

Integrated Service Area for the South: South Lee Social Work Department

Evaluation of the contribution of the child protection public health nurse to inter-professional working in child protection

An integrated health and social care model of child protection

2015

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Foreword

Any initiative that promotes interdisciplinary communication and collaboration working relationships is to be welcome.

Where an initiative assigns a resource in the form of an experienced professional from one discipline, to work in a team of professionals from another discipline, it is to be doubly welcomed.

Those whose foresight and commitment in setting up this project in 2001, and those who have worked since to ensure its objectives were realised, as is evidenced in this paper, are to be commended.

The National Children's First Guidelines stipulate that child protection and welfare is the concern of all, a principal against which few would argue. However, as this paper illustrates, the reality of putting this principal into practice can and does pose challenges.

The key learning from this paper is that where those challenges are met, not with negativity, but in a spirit of wanting to understand them; work with and through the fears presented; work to the strengths of the respective disciplines, then the prevention, early intervention, assessment and support processes are enriched and improved due to a more integrated, harmonious and complementary working dynamic, as is illustrated in the vignettes included in this paper.

In demonstrating what can be achieved on a small scale this project shows that there are great benefits to be gained for children, their families and the professionals working with them, if this integrated working model was to become the norm.

To achieve this would require a cultural change in our thinking and working practices and a structural change in the way we organise our services.

In conclusion I welcome this paper as an evidenced- based example of good interdisciplinary, integrative and collaborative practice work. Its' recommendations will be looked at seriously as a means of building on the work done and further strengthening the argument for such a model to become the norm across disciplines.

Again congratulations to all involved.

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Child & Family Agency, Cork

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Recommendations

Recommendation 1

- **There is a role for child protection public health nurses to work within the Child and Family Agency, to provide clinical expertise in the area of child health and development and to be the link between the Agency and local primary care teams.**
- **Alternatively, there is a role for a designated child protection public health nurses within primary care to support, supervise and strengthen the child protection aspect of the role of the public health nurse and to link with the Child and Family Agency.**
- **With the development of the Meitheal model¹ there is also a role for the designated child protection public health nurse to liaise with the local coordinator of this initiative in respect of the cases that involve young children who require this specific support.**

Recommendation 2

- **Public health nurses should make use of the Child and Family Health Needs Assessment Record² when making referrals to the Child and Family Agency. The assessment should cover issues specific to how parents' problems are impacting on the health and development of a child/children.**

Recommendation 3

- **Social work teams should work at a local level with the public health nursing service, to promote and better understand the child protection referral and assessment process³ and the threshold for referral to the Agency⁴.**

¹ Child and Family Agency (2013) Meitheal- a national practice model for all agencies working with children young peoples and their families Dublin: Child and Family Agency. www.tusla.ie

²O'Dwyer P. (2012) A Report on the Child and Family Health Needs Assessment Framework Project in the HSE Dublin Mid-Leinster Public health nursing service Areas of Laois, Offaly, Longford and Westmeath. Dublin: Health Services Executive

³ National Service Delivery Framework (NSCD) of the Agency will differentiate between child welfare and protection cases, such that family and child welfare concerns can be responded to by new multi-agency, community-based models for early intervention and family support. The Agency will represent the practical application of a new approach towards 'proportionate' service responses.

⁴ The Child and Family Agency (2014) Thresholds for referral to Tusla social work services. Dublin: Child and Family Agency

Recommendation 4

- **Social work teams should continue to work at a local level with the public health nursing service, so as to ensure prompt communication and follow-up following referral, thus ensuring that the child does not remain vulnerable and the public health nurse does not retain an unacceptable level of responsibility.**

Recommendation 5

- **There should be protocols in place to guide best practice in consulting with the child protection public health nurse in South Lee social work department.**

Recommendation 6

- **A course in court room skills should form part of the induction to the role of child protection public health nurse.**

Recommendation 7

- **A strategy should be developed to support assistant directors of public health nursing in developing skills in supervision so as to enable them to keep pace with the increasing complexity of child welfare and protection cases.**

Recommendation 8

- **The Child and Family Agency should ensure that the arrangements for the supervision of the child protection public health nurse are clearly understood and robust.**

Recommendation 9

- **The Child and Family Agency and the public health nursing service should take every opportunity to promote and publicise interdisciplinary training opportunities.**

Recommendation 10

- **The South Lee social work department should organise succession planning for the post of Child protection public health nurse.**

Introduction

There is a compelling need for professionals and agencies to work together to protect children. The complexities of interdisciplinary and inter-agency work in child protection are well documented. A solution, often recommended, in the enquiries and reports into child-abuse deaths is the need to strengthen and improve the quality and effectiveness of communication between professional groups whose work involves responding to child protection issues.⁵

The application of the recommendation to everyday practice has proven to be challenging. In the context of *Children First: National Guidance for the Protection and Welfare of Children*⁶, social workers and public health nurses are recognised as professionals who come into contact with a wide population of children and are believed to be ideally placed to identify welfare and protection concerns. In Ireland, health and social care practitioners share similar client groups. However, these professionals experience substantial barriers to developing and maintaining effective interdisciplinary working relationships. These barriers include a lack of understanding of professional roles and responsibilities, lack of supervision, high caseloads and mistrust between the professionals involved. These challenges are linked to poor outcomes for children and families.⁷

This analysis prompted the establishment in 2001 of a child protection public health nurse (CPPHN) post in the South Lee social work department to reduce the known barriers to communication between two professional groups - public health nurses and social workers. The project was proposed initially as a pilot by the Child Care Manager, South Lee social work department, in collaboration with the Principal Social Worker and the Director of Public Health Nursing service. This report presents an evaluation of the contribution of the CPPHN

⁵ Taskforce on the Child and Family Support Agency (TCFSA) (2012) *Report of the Taskforce on the Child and Family Support Agency*. Department of Children and Youth Affairs, Dublin, Government Publications.

⁶ Department of Children and Youth Affairs (2011) *Children First: National Guidance for the Protection and Welfare of Children*. Dublin: Government Publications.

⁷ Lord Laming (2009) *The protection of children in England a progress report* (HC330) (London: Stationery Office).
Munroe E. (2011) *The Munro Review of Child Protection: Final Report A child-centred system*. Department of Education, London, Her Majesty's Stationery Office

to working collectively with other professionals and voluntary organisations in protecting children.

The evaluation report is set out in 4 sections. The first section sets out the background to the development of the role of the CPPHN including the findings of the evaluation of the pilot phase of the post. Vignettes of the types of cases that the CPPHN was involved with at that time are also included. Section 2 sets out in a simplified form the evolution of the role of the CPPHN. A number of child protection cases with which the CPPHN was involved are presented. Section 3 details the findings from focus groups held with key stakeholders. Four main themes emerged during the course of such focus groups (assessment, communication, decision making, support and access to support through supervision) which are deemed to be the greatest contribution of the CPPHN to inter professional working in child protection. Section 4 provides the findings and presents a discussion and recommendations.

Section 1 Development of the role of the child protection public health nurse

Introduction

Events in Ireland in recent years have led to concerns about communication and information sharing within working relationships in child welfare and protection services between public health nurses and social workers. In response to these concerns a child protection public health nurse post was proposed by the Child Care Manager, South Lee social work department, in collaboration with the Principal Social Worker and the Director of Public Health Nursing service.

1.1 Joint initiative pilot project

The establishment of the CPPHN role was a joint initiative at the outset. The aim of this position was two-fold: firstly, it was envisaged that the post would improve information-sharing and communication between the public health nursing service and the social work department regarding child welfare and protection concerns; and secondly the CPPHN would carry a caseload which would encompass cases referred to her by social workers. It was also anticipated that the CPPHN would contribute to preventative interventions for families referred to the social work team. The social work department had access to very limited family support services at that time. The CPPHN role covered aspects of child welfare and practical interventions with families through nursing assessment, education, health promotion and guidance. The original job description as contained at Appendix 1 outlines the practical aspects and scope of the role. The initial post was sanctioned for a twelve-month cycle, the CPPHN commenced working in the Cork South Lee social work department in May 2001 and an evaluation of the role was undertaken after 6 months. The post was made permanent in 2002.

1.2 Evaluation of the pilot project

The six-month evaluation was undertaken to establish the benefits of the CPPHN to practitioners. Twenty-five public health nurses were surveyed by questionnaire and fourteen social workers were met in a group setting⁸. The evaluation identified that:

⁸First evaluation report & summary of findings 22 February 2002 Sheila Cahalane & Susanne Pelican Kelly

1. social workers were aware of a range of CPPHN interventions with families which they considered helpful. The positive aspects of the CPPHN's work included sharing of the work-load and an appraisal of health issues which contributed to a wider and more holistic assessment
2. a focus on the child under the age of five, an assessment of home conditions, offering support to the parent and the links to services in the community were some additional benefits cited in the evaluation. Social workers were of the view that the CPPHN should co-work cases with them which could include assessment of risk to a child especially from a neglect and health perspective
3. some recommendations were made about the referral process and that parenting classes for teenagers were desirable
4. the public health nurses expressed the view that the CPPHN role should be advisory, informative with regular joint home visiting to families
5. the public health nurses requested written communication regarding the CPPHN's engagement with each individual case and her subsequent closure of the case
6. a continued focus on familiarisation with the role of public health nurses and social workers including the hosting of joint training/information/study days would be of benefit and
7. a revision and clarification of the CPPHN job description and referral form was proposed.

The evaluation highlighted that the public health nurses wanted greater links and collaboration with social workers. The evaluation also revealed that social workers were not always aware that public health nurses were involved with families that they (social workers) were engaged with. Both public health nurses and social workers required a better understanding of the referral pathway to the CPPHN. There was a widely held view among the social workers and public health nurses that they, and ultimately children and families, would benefit from the CPPHN working within a social work team. From this evidence it was recommended that the HSE proceed with establishing the post on a permanent basis.

The vignettes that follow evidence the types of cases that the CPPHN was involved with in the initial phase of the development of the post.

Vignette 1

Family: Single parent in her 20s, who had three young children: a toddler and two older preschool children.

Background: The mother had moved from the UK to be nearer her mother and siblings but had also been a child in foster-care herself.

Referral: A joint visit with the CPPHN and the social worker to the family home revealed great neglect and that the rented house was in very poor repair. There was no effective social support structure. The children were inadequately clothed and appeared to have been fed exclusively with fast food: (the wrapping papers were still lying around). Beds were not dressed and there was no means of heating the home.

Interventions: The guidance and assistance provided by the CPPHN through regular visiting did not effect any meaningful improvement but revealed poor parental capacity to meet the children's needs.

Outcomes: Continued poor upkeep of the house and an inability to manage finances or to provide a steady routine for the children and a lack of basic care (adequate clothes and household effects) were features of this case. The poor emotional environment that the children lived in was also of concern, with little stimulation to foster their general and social development.

Follow-up: The mother who required treatment for a depressive illness, agreed to these children being received into voluntary care after a short period of assessment. They were placed with two families who lived close to each other in a different health board area. This led to the CPPHN liaising with the foster parents, planning and facilitating the assessment of the children's developmental needs and their integration into local health services.

Vignette 2

Family: An older mother who had mobility problems due to arthritis was caring for the two youngest children of her family. Some of her older children had been/were still in foster care. These young children, one with an intellectual disability, were spending time with the extended family at the weekend but the mother was challenged in providing for their physical care and also in enforcing boundaries and discipline. The older child had an enuresis problem and the mother had medical appointments.

Referral: The CPPHN was asked to make herself familiar with the health needs of the mother, to assess her physical ability to care for the children and to determine what assistance she required around impending surgery.

Interventions: During my period of intervention, the CPPHN advocated with the health services on behalf of the mother and partly co-ordinated her appointments with the hospital and community services, and the family were relocated to more suitable housing.

Outcomes: The mother underwent a hip replacement and the children had respite care. All through the involvement of the CPPHN, there was great need in this vulnerable family in which different inter-familial crises arose regularly which impacted on the children. There was a good outcome from the hip replacement with the mother improving her mobility, the new home was more child-friendly and some progress was made regarding the young child's enuresis. There were periods of misunderstanding and anger demonstrated by the children's mother.

Follow-up: At a later stage, the children were placed in foster care with separate families. The enuresis persisted and this young person and the foster family were supported by the CPPHN in its management. Both sets of foster-parents engaged well and relied on the CPPHN for support.

1.3 Summary

Some of the other work which the CPPHN was engaged with involved providing support to antenatal mothers and interventions with parents whose young children were received into care. There were also occasions when fathers assumed the care of their young children and were supported by the CPPHN.⁹ The carrying out of joint assessments of families with social workers to establish the extent of child neglect involved regular home visiting, education and providing guidance to the parents.

The enduring nature of the neglected health needs of children and their parents were frequently the impetus for the referrals to the social work department in the first instance. Issues such as management of chronic head lice, skin conditions or childhood enuresis were common. With each of these cases, the CPPHN's assessment of the child's situation, her planning and evaluation contributed to the decision-making regarding the management of the case. Attendance at professional strategy meetings, case conferences and court became part of the working brief.

⁹ Appendix 2a: *Overview of the CPPHN caseload* January 2003

Section 2 Consolidation of the role of the child protection public health nurse

Introduction

Over the years, the CPPHN role has been influenced by the many families with multiple and complex problems, who have encountered difficulties in meeting the needs of their children and parenting effectively. The role of the CPPHN has also been influenced by reforms in the child protection services including *Children First National Guidance for the Protection and Welfare of Children*,¹⁰ *National Standards for the Welfare and Protection of Children*¹¹ and the establishment of the Child and Family Agency (Tusla).¹² At the heart of recent reform is a policy shift towards providing more proactive support for children and families and for agencies to work together to maximise positive opportunities for children. The CPPHN in working across the social work team has an essential role to play in the realisation of this vision.

2.1 Context

In the integrated service area for the south, the South Lee social work department covers an area which had a population of 191,161 as per 2011 Census.¹³ The population of children aged 0-18 years was 44,904 and the younger children aged 0-5 years totalled 13,821. In 2013, at the time of this evaluation, there were approximately 70 public health nurses working in this area and the South Lee social work team had 25 professionals. In 2012, this department received 866 new referrals of which 411 were child welfare and 455 were child protection cases. In 2013, the referrals constituted 559 child welfare cases and 496 child abuse (Total 1055).

2.2 The governance relationship between the CPPHN and the social work department

In the South Lee social work department, there are four teams: the duty social work team, intake social workers, social workers for children in the community; and a team for the children in care. The CPPHN actively engages with and participates in all aspects of the South Lee social work team. (*See Diagram 1, page 19*).

¹⁰ Department of Children and Youth Affairs (2011). *Children First National Guidance for the Protection and Welfare of Children*. Dublin: Government Publications.

¹¹ Health Information and Quality Authority (2012) *National Standards for the Welfare and Protection of Children for Health Service Executive and Family Services* Dublin: Health Information and Quality Authority

¹² The Child and Family Agency was established on 1 January 2014.

¹³ Central Statistics Office (2012) *Census 2011 Profile 2 Older and Younger* Dublin: Stationery Office

The CPPHN responds to referrals from each team, but in recent years the pattern of neglect has meant that the role focuses mainly on issues concerning very young children which are dealt with by the duty team and the more in-depth assessment undertaken by the intake team. While some cases have an urgency other referrals to the CPPHN are planned referrals by the relevant team leader and social worker or originate from a case conference or professionals' meeting. The CPPHN's line manager is the Principal Social Worker who is responsible for workload review and supervision of cases.

2.3 Service developments

Given the range of issues that affect disadvantaged families and communities, new initiatives and services have been set up to address their needs in the South Lee catchment area. Many of the new services are targeted services that support specific vulnerable groups which need to be engaged with, on a constant basis for a period of time, to effect change by strengthening parenting. As a result, the social workers have a greater choice in the type of intervention available for families in need, which in turn leads to more focused referrals to the CPPHN.

These new initiatives and services include:

- the development of the social work department in the new Cork University Maternity Hospital (CUMH);
- the development of services in the Bessborough Centre with residential services for families;
- outreach parenting support and improved assessment including family support. (originally involving an outside contract and latterly incorporated in the Lime Tree family support programme);
- the engagement of social workers in the primary care team covering two areas, Bandon and Ballyphehane;
- the Teenage Sexual Health and Pregnancy Support Programme (Liberty Street House);
- Teen Parents Support Programme (TPSP); and
- Youth Health Service (YHS).

2.4 CPPHN: novice to expert

Neglect accounted for over half of the cases referred to the social work department in 2013. It is often combined with other factors such as alcohol or drug addiction or mental health problems. The impact of neglect on child development is well documented.¹⁴ The expertise of the CPPHN in neglect cases, when child development is adversely affected, is vital. The CPPHN's presentation, at team meetings, of information about developmental delay or behavioural problems, arising from neglect or abuse, contributes to a greater understanding of the interventions required to meet the needs of these children. The CPPHN's knowledge of deviations from typical growth and development makes it easier for the social work team to intervene to prevent further harm. Abuse also features prominently in the caseload of the CPPHN, which includes cases where children suffered an injury whilst in the care of a parent. These can be extremely difficult cases for the social work team to manage. The role of the CPPHN is in ongoing monitoring of and providing support to a family as they re-assume the care of their child. Children and parents with intellectual difficulties (where the ability to parent is diminished) also feature in the CPPHN caseload. Occasionally, the CPPHN appears in court in child care proceedings.

The following vignettes show the recent work of the CPPHN. When compared with case vignettes 1 and 2 (p.13,14), the case vignettes 3, 4, 5 are more complex and are representative of the increasingly challenging and difficult cases referred to the social work department.¹⁵

Vignette 3

Referral: Concern was expressed by the SW about the ability of a young mother with continued substance abuse issues, to care for her infant son.

Background: Moving from living on her own to living back in her family of origin, there was a pattern of continued evidence of drug use.

Interventions: The CPPHN visited on a regular basis and in her observations of the mother with her son; initially could not fault her care of the baby. The woman did however experience difficulties in the family home and went to live in a refuge. The CPPHN work included liaison with the PHN, reminders to the mother about appointments and close liaison with the SW team.

Outcomes: While in the refuge, this parent continued to engage with the CPPHN and SW, but displayed irritation with our involvement and failed to engage with supportive services. Developmental appointments for her son were missed repeatedly. After some time his developmental assessment was completed and onward referral was warranted.

¹⁴ Cuthbert et al NSPCC (2011) *All Babies Count: Prevention and Protection of Vulnerable Babies*

¹⁵ Appendix 2: Overview of the CPPHN caseload.

Follow-up: When mum was received into a treatment programme, the little boy was received into foster care. A change in foster-placement ensued when it became apparent that the care arrangement would be prolonged. The CPPHN attended review meetings and compiled a report for court while providing a support to the SW team and liaison with the PHN service locally and in the subsequent foster care areas. This supported continuity for this young toddler in his development, monitoring and follow-up.

Vignette 4

Background: When a young child with complex medical needs was to be discharged from hospital for the first time, the birth parents were not available to care for the young girl. In this case extensive nursing support was required in the community but a long wait ensued before suitable foster parents were identified. Meanwhile this young child required regular visiting in hospital and most importantly, an attachment figure. A suitable interim person was identified who became very close to the toddler, visiting regularly. This person received the specialised relevant training for the subsequent care required in conjunction with the newly-identified foster parents.

Referral: The CPPHN was requested to initially work jointly with the SW to assess the ability of the birth parents to care for this child on discharge from hospital.

Interventions: Continued liaison with the hospital followed to become acquainted with the little girl and her needs.

Outcomes: The constant presence of the CPPHN on the Social work team was a significant benefit to the multidisciplinary team which included community nursing, child protection Social workers, the new foster parents and the link person. All attention was focused on the young girl's needs which were extensive and required overnight community nursing, subsequent hospital in-patient care, and community support services.

Follow-up: Many planning meetings and discussions were undertaken to determine how best to meet this young child's needs from the stage when parental visitation in the hospital diminished to supporting the foster parents in assuming the care of a child with a life-threatening condition. The liaison was wide-ranging with hospital and community nursing and special needs services. She is well settled in her new family and her developmental progress is exceeding original expectations.

Vignette 5

Background Non-accidental injury (NAI) is chilling when it occurs and requires significant input from the child protection team. From the initial phase of hospital care, decisions have to be made relating to the care arrangements for the child. Frequently a child is admitted to foster care at the outset. Commonly, the child is returned home under a safety plan which includes measures around monitoring and providing supports. Where support is an ongoing arrangement, meticulous planning and care is required to parents while assuming care of the

child. Many professionals have an input into enabling the psychological wellbeing of the parents and the strengthening of their parenting skills.

Referral The CPPHN was a member of a core group which was established following a series of child protection case conferences and maintained close liaison with the SW team.

Interventions: At present the CPPHN as part of the SW team is involved in ongoing monitoring and provision of support to the family as they re-assume the care of their young child. This involves frequent visiting to the home which can include physical examination of the child and giving the parents supportive guidance,

Expected outcome: As this young child develops and is successfully integrated into a community crèche, the social services will hopefully be assured of the parents' ability and gradually reduce their monitoring role.

2.5 Supervision

Just as it is necessary for the CPPHN to review the progress and outcomes for children and their families, it is as important for her to review and reflect on the work done with families. Supervision sessions are opportunities to reflect on professional practice in an ongoing way. Reflective supervision has been emphasised in a number of recent guidance documents and reports.¹⁶ Regular supervision is critical for all public health nurses working with vulnerable children and families. The supervision of the CPPHN has varied throughout the duration of the post. Supervision was initially provided to the CPPHN by the public health nursing service, however, this was not sustained and the CPPHN sought external supervision. The governance arrangements for public health practitioners in the Child and Family Agency have yet to be formalised. It is anticipated that with this development the training and professional needs of public health nurses in the Agency will be addressed.

2.6 Professional development

Continuing professional development is an important component in the continued provision of safe and effective services for the benefit of service users. The CPPHN participated in a number of professional development activities to strengthen her practice in child welfare and protection.¹⁷

¹⁶Commission to Inquire into Child Abuse (2009) *Report of the Commission to Inquire into Child Abuse (The Ryan Report) Implementation Plan*. Dublin, Government Publications.

¹⁷ Appendix 3 *CPPHN professional development*

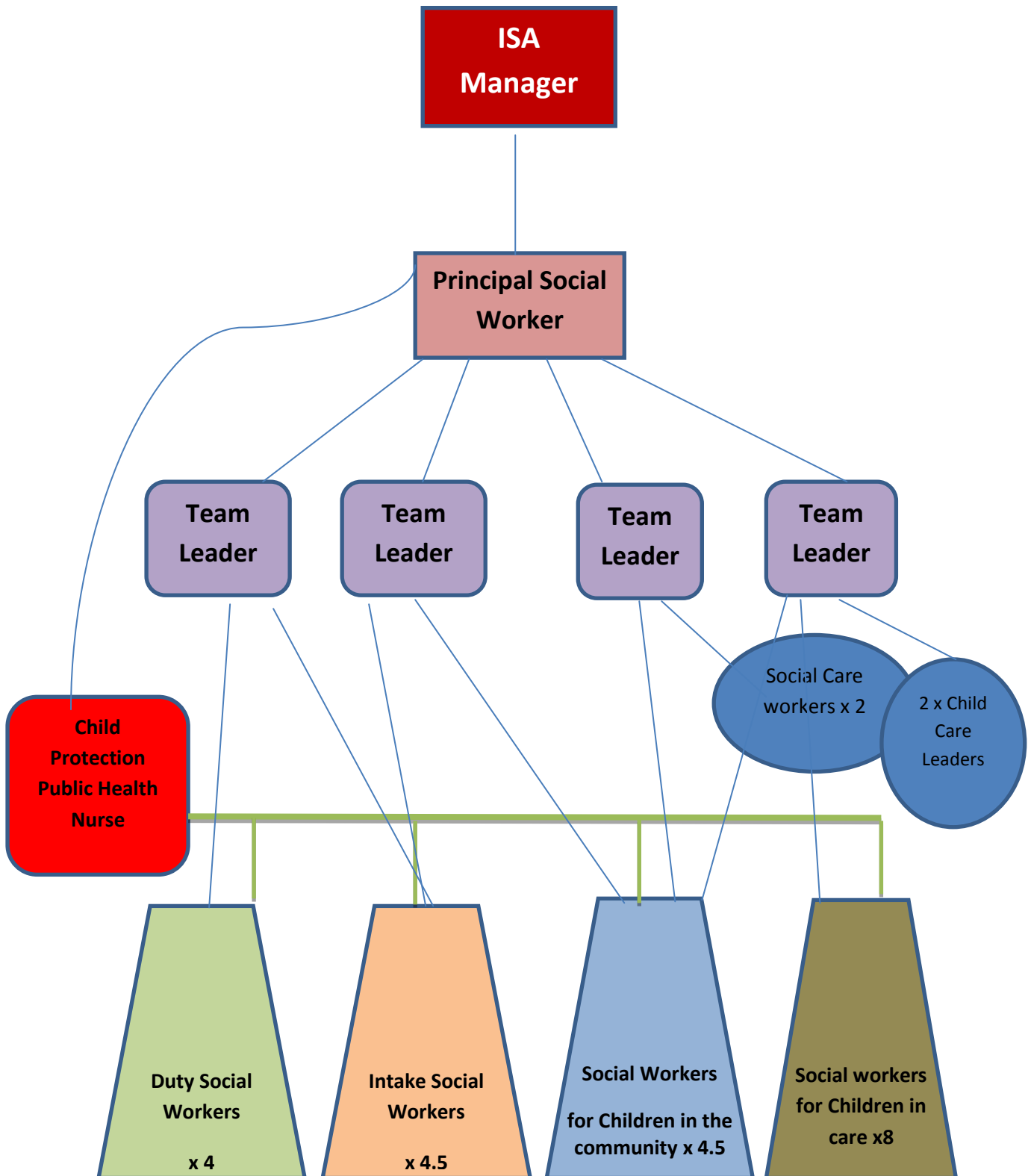
2.7 Preparation for the role

The Principal Social Worker made a few observations, in the course of the evaluation, about preparation for the role of the CPPHN in other parts of the country. She considered that a course in court room skills is an essential prerequisite to be CPPHN. Another essential requirement identified by the Principal Social Worker is that the CPPHN must have access to supervision from within their discipline.

2.8 Summary

Experience in working child welfare and protection cases is the main source of gaining expertise in practice. The CPPHN has compiled ‘case banks’ of experience to build up her knowledge of child protection over a period of 13 years in the post. The novice to expert trajectory in the role of the CPPHN has been influenced by the range and number of child protection cases encountered and educational opportunities over a period of time. These factors along with supervision support have had a positive impact on the quality and effectiveness of the child protection service in South Lee.

Table 1: Integrated Service Area for the South, the South Lee social work department¹⁸ in early 2014



¹⁸ On a daily operational basis the CPPHN reports to the Principal Social Worker and engages with the SW and team leaders on individual cases.

Section 3: Methodology and findings

3.1 Aims and objectives

The aim of the evaluation was to analyse the contribution of the CPPHN working in the South Lee social work team, in the context of child welfare and protection and in so doing, to ascertain the experiences of the main external professionals and organisation who engage with the CPPHN in protecting children.

The evaluation set out to document the experiences of the:

- Principal Social Worker;
- social work team leaders;
- social workers;
- assistant directors of public health nursing;
- public health nurses;
- school public health nurses;
- general practitioners and community paediatricians; and
- community voluntary organisations.

It was envisaged that the key findings of the project would inform an integrated health and social care model of working, which is timely given that there are presently significant structural changes in the delivery of child welfare and protection services in Ireland.

3.2 Methodology

It is clear from the objectives that the evaluation was being conducted to assess the overall contribution of the CPPHN in the context of interagency working and child protection. The data collection methods of focus groups and interviews were used to reflect this. These were conducted over a 6-8 week period in June and July 2013 by the PO'D, author of the report. Typically the interviews and focus groups lasted 60 minutes.

3.3 Sources and methods of data collection

Source of Data	No of Participants	Methods of Data Collection
Principal social worker	1	One to one interview
Social worker team members	10	Focus Group
Social work team leaders	3	Focus Group
Assistant directors of public health nursing	3	Focus Group
Public health nurses	11	Focus Group
School public health nurses	3	Focus Group
General practitioners and consultant paediatricians	9	Online Questionnaire Survey Monkey
Community voluntary organisations	6	Testimonial
Primary care social worker	1	Testimonial
Total number of participants	47	

3.4 Rationale for sources and methods of data collection

The stakeholders identified for the purposes of the evaluation are the main professionals and organisations that the CPPHN engages with in the care of children and families. Due to the range of professionals and organisations who engage with the CPPHN, the decision was taken that the most effective and efficient means of gathering the necessary information would be:

- a) organise focus groups with the stakeholders who have extensive involvement with the CPPHN and
- b) circulate a questionnaire to stakeholders who have less frequent contact with the CPPHN.

The focus group facilitator was guided by a topic guide of open-ended, semi-structured questions (Appendix 4) based on the evaluation aims and objectives. A total of five focus groups were held with social work team leaders, social work team members, public health nurses, school public health nurses and assistant directors of public health nursing. In addition, the Principal Social Worker was interviewed separately. Other stakeholders who have professional involvement with the CPPHN including family support centres and hospital based staff were invited by letter to respond to some brief questions¹⁹. The general practitioners and consultant paediatricians were surveyed using an online questionnaire

¹⁹ Appendix 5 Letter sent to stakeholders who have professional involvement with the CPPHN

Survey Monkey. This method was chosen to capture the views of the medical personnel who had less contact with the CPPHN but whose input is valued.

3.5 Limitation

Given funding and time limitations, it was not possible to gain the views and experiences of children and families with whom the CPPHN worked.

3.6 Ethical approval

Advice was sought from the research ethics office regarding ethical approval. It was considered that ethical approval was not necessary when clients and families were not included in the evaluation. However, ethical issues were considered and addressed throughout the process particularly in areas of confidentiality and anonymity.

Findings: social workers' experiences

3.7 Assessment

Across the focus groups including the social work team leaders and team members, participants reported that the most important aspect of the contribution of the CPPHN was her assessment of children known to the child protection department. In reflecting on the assessment of children and families, it was noted that the '*CPPHN's contribution to the service is 'huge' and 'a huge resource'*', and is mainly focused on the younger and more vulnerable children that the department deals with, or with any medical issue that a child may present with. A prominent sub-theme identified by the social work participants was the joint assessment of children and families. The following case illustrates this collaboration.

It is not normal practice for a social worker to undress and examine a child on a home visit. On a visit to a family home the social worker and the CPPHN realised that a young child's skin condition had greatly deteriorated due to lack of attention from the young parents. The child had been hospitalised previously for treatment of eczema and it was established that her mother was well capable of doing the treatments. On this visit however, it was observed that

the child's skin was neglected and bleeding and the little girl, aged eight months was in great distress. The CPPHN appreciated that urgent treatment was needed and was able to organise a hospital admission with the general practitioner promptly without it necessitating a visit to the surgery. The hospital staff considered this situation to be very serious and a Court Order followed which resulted in the child coming into the care of the HSE for a period of time after which she was gradually returned to the parents' care.

The social work team also value the fact that the CPPHN, with her expertise of child health and development, is able to attend at court and provide direct evidence. The assessments of children and parents play an important role in deciding on whether to grant a Court Order or not and the CPPHN is well placed to give a view as to the impact of the neglect on the child development. Specifically, a social worker claimed that the CPPHN '*can explain the significance of a child's weight plotted on a centile chart*' that is '*helpful ...on...what a child is achieving and what they're not*'.

A team leader valued the 'different mind-set' of the CPPHN. The view was expressed that her input leads to the social workers being more confident and '*surefooted*' in their assessments and that without the CPPHN's contribution, it is claimed that '*the kids would've missed out... in very serious neglect cases*'.

'I would say Sheila adds another dimension to the team and she's a different set of eyes and is coming from a different angle altogether from ourselves and yet it's a huge advantage for us working with children. I think she brings a different knowledge base'

In team leader focus group.

'Sheila is better 'able to work with the grey', ... the health need is improving yet there might be a social issue that's still very present that given a week or two or a couple of days, you'd be back into the same situation.... she's able to meld the ... social and the medical model'

In social worker focus group

A further issue that the respondents valued was that the CPPHN can provide advice to families first-hand, i.e. where there may be a medical issue, in contrast to a social worker directing the family to visit the general practitioner or the public health nurse to obtain the necessary healthcare advice. This is the view of one respondent:

"...it reduces the number of professionals that are required to make those kind of decisions so that if Sheila wasn't here, we'd have to be going on a home visit, seeing

something worrying and either trying to arrange for somebody to come, like a GP or a public health nurse to come to the house or else arranging for kids to be brought ... to a GP. It'd just make things so much longer, involve more people, and complicate decisions. I think that's what I see her as: that liaison”

In social worker focus group

A further benefit identified by the social workers was that the CPPHN demystifies the medical terms and procedures in medical reports. In this respect, one respondent noted:

‘I suppose she kind of breaks down someone's language as well for us; some of it, can be a bit clinical and to actually make sense of it makes it kind of real of what the implications might be ... and how you manage it then’.

In social worker focus group

The Principal Social Worker explains that, with input from the CPPHN, the assessment of children and families is strengthened because:

‘we give a much broader and a much fairer assessment to families, much fairer because we don't always agree...not everything should fall and rest on one assessment from one professional’

Principal Social Worker interview

The consensus amongst the social work team members and team leaders who participated in the focus groups is that their assessments are holistic and their interventions more timely given the input of the CPPHN resulting in better outcomes for children. Social workers with experience of working in other areas spoke enthusiastically of the CPPHN's role within the team indicating that every team should have a CPPHN.

3.8 Communication

In the focus groups held with the social workers, it was acknowledged that there was a time when communication with public health nurses was poor. A factor that has improved the channels of communication between both professional groups was the location of the CPPHN within the social work service.

'I think it's vital, the fact she's actually embedded next door to the social workers is very, very important ... but no amount of meetings would make up for somebody actually being in the office.'

In social worker focus group

The inclination of other disciplines to communicate with the CPPHN rather than a social worker was also acknowledged:

'...she gets a 'response from medical colleagues, that the Social workers wouldn't have the same response really'

In social worker focus group

The role of the CPPHN in maintaining communication to avoid causing disruption in the care of vulnerable children is explained by the Principal Social Worker as

'our go-between or our link'. So for a child in care, she would link in from the area the child was living in to the area the child would be moving to: that is absolutely critical for a small child but it also might be critical for a child who has maybe a life-threatening illness like sickle cell disease '

Principal Social Worker interview

3.9 Decision Making

In a professional social work setting, countless decisions are made in group settings at all stages of the child protection process. The social workers are of the view that the CPPHN's *'different background and her knowledge, experience, qualifications and skills'*, *'her different mind-set'* affect decision making at each stage of a child protection case. One social worker made the point that

'...she's very grounded in her decision making... able to categorise things really easily and able to make sense for me ... She's able to say, "Look, look at their emotional neglect or whatever ... look at the different aspects of it" and she pinpoints it very easily ... and I think she's very helpful in that sense to me.'

In social worker focus group

One of the most difficult decisions which social workers have to make is to assess the risk of maltreatment of a child who had previously experienced non-accidental injury. During the focus groups, a team leader referred to a situation where it had been planned that the parents

assume the fulltime care of a child who had experienced non-accidental injury and had been in a foster placement:

'sometimes we make a decision to return a child [to the family], however it's not without its risks and we are carrying that risk so it's quite reassuring to have Sheila coming on board there'.

In team leader focus group

The management plan for reunification of a child required frequent visiting, monitoring and support to this family and examination of the child. The presence of the CPPHN on the team was a crucial factor in decision making around the implementation of the plan. It was considered that the CPPHN 'would link in with the PHN, as well as being part of the home visiting rota. The team leader considered that this collaboration *'...add(ed) an extra layer of prevention of harm, an extra layer of monitoring and an added feature of support...to that mother'*.

Findings: public health nurses' experiences

3.10 Communication

All the public health nurses and the school public health nurses who participated in the focus groups had experience of working with the CPPHN. When asked to describe their experiences, many of the comments related to the positive communication, support and accessibility provided by the CPPHN. They were of the view that:

'She's that link which is needed' and also highlighted 'she'd always feedback which is one of the big problems is the lack of feedback from other services'.

In public health nurse focus group

'I find more it's the two-way communication with Sheila, but also that she can feed through to the Social work department which mightn't be as accessible for ourselves whereas she's there in among them'.

In public health nurse focus group

From the perspective of a school public health nurse in respect of a child welfare/protection concern, the CPPHN *'would always be my first port of call'*

An example given by a school public health nurse related to an event where she was very concerned on foot of doing a home visit:

'I did a call and it was follow-up enuresis in the home for three children. It was almost an emergency case and Sheila was out there that afternoon with her social workers. ...I would have been very stressed if somebody hadn't called that day so I came straight out that door and rang Sheila'

In school public health nurse focus group

Affirming the advantage of communication with CPPHN

'I would find that the communication and the follow up are very good because she comes back to us on the case, which is good. And I find it very good, as well, where the school is iffy about a case; she's good with them too'

In school public health nurse focus group

3.11 Support

All the public health nurses who participated in the focus group were keen to stress the support provided by the CPPHN. They described the CPPHN as *'a source of reference'*, *'a source of support'* to both the families and the nurses. The public health nurses utilised her *'knowledge of the support services'*. They experienced *'reassurance'* in relation to the families that they (public health nurses) were concerned about, as the CPPHN could then initiate a discussion on those families in the social work department. This reduced the *'isolation'* of the public health nurse. Furthermore, the public health nurse gained assurance that she may not have a role with the family on review of the concern or following referral to the social work department. The nurses felt that this support was linked to the CPPHN's experience and knowledge of public health nursing and her ability to identify with the nurses' concerns.

'I suppose to push our concerns when we feel we're not being listened to by social workers, she really follows through with it'

In public health nurse focus group

The public health nurses described how their generalist role can create challenges for the delivery of a comprehensive and timely service for families with children. Several

contributors to the focus groups noted a lack of time to work preventatively with families because of their busy clinical caseloads. The public health nurses were aware of the parenting work that needed to be done with vulnerable families that they (public health nurses) did not have the time to do, this intensive one to one work with families which was undertaken by the CPPHN. A strongly held view was noted:

'...that focused time, the time alone, because those families deserve the time as opposed to the running in and running out that we may do, so, at least, you're reassured that you know someone like Sheila is going to either give the time or put the supports in place to give the family the time to keep them out of the foster system or whatever else'

In public health nurse focus group

Reference was made by the public health nurses to a substantial 'middle ground' of cases that are not accepted by the social work department but require attention. The CPPHN has given support to the public health nurses in considering the management of these cases. The discussion with the public health nurses revealed that they struggled with 'what they were observing in family homes' and reconciling their observations with the threshold for referral to the social work department. They acknowledged that indicators of neglect are difficult to pin down, but felt supported by the CPPHN in making a plan of care in relation to how to move forward with a particular case.

3.12 Ease of access

The public health nurses valued the availability of the CPPHN and noted:

'...she's always readily available to speak to us, with our concerns... if there is a concern ...we have ready access. ...I think it's the availability of Sheila'

In public health nurse focus group

They appreciated the opportunity to use an informal consultation with the CPPHN preferring to consult with her rather than the duty social worker and considered they could brainstorm with a peer (CPPHN) in relation to the more complex social cases. Reference was also made to concerns about school going children. The examples cited relate to child welfare issues and how the school public health nurses empower the schools to make referrals directly and feel supported by the CPPHN in that regard.

Findings: Experiences of the assistant directors of public health nursing.

3.13 Support and Reassurance

The assistant directors of public health nursing recognised that the public health nursing service plays an important role in the area of child protection but were keen to emphasise that they were not experts in child protection. They ‘advise the public health nurses to contact the CPPHN’ for family situations where the public health nurses

‘...felt completely overwhelmed and sometimes it's very difficult to see the wood from the tree and be clear in terms of what needs to be done to address some of these issues’.

In assistant directors of public health nursing focus group

The assistant directors of public health nursing found that the CPPHN provided the public health nurses with clarity and a sense of reassurance and confidence in the management of the case at hand. The experience and the knowledge of the CPPHN were considered to be invaluable by the assistant directors of public health nursing. When asked to describe the most significant contribution of the CPPHN, their comments include support, advice and joint visits:

‘I would say she's extremely supportive of Public health nurses because she comes from a PHN background, she knows where they're coming from. She knows the diversity of families they're dealing with and, she's able to get an understanding of a family and maybe, initiate joint-visits so I think the support of, and the advice she can give public health nurses’.

‘...with the families who are going through the cycle of chronic neglect. Public health nurses have sometimes felt completely overwhelmed. Sheila breaks it down, often it's the joint visits, A PHN doesn't have the expertise [and] cannot do this in isolation and that's where Sheila's been key’.

‘Sheila's coming in [to the family] as a PHN but also then [with] her huge expertise in child welfare and protection and her links with the social workers so, like, she's invaluable [and] you couldn't replace her with someone else’.

In assistant directors of public health nursing focus group

3.14 Supervision

The need for public health nurses involved in these cases to have access to supervision emerged as a necessity given the challenges inherent in child protection work. The assistant directors of public health nursing were aware that in this regard the culture was changing. One assistant director of public health nursing described how

'...more recently it actually has moved towards case supervision and it's much more structured and it's sitting down and, maybe, because of the more recent reports and in light of what's coming down in terms of the assessment framework ... but more recently I think there's been much more clarity in terms of what our role is, what everybody else's role is and how you need to manage this case, so it's probably much more case-supervision, or case management - not quite case-supervision at this stage'.

In assistant directors of public health nursing focus group

What was meant by the assistant director of public health nursing in referring to case management was not fully explained. In Burn's study with social workers, case management activities meant that the focus was on discussing what has happened in the case and what needs to be done²⁰ and this emphasis on the management of the case could mean that the supportive and educative functions of case supervision are not discussed at all.

Findings: Community and voluntary organisations

3.15 Targeted support

The most effective way in which to distinguish children's needs is through primary care practitioners working in universal services. Primary care practitioners such as public health nurses routinely identify parents who would benefit from extra support but according to the public health nurses they do not have the time to make this possible. If the public health nurses had concerns about early signs of difficulties and poor parent-child interaction, they would contact the CPPHN *'because of her familiarity with the types of support services available to families'*.

On a daily basis the CPPHN attempts to seek a solution for these families from within the support services at primary care level in South Lee, for example:

²⁰ Burns, K. (2012) 'Moving beyond 'case-management' supervision: Social workers' perspectives on professional supervision in child protection' In: Lynch, D. and Burns, K (Eds.). *Children's Rights and Child Protection: Critical Times, Critical Issues in Ireland*. Manchester: Manchester University Press. <http://www.manchesteruniversitypress.co.uk/cgi-bin/indexer?product=9780719086274>

1. Togher Family Resource Centre: a voluntary community based project which provides family support, affordable early years education, mother and toddlers group, formal and informal adult education and after school activities.
2. Lime Tree Project: an outreach family support service aimed specifically at children who are at high risk of coming into care. This service combines family support and therapeutic interventions.
3. An Cliabháin Community Crèche: supports children's learning and development and
4. Brothers of Charity Early Intervention Service: provides assessment, diagnostic and intervention services to pre-school children with special needs from birth to 6 years of age.

The above support services rated the CPPHN as a highly valuable point of contact to refer to where there were concerns about a child and for accessing the family. The CPPHN's work with one family at the Togher Family Centre (TFC) is described in the following vignette.

Vignette 6: Testimonial submitted by Togher Family Centre staff member

Role of TFC: To facilitate access between the mother (who was already using the service for access with another child) and her new baby and to provide positive support for mom during handover with the foster carer and in managing any needs she may have around care of the new baby.

Role of the CPPHN: To ensure that a mother and her new baby developed good attachment, while the child was in foster care.

Positive outcomes from the CPPHN's involvement in this family's progress:

The CPPHN was a valuable support to mom in ensuring that she has as much access as possible with her new baby.

In response to the CPPHN's request for additional access, TFC made more time available. This advocacy role at an early stage in the attachment process ensured that mom and baby were given as much time as possible.

The presence of a CPPHN working with the family ensured that the focus was kept firmly on the baby.

The wealth of experience embodied in the CPPHN ensured an excellent balance between managing child protection concerns and advocating on behalf of the mother and baby as a unit.

The role was very well executed by the CPPHN in this case. The CPPHN was very clear around her needs for the family and was professional and persuasive in pursuing these needs.

The CPPHN worked in a collegial way with the staff in TFC and was cognisant of their observations and input.

The social worker who is currently working the case was well informed about the case which indicates good handover. This ensures constancy when South Lee social work department and TFC are working together.

3.16 Findings: CPPHN and disability services

The current *Children First National Guidance*²¹ recognises that disabled children are at greater risk of abuse than non-disabled children. The *Child Protection and Welfare Practice Handbook*²² highlights ways in which disabled children are particularly vulnerable. Gathering information about neglect and abuse involving a disabled child can be a complex process when several practitioners and organisations hold case notes. The experience of the disability service key worker, involved with child protection team, is described in the following vignette.

Vignette 7: Testimonial submitted by disability service key worker

Family referred to Social work department arising from a protracted history of non-attendance at medical and intervention appointments. A significant amount of time was being devoted to this child and family but with little effect. The CPPHN provided a much more cohesive system of contacts and support for this child and family and her involvement ensured that essential appointments were attended and essential surgery occurred. Through the CPPHN's involvement, the family have been able to gain support and services they most likely would not have had access to without her involvement. The CPPHN is an essential link between health, disability services and the child protection team.

3.17 Findings: General practitioners and paediatricians

General practitioners are accorded a pivotal role in identifying indicators of abuse and neglect.²³ In reality, general practitioners assume a lesser role that is ascribed to them. In *Children First National Guidance for the Protection and Welfare of Children* document, their role is largely incorporated within the primary care team roles and responsibilities and there is additional good practice information specific to general practitioners in the *Child Protection*

²¹ Department of Children and Youth Affairs (2011) *Children First National Guidance for the Protection and Welfare of Children*. Dublin: Government Publications

²² Health Service Executive (2011) *Child Protection and Welfare Practice Handbook*. Dublin: Health Service Executive.

²³ Department of Children and Youth Affairs (2011) *Children First National Guidance for the Protection and Welfare of Children*. Dublin: Government Publications

and Welfare Practice Handbook.²⁴ The CPPHN liaises with the medical profession in the gathering of medical information relating to the child, and advocate for a child who is being assessed in South Lee social work department.

Paediatricians and general practitioners (n=89) in the Cork area were surveyed online. The response rate was a disappointing 10% but the respondents all considered:

- the role of CPPHN to be beneficial to the young child under the age of 5 and to the family;
- having a health professional in the child protection team is of assistance;
- they would welcome such a role in other child protection Social work teams;
- they had a positive experience of engaging with the CPPHN; and
- contact with the family doctor increases the exchange of information;

The following vignettes illustrate the liaison between medical practitioners and the CPPHN.

Vignette 8

Referral: A young person with intellectual difficulties was living with his mother in her forties who herself was very limited by chronic health and mobility problems. This child was referred to child protection by the paediatrician because of his obesity where no improvement has been noted and the child was now ‘pre-diabetic’.

The Social work team requested that I work with the family. The GP was very well acquainted with the parental and family health concerns and was very forthcoming in his understanding of the family and in making pertinent recommendations. The paediatrician was also very direct in portraying the serious health risk for this young boy.

Interventions: Initial visitation by the CPPHN and linking the family with the nutritionist and community services did not achieve any change in this young person’s risk of progressing to a diabetic state. The CPPHN assisted with developing a relationship with the mother and son, reminders about keeping appointments and providing motivation related to exercise and improved food choices. She continued to work with the family to implement a daily exercise routine. But assistance from outside the family was required to support this young person in meeting the practical goals required to improve his health status. The medical professionals appreciated the nursing input into the care plan and continued support for this young person.

²⁴ Health Service Executive (2011) *Child Protection and Welfare Practice Handbook* Dublin: Health Service Executive.

Vignette 9

Referral: A mother in her late thirties struggled to manage her twin children (aged three) who were lively and challenging. She had previous history of depression and a difficult relationship break-up with the children's father, as well as being socially isolated. The GP at a professionals' meeting was very appreciative of the continued support by the CPPHN to this mother.

Interventions: Regular visitation to promote continued encouragement was required in each stage of the children's development: toilet-training, preschool and school commencement, engagement with allied services SLT and psychology, meeting parenting challenges etc. Continued regular weekend respite foster-care assisted the mother's ability to parent. In this case the long-time acquaintance of the GP with the parent in addition to his insight, sustained the supportive relationship of the CPPHN with this family over a span of four years.

3.18 Summary

Professionals working together are central to the thinking behind the Child Care Act, 1991 and Government policies on child protection since the enactment of that legislation. In this evaluation, health and social care practitioners, and managers have reflected on their experiences of working across professional boundaries and agencies on child protection issues. The professionals highlighted the aspects of the role of the CPPHN that they most benefit from. The CPPHN's contribution to improved outcomes for vulnerable children was repeated many times by the key stakeholders as evidenced above. Despite the participants' positive reports about the CPPHN contribution to inter-professional working, there is a need to consider the challenges in child protection work for the public health nursing service. Under the right conditions, the CPPHN is a good practice model, that could be replicated nationally and assist in dealing with those challenges.

Section 4 Discussion and recommendations

The following discussion of findings set out in Section 3 should be considered in the broader context of the Child and Family Agency and the policies published by the Agency since it was established on 1st January 2014. At the time of the evaluation, the *Thresholds for Referral* guidance and the *Meitheal Practice Model* features of the National Service Delivery Framework were yet to be implemented.

4.1 Assessment

The child protection social work department's involvement with a child originates through a referral and the information provided about any given concern may not always be adequate. Referrals are received from the general public, family members, schools and other professionals at the 'front of house' duty-desk via phone calls, electronic mail and a Standard Report Form (SRF). Handling and assessing referrals is not straightforward and typically involves checking a child's history, and establishing if the family is known to social work services and sourcing other information from professionals where gaps exist. Timescales are now standardised from referral to initial assessment to further assessment.

Shortcomings in the assessment of children in need have been a consistent feature in reports of child abuse and neglect.²⁵ Improving the assessment process requires a focus not just on individual performance but also on the context for practice.²⁶ Nationally, procedural changes including the *Standard Business Processes Project* were introduced to streamline the assessment of children in all social work departments throughout the country.²⁷ This approach requires a rapid and reliable response to the child protection concerns which consists of gathering information and assessing the needs of children, parenting capacity, family functioning and sources of support. The assessment framework is a key part in deciding how the needs of children will be met.

²⁵Turney D. Platt D. Selwyn J. and Farmer, E. (2011) Social work assessment of children in need: what do we know? Messages from Research. School for Policy Studies, University of Bristol

²⁶ *Ibid* p2

²⁶Turney D. Platt D. Selwyn J. and Farmer, E. (2011) Social work assessment of children in need: what do we know? Messages from Research. School for Policy Studies, University of Bristol

²⁶ *Ibid*.

²⁷ Health Information and Quality Authority (2012) National Standards for the Welfare and Protection of Children for Health Service Executive and Family Services. Dublin: Health Information and Quality Authority

The framework in use requires the gathering of social and medical information, drawn from a number of sources so as to obtain a holistic view of the concern. Social workers must weigh this assessment information in making critical decisions about children. This is an onerous task. If one explores the process of assessing children in need of protection what emerges is the benefit of having a CPPHN on the team, with the skills to show how parents' problems and unmet needs impact on the health and development of their children.

The social work team at South Lee social work department value the knowledge and skills base of the CPPHN. This is especially important in respect of the impact of neglect on child development, as the assessment is strengthened in an area where social work professional training has not been strong. Due to the quality of her education and training, the CPPHN is well tuned to spot behaviours that are not typical of normal child health and development. For example, in working with neglect, the CPPHN builds up evidence of a child's progress or lack of progress over a period of time. In seeking to protect children, social workers must be satisfied that a child's health and welfare has been or is being impaired or neglected and this decision will be made in conjunction with for the CPPHN, local public health nurse, general practitioner or paediatrician. The experience of the social workers is that the CPPHN's skill-set and knowledge resulted in more timely and more complete assessments for vulnerable children. They were positive that the outcomes for children were improved as a result of strengthened assessments, earlier differentiation between child welfare and child protection cases and access to more appropriate community-based services for children and families.

Recommendation 1

- **There is a role for child protection public health nurses to work within the Child and Family Agency, to provide clinical expertise in the area of child health and development and to be the link between the Agency and local primary care teams.**
- **Alternatively, there is a role for a designated child protection public health nurses within primary care to support, supervise and strengthen the child protection aspect of the role of the Public health nurse and to link with the Child and Family Agency.**
- **With the development of the Meitheal model²⁸ there is also a role for the designated child protection public health nurse to liaise with the local**

²⁸DCYA (2012) http://www.tusla.ie/uploads/content/Tusla_Meitheal_A_National_Practice_Model.pdf

coordinator of this initiative relating to the cases that involve young children who require this specific support.

4.2 Early intervention

An analysis of the recommendations of major child protection reviews emphasises the critical role that public health nurse's play in early intervention with vulnerable young children and families.²⁹ The Ryan Report implementation plan repeated the importance of the Public Health Nursing prevention and early intervention service.³⁰ In reality the public health nurses have divided loyalties between their clinical and child-health caseloads. The mismatch between expectations and the fulfilment of both roles is perhaps greatest in the area of early intervention. Recognising the early signs of parenting difficulties requires a public health nurse to be proactive in the best interests of the child. However, it is evident from the evaluation that competing priorities continue to challenge the public health nurse, in putting the needs of children first.

4.3 Referrals

There is little doubt that health and social care professionals are witnessing changes in their roles with the implementation of the Child and Family Agency National Service Delivery Framework (NSDF). The NSDF seeks to fully integrate the work of the different professionals and agencies from universal and community services through to secondary and tertiary level services. With its emphasis on disentangling child welfare concerns from child protection issues professional roles will be further developed. Much has already been done in the way of reforming the child protection limb of the Agency. Exactly how the reforms to child welfare (Meitheal Model) will be implemented is less clear.

As stated earlier, a social worker must be satisfied that a child's health is being compromised. The writer notes that public health nurses are generally not good at expressing their concerns about child neglect, and hence may not receive the feedback that they expect from social workers. Surprisingly, the child health and development concerns assessed by public health nurses are not always obvious on Standard Report Forms. It is evident from the *Threshold for*

²⁹Hanafin S (2014) Child protection reports: key issues arising for public health nurses *Community Practitioner*; 86(10):24-7.

³⁰ Commission to Inquire into Child Abuse (2009) Report of the Commission to Inquire into Child Abuse (The Ryan Report). Dublin, Government Publications.

Referral document that social workers need to have evidence of the effects on children who do not receive adequate care and protect. Public health nurses can assist themselves by making use of the *Child and Family Health Needs Assessment Framework*³¹ to name the concern. Unless the concern is made clear, in the face of 20 other referrals on a given day, it is perhaps unreasonable to expect an immediate response.

Recommendation 2

- **Public health nurses should make use of the Child and Family Health Needs Assessment Record when making referrals to the Child and Family Agency. The assessment should cover issues specific to how the parents' problems are impacting on the health and development of the child/children.**

4.4 Thresholds

Thresholds are used to assist the social worker in making an initial decision as to the next step.³² There is evidence of tensions within public health nursing practice about thresholds for referral and feedback. The views of the public health nurse respondents is that they are experiencing an expansion of their role in child protection as social workers focus on the most vulnerable children at levels 3 (multiple complex needs) and 4 (highly complex and or immediate risk of harm) on the Hardiker levels of need continuum³³. Many of the public health nurses spoke about the lack of feedback when they refer cases to social workers, leading to, in some instances, to a delay in making the referral when a response is unpredictable. A failure to respond leaves the public health nurse and the children vulnerable. Public health nurses gave examples during the course of the focus groups of attempts to moderate the risk within their own resources and expertise, before a referral is made.

The *Thresholds for Referral* document states that it's important for professionals making the referral to remain involved with the family in the intervention plan.³⁴ In practice this marks a shift for the public health nursing service, particularly if it involves more work with families

³¹ O'Dwyer P. (2012) A Report on the Child and Family Health Needs Assessment Framework Project in the HSE Dublin Mid- Leinster Public Health Nursing Service Areas of Laois, Offaly, Longford and Westmeath. Dublin, Health Services Executive.

³² Child and Family Agency (2014) Thresholds for Referral to Tusla Social Work Services. Dublin: Child and Family Agency.

³³ Hardiker, P. & Baker, M. (1995) *The Social Policy Contexts of Child Care* London: National Society for the Prevention of Cruelty to Children.

³⁴ Child and Family Agency (2014) Thresholds for referral to Tusla social work services. Dublin: Child and Family Agency.

without appropriate support and guidance. Remaining involved with a family where the public health nurse cannot affect any meaningful improvement cannot be in the best interests of a child or family. The availability of the CPPHN is reassuring for public health nurses who admit to seeking her advice in interpreting whether the vulnerable family situation reaches the threshold to be considered child neglect.

Recommendation 3

- **Social work teams should work with the public health nursing service, at a local level, to better understand the child protection referral and assessment process and the threshold for referral to the Agency.**

Recommendation 4

- **Social work teams should continue to work with the public health nursing service at a local level, to ensure prompt feedback to referrals that does not leave the public health nurse and the children vulnerable.**

Recommendation 5

- **There should be protocols in place to guide best practice in consulting with the child protection public health nurse in South Lee social work department.**

Recommendation 6

- **It is recommended that a course in court room skills form part of the induction to the role of child protection public health nurse.**

4.5 Support and supervision

The evaluation highlighted the challenges public health nurses experience in the management of neglecting and resistant families. According to the public health nurses, there are a substantial number of cases in the middle ground that do not meet the threshold for referral to the social work service and who require an intervention. The CPPHN provides support to the public health nurses in how to manage these cases. As managers, the assistant directors of public health nursing were open to saying that they were heavily reliant on the expertise of the CPPHN in that they encouraged the public health nurses to consult with her in dealing with these cases. It may be that such cautious practice among assistant directors of public health nursing is not a bad thing. It is more likely that this is a manifestation of the fact that,

at the time of the evaluation, supervision in child protection was not embedded in public health nursing practice. The need for a model of supervision emerged as a priority in the course of the implementation of the Child and Family Health Needs Assessment (CFHNA) programme³⁵. This support is necessary for all public health nurses to fulfil their role and responsibilities vis-à-vis *Children First*³⁶ and the policy document states that all practitioners must receive regular supervision by an appropriate line manager.³⁷ Regarding the qualitative aspects of what supervision should address section 6.1.3 of *Children First* proposes that it is essential that managers of all disciplines involved in child protection work acknowledge the levels of actual or potential stress that may affect their staff and take steps to address any problems.³⁸ These steps may include:

- (i) *'adequate and regular supervision of staff;*
- (ii) *regular review of caseloads;*
- (iii) *acknowledgement of positive achievement;*
- (iv) *provision of opportunities for professional development, such as training, staff rotation, special assignments;*
- (v) *development of inter-agency links;*
- (vi) *putting in place the necessary arrangements and procedures to ensure the safety and security of child welfare and protection staff'.*

The experiences of public health nurses and assistant directors of public health nursing suggest that there is work to be done if the public health nursing service is to meet the requirements of the practice principles outlined in *Children First Guidance* document. At the time of the evaluation it is evident that public health nurse supervision is not commensurate with their level of responsibility in child welfare and protection.

Recommendation 7

- **It is recommended that a strategy is developed to support assistant directors of public health nursing in developing the skills in supervision to enable them to keep pace with the increasing complexity of child welfare and protection cases.**

³⁵ O'Dwyer P. (2012) A Report on the Child and Family Health Needs Assessment Framework Project in the HSE Dublin Mid- Leinster Public Health Nursing Service Areas of Laois, Offaly, Longford and Westmeath. Dublin, Health Services Executive.

³⁶ Department of Children & Youth Affairs: (2011) *Children First: National Guidance on the Protection & Welfare of Children*

³⁷ *Ibid* p 46-47

³⁸ *Ibid* p54

4.6 Decision making

Social workers have to make decisions and act while simultaneously having to strike a proper balance between protecting the child and respecting the rights and needs of parents, carers and families. Where there is conflict, a child's welfare must come first. The reality of their statutory responsibilities means that they are not allowed the luxury of unlimited time to investigate and reflect.³⁹ Decision making is dependent on quality information as abuse and neglect rarely present with a definitive picture.⁴⁰ Towards that end, social workers need to gather information from a number of sources and build a picture of the child and family and new information can come to light that may confirm or disprove the existing view of the family. First judgments may be incorrect and changing one's mind when new information comes to light can be an unpleasant experience.⁴¹ When we add 'groupthink' to the decision making equation, there is a tendency to reach consensus and avoid conflict⁴² and groupthink can often be present in the social work environment.⁴³ However, the dangers of groupthink can be reduced when views can be challenged. The decision making picture that emerged in this evaluation is one where information and expertise is shared, due attention is given to the professional judgement of the CPPHN, there can be disagreement, and alternative solutions are raised as to which interventions are most likely to have a positive effect.

Recommendation 8

- **The Child and Family Agency should ensure that the arrangements for the supervision of the Child protection public health nurse are clearly understood and robust.**

4.7 Collaborative working with general practitioners and other groups

Nationally, emphasis on the responsibilities of all professionals working with vulnerable children has intensified.⁴⁴ The *Child Protection and Welfare Practice Handbook*⁴⁵ lists the

³⁹ Munro, E. (1996) Avoidable and unavoidable mistakes in child protection work 1996. British Journal of Social Work London: LSE Research Articles Online. Available at :<http://eprints.lse.ac.uk/archive/00000348/>

⁴⁰ Health Information and Quality Authority (2012) National Standards for the Welfare and Protection of Children for Health Service Executive and Family Services Dublin: Health Information and Quality Authority

⁴¹ Munro, E. (1996) Avoidable and unavoidable mistakes in child protection work. London: LSE Research Articles Online. Available at:<http://eprints.lse.ac.uk/archive/00000348/>

⁴² Munro E. (2008) Effective child protection (2nd edition). Sage Publications, Los Angeles, USA.

⁴³ Ibid p12

⁴⁴Department of Children and Youth Affairs (2012) Report of the Taskforce on the Child and Family Support Agency, Dublin: Government Publications.

type of information that 21 professionals and services can be expected to provide in the context of multidisciplinary child protection work. The reality is that not all professionals working with children assume their ascribed roles in child protection. Social workers reported that general practitioners have the lowest attendance rate among the professionals invited to case conferences. Yet general practitioners in this evaluation welcomed the presence of a health professional on the social work team to refer to, and acknowledged the importance of the role in particular for young children (under-fives) and families. It is evident from the participant responses, that health professionals (general practitioners, public health nurses and paediatricians) would initially seek support and advice about child neglect from colleagues who share a similar frame of reference and model of working, rather than from social workers. There is support for this view among some general practitioners in the UK who rated the health visitor as highly significant to refer to, where there was a concern about a child.⁴⁶ General practitioners in the UK saw their role in most cases as referring families on where concerns were raised, while key stakeholders expected full engagement in all stages of the child protection process.⁴⁷

Recommendation 9

- **The Child and Family Agency and the Public health nursing service should take every opportunity to promote and publicise interdisciplinary training opportunities.**

Recommendation 10

- **The South Lee social work department should organise succession planning for the post of child protection public health nurse.**

Care has been taken to ensure that recommendations are drawn from a consensus view of the participants in the evaluation.

⁴⁵ *ibid*

⁴⁶: CAIPE Centre for the advancement of professional education(2010) Response to the General Medical Council Consultation document 'Call for evidence on the role of doctors in Child protection'

⁴⁷ Appleton, J. (2012) Delivering safeguarding services in primary care: responding to national child protection policy. Primary Health Care Research and Development 13 (1) 60-71.

Conclusion

The evaluation has shown how the CPPHN contributes to inter-professional and interagency working in child protection. An inter-professional informed assessment serves as a strong base for strengthened decision making, timely interventions and improved outcomes for children and families.

There is evidence that public health nurses in primary care found work involving child protection as challenging. Issues relating to the working relationship with social workers were identified by public health nurses including the need to understand each other's roles, responsibilities and professional ideologies. This report also highlights the practical and emotional demands of child protection work on practitioners, and recommends that access to regular supervision is essential.

Tentatively, it is suggested that the CPPHN model can work and provide positive outcomes for children, in that it can withstand many of the challenges in inter-agency work at a time of significant structural change in the delivery of child welfare and protection services. There is a need for clear governance structures to be in place for this model to achieve its aims and objectives work.

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Appendix 1

Job description for child protection public health nurse in 2001

Terms of Reference:

1. To provide Public health nurse advice and support to children and their families who have been referred to a community care child protection service.
2. To provide support to families referred to a child protection team that have had a bereavement, marital break-up, family disharmony, or loss through care. Joint working with a child protection social worker would take place, where appropriate, in cases with extreme loss or separation issues occur within a family.
3. To liaise with the maternity and general hospitals on pre and post birth planning of mothers and families that are referred to the child protection service.
4. To visit homes following post birth discharge, and if required, take a direct part in the assessment process with the assigned social worker and liaise with the local public health nurse in the community.
5. Where children have been taken into care, the child protection nurse to liaise with the local public health nurse in the child's area so as to ascertain the previous public health nurse involvement with the child and ensure ongoing communication.
6. To liaise with foster parents and offer support, advice where indicated and inform the public health nurse in the foster parent's area of new placement.
7. To take a direct role in the assessment of physical and emotional abuse, domestic violence, Munchausen by Proxy and cases of neglect which are caused by the environment, health, poor nutrition, drug or alcohol abuse. These assessments will be done jointly with the area social worker. They will undertake specific tasks as part of the assessment and in accordance with their discipline.
8. Liaise with the area public health nurse and where possible undertake in partnership with the local area public health nurse the developmental screening as part of the Social work assessment in specific cases.
9. Be based within a community care team.
10. Liaise with the area public health nurse on each case it has been assigned.
11. Attend strategy meetings, case conferences, attend legal proceedings requested by the Southern Health Board, and foster care reviews if necessary.
12. To maintain contemporaneous notes on each family he/she is involved with through the community care team. Reports for meeting will be requested by the child protection team, appropriate line management. All recording will be subject to review by a line manager and must be signed off by their line manager. All case notes and reports will be kept within the child protection team.
13. Develop care plans for families and individual children in conjunction with the area social worker and their line managers.

14. Attend supervision provided by an assistant director of public health nursing.
Consultation will be provided by a team leader in conjunction with the assigned social worker for the child protection public health nurse.
15. Attend relevant training opportunities and where applicable, facilitate inter-discipline training and development team.
16. The child protection public health nurse will have access to the local health centres in the geographical are of the social work team.
17. Monthly meetings will take place between the senior social worker and the assistant director of public health nursing to discuss the progress of the pilot project.

Appendix 2a

Overview of the CPPHN caseload at supervision Jan 2003

- Requested to do a court report. Two children living with mother who had poor parenting skills. CPPHN support being phased out. CPPHN closure summary to be drawn up.
- Joint intensive home visiting alternating with SW to a case of non-accidental injury where the infant has been returned home. CPPHN support to mother and monitoring of family.
- Continued support to a single mother where there had been severe neglect and children are now having respite foster care
- Support to a family with three school-going children where persistent headlice features as part of neglectful presentation
- Support to a single parent with intellectual disability in relation to her contraception following reception of her children into care
- Second case with similar circumstances. Referral focused on the maternal self-care and health.
- Home visitation as part of Duty SW assessment of family with four children and possible neglect
- Visitation to family where new baby expected in family where there are concerns about parental capacity and neglect with older three children.
- Work with young boy with enuresis where father is now the lone care giver to five children during long psychiatric admission of the mother.
- Working with case SW in early assessment of settled traveller family with young children where parents have substance abuse behaviour.
- Mother from family with drug addiction history who has 6 children. Supervision order in place with family frequent visitation as part of assessment.
- Supporting foster carer in the management of enuresis in a young girl who has been recently admitted to care with her sister.
- Romanian mother with two children concerns re her ability to meet children's needs, visitation as part of assessment of her parenting and consistent care of children.

Appendix 2b

Overview of the CPPHN caseload - Cases July 2012

- Requested to do a review of case files where there are multidisciplinary concerns and to present report to paediatric neurologist regarding 3 children in care ages 5, 3 and 1, that had experience of domestic violence and may be living with fetal alcohol effect.
- Joint home visit with SW regarding suitability of a home and assessment of parental capacity for home-based access. Child age 1.
- Child born prematurely, still in hospital with complex medical needs from birth now age 1 year - assessment in progress about parental capability to manage home care and subsequent identification of foster parents.
- Young mother who was in care herself, assessment of her parenting of her 2 year old daughter.
- Concern about the health of a young child in foster care when tooth decay and poor dietary habits are continuing.
- 12 year old girl in foster care who is bedwetting.
- Support to the primary care SW in assisting a family, where the parents have learning difficulties, one child - diabetic, one with enuresis.
- Antenatal support to mother with learning difficulties whose 3-year-old is in care.
- Joint assessment with SW of mum with intellectual difficulties in her capacity to care for her 1 year old - presently in supported living situation.
- Support to mum who already has a child in foster care, in her management of her young son following their discharge into the community from parent and baby facility.
- Joint assessment and ongoing support to the family of children whose parents have intellectual disability and whose older children are in special school.
- Work with SW in the assessment of parental capacity, and support to a couple with 3 young children where the mother's three older children are in care. Supervision order in place
- Support work with mother who was in care throughout her childhood, in parenting a 3-year old and who subsequently became pregnant. Supervision order and then care order taken.
- Joint work with SW regarding an African family of 6 children, 3 of whom have sickle cell disease where there is child abuse and domestic violence. Father subject of a Barring Order.
- Involvement in prolonged court proceedings regarding a family of three children taken into care in mid-2011.
- Joint assessment of the maternal care of three young children living at home where mother is very uncooperative.
- Home visiting to family with a new baby where the two school-going children are in residential care.

- Work with a Roma family where the very young parents have 3 children and 4th expected, and where neglect of a skin condition had led to a Care and subsequent Supervision Order.
- Joint assessment with SW of parents whose care of an 18 month old is unintentionally neglectful due to lack of bonding.
- Work with African family where mother's ability to parent is diminished due to mental health problem and where the father has to assume the care of the two children: a 5-year old and 6 month-old baby.
- Joint assessment with SW in a very neglectful situation where three school-going children have bedwetting and skin problems, dietary concerns, assessment of parental ability/capacity.

Appendix 3

CPPHN professional development

- Sheila has been a member of the Cork City Parent–Infant Network Group, since its founding in 2009. This is a multi-disciplinary study group which meets on a monthly basis to develop relationship based practice in services for 0-3 year old by building competence through increased awareness and understanding of Infant Mental Health theory and its practical application.
- The Bessborough Centre **Attachment & Psychopathology with Dr. Patricia McKinsey Crittenden** Mar 10th-12th 2014
- HSE **Care Planning for Children and families in Primary care** Patricia O’Dwyer September 2013.
- HSE **Child and Family Health Needs Assessment** Patricia O’Dwyer 12th and 19th Sept 2013.
- Mercy University Hospital **Paediatric Continence Study Day June Rogers** 6th June 2013
- HSE Training Unit Child Care & Family Support **Court Skills Training** 22nd February 2013
- Bessborough **Attachment Theory in Practice with Professor David Howe** 17th May 2013
- Centre of Midwifery CUMH **Six Hour Breastfeeding Programme** 28th January 2013
- Bessborough **The Rhythm of Neglect Part III Children who experience Chronic Neglect** 21st September 2012
- Bessborough Cork Parent-Infant Mental Health Group. **All babies Count all day workshop** Dr. Amanda Jones and Angela Joyce April 4th 2012
- HSE **Child Safety Awareness Programme Training for Public health nurse** 18 May 2010
- SafeTALK **Suicide alertness for everyone** Training in Suicide alertness 29th November 2011
- CPI for HSE South **Participation in Nonviolent Crisis Intervention** 6 hours 27th October 2006

- UCC Department of Nursing and Midwifery **M.Sc. Nursing Studies** 2005-2006. All the assignments related to aspects of child protection and nursing practice and the dissertation, a qualitative study focused on 'Public health nurses' of child neglect in their practice' (2006).
- HSE Training Unit Child Care & Family Support **Parents Plus Early Years Programme** 14th, 15th 16th December 2005.
- HSE Training Unit Child Care & Family Support **Emotional Abuse, Neglect and Failure to Thrive in Children** Dr. D Ivaniec 10th, 11th November 2005.
- HSE Best Health for Children Child Health Training Unit, **The Nutrition in Child Health Module** 27th September 2005.
- College of Midwifery St Finbarr's **Preparation for Birth and Parenthood Facilitator's one day Workshop** 25th February 2005.
- College of Midwifery St Finbarr's **Preparation for Birth and Parenthood facilitator's one day Introduction** Course 9th December 2004.
- HSE Best Health for Children Child Health Training Unit **Developmental Surveillance Programme Behaviour Module** 26th September 2003.
- HSE Training Unit Child Care & Family Support **The Family Assessment Pack of Questionnaires and Scales (Assessment Framework)** 13th May 2003.
- HSE Training Unit Child Care & Family Support **Assessment Framework** 16th 17th January 2003.
- HSE Training Unit Child Care & Family Support **Group work Skills** 7th 8th October 2002.
- SHB Health Promotion Department **.Developing Brief Intervention Skills for Health Professionals** March 2002.

Appendix 4

Focus Group Guide Questions

Manager

- What does the CPPHN contribute to the management of children who are in receipt of Social work Services in South Lee?
- What do you see at the most important aspect of the contribution/ role of the CPPHN?
- What are the aspects of the case that would make you consider referring the case to the CPPHN?
- How has CPPHN role changed over the past decade?
- What changes if any would you like to see in the role of the CPPHN?
- Anything else that you wish to share about the role of the Child protection public health nurse?

Team Leaders

- What does the CPPHN contribute to the management of children who are in receipt of Social work Services in South Lee?
- What do you see at the most important aspect of the contribution/role of the CPPHN?
- What factors influence your referral of a case to the Child protection public health nurse?
- What changes if any would you like to see in the role of the CPPHN?
- Anything else that you wish to share about the role of the Child protection public health nurse?

Social workers

- In what way does the Child protection public health nurse contribute to the assessment of child/family in your caseload?
- What do you see at the most important aspect of the contribution/ role of the CPPHN?
- In what way does the Child protection public health nurse contribute to the multidisciplinary decision making in a case?
- How does the Child protection public health nurse contribute to the planning and management of a case?
- What kind of interventions have you observed the Child protection public health nurse engaging in with a family?
- How do you decide when the Child protection public health nurses involvement with the case is complete?
- What changes if any would you like to see in the role of the CPPHN?

- Anything else that you wish to share about the role of the Child protection public health nurse in the Social work team?

Public health nurses

- In what way does the Child protection public health nurse contribute to your management of children where there is a concern about their welfare?
- What do you see at the most important aspect of the contribution/ role of the CPPHN?
- How did the Child protection public health nurse contribute to your assessment of a child where you have a concern about their welfare?
- How did the Child protection public health nurse contribute to your planning of the management of a child where you have a concern about their welfare?
- What kinds of interventions have you been observed the CPPHN engaged in with family?
- What changes if any would you like to see in the role of the CPPHN?
- Anything else that you wish to share about the role of the Child protection public health nurse in the Social work team.

Appendix 5

Outline of letter sent to stakeholders who have professional involvement with the CPPHN

We wish to evaluate the contribution of the CPPHN to the management of children who are in receipt of Social work Services in South Lee. The research team would be grateful if you can assist us to understand how you view the CPPHN initiative in the management of children that you have had involvement with.

- What do you consider is the contribution of the CPPHN to children and their families?

- Base your reply on your experience of working with the CPPHN and give instances or examples of her input both to the family and the multidisciplinary working on the case, including reference to the health specialist contribution to the teamwork.

- How did your work with the CPPHN impact on the child and the family?