals are categorised according to 'primary report type' and its outcome must also be decided at this point. As previously outlined in Chapter 4, a substantial proportion of reports made to Oaktown during the research period were classified as 'welfare' issues (86%). This considerably higher than the national average of 57% for the same time period. Interviewees were invited to comment on this slightly unusual finding and this chapter discusses their responses. Quantitative data on the outcome of all reports received are also presented and the views of interviewees on this aspect are detailed.

Primary report type: the perspective of the interviewees

While the designation of 'welfare issues' as a report type will depend on the judgement of practitioners and the available resources in the area, it can be generally assumed that any interventions made or planned in these cases, will be 'lighter' than any action taken in response to a more serious concern.

Interviewees expressed surprise when informed of the high proportion of reports designated to this category, particularly when it was contrasted with the national figure for the same time period:

'So it is quite out of sync (with the national average) and I have to say that has been a real worry ... that in this area we are calling far too much welfare and that would be a real concern that might be adjusting itself over time because we have been having those conversations' (IP1).

It was suggested that a norm had been tacitly adopted whereby social workers on the Oaktown team were disposed towards classifying cases this way, influenced by 'group think':

'Group think can become a very "oh well that is welfare" and we have to think "there is a child living in that welfare situation and their life might be absolute rubbish". So it is finding a space for staff to have time to reflect about what is life like for this little kiddy in this family' (IP1).

A reason put forward by interviewees to explain why the proportion of 'welfare' cases was so high in the area was service availability. The waiting list for allocation to the child protection team was very long whereas categorising a case as 'welfare' might expedite intervention:

‘I think thresholds are really bound by resources so will I call it welfare and put it through the PPFS¹³ side of the house’ (IP2).

At the time the research was carried out, new services were being brought on stream to work with families where their difficulties were defined as ‘welfare’. Interviewees suggested that the prospect of having resources to offer to families meant that more cases were allowed through the preliminary enquiry stage to enable them to access these services.

Interviewees also mentioned their implicit obligation to protect an already over-stretched child protection team by diverting cases from it to a different service:

‘We had a lot of cases on intake records hanging around and the staff didn’t want to put it out to the child protection team because that team only had two staff’ (IP2).

The lack of staff on the child protection team meant that cases remained unallocated on waiting lists over long periods of time. At one point, intake team leaders in Oaktown were responsible for 300 unallocated cases, implying an onerous responsibility for frontline managers and concern at management level about the optics of such a backlog.

While front line practitioners were mindful of their over-stretched colleagues and the need to adhere to the time frames set down by performance indicators, they gave other reasons for a general reluctance to categorise a case as ‘child protection’. These included an unwillingness to give a case a label of child abuse at an early stage unless it was ‘clear cut’ (IP6). There was also an assumption that that it could later be upgraded to child protection following an initial assessment which would gather more in depth information.

This viewpoint was reiterated by another interviewee who pointed out ‘it is very hard to [come to a conclusion about] neglect based on the information that you have which would be three lines from a PHN’ (IP5). This interviewee again expressed the view that a more detailed examination of the concerns in the context of an initial assessment may result in a different categorisation.

Concern was also expressed about the implications for a family of the label ‘child abuse’:

‘I like to hope for the best rather than assume the worst and I think it is only fair on families and this is why I put a lot of effort into the preliminary enquiry piece because I just thought it was horrendous that people were getting a social work file for things that really all families are doing’ (IP6).

¹³ PPFS is an acronym for a practice framework known as Prevention, Partnership and Family Support.

Outcome

Towards the end of the IR form, the ISW is required to specify their recommendation for action on completion of the preliminary enquiry process. They must choose between:

1. No further action (NFA) / child welfare and protection (CW and P) referral closed or
2. Initial assessment (IA) required.

According to the standard business process guidance, ‘this decision is based on professional judgement supported by the information gathered during the preliminary enquiries’ (HSE, 2009: p.21) and is signed off on by both the intake social worker and the social work team leader. This decision, regarding whether a case is to be closed or to proceed to an IA, denotes the overall outcome in a case. In the current study the majority of children reported (62%) were referred on for an initial assessment. As previously outlined in Chapter 4 this is somewhat higher than the national average which was 49% for Quarter 1, 2015 (Tusla 2015b p.4). In 37% of cases in the sample, the outcome was no further action (NFA) and in a small proportion (1%) the child had ongoing involvement with the social work department, which implied that the case was already open.

The proportion of cases being referred on for an initial assessment was discussed with interviewees, particularly given the evidence from national data, cited in a previous chapter, of the high fallout rate following such assessments. Some interviewees commented that the process of conducting initial assessment can assist families to access services, for instance if there are multiple problems such as drug misuse, mental health and child behaviour problems. However, most interviewees contended that better checking would reduce the number of cases going forward for initial assessment, a point made in the previous chapter. Added to this was the stated need to strike a balance between gathering enough information to make an informed decision at the preliminary enquiry stage without straying into an initial assessment. The potential benefits of earlier and better decision making were highlighted by a number of interviewees who, noting the high attrition rate following initial assessment, favoured ‘diverting’ cases sooner rather than later, avoiding the expenditure of ‘lots of energy’ in the process (IP6).

Outcome for children, parents and families reported

The current study looked at the outcomes for the children and families reported during the research period in order to identify any patterns in relation to difficulties reported which were closed with no further action and those that were put forward for an initial assessment.

Table 12.1 presents the data on the outcomes of NFA or IA for each of the primary issues that were reported for the children in the sample. In keeping with the overall finding that 62% of reports were

referred on for an IA, this was the more likely outcome for the majority of difficulties referred. However, two exceptions to this in the sample were ‘homelessness’ and ‘teenage pregnancy and parenting’, where NFA was the most likely outcome (63% and 88%, respectively) and these findings were statistically significant. Statistical significance was also found with regard to three issues which were less likely to have an outcome of NFA: ‘neglect’ (9%); ‘impact of parental substance abuse’ (14%); and ‘physical abuse’ (17%) (χ^2 (20, N=640) = 86.4, p = < .001).

Table 12.1 Primary child issue and outcome

Primary child issue and outcome			
	Outcome*		Total
	NFA	IA	%
Domestic violence and parental conflict (n = 80)	31.3	68.7	100.0
Physical abuse (n = 79)	16.5	83.5	100.0
Sexual abuse and sexualised behaviour (n = 68)	26.5	73.5	100.0
Mental health need (n = 52)	38.5	61.5	100.0
Impact of parental substance abuse (n = 49)	14.3	85.7	100.0
Neglect (n = 45)	8.9	91.1	100.0
Behavioural problems (n = 33)	45.5	54.5	100.0
Homelessness (n = 32)	62.5	37.5	100.0
Emotional problems (n = 28)	35.7	64.3	100.0
Negative impact from parental mental health (n = 24)	41.7	58.3	100.0
Emotional / verbal abuse by parent (n = 19)	31.6	68.4	100.0
Educational difficulties / out of school (n = 18)	27.8	72.2	100.0
Lack of appropriate supervision (n = 18)	50.0	50.0	100.0
Learning difficulties or intellectual disabilities (n = 13)	46.2	53.8	100.0
Child who is abusing drugs or alcohol (n = 12)	16.7	83.3	100.0
Child to parent violence (n = 11)	54.5	45.5	100.0
Sibling violence (n = 9)	11.1	88.9	100.0
Complex needs or physical disabilities (n = 9)	66.7	33.3	100.0
Teenage pregnancy and parenting (n = 8)	87.5	12.5	100.0
Inappropriate use of social media (n = 4)	50.0	50.0	100.0
Other (n = 29)	65.5	34.5	100.0

*Proportions of outcome are presented for IA and NFA only. The small number with an outcome of ongoing involvement with the social work department were excluded to enable chi square analysis.

The link between outcomes and the difficulties reported for the parents and families in the sample are shown in Table 12.2 and again in the majority of instances, the more likely outcome was an IA. However, two statistically significant findings were revealed in this analysis and these were ‘significant relationship difficulties’, which was more likely to have an outcome of NFA (58%) and parental ‘misuse of drugs and alcohol’, which was more likely to have an outcome of IA (74%) (χ^2 (8, N=403) = 30.5, p < .001).

Table 12.2 Primary parent and family issue and outcome

Primary parent and family issue and outcome			
	Outcome*		Total
	NFA	IA	%
Lack of parenting skills (n=97)	25.8	74.2	100.0
Misuse of drugs and alcohol (n=69)	20.3	79.7	100.0
Domestic violence (n=57)	38.6	61.4	100.0
Significant relationship difficulties (n=48)	58.3	41.7	100.0
Struggling to manage child’s behaviour (n=44)	43.2	56.8	100.0
Mental health difficulties (n=43)	30.2	69.8	100.0
Accommodation issues, including homelessness (n=15)	60.0	40.0	100.0
Non-engagement with services (n=11)	27.3	72.7	100.0
Other (n=19)	52.6	47.4	100.0

**Proportions of outcome are presented for IA and NFA only. The small number with an outcome of ongoing involvement with the social work department were excluded and a number of variables with low frequencies were combined into the variable ‘other’ to make chi square analysis possible.*

Outcome – primary report type and welfare concern categories (WCC)

The data in Table 12.3 show the outcome for ‘welfare’ reports and each of the four abuse types. Of the five primary report types, ‘welfare issues’ were significantly more likely to have an outcome of NFA than the other report types (42%). In contrast, physical abuse (11%), neglect (10%) and sexual abuse (7%) were less likely to have an outcome of NFA (χ^2 (4, N=787) = 45.4, p < .001).

Table 12.3 Primary report type and outcome

Primary report type and outcome			
	Outcome*		Total
	NFA	IA	%
Welfare issues (n=675)	42.1	57.9	100.0
Physical abuse (n=57)	10.5	89.5	100.0
Sexual abuse (n=30)	6.7	93.3	100.0
Neglect (n=20)	10.0	90.0	100.0
Emotional abuse (n=5)	0.0	100.0	100.0

**Proportions of outcome are presented for IA and NFA, The small number with an outcome of ongoing involvement with the social work department were excluded to enable chi square analysis.*

Consideration was also given to the outcome of reports for the ‘welfare concern category’ (WCC) ranked as number 1 by the intake social worker (ISW). As previously outlined the IR form allows the ISW to select one welfare concern category for each case as the principal concern and does not include the reports which were categorised as one of the four abuse types. The outcomes for each WCC ranked as the principal issue for the child are presented in Table 12.4 and for the parents and families in Table 12.5. These analyses did not reveal any statistically significant patterns between difficulty and outcome.

Table 12.4 Welfare concern category ranked as number 1 (child) by the ISW and outcome

WCC ranked as number 1 (child) and outcome			
	Outcome*		Total
	NFA	IA	%
Behavioural problems (n=30)	43.3	56.7	100.0
Mental health need (n=33)	42.4	57.6	100.0
Abusing drugs or alcohol (n=14)	21.4	78.6	100.0
Emotional problems (n=14)	57.1	42.9	100.0
Learning disabilities (n=13)	46.2	53.8	100.0
Educational difficulties / out of school (n=11)	36.4	63.6	100.0
Complex health needs (n=9)	55.6	44.4	100.0
Pregnant (n=8)	87.5	12.5	100.0
Intellectual disabilities (n=5)	60.0	40.0	100.0
Homelessness (n=5)	40.0	60.0	100.0
Involved in crime (n=1)	100.0	0.0	100.0
Communication problems (n=1)	100.0	0.0	100.0
Carer (n=1)	100.0	0.0	100.0

**Proportions of outcome are presented for IA and NFA only. The small number with an outcome of ongoing involvement with the social work department were excluded to make chi square analysis possible.*

Table 12.5 Welfare concern category ranked as number 1 (parent and families) by the ISW and outcome

Table WCC ranked as number 1 (parent and families) and outcome			
	Outcome*		Total
	NFA	IA	%
Lack of parenting skills (n=50)	32.0	68.0	100.0
Misuse of drugs or alcohol (n=54)	25.9	74.1	100.0
Domestic violence (n=41)	36.6	63.4	100.0
Relationship difficulties (n=40)	65.0	35.0	100.0
Mental health problems (n=23)	39.1	60.9	100.0
Unsuitable / unstable accommodation (n=15)	53.3	46.7	100.0
Other (n=27)	48.1	51.9	100.0

**Proportions of outcome are presented for IA and NFA only. The small number with an outcome of ongoing involvement with the social work department were excluded and a number of variables with low frequencies were combined into the variable 'other' to make chi square analysis possible.*

Source of the report and outcome

As outlined in the literature, the outcome or disposal of a report is often linked with its source (Drake, 1995; Mc Daniel, 2005; Manion and Renwick, 2008; King and Scott, 2014). Analysis of the data on outcomes and reporter type is presented in Table 12.6. These data show that the majority of reports from drug and alcohol treatment services (88%), care staff (81%) and self (80%) were put forward for an IA. However, none of these findings were statistically significant. In contrast, reports from DVS were significantly more likely to have an outcome of NFA than any other source of reports (59%) ($\chi^2 (16, N=787) = 35.84, p = < .05$).

Table 12.6 Source of the report and outcome

Source of the report and outcome			
	Outcome*		Total
	NFA	IA	%
School personnel (n=126)	38.9	61.1	100.0
Family member (n=105)	40.0	60.0	100.0
Gardaí and probation (n=97)	26.8	73.2	100.0
Medical personnel (n=88)	37.5	62.5	100.0
Domestic violence services (n=58)	58.6	41.4	100.0
Vol. orgs. – children, housing and disability (n=55)	32.7	67.3	100.0
Mental health services (n=49)	36.7	63.3	100.0
Health Service Executive staff (n=48)	37.5	62.5	100.0
Tusla staff (n=44)	31.8	68.2	100.0
Care staff (n=16)	18.8	81.2	100.0
Anonymous (n=19)	21.1	78.9	100.0
Youth services (n=17)	35.3	64.7	100.0
Member of the public (n=15)	26.7	73.3	100.0
Local authority (n=8)	75.0	25.0	100.0
Drug and alcohol treatment services (n=8)	12.5	87.5	100.0
Self (n=5)	20.0	80.0	100.0
Other (n=29)	58.6	41.4	100.0

**Proportions of outcome are presented for IA and NFA only. The small number with an outcome of ongoing involvement with the social work department were excluded to make chi square analysis possible.*

Re-referred children and outcome

Consideration was also given to the relationship between outcome and whether the child was already known to the SWD. Table 12.7 presents the findings of the crosstabulation analysis and shows that children who were already known were more likely to be referred on for an IA (69%) than a NFA (31%). Known children were also more likely to receive an IA than those who were not known (49%) (χ^2 (1, N=786) = 28.63, p = < .001).

Table 12.7 Re-referred children and outcome

Re-referred children and outcome			
Is the child known?	Outcome*		Total
	NFA	IA	%
Yes (n=527)	30.9	69.1	100.0
No (n=259)	50.6	49.4	100.0

**Proportions of outcome are presented for IA and NFA only. The small number with an outcome of ongoing involvement with the social work department were excluded to make chi square analysis possible.*

Link between number of previous intake records and outcome

To further this analysis, consideration was given as to whether there was any pattern of association between the number of IRs previously completed on an individual child and the outcome as reported in the current study. When a child was already known to the SWD, information was recorded on the majority (67%) of their IR forms regarding the number of previous reports made about them. These available data, regarding the number of previous reports, were analysed in terms of outcome and the results are presented in Table 12.8. The analysis revealed no pattern of association between number of previous IRs and outcome. There was one exception, however: children with three previous IRs were significantly less likely to have an outcome of NFA than IA ($\chi^2 (7, N=360) = 17.99, p = < .05$). This, and the corresponding finding that 85% of cases with three reports on a particular child are referred forward for an IA, is reflective of the view expressed by interviewees that receipt of three reports indicates that more assessment is needed: ‘So if it is three times that something has been referred in let’s go and really drill into to what is going on’ (IP2).

Table 12.8 Number of previous intake records and outcome

Number of previous IRs and outcome			
	Outcome*		Total
	NFA	IA	%
1 Previous IR (n=117)	38.5	61.5	100.0
2 Previous IRs (n=103)	32.0	68.0	100.0
3 Previous IRs (n=48)	14.6	85.4	100.0
4 Previous IRs (n=46)	39.1	60.9	100.0
5 Previous IRs (n=24)	33.3	66.7	100.0
6 Previous IRs (n=17)	52.9	47.1	100.0
7 Previous IRs (n=2)	100.0	0.0	100.0
8 Previous IRs (n=3)	0.0	100.0	100.0

**Proportions of outcome are presented for IA and NFA only. The small number with an outcome of ongoing involvement with the social work department were excluded to make chi square analysis possible.*

Gender and outcome

These data reveal that 66% of all male children in the sample were referred forward for an IA and 34% had an outcome of NFA. Of female children in the sample 59% were referred for an IA while 31% had an outcome of NFA. These differences were not statistically significant.

Age and outcome

The age of the children in reports which had an outcome of either NFA or IA is shown in Table 12.9 and shows fairly similar proportions across all age categories of those who were referred forward for an IA and for those who an outcome of NFA. Children aged 5 to 8 years were slightly more likely than most (68%) to be referred forward for an IA and children in the 13 to 17 year old age category were the least likely (60%). None of the findings regarding age and outcome were found to be statistically significant.

Table 12.9 Age and outcome

Age and outcome			
	Outcome*		Total
	NFA	IA	%
Less than 1 Year (n=43)	39.5	60.5	100.0
1 – 4 years (n=153)	35.3	64.7	100.0
5 – 8 years (n=154)	32.5	67.5	100.0
9 – 12 years (n=149)	38.3	61.7	100.0
13 – 17 years (n=266)	39.8	60.2	100.0

**Proportions of outcome are presented for IA and NFA only. The small number with an outcome of ongoing involvement with the social work department were excluded to make chi square analysis possible.*

Rural / urban context and outcome

Analysis was carried out to ascertain whether there was any difference between outcomes in the rural part of the area and those in the urban part. This analysis is presented in Table 12.10 and shows that reports made in the rural area were noticeably more likely to be have an outcome of IA (68%) than those in the urban area (56%). However these findings were not found to be statistically significant.

Table 12.10 Rural / urban area and outcome

Rural / urban area and outcome			
	Outcome*		Total
	NFA	IA	%
Rural area (n=449)	32.5	67.5	100.0
Urban area (n=338)	43.8	56.2	100.0

**Proportions of outcome are presented for IA and NFA only. The small number with an outcome of ongoing involvement with the social work department were excluded to make chi square analysis possible.*

Qualitative findings on outcome

Examination of the qualitative data recorded on the IR forms for links between the report and the eventual outcome in the case indicates the type of difficulties which were filtered out and those that were referred forward for an IA during the preliminary enquiry stage. Primary issues reported for the

children, parents and families which showed a statistically significant relationship with outcome will be considered in this analysis. In addition, the perceptions of interviewees on the matters that challenged them at the PE stage will be discussed.

Initial assessment required

Neglect

As outlined above, reports which detailed 'neglect' were significantly more likely to be referred forward for an IA as were reports which were categorised as neglect by the ISW. Those referred for IA reported a variety of ongoing concerns in relation to the children. For example:

'The [extended] family expressed the following concerns: the children are not getting breakfast on a regular basis; they are being verbally abused by their mother (being called bastards), they are not having any affection from their mother; they are sleeping together on top bunk of bed with no duvet, pillow cases or sheets; they are witness to a number of men that Mother allegedly brings back to the family home; Child is not getting her correct medication, milk shakes (tonic), but instead they are shared between the children; the children are being socially isolated; the children are presenting as dirty and their personal hygiene is questionable' (B031505).

The small number of reports which detailed 'neglect' but were closed with no further action came from family members or from the child themselves. These cases were assessed by the ISW either to be malicious, lacking in sufficient information to proceed any further or were referred on to another agency.

Physical Abuse

Reports detailing physical abuse were also more likely to be put forward for an IA as were reports which were categorised as physical abuse by the ISW. Reports which went on to be further assessed were, in the main, disclosures made by children to a variety of professionals but most commonly to school personnel. Disclosures made by children and young people more often than not concerned a particular incident that had occurred in the recent past and, to a lesser extent, physical abuse that was ongoing. By contrast, cases reported as 'physical abuse' which were closed with an outcome of NFA were more likely to consist of retrospective disclosures of physical abuse or disclosures made by children or others, which were deemed by the ISW to be incidents of inappropriate physical discipline.

Child Sexual Abuse

Reports which detailed 'sexual abuse or sexualised behaviour' were also more likely to be put forward for an IA (74%) although this was not a statistically significant finding. However, reports categorised as sexual abuse by the ISW were found to be significantly more likely to be referred on for an IA. Reasons for no further action in these reports included instances where the child was already linked in with appropriate services and where it was considered that the reports were malicious. Cases of alleged child sexual abuse which were put forward for an IA were, in most cases, those where a child had made an allegation or disclosure or where there was concrete evidence that abuse had taken place.

Emotional Abuse

Reports which detailed 'emotional / verbal abuse by parent' were more likely to be put forward for an IA and all reports categorised as emotional abuse by the ISW were also put forward for an IA. However, neither of these findings were statistically significant.

Parental Substance Abuse

Reports alleging parental 'misuse of drugs and alcohol' and reports on the 'impact of parental substance abuse' on children were statistically more likely to be referred on for an IA than to receive an outcome of NFA. These two inter-related factors were among the most frequently reported for the children and families in the sample. Intake records detailed serious drug and alcohol misuse which, according to the reporter, were hampering the parent's ability or willingness to meet the children's needs. The majority of these reports came from concerned professionals and relatives with a very small number originating in disclosures from the affected children themselves:

'Child stated that he does not like going home due to the situation where he feels that his mother drinks a lot. Child stated that his mother spends a lot of time in the pub and he would often go home to an empty house and his mother would send food to the house via a taxi service from the pub. Child also stated that when his mother does return home there are often aggressive and angry arguments. It is understood by the school that Mother is in a relationship with a man from the locality. Child feels anxious around this man due to his level of drinking and his relationship with Child's mother' (B011554).

Reports did not proceed to initial assessment where insufficient information was provided, the report was deemed to be malicious or where it was considered that there was a protective parent in the home

or caring for the child who could protect him or her from the negative impact of the other parent's substance misuse.

No further action

As previously mentioned, 'homelessness' and 'teenage pregnancy and parenting' amongst the children in the sample were two difficulties which were found to be significantly more likely to have an outcome of NFA. With regard to issues reported for the parents, where the primary issue was 'significant relationship difficulties', NFA was a more likely outcome than an IA.

Homelessness

Reports made about children who were homeless were closed with no further action when they concerned either young people who were out of home or families who were living in homeless accommodation. For example, reports which did proceed to IA concerned children missing from home or parents who would no longer permit their child to reside with them, or specific cases such as a 17 year old mother who was homeless with her two young children and a mother who was residing in homeless accommodation with her five children who had to be taken into care due to her ill health.

Teenage Pregnancy or Parenting

All reports, except one which involved an assault, where the primary issue was 'teenage pregnancy and parenting' were closed with an outcome of NFA. These generally concerned young girls who were reported by maternity hospitals advising Tusla as a matter of course that a young person under the age of eighteen had engaged in a sexual relationship. The majority of the reports emphasised that the relationship with the putative father was consensual and no other concerns were identified in relation to the young person. At the time of the interviews, however, there was a change in the policy in the area with regard to underage pregnancies whereby parents and the Gardai had to be notified of any underage pregnancies. This change appears to have resulted from one particular case, which increased awareness of the potential vulnerability of underage mothers:

'In the past it was reported in and it was closed down, the hospital were sharing it as information only ... "there are no concerns she is just an underage Mum". Whereas now there are certain policies that have to be followed' (IP4).

Significant Relationship Difficulties

As outlined above, ‘significant relationship difficulties’ were significantly more likely to have an outcome of NFA than be referred on for an IA. The majority of reports which identified ‘significant relationship difficulties’ and were closed with no further action, related to custody and access disputes between estranged parents, oftentimes where one or both parents would express concerns regarding the care that their child was receiving either while on access visits or in the custody of the other parent. Interviewees spoke at length about the difficult and time consuming nature of these reports, claiming that ISWs were forced into trying to establish what was true and what was malicious, at times mediating between the parents in lengthy telephone conversations. In most of these cases, unless the child was considered to be at risk, callers were referred to legal services. However, as one interviewee pointed out, parents sometimes come back with further reports that they believed would be taken more seriously:

‘If you say to them on intake you need to go back to your solicitor and so on, we only deal with child protection what happens is some parent picks that up and they make a report’ (IP1).

There was a tacit acknowledgement by interviewees of the complexity of some cases and the need to avoid assumptions about their relevance. One interviewee spoke about how one such case was eventually re-categorised as emotional abuse due to the impact on the children of the continuous allegations and counter allegations. However, as already pointed out, the majority of custody and access cases were closed and referred on.

Challenging difficulties

Domestic violence and parental conflict

‘Exposure to domestic violence and parental conflict’ was the issue most frequently reported for children in the sample and it was also the most frequently reported primary issue. The majority of these reports (69%) were referred on to be further assessed. ‘Domestic violence’ was also reported for a notable proportion of families in the sample (14%) and was reported as the primary issue for families in the same proportion of reports. The majority of these reports (63%) also had an outcome of IA. While neither of the findings with regard to outcome were statistically significant, reports relating to these difficulties were reported with such frequency in the current study and were considered so challenging by interviewees that they warrant further scrutiny.

From the data recorded on the IR forms, it was apparent that reports of children witnessing physical or psychological violence perpetrated by one parent or adult relation on another in their home would be referred forward for an IA. Incidents where a child was injured during a violent incident between

adults in the home were also put referred for an IA. One report, where the children were asleep upstairs during a violent incident between parents, was also referred forward for an IA. Other reports which were referred forward for an IA included concerns about estranged parents having relationships with abusive partners or the number of admissions that a family had had to a refuge, ranging from four to forty three. However, in the main, as will be discussed below, notifications from refuges regarding a family's admission were more likely to have an outcome of NFA.

Reports of 'exposure to domestic violence and parental conflict' which had an outcome of NFA were more likely to be concerned with poor relations between separated or separating parents with children exposed to constant arguing or verbal altercations rather than physical violence or assaults. There were a small number of reports, however, where children were exposed to physical assaults by one parent on the other and the decision was taken not to proceed to an IA. When this occurred it was mainly because of information that the relationship had ended or was about to end or where it was considered that the non-abusing parent was protective, for example committing to action such as legal intervention or seeking support services. There were also reports of 'domestic violence' which did not detail any concern regarding the child's exposure to it or parental conflict which had an outcome of NFA. It is also worth reflecting here, as outlined above, that reports specifically from domestic violence services rather than other reporters were more likely to have an outcome of no further action (59%) than IA. One such report type was when the domestic violence service was reporting admissions to their service but outlined no other concerns. Another report recorded a family's 37th admission to the refuge, however, the decision of no further action contrasted with some of the responses outlined earlier to reports from other refuges.

Examples of other reports of 'domestic violence' which did not proceed to an IA were those where the reporter stated that the children had not witnessed the altercation or where the victim withdrew their statement or stated that they did not want any help.

Interviewees spoke about the challenges that reports of 'domestic violence' present, in particular the 'enduring conflict' (IP3) whereby social workers tend to place the responsibility on mothers to protect their children in the context of a violent relationship even though they are often in a powerless situation. Added to this, as outlined in a previous chapter, interviewees were concerned about the lack of follow up by the social work department when victims of domestic violence were put in this paradoxical position of victim and protector and concern was also expressed about the lack of intervention with the child. Indeed, a number of interviewees reflected on the lack of services for children who have been exposed to and impacted by domestic violence as well as the dearth of resources for male perpetrators and male victims of domestic violence.

As outlined, inconsistency was evident in the responses given to multiple notifications from refuges regarding repeated admissions. The need for more discourse with domestic violence service

providers regarding the identification of child protection and welfare concerns in cases of domestic violence was highlighted. One interviewee pointed out that while the number of admissions to a refuge can signal the need for a child protection and welfare intervention, the ISW needs to know the right questions to ask to make the right decision regarding outcome:

‘Some of those really complex ones, they are so multifaceted and can’t be seen in isolation. And actually it is very difficult to numerically say what report 1,2 or 3 we are so reliant on the information [provided] (IP4).

Mental health need

‘Mental health need’ in respect of children was reported as the primary issue in 8% of the referrals received and almost two-thirds (62%) of these reports were referred forward for an IA, while the remainder had an outcome of NFA. ‘Mental health difficulties’ were also reported as the primary issue for 11% of parents and families and 70% of these reports were put forward for further assessment. These findings were not found to be statistically significant, but the topic of mental health was raised as an important issue, particularly self-harming. Interviewees highlighted the disparity in service provision:

‘What is worrying about that is self-harming doesn’t necessarily constitute a mental health diagnosis and then there can be a real battle between services, between us and CAMHS around those pieces’ (IP4).

Reports of ‘mental health need’ amongst the children in the sample which were put forward for an IA were varied, but all detailed factors which were considered to be contributing to or causing their mental health needs. These included: parental substance misuse, death of a parent, poor relationship with a parent and exposure to domestic violence. The most commonly reported difficulty however was the perceived inability of parent(s) to adequately respond to the child’s mental health need as well as their need for support. Conversely, reports of ‘mental health need’ amongst children did not proceed to an IA when it was deduced that parent(s) were acting protectively and were in a position to meet their children’s needs. Generally reporters of self-harm, suicidal ideation, low mood or depression would be advised to bring or request the parents to bring their child to their GP and seek a referral to Child and Adolescent Mental Health Services (CAMHS). Given the frequency with which this response appeared in the IRs reviewed, interviewees were asked if it was standard policy and they responded positively:

‘Yes absolutely, in the context of a child who has mental wellbeing need but there is no indication that this is to do with anything untoward at home and there is no disclosure or no sense of any disharmony in the home. The child protection piece doesn’t exist’ (IP4).

Occasionally the ISW would make direct contact with the parent(s) but in the majority of these cases it was assumed that the reporter would do so and the case was closed. For example:

‘Child has been upset and crying a lot of the time [in school]. She told some of her friends in the yard that she was going to kill herself. She says she is deeply upset about her parents’ separation which happened some years ago A letter was sent to referrer suggesting parents bring Child to the GP and discuss appropriateness of CAMHS referral’ (B011585).

Reports which identified parental ‘mental health difficulties’ as the primary issue and were put forward for IA detailed parents who were struggling to meet their children’s needs due to their own mental health difficulties. Some reports described parents as unwilling to address their own mental health difficulties and others identified how the effects of prescribed medication were impairing parenting ability. Typically, reports described how parental mental health difficulties resulted in harm or neglect of the children’s needs:

‘Mother has mental health issues [and] is prescribed medication for anxiety, depression and bipolar or schizophrenia. She has stopped taking her medication and is drinking heavily. The children are regularly left with different babysitters Father stated that the school have concerns about the children not having lunch’ (B0315102).

Reports of parental ‘mental health difficulties’ which had an outcome of no further action tended to comprise situations where either the parent did not want any help in addressing their mental health need or another agency was involved in working with the parent. Concerns were expressed in these reports regarding the needs of the children; however, the outcome tended to focus on linking the parents into mental health services rather than addressing the child’s needs. In most cases, there had been a shift in some factor that was contributing to the parent’s mental health, for example an abusive partner leaving the family home or as in the case below the father attending a psychiatrist and an improvement in living conditions, which was considered to positively impact the parent’s mood. The children, however, may have been witness to distressing or violent situations attributable to the parent’s mental health difficulties but it was left to the parents to address this with them or link them in with support services in the community:

‘Father was extremely aggressive and agitated in the home. He had taken a variety of drugs in an attempt to take his own life. According to report Father smashed the kitchen window and set fire to his car in the driveway Father had threatened his partner with a screwdriver, she called Gardai, children were removed from the house by the Gardaí Father is attending a psychiatrist, has appointments is in much better form, kids happy with new house, have central heating and safe for kids to play outside. Partner said she has no difficulties or concerns at present, advised [by ISW] that seeing as the family have moved [out of catchment area] if she needs help or support in the future to contact SWD in Location A’ (B011578).

Interviewees acknowledged the need to sometimes dig a little deeper to ascertain what life was like for the child living with a parent with mental health difficulties:

‘Growing up with a parent with mental health problems, life can’t be great for that child but part of it is I think that we don’t have the proper tools developed at intake to know the right questions to ask about mental health and the impact on the child. So you get a referral Mom has mental health problems but what about the parenting issues: Is she moody? Is she unpredictable? Is she very flat all the time? Does she talk to the child? And we probably haven’t got [the need to ask those questions] drilled in yet’ (IP1).

Interviewees identified the difficulty of getting CAMHS to accept a referral when there are co-existing social issues and raised the question of which service is responsible for mental health need particularly in relation to young people:

‘For example we had a child who was self-harming and the GP referred her to CAMHS and the doctor, in her innocence in one way and yet with the best of intentions, was trying to explain on paper that this child is so unpredictable and she is so angry that she has alleged that her parents have starved her CAMHS wrote back and said refer her to Tusla until they have determined how profound her mental health is. So now we determine mental health! There was one indication of environmental issues I suppose we do have that battle and the reality is our colleagues in CAMHS are working under the same constraints, their thresholds have had to increase, they have had shortages and resource issues and are under serious pressure too’ (IP4).

Conclusion

At the heart of the preliminary enquiry are the decisions which must be made regarding referral categorisation and the overall outcome in a case. These two inter-related decisions are crucial to the future pathway of the case and must frequently be made with limited or poor referral information, within a limited time frame and often in a context of high demand, heavy workloads and low resources (Kirkman and Melrose, 2014; Platt and Turney, 2014; Salteil, 2016). Interviews spoke at length about the resource constraints they grappled with in Oaktown such as high demand, long waiting lists, poor service availability and over stretched colleagues.

A high proportion of referrals in the current study were classified as ‘welfare issues’ (86%) which was at variance with the national average for the same time period and interviewees provided their perspectives on why this might be the case. It is worth noting, however, as demonstrated in Chapter 4, that there was little consistency with this national average across any of the 17 administrative areas although the proportion classified as ‘welfare’ by Oaktown was particularly high by comparison.

‘Group think’ is a concept which is sometimes applied to social work decision making (Janis, 1982; Farmer and Owen, 1995; Kirkman and Melrose, 2014) and was suggested as an explanation as to why so many cases were being classified as ‘welfare’ in Oaktown at the time of the current study. It was apparent from speaking to the practitioners that some decisions on the classification of cases related less to the characteristics of that case and more to embedded norms or practices. This tendency was already noted by Pithouse (1997), Spratt (2000), Buckley (2003) and Broadhurst et al. (2010) who found that to enter the system a referral has to meet ‘local eligibility criteria’, which not only pertain to the difficulties outlined in the referral but also relate to, what they term, ‘team-specific factors’ such as available staffing and resources. Such practices were in evidence in Oaktown, for example the belief that to classify a report as ‘welfare’ may mean that the family would receive a service more quickly within the context of service availability. There was an acknowledgement by those interviewed that a categorisation of ‘welfare’ was at times given to a report to protect overstretched colleagues on the child protection team, reflective of Buckley’s (2003) finding about the impact of ‘gate-keeping practices’ and the protection of scarce resources. Interviewees also cited the need to meet performance indicators and make a decision within a short time frame as a reason why reports were sometimes classed as ‘welfare’. Such restrictive time limits and the availability of very limited information meant that workers were reluctant to give families the ‘label’ of child abuse unless they were certain, both in terms of the implications of such a label and the service it would subsequently receive. This similarly reflects Buckley’s (2008) assertions whereby intake social workers have ‘ideological concerns about labelling certain types of parenting as deficient’ (p.18). Overarching this was a reliance on the fact that the case could be upgraded from ‘child welfare’ to ‘child abuse’ after an initial assessment when more information was available thus using a categorisation of ‘welfare’ as a ‘holding category’, a tendency previously noted by Hayes and Spratt (2014: p.630), until a more informed decision could be made.

The analysis of data from the IRs also demonstrated that outcomes reached by intake social workers in Oaktown differed considerably from national averages for the same time period with 62% referred on for an initial assessment and 37% closed with no further action. However, as highlighted in Chapter 4, as with the classification of cases, there was a wide disparity in outcome across the 17 administrative areas with few reflecting the national averages. Interviewees in the main attributed this finding on outcome to the restrictions on the amount of checking that can be carried out during a preliminary enquiry. There was overall agreement amongst interviewees that more information would lead to better and more informed decisions. However, as Munro (2005) has pointed out, as did the practitioners themselves, detailed in the previous chapter, there is a need for a balance to be struck between too little and too much. There was a sense from interviewees that better and more informed decisions at an early stage would protect families from the ordeal of an initial assessment that would eventually result in a case closure.

Some significant patterns of association were found between the difficulties reported and the eventual outcomes reached. For 'homelessness' and 'teenage parenting and pregnancy' an outcome of NFA was the most likely outcome. In contrast, 'neglect', the 'impact of parental substance abuse' and 'physical abuse' were less likely to have an outcome of NFA and were therefore more likely to proceed to IA. In terms of parent and family difficulties 'significant relationship difficulties' was more likely to have an outcome of NFA while parental 'misuse of drugs and alcohol' was more likely to be referred on for an IA.

Where the primary report type was concerned, referrals categorised as 'welfare' were significantly more likely to have an outcome of NFA than the four abuse types. In contrast, physical abuse, neglect and sexual abuse were all found to be less likely to have an outcome of NFA.

The link between outcome and report source is given a lot of attention in the literature. King and Scott (2014), for example found that reports from teachers were twice as likely to be unsubstantiated as reports from other professions. In the current study, however, the sources of report most linked with outcome of IA were drug and alcohol treatment services, care staff, self, anonymous reporters, Gardaí and probation and members of the public. Although none of these findings were statistically significant. While previous research has shown reports from lay people or anonymous sources are less likely to be substantiated (Drake, 1995; Mc Daniel, 2005; Manion and Renwick, 2008), this finding was not borne out in the present analysis. Reports from anonymous sources and members of the public were no more likely to have an outcome of NFA than be referred on for an IA.

The finding that reports from DVS were significantly more likely to have an outcome of NFA (59%) is also notable and perhaps reflective of the need for child protection and welfare services to give more time and reflection to their response to these reports.

Attention was given in this chapter to an analysis of the number of previous intake records a child has had and the outcome of the report analysed in this study. This analysis showed that children who had three previous IRs were statistically less likely to have an outcome of NFA and therefore more likely to proceed to an IA, which was consistent with the perceptions of the interviewees.

A particular focus in this chapter was on the qualitative detail contained in the IR forms with regard to difficulties reported for children and families which showed a pattern of association with outcome and those which interviewees found particularly challenging.

The 'impact of parental substance abuse' on the child and parental 'misuse of drugs and alcohol' generally were two interlinked issues that were shown to be significantly more likely to proceed to an IA. As previously mentioned, parental substance misuse frequently features in empirical research on reasons for referral to child protection services (Gibbons et al., 1995; McGhee and Waterhouse, 2007; Manion and Renwick, 2008, Scott and King, 2014) so it is unsurprising that it would also

feature strongly as a reason to carry out further assessment. Reports being deemed malicious emerged as a frequent reason on the IR forms for case closure with no further action recommended.

Analysis of the qualitative data of the cases again revealed the use of localised norms and practices to filter out cases. For example: reports of teenage parenting and pregnancies were routinely closed with no further action; cases of custody and access disputes were referred on to legal advisors; in instances of 'mental health need' amongst young people reporters were indirectly referred to GPs for referral to CAMHS and parental 'mental health difficulties' did not elicit attention to the needs of children in the family.

Findings on the outcome of reported 'domestic violence' highlighted a disparity of practice, in relation to the link between the number of referrals from domestic violence services and the decision to refer for an IA. It was suggested by the interviewees that the complexity of these cases means that a reliance of number of admissions was not a substitute for good quality information and skill in ascertaining the right type of information.

The next chapter looks in more detail at when and how decisions are made during the preliminary enquiry stage.

Chapter 13 When and How Decisions Are Made

Introduction

The previous chapter presented an analysis of findings from the current study about the categorisations and outcomes reached in respect of reports made during the research period. This chapter examines in more detail the decision making process particularly with regard to the timeframes involved, the feedback provided and the way in which information is utilised to determine categorisations, thresholds and outcomes.

Time frame for decision making

As previously mentioned official guidance on the conduct of preliminary enquiries acknowledges that ‘the social worker cannot be expected to confirm the report type at this early stage’ (HSE, 2009: p.21) yet, paradoxically, this is exactly what the intake social worker must do.

According to the standard business process guidance issued to staff, a decision on the outcome of each report must be reached within 24 hours and both the intake social worker and the team leader must agree and sign off on the action decided upon. It was evident from reviewing the IR forms that, in many instances, some time elapsed between agreement being reached and endorsed by the team leader.

As can be seen in Table 13.1 below, the IRs (n=778) which recorded data on when a decision was reached showed that an outcome decision within the 24 hour time frame, i.e. 24 hours from the date of receipt recorded on the form, occurred in a little under half of the cases (49%). Decisions were reached in a further 33% of cases within one week and 15% within one month. In a small proportion of cases (4%), more than a month had elapsed before a decision was reached.

Interviewees were asked for their opinion on the 24 time frame. Their responses indicated a consensus that, with the exception of clear cut high risk referrals, the expectation underpinning the standard business process is largely unachievable. They identified obstacles such as the volume of referrals received on a daily basis and the inevitability of delays such as waiting for return calls from referrers or key professionals. A local solution had been reached as a compromise:

‘The 24 hours isn’t really realistic in order that they are able to manage their workload we had to just say after three days if we can’t make a determination we are going to have to take it to IA, put it out to the team but put in the comments section, you know, “awaiting information” and

once this information is received we need to then to make a determination whether this requires an IA' (IP2).

This statement implies that cases are being referred for initial assessment and recorded in the metrics as requiring an initial assessment, but may ultimately be closed prior to allocation for this purpose. Interviewees understandably expressed a preference for determining outcome decisions according to the content of the case rather than time constraints:

‘Who cares if it was done in 24 hours or 48 hours, I am not really bothered, is the child any safer? Was what we did effective? That is more important to me to know than you did it quickly, yeah we might have done it quickly but we might have done it really badly’ (IP7).

Table 13.1 Number of days between receiving a report and outcome

Number of days between report and outcome		
	Frequency	Valid percent
Within 24 hours	378	48.6
Within one week	254	32.6
Within one month	118	15.2
More than one month	28	3.6
Total	778	100.0
Missing	16	
Total	794	

Findings also show that, in the majority of cases in the sample (92%), the team leader had added their signature to the IR form thereby giving their approval to the course of action decided upon. In the remainder of cases (8%) there was no indication on the IR that the team leader had signed off on or approved the action taken.

Feedback to reporters

The SBP guidance requires that ‘suitable feedback to the reporter must be provided (i.e. that the report is acknowledged)’ (HSE, 2009: p.14), adding that ‘exceptions apply, e.g. where feedback might put a child at further risk. Exceptions must be recorded’ (*ibid*). Findings in the current study

show that in the majority of cases (97%), where this information was provided (n=721), reporters received a response.

According to the *Child Protection and Welfare Handbook* (HSE, 2011b) the reporter should be informed of the outcome in the case within 24 hours:

‘Persons who refer child protection and welfare concerns to the duty social worker should have their reports acknowledged within 24 hours and be informed of what will most likely happen next. Due to the circumstances of individual cases, it will not always be feasible for this timescale to be met’ (p.38).

As is discernible from Table 13.2 below, analysis of the forms on which this information was provided (n=674) revealed that a little over half of the reporters (55%) received a response on the day that they made the report, while just over a quarter (26%) had received a response within a week of their report. Smaller numbers received a response within a month (7%) and for a very small number (3%) the response took longer than a month. Some reporters (4%) had not yet received a response by the time the IRs were reviewed for the current study, which was at least six months post referral. A substantial proportion of forms (15%, n=120), showed no indication of whether the reporter had been responded to or not.

Table 13.2 Time between report and response to reporter

Time between report and response to reporter		
	Frequency	Valid percent
Responded to within 24 hours	368	54.6
Within a week	176	26.1
Within one month	50	7.4
Date of response was prior to IR date	35	5.2
Reporter hasn't been responded to yet	26	3.9
More than one month	19	2.8
Total	674	100.0
Missing	120	
Total	794	

How decisions are made

The IR form provides two separate sections where the ISW can detail the ‘actions’ they took in the course of the preliminary enquiry. Detail on decisions made in respect of a report can be recorded in either or both of these sections, but was actually recorded on only a minority of IR forms in the sample. In the majority of cases, only the outcome was recorded. The benefit of adding more detail was highlighted by interviewees who commented on its usefulness:

‘It will help this person [the initial assessment social worker], when they have done a better job here [at intake], it will be much clearer about what I am going to focus on if I get something meaty to head into, you don’t have to read the whole thing. I am front loaded into assessment from that. It just helps the next piece as well’ (IP8).

As outlined in a previous chapter, interviewees highlighted the importance of considering whether the child is already known to the service and the number of previous reports that Tusla had received about the child and family in question. As one interviewee commented ‘that history ... is really critical in terms of decision making’ (IP7). However, as will be detailed below, data from the IR forms showed that consideration was occasionally, but not routinely, given to this matter.

Information recorded on the IR forms about decision making usually consisted of a summary of discussions between the intake social worker and their team leader as well as the direction provided by the latter on how to proceed. In a very small number of cases, there was evidence of a difference of opinion between the intake social worker and the team leader about the best way to proceed but, generally, the advice of the team leader was followed and implemented and the decision made was recorded as a joint one. In cases where differing opinion was evident, that of the team leader usually took precedence:

‘Child [aged 16] got into a fight with her 22 year old adult sister, with whom she was sharing a room, regarding a disagreement about Sister wanting to turn off the light. DSW noted that the fight seemed to be a normal sibling fight that escalated to violence. DSW noted that the person who caused harm was now an adult. TL noted that despite this the parent was struggling to manage this dynamic, therefore parenting support or support with the parent child relationship is what is needed. Agreed that after DSW’s contact with the school it should be passed on to the child welfare team for assessment due to this being the third reported incident of this nature’ (A011572).

The analysis in the current study of data on decision making during the preliminary enquiry is based on and limited to information recorded in the two sections mentioned above. It is difficult to analyse and generalise about decision making in isolation from the detail and context of each separate case, but some identifiable patterns were evident in relation to the decisions made to either proceed to

initial assessment or take no further action. A wide range of case specific reasons for different decisions was recorded. In addition, however, factors unrelated to the specifics of a particular case were also instrumental in decision making and are detailed below, evidenced with excerpts of the notes written by the ISW on the IR forms.

Factors taken into account in decisions made to refer reports onwards for initial assessment

- Re-referral and the number and frequency of previous reports; in particular multiple reports about the same matter or a number of reports in quick succession.
- New concerns in a recently closed or open case and, in particular, new concerns in relation to children registered on the child protection notification system (CPNS).
- Strong advocacy on behalf of a child or family by an outside agency.
- Escalating concerns.
- Poor engagement with services by parent(s) or minimisation of difficulties. For example:

‘In [my] initial discussion with the team leader we did not deem the concerns to reach the threshold for assessment by this department as a local community support service are the appropriate service to help the family with the concern described. However following a call between the ISW and a project worker from that service, where she noted that the family were disengaging from her service and she emphasised the impact of the current situation on Child and that Mother has been unreceptive to any feedback in this regard, we agreed that the case should be sent for assessment to the child welfare team’ (A021510).

- Concern about parenting capacity in situations where parents are young or inexperienced, or when there is no protective parent in the family. For example:

‘Discussion with team leader – Both parents are unstable in relation to their drug use on an ongoing basis and Child is being exposed to her father when he is severely under the influence. Furthermore, since both parents are misusing drugs there are concerns that there is not an appropriately protective parent in the house. We agreed that this is a high welfare issue given the ongoing impact on Child. Therefore case to be sent to the child protection team for assessment’ (A011555).

- Parent(s) actively seeking support.
- Children are at a vulnerable age. For example:

‘Discussion with SWTL – Serious allegation of inappropriate physical discipline. Given the young age of the children and the allegations described it was agreed that this matter reached the threshold of high welfare and should be sent to the child protection team for assessment’ (A021529).

Factors taken into account when an outcome of no further action was recommended

- Concerns not meeting the threshold for assessment and it was considered that there were no child protection concerns evident. For example:

‘Child [aged 17] presented to an emergency department (ED) after an alleged fight with his adult brother. Child has had several presentations to ED over the past year and all injuries are relating to fighting. Child has ADHD and has not been linking with CAMHS or taking medication for the last 2 years. Mother stated that he is constantly getting into fights and being aggressive in the home. Fights between brothers have been due to Child verbally abusing his mother Child is drinking alcohol. Mother is unable to control him and he ignores her boundaries. Referrer concerned about the impact of this on [his sister] who is currently studying for exams. Discussion with SWTL. We agreed that this case is not meeting the threshold for assessment by this department’ (A021523).

- Parent(s) had responded appropriately to the reported concerns.
- Another service has agreed to monitor the child and/or family or another service considered appropriate is already in place. For example:

‘Duty social worker (DSW) advised the principal that given Child had not expressed any intention to harm herself the current referral does not meet the threshold for assessment by SWD. DSW explained to him that even if she was expressing intentions to harm herself the appropriate support route is CAMHS via the GP. DSW explained that SWD will only get involved if Mother is failing to link Child with appropriate support services. Principal and DSW agreed that Principal would make an effort to meet with Mother to suggest that Child is linked with mainstream counselling service. DSW and Principal agreed that she would send a letter confirming this plan. DSW advised she would be closing the case to the SWD but that he could re-refer in the future if he felt Mother was not acting as an appropriate support’ (A011574).

- Report was third party, considered malicious or lacked sufficient information. For example:

‘Report from a training centre regarding one of their adult trainees, his mother is volatile and he said he is afraid if she hits him he might hit her back. Referrer’s concerns is that there is a 10 year old child in the house and that she will be exposed to the conflict. DSW asked had the trainee

alleged that the 10 year old had witnessed anything specific. DSW noted that without a specific concern this would not meet the threshold for assessment by this department' (A011524).

- Parent(s) do not want the support of the SWD and the SWD deemed this to be appropriate.
- There is a protective parent in the family. For example:

'Telephone call to Father, DSW advised Father that DSW had received an anonymous referral in relation to Child stating that he was homeless. DSW advised she was ringing to check to see if everything was OK. Father said that Child was OK and was living with him now. Father asked DSW to note on the system that Child was homeless as his mother made him homeless. Child then came to his father and he is no longer homeless. DSW advised Father that she was satisfied from his feedback that Child was OK and that the case would be closed to the SWD' (A011568).

- Parent(s) are considered responsible for their children and the SWD is disinclined to have any further involvement. For example:

'Mother and Father are in agreement for Child [aged 16] to live with Friend. Number and address given to mother. Mother informed that she would like Child to phone her as she had no credit. DSW advised that she would request this but that it was Mother and Father's responsibility to ensure that they were happy as Child's parents with the current agreement with Friend from this point forward. DSW reiterated that as this in an informal private arrangement there would be no further contact from SWD, apart from a closure letter outlining the agreement between Mother, Father and Friend' (A031531).

It is notable that, particularly in the second group above, a number of what might be described as 'common sense' rationalisations were applied which had no specific basis in official guidance, but had evolved from the practice experience of intake social workers and their team leaders.

Thresholds applied in the process of decision making

As previously outlined, in addition to determining the outcome of a report, the intake social worker is required to reach a categorisation by opting for a 'primary report type' on the IR form.

Reports which were referred on for assessment by a child protection team and which clearly fitted within the 'child protection' category included: child sexual abuse; emotional abuse; physical abuse and inappropriate physical discipline; a child out of home who had not been reported missing; parental substance misuse and neglect. In most instances, IR forms revealed evidence of discussions between the intake social worker and the social work team leader. In one example, *Children First*

was referenced in the decision to refer a case forward for an initial assessment by the child protection social work team:

‘Discussion with SWTL – Child was exposed to violence and was also struck by Father during the violence. As per *Children First* definition this constitutes physical abuse and so requires assessment by the child protection team’ (A021547).

Terms such as ‘high welfare’ and on one occasion ‘medium welfare’ were sometimes used when classifying the outcome of a report, indicating the need for some qualification in the use of this ‘catch-all’ term. In other instances, the disposal of a report to the child protection social work team or the child welfare social work team for assessment was specified, indicating that some consideration had been given to the threshold of need in the case concerned.

All reports in the sample that were referred to as ‘high welfare’ and referred forward for an IA concerned recorded difficulties such as: parental substance misuse; violence on the part of the parent; parental non-engagement with services; parents who were unresponsive to or unaware of their children’s needs; inappropriate physical discipline; young people with behavioural difficulties and young people with mental health needs. With one exception, IRs specified that ‘high welfare’ reports should be sent to the child protection social work team for further assessment. Notes recorded on these IRs demonstrated some evidence of analytical thinking to justify the classification of ‘high welfare’. There was evidence in all but two of discussion between the intake social worker and the team leader regarding the best way to proceed. For example:

‘Discussion with SWTL – Child refusing to engage with appropriate supports and presenting with extremely high risk behaviours, threatening his mother’s ability to keep him in the family home. Schools level of concern indicates that mental health assessment is required as a matter of urgency. Child is not engaging with the appropriate services despite Mother trying to link him with same. Case reaches the threshold of high welfare due to the severe behavioural problems. Case sent to the child protection team (CPT) for assessment’ (A021526).

The term ‘medium welfare’ was used to classify a report concerning the impact of a mother’s drug use on her child:

‘Discussion with SWTL – While there is a protective factor in the house in the form of the maternal grandmother, there is still a valid concern about the impact of mother’s drug use on Child. Medium welfare – sent to child welfare team (CWT) for assessment’ (A021551).

A number IR forms contained recommendations for assessment by the child welfare social work team. The difficulties recorded included complex welfare issues, each with a particular set of circumstances. Some were considered ‘lower level’ welfare concerns where it was anticipated that extensive involvement would not be necessary following assessment. For example where a lone

parent had left her young children unattended for a short period of time while she went out to purchase her medication:

‘Child [aged 5] was brought to hospital with a laceration to the head. Child and his siblings were home alone when the incident occurred. Discussion with team leader. Three children: eldest is 12 and youngest is 5. Time of day: 7pm. Children left for short period in early evening when they were all watching a movie. Next door neighbour identified as a support Mother responded appropriately protectively following the incident by bringing the child to hospital. No previous concerns re poor supervision. Conclusion: while the mother left children unattended she made some efforts to ensure the children had adult support in her absence. Therefore this is a welfare matter, where mother needs support regarding appropriate supervision levels and an assessment as to whether she would benefit from a further family support intervention. Case to be sent to the CWT for IA’ (A011536).

Some ‘welfare’ reports, which were referred for initial assessment contained references to difficulties being experienced by families that were already in contact with community services. It was considered that the social work department could provide some additional support:

‘Mother contacted SWD to say she has two boys with ADHD and Aspergers and one of whom has depression and self-harms a lot. Mother has auto immune disease and is struggling to cope. She also has bi-polar. She needs help. Following receipt of letter from a mental health service requesting specific support from this department, matter sent to CWT to assess the suitability of this request. TL advised that DSW should send the case to the CWT for assessment regarding the psychiatrist’s suggestion regarding a YAP or Extern referral’¹⁴ (A011528).

Families where parental conflict or domestic violence was allegedly impacting on the children were also considered candidates for an initial assessment by the child welfare social work team:

‘Mother has removed Child [infant] from maternal great-grandmother’s (MGGM) house due to a fight over her boyfriend. MGGM, 62 years, is a protective factor who is attuned to baby’s needs. Discussion with SWTL – We agreed that Mother is demonstrating impulsive behaviour and poor decision making where she is not prioritising the baby’s needs and this had resulted in Child being removed from a stable placement with appropriate factors. This move has also limited the level of support that can be offered by support services. Case sent to CWT for assessment’ (A011544).

¹⁴ Youth Action Project (YAP) and Extern are ‘wraparound’ or peer mentoring services delivered by external agencies, particularly to young people at risk of offending or in need of intensive support.

Other cases were sent forward to the child welfare social work team for an initial assessment when community based support services had been struggling to keep the family engaged:

‘Counsellor outlined that child has been coping with many difficulties including significant anger issues. Child has attended their service on a regular basis during 2014, however, this has deteriorated since New Year. Mother has advised Counsellor that child became more distressed since Christmas noting that he is being bullied on a regular basis in school to the extent that the Gardaí have been contacted. Child has also spoken of self-harming and threatening to take his own life. Mother has been advised to ensure that Child is followed up by his GP regarding this. Child’s school have also reported similar concerns for child at this time. At present child does not want to link with the counselling service. Counsellor advised that Mother is a lone parent coping with a number of difficulties. Conversation with SWTL – discussed referral. Attempts made over the past days by duty workers to contact professionals. IR to be set up and case transferred to CWT for review and follow up’ (A021554).

It is notable that the designation of ‘welfare’ was sometimes also used as a rationale for case closure:

‘Garda advised that there is only this one reported incident recorded on the Garda system. He believes parents argue but does not believe alcohol to be a cause or factor. DSW advised that given there is only one reported incident of arguing, with no mention of assault or information to say that child witnessed disagreement, the SWD will not be pursuing an assessment in this matter and it will be recorded as a child welfare concern’ (B021528).

Responsibility assigned to parents for their children’s safety and welfare

Comments on the IR forms illustrated that the presence or absence of a protective parent in a family was a determining factor in decisions on the outcome of a report. In a notable number of reports, where the primary difficulties were identified as children’s mental health need or behavioural problems, domestic violence or custody and access disputes between parents and the outcome was ‘no further action’, the responsibility for accessing appropriate services or ensuring the safety and well-being of the child was left to the parent or parents. For example, in cases where children were expressing suicidal ideation or were self-harming, their parent was expected to bring him or her to the GP to seek advice. Where ‘behavioural problems’ had been reported, no further action by the SWD was recommended if parents appeared to be proactive in seeking support for their children. Where ‘domestic violence’ was the main reported issue and one parent was considered able to adequately protect their child, no further action was recommended and where custody and access disputes were cited, parents were encouraged to work out solutions to their difficulties together or through the courts. For example:

‘DSW advised that although Child was upset about hearing / witnessing his Dad and his girlfriend arguing he was not harmed. DSW advised that this is a custody and access issue and Dad and Mum need to go through the Courts. DSW stated that given the concerns are named and Mum is aware of these now when Child goes on access with Dad, she had a responsibility to keep him safe. DSW advised that both parents have a responsibility to protect their son. Again DSW reiterated that this is dealt with through the Courts and this SWD does not get involved in this’ (A031515).

And:

‘DSW advised Mother that if she is concerned about Child at any time over the weekend to contact the GP or bring him to A&E. She confirmed where the nearest hospital is’ (B031596).

The tendency to devolve responsibility to parents was discussed with interviewees and while most believed it was the most appropriate action to take, ‘if the parent is pro-active’ (IP1), it was acknowledged that follow up by intake social workers to ascertain if parental commitments had actually been undertaken was rare. One interviewee asserted the importance of checking whether the appropriate actions had been taken, and in particular, believed that assessment of parental capacity to respond to problems was important:

‘You need to follow up with the parent, to ensure that they will bring the child to the GP or to the nearest A&E that night, and try to screen and see what is your professional view of the parent in terms of their understanding, how did they respond to that information, was it minimised, was it a case of “oh she’s at this again, she does this all the time”. Or are they able to say “you know what we have been worried”’ (IP4).

In a number of instances, once the parent was considered to be acting proactively or protectively, no further action was taken and they were advised to come back if further difficulties arose.

The perspective of interviewees on decision-making

As the foregoing analysis has demonstrated, discussion and consultation normally took place between the intake social worker and the team leader prior to deciding the outcome of a report. While evidence of these discussions was detailed in only a minority of the IR forms reviewed, the majority of decisions made (92%) were recorded as jointly made. It may be assumed on that basis that the amount of consultation and discussion that actually took place exceeded that which was recorded on the forms. However, interviewees emphasised the need for greater debate and discussion about referrals, threshold determination and consistency of response. They also emphasised the importance of shared and reflective thinking to challenge beliefs and achieve consistency in their responses:

‘You may have a totally different threshold from your colleague because you are a bit more concerned about things than they are about things and the only way we bottom out our practice is by sharing our thinking on thresholds And once you begin to examine that with people, you begin to bottom out some of their thinking, their prejudices or preconceived ideas or anxiousness that aren’t necessarily well evidenced or well thought through in some ways’ (IP8).

Concern was expressed about a tendency to be ‘content driven’ during the preliminary enquiry stage, focusing more on information gathering than analysis and judgement. Some consideration had already been given to formalising peer discussions:

‘We are going to establish ‘RED Meetings’ – review, evaluate and decide or direct – so basically where they had a concern about a case and should it be accepted or not, it’s one of those ones that is sitting on the edge, they would bring it to a meeting where they would use a standard analysis framework, examine it and make a call from a shared decision making perspective’ (IP8).

The importance of critical professional judgement at an early stage was emphasised:

‘Yes using their questioning skills better, engaging people better, having those early conversations and then using their abilities even at an early stage to put some analysis to that and some judgement to that, even if they are doing that much’ (IP8).

It was also suggested, by a number of interviewees, that consistency of response would be better achieved by having only one or two points of contact for reports in each area:

‘[With] multiple points of contacts you will sometimes get different thresholds at play and different decision making at play because you have different personnel involved at those different points of contact’ (IP8).

The practice of appointing one worker, or a small team of workers, to handle intake was suggested as a means of promoting standardisation and consistency of responses.

Interviewees were quite preoccupied with thresholds. The thresholds to be applied to cases reported to the child protection and welfare service are set out in ‘*Threshold of Need Guidance for Practitioners in Tusla Social Work Services*’ (Tusla, 2014c). It is expected that this document will guide intake social workers and its aim is:

‘[T]o promote clarity and consistency of response to referrals to Tusla under *Children First* guidance and legislation. The primary purpose is for it to support decision making at the screening and intake stage of the process. In addition the guidance is for practitioners and managers at all levels throughout the organisation and to assist external agencies to have a consistent understanding of the thresholds for Tusla social work services’ (p.1).

The guidance identifies four levels of need: Level 1, no additional needs/child achieving expected outcomes; Level 2, children with additional needs; Level 3 children with multiple (complex) additional needs and Level 4, children with highly complex, acute and/or immediate risk of harm (*ibid*: p.2). It also provides a number of matrices illustrating the needs and risks associated with each level and the type of intervention that may be warranted and points out that children who are assessed to be at Level 4 will require a service from the social work department.

This guidance provides a good example of attempts to impose technical rationality on a somewhat unwieldy process. It is notable, however, that only one IR made reference to the definitions of child abuse in *Children First* when detailing the outcome and no reference was made in any of the IR forms reviewed to the levels of need outlined in the '*Threshold of Need Guidance for Practitioners in Tusla Social Work Services*' document (Tusla 2014c). Similarly, when interviewees were asked about the factors that influenced their decisions regarding thresholds, no reference was made to this guidance. One interviewee commented that decisions are not based on the guidance but rather on the 'information to hand' and went on to point out that:

'[G]enerally, the team leader signs off on the intake records as well so you would have that conversation really if there was a doubt in your mind about what way this is going' (IP5).

Most interviewees identified resources, the availability of staff and the availability of services as the main determinants of threshold:

'[T]he more capacity you have to respond the more you respond with but as resources get tighter the more things you push away' (IP1).

Conclusion

This chapter has shed some light on the process of the categorisation of concerns reported to the intake social work team in Oaktown, and has illustrated the context in which practitioners have to make decisions. Decisions were made and outcomes decided within the recommended time in a little under half of the reports in the sample. Adherence to the time frame remains an important performance indicator and its metrics are reported in monthly and quarterly administrative data by Tusla. Interviewees demonstrated the unofficial norm that they had established to reach outcomes as near as possible to the deadline, which sometimes involved legitimising a delay by referring the report on for initial assessment even if there was no firm evidence that this was necessary. This finding resonates with, White et al.'s (2010) conclusion that performance indicators can, at times, supersede professional judgement. It also reflects how 'speed practices' and 'deflection strategies', terms coined by Broadhurst et al (2010) can become normalised and habitual.

Official guidance obliges intake social workers to advise reporters of the outcome in the case referred, in writing, within 24 hours. Analysis of the contents of IR forms indicated that this timeframe was achieved in 55% of the reported cases. The rationale for failure to comply with this requirement was not clear, but similar non-compliance was noted in the aforementioned research by Broadhurst et al. (2010) who suggested that reticence in responding to the referrer was used as a strategy to avoid challenges to the categorisation or outcome in the case they reported.

Elaboration on the rationale for decisions reached was recorded on only a minority of the IR forms reviewed. Where additional commentary was available, it revealed a specificity of deliberations and the narrow definitions of child maltreatment applied, a point previously noted by Benbenishty et al. (2003). The designation of 'welfare', however, was shown to be far less straightforward than the process implied in the guidance on thresholds. The term 'welfare' was subject to qualification in terms of whether it was 'high' or 'medium' and practitioners had to steer an additional course of balancing and evaluating information when applying this category.

Factors which weighted decision-making towards referral for initial assessment included an emphasis on the type and number of previous referrals, highlighting the importance of quality referral information (Hayes and Spratt, 2014; Kirkman and Melrose, 2014; Platt and Turney, 2014; Saltiel, 2016). A correlation between multiple sources of information and a decision to take further action was particularly evident, replicating an earlier finding by Platt (2006). The persuasiveness of reporters in seeking assistance was also identified as a trigger for further assessment (Buckley, 2003).

As the chapter evidenced, 37% of reports received by the intake social work team in Oaktown were closed with a recommendation for 'no further action' and a number of factors influencing this outcome were recorded on the IRs reviewed. Saltiel (2015) has described this as a mechanism for managing the volume of work and potential 'flooding' of the system and Broadhurst et al. (2010) have noted how social workers in their study at times described an outcome of NFA as a 'relief'.

A common rationale for case closure or no further action was the failure of the report to reach the 'threshold' for assessment, which implied that no child protection concerns were evident. However, an overview of the IRs demonstrated that reports based on information that was vague, lacking in detail, considered malicious or couldn't be 'grounded' with key people were also routinely closed, with no further queries from either the intake social worker or the team leader. There was also evidence at times of workers being disinclined to be further involved or seek further information, a tendency earlier identified by Buckley (2003). Such gatekeeping practices were identified over a decade ago (*ibid*), and appear to have endured. The tendency to close cases where other services were involved was also identified in the current study, a strategy already identified by Platt and Turney (2014), to keep the workload manageable.

The presence of a protective parent, or a parent who willingly engaged with the social work department were often cited as reasons for no further action though practitioners were not always confident about its ultimate validity. This may reflect an emerging rhetoric, perpetrated by the statutory agency and detailed in Chapter 2, whereby parents are encouraged 'to own' their problems. It also signifies the delineation by intake workers of the boundary between state intervention and family autonomy, a tension identified in much earlier research by Parton (1991) and Buckley (2003).

The majority of decisions were signed off on by a team leader, and in a number of cases, the IR recorded discussions that had taken place. Broadhurst et al. (2010) have noted that social workers may defer to what they assume is the superior knowledge and experience of their line managers and may be reluctant to challenge their views. As demonstrated above where there was evidence in the IR of differing opinions between the TL and the ISW, the opinion of the TL determined the decision made. This could be seen to reflect a level of collusion and acceptance of local culture (Pithouse, 1987; Buckley, 2003) or avoidance of the stress of challenging a colleague (Farmer and Owen, 1995).

As outlined, a number of 'factors' were identified which appeared to influence outcomes, including several which strayed beyond those cited in either Tusla guidance documents or any of the formal decision making tools used in other jurisdictions. This could be consistent with O'Connell's (2014) assertion that such policy documents have not been well assimilated into the everyday practice of child protection social workers in Tusla or it could also be reflective of the fact that practitioners do not find the available guidance useful or user friendly. Instead, the intake social workers appeared to employ intuitive and informal reasoning (Munro, 1999; Saltiel, 2016) and localised sense making strategies (Buckley, 2003) mediated through the availability of local services (Platt and Turney, 2014). Interviewees acknowledged that thresholds are often determined more by the availability of resources than by professional judgement, a point already made in earlier studies (Mansell, 2006; Buckley, 2008; Gambrill, 2008; Broadhurst et al., 2010). Analysis revealed the rationale employed in recommendations for further involvement of either the child protection or child welfare social work teams appeared to be largely appropriate. It was in relation to reports where information was lacking and issues were somewhat blurred that the use of flexible reasoning was most evident, more frequently than not culminating in outcomes of no further action. Interviewees expressed discomfort with the sometimes paradoxical solutions they were forced to employ to demonstrate, albeit superficially, compliance with managerial requirements. They suggested some solutions, but it is not certain that these could combat the restraints to which they were subject.

The next chapter look at the rate of re-referral to Oaktown at the time the study was carried out.

Chapter 14 Re-referral

Introduction

Reports on child protection activity, published on the Tusla website, do not routinely report or comment on the rate of re-referral to the child protection and welfare services, yet this measure would provide useful information about how the system is functioning. A high rate of repeat reporting can raise questions about the quality of decision making at the time of initial referral. It can also indicate a pattern of multiple reports being made about children, sometimes in the context of acrimonious separation, or it can illustrate that reports are made about children already in the system, possibly in care. Whatever the explanation, a high re-referral rate warrants investigation in order to enlighten service planners and policy makers about the reasoning behind it.

Analysis of the intake records in the current study reveals that a little over two-thirds of the children reported (67%) during Q1, 2015 were already known to Oaktown child protection and welfare services. The remainder (33%) had been reported to Tusla for the first time. In order to examine this matter more closely, intake records which recorded the receipt of reports about a child already known to services, and in particular children re-reported within 12 months, were extracted and their contents interrogated in an attempt to explain why they recurred.

Re-referred children

Table 14.1 below provides some information on the children re-referred to Tusla. Almost half (45%) of IRs in this category that were reviewed contained no indication that assessment or services had been provided on previous occasions. Seventeen percent of IRs indicated that while the case was now closed, the child had previous social work involvement. A slightly smaller proportion (15%) of the children had previously undergone an initial assessment, but their cases had been closed by the time of the following referral. If these proportions are considered together with children who received other community services from voluntary organisations and the children who were previously in care this means that just over a third (34%) of the children re-referred had previously had substantial involvement with the social work department.

As also highlighted in Table 14.1, almost a tenth (9%) of the children re-referred had an allocated social worker at the time of the report. The high rate of multiple reports raises the question of whether multiple intake forms had been completed for the same children unnecessarily if, for example, they were already known or receiving services. This tendency had been noted in the National Audit of

Standard Business Processes for Child Protection and Welfare Social Work Services (Tusla, 2015f), which pointed out:

‘In the vast majority of these cases the communication should have been the subject of a case note or internal communication, either to the duty manager or the allocated social worker. Such communications should not, in the vast majority of cases, become the subject of a new intake record, as they relate broadly to the same concern and aren’t a “new referral”’ (4.14).

Clarification on this issue was sought in the current study through interviews carried out with staff. Their opinions were at variance with the assertions in the audit report. As one staff member pointed out: ‘technically the business process does say a new report equals a new intake’ (IP8) and another apparently agreed with this approach in her comment that:

‘[If] it is a new concern [then] that is what we count, even though they might be known to us. But part of it is and this is a big issue for the children in the care service say a child discloses abuse, it is a process, so you do your IR and you do your IA and you reach your conclusion’ (IP1).

Re-referred children who were already known to Tusla and were currently undergoing initial assessment or were on a waiting list for an IA accounted for only a very small proportion (5%) in the current study.

Table 14.1 Previous involvement with re-referred children

Previous involvement with re-referred children		
	Frequency	Valid percent
Previous IR(s), case currently closed	238	44.6
Previous SW involvement, case currently closed	89	16.7
Previous IA, case currently closed	82	15.4
Allocated case	49	9.2
On waiting list for IA	20	3.7
Open to duty	10	1.9
Previous FS involvement, currently closed	9	1.7
Other	9	1.7
IA/FA already underway	7	1.3
Child previously in care but home now	2	0.4
No information provided	19	3.6
Total	534	100.0

Number of Intake Records

The intake social worker is required to detail on the IR any significant or previous involvements that have occurred prior to this new report. In the majority of reports (67%), where the child had been previously known, the intake social worker recorded the number of IRs previously completed on the child. Of these children, one third (33%) had been the subject of one previous IR, a slightly smaller proportion (29%) had been the subject of two previous IRs, 13% had been the subject of three previous IRs as had those children who had four previous IRs (13%) and almost an eighth (12%) had been the subject of five or more previous referrals. Overall this finding shows that where information was recorded about previous involvement with the social work department 67% of the re-referred children had two or more previous IRs and 38% had three or more previous IRs.

Re-referral and length of time since previous reports

As previously outlined, official definitions of re-referral both here and in the UK include children who have been re-referred within a twelve month period (HSE, 2009; Department for Education, 2016). It was not always possible to identify the extent of previous involvement from the IR forms and it is notable that, with the exception of one interviewee, no practitioners specified the time lapse

between referrals, or the services provided to the child in the interim when discussing rates of re-referral in Oaktown. Most of the IRs (87%) which recorded information about previous reports specified the length of time that had lapsed in the interim. In a little under one third (29%) of cases, the report had been made within the last month, while over half (52%) had been during the previous year and almost two-fifths (39%) had been made between one and five years earlier.

The perspective of the interviewees on re-referral rates

Interviewees acknowledged the rate of re-referral as an important issue. While they agreed that the standard business processes have assisted them to capture the number and detail of previous referrals on the IR form, they identified room for improvement in their practices, particularly the importance of gaining an overview of each already known case when it is re-reported:

‘Now obviously at some point the social workers need to read the whole file themselves but especially as a team leader trying to prioritise cases, that history, previous number of referrals, it is really critical in terms of decision making’ (IP7).

The implications for families of re-referral were discussed by interviewees, particularly those who had undergone an initial assessment followed by case closure. It was suggested that further assessment following a subsequent report needed to ‘really drill into what is going on’ (IP2) rather than relying on the favourable outcome of a previous initial assessment as a reason for non-action. On the other hand concern was expressed about ‘over assessing’ families in an unhelpful manner:

‘We are pushing too many people into processes that potentially aren’t helpful or may not be going anywhere. Assessment, assessment and assessment and what we have then is this revolving door piece and re-referral’ (IP1).

As previous chapters have outlined, there was a general view that more efficient information gathering at the preliminary stage would preclude the need for either unnecessary assessment or re-referral.

The perspective of interviewees on the nature and content of re-referrals

The possibility that current methods of processing reports were inadvertently heightening the likelihood of re-referral was discussed by interviewees. There was a general acknowledgement that some particular problems presented by families which tended to be considered ineligible for a social work response, sometimes being classified as ‘welfare’, are being referred repeatedly. The primary examples cited were custody and access disputes, domestic violence and children’s mental health

difficulties. It was agreed that intake social workers needed to explore the events unfolding in the family with more rigour and assess whether or not child protection issues existed and required a response.

Certain patterns were evident. For example, children of parents in acrimonious relationships were often re-reported by one parent or the other:

‘I do say, you know the way Munchhausen by Proxy is gone now but I do say Munchhausen by social worker, people who actually want social workers in their lives and it’s like who wants that?! And they are asking for their children to be interviewed over and over again and they are landing kids on our doorstep saying “interview my child about what happened at the weekend” and we are like “no!”’ (IP1).

While intake social workers often direct these cases back to the courts and mediation services, it was acknowledged that further investigation might reveal a child protection issue:

‘Is it now emotional abuse because of the nature of the number of referrals and the content and parental response it is time to say look are these parents being emotionally abusive towards their child’ (IP7).

It was the opinion of the interviewees that reports about domestic violence, and in particular children’s exposure to domestic violence, were subject to a lot of re-referral. This had in fact led them to recently establish a local policy whereby three reports concerning domestic violence should be construed as emotional abuse for the children involved. They also acknowledged the need to reconsider their practice of categorising domestic violence as ‘welfare’ and recommending no further action once the mother, or victim, and children were judged to be out of immediate danger:

‘There is a need for greater follow up with the mother in these cases to ascertain whether commitments made to keep the child safe were followed through. Say we are going back out to Mum, in the same way we go out when we are closing it down, and asking is she aware of the legislations and support she can get in terms of the laws that protect them, do they go back to the partner, do they have an address to go to, perfect close it down. Does anyone ever check whether that happened, did she commit to that? No’ (IP4).

This interviewee also suggested that the impact on the child of living with domestic violence should be carefully assessed:

‘A child might say something very different they might say the significant relationship isn’t the issue, the real issue is that my Mom abused alcohol And I wonder if a child was ever to pick up this IR, you know retrospectively, and say: “Wow that doesn’t really reflect my situation”. And so we are so quick to close them because you know it’s domestic violence’ (IP4).

Interviewees also acknowledged that the issue of children's mental health problems is often re-referred and attributed this to a resource deficit, which causes it to fall between the services, often with no resolution. Reports about young people engaging in self-harm or suicidal behaviours also tended to be referred from one service to another, eventually returning to the child protection service when no help was available elsewhere, as illustrated in this quote:

'I feel very sorry for parents in those situations because often what happens is they are dealing with a very difficult challenging young person and they go to the school and the school tell them to go to Tusla, Tusla tell them to go to CAMHS, CAMHS say to go to the guards, the guards tell them to go to the addiction services, they are already really stressed and they are having to jump [from service to service] it must be very stressful' (IP1).

Data from the intake record forms on re-referral

As Table 14.2 demonstrates, the quantitative data reveal that high proportions of the children were already known for the vast majority of difficulties reported. This is unsurprising given that 67% of all of the children reported were already known to the social work department. The only statistically significant findings from this analysis were the relatively lower proportions of children who were not known and were reported for 'neglect' (15%) ($\chi^2 (1, N=793) = 8.34, p = <.05$) and 'difficult child / parent relationships' (9%) ($\chi^2 (1, N=793) = 8.22, p = <.05$). For both of these issues, the children reported were more likely to be known.

Similarly, when parent and family difficulties are considered the analysis revealed that in relation to most of the difficulties reported it was more likely that the family was known than not known (see Table 14.3 below). There were, however, some statistically significant findings within this analysis. The proportion of families where 'domestic violence' was reported and who were not previously known to Tusla (47%) was significantly higher than the overall proportion in the sample (33%) ($\chi^2 (1, N=546) = 7.91, p = <.05$). This finding means that families reported to Oaktown for 'domestic violence' were more likely (53%) to be families reported for the first time. This finding is somewhat at odds with the perception of the interviewees that a lot of families were frequently re-reported for 'domestic violence'. A further statistically significant finding was the high proportion of re-reported parents and families who were struggling to manage their children's behaviour (80%) ($\chi^2 (1, N=546) = 6.58, p = <.05$).

Table 14.2 Re-referred children and difficulties reported

Re-referred children and difficulties reported			
	Is the child known?		Total
	Yes	No	%
Domestic violence and parental conflict	60.2	39.8	100.0
Physical abuse	59.8	40.2	100.0
Behavioural problems	76.7	23.3	100.0
Impact of parental substance abuse	77.3	22.7	100.0
Sexual abuse and sexualised behaviour	68.8	31.2	100.0
Educational difficulties / out of school	72.2	27.8	100.0
Mental health need	77.6	22.4	100.0
Emotional problems	70.6	29.4	100.0
Emotional / verbal abuse by parent	62.7	37.3	100.0
Neglect	85.2	14.8	100.0
Learning difficulties or intellectual disabilities	75.6	24.4	100.0
Drug / alcohol abuse	81.1	18.9	100.0
Difficult child / parent relationships	90.6	9.4	100.0
Negative impact from parental mental health	71.9	28.1	100.0
Homelessness	78.1	21.9	100.0
Lack of appropriate supervision	57.1	42.9	100.0
Sibling violence	65.0	35.0	100.0
Inappropriate use of social media	92.9	7.1	100.0
Child to parent violence	90.9	9.1	100.0
Complex needs or physical disabilities	44.4	55.6	100.0
Teenage pregnancy and parenting	62.5	37.5	100.0
Excessive responsibility in the home	71.4	28.6	100.0
Impact of parental separation	50.0	50.0	100.0
Child involved in crime	83.3	16.7	100.0
Other	57.9	42.1	100.0

Table 14.3 Re-referred parents and families and difficulties reported

Table Re-referred parents and families and difficulties reported			
	Is the parent and family known?		Total
	Yes	No	%
Lack of parenting skills	69.7	30.3	100.0
Significant relationship difficulties	68.8	31.2	100.0
Misuse of drugs and alcohol	74.5	25.5	100.0
Domestic violence	52.6	47.4	100.0
Mental health difficulties	76.2	23.8	100.0
Accommodation issues, including homelessness	66.7	33.3	100.0
Non-engagement with services	64.7	35.3	100.0
Socially isolated	35.7	64.3	100.0
Struggling to manage child's behaviour	80.0	20.0	100.0
Family with someone involved in crime	66.7	33.3	100.0
Financial issues	62.5	37.5	100.0
Disabilities / health problems	100.0	0.0	100.0
Family under threat	66.7	33.3	100.0
Adolescent parents	66.7	33.3	100.0
Parent deceased	0.0	100.0	100.0
Learning disability	50.0	50.0	100.0
Other	60.0	40.0	100.0

Analysis was also carried out on the smaller number of children (n=163) and parents and families (n=103) who were re-reported within one year. This analysis is set out in Table 14.4 and Table 14.5 below. While there were no statistically significant findings in either group, these data compare positively with the perspectives of the interviewees in relation to re-referral patterns in their area. For these children, the issue which was reported with the most frequency was 'behavioural problems' (12.3%). 'Exposure to domestic violence and parental conflict' and 'mental health need' in addition to 'homelessness' and 'educational difficulties' each accounted for 11%. For the parents and families re-reported within one year, a 'lack of parenting skills' was the issue most frequently reported while 'significant relationship difficulties', which includes custody and access issues was also identified in almost a quarter (23%) of cases re-reported.

Table 14.4 Child difficulties re-reported within one year

Table Child difficulties re-reported within one year		
	Frequency	Percent**
Behavioural problems	20	12.3
Exposure to domestic violence and parental conflict	18	11.0
Mental health need	18	11.0
Homelessness	18	11.0
Educational difficulties / out of school	18	11.0
Sexual abuse and sexualised behaviour	15	9.2
Learning difficulties or intellectual disabilities	13	8.0
Physical abuse	12	7.4
Emotional / verbal abuse by parent	12	7.4
Impact of parental substance abuse	10	6.1
Emotional problems	9	5.5
Drug / alcohol abuse	9	5.5
Neglect	8	4.9
Difficult child / parent relationships	7	4.3
Lack of appropriate supervision	7	4.3
Complex needs or physical disabilities	4	2.5
Negative impact from parental mental health	3	1.8
Inappropriate use of social media	3	1.8
Child to parent violence	3	1.8
Sibling violence	2	1.2
Teenage pregnancy and parenting	1	0.6
Impact of parental separation	0	0.0
Child involved in crime	0	0.0
Excessive responsibility in the home	0	0.0
Other	8	4.9
Total*	218	

*Totals do not add up to 163 as referrers could re-report more than one difficulty for each child.

**Percentages do not total 100 because values were calculated out of the total number of children re-reported within a year (n=163), rather than the total number of difficulties re-reported (n=218).

Table 14.5 Parent and family difficulties re-reported within one year

Parent and family difficulties re-reported within one year		
	Frequency	Percent**
Lack of parenting skills	27	26.2
Significant relationship difficulties	24	23.3
Struggling to manage child's behaviour	19	18.4
Misuse of drugs and alcohol	16	15.5
Domestic violence	15	14.6
Mental health difficulties	13	12.6
Accommodation issues, including homelessness	12	11.7
Non-engagement with services	6	5.8
Financial issues	3	2.9
Disabilities / health problems	3	2.9
Family with someone involved in crime	0	0.0
Family under threat	0	0.0
Adolescent parents	0	0.0
Parent deceased	0	0.0
Learning disability	0	0.0
Other	0	0.0
Total*	138	

*Totals do not add up to 103 as referrers could re-report more than one difficulty for each parent and family.

**Percentages do not total 100 because values were calculated out of the total number of parents and families re-reported within a year (n=103), rather than the total number of difficulties re-reported (n=138).

Sources of re-referral

Interviewees contributed their perceptions on the source of re-referrals. One opinion proffered was that families who had previous involvement might be more inclined to make contact again when a new difficulty or concern arose. It was also observed that certain families might have a long association with the social work department:

‘If they have contacted the department before or if they know that there was social work involvement before they are more inclined to pick up the phone because if there was a concern for a child in the past, they might even have the name of someone But yeah some families almost have a reliance on the social work department to fix problems and that is the first resource

that they go to, 'I'll ring the social workers and see if they can sort it' There could be generation of families who have contact with the social work department and they don't see it as unusual' (IP5).

As Table 14.6 demonstrates, higher proportions of children were known than not known by all of the referral sources in the current study, however, there were statistical patterns of association for four of them (χ^2 (16, N=793) = 54.5, p = <.001). Over two-fifths of the children (43%) reported by school personnel had not been previously known to Tusla indicating that schools are identifying concerns about children that are not being reported by other services. Similarly, 45% of the children reported by medical personnel were not previously known to Tusla, also indicating that these professionals are reporting significant proportions of children who might not otherwise have been reported. Conversely, voluntary organisations (13%) and care staff (0%) reported significantly low levels of children who had not been known to Tusla. This could be explained by the fact that child protection services may have been the instigators of their contact with the services concerned.

Table 14.6 Re-referred children and the source of the report

Re-referred children and the source of the report			
	Is the Child Known?		Total
	Yes	No	%
School personnel	57.1	42.9	100.0
Family member	73.6	26.4	100.0
Gardaí and probation	63.3	36.7	100.0
Medical personnel	55.1	44.9	100.0
Domestic violence services	63.8	36.2	100.0
Voluntary organisations – children, housing and disability	87.3	12.7	100.0
Mental health services	66.7	33.3	100.0
Health Service Executive staff	79.2	20.8	100.0
Tusla staff	57.8	42.2	100.0
Care staff	100.0	0.0	100.0
Anonymous	89.5	10.5	100.0
Youth services	76.5	23.5	100.0
Member of the public	66.7	33.3	100.0
Local authority	87.5	12.5	100.0
Drug and alcohol treatment services	100.0	0.0	100.0
Self	80.0	20.0	100.0
Other	48.3	51.7	100.0

Analysis was also carried out on the source of the reports for the children who were re-referred within one year. The results of this analysis are presented in Table 14.7 and show that in the current study schools were the source most likely to re-report children within one year, followed closely by domestic violence services and HSE (health) staff. Two findings from this analysis were found to be statistically significant: the high proportion of reports from HSE staff (96%) where the child was re-reported within one year and in contrast, the low proportion of children (8%) re-reported by anonymous sources within this time frame (χ^2 (12, N=314) = 48.05, p = <.001).

Table 14.7 Re-referred within one year and source of the report

Re-referred within one year and source of the report		
	Frequency	%
School personnel	25	15.3
Domestic violence services	23	14.1
Health Service Executive staff	21	12.9
Medical personnel	18	11.0
Voluntary organisations – children, housing and disability	17	10.4
Family member	13	8.0
Gardaí and probation	10	6.1
Tusla staff	5	3.1
Mental health services	5	3.1
Youth services	5	3.1
Care staff	1	0.6
Anonymous	1	0.6
Other*	19	11.7
Total	163	100.0

*Source of report with very low frequencies were collapsed into 'other' to enable chi square analysis.

Ages of the children who were re-referred

The age of the children re-referred and specifically those re-referred within a year in the current study were considered, the findings of which are presented in Table 14.8 and Table 14.9 below. There were no statistically significant differences in the proportions of children re-referred or in the proportions of children re-referred within one year among the four age groups.

Table 14.8 Re-referred and the age of the child

Re-referred and age of child			
	Is the Child Known?		Total
	Yes	No	%
Less than 1 year	72.1	27.9	100.0
1-4 years	60.0	40.0	100.0
5-8 years	66.2	33.8	100.0
9-12 years	66.4	35.6	100.0
13-17 years	73.7	26.3	100.0

Table 14.9 Re-referred within one year and age of the child

Re-referred within one year and age of child			
	Re-referred within one year?		Total
	Yes	No	%
Less than 1 year	66.7	33.3	100.0
1-4 years	41.8	58.8	100.0
5-8 years	57.4	42.6	100.0
9-12 years	57.4	42.6	100.0
13-17 years	50.4	49.6	100.0

Conclusion

This chapter has presented the findings from the current study pertaining to referrals about children already known to services and those re-referred within one year. Bearing in mind that the literature identifies previous involvement with social services as an important predictor of future involvement (English et al., 1999; Fluke et al., 1999; Forrester, 2008; Bae et al., 2010; Heile et al., 2013; Fuller and Nieto, 2014; Casaneuva et al., 2015; Eastman et al., 2016) analysis was completed and is presented on children who were previously known within all time frames and those who were re-referred within a year.

Analysis showed that over two-thirds of the children reported during the time frame of the current study were already known to Oaktown child protection and welfare services and, although complete

information was not provided for all cases, it appears that 52% of these re-referrals occurred within a year. Staff who were interviewed agreed that a pattern of re-referral warrants particular attention and also acknowledged, from their experience, that custody and access cases, domestic violence and mental health need amongst young people were subject to a high degree of re-referral.

Although the statistical analysis did not reveal an increased likelihood of ‘exposure to domestic violence and parental conflict’, ‘mental health need’ or ‘significant relationship difficulties’ in comparison with other difficulties, children and families who were re-referred were frequently reported for these difficulties during the current study. Current practice norms such as the classification of custody and access disputes and domestic violence as ‘welfare’ without thoroughly ‘drilling down’ to gain more information were identified as contributors to re-referral. The tendency, identified in the previous chapter, for concerns that are brought to attention by ‘protective’ parents to get weaker responses could explain why ‘behavioural problems’ repeatedly feature in the reports of those re-referred when help is unavailable elsewhere.

Significance testing confirmed a pattern of association between children who were already known and ‘difficult child / parent relationships’ and parents who were ‘struggling to manage child’s behaviour’. Added to this ‘behavioural problems’ was the issue reported with the most frequency for the children re-reported within a year. These findings are indicative not only of the prevalence of behavioural problems amongst children and the concerns expressed by other people about it, but of the dearth of services available to support parents in addressing it.

Research has demonstrated that neglect is an issue which can be difficult to identify and address (Walsh et al., 2006; Department for Education, 2014; Buckley and Buckley, 2015) and as such it has been shown, in empirical research, to be an issue which is frequently re-referred (DePanfilis and Zuravin, 1999a; Connell et al., 2007; Manion and Renwick, 2008; Heile et al., 2013; Fuller and Nieto, 2014; Eastman et al., 2016; Jedwab et al., 2017). In the current study, significance testing showed this to be the case and children that were reported for ‘neglect’ were more likely to be known.

The finding that the most significant sources of re-referral were education services, along with medical and health services, endorses the focus in the literature on the unique role of schools as identifiers of difficulties facing children (Giovanni, 1995; Mc Daniel, 2006; Walsh et al., 2006; King and Scott, 2014; Bourke and Maunsell, 2015). Schools also emerged as the source most likely to re-report a child within a year. The fact that schools were identified as frequent re-reporters could be construed as a mismatch between expectations held by schools and the capacity of child protection and welfare service to resolve the difficulties that they identify, the majority of which concerned children’s mental health and behaviour.

These data demonstrate that, regardless of the reason for re-referral, families are likely to experience the process of ‘bouncing’ in and out of the system as unhelpful. It was noted that a certain degree of

administrative malaise encouraged multiple form filling when alternative processes should be used. It was also noted that while the standard business processes are helpful in guiding some aspects of intake, they are no substitute for comprehensive examination of available information, including that held in earlier records and case notes. Overall, interviewees acknowledged the importance of taking a fresh approach to each referral and refraining from reliance on previous positive outcomes to justify taking no further action on a new report.

This chapter has concluded the reporting and analysis of findings from the current study. The next chapter reflects back on the literature reviewed, making links where appropriate with these findings. It also draws out the implications arising from the current study.

Chapter 15 Discussion and Concluding Comments

Introduction and contribution to knowledge

While a number of Irish studies have been conducted in the past on the ‘work world’ of child protection and welfare services (Ferguson and O’Reilly, 2001; Buckley, 2003; Kemp, 2008; Mc Gregor, 2014b; O’Connell, 2014) reporting trends have not been interrogated in any depth. Without adequate ‘intelligence’ the operation of the system will not only lack a sound empirical basis, but might also be vulnerable to political whims and unintended consequences when reforms are introduced. This point was made by Buckley (2012) who went on to highlight the inadequacy of available statistical data on the nature of harms experienced by children and the specific responses made to families and reporters. The current study has endeavoured to address that gap and elucidate the operation of the system at a micro level. It provides detailed information and, in doing so, demonstrates how far reforms in Ireland have synchronised with the current international models of service delivery. It also questions whether the system is fit for purpose, that is, whether it is able to provide the most appropriate responses to the safety and welfare needs of the children and families it was established to serve. By examining the total *intake* of reports in one administrative area over a three month period, this current study has produced comprehensive statistical data, for the first time, on child protection and welfare reporting in Ireland. This includes the nature of concerns reported, the source of reports and professional identity of reporters, the initial outcomes following reporting and a number of associated links that have emerged from the analysis. In addition to an analysis of intake records, the views of practitioners and managers, ascertained in interviews, have provided an insight into the nuances and complexities that underpin professional decision making at the Front Door of Irish child protection and welfare services. The central aim of the current study was to examine the way by which reports to Irish child protection and welfare services are initiated and processed at the Front Door and to do so, six key research questions were posed:

1. What were the difficulties being experienced by the children and families reported?
2. Who was making the reports and what difficulties were they reporting?
3. What was the outcome of the reports at the end of the preliminary enquiry stage and what criteria were used to decide on categorisation and final outcome of cases?
4. Was there a relationship between the type or origin of reports and later decisions made in respect of the report?
5. What was the rate of re-referral and what were the difficulties being experienced by the children and families re-referred?

6. Was the new level of policy and standardisation helpful to practitioners at the Front Door and what impact did it have on the processing of reports?

This final chapter will contextualise the findings of the current study within the existing research and demonstrate how this thesis has augmented the existing knowledge base. It will draw out and present the implications of the study findings in relation to two interlinked domains. The first one is the front door itself, and whether it can be transformed into a receptive and efficient entry point to services rather than a filtering process where eligibility is determined more by expediency than presenting need, the second is more philosophical and considers the nature of the child protection and welfare system as a whole, reflecting on its purpose and function with reference to both the findings of this study and international research.

Revisiting the methodology

The current study provides a ‘snap shot’ (Thomas, 2011) of the type of difficulties reported and outcomes decided upon in one statutory child protection and welfare administrative area during one quarter of 2015. A case-study research design was used comprising both quantitative and qualitative methodologies. The generalisability of a case study is debated in the literature, however, it is suggested that its reputed subjectivity is construed as an exemplar and a means to better understand social phenomenon (Flyberg, 2006). It is further postulated that the focus on the narrative, which often characterises case study design, be seen as a strength which adds weight to its processes and conclusions (Thomas, 2010). Bearing in mind the limitations to the generalizability of the findings, outlined in Chapter 6, the current study helps to form a picture of the difficulties that bring children and families into contact with child protection services, as well as the type of response they receive, and provides important new insights into this area of interest.

The study employed a mixed method design to answer the six research question posed comprising both quantitative and qualitative data gathering and analysis. Using the typology of mixed methods, afforded by Teater et al. (2017), the current study was considered an explanatory mixed methods design whereby the qualitative interviewing of practitioners, and indeed the qualitative data recorded on the intake record forms, were used to add depth to the findings of the quantitative data. The design was also characterised as ‘emergent’ (Creswell and Plano-Clark, 2011), as the analysis of the quantitative data gathered from the intake record forms was used to shape the later qualitative interviews.

Univariate and bi-variate analysis of the quantitative data gathered was carried out and a series of crosstabulations were used to explore the relationships between key variables. Chi-square analysis was completed to ascertain whether the relationships between variables were statistically significant.

Particular attention was given to the reporting of such instances in the write up and in the discussion of findings.

The Irish child protection system and the current policy and legislative context

As earlier chapters have demonstrated, most modern Anglophone child protection systems operate somewhere on a continuum between a child protection and a welfarist orientation (Gilbert, 1997; Spratt, 2001; Gilbert, 2012). The literature has also highlighted the way in which some jurisdictions have begun to broaden their orientation to incorporate children's rights and child development approaches (Gilbert, 2012). The Irish child protection system never adopted a 'strong or polarised orientation' (Buckley and Burns, 2015: p.278) but, as some commentators have put it, is influenced by three core and inter-related discourses: the need to purge past shame; the need to address systemic failures and the need to incorporate a child-centred and children's rights orientation (Mc Gregor, 2014).

The evolution of the Irish child protection system has deep historical roots which must be considered to understand the 'history of the present' (Mc Gregor and Quin, 2015). The Irish state was slow, by international comparison, to assume a role in the provision of social services, not least because of the 'constitutional and ideological reverence for the family' (Buckley, 2003: p.10) and reluctance to interfere within that unit. Echoes of this 'reverence', as will be discussed below, are still evident today in the current system and in recent discourse emerging from Tusla, the statutory service, which emphasises the need for families 'to own' their difficulties.

A series of high profile child abuse scandals in the 1990's wrought significant changes to the Irish system and, in line with other child protection systems in the Anglophone world, concern about risk led to increased bureaucratisation and proceduralisation. Irish services have recently tried to foster a welfarist approach, at least in principle, by focusing on the promotion of family support and early intervention, in the development of the new Child and Family Agency, Tusla. Added to this, the Irish system has adopted a children's rights approach with notable advances in legislative and policy change. However, the aspiration to embed a child and family centred needs based approach, evidenced in the Agency's new service delivery framework, is threatened by an enduring aversion to risk, illustrated by an increasingly mechanised system and the impending introduction of mandatory reporting for key professionals.

There are calls within the international literature for a new paradigm to underpin the provision of child protection services, one which should focus on advocacy, alleviating poverty and developing family and community strengths. Advocates also seek a greater focus on children's rights beyond the protection of children from adult perpetrators. The prevalence of the predominant discourse, which

includes investigating large numbers of ultimately unfounded reports (Bywaters, 2015), registering increasing numbers of children (Bilson and Martin, 2016) and taking children into long term care (Gilbert, 2012; Bilson and Martin, 2016) has been challenged, due to lack of evidence that it is preventing further harm. However, recent empirical research in the UK has confirmed that this forensic paradigm remains very robust (Hood et al., 2016) and that it is diverting needed funding from early intervention and the alleviation of the poverty and deprivation that families are struggling with on a daily basis. This current study indicates a similar pattern in Ireland, where a high proportion of the reports received are referred forward for initial assessment and further investigation with little apparent consideration being given to the poverty and deprivation that the reported children and families may face. The review of national administrative data also illustrates a high degree of filtering, with high proportions of reported cases discarded from the system after initial assessment. For example, national administrative data for 2015 provides some limited information on the outcome of cases after an initial assessment is carried out (Tusla, 2015e) and highlights the significant proportions that were closed with no further action: 65% of all ‘child welfare’ referrals and 52% of all ‘child protection’ referrals. This is indicative of a very high attrition rate and resonates with Bywater’s (2015) observation that substantial proportions of cases are subject to an unnecessarily investigative approach which could perhaps have been closed at the preliminary enquiry stage. This raises the matter of whether filtering at the Front Door should operate along a different set of considerations, a key question which the current study has sought to address.

The unintended consequences of bureaucratisation

As research and theory reviewed in earlier chapters have demonstrated, effective social work practice is predicated on a good ‘helping relationship’, the achievement of which is often obstructed by the neo-liberal preoccupation with risk and resultant bureaucratisation (Howe, 1992; Munro, 2011; Buckley, 2012). Added to this, commentators have highlighted the misfit between the techno-bureaucratic language of heavily proceduralised systems and the unwieldy and unpredictable nature of child protection social work (Buckley, 2012; Featherstone et al., 2012). Research carried out on the Integrated Children’s Services project in England has shown that technology based information systems do not necessarily enhance social work practice or make the associated tasks any easier (White et al., 2010). Instead, it is argued that such systems can lead to the prioritisation of risk over improvements to practice (Featherstone et al., 2012). Nevertheless, albeit somewhat more slowly than most other Anglophone countries and despite exhortations to learn from mistakes made in the English system, the current study illustrates how heavily proceduralised Irish services have become. In their current form ‘standard business processes’ and performance indicators are core drivers of practice and the return of monthly administrative data is used to measure the efficiency, if not the

effectiveness, of service provision. As previously outlined, each phase of a case career is characterised by time frames and tasks to be carried out. A pending national information system will add another level of administration to each stage and force practitioners into more standardised practices. Ironically, the current study has demonstrated how practitioners have subtly adapted some of the standard processes by creating localised norms on the basis of their practice wisdom.

Systems which are highly proceduralised rely on an assumption that child maltreatment is easy to detect and address and that failure to do so is the fault of the individual worker (Buckley, 2008). Wider contextual concerns and complex, multifaceted difficulties, which cannot be easily classified by the system, are more often ignored and more readily disposed of in favour of those that can. The Irish child protection system is premised on professionals and others reporting children and families to the Front Door, reports being quickly assessed and processed and the children most in need put forward for further assessment and intervention. As such, and as the current study has shown, the system easily deals with straightforward allegations of identifiable abuse and this was evidenced in Oaktown by the high proportions of 'abuse' cases that went forward for initial assessment. However, cases categorised as 'welfare', which by their nature are less straightforward and take more time and information to properly assess, were the category most likely to be screened out of the system. Yet, some of the reports in this category described situations where children and young people's safety and welfare were significantly compromised even if they did not fit within orthodox criteria for further action.

The imposition of a time limit, developed to avoid the risk of cases drifting in the system, dictates that reports received must be categorised and disposed of in 24 hours. Yet, as the analysis of quantitative data in the current study has demonstrated, this goal is largely unachievable. Less than half (49%) of decisions were reported to have been made within the 24 hour time frame. Time constraints forced practitioners to make a decision, but the appropriateness of some of the outcomes and the impact of pressure on individuals' capacity to process and reflect on information was queried by practitioners and managers who were interviewed. This provided another example of where a local solution evolved to deal with a bureaucratic dictate. For example, if an outcome could not be decided upon within three days then that case was put forward for an initial assessment, not because it necessarily needed an initial assessment but to move it out of the preliminary enquiry stage. This is a clear example of how the drive to mechanise and proceduralise social work processes may be counter-productive as the work has to be tailored to respond to technical requirements rather than the presenting need, a point also made by White et al. (2010).

A further example of the mechanisation of the intake process is the requirement for reports to use a particular standard form. The intention behind this was to facilitate the provision of good quality information on which to base referrals, recognised as an important factor in the literature (DHSSPS,

2008; Kirkman and Melrose, 2014; Platt and Turney, 2014; Saltiel, 2016). However, findings from the current study revealed that the standard reporting form was only used in 9% of the reports received, implying that its utility was limited and that it imposed constraints on referrers.

As previously outlined, the current aim of child protection and welfare services in Ireland is to have one point of entry, the Front Door, for referrals in each of the 17 administrative areas. The rationale behind this objective is the provision of one obvious point of contact for potential referrers. At an agency level, this arrangement was intended to improve consistency of response, particularly in the application of thresholds. The Front Door, however, is not a literal Front Door, but rather a metaphorical one. While the newer arrangement might be appropriate for professional reporters, it is less accommodating for families and members of the public who, as revealed in the current study, made the largest proportion of reports. While *Children First* states that ‘(a) report can be made in person, by telephone or in writing’ (3.4.1), child protection services have moved away from the provision of a clinic type, drop in service where reporters could previously have had face-to-face contact with a social worker. In Oaktown, if families or children presented at the SWD, they could meet a social worker, however, there was no official option available in this regard and it was not encouraged. The modern day manifestation of one ‘Front Door’ is one phone or fax number or one postal or email address for people to use. This study showed how only a tiny proportion of the reports received (3%) were made in person and of those the majority were made by family members.

It could be inferred that the nature of the referral pathway deters help-seeking from the children and families most in need of it. Research has shown that families who self-refer are less apprehensive (Spratt and Callan, 2004; Buckley et al., 2008) and more willing to engage (Buckley, 2003; Spratt and Callan, 2004; Buckley et al., 2008), which can lead to better outcomes for their children (Saint-Jacques et al., 2006; Jackson, 2016). Likewise, when children self-refer, they are easier to engage and assist (Wattam, 2002). Only five children initiated contact in the current study, replicating other research which indicates a low rate of self-referral among children generally (Wattam, 2002; Schreiber et al., 2013).

Notwithstanding the restrictions imposed at the Front Door, the current study demonstrates a high demand from families for assistance with aspects of their children’s lives. Yet, the design of the current system is more suited to eliciting reports from professional rather than family or community sources. It appears, therefore, that streamlining of services has had the paradoxical effect of discouraging contact by those who need it most.

Reporting trends

Administrative data and commentary on child protection reporting in most Anglophone countries shows that, with some limited exceptions, reporting levels are continuing to increase and the same is true for Ireland. However, unease is expressed in the literature with regard to the amount of child maltreatment that goes unreported (Webster, 2005; Finklehor, 2017). Child death and serious case reviews consistently identify failures to report (Department for Education, 2014), commentators note that levels of substantiated cases of child abuse measure only a small proportion of the actual level of abuse (Drake et al., 2003; Gilbert et al., 2012; Jedwab, 2017) and the limited number of prevalence studies that have been carried out indicate a much higher level of child maltreatment than is ever reported (Mc Gee et al., 2002; Gilbert et al. 2009; Radford et al., 2011; Parton, 2014a). For example, the current study found that ‘exposure to domestic violence and parental conflict’ was reported for one in seven children in the sample and that ‘domestic violence’ was reported for one in seven families. However, as previously mentioned, recently available statistics showed that in 2012 while one in three Irish women have experienced some form of psychological violence and one in four report some form of physical or sexual violence (FRA European Agency for Fundamental Rights, 2014), 79% of women victims have never reported a serious sexual or physical assault perpetrated by their partner or a non-partner to anyone (Safe Ireland, 2016). Findings from that study therefore serve to further highlight the underreporting of such difficulties in Ireland. Presently, the rate of referral to Irish child protection and welfare services in relation to the child population is below that of other jurisdictions, for example England, Wales and Northern Ireland. This may change when the planned introduction of mandatory reporting is realised in Ireland, however, whether these increases will contribute to the better detection of maltreated children remains to be seen.

Reasons for the reluctance of professionals to report child maltreatment have been identified in the literature and need to be addressed in order to ensure that vulnerable children get the services they require (Bunting et al., 2010; Gilbert, 2012; R. Buckley, 2013; Buckley and Buckley, 2015). The lack of evidence to support suspicions, tightly framed abuse definitions, concern about causing damage to their client-worker relationship and a lack of faith in the child protection system to adequately respond have all been identified as barriers. While awareness and training will partially address these (Bunting et al., 2010) self-doubt and the personal challenges experienced by practitioners also need to be tackled (Buckley and Buckley, 2015).

Key reporters to Irish child protection services

Administrative data from Ireland and internationally show that the most frequent reporters to child protection systems are police, the education sector, health and social services and friends and families. All of these groups, as well as many others, were represented in the current study, with

schools and family members revealed to be the two largest groups of reporters. However, interviewees were concerned about underreporting, in particular by schools and also by GPs, health staff and professionals who have regular contact with adults whose difficulties may be impacting on their ability to adequately care for their children. Their anxiety about underreporting by GPs and health staff was confirmed by the low level of reports made by these two sources in the current study.

Significantly, the current study revealed a particular trend with regard to reporting by schools in the sample. Patterns of association were found between reports received from schools and ‘physical abuse’, ‘behavioural problems’, ‘emotional problems’ and evident parenting deficits, manifested by children’s neglected appearances or an unwillingness or inability of the parent to meet the child’s needs. Also of note was the low number of reports received from schools regarding domestic violence as an issue in families, a fact which also troubled the practitioners interviewed. While schools are generally acknowledged to be a vital source of reports, empirical research has highlighted the paradox that they are ‘both the largest reporting source and the largest underreporting source’ (Crenshaw, 1995: p.1095). In particular research has highlighted, consistent with the findings in the current study, that teachers are more likely to report difficulties which are easily identifiable, for example physical abuse (Walsh et al., 2006; Jonson-Reid et al., 2007; King and Scott, 2014) and those which affect children’s school performance, such as behaviour problems, rather than difficulties which relate more to family functioning. This is an important finding given the particular role of teachers as the first line of defence for children who may be experiencing maltreatment.

There was a notable pattern evident in reports made by family members, which concerned the ‘impact of parental substance abuse’ on children and ‘significant relationship difficulties’ between children and their parents. When all reports by non-professionals were considered together, patterns of association emerged for the issues listed above as well as ‘neglect’ and ‘emotional / verbal abuse by parent’. The reporting of these issues resonates with Giovannoni’s (1995) research from over twenty years ago which indicated that neighbours and non-mandated referrers tend to reflect difficulties which are visible ‘through the window’ and thus, unlike the education sector, identify matters that relate much more to family functioning. Overall, these findings with regard to the disparate difficulties reported by schools and family members reflect Mc Daniel’s (2006) assertions that non-professionals are privy to different aspects of people’s lives and therefore report different issues. Yet, as demonstrated in the current study, the system privileges reporting made by professionals in the design of intake systems.

Research shows that families often approach their contact with child protection services with apprehension, trepidation and negative stereotypical views of social workers. Such feelings, borne out of the perception that the child protection system is very powerful, can be alleviated by the provision of accessible and approachable services. As Buckley (2017) has highlighted, however, with

the system in its current form, the drive towards streamlining the service, the attendant time pressures and the lack of face-to-face contact can mean that engaging with families in a meaningful way at the initial stage is not achievable. Findings from empirical research have also drawn attention to the fact that increased proceduralisation and high thresholds can mean that families who self-refer are actually less likely to receive a service (Buckley et al., 2008). This reliance on the presence of a 'protective parent' as a reason not to provide a service to a child or family is a finding which recurred throughout the current study and will be discussed in more detail presently.

Reporters and outcome

Empirical research has established a link between the source of a report and its eventual outcome (Drake, 1995; Mc Daniel, 2006; Manion and Renwick, 2008; King and Scott, 2014). The current study has provided an example of this trend in relation to referrals from domestic violence services, which were shown as liable to an outcome of 'no further action'. Significantly, an overview of the two data sources revealed a dissonance between the actions of practitioners and the concern that they verbalised at interview about the impact of domestic violence on children. Interviewees acknowledged their anxiety about an over reliance on a 'protective parent', usually a mother, to keep their children safe and the lack of follow up to ascertain if she had been able to do so. They identified a conflict between official policy, according to which a family's involvement with domestic violence services often precluded involvement by the social work department, and their professional view that children are harmed by exposure to domestic violence. To accommodate this they had adopted a localised norm whereby three referrals of domestic violence led to the re-categorisation of the case to emotional abuse.

The misfit between the difficulties reported and the response made by the system

The 'exposure of children to domestic violence and parental conflict' and a 'lack of parenting skills' were the most frequently reported difficulties and were most frequently recorded as primary concerns. 'Lack of parenting skills', as recorded, included an inability or unwillingness to meet the child's needs and was frequently reported alongside other difficulties being experienced by the parent, the most common of which was parental substance misuse. Children were also frequently reported for 'physical abuse', 'behavioural problems' and the 'impact of parental substance abuse'. As well as a 'lack of parenting skills', parents and families were often reported for relationship difficulties, the 'misuse of drugs and alcohol' and 'domestic violence'. Some particular findings emerged with regard to the age and gender of the children reported. For example, older boys were found to be more likely to experience 'behavioural problems' and while older children experienced

certain difficulties with more frequency, younger children were most impacted by parental substance misuse.

Practitioners acknowledged that reports regarding custody and access, domestic violence and children's mental health can be re-referred numerous times before a response is made. In keeping with the views of the practitioners, the level of reports for relationship difficulties (which included custody and access disputes) and 'mental health need' amongst those re-referred, while not found to be statistically significant, accounted for some of the largest proportions of re-referral in the sample. Domestic violence was also a commonly cited as a reason for re-referrals, a trend previously identified in other studies (DePanalis and Zuravin, 1999b; Jebwab et al., 2017).

The analysis of the quantitative data showed significant patterns of association between certain issues, many of which are acknowledged to be complex and difficult to discern. For example, 'neglect' and 'difficult child / parent relationships' featured highly amongst those re-referred. Neglect is known to be complex to identify and address (Walsh et al., 2006; Department for Education, 2014; Buckley and Buckley, 2015) and as a result may be subject to frequent re-reports as referrers find more evidence to affirm their concerns (DePanfilis and Zuravin, 1999a; Connell et al., 2007; Manion and Renwick, 2008; Heile et al., 2013; Fuller and Nieto, 2014; Eastman et al., 2016; Jedwab et al., 2017). The point at which parent-child relationship difficulties reach the eligibility threshold for services is also difficult to discern (Manion and Renwick, 2008) and can be difficult to assess and address, thereby resulting in numerous referrals to child protection services. Indeed, a large proportion of parents who were struggling to manage their children's behaviour were already known to Oaktown (80%) and 'behavioural problems' was the child issue which featured most frequently amongst those who were re-reported within a year.

A significant association was revealed in the current study between previous knowledge of a child and the outcome of a report about them, showing that if a child was known an initial assessment was more likely to be conducted. As mentioned above, practitioners in Oaktown had developed a localised response or 'rule of thumb' (Kirkman and Melrose, 2014) whereby if a referral about domestic violence was received three times, it would be re-categorised as emotional abuse. As also mentioned above, the same norms were applied to multiple reports on families, whereby an outcome of NFA was less likely on the third referral.

The overall profile which emerged from these findings on referral and re-referral were difficulties which mainly related to parental capacity and family functioning rather than clearly defined or 'typical' abuse situations amenable to the straightforward classification of a child protection concern that the system can accommodate. Rather, as previously highlighted by Benbenishty et al. (2003), decisions regarding these reported difficulties necessitate case by case deliberations. Yet, as Munro (2005a) has pointed out, reflective decision making is compromised by time constraints and limited

information. As one practitioner pointed out ‘it is very hard to find neglect based on three lines from a PHN’ (IP5). Overall, findings from the current study highlight a discernible dissonance between what the intake system can efficiently process and the sort of assistance required by the majority of families and those reporting on their behalf. The picture which emerges is one of numerous families requiring help with child rearing, interpersonal difficulties and managing children’s behaviour, sometimes complicated by substance misuse. Practitioners who were interviewed confirmed what the numerical data was indicating, that when reports concerning many of these families failed to meet the criteria for further action by a social work department, they were reported again and again, presumably in anticipation that services could ultimately help them.

Decision making

The core task of an intake social worker is to determine the disposal of reports. This process is portrayed in the literature as comprising difficult, complex and challenging decisions, which must often be made within a context of high demand and heavy workloads, limited resources, limited time, poor supervision and a lack of or conflicting information and many of these conditions were described by the interviewees as they discussed the intake system in Oaktown. Of central importance is the manner in which the information that has been gleaned is then interpreted (Munro, 2005b). In the current study concern was expressed by interviewees about the tendency of intake social workers to be very ‘content driven’ at the preliminary enquiry stage and to focus more on information gathering than the critical task of interpretation.

In response to pressure for greater accountability, many Anglophone countries have developed and implemented the use of standardised decision making tools and instruments in an effort to rationalise the processes of interpretation and decision making. As outlined in the literature review, research and evaluation have challenged the utility of such tools, for example finding them too linear and static to effectively assess and intervene in the dynamic and evolving difficulties associated with child maltreatment (Gillingham and Humphreys, 2010). To date, the Irish child protection system has not adopted any standard decision making tool but instead has produced a suite of guidance documents and checklists to assist intake social workers with decision making. Qualitative findings from the current study, both from interview and the intake record form data, have demonstrated that guidance from national policy documents or guidelines relating to assessment or thresholds were in fact rarely utilised. It also became evident that some decisions on both the categorisation and disposal of reports related less to the characteristics of a particular case and more to ‘localised practice norms’, a theme already noted in other research (Pithouse, 1997; Spratt, 2000; Buckley, 2003; Broadhurst et al., 2010), or ‘local eligibility criteria’ (Broadhurst et al., 2010), which at times were mediated through the availability of local services (Platt and Turney, 2014). For example, interviewees

reflected on how the thresholds they applied to the decisions made were heavily influenced by the availability of resources. An example of the use of 'localised practice norms', as mentioned above, was the decision to carry out an initial assessment when a decision could not be made within three days or when three referrals were received about the same child. These were most evident in cases that did not readily fit with 'the relatively straightforward framework outlined in the child protection guidelines' (Buckley, 2003: p.90). The use of localised norms often guided practitioners to what appeared to be appropriate decisions, particularly where children seemed to be at serious risk, but the less clear cut cases were more vulnerable to exclusion associated with the lack of resources.

There were also examples of 'sense making' practices used which were highlighted in the 'factors' which were commonly referenced in the decisions made and will be discussed further below. These were characterised by a specificity of deliberations and narrow definitions of child maltreatment.

Outcome and decision making

In the current study, the outcome of the preliminary enquiry stage was examined in terms of the classification and the ultimate disposal of the report. In Oaktown, the proportion of reports classified as 'welfare' during the study period was well over four-fifths of the total received (86%) which, it could be hypothesised, is consistent with the nature of the difficulties reported. In terms of the disposal of reports 62% were put forward for an initial assessment and 37% were closed with no further action.

A detailed examination of the outcome of each difficulty reported revealed that cases categorised as 'welfare' were the least likely to proceed to initial assessment with 42% of these cases having an outcome of NFA, which was a statistically significant finding. Conversely, very high proportions of the cases categorised as abuse were put forward for an initial assessment.

In terms of the particular issues reported for children and families in the sample, there were some discernible patterns in relation to the early processing of reports. A significant link was found between reported 'homelessness' and 'teenage pregnancy and parenting' and an outcome of 'no further action'. Detail on the referral forms showed that the former was not considered to be within the remit of child protection services and the latter was seen as more appropriate for child health services and referred on accordingly. Both the qualitative and quantitative data demonstrated a further link between family relationship difficulties and early closure, particularly in respect of custody and access issues which were normally referred to legal services. Other visible trends within the qualitative data included the routine onward referral of child mental health and closure of adult mental health referrals without consideration of the needs of the children in the family. Difficulties which were found to be significantly related to an outcome of initial assessment, as well as cases

categorised as abuse, were the ‘impact of parental substance abuse’ and parental ‘misuse of drugs and alcohol’.

As alluded to above, a range of factors were taken into consideration in the decision made by an ISW regarding the disposal of a case. These factors were characterised in this research as ‘sense making strategies’ which were also embedded within ‘localised practice norms’ and appeared to be based more on common sense reasoning than the sort of technical evaluation implied in official guidance. For example, a correlation was evident in the qualitative data between multiple sources of information and a decision to put a case forward for an initial assessment, a link also previously highlighted in a study by Platt (2006). The persuasiveness of reporters in their detailing of the child and family’s needs was also identified as a trigger for further assessment, replicating an earlier finding by Buckley (2003). A common rationale for ‘no further action’ was the conclusion that the concerns reported failed to ‘meet the threshold for assessment’. It was also apparent that reports that were considered vague, lacking in detail, malicious or those that could not be ‘grounded’ with key informants were routinely closed with no further information sought. Such gatekeeping practices were previously identified in other empirical research on intake systems (Buckley, 2003). As highlighted above, with regard to domestic violence cases, the involvement of another service was also used as a reason to close cases, which has been described in the literature as a strategy for keeping the workload manageable (Platt and Turney, 2014). A further identified reason for case closure was the presence of a ‘protective parent’. This was exemplified in earlier chapters where a parent was relied upon to seek appropriate care for their child’s mental health needs or behavioural difficulties. The reliance on the ‘protective parent’ in the decision made about the disposal of a case was considered reflective of an emerging rhetoric from Tusla about the need for parents ‘to own’ their difficulties and also of the delineation by intake workers of the boundary between state intervention and family autonomy, an ideology which has deep roots in the foundation of the Irish state (Ferguson and O’Reilly, 2001). Practitioners, however, expressed unease about an over-reliance on a ‘protective parent’ without any follow up to ascertain whether they had followed through on commitments made.

The portrayal of decision making strategies used by the practitioners in Oaktown outlined by this research is unsurprising, given the findings from other empirical research, about the very particular setting of an intake system and the inherent pressures outlined above. Paradoxically, while interviewees repeatedly discussed the need for consistency of responses, the decision making strategies they employed mitigated against this. At a broader level, inconsistency was in fact reflected in all of the 17 administrative areas of Tusla, both in terms of the categorisation and ultimate disposal of a case, where very few were any way representative of the national average, itself a somewhat mythical statistic.

Outcome, a subjective endeavour

National administrative figures, published monthly and quarterly by Tusla, provide an insight into the mean trends of child protection and welfare reporting across the country. The most notable change over recent years has been to the proportion of those reports that are classified as ‘protection’, requiring a robust response, and the numbers classified as ‘welfare’, requiring a different type of approach. Up to three years ago the breakdown between ‘welfare’ and ‘protection’ referrals remained fairly constant, with just over half relating to ‘welfare’ and just under half relating to ‘protection’. The last three years, however, have seen this gap widening with figures for 2016 revealing that a substantial majority of the referrals (60%) were ‘welfare’. As already mentioned in Oaktown the difference was even more pronounced with 86% of the referrals received categorised as ‘welfare’.

The task of categorising a case as ‘welfare’ or ‘protection’ is reputed to be a very subjective endeavour (Spratt, 2001; Hayes, 2006; Hayes and Spratt, 2009; Hayes and Spratt, 2014) and empirical research with social work practitioners has clearly evidenced this (Hayes and Spratt, 2014). As this and other studies have shown, there is a degree of ambivalence attached to the label of ‘child welfare’. Child death reviews have shown how a categorisation of ‘child welfare’ is applied even when risks are apparent (National Review Panel, 2014) and ultimately as Hayes and Spratt (2009) argue, while it may imply ‘child protection light’ it is still forensic in orientation.

Interviewees in the current study discussed how at times they used a ‘child welfare’ categorisation as a ‘holding category’ (Hayes and Spratt, 2014) until a more thorough assessment could be carried out. Another reason postulated was reluctance to apply the more stigmatising label of ‘child protection’ unless there was a clear case to do so. Interviewees also spoke of ‘gate keeping practices’ (Buckley, 2003) whereby colleagues attempted to protect each other in pressured circumstances by diverting cases elsewhere. What is apparent from these reasons is that categorising a case is, as Hayes and Spratt (2014) have pointed out, a very subjective and localised task.

International administrative data and research has shown the emergence of a trend whereby reports of physical and sexual abuse are decreasing while neglect and emotional abuse are increasing (Gilbert et al., 2011; Hart and Glaser 2011; Trocmé et al., 2014; Bilson et al., 2016; Finkelhor, 2017). Irish national administrative data demonstrates a mixed picture, although particularly notable is a doubling of the number of emotional abuse reports from 2015 to 2016. There is agreement amongst commentators (Trocmé et al., 2014; Gilbert et al., 2012; Humphreys, 2008) that the increase in emotional abuse reports is largely due to the expansion of categories of child maltreatment to include exposure of children to intimate partner violence, concern amongst reporters about the risk of future maltreatment and increased awareness about the emotional and cognitive impact of child maltreatment. Additionally, as the current study has shown, localised practice norms and sense

making strategies, evolved through conversation and discussion at area level, result in ‘shifting’ thresholds as pressure rises and different services become available.

The principal function of the preliminary enquiry stage is to filter out inappropriate cases and identify those requiring further action. Reflecting on data for their local area, interviewees reached a consensus that too many cases were being put forward for an initial assessment, placing unnecessary stress on families who will ultimately receive no service and expending time and effort on what Hood et al. (2016) have described as ‘navigating thresholds and boundaries’. Similar concerns were reflected in much earlier empirical research carried out by Gibbons et al. (1995) and yet they continue to endure today (Bilson et al. 2015; Bilson and Martin, 2016; Hood et al., 2016).

When invited to discuss the rationale applied to deciding on the disposal of a case, interviewees commented on the dilemmas involved in deciding how much information to gather and how to know when enough has been gathered. The related issues of which persons to contact and the degree of information sharing that is permissible under data protection laws were also revealed as key influences on how far to probe. The majority view amongst interviewees was that more checking at an early stage would result in more effective filtering. This contention was upheld by the quantitative data analysis which revealed a positive relationship between extensive checking and an outcome of no further action, as well as the converse. The benefit of extensive checking was also supported in a recent internal audit carried out on Irish child protection and welfare services which asserted that there is a ‘strong case to be made’ for more extensive information gathering to be carried out in advance of an initial assessment (Tusla, 2015f: p.14). However, as the current study indicates, the requirements of the administrative system to expedite the processing of reports poses a challenge to this goal. A question could also be raised about the purpose or utility of a system where the priority is to eliminate as many requests for services as possible, and this will be considered in the concluding section.

Conclusion

This study has demonstrated how child protection services in Ireland are streamlined and standardised in a manner that has satisfied the need of the system to report on its own activities in a way that shows transparency and accountability. It has also shown that the standard business processes employed by the system are capable of providing an appropriate and efficient response to children who are at current or potential risk of harm. However, to use a term coined by Hood et al. (2016), the current study has, overall, shown that the system is ‘managing rather than meeting’ the needs of those reported to it. Many important implications emerge from the current study and two key questions may be asked. Firstly, should there be a Front Door or what might replace it? That is, should there be public and state recognition of the limited remit of statutory child protection services,

paving the way for the establishment of alternatives? Secondly, how can the services provided at the Front Door be improved? For example, should the statutory service adapt its skill mix and available resources to enable itself to better meet those presenting with ‘child welfare’ needs and prevent further escalation.

It is Higgins’ (2015) contention that within contemporary writing and debate on child protection social work old debates on laissez faire and paternalism of the welfare state have given way to debates regarding the ‘narrow conception of social work and (the need for) a broader, more encompassing model’ (p.9). Concerns about the manifestation of this ‘narrower’ version of contemporary statutory social work have been outlined throughout this thesis and include: the narrowing of child protection work to a focus on protection from abuse rather than prevention of abuse (Featherstone et al, 2014); the dereliction of the client-worker relationship and the importance of social work as a both a human and a humane service (Featherstone et al, 2014); the over proceduralisation and bureaucratisation of child protection work and, within this, an over emphasis on doing the thing right rather than doing the right thing (Kemp, 2008).

Parton (2014b) writing on the provision of social services in England observes ‘social work has been reduced to a very narrow forensic concern with child protection’ (p.2043). As previously outlined there are many calls within the literature for a new paradigm to underpin social work which should give greater attention to structural factors and community cohesion, promote early intervention and prevention and focus more on children’s rights. It is Parton’s (2014b) contention that the current narrow approach promotes a very individualised child protection system and operates as an obstacle to social work developing more progressive ways to tackle the ‘social problem of child maltreatment’ (p.2053) by addressing wider social and economic forces. In a similar vein, Featherstone et al (2016) suggest a social model for social work (drawing on lessons from the fields of disability and mental health) which recognises that ‘structural inequalities, including poverty, sexism and racism, impact in interrelated ways on people’s lives’ (p.13).

This thesis has sought to provide an insight into the evolution of statutory social work in Ireland and for the first time provides empirical evidence on the operation of child protection and welfare services within the current policy and legislative context. It has shown that the emphasis on the prevention of abuse remains the principal focus at the Front Door and that, within the decisions reached, little or no consideration is given to the structural context in which families and children are living nor the impact of poverty and deprivation on the difficulties faced. Yet, as has been highlighted in this thesis, reports of neglect and emotional abuse now greatly outnumber those of physical and sexual abuse in most Anglophone countries and addressing such reports require a response rooted in early intervention and prevention and one which attempts to tackle structural issues such as poverty and deprivation.

At a policy and legislative level it is suggested within the literature that a more developmental or public health approach to the provision of social work services is required (Lonne et al., 2009; Gilbert et al., 2011; Parton, 2014a; Featherstone et al., 2014; Higgins, 2015; Bilson and Martin, 2016). Such an approach would situate the protection and welfare needs of children within a wider developmental context and widen the notion of child abuse by ‘integrating abuse into the mainstream of the health or well-being of the nation’ (Higgins, 2015: p.12). A need for the sharing of what Buckley (2003) has termed “‘the dirty work’ of child protection with other professionals’ (p.90).

A number of suggestions are made within the literature as to how the delivery of such services could be actualised. For example, Cooper et al (2003) have suggested a model of more systemic service delivery based in schools, health centres and communities, the notion that instead of child protection systems expanding to meet all identified needs in both a preventive and protective manner, schools and the voluntary sector would assume more responsibility in this regard. The importance of the education sector as protectors of children emerged in the current study, evidenced by the rate of reporting albeit of a narrow range of concerns; this makes the case for further investment in the capacity of the school system not only to identify but to respond to the needs of children on site. The same implications could be stated in respect of health services.

It is important to acknowledge that governments have not been deaf to calls to prioritise early intervention and some strides have been made in this regard, evident in the refocusing of child protection services in the UK and initiatives such as the differential response model (DRM). There has been more of a tangible commitment by the Irish government to early interventionist and preventative services in recent years actualised in the development of the new service delivery framework and new initiatives such as Meitheal. Strengthened links with the voluntary and community sector will undoubtedly lead to more attention being given to structural issues. However, the recent introduction of mandatory reporting and the expected increase in the numbers of children and families being reported may serve to divert attention and resources away from such initiatives going forward; only time will tell whether or not this will make a significant difference to service delivery. It is also evident from the current study that such initiatives are not sufficient in themselves and a large proportion of difficulties categorised as ‘welfare’ continue to present at the Front Door which ultimately are disposed of and do not receive a service. A study co-authored by the author and published a decade ago (Buckley, Whelan, Carr and Murphy 2008), highlighted the need for a separate agency to deal with family violence, including domestic violence and custody disputes, arguing that the statutory service lacked the capacity to deal with this issue. The need for such an arrangement is further illustrated by the current study, as is the need for a service to meet the emotional and behavioural difficulties of young people. The 2015 annual report of the National Review Panel, which examines child deaths in Ireland (National Review Panel, 2015), highlighted how the psychological problems of adolescents who had committed suicide had fallen into a vacuum

between child protection and mental health services and argued for government attention to be paid to this group of vulnerable young people and the provision of appropriate services that can be directly accessed by families.

Some commentators (Lonne and Gillespie, 2014; Lonne and Parton, 2014) attribute a role to media coverage in garnering public support for such a public health response. These authors highlight the vital role played by the media in drawing attention to the deficits in child protection systems, informing the public about child maltreatment and effecting change within the system. While there are drawbacks to this important role, namely the at times individualistic and reductionist portrayal of incidents which results in the role of structural and societal factors in child maltreatment being masked, it is suggested that greater attention to positive stories regarding successful interventions and more attention given to the voices of children and families could result in more public awareness and support for the need for early intervention and prevention strategies. Citing Richard Krugman Lonne, Parton (2014a) asserts ‘the Western world no longer needs enlightenment of child abuse as an issue but, rather, a focus on whether or not programs are effective’ (p.834).

As mentioned above a greater focus on children’s rights is seen as an important aspect of child protection services (Parton, 2014a) and Ireland has made meaningful strides in this regard both at a legislative and policy level. However, as this study has shown, children and young people are disempowered from self-referring to the service charged with looking after their needs for welfare and protection and the system has been shown to very much favour reports made by professionals. It does seem quite paradoxical that the service designed to meet the protection and welfare needs of children doesn’t appear to be accessible by them.

Ireland is operating a child protection system with many parallels to its counterparts within the Anglophone world. The current orthodoxy underlining these systems is being increasingly challenged however and the findings of this study support the view that while the need for a statutory child protection service remains there is a greater role to be played by society at large and other service providers in the protection of the nation’s children.

Findings from the current study, from the literature and administrative data reviewed show a system which is struggling to deal with the type and volume of reports it is receiving within a context of limited time frames, heavy workloads and inadequate resources. The current study was limited to the extent that it did not follow reports beyond the initial phases of processing. However, within that context, the findings indicate a number of changes which could be made to the Front Door to improve its effectiveness.

In terms of the operation of the Front Door the current study has unpacked official data to reveal in detail the nature of difficulties reported to the system and the main concerns experienced by families. It has shown a difference between two types of equally serious problems. Firstly, those identified by

professionals, which are noted through their interactions with children and relate to issues such as behaviour and appearance, and secondly the factors that families themselves struggle with, which are connected to the way they relate to each other and parent their children. The study has also identified a number of linkages between the referrers, the problems they identify and the outcomes for children and families. Importantly, as mentioned above, it has found that arrangements for reporting concerns about children privilege professionals over lay referrers, even though the latter group comprise the larger proportion of those seeking assistance. Both the Irish and the international research literature have highlighted the proportion of referrals that are screened out of the system and this study demonstrates that the reports most likely to be eliminated are those which concern family functioning, entrenched relationship difficulties, homelessness, mental health and children's behavioural problems. All of the above are recognised as complex, negatively and cumulatively impacting on children and not readily amenable to resolution in non-statutory settings, as evidenced by the rate at which most of them were re-referred. Many of these problems are brought to the intake system by families who are then advised to avail of services elsewhere as their issues are categorised as 'welfare' and do not meet eligibility for further action. Added to this a paradoxical norm is that families that are seen to be acting pro-actively in help seeking are considered protective and less likely to receive assistance. It cannot therefore be claimed that the goal of achieving consistency at the Front Door is met. However, the most significant and revealing finding of the current study is a misfit between many of the needs of children and families, particularly those concerned with relationships and parenting capacity, and the operations of the system in terms of how it receives, processes and ultimately disposes of requests for assistance.

At the level of the individual worker, the skill mix needs to be addressed and improved to offer a more effective response to the difficulties that are presenting. Practitioners at the Front Door need to know the right questions to ask and a greater awareness of the impact of certain issues on children in their decision making, in particular substance misuse, domestic violence and parental conflict and adult mental health. Issues relating to family conflict and domestic violence, for example, were identified as challenging by those interviewed both in terms of the response provided and the frequency with which they were subsequently re-referred. Staff operating the Front Door who may be more likely to define their work as being predominantly with children may experience a lack of confidence in their work with adults, particularly those involved in conflictual relationships (Buckley et al, 2011). Added to this, concern has repeatedly been expressed by commentators regarding the consequences of domestic violence being categorised as emotional abuse, a practice which was reported on in this study, and how this results in an inflation in the level of reporting leading services to be able to offer only a forensic type of screening (Friend et al, 2008; Connolly, 2009; Buckley et al, 2011). While ultimately it is suggested that a separate agency to deal with these difficulties would be the preferred option, in the meantime there is room for an acknowledgement of the need to identify

and address shortcomings in skills, in order to identify and address these difficulties effectively. There is an important stipulation to this and the development of any new approaches developed and that is ‘whatever approach is tried, it is crucially important that no paradigm dominates to the extent that the concerns affecting children and their carers fall through the net’ (Buckley et al, 2011: p.132).

This study has demonstrated that a sizeable proportion of reports cannot be readily processed through a highly mechanised operation in ways that effectively address the needs of families and children. It appears that streamlining of services has had the paradoxical effect of discouraging contact by those who need it most and begs the question of whether child protection services have evolved to a point where it has disenfranchised those it is intended to serve. Featherstone et al (2014) have written about the need for a reimagining of child protection work to the point where it becomes ‘infrastructure light and relationship heavy’ (p.155). A good trusting relationship between the client and the social worker has long been considered as a key component to a successful outcome yet the development of such a relationship is undermined by recent trends in the Irish child protection system. As highlighted by this research, the inherent pressures at the Front Door of increased reporting levels, restrictive time limits and the increasingly proceduralised system within which workers and service users must interact. As Buckley (2017) has pointed out ‘egalitarian and respectful relationships simply do not fit with current reporting regulations, standard business processes and other administrative requirements’ (p.85).

There are some modifications which could be made to the system which could go some way towards reversing this trend, for example an increase in the time allowed for the preliminary enquiry would give the intake social worker more time to consider the nature of the referral received. More clarity is also needed regarding checking with key informants. In the absence of clear national guidelines localised practices are developed, making the pursuit of a consistent streamlined service difficult to achieve. The intake record form needs to be re-developed and should record the ethnicity and socio-economic status of children and families reported. This would provide important information in understanding how these demographic characteristics interact with child protection and welfare needs. Good quality referral information is essential at the Front Door and having a user friendly referral process is an integral part of this. To this end the standard reporting form needs to be re-developed and the use of it by reporters better enforced. It is notable that in Tusla’s recently launched Child Protection and Welfare Strategy 2017-2022 (Tusla, 2017d) *Signs of Safety*, defined as ‘a strengths-based, safety-organised approach to child protection casework grounded in partnership and collaboration with children, families and their wider networks of support’ (p.2), is being implemented across the organisation as the new national approach to practice. This innovation will result in changes to the referral and preliminary enquiry stage and may address some of the suggested changes outlined above.

Considerations should also be given to better facilitating children and families to make reports at the Front Door, thereby enabling face to face contact with the intake worker at the point of making a referral. Children do not find child protection services accessible, this study showed how very few children self-refer and currently they are very rarely checked with during the preliminary enquiry stage. As previously outlined there are advantages to encouraging children (and families) to self-report and as the main focus of concern in child protection and welfare services their views should be sought at the earliest opportunity within the process.

Technology to accompany social work practice at the Front Door should be embraced, given its prominence and importance in the era in which we live, but as highlighted in an earlier chapter such systems must be incorporated meaningfully into everyday practice and in consultation with those who will operate them.

As this concluding chapter has shown the positive effect of repairing the locks and oiling the hinges of the Front Door will depend to a large degree on attention to the wider context. Consideration of the two domains of 'intelligence' highlighted in this thesis, insights into the day to day operation of the system and reflections on the elements of an effective child protection system, renders the potential to effect more constructive reforms more visible. A rights based, well integrated network of services at institutional and community levels right across the health, education, justice and welfare sectors is likely to have a dual effect of easing the pressure on the Front Door and facilitating a smooth passage through it.

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Appendix 1 Sample Intake Record Form

INTAKE RECORD TEMPLATE - CHILD WELFARE AND PROTECTION

SECTION A

1. Report	Date		Report No		Case No.	
2. Details of Child						
Name		Sex	M ☐ F ☐	D.o.B		Age (approx)
PPSN		Other ID				
Additional Information e.g. School/ Occupation/Other						
5. Reporter						
Name				Reporter's relationship to child		
Address				Telephone No's		
Reporter wishes to remain anonymous?	Y ☐ N ☐			Discussed concern with parents/guardians	Y ☐ N ☐	
Additional Information e.g. School/ Occupation/Other						
6. Parents Aware of Report						
Are the child's parents/carers aware that this concern is being reported to the HSE?					Y ☐ N ☐	
7. Details of Report						
8. Mode of Report						
Letter	☐	Fax	☐	Email	☐	In Person
Telephone	☐	Garda Notification	☐	SRF	☐	Other Please Specify
9. Source of Report						
Self	☐	GP	☐	Probation Service	☐	Courts S47/S20/Other
Parent/Guardian	☐	Garda Síochána	☐	Local Authority	☐	Foreign Nat. Service
Other Family member	☐	Voluntary Agency	☐	Government Agency	☐	Other Please Specify

Other HSE Officer	☐	School	☐	Anonymous	☐		
11. Details of Person Allegedly Causing Harm to Child <i>{Extra pages may be added}</i>							
Name			Sex	M ☐ F ☐	D.o.B		Age (approx)
Address				Relationship to child			
				Telephone			
Additional Information e.g. School/ Occupation/Other				Details of contact with child			
Details of any known contact with other children				Location of child			

SECTION B

12. Known to Social Work Department	
Based on information known at this time, is child/family known to Social Work Department?	Y ☐ N ☐
If yes, what is the significance of previous involvement /incidents to this referral? In particular (but not only), make reference to any, previous Notification(s) to CPNS. Child Protection Conferences and or Family Support interventions.(*e.g. Carer/Sibling/Other):	
13. Other Checks <i>(This information is recorded in case notes but it may appropriate to highlight particular details on this form.). Also check with the Child and Family network coordinator to see if a Meitheal is being or has previously been undertaken.</i>	

SECTION C

14. Primary Report Type		Welfare Issues ☐			
Neglect ☐		Physical Abuse ☐		Sexual Abuse ☐	Emotional Abuse ☐
15. Welfare Concern Category - YOU MUST NUMBER IN ORDER OF PRIORITY					
Child who is:					
Pregnant	☐	Involved in crime	☐	Whose adoption placement has broken down	☐
A carer	☐	Abusing drugs/alcohol	☐	Educational problems / out of school	☐
Homeless (Youth)	☐	Separated, seeking asylum	☐		
Child with:					
Emotional problems	☐	Complex health needs	☐	Physical disabilities	☐
Behavioural problems	☐	Specific learning disabilities	☐	Intellectual disabilities	☐
Mental health needs	☐	Severe sensory disability	☐	Communication problems	☐
Parents: (Children of parents)					
with learning disability	☐	with mental health problems	☐	whose accommodation is unstable /unsuitable	☐
who lack parenting skills	☐	who misuse substances	☐	who've decided to place the child for adoption	☐
who are adolescents	☐	with disabilities/health problems	☐	who are homeless ☐	who are deceased ☐
Family/Household: (Children of families)					
with a known abuser	☐	with someone involved in crime	☐	where domestic violence is a factor	☐
Socially isolated family	☐	with financial difficulties	☐	with significant relationship difficulties	☐
Siblings have disabilities/chronic health problems		☐	members have history of causing serious harm to others		☐

where parental substance misuse is an issue	☐		
Other – please specify			☐
16. Action on completion of Intake/Referral			
No further action (NFA) Inappropriate Referral CWandP Referral Closed	☐	Initial Assessment required	☐
Tick as required - See guidance:			
Strategy Meeting	☐	Emergency intervention required	☐
Notified to An Garda Síochána	☐	Provision of information and advice only	☐
Referred on to other professional agency for alternative/supporting services			☐
Referral to Meitheal			☐
Notes/Comments (Related to action)			
17. Reporter Acknowledgement		18. Agree action	
Has the reporter been responded to?		SW/Professional (Sign Off)	Date:
Y ☐	N ☐	Date:	
		Team Leader (Approve)	Date:

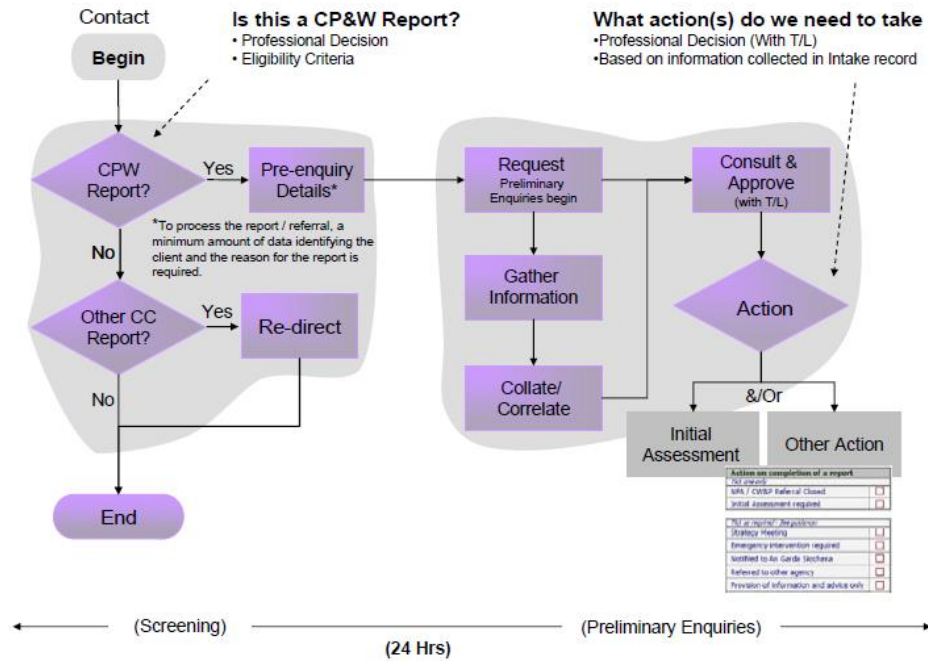
SECTION D

19. Allocation Status		20. Allocate Worker (Designated Worker allocated to case)			
Name:		Profession			
Location:		Telephone:		Date allocated	

Source: (HSE, 2009: pp.16-18)

Appendix 2 Screening & Preliminary Enquiries Chart

Screening & Preliminary Enquiries Chart (Overview)



Source: (HSE, 2009: p.10)

Consent Form

Is the Front Door Open?

Child Protection Reports in a Changing Policy and Legislative Context

I _____ met with Sadhbh Whelan, PhD Student from the School of Social Work and Social Policy, Trinity College, to discuss the preliminary findings from her research study which is looking at child protection reports that are received by Tusla, the Child and Family Agency.

I agreed to the discussions being recorded and I am happy for the information and insights I provided to be used to inform the overall findings in this study.

I am aware that the information I have provided will be treated as confidential, within the limits that have been explained to me, and that all identifying information will be changed in any report, paper or publication arising from this study.

It has been explained to me that all information, recordings and transcripts, will be stored securely on a password protected laptop and will be destroyed after the requisite period of time in keeping with Trinity College Dublin's '*Policy on Good Research Practice*' (2014).

Signed _____

Date _____

Appendix 4 Interview Schedule

Welcome, introductions and consent form

Detail of study, consent form, limitation of confidentiality

What is your role in Tusla and how long have you worked there?

The intake system

Can you describe how the intake system operates in your area from the point of receiving a report until a final decision is made on outcome?

How do you think the intake system is working?

What impact do you think the system of one 'Front Door' is having on service provision?

What impact are PPFS and Meitheal having on current service provision in your area?

The preliminary enquiry stage

What is your opinion of the 24 hour time frame allowed to carry out a preliminary enquiry?

Are all preliminary enquiries carried out within 24 hours?

Are there any impediments to carrying out a preliminary enquiry within 24 hours? If yes, can you describe what they are?

Access to intake services

Do you think there should be a drop in clinic at intake for members of the public and others?

Is this something reporters / parents would value?

What difference would meeting people in person make?

Mandatory reporting

What is your expectation when mandatory reporting is introduced?

What impact do you think it will have on the volume of reports?

How do you think the system will manage the expected increase in volume?

Preliminary findings

Preliminary findings indicate that high proportions of reports in this area are being categorised as welfare (86%). What is your opinion of this finding?

What is your opinion of the thresholds being applied at the preliminary enquiry stage?

What influences /informs thresholds?

Preliminary findings indicate that 62% of reports received in this area were put forward for an initial assessment. What is your opinion of this finding?

Checking during the preliminary enquiry stage

What is the area's approach / policy to carrying out checks during the preliminary enquiry stage?

Should more checking be carried out at preliminary enquiry stage? What difference would that make?

Do you think more checking would impact the volume of reports being put forward for IA?

Are professionals ever contacted without parental consent? What strategies are used to get around this?

What impact has there been from public health nurses no longer being part of Tusla?

Difficulties reported

What is your opinion of the difficulties most frequently reported in your area?

Reporters

Preliminary findings indicate that the principal reporters are school personnel, family and Gardai & probation. What is your opinion of this finding?

What type of difficulties do the different sources report?

Are there are reporting sources who you would identify as being poor reporters of child protection difficulties?

Re-referral

Preliminary findings indicate that 67% of those reported were already known.

What is your opinion of this finding?

What kind of difficulties do you think are subject to re-referral?

Guidance documents

What guidelines or policy documents are available to you to help you in your work?

To what extent do you use / refer to them?

Suggestions for change

Is there anything you would change about the intake system or anything you can think of that would be of help to intake social workers?

Appendix 5 Source of the Report – Breakdown of Reporter

Table 1 Source of the report, school personnel

Source of the report, school personnel		
	Frequency	Valid percent
Principal	97	77.0
Deputy principal	13	10.3
School designated liaison officer	9	7.1
Teacher	3	2.4
Home school liaison officer	2	1.6
School counsellor	1	0.8
School chaplain	1	0.8
Total	126	100.0

Table 2 Source of the report, family members

Source of the report, family members		
	Frequency	Valid percent
Mother	43	40.6
Father	23	21.7
Grandparent	19	17.9
Aunt	9	8.5
Sibling	6	5.7
Uncle	4	3.8
Cousin	1	0.9
Parent	1	0.9
Total	106	100.0

Table 3 Source of the report, Gardaí & probation

Source of the report, Gardaí & probation		
	Frequency	Valid percent
Gardaí	75	76.5
Probation officers	9	9.1
Garda child protection unit	8	8.2
Juvenile liaison officers	3	3.1
Garda specialist interviewers	2	2.0
Garda ombudsman officer	1	1.0
Total	98	100.0

Table 4 Source of the report, medical personnel

Source of the report, medical personnel		
	Frequency	Valid percent
Medical social worker	60	67.4
General practitioner	15	16.9
Nurse	6	6.7
Medical staff, sexual assault treatment unit	4	4.5
Hospital consultant	3	3.4
Forensic medical examiner	1	1.1
Total	89	100.0

Table 5 Source of the report, domestic violence services

Table 5 Source of the report, domestic violence services		
	Frequency	Valid percent
Women's refuge staff member	51	87.9
Voluntary organisation staff member	4	6.9
Women's refuge manager	3	5.2
Total	58	100.0

Table 6 Source of the report, voluntary organisations

Source of the report, voluntary organisations		
	Frequency	Valid percent
Children's organisations	30	54.5
Housing organisations	18	32.7
Disability organisations	7	12.7
Total	55	100.0

Table 7 Source of the report, mental health services

Source of the report, mental health services		
	Frequency	Valid percent
Mental health social worker	15	30.6
Child and adolescent mental health services	14	28.6
Voluntary organisation	13	26.5
Adult mental health service	7	14.3
Total	49	100.0

Table 8 Source of the report, Health Service Executive (HSE) staff

Source of the report, HSE staff		
	Frequency	Valid percent
Public health nurse	40	83.3
Psychologist	2	4.2
School age team	2	4.2
Speech and language therapist	2	4.2
Environmental health officer	1	2.1
Senior medical officer	1	2.1
Total	48	100.0

Table 9 Source of the report, Tusla staff

Source of the report, Tusla staff		
	Frequency	Valid percent
Child protection social worker	21	46.7
Out of hours social worker	17	37.8
Family support worker	4	8.9
Education and welfare officer	3	6.7
Total	45	100.0

Table 10 Source of the report, care staff

Source of the report, care staff		
	Frequency	Valid percent
Residential care worker	11	57.9
Foster carer	8	42.1
Total	19	100.0

Table 11 Source of the report, anonymous

Source of the report, anonymous		
	Frequency	Valid percent
Anonymous	19	100.0
Total	19	100.0

Table 12 Source of the report, youth services

Source of the report, youth services		
	Frequency	Valid percent
Youth workers	8	47.1
Counsellor	7	41.2
Manager	2	11.8
Total	17	100.0

Table 13 Source of the report, members of the public

Source of the report, members of the public		
	Frequency	Valid percent
Neighbour	12	80.0
Landlord	2	13.3
Friend	1	6.7
Total	15	100.0

Table 14 Source of the report, local authority

Source of the report, local authority		
	Frequency	Valid percent
Social worker	7	87.5
Employee	1	12.5
Total	8	100.0

Table 15 Source of the report, drug and alcohol treatment services

Source of the report, drug and alcohol treatment services		
	Frequency	Valid percent
Addiction GP	3	37.5
Counsellor	2	25.0
Project worker	2	25.0
Social worker	1	12.5
Total	8	100.0

Table 16 Source of the report, self

Table 16 Source of the report, self		
	Frequency	Valid percent
Self	5	100.0
Total	5	100.0

Table 17 Source of the report, other

Source of the report, other		
	Frequency	Valid percent
Social worker from another jurisdiction	6	20.7
Police from another jurisdiction	5	17.2
Chairperson child protection hub	3	10.3
Psychologist national learning network	3	10.3
PPSN Registrar	2	6.9
Elected representative's constituency officer	2	6.9
Court appointed psychologist	2	6.9
Designated liaison person, citizen's information centre	1	3.4
Designated liaison person, Department of Social Protection	1	3.4
Elected representative	1	3.4
Manager learning centre	1	3.4
Solicitor	1	3.4
Speech and language therapist, children's detention school	1	3.4
Total	29	100.0

Appendix 6 Child Difficulties Reported by School Personnel

Child difficulties reported by school personnel		
	Frequency	Percent**
Physical abuse	30	23.8
Behavioural problems	29	23.0
Emotional problems	25	19.8
Educational difficulties / out of school	20	15.9
Mental health	19	15.1
Exposure to domestic violence and parental conflict	17	13.5
Sexual abuse and sexualised behaviour	15	11.9
Neglect	12	9.5
Learning difficulties or intellectual disabilities	10	7.9
Impact of parental substance abuse	8	6.3
Lack of appropriate supervision	6	4.8
Sibling violence	5	4.0
Emotional / verbal abuse by parent	5	4.0
Inappropriate use of social media	4	3.2
Child abusing drugs or alcohol	4	3.2
Difficult child / parent relationship	3	2.4
Excessive responsibility in the home	3	2.4
Homelessness	2	1.6
Negative impact from parental mental health	2	1.6
Impact of parental separation	2	1.6
Complex needs or physical disabilities	2	1.6
Child to parent violence	1	0.8
Teenage pregnancy and parenting	0	0.0
Child involved in crime	0	0.0
Other	6	4.8
Total	230*	

*Totals do not add up to 126 as reporters could refer more than one difficulty.

**Percentages do not total 100 because values were calculated out of the total number of reports made by school personnel (n=126) rather than the total number of difficulties reported (n=230).

Appendix 7 Child Difficulties Reported by Family Members

Child difficulties reported by family members		
	Frequency	Percent**
Impact of parental substance abuse	27	25.5
Educational difficulties / out of school	15	14.2
Emotional / verbal abuse by parent	15	14.2
Behavioural problems	13	12.3
Sexual abuse and sexualised behaviour	12	11.3
Neglect	12	11.3
Exposure to domestic violence and parental conflict	11	10.4
Emotional problems	9	8.5
Physical abuse	8	7.5
Mental health	7	6.6
Child to parent violence	6	5.7
Child abusing drugs or alcohol	5	4.7
Learning difficulties or intellectual disabilities	5	4.7
Difficult child / parent relationship	4	3.8
Sibling violence	4	3.8
Impact of parental separation	3	2.8
Impact of parental mental health	3	2.8
Excessive responsibility in the home	1	0.9
Inappropriate use of social media	1	0.9
Lack of appropriate supervision	1	0.9
Complex needs or physical disabilities	0	0.0
Child involved in crime	0	0.0
Homelessness	0	0.0
Teenage pregnancy and parenting	0	0.0
Other	5	0.0
Total*	167	

*Totals do not add up to 106 as reporters could refer more than one difficulty.

**Percentages do not total 100 because values were calculated out of the total number of reports made by family members (n=106) rather than the total number of difficulties reported (n=167).

Appendix 8 Source of the report and gender of the children

Source of the report by gender			
	Gender		Total
	Male	Female	%
School personnel	48.4	51.6	100.0
Family member	50.9	49.1	100.0
Gardaí & probation	47.9	52.1	100.0
Medical personnel	43.4	56.6	100.0
Domestic violence services	39.7	60.3	100.0
Voluntary organisations – children, housing & disability	57.4	42.6	100.0
Mental health services	46.9	53.1	100.0
Health Service Executive staff	53.2	46.8	100.0
Tusla staff	44.4	55.6	100.0
Care staff	42.1	57.9	100.0
Anonymous	47.4	52.6	100.0
Youth services	58.8	41.2	100.0
Member of the Public	73.3	26.7	100.0
Local authority	25.0	75.0	100.0
Drug & alcohol treatment services	62.5	37.5	100.0
Self	40.0	60.0	100.0
Other	46.4	53.6	100.0