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The knowledge and practice of health visitors in North Wales in relation to child neglect : a critical enquiry

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The Knowledge and Practice of Health Visitors in North

Wales in Relation to Child Neglect: A Critical Inquiry

Thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy in the University of Wales, April 2006

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DECLARATION

This work has not been previously accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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SUMMARY

The knowledge and practice of health visitors in North Wales in relation to child neglect: a critical inquiry

Aim: The aim of this thesis was to determine the factors that predisposed health visitors to act and how they acted to prevent and protect children from neglect.

Background: There is empirical evidence of resilience and risk associated with child maltreatment and to a lesser extent child neglect. Knowledge relevant to health visiting supports the service improving the health and development of children but there is little evidence about the impact the service has on preventing and supporting incidences of child neglect.

Method: The philosophy of Jurgen Habermas underpinned this multi-method approach which included a retrospective case control, health visitors' narratives, and, a survey of parents' preferred sources of support.

Findings: The case control study found three variables with predictive ability of child neglect – management and handling of child, behaviour perceived a problem and poor school attendance. The two phase process of analysis of health visitors' narratives indicate (1) a four stage process of intervention – establishing a relationship, accessing the context of the family, clarifying and revising interpretations and determining levels of concern and (2) interests and inequalities relating to three styles of communication. Rhetorical persuasion, rather than normative or coercive rhetoric, was the most effective form of communicative action to support families and improve the quality of life of children. From the survey many of the variables strongly associated with child neglect were also found to be those for which parents were less likely to seek help.

Conclusion: Extrapolated from the findings is a new conceptual framework for health visiting practice – *Health Visiting as Communicative Action* and the recommendation that health visitors take lead responsibility for children in need when children's health and development are the major concern.

CHAPTER ONE

CHILD NEGLECT: THE INSTRUCTIONAL AND EMPIRICAL-ANALYTICAL KNOWLEDGE

1.1 INTRODUCTION

This thesis contributes to the empirical evidence of resilience and risk associated with child neglect. The identified buffers to increased risk provide a firm foundation on which to build preventative services. In particular, the empirical evidence for how health visitors apply this knowledge and how they work with families when there is suspected or actual neglect of children's needs is explored. Empowerment is a major goal of the theoretical underpinning for health visiting. Working with issues of child maltreatment, such as child neglect, health visitors must also be cognisant of theories that underpin safeguarding children and child protection practices. Consequently, there are potentially three interests that apply to health visiting and child protection services. They are empirical, experiential and emancipatory interests. How these interests apply to health visiting was investigated using a multi-method approach that included a case-control, a narrative and a survey study.

This first chapter: Child Neglect: The Instructional and Empirical-Analytical Knowledge is based upon a detailed examination and understanding of a range of research literature related to child neglect. Immediately after this introduction, the chapter begins with the proposal by Ney and colleagues (1993) that child neglect is the precursor to child abuse. This is followed by a review of definitions of neglect, the empirical evidence of risk of neglect and the empirical evidence of protective factors and resilience.

Chapter Two: The Practical and Emancipatory Interests of Health Visiting examines the second science and interest defined by Habermas is the historical-hermeneutic science, in other words, the 'practical' interests of health visitors. Historically, health visitors developed from the philanthropic intent to help the poor, the sick and the needy. In their professional roles health visitors have remained relatively close to their roots, but like so many community agents they perform according to a

political agenda. Unfortunately for health visitors the result of current public policy is a legitimate political agenda to provide a universal, non-stigmatising service but little or no legitimacy to act when parents breach their parental responsibility. The barriers to achieving the aims set them is inconceivably the inconsistencies between health visitors and social workers' perceived level of seriousness of the impact of family difficulties on children. As social services have lead responsibility for child welfare any unresolved differences of opinion can, seemingly, negate early identification of impairment and early appropriate intervention until the seriousness complies with child protection criterion.

Chapter Three: Rationale for Adopting Habermas' Critical Theory to Guide the Study; sets out the theoretical position of the researcher and the theoretical rationale for the study. The various theoretical foci of health visiting, the ecological model that is recommended to underpin the practice of safeguarding children and Habaermas's critical theory are analysed in terms of the notion of systems. That is, environmental influences on children and their families and the appropriateness of systems or environmental models for research purposes. Habermas's critical theory is justified on the grounds of its potential for integrating multiple sciences, epistemological, hermeneutic and emancipatory, to illuminate more widely the social reality of health visiting. .

Chapter Four: Research Methodology outlines the purpose of the study and the research design of the multi-method approach. Study 1, a case-control study, applies the natural science approach. Study 2 adopts hermeneutic and critical-oriented science by interpreting health visitors' narratives of their work with families with a child categorised as 'neglected'. Study 3 takes a critical-oriented focus to investigate the legitimacy of health visiting as a preferred source of support for childcare and parenting difficulties.

Chapter Five: Health Visitors' knowledge of Factors Relevant to Children's Health and Development presents the findings of the case-control study. Multiple variables were reported with 32 variables differentiating between the neglected and non-neglected samples. Statistical analysis of 32 variables found three variables with predictive ability. The study supports health visitors applying evidence-based

practice, a breadth of empirical knowledge relevant to promoting children's health and development, and preventing child neglect.

Chapter Six: Health Visitors' Narratives of Working with Neglected Children and Their Families explores seven health visitors' stories of their interactions with families that they perceive as 'neglected'. Constructed meanings and interpretations are offered in two stages. The first stage elicited a process of assessment and intention of intervention. The second stage gives consideration to the health visitors' interests when working with the children and their families and the inequalities that resulted, mainly due to the application of different styles of communication.

Chapter Seven: Health visiting as a Preferred Source of Support for Parenting and Childcare Needs or Problems incorporates, in a survey, the predominant problems found in the case-control study. The development of the survey also builds upon the tensions some health visitors experienced in their attempts to engage constructively with families by hypothesising that parents may not be accepting of health visitors for certain needs or problems. Although the results support health visitors as the most preferred source of support a fundamental finding in terms of seeking support is not the source but the reluctance to admit to certain crucial factors.

Chapter Eight: Discussion – Health visiting as Communicative Action, draws upon the findings about the knowledge and practice of health visiting and adults' preferred source of support for parenting and childcare problems. The resulting theoretical construct is of health visiting as ecological and systems-grounded that works at the 'pre-contemplational' stage of change. The most effective 'interest' of health visiting, in terms of improving the quality of life of vulnerable children, was rhetoric that encouraged both parents and health visitors' expression of meanings related to parenting and childcare.

Chapter Nine: The implications for health visiting practice as a result of this study are summarised. Also summarised are the research, educational and practice recommendations and limitations of the study.

1.2 CHILD NEGLECT: THE PRECURSOR TO ABUSE

Despite being a societal phenomenon for centuries (WHO 1997a) "child abuse is still a major unrecognised problem, impairing the health and welfare of children and adolescents" (WHO 1997b). In Britain one child under five years of age dies each week due to abuse and neglect (NSPCC 1999). Neglect is the most prevalent of maltreatments in the United Kingdom as can be seen from the comparison of the percentages of all types of abuse recorded for 1999, 2002 and 2004 and presented in table 1. It is on average 14.5% more common than physical abuse, the next highest prevalent type of child maltreatment. The percentages in table 1 do not total 100% as a multiple category is also applied (15% for England, 12% for Northern Ireland, 13% for Scotland and 13% for Wales). The NSPCC (2005) statistics for 1999, 2002, and 2004 show a staggering increase in Wales (814 to 922) and in Scotland (558 to 809). Abbreviations in Table 1 related to types of maltreatment such as PAbuse for physical abuse, EAbuse for emotional abuse and SAbuse as sexual abuse.

Country	1999	2002	% Neglect	% PAbuse	% EAbuse	% SAbuse	2004
England	13,900	10, 100	39%	19%	17%	10%	10,600
Northern Ireland	548	625	39%	26%	14%	9%	509
Scotland		558 (2001)	40%	33%	13%	13%	809 (2002)
Wales	814	789	40%	22%	18%	7%	922

Table 1.1: Child neglect (only) cases registered in 1999, 2002 and 2004 (2001 to 2002 for Scotland). Source: NSPCC 2005.

The importance of child neglect is not just the high prevalence or the deleterious damage to children's lives and their future as adults, although both are fundamental to the realisation that neglect deserves recognition in its own right and not, as is common, as an appendage to child abuse. The crucial factor, as Ney and colleagues (1993) suggest, is that neglect is likely to be the precursor to abuse. Physical and

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emotional neglect are likely to occur before sexual abuse (Ney et al 1993) and typically to be experienced at a younger age than abuse (Ney et al 1994). The earlier maltreatment occurs the more vulnerable a child is and more devastating the consequence (Scannapieco & Connell-Carrick 2002). Ney et al (1993) also found emotional neglect to have the most negative impact. Furthermore when neglect precedes abuse the effect of neglect has been found to be greater than the effect of abuse.

1.3 DEFINITIONAL ISSUES OF CHILD NEGLECT

The general, international consensus about the commonality and pervasive nature of neglect upon children's health and development has almost become matter of fact (Becker et al 1995; Rose & Meezan 1993; Schumacher et al 2001; Boehm 2002) but there is no generally accepted definition for child neglect (Black 2000). Throughout the existence of a child protection system, child neglect has, periodically, emerged and submerged with the ebb and flow of public opinion and, more recently mass media presentation. Similarly, definitional variations and competing aetiological findings have failed to adequately account for child rearing patterns. Just as Kempe & Kempe (1978:17) suggested of the 19th century, child neglect and abuse "could not be acknowledged as a social ill, changes had to occur in the sensibilities and outlook of our culture". Accepting the changes in our culture's sensitivities to children having a right to their needs being met and the cultural influences on parents' ability to meet them ought to be as much a part of child protection work as evidence-based practice (Taylor & White 2001).

However, not until recently has the prevalence of child neglect produced such serious concern as to suggest a professional 'neglect of neglect' (Wolock & Horowitz 1994; Cantwell 1997). Currently, a new assessment framework is being implemented that claims to incorporate sensitivities towards prevention of abuse and neglect by means of identifying children whose health or development will be impaired without some service provision (DOH 2000; NAFW2001). What those sensitivities are of child neglect is worthy of examination beginning with an historical account of British legal definitions.

1.3.1 An historical account of British legal definitions

There is one agreement about definitions of child neglect and that is that there are problems inherent in reaching a concrete definition (Giovannoni 1989; Rose & Meezan 1993; Dubowitz et al 1993; Crouch & Milner 1993). In Britain, the child protection service focus on neglect has gone from neglect as abandonment, desertion or taken into care of other than their parents (Ministry of Health - Children Act 1891) to the ability of parents to meet children's basic needs (Dubowitz, Pitts & Black 2004). In earlier Children Acts parental responsibilities were evident in that the Act charged the court to "refuse right to custody of the child" (3.1) if fathers' conduct was not approved by the court. Only fathers at that time had legal custody of children. Support was given for keeping children with their families but rehabilitation of the family was certainly not an automatic course of action for those fathers found to be "unmindful of his parental duties" (Children Act 1891: 3.3). By 1908 there was a requirement to register with local authorities the whereabouts of children cared for, for reward or maintenance. This was the beginning of an early widening of the definition of child maltreatment from biological fathers to any child's caregiver. The Children Act 1908 also specified the new role of "infant protection workers". These workers were responsible for inspecting the premises and satisfy themselves that the provision for infants was adequate. Refusal to comply with the infant protection workers could result in a warrant for access and the removal of the child if the premises were found to be dangerous or unsanitary.

Then followed the attention to physical effects of neglect (Erickson & Egeland 1996) with evidence of inappropriate provision of children's needs including "negligence, ignorance, inebriety, immorality, criminal conduct or similar unfit causes" (Ministry of Health - Children Act 1908: 5.1b) that inhibit the provision of adequate food, clothing, medical aid, or lodgings (12.1b). By 1933 the same provisions applied but so did **"failure to take steps to procure it to be provided"** (Ministry of Health - Children & Young Person Act 1933: 12.1b). What these early Children Acts did was to begin the formulation of a standard of provision that included seeking help. The expectation that parents would seek help was lost in later Acts that began instead to focus on the serious effects on children's health and development (Department of Health - Children & Young Persons Act 1963) and

proper health or development that is avoidably prevented or neglected (Department of Health - Children & Young Persons Act 1969) and to promotion of health and development of children (Department of health - Children Act 1989). Contemporary guidance recommends the seeking of help is to be viewed as a parental strength (DH 2000; NAfW 2001).

For protective purposes (compulsory intervention) the definition of neglect has again narrowed to "the persistent failure to meet children's needs" (DOH 2000; NAFW 2001). This was at a time when the reported cases of neglect increased. One complexity in determining a definition is the interdisciplinary and lay concept that "must take into account the social roles of the definer" (Rose & Selwyn 2000: 181). As Erickson & Egeland (1996) points out, legal definitions are relatively precise. Others' definitions are not so precise and this can lead to discrepancies and strained professional relationships between health, education and social workers (Birchell & Hallett 1995). These legal definitions are based more on consensus than empirical evidence (Polansky et al 1968) as rarely was neglect considered a phenomenon in its own right until relatively recently (Paget et al 1993).

1.3.2. Lay and worker definitions

More complicated are the differences in definitions found between mothers and workers. When Rose and Selwyn (2000) interviewed 42 English and African mothers and 26 English and American social workers, and Rose (1999) interviewed 91 mothers of African American heritage and 70 workers, some agreement was confirmed about the sequence of rating from serious to least serious. Consistently, mothers rated neglect more serious than workers. However, what is considered serious is not what is judged to be harmful to a child. For example, all mothers agree physical care to be serious but neither mothers nor workers believe poor physical care to be harmful. Workers observations of children as 'dirty, smelly' although noteworthy enough to record was not serious enough to require action to be taken (Fitzgerald 1996). For some reason there is a distinct lack of understanding about the consequences of poor physical care to a child's emotional and social health (Lutzer 1990).

Threats to emotional health are judged to be the most harmful scenario by all mothers and British workers and judged overall to be the more serious (Rose & Selwyn 2001) just as Dubowitz (1998) and Hong and Hong (1991) found among American and Chinese and Hispanic mothers, respectively. Injurious parental behaviour, such as substance abuse (Wang & Daro 1998) and poor physical care are judged more serious by British mothers. This inconsistency between threats to emotional health being serious but not judged harmful is recognised by Daniel (2000) who found child care workers claimed emotional wellbeing to be important and then were seemingly dismissive of the quality of 'attachment' for a child who remains with a sexual abuser.

From the seriousness with which mothers judge neglect it is not surprising to find that 90% of lay people in urban and rural communities would report concerns about lack of food, abandonment, and an eight year old child left baby-sitting, lack of medical care, poor school attendance and poor hygiene (Craft & Staudt 1991). These statements are the tangible accounts of people's abstract concept of 'child neglect'. Research evidence supports the lay definition of child neglect as a lack of "adequate food, clothing, shelter, cleanliness, stimulation, medical care, safety, education, and love and control" (Minty & Pattison 1994: 736); a view supported by Giovannoni and Becarra (1997) and Zuravin and Taylor (1987). More recently, although professionals might have rhetorically applied a similar definition for preventative practice the applied definition remains the 'persistent' neglect of children's needs (Dubowitz et al 2004; Straus et al 2005).

However, the examples if reported to social workers would not automatically be substantiated as neglect. In a study of social workers' definitions of child neglect Rose & Selwyn (2000) found poor school attendance and hygiene was less likely to be treated seriously by social workers. Professional substantiation would more likely follow reports of a child begging for food, child outside on a winter night inadequately clothed, parents with learning difficulties unable to resolve an infant's nappy rash and a child not collected from a baby-sitter. In effect, these situations conformed to the legal definition of evidence of persistence of neglect or actual harm. Reported in the inquiry into the death of Victoria Climbie (Laming 2003) are equally narrow definitions of neglectful circumstances that found health, police and other professionals not accepting lay reports or concerns of colleagues. The

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professional definition of child neglect is seemingly a lower threshold of concern despite neglect being the easiest form of maltreatment to observe (Glaser 2002). Rose is conscious of the efforts made in North America to raise public awareness of child maltreatment and the responsibility of the public to report cases but would ask more of them. Conversley, as Craft & Staudt (1991) confirm, there is the willingness to report among lay people, but the key to effective action is professional substantiation. Rose's (1999) criticism about individual responsibilities should extend to workers for their application of a narrow construct of child neglect that is not always culturally sensitive.

1.3.3. Divergence and convergence in definitions of child neglect

Consensus reigns in that neglect is accepted as a distinct subtype of child maltreatment (Scannapieco & Connell-Carrick 2002) but there is no doubt that child neglect means something different to different people (Dubowitz & Newberger 1989) in respect of preventing child maltreatment (Erickson & Egeland 1997) and health workers who attempt to procure early resources (White & Spiegel 2000). DePanfilis & Zuravin's (1998) point of view is that too much time has already been spent on shortcomings and revisions of definitions instead of formulating standardised and well-operationalised definitions and on measurement research. She is probably right in that there are more commonalities than differences in definitions of child neglect but some level of consensus is essential if health, social, education, voluntary sector workers and the police are to effectively work together.

In terms of attempts to standardise and formulate ways of working with neglect some movement has been made towards clarifying different levels of neglect and types of neglect. Levels of neglect are conceived as spanning four levels of parental behaviour or 'supervision' (Loeber & Stouthamer-Loeber 1987). First, there are families who engage with services and those who do not (Gelles 2000), and this avoidance or rejection of services can span all other levels. The second level is parental failure to provide basic needs (Corcoran 2000) and supervision (Loeber & Stouthamer-Loeber 1987). The third level is a lack of parental involvement with their children (Loeber & Stouthamer-Loeber 1987; Coohey 2003) and a consequent lack of children's involvement with their parents (insecure attachment). The fourth and most serious level is dangerous parental behaviour necessitating compulsory or

legal action (Farrington 1994; Gelles 2000) because of the perceived or actual damaging consequences for the child (Burke et al 1998; Corcoran 2000). Parents' behaviour at this level may conform to what Polansky et al (1979) described as 'apathy-futility' syndrome. Whatever level of supervisory neglect professionals apply, when making judgements about supervisory neglect two other sets of factors were also found to be influential. They were the characteristics of mother (such as motivation, substance use and prior involvement with child protection services) and characteristics of the workers (perceived potential for increased risk) (Coohey 2003).

Any of the levels may apply equally to the essential needs of children such as "adequate food, clothing, shelter, cleanliness, medical care, safety, education and love and control (Cantwell 1997; Minty & Pattinson 1994: 736; Giovannoni & Becarra 1979; Rose & Meezan 1993; Oates 1996; Zuravin & Taylor 1987). These essential needs of children can be further subdivided into the five types of neglect outlined by Oates (1996) as physical, emotional, safety, educational and neglect of medical care. The eight types described by Zuravin & Taylor (1987) and the twelve need subgroups into physical, psychological and environmental types of neglect identified by Dubowitz et al (2004) can easily be subsumed within Oates' categories of neglect, for example, lack of nutrition and lack of hygiene contribute to physical care. A lack of physical health care and lack of medical health care are similar and could just as easily contribute to either health neglect or medical neglect. A sixth subtype is proposed that is an expansion of the outward expression of stimulation, love and control deemed appropriate depending upon the child's age and maturity (Stevenson 1998); social neglect. Therefore, six main subtypes of neglect can be identified along a continuum of severity as outlined in table 2.

By applying the various types of neglect presenting an aggregate effect of inadequate provision can be realised, such as medical neglect, educational neglect and supervision neglect. Interventions can then initiate more appropriately oriented goals rather than attempt to apply interventions to a vague generalisation of neglect. The latter has little chance of improving medical care, educational attendance and supervision. Likewise, defining the level of unmet need is preferred by some commentators (Dubowitz et al 1993; 2004). In this way a level of severity with

observable effects can be proportionate to the immediacy it demands (Erickson & Egeland 1996).

English et al (2005) and Roditti (2005) draw into these neglectful scenarios the gap between parental failure and the utilisation of wider environmental support. Parents are aware of the standard of parenting expected of them (Westman 1999) and mothers, in particular, understand their responsibility for the health and wellbeing of their children (Foley 2001). Though Foley is also mindful of the mothers who do not have the personal or material resources to meet their own and their children's needs resourceful or not, the Government expects parents to seek support (DH1999). Why, then, researchers and professionals continue to perpetuate the myth than child neglect is more difficult to assess and observe than abuse is uncertain (Gershater-Molko et al 2000). For the most part neglect is visible (Gershater-Molko et al 2000; Glaser 2002), and more visible as severity increases, to either lay or professionals. What remains contentious is whether a standard for adequate child care should be arrived at (Dubowitz 1999). Another contention is the confidence we have in knowing the effect of the defined neglect on a child (Erickson & Egeland 1996). A synthesis of the definitions discussed above is presented in Table 1.2.

Notwithstanding these challenges it must be evident to all that without acceptance of the various levels, service interventions, research evidence and social policy developments will be hindered. Without having some guide as to what is an acceptable standard of child care and the effects of parental behaviour on children from, for example, substance exposure (Twomey et al 2005) and parental neglect of children's needs (Straus et al 2005) precise levels of family support cannot be delivered. Should differing levels of parental behaviour be incorporated a revised definition might view child neglect as the lack of adequate provision, but one which requires adequate clarification according to the impact on children. This is exemplified in the World Health Organisation's definition of 1999 that stated *"Neglect and neglectful treatment is the inattention or omission on the part of the caregiver to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter and safe living condition, in the context of resources reasonably available to the family or caregivers and causes, or has a high probability of causing harm to the child's health or physical,*

mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible" (http: //www.who.int/violence_injury_ prevention/violence/neglect/en. 2005).

Type of neglect	Example	Author
Physical	Failure to provide or inadequate food, clothing, shelter Inadequate hygiene	Zuravin & Taylor 1987; Cooper 1985; Rose & Meezan 1993; Oates 1996; Cantwell 1997; Dubowitz et al 2004 Giovannnoni & Becerra 1979
Emotional	Lack of attentive, responsive behaviour Lack of affection, physical contact and making allowances for annoying behaviour Exposure to unwholesome circumstance Fostering delinquency Leading to withdrawal and developmental delay	Cantwell 1997 Cooper 1985 Rose & Meezazn 1993 Giovannnoni & Becerra 1979 Oates 1996; Dubowitz et al 2004
Educational	Inadequate education Child kept away from school to work or baby-sit or as a carer for a sick or other wise incapacitated parent or accepting school phobia without seeking medical help Not allowing space in which homework can be done	Rose & Meezan 1993; Giovannnoni & Becerra 1979; Zuravin & Taylor 1987; Cantwell 1997 Oates 1996 Cantwell 1997
Safety	Failure to prevent reasonably foreseeable and avoidable injuries Abandonment Inadequate supervision	Cantwell 1997; Oates 1996 Giovannnoni & Becerra 1979; Zuravin & Taylor 1987 Rose & Meezan 1993; Oates 1996, Zuravin & Taylor 1987; Cantwell 1997; Polansky et al 1981
Medical	Inadequate medical care Lack of medical health Refusal of necessary medication for chronic conditions	Rose & Meezan 1993) Zuravin & Taylor 1887; Cantwell 1997 Oates 1996
Social	Not teaching social interaction skills and age appropriate limits and goals Lack of guidance and control, responsibility and independence Social difficulties Exploitation of child labour	Cantwell 1997 Cooper 1985; Dubowitz et al 2004 Cooper 1985; Kadushin 1988 Dubowitz et al 2004 Polansky et al 1981

Table 1.2: Synthesis of types of neglect

1.3.4 British professionals' perspective on neglect

As a snapshot of British key workers' opinions Stone (1998) portrayed professionals stuck in their own ideological perspective. Despite a high level of

agreement among educational, health and social workers about significant features in vignettes of neglect, a focus group compromised solely of social workers rated children's needs to be proximal to parents' social factors, compliance with service, adverse parenting characteristics and family dynamics. The least significant features were directly child related, which suggests an underestimate of the seriousness of neglect upon children (Minty & Pattinson 1994). The result is that social workers may wait until there is impeachable evidence that child neglect has occurred and intervene to address the influencing family characteristics and family dynamics only then rather than at an earlier stage to aim to prevent neglect happening. This application of a definition of neglect is described by Rose & Selwyn (2000: 181) as a higher threshold than applied by health visitors in their primary care roles. In defence of the higher threshold Rose & Selwyn (2000: 181) suggest that definitional components permeate between a social-medical model, the influences on the child's health and development and a social-legal model of neglect with "emphasis on collecting enough evidence to be able to prove neglect in court".

Elicited social workers' perceptions of neglect and sexual abuse gave some indication of an 'a priori' knowledge about neglect to be "families living in extreme poverty, in which the basic physical care of children was lacking..." "chaotic", "unsupervised", "under-stimulated"...mostly single [parents] ...with one or more of a range of problems from some learning difficulties, physical or mental health problems, to alcohol and drug addiction... who had a long relationship with social services...the parenting was hovering on the edge of "not good enough" (Stevenson 1998: 14-15). The above argument would suggest, therefore, that situational factors play the greatest part in defining neglect for practical implications.

1.3.5 Contemporary construct of neglect

It is these situational factors that contribute to the narrower definition of 'minimally adequate' care (Cantwell 1997; Straus & Kantor 2005). As a result neglect is not taken seriously enough by professionals (Minty & Pattinson 1994) nor were child protection services providing sufficiently specific interventions (Wolfe 1993; Tunstill & Aldgate 2002). This may, in part, have been due to a lack of empirical evidence of behaviours conceived as being neglectful and that might be harmful (Straus & Kantor 2005). Briggs et al (2005) concur and support a conceptualisation

of neglect that is based upon children's developmental needs; an approach which at least in primary health care and legislation, has become contemporary practice (DH 1999a; NAfW 2000). Moreover, the search for children's needs is not confined to physical and emotional support and affection within the family but also the protection from conflict and violence (Dubowitz 2005) both within the family and the community (Briggs et al 2005) and the multiple external family members that care for neglected children (Roditti 2005).

1.4. EMPIRICAL EVIDENCE OF RISK OF CHILD NEGLECT

If, as Polansky et al (1975: 984) suggest, neglect and abuse are "aetiologically distinct", without additional contemporary original and replication inquiries into child neglect specifically it is difficult to know if actions are appropriate to the needs of families whose children are 'neglected'. It is for this reason that only studies including a distinct neglect sample are included in the summary of the aetiologically distinct evidence that follows. The content review is informed by a literature search using ASSIA, ERIC, Medline, PsycINFO and Sociological Abstracts (from 1982 to March 2005) and applying the key words, neglect and causes, risk, risk factors and resilience, protective factors and salutogesis. The result is outlined in Table 1. 3. From a total of 23,976 articles 5,906 were research articles, of which 235 were specific to child maltreatment and only 41 specific to child neglect.

	All	And research	And child abuse	And child neglect
Risk – (including risk factors)	20246	4531	185	34
Resilience – (including protective factors)	3670	1348	50	7
Salutogenesis	60	27	0	0
Total	23,976	5,906	235	41

Table 1.3: Key words that informed the risk/resilience and child neglect literature search.

A review of the resilience and salutogenesis literature found they had in common positive variables that were perceived as competence (Sagy & Dolan 2001). The protective factors of resilience ranged from unconditional love, trusting relationships, psychological health of family members to a child's educational achievement and level of self-esteem. Salutogenic protective factors included gender, age, education, social class, hardiness of fathers and health challenges. Further exploration of resilience and salutogenesis follow the literature review of risk factors associated with child neglect.

Informing this literature review are as many literature reviews about child maltreatment (that included child neglect) as there were research projects. Risk specific to child neglect covers an historic perspective (Swift 1995), risk factors (Schumacher et al 2001), substance misuse (Kearney 2000), effects of child neglect on children (Crouch & Milner 1993; Hildyard & Wolfe 2002), and those taking a more broad-spectrum approach to synthesize the empirical literature (prior to 1993) in order to establish direction for future research (Paget et al 1993). These are discussed along with other research evidence and divided into chronicity of neglect and family context. The latter is subdivided into parental characteristics, child characteristics, effects of neglect on the child and social context.

1.4.1. Chronicity of neglect

There is support for degrees of severity but not as levels of supervision suggested by Loeber & Stouthamer-Loeber (1986). Nelson et al (1993) decided upon a hierarchy of neglect for research purposes. They chose to divide neglect cases into three groups; 'referred cases' suspected of but not confirmed as neglectful, 'confirmed cases' known to the child protection service for less than 3 years and 'chronic cases' known to the child protection service for more than 3 years. Child fatality reported by Mangolin (1990), and Squires and Busuttil (1995) might classify as the fourth level of severity.

Without a record of some indication of the chronicity of neglect a child can be left lingering in serious neglectful circumstances by each new observer who sees only a scintilla of the real situation. An example of this was found in the relatively recent case of the death due to neglect and abuse of Victoria Climbie (Laming 2003).

Evidence to the inquiry showed that throughout her short life in England, Victoria's health deteriorated from early signs such as weight loss, unkempt appearance, agitated state when carer (aunt) presented Victoria as a "wicked girl" (p28), burn like marks on face, bloodshot eyes, urinary incontinence at age 8 years old to hunger, immobility, unconsciousness and multiple system failure. Regrettably, the signs indicative of neglect were either not recognised or not acted upon. The first referral to social services after only one month in England was an anonymous concern about Victoria's physical care; a new referral that might already have been at chronic level. Nevertheless, at this stage signs were compatible with those defined by Nelson et al (1993) as a new referral but unconfirmed, in that the problems were mainly physical health oriented.

Chronic cases in Nelson et al's study had larger families, with children approximately two years older than other levels of seriousness with parents expressing inappropriate expectations, a lack of knowledge about child development and more problems generally (Gaudin & Polansky 1986; Kinetson et al 2005). Surprisingly, the level of social support was not significantly diminished between neglect groups. Nevertheless, the average number of community agencies involved with chronic neglecting families was 5.7 (Nelson et al 1993). Given that the average chronically neglecting families received services for three or more years from contact with 5.7 community agencies implies a considerable sum of money incurred to support the families. Taking a recently reported British cost for one child in need (coded N1 -abuse and neglected) (DOH 2002) of £120 for an average of 2 hours of services each week over three years the cost for social service intervention, would be £18720. As the interventions are usually multi-agency, and long-term, for families with above average number of children the cost for each family with neglected children must be considerable.

However, there is evidence to suggest that only a small number of families receive appropriate levels of services early. For example, of the majority of families (70%) referred to 82 social services departments in England, only 10.8% received day care. Similarly, of the 29% of families identified with a drugs problem, only 4-5% received drug counselling (Aldgate & Tunstill 1995). Relevant agencies cannot escape the fact that some families' chronicity will be advanced by failure to provide appropriate services when most needed. Even when recognised and family support

is initiated for cases of chronic neglect the evidence for those who do engage with services shows that only 40% improve (Daro 1988). If advocated as a standard for the outcome of service intervention surely a 60% failure rate would be rejected.

What is often overlooked is the circumstance that contributes to fatal neglect. By comparing fatalities as a result of physical abuse (48) and neglect cases (43) Margolin (1990) found on average more boys than girls are neglected, and, as supported by Squire and Busuttil (1995), found that neglect usually occurs below the age of three. Squires and Busuttil (1995) examined 1,647 cases of child fire fatalities and came to the conclusion that most were accidental; accidents due to absence, absence to protect, to supervise or to just not be there for their children. Fatal neglect from fire predominantly occurs in the home (88%), mainly the bathroom (30%), with 30% of incidents resulting from children's actions such as playing with matches, cigarette lighters, coal or electric fires, or inflammable liquids. Fatalities from chip pan fires were usually associated with intoxication of one parent (84%). The fires were probably neglectful, as Squires and Busuttil (1995) propose, but not deliberate. Mongolin (1990) rather ascribed deliberate action of parents. This difference in interpretation may in part be due to a difference in sampling from fatalities from house fires (Squire & Busuttil 1995) and substantiated cases of severe abuse or neglect, such as a child placed in a refrigerator (Margolin 1990).

Consequently, the implications of the findings related to chronic neglect are that early attention to caregivers' physical health problems and ability to provide and supervise their children is needed. Additional support is likely to be needed for alcohol and drug misuse and for helping the most seriously disadvantaged, poorer and larger families in response to increasing difficulties. Although chronically neglected children are reported to be older than physically abused children it is likely that it has taken longer for child protection services to substantiate the case of child neglect than would be the case for physical abuse. In terms of fatalities, creativity is needed in accident prevention programmes to raise awareness about chip pan fires, fires due to alcohol and drug misuse, children playing with fire hazardous material, bathroom incidents and the general absence of parenting.

1.4.2. Parental characteristics

Understanding neglect will involve acceptance of the combined culturally sensitive definitions of child neglect. Many of the sensitivities are related to particular characteristics within the family context and in particular, parental characteristics, child characteristics and social context. Beginning with parental characteristics, retrospective case control studies by Wolock & Horowitz (1997) and Zuravin (1988) compared the fertility patterns of mothers. Feldman (1998) was concerned with parents with 'intellectual disability', while Rohrback & Twentyman (1986) assessed for impulsiveness and child-related stress among abusing, neglecting, and non-maltreating mothers. Socio-economic factors were the focus for Chaffin et al (1996), Zuravin (1987), Polansky (1992), Kotch et al (1995). The main findings from Zuravin's study were the recurring themes that neglect families have more children and that mothers begin their families at an earlier age. Two fertility patterns were associated with neglectful families. One is the number of unplanned children and the second is the number of children in the family by different fathers (Zuravin 1989; Wolock and Horowitz 1997). The size of family was found to be a good predictor of neglect and child abuse (Zuravin 1989; Wolock and Horowitz 1997).

In terms of responsiveness, Christiansen et al (1994) found neglectful mothers (n=22) had lower self-esteem than control mothers (n=22) (r = -0.34) which is interpreted by Polansky (1992) as less confident, less outgoing, with less social skills. These may play a part in neglectful mothers' impulsiveness reported in relation to their children's needs (Rohrbeck & Twentyman 1986: Polansky 1992). The impulsiveness may be an inability to interact with the child as neglectful mothers engaged with fewer verbal instructions, verbal play interaction and non-verbal affection behaviour than non-neglectful mothers (Bousha & Twentyman 1984; Christiansen et al 2000). One type of responsiveness considered to be particularly worse for children than experiencing abuse is a parenting style that is low warmth and high criticism (Dubowitz 2005; Chapple et al 2005). This is negative interactions that accumulate to continually remind the child they are unloved (Fitzgerald 1995). Also found detrimental was parental inattentiveness and infrequent interactions that encouraged frequent unsupervised viewing of television (Slack and colleagues 2004).

Research into fathers' contribution to child rearing is in its infancy and as such the significance of fathers' attitudes to family, relationships with women and children is an important area of inquiry. Nelson et al (1996: 505), through structured interviews and self-reporting measures, found fathers' regular contact with neglected children to be "the only social support that reduced the likelihood of neglect" among Native American families. Fathers will be invisible in child care research if opinions prevail that fathers make little contribution towards domestic tasks and are also seldom considered to be caring and competent (Dennis & Erdos 1992; Lacharite et al 1996). Even the evidence from the case-control study of 24 neglectful and 24 non-neglectful families by Lacharite and colleagues is contradictory. Lacharite found fathers among neglectful families to be less supportive and more violent. On the other hand, results of a questionnaire by Coohey (1995) found partners of neglecting mothers generally, gave more emotional support than maternal grandmothers.

Similarly, in cases of failure to thrive, Iwaniec & Sneddon (2002) found fathers amenable to supporting their marital partners. This change of attitude towards fathers is put down to parents no longer feeling responsible for their child's failure to grow as was evident in early studies (Iwaniec et al 1985) as a result of an attitudinal change in society towards fathers' care-giving role (Iwaniec & Sneddon 2002). Unfortunately, this societal acceptance and fathers' observance of an increased supportive role has added little to the stability of family life. Rather, Perry 2000) suggests the relaxation in rigid sex roles has coincided with one in four children experiencing their parents' divorce, resulting in a lack of significant fatherly involvement in neglected children's lives (Thisdelle 1996). What must be borne in mind is that the increased divorce rate is a societal trend, and not specific to child neglect, with nearly half of all children seeing their parents divorce (Office for National Statistics, Census 2001). Likewise cohabitation, generally seen as a transient state, is a pattern of relationships that is changing with the average length of cohabitation increasing by 70% from 1980s to 1995) (Murphy & Wang 1999). Consequently, the cause and effect implied by Perry (2000) between relaxed sexual roles and changes to family structure is too simplistic an explanation and is not specific to families with neglected children.

The increased divorce rate corresponds with an increase in single parenting, at least as a life-cycle stage (Ford & Millar 2005). There is a well established link between single parenting status and chronic neglect, poverty and unemployment (DiLeanardi 1993; Gillham et ala 1998; Polansky 1972: Zuravin et al 1991). Single parent status is inevitably accompanied by a drop in living standards after separation or divorce of parents, and a lack of security (Perry-Jenkins et al 2000). Perry-Jenkins et al (2000) ascribe the drop in living standards to infrequent payments of child maintenance and money provided only on an ad hoc basis for clothing and leisure activities whereas the lack of security is specifically related to the parent who leaves the marital home. The serial partnerships of neglectful mothers suggest not only economic hardship, but hardship in maintaining human relationships, and for this reason financial resources of themselves are insufficient (Guterman & Lee 2005).

Further compounding financial hardship and affecting the ability of some parents to provide adequate child care is substance misuse (Roditti 2005). Longitudinal analysis of measures of neglect among boys (n=344) aged 10 to 12 years old among a sample of substance misusing parents found parental emotional distance (Kirisci et al 2001). Kirisci and colleagues also found children reported more serious neglect by their mothers than their fathers and an increased risk of involvement and severity of substance misuse at the age of 19. An attempt to counteract this pessimistic view is a "one-stop-shop" intervention (New Choices) for substance misusing mothers and their children. The support programme that measured social support, mental health, nutrition and parent and child development before and after the programme found significant improvements in maternal empathy and children's social competence (Niccols & Sword 2005).

One 'risk' factor of neglect that has received little attention is parents with learning disabilities (Feldman 1998). In a case study presentation, Feldman exemplifies how workers can be blinded by parents' learning difficulties instead of focussing on a measurement of parenting ability and remedial intervention. This American case study is similar to finding about service treatment for British parents with learning difficulties who received an inadequate service due to an 'over zealous' approach to the assessment of risk (Social Service Inspectorate 1999). Child protection services were found to presume parental incompetence and a deficit of skills without formal assessment of parenting. This approach often resulted in system abuse that did more

harm than support or protection of family members (Booth 2000). Other parental behaviours associated with child neglect such as alcohol and drug misuse (Rohrbeck & Twentyman 1986; Chaffin et al 1996) and mental health problems (Chaffin et al 1996) can have a similar effect of diminishing parents' ability to care for children adequately (Dubowitz 1999b).

Thus, learning disabilities, domestic violence, violence, and alcohol and drug misuse are, potentially, part of the havoc within some families but the links to child neglect are only beginning to emerge because research has tended, instead, to explore child maltreatment. The results are therefore inconclusive from a neglect sample, but Freisthler's (2004) census tracing study (n940) supports the association of 'substance abuse and neglect' and 'alcohol and neighbourhood rates of child maltreatment', respectively.

It would appear, therefore, that influencing vulnerable factors in neglectful parenting are unsuccessful family planning, frequent changes of father figures, parents' attitude to the family unit and sex roles together increase the likelihood of an unstable family and lack of motherly affection and verbal interaction with their children. Parents with learning difficulties should be judged in the same way as other parents, according to their ability to provide adequate parenting. However, when comparing the strength of association and effect size, Schumacker and colleagues (2000) found only three parental characteristics with moderate to large effect size. Schumacher and colleagues (2000) measured the effect size of risk factors as correlation coefficient: 0.10 small effect, 0.30 medium effect, and 0.50 large effect size. The first is **fertility** (i.e. greater number of unplanned conceptions, pregnancies and live births) (0.57). The second is **mothers' impulsiveness** (0.50 – 0.65). The third is **mental capacity** to parent adequately due to (a) substance abuse (0.31) (b) or antisocial personality disorder (0.33) and (c) parental proneness to abuse and neglect. This proneness could be prevented if attention is given to mothers' lack of verbal and affectionate behaviour that Schumacher et al (2000:245) summarised as "a clear finding that neglectful mothers seem to interact less or less positively with their children", an effect size of 0.68 – 0.91.

1.4.3 Child characteristics

Few unique characteristics of neglected children have been identified (Gaudin 1993). Those that have been identified are related to temperament; a component of personality. Viewed from a psycho-biological perspective personality is interpreted in terms of responses to interrelated biological, social, cultural and environmental factors. Crittenden's (1988) study of parent and child interactions suggest children's exposure to their mothers' inattention results in them developing patterns of withdrawal and extreme passive behaviour or undisciplined activity. Either pattern of behaviour is likely to result in further inattention and distancing of the child. More recently, personality expressed as non-compliant, defiant, oppositional, stubborn or socially hostile was found to be associated with maternal education, maternal malaise, feeding and sleeping problems (Polnay 2000). Viewed from a psychoanalytical perspective, temperament is a defence mechanism central to personality (Carter et al 2001) that is influenced by repressed anxieties, internal conflicts and unconscious forces impact upon personality development.

Child temperament was explored by Harrington et al (1998), who like Crittenden believed it to be a relationship component within the family context. Harrington et al used the notion of 'difficultness' as the operational definition along with numerous measurement instruments to explore an association between child temperament and environmental factors. The findings suggested that stressful effects on mothers influence the way they interpret a child's behaviour as 'difficult'. In support of Harrington et al's (1998) findings, Carter et al (2001) conducted a survey of recollections of childhood care of 164 adults (outpatients) with personality dysfunction and low self-directedness associated with high harm avoidance. The survey results revealed low reward dependence and low parental care (neglect). Similarly, compared with non-neglected children a correlation was also made between negative mothering and less positive children's behaviour (Bousha & Twentyman 1984).

However, there may be, at least, two barriers to mothers' interpreting positively their children's behaviour. Harrington et al (1989) found a positive correlate between positive interpretation and stress with low maternal support and with mothers' coping capacity. The consensus would seem to be that children's

behaviour is influenced negatively by negative parent and child relationships and social or verbal family behaviour (Edwards, Shipman & Brown 2005) and mothers' interpretation of their children's behaviour. In turn, the level of social support and mothers' ability to cope may influence, negatively, their interpretation of their children's behaviour. Enquiring into children's personality and mothers' meanings of behaviour perceived as problematic may be reasonable topics for engaging mothers to reflect upon children's behaviour and how that affects how they respond to the children

1.4.4 Effects on the child

Whatever the type of neglect, the effect on children goes beyond the personality, or character and temperament of children. It is the multiple effects of neglect that have moved child care services towards a child-centred health and development perspective by which interventions are to be determined (DOH 2000: NAFW 2001). To this end the review of comparison studies described here will take a developmental approach but only in relation to preschool aged children. The reason for this is because effective primary prevention at an early stage could limit long-terms effects (Taylor & Daniel 1999). Firstly, physical neglect is compared with failure to thrive. Both may have a low weight for age and failure to thrive children may be neglected (Mackner et al 1997). Differences between the two have been investigated by case-control study of children (n177) and Mackner et al suggest that child characteristics were not predictive of failure to thrive. It is difficult to accept this finding when dysfunctional parent-child interactions along with family conflict are considered causal links to failure to thrive. For example, when a failure to thrive (FTT) child is removed from a stressful family situation the child's growth and development invariably improves (Iwaniec et al 2003).

Similar to neglect, FTT is usually diagnosed within the first 2 years of life, due to feeding problems, lack of nutrition, lack of nurturing stimulation (emotional neglect) (Iwaniec et al 2003) and living in poor environments – unhygienic and unfit or dangerous for children's habitation (physical neglect). What is often overlooked, especially with the latter example of physical neglect is society's role in perpetuating some adverse life circumstances such as inadequate housing and other "socially determined adverse life events" (Rogosch et al 1995). FTT may also be

the result of illness whereas neglect may also be a lack of medical care, education, social interaction and safety. Arbitrary termination of feeds by mothers was a characteristic of mothers of neglected and failure to thrive children. It would be easy to conceive of failure to thrive as a level of neglect due mainly to inadequate nutrition to sustain a normal growth rate (Black et al 1994; Crittenden 1987; Skuse 1993; Taylor & Daniel 1999) exacerbated by social influences (Frank et al 1994; Iwaniec 1995).

Concurrence is also found for physical and cognitive growth in neglected children. Early cognitive effects of neglect are reported (Egeland & Sroufe 1981; Howing et al 1993) on cognition as early as 24 months when neglected children were found to be less enthusiastic, more frustrated and angrier when problem-solving (Egeland & Sroufe 1981). A longitudinal study by Egeland and Sroufe (1981) found that by 42 months of age neglected children were less flexible or creative with less impulse control when confronted with an obstacle box (Egeland et al 1993). Language and cognitive deficits are also reported by Allen & Oliver (1982) that impact on children's educational opportunities. Compared with a non-neglected sample (n=7) neglected children's (n=7) school performance was poor and markedly decreased as children entered high school (Leiter & Johnsen 1994; Kendall-Tackett & Ecenrode 1996). An accumulative effect is seemingly experienced by neglected children with the effect size of educational performance noted as .02 in elementary school, .45 in junior high school and .30 as they progressed to later years in high school (Kendall-Tackett & Eckenrode 1996).

More recently, predictive unmet needs and the psychological and emotional outcomes of child neglect have been attributed to neuro-developmental consequences (De Bellis 2005). Teicher and colleagues (2004) measured the corpus callosum (CC) of abused and neglected children (n28) among (n51) children admitted for psychiatric assessment and 115 healthy control children. The neurological findings were abused and neglected children with 17% smaller CC. They report neglect to be the strongest experiential factor. An association has also been identified between unmet needs and the non-acceptance of services deemed desirable to meeting children's needs (unmet care) with the development of children's aggression (Knutson et al 2005).

However, Kendal and colleagues (2005) question the relationships between disability and maltreatment generally. They ask which came first the disability that places children at higher risk or maltreatment that predisposed children to disability. English and colleagues (2005) argue that early language impairment equally impairs general development and that interventions must be sufficiently early to prevent global impairment. Sciences in relation to disability and maltreatment may be a long way off determining a definitive relationship.

Exploration of moral development found three observational studies specific to neglect. The first study relates to children's perceived unfairness of resource distribution. The authors of this study (Smetana et al 1999) hypothesised that this perception is related to children's own experiences of neglect. Observations of mothers and their physically abused and neglected children in a 'cleaning up' scenario, found children expressed negative effects. On the one hand, physically abused children had a tendency to comply whilst neglected children were more passive and suppressed (Crittenden & DiLalla 1988; Koenig et al 2000). In summary, the word suppressed fits the picture presented of early neglectful childhoods. Suppressed enthusiasm, language development and school performance generally contrast with periods of frustration and anger in problem solving.

In terms of emotional states, neglected children not anticipating physical retaliation are more likely to be angry. Those experiencing both neglect and physical abuse have been found to display compliance and frustration (Egeland et al 1993). Dealing with the emotions of others is complex and the lack of positive interaction leaves them more emotionally inept than physically abused children (Crittenden 1985). In summing up the neglected child, Erickson et al (1989) describe him or her as unhappy. The neglected child will likely display an avoidant or resistant attachment, just like their mothers (Crittenden 1997). Such behaviour may exhibit passivity, aggression and unhappiness as antisocial, conduct disorder, criminally and psychopathology.

Living with domestic violence, parental substance misuse and mental health problems leaves children realizing that a problem exists but not always why it exists. Extreme worry about self and their parents has been found among children experiencing these parental characteristics. In response, what these children wanted

was someone who would listen to them and talk to them; provide age-appropriate information; and someone to help them to think through their problems in order to understand the family situation. In essence, children want someone they could trust, who provided reassurance and confidentiality and help them to make decisions (Gorin 2004).

The catalogue of negativity ascribed to the neglected child is a sad picture of vulnerability that creates disadvantage long before the child even enters school. Language and interaction skills may be in deficit by the end of the first year or two. From then on the deficit seemingly increases.

1.4.5 Social context

Parental and child characteristics are but only part of the whole picture. Poverty mechanisms such as material hardship and infrequent employment as well as parental characteristics of low warmth such as use of physical discipline and parents encouraging the frequent use of television rather than giving children their attention were predictive of child neglect (Slack et al 2004).

Partner and maternal grandmother support is identified as important to a mother's ability to function effectively (Coohey 1995). Coohey selected a matched sample of neglecting mothers (n69) and non-neglected mothers (n138), disproportionately African American, attending parenting classes. All had a mother and partner. Findings support the hypotheses that neglecting mothers receive fewer resources than non-neglecting mothers. Turning to maternal mothers for support might elicit some childcare services such as baby-sitting and might provide the occasional money. They were less likely to provide emotional support, help with decision making and housework, to provide companionship or be perceived to listen to their daughters. This relationship is reciprocal in that mothers gave little to maternal mothers also. Overall, maternal mothers were perceived to be more angry, less warm or caring, and this Coohey suggests might be the reason for daughters not seeking help from their mothers.

However, partners did give emotional support, but they were reluctant to baby-sit. The most important difference between the two groups of mothers is that neglecting mothers had less contact with their partners; the relationship was comparatively

short term; they were less likely to live with their partner; and partners were less likely to be fathers of the children. Coohey suggests the reason for lack of social support and the reluctance to seek help from these significant others is due to childhood experiences when the emotional comfort was not available and hence in later years was not expected. Thus, prevention opportunities lie in personality and behavioural traits of the mothers (Coohey 1995). More specifically, Coohey lists the traits as apathy, inability to nurture, withdrawal and failure to request help.

Primary prevention focus	Secondary prevention focus
Parents' lack of family planning, Substance abuse, Mothers lack of affection for and interaction with their children, Fathers' lack of physical support, Lack of social support generally, Poor growth, delay in language and cognitive development, Children's temperament perceived to be difficult, and Unhappy child.	Type(s) of neglect – physical, emotional, educational, medical, safety, and social, Level of acceptance and engagement with service provision. Different levels of chronicity: 1. Early referrals – parents' physical health problems, 2. Continued need for services for more complex family problems such as substance misuse or an escalation of problems, 3. Long-term chronic cases where delay in substantiating neglect necessitates developmental and behavioural treatments, and 4. Fatalities, mainly due to lack of supervision that require accident prevention programmes that stress the adequacy of supervision.

Table 1.4 Primary and secondary prevention foci

Taking a lead from the relevant literature that focuses on mothers it is easy to appear to blame mothers for neglecting children (Swift 1994). Swift (1994) claims the personal characteristics of mothers and the blaming of mothers has overshadowed the very real social and economic problems that engulf their lives.

Certainly, not all decisions are fair as Saunders et al (1993) found. Despite there being no evidence that more African American families neglect children than white families African American families are more likely to be referred for lack of supervision and the child's hygiene. Fairness in engaging families with child protection services should be based on firm evidence of a need for intervention and the provision of services specific to those needs.

This review of empirical evidence of risk to child neglect suggests two distinct prevention foci. The first is primary prevention. In an attempt to stop child neglect occurring the risk factors requiring interventions that include parents' lack of family planning, substance misuse, mothers' lack of affection and interaction with their children, fathers' lack of physical support, lack of social support generally, delayed child development, especially in language and cognitive development, and children's temperament perceived to be difficult. The second focus is secondary prevention. Once neglect of children's needs is suspected, and in order to make a decision about suitable interventions, services would be wise to consider the types of neglect experienced by children, the level of chronicity and parents' acceptance or not of service provision. A summary of these primary and secondary prevention foci are presented in Table 1.4.

1. 5 EMPIRICAL EVIDENCE OF PROTECTIVE FACTORS AND RESILIENCE

One important lesson learnt from pathogenic research is that seldom does a single risk factor impact on children's development (Werner 2003). Protective factors have been identified that are considered to buffer against any risk exposure sufficiently to avert adverse outcomes (Werner & Smith 1992; Bolger & Patterson 2003). Investigations into this relationship are collectively called resilience research. Werner & Smith were the first to postulate a risk and resilience perspective (Wong 2003) after tracking, from birth to 40 years of age, the cognitive and psychological development of babies born into poverty, with perinatal problems (Werner & Smith 2001). Different stressors were experienced at different stages of life for 72 (of 489) children but in adulthood they were functioning competently, socially,

interpersonally, emotionally and physically. This also applied to a number of individuals with learning disabilities.

At about the same time that 'resilience' as a phenomenon was growing in acceptance another perception of strengths was also being promulgated. A salutogenic model of health was introduced by Antonovsky in 1987 and like the resilience model health is seen as a continuum from positive variables to perceived competence (Sagy & Dotan 2001). It is this introduction and expansion of resilience and salutogenesis that is explored in this last section of the chapter. First to be discussed will be the definitions of resilience and salutogenesis, followed by the empirical evidence associating protective factors and resilience or competence, resilience in child maltreatment and the preventative focus related to competence.

1.5.1 Definitions of resilience and salutogenesis

Twenty five years ago research began to question the existence of positive factors and in particular how approximately one third of children living with risk and psychopathological factors could remain healthy, happy and successful (Werner & Smith 1982; Garmezy 1993). This complimentary field of investigation began to bridge the divide between the previously negative risk factors that have resource implications and vulnerable factors that can be modified through inherent or acquired protective factors (Schoon & Parsons 2002); those of **resilience**. Resilience is defined by Luther and Cicchetti (2002:858) as the "dynamic process wherein individuals display positive adaptation despite experience of significant adversity or trauma". This perception of successful adaptation despite "challenging or threatening circumstances" is shared with Masten, Best & Garmezy (1999:426). Resilience may be defined as "the ability to bounce back from adversity, frustration and misfortune" (Janus 2002:117) or "Normal development under difficult conditions" (Daniel et al 1999). The considerable consensus as to what constitutes resilience is:

- Children living in conditions of risk
- Demonstrating better than predicted outcomes,
- Due to some intervening process (Shaffer 1996; Masten & Coatsworth 1998; Rutter 1987; Smokowski 1999).

Unlike resilience, salutogenesis is less well known. An explanation close to Antonovsky's (1987) original work is of a model of health with a pivotal underpinning concept of a sense of coherence (SOC). Coining the term salutogenesis Antonovsky deliberately attempted to embrace well-being and happiness as well as to engage individuals to examine how they become healthier and less ill (Bengel et al 1999). The main premise is that all people throughout their life course become healthier or less ill, including people with chronically illness. For example, promoting health based on the concept of salutogenesis, the quality of life was markedly improved and the progress of the disease slowed for people with Alzheimer's-related dementia (Verghese et al 2006). Influencing the change in health status is the sense of family coherence, which is considered by Antonovsky to have three components – comprehensibility, manageability and meaningfulness. Comprehensibility is the 'cognitive processing pattern' of familiar and unfamiliar information, manageability is a person's ability to perceive resources at their disposal and meaningfulness is of life that to the person makes sense emotionally, and can be viewed as challenges rather than burdens (Bengel et al 1999).

Werner and Smith (1992; 2001) found that life and health are dynamic, with different stressors at differing times influenced by experiences with the environment. Whether a sense of coherence is a concept that can predict future coping with less health is uncertain. Applying the concept of prediction to salutogenesis is of itself problematic as there are those who would suggest that the SOC "will not replace or succeed the risk factor model, but it can be seen as a significant reminder not to concentrate exclusively on risk factors" (Bengel et al 1999: 88). What it does offer is a way of helping individuals explore their own meanings to factors that contribute to being healthier or less ill. What salutogenesis is not is a name for interventions based on resource allocation, or preventative measures without the exploration of coherence (Bengel et al 1999).

Considering both positive and negative adjustments to life experiences is a more balanced, fitting approach (Lengua 2002) and an obvious choice for assessment and intervention as professional guidelines dictate (DOH 2000; NAFW 2001). Likewise there is little doubt that having an understanding of resilience, as well as risk, is important to gaining a complete picture of children's functioning (Kinard 1998). It focuses attention on positive outcomes and not just negative ones, emphasises

strengths and not just deficits, and the resilience related research makes a commitment to understanding the underlying processes involved in the building of protective factors in the face of adversity (Luthar & Cicchetti 2000; Finkelstein et al 2005).

1.5.2 Salutogenic research

Similarities can be found between resilience and salutogenic research related to gender and age. Using a resilience framework to examine the relationship between family demands and care giving for children with asthma Svavarsdottir and colleagues (2000) found a sense of coherence and family hardiness associated with mother's well-being and family hardiness for father's well-being. These gender differences in adulthood mirrored differences in the relationship between SOC and gender in childhood. In childhood the relationship of SOC and gender and resilience and gender is contentious. Being a girl is generally considered a protective factor (Tiet et al 2001) whereas boys have been found to have a higher SOC score (Antonovsky & Sagy 1986). What this may mean is that girls and boys have different ways of interacting with adversity. Girls may have more positive factors that create a positive mental process in the presence of adversity whereas boys have a stronger sense of coherence in that when confronting challenging circumstances they have a belief in their ability to overcome the experience or they view the circumstances as a normal life event (Kobasa et al 1979). One relationship similarity is that, like resilience, the sense of coherence seemingly increases with age (Coe et al 1992; Larrson & Kallenburg 1996). People who experience adversity, seemingly, learn from the experience and adapt their behaviour to become increasingly self-determined (Johnson 2004).

The major difference would appear to be education and social class and lived ill-health challenges. Education was not correlated with SOC (Gerbert et al 1997; Larrson & Kallenburg 1996) among adults but it is an important protective factor for children (Tiet et al 2000. 2001). This age difference is probably due to the growth and sustainment of self-esteem and valued skills that are developed through their experience of adverse circumstances (Newman & Blackburn (2002). In terms of academic success (Navarro 2003) extracurricular and community activities were the most essential protective factor. In relation to different socio-economic status,

family size or ethnicity SOC appear to differ (Bowman 1996). In childhood, socio-economic status had no effect on SOC but in adulthood it did (Larrson & Kallenburg 1996). A construct of socio-economic status will increase with age as will consciousness of ones' position in society. Together they parallel the gradient risk of most diseases (Smith et al 1996); the lower the socio-economic status and the lower the perceived position in society the more likelihood of risk of disease. These differences between children's and adults' sense of coherence is an important concept because it demonstrates that the same concepts used as a protective factor may not be indicative of a healthy outcome in adulthood. This conclusion is drawn from the finding that SOC does not determine emotional bond and communication with parents but that the process within which these take place such as an unstable environment is related to a lower SOC (Antonovsky & Sagy 1986). It is therefore not surprising to find that SOC correlates with health measures (Carmel et al 1991) and unemployment among young people (Axelsson & Ejlertsson 2002). Without a sense of confidence in our internal and external environments individuals cannot predict a high probability that things will work out as expected (Antonovsky 1987; Johnson 2004).

When assessing children's health and development it is mothers' competence and wellbeing that are taken into account but fathers' wellbeing or hardiness is of equal importance. Hardiness, in this context, is the ability to resist negative outcomes of stress (Bengel et al 1999). Similar to resilience, hardiness has three components, which are described by Kobasa et al (1982) as commitment (an active interest in all areas of life); control (a belief in being in control and can have an influence on their life); and challenge (an acceptance of change as normal and an opportunity for growth). Bengel and colleagues view commitment as similar to Antonovsky's meaningfulness but that is where the similarity ends. Control and challenge differ from Antonovsky's salutogenesis. Control is narrowed to self control or control by others (or something) that may lead to mistrust of others' perceived power. Challenge is viewed as emphasising change rather than stability. Both of these latter perceptions could be detrimental to family members living with domestic abuse. Encouraging women and children to increase their self control with the intention of increasing health chances through changed behaviour may conflict with fathers' perceived role (or control). Handiness may, therefore, buffer against stress for a

positive outcome should the environment allow but SOC is less predictive of outcome and more concerned with basic attitudes that dependent upon situations.

As a result of the increasing supportive evidence of the relation between SOC and healthy outcomes, it is proposed that SOC is the best predictor of quality of life (Cederblad & Hansson 1996). What is more important is that self-reporting of SOC may be more telling about health status that medical ratings of health status (Wells & Kendig 1999). Low SOC correlates with lower health status (Callahan & Pincus 1995), with depression, anxiety and poor physical health (Callahan & Pincus 1995; Frenz et al 1993), feelings of overload, physical and psychological complaints (Gallagher et al 1994) and parents with sick disabled children (Margalit et al 1992; McSherry & Holm 1994). Salutogenesis, as a sense of coherence, is a measure of individual's sense of coherence that does appear to correlate with experience of particular stressors.

Some researchers have questioned the validity of the SOC score due to its high correlation with mental health inventory scores (Ben-Zur, Duvdevany & Lury 2005) and the lack of discriminative validity between SOC and depression and anxiety (Kravetc et al 1993; Languis et al 1992). Nevertheless, there are those who confirmed the long-form SOC scale to be reliable (Callagan & Pincus 1995), the manageability scale in particular explaining 80% of the variance of the SOC scale among pregnant women (Dudek & Makowsko 1993). Compared to the General Health Questionnaire (Goldberg 1989) and in relation to psychiatric symptoms, the SOC correlated well (Sammallahti et al 1996). In bringing together the two concepts of resilience and salutogenesis the modified SOC (Sagy 1988) was able to determine that individual children's perceived competence correlated with family sense of coherence and a sense of school membership (Sagy & Dotan 2001). It would seem that there is value in combining the two concepts of building resilience and at the same time exploring individual's perceived sense of coherence.

1.5.3 Resilience research

Just as there are reservations about SOC there are reservations to using the concept of resilience. Resilience or invulnerability may denote a healthy stability, personality and behaviour (Bengel et al 1999) but these terms may also ascribe

blame to individuals who do not achieve particular 'healthy' traits that have been found to withstand adversity (Luthar & Cicchetti 2000). To reduce the potential for putting undue blame on people, Luthar and Cicchetti advise against the use of resilience as an adjective for 'resilient children' in order to avoid confusion with sturdiness and invincibility, because children cannot make themselves resilient. Family and social relationships and environments also play an essential role in resilience building. When referring to resilience Luthar & Cicchetti advocate that its application be specifically related to resilience adaptations or trajectories.

From the early research into resilience a collection of characteristics has developed that are not surprisingly. Grotberg (2003) concludes from a review of the literature that resilience increases with age. Consequently, working with very young children to promote resilience is a desirable focus for preventative interventions, and hence the development of early years interventions. The most positive childhood experiences that facilitate the development of protective factors increase the likelihood of resilience. The protective factors associated with the greatest degree of resilience was found when children experienced positive parental relationships, healthy family relationships, concern for their overall development, and extra-familial relationships. Positive parental relationships include a sense of being loved (Mrazek & Mrazek 1987) or unconditional love (Bronfenbrenner 1979), trust (Wolin & Wolin 1993), mothers perceived positively by their children, and a psychological healthy father living at home (Conrad & Hammen 1993) a positive emotionality and self-regulation (Lengua 2002), and self-esteem (Finkelstein et al 2005; Wolin & Wolin 1993).

Protective factors related to healthy families are social competent mothers (Conrad & Hammen 1993), family cohesion (Weist et al 1995), the quality of parenting (Masten et al 1988; Tiet et al 2001), family support and closer parental monitoring (Tiet et al 2001), better family functioning (Tiet et al 2001), higher educational aspirations (Tiet et al 2001), parent support for children experiencing community violence (O'Donnell et al 2002), and a sense of family coherence (Sagy & Dotan 2001). The protective factors associated with families with a concern for children's overall development are encouragement of autonomy, a higher IQ (Tiet et al 2001), hope and responsible risk taking (Mrazek & Mrezek1987).

Extra-familial protective factors are positive school experiences and positive social experiences involving non-biologically related adults. Positive school experiences also help foster a higher IQ, (Tiet et al 2001), as do higher educational aspirations (Tiet et al 2001) and achievements (Wang et al 1994). School support for children experiencing disadvantage (or adversity) such as community violence (O'Donnell et al 2002) can be important to developing resilience. Peer support too moderates adversity by their acceptance (Criss et al 2002), and moderates against harsh discipline when peer relationships are categorised as friendly (Criss et al 2002) and enables school children to develop a sense of school membership (Sagy & Dotan 2001). Additional factors are emotional support outside the family (Loesel 1992; Werner 1994), social support generally (Sagy & Dotan 2001) and contact with a competent adult (Tiet et al 2001). Genetic factors include higher IQ (Tiet et al 2001) and being female (Tiet et al 2001). For most children these factors are part of a healthy family life but where healthy family life is not experienced these factors give some guidance to interventions that could increase children's ability to 'bounce back' from adversity.

1.5.4 Effect size for protective factors related to child maltreated

In cases of child maltreatment, children experiencing acute forms of maltreatment demonstrate increased resilience compared to those experiencing chronic maltreatment (Mrazek & Mrazek 1987; Shaffer 1996). To establish the effect size for protective factors the same effect sizes are employed as Schumacker et al (2000) used to identify risk factors for child neglect. That is, small effect size = 0.10, medium effect size = 0.30 and large effect size = 0.50. Where protective factors are reported, children's individual protective factors are most strongly related to parent support (O'Donnell et al 2002; Tiet et al 2001; Spaccarelli & Kim 1995). In terms of outcomes for sexually abused girls, parental support was the only factor related to greater social competence (Spaccarelli & Kim 1995). Mothers' sensitivities and emotionally responsiveness to their children is a factor in the reduction of intergenerational maltreatment (Egeland et al 1993). Prospective observations of premature babies admitted to an intensive care nursery found differences between families who did not repeat maltreatment and those who repeated maltreatment (Hunter & Kilstrom 1979). The protective factors identified in Hunter & Kilstrom's study were mothers regular contact with the baby (0.95 and 0.44 respectively),

extended family visiting the baby (0.85 and 0.22), mothers who planned their family to ensure adequate space between pregnancies (0.80 and .033), father visiting the baby (0.80 and 0.67), and adequate child care arrangements (0.-73 and 0.22).

For older children, parental support continued to be the predominant protective factor for children not exposed to violence (0.68), children who witnessed violence (0.69) or children who were victims of domestic violence (0.64) (O'Donnell et al 2002). A large effect size for parental support was found for increased self-reliance among children who witness domestic violence (0.71). The effect size from witnessing domestic abuse but not becoming a victim may be of importance in differentiating between vulnerability and risk. These children can develop resilient tendencies of alertness to predisposed violent environments and vigilance when witnessing violence that may increase their vulnerability (Mrazek & Mrazek 1987) but protects them from becoming 'at risk'. For example, a medium effect for parental support predicted resilience against substance abuse (0.52). Parental support is followed, in descending order of effect size, by school support for children not exposed to violence, 0.54, witnessing violence 0.39 and victims of violence 0.38. Similar to parental support, school support can predict resilience against substance abuse but mainly among the children who are victims of domestic violence (0.51) and against school misconduct (0.62).

A comparison study of disadvantaged and advantaged children (socio-economic disadvantage, born premature and with mothers with psychopathology) supports the combined disadvantage as a potentially serious risk to children's health and development. Although resilience and salutogenic studies suggest the impact of such disadvantage ought to be buffered by protective factors, the evidence is inconclusive. Tiet and colleagues found only moderate to low effect size for protective factors. Unfortunately, for the disadvantaged children the protective factors were contrary to the likely childhood experiences. The protective factors in descending order of effect size were lower levels of adverse life events (-0.48), closer parental monitoring (0.44), absence of a sense of meaningfulness to family functioning (-0.37), and an absence of maternal psychopathology (-O.36). When comparing socio-economic status, Schoon & Parsons (2002) found family stability to be the protective factor with the largest effect size (0.69). Children with the most

resilience, that is attaining an above average competence in overall growth and development, experienced socio-economic advantage. Born premature and into poverty is referred to as a 'double jeopardy' (Bradley et al 1994). The sample of such children in Bradley and colleagues study found at the age of 3 years, only 12% classified as resilient. Conversely, Tiet et al (2001) found only medium effect size.

1.5.5 Risk and resilience as the process between multiple social trajectories

Given that individuals swing back and forth along a health and illness continuum and can experience adverse social trajectories and different social contexts at different stages in life, levels of perceived coherence and resilience adaptation to adversity will also change over time (Mrazek & Mrazek 1987). The social trajectories of both parents, that may include unemployment, substance dependency, physical or mental illness, will require a child to draw upon self-righting factors (strengths) to protect them from developmental impairment. The effects of living with poverty have been found to be cumulative (Egeland et al 1993) and similarly, it cannot be assumed that past resilience adaptation will be sufficient to ride out yet additional challenging life events. Pre-school advantage may not always moderate against future childhood and young person vulnerability. Criss et al (2002) found peer acceptance and peer friendship to be less effective against substance abuse or school misconduct or delinquency among victims or domestic violence (O'Donnell et al 2002). The reason for this is that some children's peer relationships can have a negative effect rather than a protective one (Criss et al 2002). In these cases children will likely externalise negative behaviour (Criss et al 2002; Hall & Webster 2002). Hence children's resilience adaptation must be determined by their "display of competent functioning in certain areas despite past or present maltreatment" (Heller et al 1999: 325).

Studying developmental competence, as an indication of adaptability to maltreatment has revealed a bleak picture for children maltreated. Even after experiencing an early secure attachment few maltreated children were found to be consistently competent over the pre-school years (Egeland and Farber 1987). Attempting to explain the adaptive or maladaptive processes Cicchetti et al (1993) examined areas of strength and vulnerability. Though levels of competence were

found for maltreated children and children not maltreated, there was a significant difference between the study groups. There were more maltreated children with no or only one area of competence. Cicchetti and colleagues' exploration of the processes underlying potential adaptation could find no significant different in ego-control and self-esteem. What did differentiate maltreated children from non-maltreated children was ego-resiliency (0.18 and 0.28, $p<.04$) and lower intelligence (87.75 and 93.81, $p<.01$) respectively.

Hence, it is not inhibition or ease of expression of self (ego-control) or having a comfortable, safe and positive view of self (self-esteem) that protects against adversity but the ability to adapt to situational contexts (ego-resiliency). Ego-resiliency is the personality construct for understanding motivation, emotion and behaviour (Letzring et al 2004). Central to ego-resiliency is the child's "ability to alter his or her characteristic level of boundary "permeability-impermeability" (Cicchetti et al 1993) or the modification of a child's "level of control, in either direction, as a function of the demand characteristics of the environmental context" (Block & Block 1980). Cicchetti and colleagues add the notion of elasticity to the construct of ego-resiliency, the ability to react to different circumstances and environments and be able "to return to their original forms in the absence of pressing environmental stressors" (p633). Ego-resiliency supports the situational-dependence and the cognitive-affective process of the resilience perspective. Nevertheless, it would be unwise to dismiss the salutogenic situationally-independent perspective which, similarly, attributes cognitive patterns (comprehensibility); cognitive-emotional patterns (manageability); and motivational patterns (meaningfulness).

Combined salutogenesis and resilience perspectives offer insight into basic attitudes that can be draw on when there is an interactional demand for resources. The cognitive-affective process of resilience points to protective factors that buffer against the effects of adversity. The idea of basic attitudes that are situationally-independent conjures up the notion of stability that can contribute to healthy development despite complex situational demands and regrettably, likewise illness development. In terms of resilience, the protective factors are internal, external and social resources. In terms of salutogenesis, basic attitudes are (1) the ability to differentiate familiar and unfamiliar situations (cognition); (2) perceiving self to

have (or not) the necessary resources to meet the demands of the situation (cognitive-emotional); and (3) accepting the challenge worthy (or not) of engaging with (motivational). However, some would contend that the salutogenesis model has not been tested and is untestable and as such it cannot replace risk and resilience (Bengel, Strittmatter & Willmann 1999) but it can offer new insight that makes the model worthy of investigation.

Following many years of resilience research the International Resilience Project (IRP) argues there are three categories of protective factors. Rather than include social skills with internal strengths the IRP have chosen to categorise social skills as a separate category. The value of this approach is to highlight the importance of children's social skills that ought to give some direction for the promotion of resilience adaptation. External support and resources in this context are external to the child rather than external to the family as applied above. The three IRP categories are, therefore, (1) external supports and resources, (2) internal personal strengths, and (3) social interpersonal skills. The traits of each category are listed in table 1.5.

External supports & resources	Internal personal strengths	Social interpersonal skills
Trusting relationships	A sense of being loved	Creativity
Access to services:	Autonomy	Persistence
Health	Appealing temperament	Humour
Education	Achievement oriented	Communication
Welfare	Self-esteem	Problem solving
Security	Hope,	Impulse control
Emotional support outside the family	Faith and a belief in God, Morality,	Seeking trusting relationships
Structure & rules at home	Trust,	Social skills, and
Parental encouragement of autonomy	Empathy	Intellectual skills
Stable school environment	Altruism, and	
Stable home environment	Locus of control	
Role models, and		
Religious organisations (morality)		

Table 1.5: Categories of protective factors

1.6 CHAPTER SUMMARY

In summary, whatever the difficulty in reaching a concrete definition of child neglect, lay people judge neglect more seriously than professionals and are willing to inform on families not meeting children's needs. There are various categories of neglect ranging from physical, emotional, educational, medical, social, and safety neglect. Pathogenic, epistemological research has identified statistical significant risk factors that increase the likelihood of neglect. They are parental behaviour, children's temperament, and general unsupportive family contexts. A lack of early interventions or inadequate resources for health problems, a build up of family problems, children's delayed development and parent's reluctance to work with services can all contribute to the development of chronic cases of child neglect where treatments are largely ineffective. Offering a buffer to increased risk are protective factors that may build towards resilience. Almost opposite risk, resilience develops from a stable environment, positive parental relationships, positive relationships between children and parents, parents who share concern for their children's development and children having a sense of self worth. Together empirical evidence of risk (or vulnerability) and resilience building (or protective factors) provide firm foundations upon which to construct more effective parenting and childcare that enable children to cope with adverse life experiences.

CHAPTER TWO

THE PRACTICAL AND EMANCIPATORY INTERESTS OF HEALTH VISITING

2.1 INTRODUCTION

The buffers to increased risk of child neglect identified in chapter one provides a firm foundation on which to build preventative services that promote the health and development of children. Although health care, especially health visiting, takes a lead role in the promotion of health and well-being (DH 2004) and social services maintain the lead role for children about whom there are welfare concerns (DH 2002), joint working to identify and meet the needs of children is at the forefront of children and parent support services. Child protection has become one component (Dalgleish 2003) of the prevention to protection continuum.

Health visitors' preventative role has a structured child health promotion programme (DHSS 1980; Hall & Elliman 2003) often referred to as generic or routine health visiting. Additional home-based and group-based parenting programmes and some with a therapeutic characteristic are available to complement routine work. Together these options, anecdotally at least, offer a flexible needs and service matched opportunity but the research literature does not uphold this view. Rather, structured programmes are encouraged and training given but the impetus towards increased implementation is more organizational than health visitor driven.

As most parents provide adequately for their children, most parents' information needs are met with the routine health visiting services. Vulnerable parents require a more in-depth support service tailored to their unique needs. When concerns arise about impairment of children's health and development or ill-treatment (DH 1991) health visitors and other agencies are expected to refer children to social services departments for specialist support. However, as there are no studies that have evaluated the effectiveness of the health visitors' service to prevent child neglect and protect children from the effects of neglect a more appropriate starting point is to explore the role of health visiting to highlight 'What knowledge influences health

visitors to act to prevent child neglect?' This is followed by an overview of the research evidence to answer the question 'How do health visitors act when confronted with child maltreatment?'

2.2 THE ROLE OF HEALTH VISITORS

However, before examining the literature it is expedient to first provide a brief explanation of the health visitors' role. For many years the health surveillance and monitoring of children's health has been standardized (DHSS 1980; Hall 1989, 1991, 1996; Hall 2000; Hall & Elliman 2003). It is a service that parents view positively (Orr 1981; Spencer 1980; Chazan et al 1980; Barker 1984). However, exclusivity to mothers and babies is not the government's intent as health visitors are also to "provide support and advice to the whole family" (DH 2001: 11); that is, an age wide population focus. To support developments the government established an independent charity, the National Family and Parenting Institute (NFPI), to provide a strong national focus on families and parenting. This has gone some way towards outlining service trends and options for development, according to commissioner, provider, policy-makers, professional and parents' views. A consultation exercise has resulted in the compilation of evidence about family and parenting support (NFPI 2001). From the findings there is support for universal services such as pre- and post-natal support, telephone help-lines and publications. The key proposal is for health visitors to play "a pivotal family service role [...] offering support to families across the child age spectrum." (p6).

For health visitors this work is envisaged to maintain their traditional face-to-face work and act as a referral point, and help set up self help groups. Changes are to standardize developmental checks and information sessions, rationalizing post-natal visits and a closer synchrony with midwives. Responses from the Community Practitioners' and Health Visitors' Association (2001) and The Children Society to the consultation process are supportive of the widely acclaimed universal services (Underdown & Dewell 2001). Areas without consensus relate to: (1) the reduction in post-natal visits by health visitors, (2) the quality of ante-natal classes for both men and women, and (3) the CPHVA uncertainty about merging children and family services and rejection by The Children's Society

Consensus is seemingly reached on health visiting as a non-stigmatizing, universal support for families (Underdown & Dewell 2001). There is agreement for a synergy between health visiting and midwives during the ante-natal period and the involvement of health support workers (CPHVA 2001) or voluntary workers to provide support work to parents in a variety of settings. There is also agreed potential for including couple counselling and making the seeking of help more easily acceptable and accessible within universal services. Finally, it is agreed that every parenting trainer will receive nationally accredited training. All this adds up to a widening of universal services by a wider network of agencies (NFPI 2003), with children and their families as the focus and health visitors taking a lead role.

2.2.1 The ebb and flow of health visiting

Promoting health is no longer the raison d'etre of health visiting but everyone's business and the truly preventative service that aimed to stop child neglect occurring that was health visiting has become a public health concern (Cowley & Appleton 2003). Nevertheless, health visiting will take the lead in such work; a profession that is fundamentally universal in the service it provides, primary (or early) preventative in its focus and ecological in its exploration of social problems. These basic tenets of health visiting are as relevant today as they were 140 years ago.

Yet turbulent times for health visiting have ebbed and flowed over their 140 years. Threats of discontinuity (Cowley 2003) may be temporary but a decline in numbers continues (Cowley et al 2002). Currently, there are insufficient numbers of health visitors being trained to replace the workforce due to retire in 5-10 years time. Cowley, Buttigieg and Houston (2002) are also of the opinion that health visiting compared to nursing is unclear, their education and training is less structured, less coherent, and without a model that addresses contemporary health needs, such as not having the knowledge and skills to manage behaviour problems (Hutchins & Nash 1998). This reduction in workforce will ill prepare them for the expansion into the broader age and health needs range, other that is, than as team leaders of a less-qualified, differently trained (and less expensive) family-centred and public health programme (Baggaley & Kean 1999).

Solace may be drawn from the plethora of published support for health visiting from The Report of the Commission in Child Health Services (1976) to the document Saving Lives: Our Healthier Nation (DHSS 1999a) where health visitors are recognised as key practitioners with an important role to play. That role was viewed as "strengthening the role of the NHS in health improvement and prevention and to develop services that are accessible, convenient and delivered to a consistently high standard" (DOH 2001: 7). Changes to the role will likely replicate the public health and radical environmental and structural reforms of the day (Appleton & Cowley 2000). That is, the combination of a more personal as well as a therapeutic service (Ashton & Seymour 1988) but with expectation of collective responsibility (Foley 2001). The relationship between health visitors and families is terminated and re-established by the family (Dingwall et al 1995). The inference is for a parent-led service with families accessing services as needs dictate. In response parents want parenting to be seen as "the most important job anyone can take on" (Keep 2000: 2).

Leaving change to a laissez-faire process will not be enough. Health visitors may be wise to learn from their past and recognize the need to be more flexible as demands for and value in their service have a tendency to reflect social problems. The demand for health visiting increases in times of increased social problems and decreases in times of relative stability. Dingwall (1987: 28) described the demand and supply relationship in health care as "the call is the same; society is in decay, something must be done, somebody must do it, and that somebody turns out to be a community nurse". That time has come and it is health visitors who are either in political favour or, pessimistically, political will can find no other 'ideally placed' community nurse to take the lead role.

Clearly, some are sceptical of health visitors' ability to change as Brocklehurst (2004a: 139) implies when he asks if health visitors can be "trusted to modernize themselves". The future of health visiting, whether in their current format or a changed format, will depend upon their ability to accept and adapt to the change process and in the final analysis be found to make an effective contribution when the evaluation of the early years (Sure Start) 10 year project is completed.

2.3 EVIDENCE OF PREVENTION AND EARLY INTERVENTION

Two systematic reviews have attempted to establish the cost-effectiveness of the Child Health Surveillance programme (CHP) and the effectiveness of domiciliary health visiting with mixed results. The systematic review was intended to estimate the cost of individual components of the child health surveillance programme in order to inform future policy planning. Sanderson et al (2001) concluded that the delivery of the programme varied widely and the child health promotion programme and health education were often delivered simultaneously. Hence, it was difficult to identify the cost of individual components. The second systematic review (Elkan et al 2000) found, from a mainly American literature, evidence of home visiting improving parenting skills, the quality of social support for mothers, rates of breast feeding and detection and management of post-natal depression. For children, improvements were in relation to the amelioration of several child behaviour problems, intellectual development among those of low birth weight and failure to thrive and accidental injuries. This evidence supports health visiting building protective factors that improve children's temperament, education, health and competent parenting that can prevent or buffer children against the effects of child neglect and other adversity. Yet, "no conclusions could be drawn concerning the effectiveness of home visiting in reducing the incidence of child abuse and neglect" (Elkan et al 2000: iii).

Only one United Kingdom home visiting research article was included in the systematic review related to child protection but the parenting programmes were delivered by non-professionals (Johnson et al 1993). This supports the opinion of Elkan and colleagues (2001:213) that there is "remarkably little in terms of research or 'hard facts' concerning health visitors' work in child protection". In particular, there is "very little detail of how health visitors work either when confronted with a suspected case of abuse, or in the subsequent referral and management of relations with the family".

2.3.1 Early child health and development needs

What is evident is that health visitors engage to prevent or reduce vulnerability (or risk) and promote protective factors (or resilience). To explore these further, the literature expands upon the knowledge of universal services provided by health

visitors and the services they provide for vulnerable families in order to identify early barriers to child health and development. Encompassed within the promotion of children's health and development there are three issues which are discussed here. They are the child health promotion programmes, parenting programmes and the communication of professional judgement.

In terms of universality, every child will be seen by a health visitor for health checks at least once. Among the population of children, 11,000,000 (DH 2003a) there is estimated to be 3-400,000 children in need of additional services. That is approximately 3.3% of the children population. This divide between children in need and those who did not requiring additional services exemplifies the traditional early child health and development service and a service provided specifically for identified needs that might affect health and development.

Child health promotion programme (previously child health surveillance) enables the giving of advice, at appropriate times, on growth and developmental monitoring, immunisation, feeding, sleep patterns, and behaviour problems (DOH 1987). What child health surveillance entails is constantly under review from a multi-disciplinary working party set up by the British Paediatric Association (Hall 1989, 1991, 1996, Hall & Elliman 2003). There is an expectation of conformity to this perceived evidence-based, best buy, preventative child health programme (Hall & Elliman 2003).

The assessments within the programme are, generally, positively received. Johnson and colleagues (1990) elicited the opinions of mothers (n260) and found the assessments to be informative and reassuring, though one limitation was a lack of information about the assessment procedure. Proactively, and in response to identified needs, accident prevention is also incorporated into the programme. The relevance to the reduction of child neglect fatalities is outlined in chapter 1 and is routinely discussed at developmental assessments. Kendrick and colleagues (1999) explored the effectiveness of safety advice and the provision of safety equipment to disadvantaged families and found the training programmes to increase awareness of accident prevention and reduce the more serious injuries requiring hospitalisation. What it did not do was reduce the frequency of minor injuries requiring hospitalisation.

Should parents attend the early child health promotion programme there is ample opportunity for them to communicate their needs and generally, mothers take seriously their parental responsibility (Westlake & Pearson 1997). When information is needed it is to health visitors they mostly turn (Marden & Nicholas 1997). However, turning to health visitors is not a preference for all mothers, as Bown et al (2000) found in a postal survey of low-risk mothers (n 405) who preferred their partners as a source of help. Low-risk implies fewer needs or problems and thus these mothers probably have no need for extra-family support. When information needs are required, they are for health (91%, 32 of 35), care (86%, n 30) and development of children (80% n 29) (Marden & Nicholas 1997).

However, the needs of a group of young parents living in a disadvantaged location wanted more than information needs. Their needs were more practical. It would seem that disadvantaged family and environmental factors influence more pragmatic needs. For example, the young people in Gill's (1992) study identified money, employment prospects and improvements to a non-hostile environment as important. Although hostile environments may not, routinely, be within the remit of routine health visiting, other than for referral to appropriate others, two health visitors were reported to have played a lead role in a relatively recent multi-agency regeneration project with positive effects (Stuteley 2002).

Evidently for some parents, health visiting support is not their preferred source of support. They are already disadvantaged and if they hold parallel responsibilities for parenting, as well as a strong sense of culpability when things with their children are not right, they may be reluctant to access health visitors (Westlake & Pearson 1997). As Westlake and Pearson explain, mothers who fear health visitors make judgement about their parenting skills are unlikely to view health visitors as either friend or confidante. Never the less, those who want access to health visitors will find them very easy or quite easy to approach (96% programme parents, 92% non-programme parents) (Hogg & Worth 2000).

2.3.2 Parenting programmes

Rather than let parents decide when to seek help, some health services have assumed a collective view, especially of new mother or parents lacking experience

and knowledge about childcare. In response to this assumption they have recommended the implementation of the home based, Child Development Programme (CDP) (Barker 1984) or similar programmes. Such prescriptive approaches would seemingly be against the notion of empowerment but the revised CDP, the Positive Parenting Programme (PPP) was found to be generally positive (Whittaker & Cornthwaite 2000) - at least, that is, to the age of 1 year (Deave 2003; McHugh & Luker 2001). Having experienced First Parent Health Visiting Schemes (FPHVS) few complaints have been noted (Barker 1984). Ranging from a low rate of 3% to 7% (n 384 – 166 parent programme and 218 generic health visiting) parents suggest the FPHVS (6 of 166, (4%) and generic health visitors (14 of 218, (6%) respectively, could be more accessible and available. Mothers also thought health visitors could give more parenting and child development advice (6%), more practical advice (6% and 7%), initiate contact (6% and 3%), have better listening skills (5% and 4%), and spend more time with mothers (5% and 7%) (Deave 2003).

Equally positive, Hogg & Worth (2000) found programme health visitors to be less directing but an equal balance was achieved between giving direct advice and helping parents to make their own decisions, from both programme and generic health visitors. Giving direct advice need no be perceived as a negative response, as some parents wanted advice rather than be left to solve their problem. Overall, these studies suggest that parenting programmes were agreeable, but they are just marginally more agreeable than non-parenting programme-oriented health visiting.

In fact, it may not be the actual parenting programme that is agreeable but contact with health visitors that Deave (2003) and Hogg and Worth found to be most useful to mothers (n174 – 43% programme and 58% no programme) because they facilitated private and in-depth discussions. However, privacy may not be the major factor as the majority of parents (69%) favour both group and one-to-one settings. Only 25% of parents favour a one-to-one parenting programme (Hogg & Worth 2000). Crucially, in terms of deciding a need for programmes it is health visitors who are less enthusiastic about delivering first time parenting programmes.

Health visitors (62%, n43) were said to be positive about the underlying principle of empowerment (Deave 2003; McHugh & Luker 2001) in the programmes but were less positive about the expected outcomes (Emond et al 2002). Whether or not the

programmes deliver the expected outcomes of improved child development knowledge, maternal self-esteem and empowerment, it is difficult to accept McHugh and Luker's (2001) findings that health visitors perceived parenting programmes to be a good use of their time (45, 65%) or that they enjoyed using the programme (37, 54%). If so, then surely more than 296 of the 1400 new mothers would have received the parenting programme as management desired.

A perceived disadvantage to parenting programmes is that they might increase parents' demands for home visiting (Whittaker & Corthwaite 2000). Presumably having been made aware of the range of the service and gained insight into their own and their children's needs, parents will choose to use the service more. Parents' demand for visits could be interpreted as a positive shift towards empowerment as Johnson, Howell and Molloy's (1993) randomised control trial found. The comparison of the first time mothers (n=232), allocated to an intervention group (n=127) or the control group (n=105) or a group of experienced mothers (n=15) show increased self-esteem and uptake of immunisation among the intervention group. Similar improvements were noted by Whittacker & Cornthwaite 2000) for immunisation rates (85% programme & 65% control), as well as a delay in weaning children (19% & 47%), reading to their children (98% & 54), and improved developmental stimulation related to the parenting programme group (p<0.01).

Health visitors implementing the positive parenting programme perceived the disadvantages to be increased paperwork, isolation from traditional practice health visitors and deskilling of health visiting generally. Some health visitors (17 of 82) found the programme unworkable for some groups and difficult to incorporate into practice (6 of 82). The reluctance of health visitors to implement positive parenting programmes may have been due to being unfamiliar with the revised CDP and communication difficulties between PPS staff and conventional staff (Whittaker & Cornthwaite 2000). What must be borne in mind is that imposed first time parenting programmes will only serve to irritate those mothers who view health visitors as having 'singled [them] out' (McHugh & Luker 2001: 36). Conversely, when parents are given the option, the choice may not be just whether or not to enter a programme but also whether the programme meets their unique set of needs and whether a one-to-one or a group setting is preferred. Overwhelmingly, the most

beneficial aspect of CDP or other first time parenting programmes is contact with health visitors (Hogg & Worth 2000).

2.3.3 Communicating professional judgement

Parenting programmes assume needs. Generic health visiting interacts with families to identify needs and plan appropriate services to meet needs (Appleton & Cowley 2003a). Appleton & Cowley's observations of home visiting found only 5 (of 53) health visitors using formal guidelines. During the observed home visits a pattern of professional judgement emerged as a process of listening to people, coming to an understanding, checking out the understanding and agreeing how to proceed. For some health visitors sharing information with parents is more rhetorical than real, though the 'subtle sharing' is perceived to be more context determined than a lack of communication. The subtle sharing is suggested as a way of building strengths instead of focusing on limitations.

Conversely, proactive interaction through, health visiting, home visitation could be perceived as organisational or state control. If not obvious or disclosed the search for needs must be seen as prying into the private life of a family. The clinical gaze (Foucault 1973) of health and social services to families with young children is based on personal management of children and organisational goals (Edwards & Polay 1994). Interviewing midwives (11), health visitors (16), social workers (38), and voluntary workers (18) to elicit their perceptions of needs of families with young children Edwards and Polay found a shared belief that families ought to be helped to help themselves because of a conceptual danger of dependency from such activities as face to face interactions. Constraints and ideas that influenced their practice were "the juxtaposition between the structural and the personal" (p33). Whether the concerns were poverty, housing or debt they acknowledged societal, structural influences on people's lives but also a personal responsibility "in managing their children and households" (p33). Edwards and Polay concluded listened and befriended families to be valued aspects of supportive practices but such activities were constrained by organisational or professional ideologies.

The complexity of health visiting is in trying to balance a policy agenda (the organizational or instructional purpose for contact) and a people agenda (such as

poverty or domestic violence) (de la Crusta 1994). The immediacy of the people agenda will take precedence but surely only if family members are agreeable to discuss or address the health needs. Hence, sensing something was wrong and identifying an anomaly cannot be labelled at the time of first encounters (Ling & Luker 2003). The intuition of something being wrong may act as the precursor to further discussion but only if the family feel empowered enough to actively engage in discussion. Only discourse that can unravel for both parties the variability of parent and health visitors' understanding and ambiguity or uncertainties about anomalies can lead to a shift in interpretation to better understand what is wrong (Cowley 1995; Ling & Luker 2003).

In an attempt to make clear what it is that health visitors do, some managers have developed a pre-determined list of needs for health visitors to use during their interactions with families. The result was disempowering for both mothers and health visitors (Mitcheson & Cowley 2003). Ten health visitor volunteers, five using the assessment and five not, allowed a rudimentary comparison to be made. Mitcheson & Cowley conclude that the assessment questionnaire hindered the communication process that they describe as a disempowering, covert, professional style. Cues were missed by health visitors and their questioning style was insensitive rather than the open, conversational style of communication advocated by Bidmead, Davis & Day (2002).

In terms of cultural needs, parents want services that are sensitive to their culture (Moorman & Ball 2001) but in this area health visitors are found wanting. In the interviews with parents Moorman and Ball found language to be a barrier to communication. Sharma, Lynch & Irvine (1994) also found language a barrier between Vietnamese mothers (n40) and health visitors (n73) with help from interpreters sought by only 48% of health visitors. Sharma and colleagues also found knowledge of educational material lacking. More health visitors admitted not knowing of the existence of such material (n28) than gave educational material routinely (n13). It is therefore not surprising to read that "Vietnamese mothers do not perceive health care staff as a source of advice about weaning infants" (Sharma et al 1994: 354).

On the other hand, through semi-structured interviews to examine health visitors' work in relation to Pakistani women Bowes and Domokos (1998) found Pakistani women (n= 62) value health visiting though poor access to interpreters was also a problem. Unpopular aspects of health visiting were directive, interfering practices and bossiness. Communication was, nevertheless, better with health visitors than with general practitioners. White women living in the same area (n=68) were also interviewed and they too appreciated health visitors taking time to talk and listen. Both Pakistani and white women and health visitors (n=50) described the need to build relationships. Mothers viewed, more positively, their relationship with general practitioners (n=25) (Bowes & Domokos 1998). Pursuing an enabling role was stressed by health visitors but this is an area of practice perceived to be problematic due to the competing pressure to quantify their work.

Health visitors and mothers do not always share the same interpretation of the goals for interventions. Health visitors and midwives' goal orientation towards the promotion of health, for example, is thought to be through increasing the confidence of mothers in their abilities to parent but what were not tangible areas of practice were discourse around self-esteem and empowerment (Edwards & Polay 1994). Implicit in this conundrum are different components of self-efficacy, such as personal beliefs, capabilities and power to organize and execute appropriate actions (Bandura 1997). Montigny and Lacharite's (2004) conceptual analysis of parental efficacy showed "complex, multi-directional relationships with multiple variables" with a match or mismatch of beliefs among family members. It would seem that clearer defined goals are required against which an evaluation of provisions can be made such as the use of the Parental Efficacy Scale (Reece 1992) when concerns are raised. What Montigny and Lacharite also found was an under-investigation of fathers' efficacy that leaves a misleading interpretation of mothers' efficacy as parental efficacy. It is perhaps time to compare both parents' perceptions of the strengths they bring to their parental role and what they perceive the other parent to hold (Montigny and Lacharite's 2004).

Overall, contact with health visitors is agreeable and the child health promotion programme is informative and reassuring to parents. Parenting programmes are marginally successful but, in comparison to the scale of the child health promotion programme, the programmes need to be more widespread and optional to dispel any

lingering notion of targeting 'poor' parents. Agendas for communication are organisationally driven with minimal sharing of knowledge about procedures. Cultural competencies can be are a weakness of health visiting but, then again, the health visitors' relationship with parents can be empowering as long as respect is shown for parents as the crucial individuals in a child's life.

2.4 VULNERABILITY DEFINED

Unfortunately, society is not equal and some parents and their children are more vulnerable that others. To explore health visitors' concepts of vulnerability was first examined by Appleton (1994, 1996) who explored health visitors' criteria and procedures for defining, identifying and assessing vulnerability. The methodologies used were a postal survey of health visitors (102) and in-depth interviews (12) (Appleton 1994). Her findings describe vulnerability as an ambiguous term and a continuum incorporating a complex mixture of factors (n47, 81%). Professional judgement relating to vulnerability does not easily conform to official guidelines thereby it is perceived as role conflict and role diversity. Not that this is problematic as it supports Cowley's (1995) construct of 'ambiguity'. The mixture of factors may be internal and external factors such as "a lack of support, emotional or practical" (HV 39, p1137). A continuum of vulnerability is identified as low, medium, high and legitimated concern (that equates with formal child protection concerns). Implicit in the identification and management of child neglect, ambiguity arises from the different levels of concern applied by different workers. A high level of concern for one practitioner is not the same level of concern for another.

Working with vulnerability is explained as health visitors become identifiers of vulnerability, support agents, referral agents, when required, and reluctant monitors (Appleton 1996). This is the primary preventative work overlooked by others. Identification cannot occur without knowledge of and exposure to the family or community. In a supportive role, health visitors give advice, boost parenting skills and parents' self-esteem, give encouragement and advocacy (n40, 69%) and to a lesser degree promote health (n9, 16). Referral involves recognising situations where additional resources might facilitate a change in circumstances but as one health visitor stated "I mean the problem is that the resources are not really there"

(HV19, p915). The result is that health visitors are left supporting vulnerable families alone. Resources reported were in descending order, family centre (30 of 58), local authority playgroups (19), Homestart (18), child and adolescent mental health centres (18), family aid worker/home help (14), counsellors (12) and special needs team (11). Health visitors' complaints were mainly about social services and related to their lack of input to vulnerable families, that is until a crisis or abuse occurs. Continued support for families is an expectation but to monitor families, as in the sense of policing families, is not perceived as health visiting practice but the responsibility of others.

2.4.1 Children's needs

Vulnerable factors for children are speech and language delay (Laing et al 2002), behaviour problems in children (Coe et al 2003; Spencer & Coe 2003) and for parents there is depression (Deaves 2001: Sheppard 1996), and domestic violence (Bucchus et al 2003; Peckover 1998). Many more articles address these same problems or needs but from a training orientation that will be discussed later. First, speech and language delay are often found in cases of child neglect (Allen & Oliver 1982; Culp et al 1991; Fox et al 1988) but also present as features of deafness, cerebral palsy, rare congenital disorders and autism (Hall 2003). Hall (2003) distinguishes between simple delay in language development and specific language impairment.

Speech and language screening was a common enough practice for many years but the evidence of formal screening is now in question and the study by Laing and colleagues (2002) support this contention. Laing and colleagues blind tested two screening methods, the structured health visiting screening and a parent-led method of expressed concerns (questionnaire) that were later retested by speech and language therapists using the Reyall developmental language scale. The results do not support either method as an effective screening tool. Sensitivity and specificity for health visiting screening was 66% and 89% and for parents' concerns, 56% and 85% respectively. A high predictability is preferred for a screening instrument but this high, rather than an accurate identification of a language problem, is not acceptable.

Children's behaviour problems may creep upon families over the early years but there is a suggestion that early identification is possible. Exploring the service provision and cooperation of services for preschool behaviour problems Coe, Spencer, Barlow, Vostanis and Laine (2003) surveyed health visitors (36), nursery nurses who work closely with health visitors (16), community paediatricians (4), consultant psychologist from CAMHS (1), education service personnel (5), social service managers (4), and voluntary service providers (8). In terms of parenting programmes for behaviour problems health visitors' preference for individual parenting programmes (46%) over group programmes (28%) re-emerges. Service provision is explained as identifying problems and referring on to specialist nursery nurse, community paediatrician, general practitioner and social services. Appreciation of the opportunity to directly refer children to Child and Adolescent Mental Health Services is less satisfactory than might initially appear due to the constraint of long waiting lists and a lack of knowledge about available resources (Coe et al 2003). Knowledge of services is more global, city wide services (28.6%) than of local services (13.36%) and knowledge of the underpinning theories of service provision marginally better (8, 22%) than knowledge of local services.

An examination of child health surveillance records at 8 weeks, 8 months and 3 years showed an association between parent- reporting behaviour problems at 3 years with the family living in rented accommodation and living in a smoking household (Spencer & Coe 2003). After following through children's behaviour Spencer & Coe (2003) concludes behaviour problems at 3 years old can be predicted at 8 months (sensitivity of 13.9% and specificity of 95.7%)

2.4.2 Parents' needs

What is plainly clear, when searching for health needs, is that parental needs impact on children and the family as a whole. Low-income is associated with postnatal depression (Deave 2001; Sheppard 1996) and multiple health needs (Shepard 1996). In Deave's (2001) study a community of vulnerable women had a high risk of unemployment (22 of 78, 28.2%) and Sheppard found families with 8 or more health needs dependent upon unemployment or other benefits (100%) and families with 4 or more health problems (92.4%) dependent upon benefits. The chicken or the egg argument seemingly supports low-income as a causal factor to ill-health.

Nor surprisingly, lone parent families correlated strongly with low income (chi sq=7101, p0.000) having a tendency to cluster in specific localities where the premature death rate was high. The correlation between low-income and health needs serves as a reminder of the philanthropic roots and continued focus of health visiting on the 'poor' and the importance of searching for health needs in the midst of low-income.

Once women experience physical and chronic ill-health, a high percentage (76%, 6 of 8) will be prone to subsequently develop depression. Women with an Edinburgh Postnatal Depression Scale (EPDS) indicative of postnatal depression also experienced poor housing (16%) and relationship problems (60%) (Deaves 2001). Deaves concluded that vulnerability factors were more predictable of postnatal depression that the EPDS. The EPDS was found to be more useful in recognising anxiety about pregnancy. Protective factors of postnatal depression are seemingly being "prepared and happy" about the pregnancy and being in a long-term relationship with no risk factors. The impact on children is the affect it has on parenting skills (Dent & McIntyre (2000)

The same level of impact on parenting skills may not be present with domestic violence unless associated with mental illness (Dent & McIntyre 2000). A less serious label of stress was links with domestic violence after Bacchus, Mezey & Bewley (2003) interviewed 16 women with experience of domestic violence and 24 health visitors. All the women experienced stress within the last year and their stress was related to financial, housing difficulties and depression. Of this relatively small sample, 6 were diagnosed as depressed, 5 were on medication and 3 admitted to attempting suicide.

Peckover (1998) suggests domestic violence is a feature of health visiting but more women sought help from their General Practitioners (GP)(4) than health visitors (2) (Bacchus et al 2003). Women's explanation for this was that GPs are more honest, but the four women had exposed themselves to experienced health care practitioners, perhaps with the intention of disclosing the violence. Disclosing to health visitors would have been difficult for these women, yet the women scored highly on the EPDS. So if routinely administered the EPDS ought to identify women experiencing stress. The next step for health visitors would be to ask about

domestic violence as women said they would not mind this. If affirmative, women want information about appropriate agencies, refuges and Woman's Aid.

Parents with children exhibit serious behaviour problems may not have any more need for services for family problems and relationship problems than milder cases of families requiring services (Window et al 2004). What Windows and colleagues identified as parents' needs in such cases was knowledge and understanding of their children's difficulties, information about services or management of children's difficulties. From an overview of a number of studies about parents' needs Moorman and Ball (2000: 43) concluded "parents want flexible services, where they are treated with respect, which they can use easily, and which are sensitive to their cultural needs".

2.4.3 Service focus initiated by others

The universal approach and early interactions with families has led many mental health professionals, especially psychologists and psychiatrists to take an interest in health visitors' ability to identify mental health problems (Appleby et al 2003; Sheppard 1996; Dent and McIntyre 2000; Elliott et al 2001; Puura et al 2002) and behaviour problems (Weir & Dinnick 1988). An average of 5 days training to provide new knowledge and skills improved the identification of health needs. The first study to examine the rates of depression identified by fourteen health visitors (Shephard 1996) interviewed 701 women using the Beck Depression Inventory (BDI) to identify depression rates among the clients of health visitors. The results show an approximate 25% depression rate. However, health visitors used a degree of arbitrariness to distinguish depressed women from those who were not depressed. The factors used to distinguish depression were: women who lacked satisfaction with their life; women who were disappointed with, disgusted with, or hated themselves; and women who were experiencing a sense of failure. Sheppard suggests the study demonstrated the importance of depression to health visiting.

Also concentrating more on the day to day practice of health visitors, Dent and McIntyre (2000) surveyed families to determine the prevalence of mental health problems and those whose illness impacted on their parenting role. From the large sample of 10,800, the authors found 645 (6%) families who, in the opinion of 46

health visitors, had a parent with mental health problems. Of these, the opinion was that parenting was adversely affected in 264 families. This is the only study to find similar findings between health visitors and specialist mental health workers.

Three studies introduced training and tested its application to identify postnatal depression (Appleby et al 2003; Elliott et al 2000) and children's mental health (Puura et al 2002). Relatively large numbers of health visitors received training (n97, n151). In Appleby and colleague's study the group undertook 2 days training in postnatal depression, use of EPDS, detection and cognitive-behavioural counselling. Seventeen health visitors were also videoed. The findings after examination of clinical records showed health visitors who had been trained detected more mental health symptoms and applied the therapeutic techniques more readily. This improvement in skills was said to be without increased cost.

In Elliott and colleague's study the group undertook 5 days training in postnatal depression and active listening, needs assessment and treatment. EPDS scores on women assessed before training and on women after training were compared. The significant change (p 0.05) was the use of a lower cut off and an overall reduction in depressive symptoms at 3 and at 6 months postnatal. There is some recognition of a possible change effect but there is no control of the longitudinal study to offer more reliable evidence of the effects of the training and implementation of new knowledge and skills.

The training to promote children's mental health lasted the longest, 8.5 days, and incorporated parent counselling and promotional interviews. Initiation of the training was via The European Early Promotion Project but only the British contribution is reported here (Puura, Davis, Papadopoulou, Tsiantis 2002). The project involved antenatal interviews, postnatal interviews, needs assessment, continuing service, and intervention. Health visitors used two measurement questionnaires on (1) content of training and (2) the constructs of helping. Subsequent home visits by psychologists and psychiatrists interviewed mothers using a battery of instruments to evaluate the accuracy of health visitors' judgement (Structured Clinical Interview for DSM-IV (Brown & Rutter 1966, Quinton, Rutter & Rowlands 1976), HOME Inventory (Bradley & Caldwell 1979), Bates Infant

Characteristics Questionnaire (Bates, Freeland & Lounsbury 1979), Parenting Stress Index (Abindin 1990), and Family Grid (Davis & Spurr 1998).

Outcomes from training were reported as all demonstrating improvements. Findings that related to the application of the training show that mothers were less dissatisfied and found trained health visitors more helpful than the traditional service. Dissatisfaction rates like the satisfaction rates vary by a relatively small amount (11%, n11). The greatest margin of difference was in the accuracy of identified needs, a margin of 18.5%, that is 68%, (n77/113) for trained group compared with 49.5% (51/103) for the control group. Thus, traditional health visiting was seemingly helpful but comparatively, the parent adviser programme (Puura, Davis, Papadopoulou, Tsiantis 2002) produced the greatest improvement in identified needs. Rather than a cause for concern these results ought to be as much a cause for celebration for health visiting skills; especially given the rigour with which accuracy in identifying mental health problems was evaluated but obviously improvements can be made.

Literature evidence so far is exemplary of a service that is both satisfactory and dissatisfactory. Many factors influence health visitors to act to build protective factors, rather than address risk. For children there are health and developmental checks and behaviour problems. Mothers' ability to address childcare needs, their relationship with the child and partner, feelings about their mothering role and knowledge of accident prevention are taken into account. Vulnerability factors such as mental health problems, domestic violence, adverse family environments, children's behaviour problems and multiple needs also contribute to influencing health visitors to act to prevent child neglect and abuse. The sharing of such sensitive, personal and embarrassing information is suggested as reliant upon a relationship of trust between parents and the health visitor (Normandale 2001).

If the interaction is intended to empower mothers then health visitors are failing in this endeavour. Mother perception of empowering practices included listening to mothers; developing personal power, and supporting changes mothers make. Regrettably, most mothers commented on disempowering practices such as aiming to change mothers' behaviour and continuing to try to find something when there is nothing wrong.

2.5 SAFEGUARDING CHILDREN

A recent review of the Scottish multi-disciplinary child protection service (Daniel 2004) found health and educational agencies where not integral to but rather referring children *into* the child protection systems. Some inconsistency of concern was also found among health visitors. They were found to go to tremendous efforts to ensure children attend medical appointments but they were less persistent in following up persistent failures to attend. This may be the prioritizing of work towards preventing families from moving along the continuum of vulnerability to child protection (Appleton 1994). The main tension in child protection work was associated with child neglect cases (Daniel 2004). This is the 'grey area' health visitors recognize when vulnerable levels are increased and they have concerns for the children of the family but social services do not share the same concern (Nettleton 1991: Appleton 1994).

Although intended to explore how health visitors act when confronted with child neglect the focus for this section of the literature review will of necessity cover child maltreatment generally, as no literature was found that reported specifically on health visitors' contribution to working with child neglect. Using the same databases and years of publication, only studies reporting on UK health visitors are included here. The Randomised Control Trials (RCT), gold standard for research studies was not applied as no RCTs were found. Moreover, characteristics of health visiting would appear to confound such methodology (Lemmer, Grellier & Steven 1999). Also there are those who believe RCTs cannot be generalised to 'real life' situations (Elkan et al 2000: 3). However, had a choice been available RCT's would most certainly have been included.

The key words used to identify the literature were health visitor, child neglect, child in need or at risk and research or empirical or evidence. The literature search found 275 articles supposedly research studies, but further exploration found that many were not research based. Some publications focused on health visitors as a source of data collection or they did not report findings specific to health visitors or there was a shared focus with social workers and school nurses. Excluding these studies dramatically reduced the number of publications to seven, (Appleton 1996; Crisp &

Lister 2003; Edwards et al 1998; Gallagher & Jasper 2003; Ling & Luker 2000; Taylor & James 1987; Taylor & Tilley 1990) as outlined below in table 2. 1.

	Health visitor	Research	Final selection
Health visitor (3726)			
Child neglect (284)	8	5	0
Child in need (498)	20	17	0
At risk (1674)	247	157	7

Table 2.1: Key words for health visitor and child maltreatment literature search.

2.5.1 Knowledge of child protection

Health visitors were regularly involved with work to protect children (Crisp & Lister 2003) but identification of the need for protection was mainly by intuitive awareness (Edwards et al 1998; Ling & Luker 2000) and increased vulnerability (Appleton 1996). This they share with community mental health nurses who were also less dependent upon research evidence than other primary care practitioners. When risk was identified, communicating risk was "trying to get [people] to understand that there was a risk" (Edwards et al 1998: 2927) rather than persuading them with up-to-date information. Even in decision making, in particular family group conferences, professional rhetoric may seemingly champion empowerment for parents but they were found to express little faith in parents' ability to protect their children (Gallagher & Jasper 2003).

Exploring the understanding of professional responsibilities in relation to child protection Crisp and Lister (2003) interviewed a purposive sample of key nurses (n99). The sample consisted of health visitors (n36), new public health practitioners (n16), community mental health nurses (n14), those working in the field of

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substance misuse (n11), family planning nurses (n5), district nurses (n6), nurses working with people with learning disabilities (n1), senior trust managers (n8) and practice development nurses (n2). From such a wide range of practitioners it is surprising to find no shared understanding about the definition of child protection. Having regular contact with child protection issues health visitors were not averse to the work but they did feel that their primary care colleagues consigned this responsibility to them (Crisp & Lister 2003). Such consignment may not be altogether unrealistic considering health visitors are exposed to more families with children than their colleagues.

It was during those encounters that health visitors became aware that something was not right (Ling & Luker 2000). Ling & Luker suggest homogeneity is not found among child protection 'cases' but that all are unique. To demonstrate this uniqueness they present three cases where health visitors became intuitively aware of 'indicators of concern'. The indicators in question were something unpleasant about the father valuing his ability to exercise his power; something wasn't right about no visible signs of a baby; and knowing mother's unrealistic expectations the situation wasn't right.

There is an implied uniqueness to the intuitive awareness about the felt unease that was not shared by other agencies in case one until it was confirmed that there had been reported concern about the father. Cases two and three were not substantiated cases of child neglect in the sense that there was persistent neglect but both cases highlight how irregularities that if confronted early, can prevent neglect in the future. Case two found a baby inappropriately covered completely with a blanket in the cot; a discovery made due to an uneasy feeling about no evidence of a child in the house. Case three followed logically the whereabouts of the baby. Mother, unaware of her new partner's (of days) surname and address and who has taken the baby out, is assisted to reflect on the situation and a valuable lesson in appropriately safe supervision is conveyed.

All three health visitors referred to intuition as an explanation but it was an explanation that the least experienced health visitor was uncomfortable using as it was not scientific. Ling & Luker (2000) draw parallels with their findings and those of Robinson (1995) and the conflict inherent in health visiting between scientific

and situation specific knowledge. The conclusion was that health visitors detect child maltreatment, and early patterns of parental behaviour, or parental characteristics, conducive to causing impairment or harm to their children (Ling & Luker 2000). Moreover, intuition can be seen not as an end or professional judgment but a 'gut feeling' or unexplainable sense of something being wrong that involves testing the validity of the awareness. The intuitive nature of identifying child maltreatment is described as health visitors having a 'mental boundary' (Luker & Lung 2000).

2.5.2. Protecting from impairment and harm

This 'mental boundary' was ostensibly the point at which health visitors became referral agents for unmet needs (Appleton 1996) - that is, referring to family centres as few alternative resources were available (Appleton 1996). Current provisions are the same family centres and the hybrid integrated children's services (intended as a centre with multi-agency representation to address multiple needs), sometimes referred to by some as a 'one-stop-shop' (Tisdall, Wallace, McGregor, Millen and Bell 2005). The latter was of particular value to Scottish parents accessing these services (Tisdell et al 2005; Ranson & Rutledge 2005). Not that referral necessarily means acceptance of the service or positive outcomes. As with attrition rates of parenting programmes 38.5% (10 of 26) of parents did not perceive the service positively (Tisdall, Wallace, McGregor, Millen and Bell 2005) nor did family centres transform every family (Ranson & Rutledge 2005).

The 'practice' of child protection, whether of family centres and integrated children's services or health visiting practice, is the validity of the self-knowledge (empirically or intuitively) or achieving an understanding of the social situation that gave rise to concern (Ling & Luker 2000). Not being allowed to see the child in case one (above) the health visitor returns later and is increasingly concerned about the power over others the father is perceived to value. Asking to see the baby elicits the hazardous swaddling of the baby in case two. Sometimes discussing the case with a colleague can validate the intuitive awareness as in case three. In all three cases the health visitors' intuitive knowledge acted as a 'silent alarm' (p577). This practice is about investigating the situation through discourse in order to raise self-

awareness in those involved, to prevent impairment and harm of children and to resolve any presenting problems.

Such practice is achievable through the regular direct involvement with families and child protection issues. A contentious issue for health visitors is the 'supervisory role' that social workers attempt to impose on them (Crisp and Lister (2003). A supervisory role usually follows expressed concern that does not meet the perceived criteria for social service involvement when the health visitor can be left working alone with vulnerable families (Appleton 1994). This is reflective of the conflict between health visitors and social workers, which ought presently to be outdated practice for both workers. The conflict described by Taylor & Tilley (1989a) is of social workers accusing health visitors of 'overreacting', 'hype up situations', and referring 'stupid, petty little things' (p15). One health visitor was accused by social workers of being "unable to translate her observations and feelings about the case" (Devaney 2004: 32). Health visitors accused social workers of being "more concerned with helping parents than protecting children" (p14-15) and of "telling them but they don't tell us" (p15).

This tension at the threshold for responding to child welfare concerns has, seemingly, persisted for many years. More than thirteen years after Taylor and Tilley (1989a) raised the issue of conflict between health visitors and social workers it was still a serious concern. The Joint Chief Inspectors' Report on Arrangements to Safeguard Children (2002) reported social services ability to provide an adequate response for children, only, if they were at high risk of serious harm. The scale of the problem of meeting children's needs through social service intervention is disturbing. Forty five percent of inspected social service departments (n35 of 67) "could not be judged to be serving most or all children well" (Social Service Inspectorate 2004: 6). As a consequence, if health visitors concluded from their assessment a child-in-need situation they would likely be disappointed and more satisfied with social services response if the case warranted a child protection investigation.

Severe difficulties in recruiting and retaining social workers in the field of child welfare and child protection were the main organisational reason for priority being given to children at high risk of harm (Social Service Inspectorate 2002). A second

difficulty was the different features that influence decision making at the thresholds of child in need and child protection. Most enlightening Platt (2006) found three features that influenced social workers' decision to proceed to initial assessment of children in need. They were (1) needs for which parents could be held accountable; (2) that constituted a risk to the child; and (3) corroborated by other professionals. To investigate for child protection concerns two additional features were taken into account; (4) the specificity of the reported harm to a child or (5) the workers' interpretation of particular seriousness. In order for health visitors and others to improve their chances of successfully referring their concerns Platt suggests information should be presented under these five features.

Taylor and Tilley (1989a) also ascribe the tensions between the two professions to lack of resources to do the job but they also ascribe misunderstandings about each other's roles. In particular, they cite the ambiguity of some health visitors wishing to be involved in the legal/bureaucratic processes as well as not wishing to compromise their relationship with families. Reference to undermining relationships was also found by Taylor and James (1987). Other aspects of their work that caused health visitors (n19) the most anxiety and concern were children not developing properly (100%) and suspected non-accidental injury (73.7%). Health visitors appeared to judge concern according to children's health and development and expect to be involved in the decision making processes whilst social workers appear to focus on parenting as a risk of harm, especially if others concur. Thus referral of a child protection issue will probably gain social work attention. Impairment of health and development that is not suspected or actual child abuse or neglect will likely be contentious. The cases that gave health visitors the most anxiety were these 'borderline' or 'grey areas'.

Such interpersonal difficulties are mainly communication failures that originate from a lack of respect or mistrust of others perspectives (Brendon et al 1999) and that are more psychological than physical (Reder & Duncan 2003). The failure is in the transfer of information that is not always understood by others. Reder & Duncan explain that communication is a way of thinking that incorporates the "myriad of feelings, attitudes and desires that add up to interpersonal relationships" (p86). They recommend efforts be made to enhance the thinking capacity of workers by creating

opportunities to review and rehearse communication with each other, encourage systematic thinking and be cognisant of others' perspectives.

Contemporary practice expects both health visitors and social workers to apply the category of children in need, and categories of abuse and neglect (Children Act 1989); adhere to the same key principles of practices aimed at safeguarding children from impairment, harm and ill-treatment; and contribute to the Assessment framework for Children in Need and their families (DH1999; NAfW 2000). That includes practitioners talking about concerns, seeking parental consent for referral to social services and framing concerns according to three domains (children's developmental needs, parental capacity and family and environmental factors) of the Framework for Assessment of Children's Needs (DH 1999; 2000). Accordingly, disclosure, observation and measurable information ought to be shared where concerns are raised about children's welfare. What is not in dispute is the 'ideal' position health visitors hold that places them as the "best person to help a family in crisis" to identify any escalation of risk (Taylor & James 1987: 330).

Health visitors' frequent contact with families seemingly increases the potential to see something amiss and thereby identify more child neglect. Comparative evidence, however, does not support health visitors protecting children other than anecdotally, and neither could it be argued that social workers protect children. An exploration of performance management in child protection in Northern Ireland (Devaney 2004) found measures designed to monitor the operation of the system but not the impact services have on the lives of children. In fact, Devaney (2004) is critical of the delay of social services to take seriously cases referred to them. Mainly intuitive awareness is offered as the means of identification of child protection issues with a cautionary approach taken to communicating risk.

Tensions are, therefore, inherent in health and social workers attempts to balance organisational and personal ideas about children and family needs and how these can be met. Intuition is one means by which health visitors suspected impairment or harm to children. Another was the 'mental boundary' reached when unmet needs were continuously unmet and when health visitors became referring agents. Should parents not engage with deemed appropriate services or refuse social service intervention or social services refuse to provide interventions health visitors took on

the role of supervisor that they believed to be the remit of social workers. Rather than finding a way to highlight the resource deficits to other workers, explicitly stating priorities for referral, coming to a consensus about threshold features and finding alternative ways of addressing early unmet needs it is feasible to expect misunderstanding and mistrust among those who experienced referral tensions. What is clear is that blame for tensions between health and social workers cannot be apportioned to one agency. Rather, both agencies must accept their failure to communicate effectively, purposefully, and with meaning that is relevant to others.

The qualitative design chosen for all seven studies used interview methods of data collection. Although not considered the 'objective' bone fide, scientific method the interview placed an emphasis on the practice (Carson & Fairbairn 2002) of health visitors. Sample size of health visitors was relatively small (range 3 to 36) with an average of 13.8. The results, therefore, cannot be generalised to health visiting practice but serve as exploratory studies of relevant concepts that can point the way to further research. Nevertheless, the findings together offer insight into the various concepts of health visiting practice towards child protection; understanding responsibility (Crisp & Lister 2003); vulnerability in relation to child protection (Appleton 1996); identifying risk (Ling & Luker 2000); communicating risk (Edwards et al 1989); management of cases (Taylor & James 1987; Taylor & Tilley 1990); and experiencing family group conference (Gallagher & Jasper 2003).

2.6 CHAPTER SUMMARY

To summarise, the role of health visitors enables them to access families and learn about health needs and problems. Many health and social needs were identified. Whether interacting with routine health visiting or through a parenting programme most mothers found health visitors to be an agreeable source of information. Use of screening instruments does not enhance the identification of health needs but detract from people's real needs. The exception is screening for postnatal depression. All too often depression was accompanied by multiple needs which require an action plan for all presenting needs. Likewise, the reported prevalence of depression among approximately 25% of mothers supports further training for health visitors to identify and manage depression.

There is also a need for health visitors to become culturally proficient in order to more effectively identify the health needs of non-English speaking children and their families. In response to identified needs, especially sensitive issues and with vulnerable people an open, honest, trusting relationship is advocated to enhance health visitors' ability to explore people's meanings of their health and the social and cultural aspects of life.

The knowledge, the practice and the principle of working towards individual or collective family responsibility from a health visiting perspective is in urgent need of exploration. Whatever phenomenon is chosen to explore health visiting, it is inevitable that many and varied health and social needs will be made known but no phenomenon can be more important than parenting. Nor can there be many more important childcare foci than the prevention of child neglect that can precede child abuse. Exploratory research is recommended into the knowledge of health visitors to establish the range and any specific focus taken to prevent child neglect and protect children. Ling and Lukers' (2000) study has begun to explain how intuitive knowledge is used to identify child protection issues. Some tensions between health visitors and social workers were found for which clearer divisions of responsibility were recommended (Taylor & Tilley 1989b). Children's developmental needs, non-accidental injuries and 'grey areas' were the main concerns health visitors expressed in relation to children at risk (Taylor & James 1987). To build upon this work further the study is required to explore how health visitors work with families who are experiencing vulnerability conducive to risk of neglecting their children's needs and substantiated child neglect.

STUDY NUMBER	SOURCE	METHODOLOGY	SAMPLE	PURPOSE
1	APPLETON (1996)	INTERVIEW	HEALTH VISITORS (N12)	EXPLORE HEALTH VISITORS' ROLE IN IDENTIFYING AND WORKING WITH VULNERABILITY IN RELATION TO CHILD PROTECTION

2	CRISP & LISTER (2003)	QUALITATIVE DESIGN — INTERVIEW	HEALTH VISITORS (N36) AND A MIX OF PRIMARY CARE WORKERS (N36)	EXPLORE NURSES' UNDERSTANDING OF THEIR PROFESSIONAL RESPONSIBILITIES IN RELATION TO CHILD PROTECTION
3	EDWARDS, MATTHEWS, PILL & BLOOR (1989)	QUALITATIVE DESIGN — FOCUS GROUPS X 6	HEALTH VISITORS (N6) AND OTHER PRIMARY CARE WORKERS (N30)	IDENTIFY THE CURRENT PRACTICE OF COMMUNICATING RISK
4	GALLAGHER & JASPER 2003	QUALITATIVE DESIGN — HUSSERLIAN PHENOMENOLOGY	HEALTH VISITORS (N4)	EXPLORE HEALTH VISITORS EXPERIENCE OF FAMILY GROUP CONFERENCE
5	LUKER & LUNG (2000)	QUALITATIVE DESIGN - ETHNOGRAPHY	HEALTH VISITORS (N3)	EXPLORE THE MEANINGS HEALTH VISITORS ATTACH TO EVENTS CONCERNING THE IDENTIFICATION OF CHILDREN AT RISK OF CHILD ABUSE
6	TAYLOR & TILLEY 1989	INTERVIEW	HEALTH VISITOR (N7) AND SOCIAL WORKERS (N4)	ROUTINE RECOGNITION AND MANAGEMENT OF ACTUAL AND SUSPECTED CHILD ABUSE
7	TAYLOR & JAMES (1987)	INTERVIEW	HEALTH VISITORS (N19)	IDENTIFYING AND MANAGING CHILDREN AT RISK

Table 2.2: Health visitors' actions in relation to child maltreatment

CHAPTER THREE

RATIONALE FOR ADOPTING HABERMAS' CRITICAL THEORY
TO GUIDE THE STUDY

3.1 INTRODUCTION

There is a relatively extensive body of knowledge about child maltreatment and to a much lesser extent about child neglect. Empiricism (the application of positivism or the methods of natural science) has been the main nature of inquiry. In contrast, the body of knowledge relevant to health visiting is comparatively miniscule and has emerged mainly from narrative inquiry (sensitivities to the stories people tell about aspects of their lives). Combined knowledge of child maltreatment or child neglect and health visiting is, seemingly, in an embryonic stage and thereby a potentially fruitful line of enquiry from which to expand the current body of knowledge. This chapter sets out the undertaking of this research project by explaining the theoretical position of the researcher and the theoretical rationale for the study to the methodologies applied to exploring the social reality of health visiting. Social reality, in this context, is health visiting "predicated on a shared body of beliefs and perceptions through which 'reality' is defined" (Ferguson 2001: 243).

Early conceptualizing of the work in this thesis began with a proposal to the Welsh Office Research and Development (WORD) for a study that aimed to identify the needs of children for whom a concern is raised and to determine which of the needs could be addressed and by whom. The WORD grant awarding panel was of the opinion that the project was too ambitious and recommended a trial of the proposed assessment instrument. Acting in accordance with the recommendations and with the support of the North East Wales NHS Trust, Research and Development Committee (formally the Clwydian Community Care NHS) (Appendix 1) the first part of this three part project commenced.

The overriding principle in this research design, as in any research design, is its concern with turning research questions into projects (Robson 2000). In order to attempt to answer research questions the principal consideration is the selection of appropriate methodologies that have high compatibility between the essential components of the research project. They are:

- What the study is trying to achieve (Purpose)
- What theory will guide the study (Theory)
- What questions will achieve the purpose (Research questions)
- From whom will the data be collected (Sampling)
- What specific techniques will be used to collect, and analyse the data (Robson 2000).

Following the logical sequence of this list of components, the purpose of the study is to *determine the factors that predispose health visitors to act and how they act to prevent and protect children from neglect*. The remainder of this chapter offers the rationale for choosing to be guided by Habermas's critical theory. Research questions, sampling and methods are presented in chapter 4.

In order to offer a rationale for choosing critical theory for the theoretical position of this study, it is important to make sense of why the various theoretical foci of health visiting and safeguarding children are not considered suitable. Although, fundamentally, they all incorporate systems they are at a family trajectory level (Hall & Callery 2003) or they are a connection between systems theory and human sciences (Monsour 2002), few models exist. As the instructional guidance for safeguarding children recommends the application of an ecological approach to the assessment of children in need (DH 1999; NAfW 2000) the discussion begins with an exploration of the ecological model, in order to present a relationship between systems. This is followed by the commonalities and differences of the ecological perspective to health visiting models. Drawing upon the commonalities, in particular the concept of systems, the rationale for selection of Habermas's critical theory is presented.

3.2 ECOLOGICAL SYSTEMS MODEL

A pluralism of theories (biological, psychological and sociological) embraces systems (Bertalanffy 1975; Minuchin 1974; Bronfenbrenner 1979; Parsons 1971; Habermas 1984) and has been utilised to understand child neglect and abuse (Bronfenbrenner 1979; Belsky 1993; Garbarino 1991; Dubowitz 1999). A synergy of systems is achievable with ecology as a general theory that can be used to study a range of problems. The majority of these natural science approaches study small parts of a phenomenon that purport an understanding of living systems. However, in the opinion of Watson and Williams (2004) they cannot address an understanding of the whole; that is, a whole that is more than the sum of its parts which is the basic tenet of Bertalanffy's (1975) systems theory.

Hence, systems theory could be viewed as the integration of the micro-systems (individual and family) and the wider macro-systems (society and economics) as a whole. Although suggestive of an integration of systems as a holistic approach to linking levels of influence on behaviour, it has an inherent macro-micro dualism or a dichotomous analysis of society at different levels (Layden 1994). According to Layden, micro-analysis considers the social interactions of daily life at personal and family level. Macro-analysis focuses on a wider society that includes organisations, institutions and culture. In terms of child neglect and abuse, Calder (2003) and Dubowitz (1999) see this more as an empirical distinction and a theorising distinction that should go hand in hand to inform child care work. At the micro-level is the application of attachment theory (Howe 2003) that Bowlby (1988) suggested was necessary to prevent child neglect. At the macro-system level there are the economic and social conditions conducive to health that must be provided by the wider society to those in need, to enable then to function as society expects (Green et al 1996).

Layden (1994) agrees that these levels should be interwoven and argues that a presented dualism of the micro and macro-levels of analysis falsely separates the differing levels. Inherent in the dualism, as it applies to childcare practice (DH 2000), is the formulation of the notion of needs that are related to the social system. The need for housing, health care or social welfare may be interwoven in that an

appropriate social system exists to make corrections to these needs. What cannot be guaranteed, though, is that the needs of people, for example, requesting day care facilities, will necessarily be met by the services of these social systems (Tunstill & Statham 2000). Rather, a dehumanising of needy people can take place due to the lack of power that people perceive when faced with social structure (Kent et al 2000). Such symbolic interactionism, therefore, ought to be the interaction with things that have meaning, but the meanings of professionals and families, derived as they are from their many and varied social interactions, will undoubtedly differ.

Between the poles of the micro and macro-systems Bronfenbrenner (1979) described the meso-system and exo-system. The meso-system can have a direct impact on the child and family (e.g. play school) whereas the exo-system has indirect impact on the child (e.g. parent employment). Professionals may view these systems as interactive processes that are interwoven but for socially isolated families who cannot meet their children's needs (Coohey 1995) the same meanings may not apply, nor be modified. As a systems perspective acknowledges, any attempt to change and regain equilibrium within the family will likely be minimal for socially isolated families who have little or no interaction with extra-family processes.

In turn, health visitors' work will be determined by the extent of their interactions with different systems and the meanings attached to them in relation to the families they interact with. In essence, the health visitors' 'tool box' of available resources is dependent upon his or her contacts and his or her understanding of the different systems. Revising Bronfenbrenners' macro, exo, meso and macro-systems, described above, Dubowitz (1999) and Sidebotham (2001) introduced an ontological level at the micro-system level (the knowledge of meanings held by individuals). The acceptance of the notion of an ontological level can no longer only be the collective families' interaction with systems and the meanings held about the systems but the multiple interactions and multiple meanings of family members. These meanings are important because, it would seem, that families accept or reject social systems on the grounds of meanings elicited from their experience with the social welfare system, such as "friendly, interested, concerned and very keen to help in collaborative ways" or "uninterested, ineffective, unsupportive, unreliable and unavailable" (Dale 2003: 153).

At a professional level, McClure (2000) proposed an integrative ecology that purports to incorporate complex biological, psychological, sociological, developmental and supportive natures of individuals. He is supportive of the use of a variety of approaches from the multi-disciplinary aspect of safeguarding children services, whereas, Calder (2003: 29) is critical of the divergence of theories that professionals have "adhered rigidly to regardless of the circumstances of the case". Unlike McClure (2000), Calder would appear to consider divergence of theories to be blinkered thinking that has led to a failure to offer a holistic framework. Just as Sidebotham (2001) feared, some are unquestionably accepting of the ecological model but intent upon integrating their own practice theories to the ecological model. Calder (2003) recommends uniformity of analysis at different ecological levels, for example, psychopathology (the science of the nature, functions and phenomena of a sickly mind) at an ontological level. This match of psychoanalysis and psychopathology, according to Habermas (1998), is corrupt because the understanding does not illuminate people's meanings, which must precede a shared understanding.

These tendencies to concentrate on individual personality characteristics and abnormal characteristics, respectively, are interpreted by therapists according to the theoretical explanations held. Habermas, in common with others advocates a more interactive approach (Wilson & James 1995). Habermas's interactive approach goes beyond social relations and environmental settings to include distortion of communication. He sees some interactive perspectives as barrier to exploring individual lifeworlds. That is unless interactions reach an understanding as in a Heideggerian hermeneutic approach. Unfortunately, one view may not be truthful to another's view. In health visiting parents' views may not always be truthful in terms of children's state of health and development as many inquiries into the deaths of children from child abuse and neglect testify (Reder et al 1993). Interaction with parents may be essential but to rely solely on what parents offer might be considered foolhardy. Meanings and interpretations must also be subject to the more objective assessment of children's health and development. Once concerns are raised an interactive approach (to elicit the lifeworld) must be combined with a critical review of explanations and these balanced against what ought to happen.

Moreover, Habermas (1981/1987) argues that sociological perspectives look only at one of the three components of the lifeworld, the (1) institutional system may be looked at rather than all three components of the lifeworld. He suggests sociological theory may give less attention to (2) culture and (3) personal components of meanings. As if in recognition of the cultural lifeworld component, Calder (2003) recommends socio-interactional and socio-cultural models of interaction. Conversely, Dale (2004) found, it was the different styles of interaction that enabled or constrained cultural and personal meanings. Communication that focuses on the 'world view' or 'system' perspectives eclipses the personal lifeworld and it is this 'worldview' that Heidegger considers the 'truth' of language. That is the normative criterion that overrides the personal meanings of words used. Heidegger's lifeworld is natural attitudes of ordinary people (phenomenology) that contrasted with the objective, mathematical, and theoretical perspective or natural science or the system. In contrast, Habermas's lifeworld encapsulates the "informal and unmarketized domains of social life: family and household, culture, political life outside of organised parties, mass media, voluntary organisations and so on" (Finlayson 2005: 51) that is the horizon for cultural and group meanings and understanding. Furthermore, Habermas calls for personal components of meaning of the lifeworld to be valued and engaged with in communication that is persuasive in nature. Habermas (1981) was in favour of differentiating between the communication of the system (strategic action) and the personal meanings of the lifeworld (Mayhew 1997). In effect, rather than always unite systems there are, seemingly, times when an uncoupling of the system (economic and political) and the lifeworld is called for.

The sharing of different perspectives between different disciplines in a multidisciplinary setting could be interpreted as the opportunity to bring various systems together. McClure, for example, is tolerant of the theoretical considerations of other disciplines. In the same way, Belsky (1993) argues for the inclusion of several of the levels or systems in research but Sidebotham (2001) views the complexity of the model to be "too unwieldy". This view may be justified as reductionism, adopted by health promoters whose concern with the environment has narrowed the focus towards resources that facilitate or hinder health behaviour change such as smoking, reducing substance misuse, nutritional changes and road safety (lighting, signs, seatbelts, helmets and airbags) (Stokols 1992). As a result the

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theories people hold about their lives (their lifeworld) are not readily heard. Likewise, the extensive ecological research has utilised a combination of theories to bridge the different subsystem but not all have been tested at the same time. The tendency was to investigate the micro- and meso-systems, such as preschool activities in the home and children's competence in school (Tudge et al 2003), low-income and social competence (Fantuzza et al (1998) and unemployment as a predictive variable to child maltreatment (Krishnan & Morrison 1995). Research evidence that has effectively incorporated all systems to bridge the individual (lifeworld) or family levels though community services to the economic and political levels is missing.

3.3 THE LACK OF HEALTH VISITING THEORY

Just as multiple systems within an ecological framework would appear difficult to apply for research purposes health visiting does not have a practice framework sufficiently versatile to embrace individual, family, group and community health needs (UKCC 1992). In the nursing literature, systems theory has influenced the exploration of meanings, norms of family members, and their definitions of family health (Wright & Leahey 2000). Even without theoretical assumptions interrelated processes have been identified (Hall & Callery 2003). Using grounded theory, Hall and Callery explained how dual-earner couples with pre-school children managed work and family life. In other words when family members life trajectories are in balance the family functions better. When the trajectories are imbalanced there is likely to be family tension and an inability to provide for (or neglect) each others' needs. In Mansour's (2002: 6) view "some systemic structure has to be assumed" and a phenomenological model is most appropriate. Phenomenology is a consideration addressed in 3.5.

What health visiting models there are, likewise, hint at divergence of parts. An analysis of the divergence implies both an eclectic approach and a dichotomous approach. The eclectic approach is implied by the description of health visiting "moving between various models" (Elkan et al 2000: 1316) because "there will never be one all-encompassing model of health visiting, given the dichotomous practice" (Robotham & Sheldrake 2000: 2). The dichotomous nature is upheld by a

number of authors (Billingham 1991; Chalmers & Kristajanson 1989; Cowley 1995; Twinn 1993; Robinson 1982). Robinson's (1982) model, for example, is typical of a system divide between the individual and family oriented problem-oriented. It also divides a relationship-centred approach from public health, medical and social models.

Systems within health visiting models are more implicit than explicit. As the intermediary between individuals, families, groups and community resources and makers of policy health visitors interact with the range of ecological systems. Twinn's (1991) model embraces ecology with its advice giving and environmental control paradigms. Nevertheless, this dichotomy is enveloped in eclectic practice that helped families to identify needs and agree resource options or draw upon their own resources. The eclecticism spans advice or information resources to intensive family support. Yet, distinctions between the applied approaches lack tangibility. One reason for this is that health visiting was often perceived as 'chats' (Robinson 1982: 598). This potentially imprecise form of conversation has a serious purpose. Littlewoods (2000) claims the 'chats' are in reality negotiations of sensitivities both of health visitors and families. If so, the non-directive but collective paradigm identified by Twinn (1991, 1993) could well be 'emancipatory care' that takes into account community sensitivities and 'psychological development'. Unfortunately, in Twinn's model the meaning of emancipation care is to encourage individuals and families to network with community groups instead of engaging with individual meanings and values. The model is also unsuitable because it is based upon Beattie's public health focussed model that is determined by bureaucratic rules (Carnwell 2000). It does not equate with the Habermasian meaning of emancipation that "aims at liberating human beings from relations of force, unconscious constraints and dependence on hypostatized powers" (Dews 1999: 57).

A relationship interest is most prominent among health visiting frameworks from Robinson's relationship-centred approach to Chalmer's (1992) theory of giving and receiving and Cowley's (1995) Health as a Process model. Drawing upon Beattie's account of health are Chalmers and Kristajanson's public health model and Twinns' paradigms. Cowley's model is unique in identifying a mainly interactional experience. Her Health-as-Process model combines an educational concept, potential resources for health concept and a caring concept. Intrinsic to this process

is a therapeutic relationship where the health promoter creates an environment that is safe for family members to share their feelings and thoughts and is conducive to them examining their behaviour and the potential for change (Leddy 2003). This therapeutic relationship is also the opportunity for a mutual learning experience for both the health visitor/health promoter and lay people. This therapeutic interaction is consistent with components of Peplau's (1952) (Normandale 1995) and Neuman's (1982) models of nursing (Bennett 1998).

Peplau's interpersonal model concerns the nurse-client partnership towards problem-solving. Inherent in the model is the notion of empowerment and client taking responsibility for their own health. Its main weakness is the lack of allowance for environments outside the relationship. Neuman's system model is also based on the nurse-client relationship but, in contrast, is also accepting of internal and external environments and the impact these have on individuals and families (Berkey & Hanson 1991). The models offer structure for health care at either an individual level or systems level but both share a therapeutic approach to health promotion. That is, Peplau's model allows for expression of personal and social capacities towards achievement of health and Neuman's model the examination of environmental stressors in order to make adjustments for optimum levels of health. Both models provide direction for work that is preventative in nature and which can employ educational and therapeutic approaches. Elsewhere, I have supported such relationships and argued that some health visitors are providing therapy when using a hermeneutic phenomenological approach (Cody 1999).

Where necessary, health visiting interventions aim for change. Prochaska and DiClemente's (1983) trans-theoretical model (TTM) of change has been recommended for the implementation of the Framework for Assessment of Children in Need (Horwath & Morrison 2000) to differentiate the stages of engagement with change. Stages in the model are precontemplation (lack of awareness about health behaviour); contemplation or preparation phase (person thinking of change); action (an active attempt to change); and maintenance (maintaining the desired confidently) (Orbell & Sherran 1998). There has been uncritical acceptance of this model but some are beginning to question its validity. Etter (2005) criticises the concept of 'stages of change' for being too haphazard a mix of behaviour,

intentions, past experiences and duration of attempts to change. Povey and colleagues (1999) conceive of the timing between stages of the model as unrealistic (Sutton 2005) as it does not address raising consciousness, self-evaluation, self-liberation and establishing helping relationships that predetermine preparation for change (Leddy 2003). All too often professional concern focuses on the contemplational stage, assuming some awareness about how to change. Health visiting is unique in working at the precontemplation stage and beyond. Never the less, unlike many models that expect dramatic change, the transtheoretical model is more realistic by accepting that change can be punctuated by relapse and struggles (Kreuter & Lezin 2002) as a result of life experiences. Regrettably, as the only model of health promotion advocated for use in safeguarding children, it is of questionable reliability.

In relation to the assessment of children and families criticism of TTM is threefold. Firstly, the model is considered to be more atheoretical than trans-theoretical and has been adopted without rigorous evaluation of the theory (Roberts 2005). Secondly, the model has not been tested in respect of parental capacity (Corden & Somerton 2004). The suggestion that parental behaviour is influenced at a subconscious level (Corden & Somerton 2004) would make measurement difficult. As such Corden and Somerton question whether there is a need for precontemplation or a period of preparation. On the other hand, any attempt to improve the health, development and safety of children might necessitate making conscious parents' perceptions of children and parenting. No definitive answer is currently available, as a measure of precontemplation has not been tested. Thirdly, Corden and Somerton perceived the model to be inappropriate for parenting assessment due to the difficulties inherent in determining when a parent has progressed for precontemplation to the contemplation stage or other stages in the model, especially for patents with learning difficulties or mental illness. Whether all or part of the TTM is perceived useful or not, the notion of a precontemplation stage has value. By ascribing to the view of Reder & Duncan (2003) the value of the precontemplation stage is the need for consciousness-raising, and the information processing of communication and reflection to acquire meaning and understanding, not towards change alone but reflecting on peoples' power to act.

3.4 THE THEORETICAL POSITION OF THE STUDY

Rather than view the quantitative and qualitative approaches as opposing positions the combination, in this study, is as Carson and Fairburn (2002: 20) suggest "simply different ways of gathering data". Both are equally valued as methods that are appropriate but for different research questions. Reflexively, and probably primarily, it has to be acknowledged that the choice of research question and theory reflects the values of the researcher. In view of that, it is imperative that I state my position so the reader can judge the theoretical, methodological and interpretive relationship of this study.

The values underpinning the theoretical choice stems from life experiences, and in particular health visiting experiences, motherhood and scientific evidence that have contributed to how I view child neglect. Together they confirm that most parents demonstrate love, affection and respect towards their children. During health visiting experiences, admiration was felt for the minority of parents who demonstrated the same attributes and provided adequately for their children despite having few resources. As a mother I could not fail to understand the fiscal, time and energy costs incurred in being a parent. For an even smaller number of families frustration and a sense of helplessness was felt in response to parents who were passive, withdrawn, unable to respond appropriately to their children's cues for attention, basic provision needs and needs for stimulation (Carlson et al 1989; Crittenden 1985; Crittenden & Ashworth 1989) and who themselves exhibit 'helplessness' (Crittenden 1985). Arguably, a disproportionate amount of health visiting time was spent with families exhibiting 'helplessness'. The greatest sadness of this experience was entering an impasse with 'helpless' families' abdication of their parenting role that scientific evidence supports has an adverse effect on children's health.

For the latter families the process of parent and infant bonding to each other had gone sorrowfully wrong and had failed to provide a secure attachment base for their social and psychological health and development (Holmes 1996). Holmes suggests that once established, insecure attachments persist and with them a sense of uncertainty. In adulthood the felt security in their world of employment, housing, health and wealth will affect how they provide for their children. It would seem that

political interventions favour two competing paradigms. One is the authoritative parent, setting rules, guiding and correcting perceived risk. The second paradigm is the provision of services that tends to perpetuate dependency (Marris 1996). A third way is proposed by Marris (1996: 198) that builds upon the perceived value of collaboration to reduce uncertainty "because most of our uncertainties arise from the unpredictability of other people's behaviour". Philosophies of child health and welfare services, professional guidelines to safeguard children, professional language and new interventions such as Sure Start are attuned to this third way - Sure Start being the government funded multi-interventional programmes for disadvantaged families living in disadvantaged geographical locations.

Sure Start is the main 'early years' service that developed as a result of published evidence of service failures, such as Child Protection: Messages from Research (DH 1995) and the findings and recommendations of Report of the National Commission of Inquiry into the Prevention of Child Abuse (Mostyn 1997). The published research evidence presented a picture of child protection service that was preoccupied with investigating abuse, and to a much less extent neglect, and failing to prevent child abuse or providing adequate treatment for abused children. Not only did the National Commission Inquiry confirm "some uncomfortable truths about the treatment of children in the United Kingdom" (Mostyn 1997: 7) political and economic shortcomings are also evidenced. Some of "the main messages from the evidence were:

- A large number of expensive inquiries into child abuse over the past twenty years have produced recommendations that have not been properly implemented. Money is found for inquiry but not for the action required to deal with the problems revealed.

- Children are not helped by the fragmented and conflicting policies, values, objective and responsibilities at national and local levels. They suffer as a result of the lack of a powerful and co-ordinating government voice.

- There needs to be a fresh approach to the planning and funding of children's services. Costing must not be allowed to influence acceptance of a higher level of risk. Available resources for services affecting children can be used more effectively.

- Shifting the emphasis to a preventative approach to child abuse **must not leave vulnerable children at increased risk**" (The emphasis here follows that of the report.)

Having amassed the evidence available in the 1990s the government isolated poverty, social isolation and full-time work opportunities for women to be tackled (Civitas 2006). In terms of family support the purpose was to provide (1) children with the best possible start in life, (2) better support for parent, and (3) information for parents on the more general support available. Not only were these to be initiated throughout Sure Start but also the National Family and Parenting Institute, National Parenting helpline, and an enhanced role for health visitors (Home Office 2002) and other community services.

Collaboration between statutory and voluntary services will be essential to provide for all children and parents. The challenge of collaboration is to establish a mutually respectful society (Marris 1996) whereas the apprehension felt is less trusting that the ideal of a mutually respectful society is achievable. In the immediate future my apprehension is about how health visitors in particular, and others, will achieve a mutually respectful relationship with parents in a timescale that allows neglectful parents to accept their parental responsibilities, and takes place before impairment and harm to children is manifest. Consequently, my interests are in (1) the empirical knowledge of child neglect and which aspects health visitors act upon, (2) how health visitors act to remedy signs suggestive of child neglect, and (3) whether they act to lessen the helplessness of parents and emancipate parents from any perceived powerlessness in their lifeworld and in the social systems that they encounter.

3.5 FROM EPISTEMOLOGY TO COMBINED INTERESTS

No matter what the philosophical preference I may hold epistemology cannot be ignored. It is the basis of a major shift in the conceptualisation and delivery of health care (Loughlin 2000) that generates the 'evidence-base' for practice. However, while it is difficult to argue against the control of the quality of 'evidence' that the relatively new National Institute for Clinical Excellence (NICE)

aims to achieve the reliance upon empirical evidence, and in particular randomised controlled trials (RCT), the concept of 'evidence' ought to be challenged. Firstly, health visiting, as with nursing generally, has embraced other forms of experiential knowledge that provide the evidence of embodied existence (Benner & Wrubel 1989; Lawler 1991). For this type of evidence, that is so in tune with the interactive process of health visiting and individual needs can be discounted by others concentrating on whole community needs (Cowley 2002) Secondly, the application of empirical 'evidence' that is politically motivated to enable and control judgements and decision making cannot be ignored. Non-measurable expressions of evidence also need to be heard and given meaning. Habermas (1987) would go further to suggest this control of judgements and decision making be challenged by virtue of the people's meanings and understandings. Hence, application of a combination of philosophical thinking will be required to advance the knowledge base of health visiting.

Empirical evidence will provide the measurement exercises to estimate risk, incident rates, prevalence and causes of disease or impact of disease on a particular population (Rothman 2002). Hegel's critique of epistemology is the way it ensnares itself with the given, prior knowledge as objectivity. From such a standpoint, any measured reality prejudges the answers. Hegel also applied this same argument to phenomenology, which is viewed as reflection of self-knowledge, but as the self knowledge is already known it cannot be objective (Habermas 1968/1987). Knowledge is therefore the activity of knowing or the receptiveness of cognitive processes, in other words the instrument of prior knowing or the medium through which knowledge enters one's world. According to Habermas (1968/1987) the rigidity of empiricism to rules and the acceptance of methodologies are seen as losing sight of the possibility of experience.

Habermas prefers a hermeneutic style of phenomenology to understand experience rather than the description of an experience of a phenomena, or 'things' (Priest 2004: 4). In the application of the descriptive style of phenomenon the researcher listens and extrapolates the essential meanings of participants' lived-experience of the phenomenon under investigation (Kleiman 2004). Interpretive phenomenology or hermeneutics (the art of understanding) aims to reach an understanding of participants' unique meanings (Kleiman 2004).

Essential to understanding is language through which we experience the world (Byrne 2001) and it is the comparing of meanings that offers new insight. Of the three schools of hermeneutics described by Dowling (2004) only Habermas's critical paradigm is advancement of participants' knowledge rather than the researcher. Heidegger, Gadamer and Habermas all view hermeneutics as processes of understanding. However, the differences are more complex and confusing.

Where Heidegger's focus is on the notion of Being-in-the-world and being inseparable from that world, Gadamer has advanced Being-in-the-world with the concept of there not being a true interpretation of text because understanding must take into account different contexts and co-existing different interpretations (West 1996). Both Gadamer and Habermas are associated with critical hermeneutics but Gadamer from a philosophically, conservative tradition of prejudgement and Habermas from communicative rationality that connects "work and interaction on the one hand and distinct categories of knowledge and rationality on the other" (West 1996: 72). This West calls 'transcendental pragmatism' which provides a framework for natural science and hermeneutics (in Habermas's view - psychoanalysis). This framework is unique. Psychoanalysis in the Freudian sense is the therapeutic approach to identify the past and present unconscious connections through self-reflection and behaviour whereas a slightly different interpretation is offered by Habermas (Dews 1999). Such illumination of meanings is what Habermas calls Mundigkeit, which means maturity. According to Dews (1999) maturity in this context is autonomy and responsibility and the psychoanalysis approach is the model by which emancipatory interests (towards maturity – autonomy and responsibility) can be guided. By analysing the presuppositions and foundations of knowledge Habermas presents a three-fold classification of scientific inquiry that represents the interests and related scientific inquiry as:

1. Technical cognitive interest – natural science

2. Practical interest – hermeneutic-historical science

3. Emancipatory interest – critically-oriented science (Dews 1999).

3.6 HABERMAS'S CRITICAL THEORY

Habermas's theory of society is critical theory based on knowledge and human interests. It draws out the motivational implications for work and interaction. Often accredited to the 'Frankfurt School' of philosophers, Calhoun and Karaganis (2001) suggest that critical theory is "a more general project of reflection on the possibilities and realities of modernity (or modern society)". Habermas is refreshing in not perpetuating a dualism between natural and cultural sciences. His theories, therefore, offer this study, health visiting, and, I suggest, safeguarding children services, a better philosophical and scientific basis than current conceptual frameworks. They offer the opportunity to be creative in the use of quantitative (fixed) and qualitative (flexible) research methodologies for the purpose of engaging with different interests. His methodology offers a way of understanding the social situation and true interests of actors in the social structure. Such enlightenments could lead to new insights, attitudes and change in the knowledge and interests of health visiting, as well as the concepts that flow from the comprehensive literature review of previous chapters.

3.6.1 Knowledge and Interests

Knowledge and Interests (Habermas 1987) is a shift from an earlier reliance on historical influences to embrace epistemology. Habermas discusses how conceptual models of human knowledge are determined by cognitive 'interests' that are anchored in social existence (Dews 1999). Different interests may shape different ways of knowing but a universal knowledge or morality may be achievable by virtue of the above three irreducible 'interests'. The technical cognitive interest is related to work actions. For example, the social scientist may be interested only in control of observations, measurable scientific domains such as physics, chemistry and biology. Chapter one outlines just such empirical knowledge of child neglect, that is considered to be the way an individual, or organizations, control and manipulate their environments, which is sometimes called **'work knowledge'** (Habermas 1979). On the other hand, a health visitor might follow a research-evidenced guideline to assess for delayed or impaired child development against normative scales. This knowledge is an example of what Habermas calls

epistemological-analytical sciences that use hypothetical-deductive characteristics to develop knowledge.

Practice and emancipatory interests are related to **'practical knowledge'**, which includes (1) human social interaction or 'communicative action' and (2) emancipatory knowledge. This social knowledge is governed first by patterns of communication, which define reciprocal expectations about the behaviour between individuals and workers. Although related to empirical and analytical propositions, the validity of practice knowledge is usually grounded in a mutual understanding of the intentions of the behaviour. The means and conditions of the communication are used to determine appropriate action. Therefore, "Interactions are communicative when the participants coordinate their plans of action consensually, with the agreement reached at any point being evaluated in terms of the inter-subjective recognition of validity claims" (Habermas 1990: 58).

Habermas distinguishes between communicative (one seeks to motivate another within a bonding relationship) and strategic action (one seeks to influence the behaviour of another). The influences of strategic action may be by sanctions (such as compulsory interventions in family life; child protection register; legal constraint); with a corresponding sense of gratification at having influenced a desired outcome. Strategic action is uncritical. **Critical-oriented knowledge** is knowledge that identifies self-reflection and involves how life history "has expressed itself in the way one sees oneself, one's roles and social expectations." Insights gained through critical self-awareness are emancipatory in the sense that at least the individual can recognise the correct reasons for his or her problems (Habermas 1981). Knowledge is gained by self-emancipation through reflection to a transformed consciousness or *'perspective transformation'*.

As a grand theory of society Habermas integrates the system with the lifeworld. Both the system and lifeworld have a specific rationale, purpose and interactive styles. The system is objectively judged by theory and truth (instructional interest), whereas the lifeworld is subjective and communicative towards both a means to improving the presenting need or problem (practice interest) and to reciprocal understanding through reflection (practice-emancipatory). The relationship of the

system and lifeworld with instructional and practice interests are presented in Table 3.1

Knowledge	Empirical-analytic (Natural science)	Historical-hermeneutic (Interpretive)	Critically-oriented (Self-reflective)
Interests	Instructional Technical work	Practical (Interaction) Successful communication	Practical (Interaction) Reflection
Action	Purposive rational Prediction & control	Communication Reaching understanding	Communication Emancipation
Field of study	Things or events	Persons, communication and actions	Distortion of power, communication and action

Table 3.1: Habermas's related interests and scientific inquiry

3.6.2. Critical theory as research

To take one interest on its own would be an inadequate, one-sided interpretation of a phenomenon (Dews 1999). Dews (1999) rather sees Habermas's own application of critical social science as making distinctions between various perspectives, domains and purposes into unified theories and approaches to explain the micro- and macro-systems in order to criticise and change modern society. As a result it is a combination of the implementation of empirical evidence and effective communication enables individuals, families and social agents to reflect upon their meanings of the evidence and meanings of their lifeworlds. The result ought to be family members and workers who have an understanding of how specific aspects of work knowledge is applied and what actions are, mutually, perceived to be of benefit to the overall goals of "improv[ing] children's life chances, to change the odds in their favour" (Blair 2003: 1). Similarly, there should be an understanding of a fragmented picture, of presented falsehood, or a pattern of seeking help that Reder and Duncan (2003: 93) refer to as a "relationship to help".

Attempts at being critical unfortunately can be confused with criticism and a range of meanings, all of which implies negative evaluation. On the contrary, critical "is

making visible ideological mystification and methodological demystification" (Morrow & Brown 1994). Phillips (2000: 4) suggests that to be critical is to take nothing for granted, and that the art of criticism goes beyond mechanical means and towards a developed sensitivity to form decision. Further, Rasmussen (1996: 11) describes it as a 'tool of reason' that can transform the world and that critical theory can change society. Critique is both empirical knowledge and self-reflexivity.

Empirical knowledge may contribute to why workers interact with families but the action is not predetermined by this knowledge as this can only emerge from the actual discourse between workers and families (Johnson 1999). For Habermas (1973) the potential for self-reflexivity is built into the discourse providing it elicits the nature of the social situation and the true position and interests of the participants. Enlightenment is then gained from the discourse, leading to new insights and changed attitudes that with appropriate tactics and strategies can liberate from oppression. The emphasis on discourse, and thereby the practice knowledge gained through communication, is not to denigrate empirical, or work knowledge as each type of knowledge emphasises different aspects of knowledge (Burton & Kagan 1998). Rather, the meta-methodology of the Habermasian distinction allows for different decision rules (Hammersley 1995). The dominant focus of technical knowledge may be finding if the rationale for action is fact or ideology or reasoned argument through self-reflection to reach emancipation (Jimenez 1996).

Implementation of Habermas's theory has tended to use interviews alone and has shown a dominance of instrumental action over communicative action, for example, in midwifery practice (Hyde, Roche & Reid 2004) and medicine (Barry et al 2000). Hyde, Roche and Reid found communicative action severely limited by the protocols controlled by obstetricians. Hence, it is proposed that to understand the whole of everyday life experience of health visiting, multiple methodologies are essential to accessing both the system (technical science) and the lifeworld ("symbolic space [of health visitors] when engaged with the family context] where meaning, solidarity and personal identity are linguistically communicated") (Hyde & Roche-Reid 2004).

3.6.3 The Interest in Emancipation

Child neglect, as with other social problems of our day, is deeply rooted in the different levels of societal ecology, or systems. Workers who are in frequent contact with children and their families can only make a difference if they strategise together, share complementary aims and objective and work as partners with all stake holders. The principles of health visiting, as listed below, are essential components of corporate, early, child care provision.

- The search for health needs;
- The stimulation of an awareness of health needs;
- The influence on policies affecting healthy;
- The facilitation of health-enhancing activities. (CETHV 1977; Twinn & Cowley 1992).

Two of these principles require a more intimate level of communication with families. One is the search for health needs and the second is the stimulation of awareness of health needs (Cowley 1995). This communicative intimacy was observed by Cowley in health visitors' readiness to enquire about particularly stressful periods and their vigilance in picking up cues to peoples' wish to voice anxieties. In essence health visiting at certain levels of interaction resembles 'consciousness raising' or emancipatory education (Friere 1970; Mezirow 1981) that must stem from emancipatory interest (Habermas 1981).

Not only is empowerment and partnership an integral part of health visiting and safeguarding children services it is also implicit in health promotion (Leddy 2003). Conceptualised as the link between health and community participation (Robertson & Minkler 1994) empowerment is a positive and proactive approach to self-determination. How far the power can be shared in the relationship between health promoter and individual or group, will depend upon the degree of giving and taking of information, easier access to resources and a levelling of jargon type language (Labonte 1994). Without notable changes in these areas Labonte (1994) warns that people will continue to be the object of health promoters' action and thereby disempowered. Moving some way towards empowerment, the Child Health Promotion Programme (Hall & Elliman 2003) places less emphasis on surveillance and more on child health promotion even to the extent of perceiving a day when

screening could become obsolete. Sadly, although a self-empowerment model is mentioned and viewed as being "achieved by the development of assertiveness and self-esteem" the more general rhetoric of intervention is professional initiation.

Emancipatory interest is practice that aims to empower, make autonomous and encouraging the taking of responsibility that comes from discursive, reflective interaction (Blauh 1995), or what Habermas (1984) calls communicative action. Emancipation cannot be achieved by the strategic routes of childcare management services, traditional health education or emancipatory knowledge because of a perceived imbalance in the worker and family relationship (Boychuk, Duchscher 2000) that concentrate on control and compliance to others' construct of healthy lifestyles. This interest in strategy is of value in understanding health, child neglect and risk of impairment or significant harm, but emancipation is unlikely without some attempts to rebalance the one-sided causal understanding with subjective interpretations from family members, otherwise communication that is reciprocal, mutually respectful, and above all truthful will not be achieved (Summer 2001).

Sumner's (2001) representation of Habermas's (1995) Theory of Communicative Action sheds light on how interactions can be less authoritarian. Testing the contention that new nursing aspires to communicative action, by interviewing 18 hospital-based nurses, Sumner (2001) concludes that some patients have the knowledge and confidence to talk and take more control over their care. Although the framework for Sumner's study was Habermas, it is difficult to conceive of access to people's meanings of their world through interviews about nursing. None the less, a therapeutic encounter is implicit in mutual exploration of knowledge that contributes towards shared understandings. Consequently, Habermas's critical theory offers the combination of thinking and the combination of modes of relevant inquiries to encapsulate the accepted epistemological (evidence-based) knowledge, experiential knowledge and reflective knowledge that combine to critically review the application of 'interests' to the goals of emancipation (including maturity, autonomy and responsibility.

3.7 CHAPTER SUMMARY

The ecological model with its four (or five) systems, proposed to underpin the framework for assessment of children in need is too complex for research purposes unless, that is, that only one or two systems are being measured. Health visiting does not have a practice theory. To explore knowledge and practice the alternative was to turn to the natural sciences and hermeneutics. As most theories have a tendency to embrace one particular paradigm and Habermas critical theory is unique in providing a framework that is open to creativity and an acceptance of different paradigms Habermas's critical theory was chosen to frame this study. In particular, the acceptance of empirical science along with the more subjective hermeneutic and emancipatory sciences is a promising aspect from which to launch a multi-method approach.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 INTRODUCTION

This chapter continues with exploration of the five essential components of the research project (Robson 2000). The first and second components were addressed in chapter three but are, briefly, repeated here as way of a reminder and also so a comparison can be made between the purpose and theory and the three remaining components: research questions, sampling and methodology. The purpose of the study is to *determine the factors that predispose health visitors to act and how they act to prevent and protect children from neglect*. Habermas's Critical Theory guides the project. The chapter begins with an overview of the research design.

4.2 RESEARCH DESIGN

The research design is a multiple-method approach that includes both fixed and flexible methods (Robson 2000). That is, fixed as in quasi-experimental case control and non-experimental survey and flexible as in narratives. Using the terms fixed and flexible approaches rather than quantitative and qualitative serves two purposes. Firstly, it avoids the claim of 'methodolatry' (Chamberlain 2000: 164), that is, "the privileging of one methodology over another", and secondly it overcomes subjective-objective polarisation in preference for the forging of an understanding of the relationship between knowledge and practice (Morrow & Brown 1994) that is suited to identifying the potential for change.

Firstly, methodolatry exists and thrives among partisans of the quantitative research paradigm. In the words of Underwood (2000: 10) "Double blind randomised controlled trials (RCT) are the only research design that can eliminate the biases that affect any other form of research". Double blind RCT are a more rigorous clinical research design of RCT in which, not only are groups randomly allocated to

a group, neither the physician or staff nor the patients know which group is receiving treatment and which group is either receiving a placebo or treatment. Though the RCT is viewed as the 'gold standard' of research methodologies it does have a few dissenters (Johnson 1999; Oakley 2000; Pawson & Tilley 1997). Viewed as providing the best evidence for effectiveness (Cochrane Controlled Trials Register 1989-2003) for what form of care (or treatment) works, RCT also provide a strong political justification for the rationing of scarce resources (Oakley 2000). That is to suggest the relevant research questions are concerned with effectiveness, both beneficially and financially but some are sceptical (Schulz et al 1994; Oakley 1996).

Used to attributing effectiveness to a clinical treatment or intervention RCT can generate biased results if not properly randomised. Non-random manipulation of comparison groups was suspected by Schulz and colleagues (1994) after reviewing 206 publications reporting RCT. Scepticism was based on the findings of 32% not describing an adequate method of randomisation and 23% not describing the steps taken to conceal assignment of treatment. As well as the potential for generating inconsistent findings RCT do not provide any understanding of the phenomenon under investigation nor what influences people to engage with or reject the so called effective programmes (Pawson & Tilley 1997). Distinguishing between qualitative and quantitative methods is to "serve to conceal and confuse theoretical positions" (Morrow & Brown 1994). However, Habermas and Oakley both accept the equivocal nature of the difficulties but argue for the continued use of empirical methodologies, usually RCT strategies or similarly rigorous methodologies.

From engaging in health promotion and education research Oakley (2004) argues that it is often not the suitability of the methodology used to explore the research question that influences the carrying out of research but the differences between the agenda of policy makers and researchers. Similarities for both are the increasing acceptance of empirical knowledge to influence political actions. Resulting policies are then disseminated through professional guidelines that purported to be 'evidence–based' (DH 1999, NAfW 2000, DH 2004a). "Evidence based practice (EBP) that is an approach to health care wherein health professionals use the best evidence possible... [which] involves complex and conscientious decision making based not only on the available evidence but also on patient characteristics,

situations and preferences" (McKibbon 1998). However, the goals of research and consequent dissemination can be different for researchers and funding decision makers. Researchers' goal may be increasing the knowledge base and publication of findings whereas the decisions makers' need is to make positive changes to practices. Some practitioners have been reported to fear the concept of EBP being hijacked by policy makers as a cost-cutting exercise (Sackett et al 1996) and reduce practice only to those with adequate evidence. Such fears may also stem from the reluctance of some to change for there can be no doubt that in any attempt to keep abreast of evidence requires "you not only read the right papers at the right time [but] then to alter behaviour (and, what is often difficult, the behaviour of other people) in the light of what you have found" (Greenhalgh 1997).

Oakley (2004) would urge both researchers and policy makers to agree, early in the research process, the rigour of methodologies for the purpose intended. Otherwise, the analogy of "a drunk uses a lamp-post more for support than illumination" (RDSU 2006) may apply to the 'evidence'. Habermas concurs, when viewing a singularly empirical investigation to have limitations in relation to some research intentions. He considers the empirical investigation to lack rationality for peoples' interactions (and thereby their dissipate values and traditions) but he sees no alternative to including empirical (empirical-analytical) methodologies when exploring cognitive interests in relation to work knowledge (West 1996).

To digress, briefly, for the purpose of defining relevant terminology, epistemology is the branch of philosophy that addresses philosophical problems surrounding the "theory of knowledge" (Habermas 1987). Epistemology is the term used by Combe to describe the maturity of scientific knowledge based on observation to discover laws (West 1996). A critique from a critical theory perspective by Habermas of the theory of knowledge is that science no longer merges with philosophy but has become methodology "pursued with a scientific self-understanding of the sciences" (p4). In other words, there is a merge between methodology and science as in RCT as the science of effectiveness. With this certainty about knowledge came positivism. A positivist is someone who is accepting of (1) the empiricist account of natural science to be adequate (or knowledge as an *a posteriori* – knowledge achieved after experience) and (2) cognition that has the same structure as natural science (West 1996). In turn, Pierce understood natural science to be the logic of

procedure to obtain scientific theories (Habermas 1987). Habermas agrees with this description of scientific change but rejects its claim to universal validity. A pragmatic requirement for practical endeavours such as health visiting, and knowledge about communities is communicative action (or interaction), according to Habermas. Natural science cannot be universal without recourse to mutual understanding and reflection. Nevertheless, the knowledge derived from objective ways of knowing plays a part in building knowledge, in particular, to add strength to deciding treatment options that are advocated by the National Institute for Clinical Excellence (NICE) following systematic analysis of related research.

Secondly, inherent in empiricism (the doctrine that affirms that ideas and knowledge are *a posteriori* and denies they can be *a priori*) and more contemporary positivism is dogmatic reasoning that aims to manipulate and control our understanding of nature and man with mathematical procedures. Although Habermas (1987) agrees with the view that empiricism can provide objective and mathematical understanding, he sees no need to reject it outright in favour of subjective methodology, or visa versa. Rather, in the case of Habermas's critical theory there is no polarisation of the objective and subjective positions but a belief that the methodologies of science are multiple for multiple interests. This is a view that supports good research according to its appropriateness for a particular kind of investigation and for addressing particular kinds of theoretical and practical problems (Denscombe 2003). In terms of the critical theoretical position of this research project the appropriate research classification is within a sociological, qualitative research paradigm. The practical problem of child neglect has traditionally been investigated using empirical research. Habermas embraces both paradigms.

4. 2. 1. Trustworthiness of research

Whatever method is used there is an expectation that research will be critiqued by practicing professionals, and others, to whom the research has relevance (Morrow & Brown 1994). Trustworthiness is used here as an overarching concept for critiquing methodologies. Although commonly used to describe whether qualitative research has been conducted according to the general rules governing research practice, trustworthiness could be perceived to span all types of research. This premise is

based on the expectation that exposure to, and critique of, the written word will be judged. Derrida (1976) suggested philosophers felt there was something dangerous in writing. The dangerousness lay in the way writers expressed 'what they *say*' about their ideas. As critical social theorists claim that social inquiry ought to combine philosophy and social sciences (Seidman & Alexander 2001) then the trustworthiness (and dangerousness) for researchers is, similarly, in the writing of their thoughts and/or feelings and actions during the research process that are represented in their theses, as mine are in this thesis. Trustworthiness is necessary to retain trust in research (Whitbeck 1995). That is, that there is no fraud or negligence. Fraud relates to the researcher making false representation, being aware of the misrepresentation and having reckless disregard for the truth or there is a deliberate intent to deceive others. Negligence is departure from trustworthiness that may be honest mistakes that any conscientious researcher may make or, more seriously, reckless exaggeration of the strengths of the evidence or distortion of the evidence (Whitbeck 1995).

From a Habermasian perspective, trustworthiness relates to language, either spoken or written. Criteria for judging communicative action towards understanding and emancipation has four claims to trustworthiness. They are:

1. Language that is comprehensible to participants in terms of morality and rightness
2. External reality that is truthful
3. Internal reality of each participants' own feelings, and
4. Beliefs and intentions which also concern truthfulness and sincerity

In the words of Habermas (translated by McCarthy 1984) "The speaker has to select a *comprehensible* expression in order that the speaker and hearer can *understand one another*. That is, the speaker has to have the intention of communicating a *true* propositional content in order that the hearer can *share the knowledge* of the speaker, the speaker has to want to express his intentions *truthfully* in order that the hearer can *believe in* the speaker's utterance (can trust him): finally, the speaker has to select an utterance that is *right* in the light of existing norms and values in order that the hearer can accept the utterance, so that both speaker and hearer can *agree with one another* in the utterance concerning a recognised normative background"

This explanation of Habermas's four claims to trustworthiness of language compare favourably with his three validity claims of truth, rightness and truthfulness (Finlayson 2005). In the above quote the claim to truthfulness is the presupposition that what is spoken or written is both right and true. A validity claim to truth is based on the reasoning presented that leads the hearer or reader to be convinced by the reasoning. A valid claim to rightness has a moral content in that statements are based on justification. Hence, the language or text is comprehensibly understood in terms of truth and rightness. Consequently, trustworthiness of any research methodology is truthful representation of the research process, the truthful reasoning embodied in the communication, and justification for both the process and findings that uncovers a truth of the explored phenomenon.

The validity of trustworthiness of different methodologies is differently assessed. In fixed, empirical methodologies objectivity is the most important criteria which is judged by validity (the extent to which research instruments measure what it intends to measure) and reliability (the extend to which research instruments produce the same results if used more than once (Holloway & Wheeler 1996). In more flexible methodologies the criteria for trustworthiness includes credibility, dependability, confirmability and transferability (Guba & Lincoln 1994). Credibility is confirmed when the reader recognises the situation described as closely related to their own experiences. Dependability refers to the stability of the data over time and over conditions. Confirmability is the potential for congruence of the accuracy, relevance and meaning between participants. Transferability is the extent to which the findings can be transferred to other groups (Polit & Beck 2004).

Furthermore, more than one methodology is often essential "to put the researcher in a frame of mind to regard his or her material critically" (Williamson 2005: 10), and increase the validity, reliability and trustworthiness of the interpretation to emerge (Silverman 2000). A mixed method approach is considered essential in this case to answer the research question 'What factors predispose health visitors to act and how they act to prevent and protect children from neglect? For example, the empirical evidence can be viewed as the 'normative' knowledge that has become the agreed social reference for working with certain needs or conditions. This is the evidence-base of practice; the integration of clinical evidence and clinical guidelines into individual expertise (Appleton 2000). Of Habermas's three different approaches,

this normative knowledge is empirical-analytical science (positivism) used to direct working practices that may or may not conform to people's own knowing about childcare, parenting or child neglect for example. To compare such 'normative' knowledge with health visitors' attempts to engage with people's own knowing is to establish whether false understandings operate and if so offer the impetus for change (Bhasker 1986). The second approach of Habermas, hermeneutic-historical science, is engagement with people's own knowing. An analogy to explain hermeneutic-historical science is an autobiography that unfolds people's subjective (individual) meanings and values that are articulated to reach an understanding of the phenomenon under investigation. Through increased understanding from such communicative activities a critical science is employed to eliminate misunderstanding and distorted views in order to "free from unnecessary domination in all its forms" (West 1996).

In the final analysis the comprehensive communication described above attempts to criticise and compare the application of normative knowledge and subjective understandings of social realities in such as way as to shift *what is* to *what ought to be* in terms of freedom and emancipation (McCarthy 1978). This is the third approach Habermas describes as the critical-emancipatory science. This critical-emancipatory science is more concerned with what is concealed than what is revealed. Incongruence between critical approaches to identify *what ought to be* with freedom and emancipation is not lost on Guba and Lincoln (1994) who recognise the particular imbalance between relatively powerful researchers with powerless people. They and others (Mertens et al 1994) recommend overcoming this imbalance of power by analysing how and why resulting inequalities are reflected. Inequalities can be in the form of cultural expectations where a health visitor who suspects domestic abuse might expect the mother to act to put a stop to it. On the other hand, the mother wanting the abuse to stop does not want to lose the family home. Truthfulness between the health visitor and mother can offer opportunities for the mother to plan her future without the domestic abuse when she feels sufficiently empowered to do so.

Being prepared for identifying the potential for change in power relationships recognises that the historical construction of health visiting is established from some fundamental principles and not completely arbitrary (CCETHV 1977). Behind

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the practice of health visiting is operating a basic structure that influences health visitors' construct of health visiting. From a critical theory perspective that basic structure is shaped by a dominant political and social interest that in turn influences autonomy to practice within the given epistemological evidence and related guidelines. It also claims that the interest cannot be neutral of human values (Morrow & Brown 1994). Critique, therefore, analyses the inequalities perceived in political, social and human value interests between research evidence and the reality of family life. The combination of recorded evidence and narrative ought to identify whether social problems and/or real family meanings are of interest to health visitors. The inequalities of communicative expectations between health visitors and parent is tantamount to power inequality with health visitors perceived as authoritative figures, who hold more knowledge than parents. Inequality is an integral part of the critical theory research process (Harvey 1990). Together Habermas's three different approaches, that combine fixed and flexible methods embraces the dualism of subjectivism and objectivism (Gibbens 1984) as a trinity.

Further critical appraisal is added to the research process by using a multi-method approach to gain 'added value' (Green & Thorogood 2004: 205) to both broadening understanding and strengthening the trustworthiness of the analysis. Documentation is weak in terms of demonstrating a duty of care and as such understanding from health visitors is essential to answer the questions related to health visiting practice. Likewise the legitimacy of health visiting for childcare and parenting needs or risk to children's health and development is approached from both a health visiting and lay perspective. Combining documentation and narratives sources and narrative and survey permit triangulation, the "getting a fix on [something] from two or more places" (Robson 2002: 371). The 'fix' on noteworthy factors and on the legitimacy of health visiting will help to avoid inappropriate certainty from one source. In this study, trustworthiness begins with the questions posed (Carpenter 1995) the validity and reliability of assessment instruments, the reasoning and justification of health visitors' narratives to the themes constructed and the degree to which the study conform to critical theory

As there are three discrete studies that constitute to the whole project the research questions, methods and sampling strategies of each will be presented separately.

4.3 CASE CONTROL STUDY: STUDY 1

The 'fix' for this study is on health visitors' work and practice knowledge. Habermas, views human knowledge as different ways of knowing that is shaped by three interests, as already mentioned in 3.6.1. In nursing, the fundamental patterns of knowing are described as aesthetics, personal knowledge, ethics and empirics (Carper 1978, 1992). Aesthetics is similar to intuitive expertise (Benner 1984) that "accounts for the variables that cannot be systematically related or quantitatively formulated" (Carper 1992: 77). Personal knowledge is self-knowledge gained from reflecting on experience of engaging rather than detachment (Carper 1992). Ethics is concerned with choosing, justifying and judging action as most appropriate for each engagement (Carper 1992). These three ways of knowing are similar to Habermas's 'practical knowledge that incorporates experiential personal and critical knowledge.

The fix or interest of empirics (Carpers' fourth pattern of knowing), is "concerned with matters of fact that are expressed in description or the statements of relationships between phenomenon that are asserted to be true or probable" (Carper 1992: 76). As this knowledge provides technical control that is guided by the EBP of mainly natural science inquiry (Habermas 1968/87) and is often implemented as policies and procedures an element of control can be placed on practice (Craib 1992). The notion of control, excludes the contribution made by practice knowledge and is not perceived as an altogether negative concept. It can also be viewed as "a necessary component of good practice" in relation to child neglect (Tanner & Turney 2003). It seems appropriate, therefore, to include a natural science method in this multi-method study in order to elicit a more objective means of health visitors' knowledge of child neglect to compare with their subjective understandings.

Study one, is a retrospective, case-control study that is used to compare the life experiences from birth of children classified as 'neglected' and a control sample. The rationale for the choice of case control studies was the potential for estimating the association of related variables and the odds ratio of the variables to neglect occurring. According to the grading of research methods from 1++ (high quality) to 4 (expert opinion) the case control study is graded 2- to 2+ (Habour & Miller 2001:

327) and, as such, the findings should offer a high degree of quality to inform practice. Although the case control samples were not randomly determined they were matched according to age (date of birth were possible or nearest date), sex and locality of residency. Hence the case control studies may not be as reliable as the RCT but it still offers moderate probability that relationships found may be causal.

The research questions for the case control study are:

- What factors do health visitors identify as a cause of concern in relation to children's health and development?
- How valid and reliable is the assessment instrument for assessing risk of child neglect?
- Which factors are predictive of child neglect?
- Which factors are identified sufficiently early (pre-school) to facilitate preventative actions?

4.3.1 Method

In choosing the case-control method to attempt to answer the above research questions it was anticipated that the study would identify family characteristics, events or experiences that differentiate those children who experiencing child neglect from those not neglected. It was anticipated that needs or risk among the 'neglect' sample would differ significantly from the control sample. This retrospective approach, sometimes referred to as 'ex post facto', provided a way of examining what went alongside or before (Cormack 2000) the child neglect. To aid the collection of this information a list of indicators of child neglect was compiled from the literature and established risk assessment instruments (Appendix 2). Indicators were then agreed as relevant for the study by the researcher and community paediatricians as they closely represented their experiences of neglect. Neglect was the dependent variable with 32 independent variables (Appendix 3). A protocol was also agreed to ensure all researchers understood how to apply the assessment instrument (Appendix 4). Although I completed almost all of the 166 case assessments, my supervisor completed a small number and six community medical officers completed one each.

Though not intended as a measure of child neglect but a means of identifying factors noteworthy enough for recording in child health records it is conceivable that some might interpret the research instrument as a risk assessment. The reservation with using a 'risk' assessment approach is the contemporary shift in emphasis from risk to need (Calder & Hackett 2003; Cooper 2003; Dalgleish 2003). Such reservations are more politically constructed than socially constructed as the language of professional guidelines has changed without equal acknowledgement that where there is a risk there is also a need (Calder 2003; Cooper 2003). Drawing upon the empirical evidence of child neglect and abuse, need is likely to be the opposite of risk. For example, where domestic violence or drug misuse is a risk the need is no violence or a controlling of violence and drug use. Alternatively, the need may be for the building of protective factors to lessen the impact of any adversity experienced as a result of such behaviour, as summarised in Chapter 1.

4. 3. 2 Sampling

Documentation used for the case control study was child health records, special needs files (kept on children with learning difficulties, children 'in care' and children abused and neglected), and files kept by specialist nurses for child protection. The documentation was of two groups of children, 83 neglected and 83 not-neglected children. The samples were matched as already mentioned above, by date of birth, sex and locality in an attempt to reduce variability between the groups (Lang & Secic 1997). For the purpose of collecting and returning child health records to relevant practitioners the Research into Neglect was labelled an audit of neglect'. Colour coding was used to distinguish 'neglect' and 'control' cases (Appendix 5).

As the sample is obtained in order to derive a statistic from the sample that estimates a corresponding parameter to the population, too small a sample might not detect a significant effect and too large a sample may be too expensive or a waste of resources by collecting more data than is necessary (Lang & Secic 1997). Ideally, sample size is calculated prior to the commencement of the study with the aid of statistical power calculations that include the potential effect size, the desired power and the alpha level. Effect size is the smallest meaningful difference squared (e.g. a difference of 0.5 squared = 2.5 effect size). Reported effect sizes for risks to child

neglect ranged from 0.3 to 0.6. (Schumacker et al 2000). Power equals 1 - beta where beta is the probability between 0 and 1 of committing a Type II error (wrongly concluding there is no difference when there is). Beta is usually 0.1 (for 90% power) or 0.2 (for 80%). The power of 80% is chosen for this study. The alpha-level is the threshold of statistical significance chosen by the researcher. It is an arbitrary value usually set at 0.05 or less of committing a Type I error (wrongly concluding a difference exists when there is none).

As in any research project, justification of the sample size is important to determine if the study design – case control study, with the total sample size of 166, was adequate to address the research questions sufficiently to detect a higher than moderate effect size (0.5) as statistically significant (Cohen 1988). Clark-Carter & Marks (2004) calculate 64 people will be the required sample size for a study with a non-directional research hypothesis (to predict a difference rather than a specific change) if intended to detect an effect size of 0.8. Another recommendation for determining the sample size for multiple regression analysis is a minimum of five times the number of variables (Tabachnick & Fidell 1989; Demaris 1992). An assumption of 32 variables would require a sample size of 160 but as only six variables were found to strongly correlate with the independent variable (carestatus) only six were entered into the logistic regression test. Hence, according to this rule of thumb, a sample size of 30 might have sufficed. Another rule of thumb is to calculate sample size for multiple regression by using the formula $N \leq 50+8K$ (K is the number of independent variables) (Newton & Rusestam 1999: 251; Field 2005: 173). This formula assumes an alpha of 0.05, a power of .8 and a medium effect size (0.03). Application of the formula concludes N = 50 + 8(6) or N = 50 + 48 = 98.

The sample size appeared to be adequate for correlation and multiple regress tests. The difference between multiple regression and logistic regression is that in a multiple regression each predictor has its own coefficient with Y predicted from a combination of variables. In logistic regression instead of predicting the value of Y from the predicting variables (Xs) the value of Y occurring is given according to the value of the predictor variables (Xs). As the study also wanted to test the value of individual predictors a different formula is recommended (Field 2005) that includes a minimum sample size of 104 + k or 104 + 6 = 110. These recommendations are,

of course, oversimplifications and do not give the statistical power of the test for the effect size found. For this purpose Field recommends computer aided programmes.

Following this recommendations a further calculation was undertaken using one of the many computer aided programmes now available, G*Power. A post hoc application of the F-Test for Multiple Correlation and Regression (MCR) for a single set of predictors of a dependent variable concluded:

Input:	Alpha:	.05
	Effect size "f2"	.3
	Total sample size	160
	Predictors	6
Result:	Power (1-beta)	0.9999

This G*Power result reinforces the data to be sufficient to satisfy the relatively simpler correlation tests and for multiple regression to the power of 0.9; or a 10% chance that of missing a conclusion that a change has occurred when it had not.

Neglect cases were identified as substantiated cases and the children's names recorded on the Child Protection Register. Substantiation in no way refers to some pure form of neglect but a multi-agency consensus of child neglect. For example, it is easy to see how professionals can formulate an informal diagnosis of child neglect before attending a group meeting where the diagnosis may be reaffirmed by others (Munro 1998) leading to 'proof' of neglect. Nevertheless, there is some evidence to support a moderate correlation between child protection services substantiation of child neglect and more formal measurements (Black et al 2005).

4.3.3 Data collection (e.g. instrumentation)

A valid and reliably tested neglect instrument was not used as one did not exist at the time data was collected in 1998. Nor has one developed in the meantime, other than the measure of neglect after the event; the graded care profile (Srivastava &

Polnay 1997). This new instrument was not considered appropriate for two reasons. Firstly, it measures neglect when already identified and in collaboration with parents. It serves to provide a clearer understanding of specific childcare provision both before and after intervention Child health records reported concerns, mainly of health visitors, at different periods in childhood that were not necessarily related to child neglect. Secondly, the foci of concerns differ. Factors, such as domestic abuse or substance misuse might not surface from an assessment using the graded care profile that measures (1) physical care, (2) safety, (3) love, and (4) esteem. These areas are further divided into sub-areas graded from 1 to 5; one the best outcome and 5 the worst outcome. Many sub-areas were not reported on child health records, to take just one example, nutrition is a sub-area of physical care that requires a judgement about quality, quantity, preparation and organisation of food. Information recorded in child health records was not as detailed as the graded care profile requires.

Instruments specifically for child neglect such as the Childhood Level of Living (Polansky et al (1972) the Child Well-Being Scale (Magura & Moses 1986), the Nine Item Checklist for neglect (Muir et al 1989), Scale for Assessing Neglecting Parenting (Munty & Pattinson 1994) and the Child Neglect Index (Trocme 1996) fundamentally assess parenting, or rather a mother's ability to meet a child's needs, and the child and mother relationship. Mothers' history of violence and financial status feature in Muir et al's Nine Item Checklist.

Of these instruments it would seem that the Child Well-Being Scale is the preferred choice (Gaudin et al 1992) despite claims of validity and reliability for the Childhood Level of Living Scale. The reason put forward by Trocme (1996) is that both these scales have vague conceptualisations of neglect, such as a 'lack of draught insulation' and 'well-being'. A perceived disadvantage of using these international or national instruments, with questionable validity and reliability was the potential for them not to identify relatively new social problems such as substance misuse.

Length of the neglect instruments may have been a deterrent to their use, ranging from 43 to 99 items (even in abridged versions). In contrast Trocme's Child Neglect Index is short but like the Grades Care Profile its purpose is to substantiate neglect

and specify the types of neglect after occurrence. Some generic risk assessment instruments such as the Child Abuse Potential and Parenting Stress Index (Holden, Willis & Foltz 1989); Maternal Characteristic Scale (Polansky et al 1992); Scale for Assessing Neglecting Parenting (Munty & Pattinson 1994) intended to identify early need and risk, but tend in reality to also have been a substantiated effort of confirm neglect usually among already known vulnerable groups. The only brief instrument closest to the prevention of neglect, in that needs are identified early, was the New Zealand, Nine-Item Checklist by Muir et al (1989). Unfortunately, this instrument was not suitable as it was intended for use during pregnancy to identify potentially neglectful mothers. It would not have been broad enough, therefore, to incorporate the number of factors that health visitors might assess, such as parental skills and children's health and development.

By devising a separate instrument from contemporary evidence and practical experiences the current social problems associated with child neglect can be revised. However, it must be borne in mind that the documented evidence is mainly health visiting and a reasonable representation of their knowledge of factors associated with potential or actual neglect. Drawing on the strengths of the various instruments the 32 variables selected as part of the assessment instrument closely conformed to the three domains of the Assessment Framework for Children in Need (DOH 1999; NAFW 2000), that is child wellbeing (Child Health and Development), parenting skills (Parenting Capacity) and social and environmental factors. The only deviation was family history, which, in hindsight, could just as easily have been incorporated into either parenting skills or social and environmental factors.

The format of the assessment instrument used in the study was enlarged sufficiently for researchers to record relevant information and the date the information was recorded. A comparison of factors for each year was originally considered but as only the date was recorded and not the child's age this form of comparison was abandoned. To do otherwise would have required all dates (which accounted for many in each assessment) to be converted to ages and that would have been too time-consuming. Instead a comparison was made of pre-school and school age children. This is equally suitable as documentation related to the pre-school years is predominantly completed by health visitors.

Documents were coded 'N' for neglect and 'C' for control and numbered 1 to 83. Matched pairs of documents were tied together and data collected from pairs but on separate sheets. The documents were requested, stored and returned from a central point, child health administration. Data collection was undertaken in an allocated room in the administration building so that the documents never left the building.

From the four criteria for assessing the quality of documentation as data of evidence (Bryman 2004) the advantages of using child health documentation are the authenticity and representativeness whereas the disadvantages were credibility and meaning of the content. In terms of authenticity the evidence that the documentation provided was genuine and unquestionable the origin of the signatories on the date recorded. Recordings were also representative of the type of evidence expected in child health records, that is, the health and developmental status according to children's chronological age. Two excellent examples of quality documentation were care planning that made explicit the needs and difficulties for which children and their parents required support and an extensive summary of events tabulated according to date of the event, description of the actual event, concerns and response of significant persons and clearly stated outcomes.

On the other hand, credibility of the evidence was likely to be distorted due, in part, to the scant reporting of difficulties, and the possibility of error in the interpretation of observations and interpretation of events categorised as neglectful. Recordings often lacked information and interpretation and thereby the meanings were unclear and lacked comprehensiveness. One example was visits to a family's home which resulted in failure to gain access and recorded as "no access". There was no indication as to whether the visits were planned or opportunistic. Thus it was impossible to interpret the "no access" as an avoidance of contact (from a planned visit) or an unfortunate, opportunistic visit undertaken when the family were not expecting the health visitor to call.

4. 3. 4. Analysis

The data generated for Study One was analysed using the computer statistical package Statistical Package for the Social Sciences (SPSS) for Windows (9.0). In the first, descriptive analysis of the sample (Appendix 6) and the frequency of

documented factors were identified to answer (1) what factors health visitors identify as a cause of concern in relation to children's health and development? (Research question one). Alpha correlation coefficient was used to test the reliability of the instrument before following with correlations tests, using chi-square, to determine the strength of relationships between the dependent variable (neglect) and the independent variables. The coefficient of the instrument as a whole and separately the subsets of the instrument were tested.

Where strength of correlation was found the predictability of the variables was determined by logistic regression. Logistic regression was used as the dependent variable and independent variables are categorical (Tabacknick & Fidell 1996). This produced a model of predictability of child neglect (from the whole data) and a model of predictability for early interventions (pre-school data).

4. 3. 5 Trustworthiness of data

Often referred to as validity and reliability in fixed methodologies, trustworthiness is the truth or accuracy of the research process (Cormack 2000). Utilising Habermas's critical theory the difficulties health visitors recorded are perceived as actions that are primarily coordinated through language. The language or speech that is used is believed to be a commitment based on good reasoning. These commitments have a moral status or what Habermas calls 'validity claims' (Finlayson 2005: 26). The rightness and truthfulness of validity claims are explained at 4.2 (page 90). However, the traditional interpretations of validity are also taken into account. In relation to external validity, the findings are capable of being generalised beyond the sample for the notion of factors related to child neglect but the sample size is too small for a strong effect size. Internal validity, especially content validity of measuring the neglectful circumstances under investigation is as accurate as the reality of practice providing all concerns are recorded. The documented evidence in child health records are a relatively trustworthy indicator of health visitors' knowledge of child neglect because the factors are recorded by them, more often than not before a child neglect 'diagnosis' has been made.

Along with content validity, it is traditional to consider criterion and construct validity (Neale & Liebert 1986). Criterion validity, the relationship between instrument scores and the occurrence of neglect, of this study is impossible to measure as no valid and reliable instrument was used to compare the study instrument with. In fixed or quantitative research terms this will be considered a weakness but as Edwards (1994) concludes many instruments, particularly predictive instruments, have been found to be inaccurate. As the study was not to predict child neglect but health visitors' knowledge of factors related to child neglect and from that knowledge to determine if a predictive model is possible, the instrument is more explorative than predictive and as such criterion validity is less an issue. However, the various constructs of child health and development, parental capacity and social and environmental factors enable a range of valid constructs of theoretical considerations to enmesh (genetic, psychological, sociological, attachment and ecological). Statistical success may be viewed as the primary scientific goal of case control studies but in theoretical terms there must be acceptance that interactions of these explanations and belief systems play a part in our "realistic account of causation" (Sayer 1992: 131).

4.4 HEALTH VISITOR'S NARRATIVES OF WORKING WITH NEGLECT: STUDY 2

The main objective of the narrative study was to elicit an understanding of contemporary health visiting practice in relation to child neglect. Relevant literature in chapter 2 demonstrates a coupling of preventative and reactive practice with a systematic approach or process to health (Appleton 1996; Cowley & Billings 1999). Whether their work identified a similar process and whether the goals of practice can uphold specific interests in health promotion, health protection and emancipation are central concepts in the formulation of the research questions. The research questions for the narrative study were:

- *What factors do health visitors identify among families with a child who is categorised as neglected?*
- *What actions are taken in response to the identified needs or risks?*

- *What interests or inequalities, if any, are reflected in their work with families (e.g. health promotion, health protection, emancipation, other?*
- *Why might these inequalities exist?*

4. 4. 1 Method

Conforming to Habermas's support of hermeneutics to understand practice and self reflection, various flexible methods were discounted in preference of narrative discourse. Questionnaires were considered too heavily structured to elicit subjective meaning and social reality. Previous experience of work load analysis of health visiting influenced the rejection of observational methods because a public view was found easier to interpret than a private view. Both Cornwell (1984) studying health beliefs and West (1990) studying families with a disabled child experienced this same phenomenon. Structured interviews and survey were rejected on the grounds that they can be "socially and linguistically awkward" (Stone & Campbell 1984). One alternative was informal interview but because of the potential for interviewees to feel led into providing a 'right' answer or interviewer asking the wrong question about the experience (Porter 2000) this, too, was rejected.

Narrative differs from traditional ethnographic approaches in that ethnography is concerned with events (Riessman 1993) and not the story about the events. Narrative can be elicited as the 'lived experiences' of a phenomenon using a phenomenological method. Husserlian, descriptive phenomenology reveals conscious experiences, without reflection, to discover meanings of essential concepts relevant to the phenomenon under investigation (Kleiman 2004). Hermeneutic phenomenology or interpretive phenomenology aims to uncover hidden meanings. The main difference between these two types of phenomenology is said to be the use of bracketing (Ray 1994). Bracketing is the suspension of the researcher's presuppositions and is recommended by Husserl but not recommended by Heidegger (Dowling 2004). The argument against bracketing is that people, as Beings (present in the world), cannot easily, if at all, suspend their presuppositions. If exploring health visitors' experiences to elicit their meanings or interpretations either phenomenological method might have been chosen. It could even be argued that interpretive phenomenology was in fact appropriate as the narratives as text was interpreted. The difference was that the overall purpose was not only experiences but the experiences in relation to the 'interests' of health visitors as they

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related to child neglect. Consequently, the focus of interpretations of the narratives was, to some extent, preordained by the critical theory framework in relation to communication and emancipation and not the phenomenon of child neglect, specifically.

The perceived strength of the narrative method, where people tell their story in relation to a phenomenon, is that the social world can only be understood from the stories of those involved in order to illuminate their meanings and motives for their actions (Morrow & Brown 1984; Porter 2000; Ricouur 1981). Narrative when written provided a way of accessing this same data uncontaminated by the researcher but ripe for interpretation. Once the narrative becomes text it is the object of analysis and has the potential for reaching an understanding through the enclosed meanings and motives (Porter 2000). In this study narrative involves health visitors writing a story and places an emphasis on practice as it "is more respectful of nursing [and health visiting] practice". Carson & Fairbairn (2002: 17) go on to state "since it does not seek to impose a pre-existing methodological framework upon it".

In support of the use of a pre-existing methodological framework for a narrative study I would argue, first, that the narrative is the object of the inquiry (Morrow & Brown 1994). The narrative can be analysed from various foci and, in reality, is likely driven by the researchers' personal interests when a pre-existing preference (or personal conceptual framework) is taken. Secondly, it is the 'fit' of the use of narrative for the research purpose that is most important. McLoad and Balamoutsou (2000) are of the opinion that researchers may need to create their own methods for narrative analysis. Alternatively, if there is in existence a framework that offers an appropriate means of analysing narrative then it would be futile to create new methods without first testing those that do exist.

The narratives are significant stories because the language used creates the reality of the health visitors' experience. According to Goncalves (1995) people make sense of their lives by telling stories that are organised around key experiences. Embodied within the stories are the events, situations and persons significant to the person's real world (Denzin & Lincoln 1994), as well as the excuses, myths and reasons for 'doing and not doing' (Bruner 1992). Telling stories allows us to construct, reconstruct and deconstruct the realities of our lives and by doing so to illuminate

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who and what we are. Used in psychotherapy narrative provides the opportunity to bridge the gap between a person's knowledge of the world and more scientific knowledge (McLeod 1997). This gap that McLeod refers to is the interrelated practice and work knowledge described by Habermas. The stories when analysed will tell some shared beliefs and values but they also carry an understanding about the meaning of their lives as health visitors that are unique to each person.

Once recorded the narratives become open and uncoerced text that can be read by others and which, with repeated readings, is ripe for interpretation. Text in this context is discourse fixed by writing (Riceour 1981). Riceour, in developing a theory of language, postulates that writing takes the place of speech and that every sentence refers to something that would otherwise have been the spoken discourse. Furthermore, Hoyt (1994) draws a distinction between the interpretation given by the teller of the story and that of the reader. The reader, even if an experienced health visitor may not have experienced the same events in the same way and may need to look beyond the event to encompass the context in which the event or plot took place. There is also the potential for a more profound, unconscious meaning of health visiting which can be evoked through frequent reading and rereading, focusing on the contextual nature of interactions (Taylor 1995). The twofold purpose of analysis is the researcher's interpretation of the text and the narrators' interpretation of themselves within the context. The role of narrative in nursing research is in its infancy (Frid et al 2000) but the potential for casting new light on experiences is well established (Freud 1905 [1956], Riceuor 1981, White & Epston 1990). In preparation for this narrative study a trial narrative project was conducted. The trial narrative study investigated the nature of nursing (Cody & Squire 1998) and was found to be an effective method for illuminating an interpretation of nursing as caring through communication and rapport.

4. 4. 2 Sampling

The intended sample for this study was a purposive sample of 24 health visitors, four from each of the six unitary authorities in North Wales. The health visitors were to be selected because they were known to have worked with one family with a child categorised as 'neglected' or where there was a serious concern. The involvement with the family was to have been after 1996. This timescale allowed

for anticipated change in practice as a consequence of the call for a refocus to prevention (DOH 1995) and the implementation of the Children Act (1989) and in particular the category of 'children in need' (Children Act 1989: s 47). Unfortunately, only seven narratives were received. From discussing the study with specialist nurses it seems that they and the health visitors invited to participate in the study would have preferred to be interviewed rather than write a narrative. Admittedly, an interview approach could have been adopted but the temptation to influence the narrative, verbally or non-verbally, was felt to be too great to risk losing sight of each participant as a unique person with unique interests or motives despite working to the same professional instructions.

4. 4. 3 Data collection

Approval was sought from the Directors of Nursing from the three local NHS Trusts (Appendix 7). With approval granted, health visitors were invited to complete narratives by their respective senior nurse for child protection. Senior nurses for child protection hold a supervisory and advisory role in cases of children in need and child protection and are therefore suitably placed to know of all current cases and the health visitors attached to the cases. Categorised as 'neglected' means the child's name is recorded on the Child Protection Register or where there are serious concerns about the child's health and development due to the neglect of their needs sufficient to warrant the sending of a 'report of concern' to significant child protection personnel. A letter requesting support from the senior nurse for child protection support (Appendix 8), a letter of invitation to health visitors (Appendix 9), instructions for the narrative (Appendix 10) and a stamped addressed envelope were supplied to the senior nurses for child protection. A lack of response initiated a further letter to specialist nurses requesting their support (Appendix 11). The narratives were returned directly to the researcher in the stamped addressed envelope provided. Neither the selection of health visitors, nor those who refused to participate nor the 'neglect cases' chosen was known to the researcher. However, health visitors could wave their right to anonymity in order to receive feedback should they wish to do so but in all correspondence and publication all narrators were given a code and names were changed.

4. 4. 4 Data analysis

Transcription of the narratives was not necessary as the written narratives were already transcribed but require coding to begin the cyclical process of data analysis. This was the revisiting of the text to elicit understanding of the different processes and interests. Effectively, the researcher engaged in two cyclical processes. The first aimed to answer the first two research questions (1) What factors do health visitors identify among families with a child who is categorised as neglected and (2) What actions are taken in response to the identified factors?. The second cyclical process aimed to answer the third and fourth research questions (3) What interests or inequalities, if any, are reflected in their work with families (e.g. health promotion, health protection, emancipation, other) and (4) Why might these inequalities result?

Coding of the narratives began by using QSR NUD*IST (Gibbs 2002). Lines of the narratives are given numbers to provide a map of the interpretations offered and assists readers to critically review the interpretations (Appendix 12). However, NUD*IST was abandoned because the creation of attributes, nodes, node sets and links caused me to loose sight of the overall contexts of the narratives. Instead, data analysis took on a staged process which incorporated some critical discourse analysis skills.

Each cyclical process (from data collection to analysis to data collection and so on) was divided into the following first three stages, and then together the emerging explanations from the two cyclical processes underwent stages four and five, as outlined by Porter (2000). The stages are:

1. A familiarity and making sense of the data to identify patterns of behaviour
2. Mapping out variations, limitations and exceptions to the patterns being examined
3. Exploration and elaboration of the patterns identified to elicit understanding of meanings and motives that lie behind the behaviour,
4. Building of explanations into a theoretical model and
5. Confirmation and modification of conclusions.

Porter's model of data analysis is more akin to critical theory than the nursing traditions of hermeneutic analysis suggested by van Manen (1990), Madison (1988) and Leonard (1994) because it facilitates the potential for change. The goals of other models are to discover meaning and understanding (Benner 1994). Unlike phenomenology but similar to grounded theory the hermeneutics of critical theory is about extracting theoretical models. Some thought was given to the application of critical discourse analysis (CDA) for the purpose of data analysis because it stems from Habermas's (1973) critical theory (Fairclough 1993). CDA aims to uncover the assumptions hidden in language or written text by systematically exploring power imbalances, social inequalities and other injustices (Fairclough 1993). Although van Dijk (2000) acknowledges there is no unitary CDA framework Huckin (1997) has attempted to draw some useful skills from a range of approaches. Some of these skills were interwoven into Porter's stages of data analysis for the analysis of health visitors' narratives. Consequently, no specific CDA framework was used but the CDA skills utilised in both cyclical processes were:

- Firstly adopting an uncritical manner to the text to identify what factors were identified.

- Framing the details into a coherent whole by using headings to emphasise the process of identification and actions taken in response to the identified factors.

- Analysing the language used to identify the ideological position of health visitors to the identification of early needs and assessment of risk

One additional CDA skill was used in the second cyclical process. That was:

- Adopting a critical manner when returning to the text for further reading and analysis to uncover any hidden interests and inequalities reflected in the text.

4. 4. 5 Trustworthiness of data

Arguably, as the narrative study was a flexible method of inquiry the trustworthiness of credibility, dependability, conformability and transferability (Guba & Lincohn 1994) could have been utilised. However, as the study was

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underpinned by Habermas's critical theory it seemed appropriate to use the Habermasian moral and expressive claims to trustworthiness - truth, rightness and truthfulness described at 4.2.1. Specifically, that is the rightness of the language used for the difficulties the disadvantaged families encountered; the true of expression about families and health visitors' concerns, and actions; and the truthfulness of families and health visitors' feelings about reaching mutual understanding of meanings for parenting and childcare and the difficulties encountered when attempting to meet children's needs.

Moral and expressive claims to trustworthiness (Outhwaite 1994) go further than exploring language. It is a comparison of the experience written about and the realities embraced as cultural norms. Comparison of participants' realities is also postulation towards agreement, or shared understandings. Both the cognitive and communicative actions of language are subject to the moral judgements of interaction and the interactive competence of participants. In this way the power and powerlessness of participants can be identified. The physical (ability to communicate), emotional (competence to communicate), relational (autonomous to engage in communication) issues can be explored. Accordingly, critical analysis not only takes the stories told and interprets them, but questions the motives and intention of the actions described to provide a theoretical model. Although discussion with others strengthens the trustworthiness of the developing theoretical perspective to 'maximise validity' (Green & Thorogood 2004: 191) the researchers' interpretations were not shared with participants. Nevertheless, the trustworthiness of the study can be judged from the reasoning used to interpret the text, the justification offered for the findings and a transparency of an audit trail to place in context the interpreted text from health visitors' narratives.

Succinctly, the trustworthiness of critical theory is, therefore, the truthfulness and rightness of the reasoning and justifications for the rules of communication, the relationship between language, the taken-for-granted (routine) social life and the critique of the relationship that focuses on aspects of the life of, in particular, disadvantaged members of society in order to move them towards a more emancipatory position (Maggs-Rapport 2001).

4.5 SOURCES OF HELP SURVEY: STUDY 3

Health visitors are given the role and responsibility of identifying health needs (study one) and responding to those needs (study two) by supporting families. This work is dependent upon a mutually respectful relationship with parents. The National Assembly for Wales (2000: 7.6) refers to a relationship as a partnership and describes it as "a presumption of openness, joint decision making, and a willingness to listen to families and capitalise on their strengths" that begins with "Treat[ing] all family members as you would wish to be treated, with dignity and respect" (7.8). For one young secretary and mother this presumption of openness was questioned when she realised (whilst typing the report for study one) that parent-held records (that give a pretence of openness) are not the only source of information kept about children and their families and the additional records parents rarely have access to are Joint Professionals Records (Knowles et al 1999).

On the one hand, health visitors are expected to respect and accept that "it should be the decision of parents when to ask for help and advice on their children's care and upbringing" (NAFW 2000: 1. 1.5). On the other hand, they can override parents' consent if "the safety and welfare of a child dictate" (7.30). Stevenson (1998) is of the view that primary health care delivered by health visitors has the potential for a 'more realistic application of notions of partnership' than a continuum of supportive and protective services (Morrison 1996) because by continuing family and home visitation until children are school age (and sometimes beyond) they can maintain some sense of parent power. Then again, a point can seemingly be reached when parent power can be ignored (Ryburn 1997).

My collaboration in Wenger et al's (1998) study that explored mothers' support networks highlighted the lack of consideration for professionals as part of support networks. Wenger et al (1998) defined social networks as "all those adults who live with the mother or were named as available, or were perceived to be available, to instrumentally help or offer advice or emotional support". Within this definition it is conceivable that health visitors might have been included as they claim to provide support for families (Goodwin 1988) and are generally perceived as providing a non-stigmatising service. From the perspective of these young mothers in North Wales health visitors were not part of their social support. With health visitors

meeting normative and professionally defined criterion to avoid ill-health and harm (Lightfoot 1995) parents will feel less of a sense of satisfaction than with interventions that meet their defined needs (Hall 2000). For example, even when in daily contact with day care providers, mothers might discuss parenting difficulties but they would not include them in their social network (Shpancer 1999). What this might suggest is that parents are discerning seekers of help. Their first point of contact is, not surprising, often partner, parents and friends (Wenger et al 1999) with professionals contacted when the need escalates and is perceived as a problem.

It may be that the political legitimacy of the designated roles and responsibilities of health visiting no longer parallels the legitimacy ascribed by parents. Lay support is unquestionably preferred (Wenger et al 1999), but it is less clear which source of help is preferred by parents for which parenting and childcare problems associated with child neglect. To shed some light on the legitimacy mothers placed on agency support for parenting and child care difficulties study three originally planned to engage a group of young mothers in focus groups as the ethical approval from Central Sub-Committee alludes to (Appendix 13). Unfortunately, just before the study was due to commence The Children's Society in Caernarfon was closed and the community workers redeployed. The necessary revision of study three resulted in the development of a questionnaire that included the parenting and childcare needs identified in study 1 and used to answer the research questions:

- *For which childcare and parenting need are health visitors a preferred source of help?*
- *Do parents, having experience of health visiting, have a different perception of health visitors as a source of help from none parents?*

No surprising differences are anticipated between the survey participants who were also parents and those who were not. As a general consensus is expected as to what is an appropriate source of support for certain parenting and childcare needs or problems in the questionnaire. The possibility that a difference may exist is conceived from parental attitudes to health visitors rather than the service generally. Parents, particularly mothers, have been reported to turn to health visitors for information about health and children's developmental needs (Marden & Nicholas

1997). Findings by the Scottish Executive (2005) concurs that the majority of mothers interviewed stated health visitors were approachable and friendly. This evaluation of 'Starting Well', a project similar to the Sure Start project in England and Wales also found brusqueness and unfriendly attributes reported by less-receptive mothers'. Similarly, the more disadvantaged parents or parents who fear judgement of their parenting skills were found to be reluctant to engage with health visitors (Westlake & Pearson 1997). Thus the proposition for this study is that more similarities than differences will be found.

The perceived importance of exploring preferred sources of support for parenting and childcare needs and problems is two fold. Firstly, other than through the focus group approach there is little research evidence of peoples' views being elicited about the services they prefer (Briggs & Garner 2006). If outcome measures can be an indication of the value of a service, then, primary care services for women with an alcohol and drug problem is not successful in improving the health of the women and their babies (Doggett, Burrett & Osborn 2006); and thereby may not be valued in the same way that workers expect. What was a positive outcome was an increased engagement with drug treatment services. Hence, it could be that only the engagement with the service is what the women wanted and they perceived the support for their own or their babies' health needs coming from a different service to that provided by the drug treatment service? It is important to match services with the support people want. Secondly, the survey aims to find support or refutation for health visitors as a preferred source of support for parenting and childcare needs and problems. As such the survey will provide another 'lens' on the practice of health visiting as viewed by adults.

4. 5. 1 Method

Survey by use of a questionnaire, the most useful and popular method used in health research (Marks 2004), was the method chosen to exploring parents' preferred choice of support. This self-completion questionnaire ensured greater anonymity and as a single item, multi-choice questionnaire it was economical to use both from the research perspective and the respondents' time and effort.

A pilot study was conducted using a similar opportunistic sample of 56 student nurses (in their first year of training) with an earlier questionnaire. The questionnaires were delivered and collected by the researcher from a group of students prior to a study day. Each student was given an envelope with the questionnaire inside. Those not wishing to participate could then return the unanswered questionnaire in the returning envelope without anyone knowing. All were complete. The results show that all of the group were parents, 52 mothers and 4 fathers. The problems that these parents identified as the one they were more likely to seek help from health services about are in descending order, drug abuse 73%, child's aggressive behaviour 71%, alcohol problems 62%, tantrums 57%, discipline 51%, feeling inadequate 46%, and needing help 42%.

The pilot demonstrated a couple of weaknesses. The first was the use of health services and social services rather than the key workers in child neglect, health visitors and social workers. A second oversight was not to instruct and reinforce selection of family, friend or neighbour only if they would not seek help from any other source. Responses gave two or more sources of help and as such the above results do not necessarily indicate health service as the preferred source of help but one of usually two and sometimes three. The sample of parents was a surprise finding as it was assumed that a group of student nurses (in their first year of a full-time university programme) would be predominantly young people and most would be non-parents.

4. 5. 2 Sampling

A further larger opportunistic sample was accessed for the study. The then Head of School (Nursing, Midwifery and Health Studies) gave his consent to my request for student nurses to participate in this study to make arrangements and meet with students. Only half of the students were parents and as such this sample was less informed about involvement with health visitors that the one original planned with mothers. Nevertheless, the sample of non-parents could provide some measure of their preference for health visiting from having vicarious knowledge through their lay community contacts or more general health service knowledge. The 103 students in their first semester of the first year of study had received little direct childhood content to their study but they had discussed community services such as

the roles and responsibilities of community nurses, in preparation for their first community placement.

4. 5. 3 Data collection

The revised questionnaire (Appendix 14) was administered in the same way as the pilot study, but this time to a different group of students. Each student nurse was given an envelope that contained the questionnaire and was to be used for returning the questionnaire. They were then informed verbally that the study was intended to elicit people's preferred choice of help. This gave the opportunity to reinforce the requirement for only one social and one professional (agency) response. All the envelopes were returned. One was incomplete and two were void due to the selection of more than one preferred agency support. The final number of correctly completed surveys was 100.

4. 5. 4 Data analysis

The aim of analysing data from this survey was illumination rather than generalisation. As one of the cyclical processes of the narrative analysis provided an understanding of how health visitors perceived themselves this data analysis was intended to either sequentially support or refute the previous analysis (Milburn et al 1995). Frequency tests, using SPCC, compared the parenting and childcare needs or problems to sources of social support and agency support.

4. 5. 5 Trustworthiness of data

Rigour of the analysis in this study, and the multi-method study as a whole, stems from the transparency of the relationship between the studies and the specific questions asked in the questionnaire Credibility is twofold - the adequate identification and description of participants (Holloway & Wheeler 1996) and the description of the experience of the study by the researcher (Koch 1994). The trustworthiness, therefore, cannot rule out the possible influence that the community information the sample received before participating in the survey may have had on responses.

The triangulation of the research questions (interests) and the different knowledge espoused by Habermas are outlined in table 4.1.

Knowledge	Empirical-analytic	Historical-hermeneutic	Critically oriented
Overall purpose	To determine the factors that predispose health visitors to act and how they act to prevent and protect children from neglect.		
Interests	What factors do health visitors identify? Which factors are identified early for preventative action? How valid is the utilised assessment instrument? What factors are predictive? For which childcare & parenting needs are health visitors a preferred source of support?	⟶ ⟶ What actions are taken in response to identified needs/risk? What interests or inequalities are reflected in the work? Why might inequalities exist?	⟶ ⟶ ⟶

Table 4.1: The triangulation of research questions (interests) and the different knowledge espoused by Habermas

4.6 ETHICAL APPROVAL

A research protocol and all study instruments were submitted as required to the North Wales Ethics Committee and granted approval after some suggested amendments (Appendix 13). The ethical principles on which samples were selected and information treated were:

- Informed consent
- People autonomy
- Protection of privacy

Informed consent involved the giving of information about the purpose of study two and three. Participants were then in a position to make an informed judgement about their involvement. People autonomy was also especially relevant in studies two and three where invited participants were aware of the right to refuse to participate and withdraw at any stage of the research process.

A large number of health visitors (21) exercised their right not to participate in the study. In relation to the case control study this was less a consideration. It was child health records rather than children who were the source of data. This conformed to the Department of Health (1991) recommendations that children should not be involved in research unless absolutely essential. In hindsight, parents of children categories as neglected could have been contacted for their consent to access their child's health records. As this was not a concern to the ethics committee it did not occur as a possible ethical consideration until afterwards. Finally, protection of privacy was an assurance throughout each stage of the research process. It could be argued that not seeking parental consent to children's records ensured greater privacy than if parents were contacted and they were then to inform others of the study. Coding of all participants and child health records ensured anonymity was maintained. Pseudonyms were used only for reporting the findings of study two to ensure health visitors could not be identified.

4.7 CHAPTER SUMMARY

This chapter outlines the methodology pertinent to the research and details the methods used in each of the discrete studies, which make up the substantive research. The chosen multi-method approach is designed to utilise case-control, narrative and survey methods to determine the factors that predispose health visitors to act and how they act to prevent and protect children from neglect.

Study one was intended to identify the factors associated with child neglect and those identified by health visitors (during the pre-school years). The strength of association of factors to neglect was determined to develop where possible a model of need associated with child neglect.

Study two took a further but different 'fix' on factors from the documented evidence in study one to health visitors' narratives. It was anticipated that the narrative data would identify need or problems and include health visitors' responses. Sufficient data was forthcoming to provide the emergence of a response and interpretation of health visitors' motives and interests in their work with families. Analysis of data points to factors that health visitors can legitimately engage with and some they cannot due to families' acceptance or otherwise.

Study three intended to further investigate the legitimacy of health visiting as a source of families' support in relation to specific factors by using a survey method. It is anticipated that adults (parents and non-parents) will demonstrate a discriminating preference for sources of support for different problems.

The ensuing chapters present the results in turn beginning with Chapter Five which provides a profile of the children neglected, factors identified as a cause of concern and predictive factors for preschool and school age children. Chapter Six outlines a four stage process of assessment and intervention and three styles of communication that seemingly are used for different interests. Inequalities of intervention are proposed as potentially due to an appropriate use of communicative styles for the presenting problems. Chapter Seven supports adults as discerning seekers of support. More importantly, the survey findings identified a number of problems for which adults are reluctant to seek support from family, friends or professionals.

CHAPTER FIVE

HEALTH VISITORS' KNOWLEDGE OF FACTORS RELEVANT TO

CHILDREN'S HEALTH AND DEVELOPMENT -

CASE CONTROL – STUDY ONE

5.1 INTRODUCTION

The purpose of this chapter is to identify the factors that health visitors documented in the child health records of 83 children whose names were recorded on the Child Protection Register as neglected and a control group of 83 children whose names were not on the Child Protection Register. The chapter first explains the preparation of the data in order to determine the point of divergence between the recorded variables for the group of neglected children and the control group. Data analysis progressed to identify the strength of the relationship between independent variables and the dependent variable. Lastly, logistic regression was undertaken to find a small number of variables that together have predictive ability of neglect or non-neglect occurring from the sample as a whole and for the preschool age group and school age group. Insight is gained from the findings of this study in terms of a combination of variables that foretell problematic childcare situations that may precipitate child neglect at a preschool age and school age, that match the informal stories often told of child neglect. The combination of variables was inappropriate care, behaviour perceived as a problem, and poor attendance to preschool playgroup and nursery facilities or school.

5.2. PREPARING THE DATA FOR ANALYSIS

The data collected were entered directly into Statistical Package for the Social Sciences (SPCC) version 0.9 through the data entry options by coding documented factors with numbers. Once coded, the factors were referred to as variables with each of the categorical variables assigned on two or more values (Berry 1993). These values represent variants; for example the number of *changes to family*

structure was valued as either 0-2, 3-5 or 6+ and not recorded. The value 0-2 takes into account the changing nature of family life to reflect contemporary separation and divorce rates. Other values cover the extent of the variants found in the data. Variables and values less easily divided were discussed at length with relevant specialists. For example, expert opinion of representatives of the North Wales Police Force was sought to reduce the many *criminal activities* to three values and a fourth represents 'not recorded'. A break-down of these values can be seen in table 5. 1.

Value 1	Value 2	Value 3	Value 4
More serious	Serious	Least serious	Not recorded
Murder Attempted murder Schedule 1 offender Sexual abuse Rape Unnecessary suffering to a child Firearms offence	In prison for violence Convictions for assault Abandoning children Domestic violence Stabbing Threatening behaviour Several jail sentences Burglary	Shoplifting Rent arrears Stealing from electricity meter Motoring offence Benefit book lost	

Table 5 1: Constructs of criminal activity

The 'not recorded' value not only relates to criminal activities, but to all other variables not recorded. Not recorded does not imply missing data but a presumption that the variable did not present. Only data known about the children and their family would be recorded. Health visitors may have be intuitively aware that something was wrong and suspected a particular variable, but if families hide their experiences from health visitors or health visitors have no knowledge of relevant factors they cannot record them. An examination of the two case note groups, as Hair et al (1995) recommend, found an important pattern in recordings that support this decision. The significance of this examination of recordings is indicative of a sample that is non-randomised (Hair et al 1995) which the neglect sample and control sample confirm. More importantly, the patterns of recordings represent a practice of recording mainly adverse factors. Only where families had experienced

difficulties were positive factors recorded as if to serve as a progress statement. A contradiction to the rarely positive statements was in relation to the implementation of the Child Health Promotion Programme. Competences in children's health and development for chronological and other circumstances (disability) were recorded on the national child health assessment forms. It was seemingly, the recorded 'knowledge' of adverse circumstances and the assessment of children's health and developmental status that influence decision making.

Arsham (2004) explains the value of statistics as the way it processes the data that on analysis becomes information. This information becomes factors that are added to the relevant body of knowledge. It is considered important to draw knowledge from the data presented rather than artificially to create a near random representation of a population sample. In this way the knowledge recorded can reveal what factors are related to the decision of 'child neglect'. Overall, interpretations of the data are the identification of knowledge and how it is used to make decisions about children who are or are likely to be neglected. The examination of patterns of recording information implies that 'not-recorded' values are treated as a positive in the absence of concern.

5.3 PROFILE OF CASE NOTE SUBJECTS

Among the 'neglect' cases a higher number of females (46, 55.4%) than males (37, 44.6%) were registered on the Child Protection Register for neglect. The age at which registration for child neglect occurred is presented in Figure 5.1 below. Generally, a relatively early identification of child neglect occurred by the age of 2 years for 51.8% (n43 of 83). Prior to entering school 72.3% (n60 of 83) of cases were recorded as neglected. School age children accounted for 27.7% (n 23 of 83).

The scale of the problem of child neglect is made more realistic when it was found that 65% (n 54) of the neglected cases were from as few as 19 families. The mean number of children for these families is 2.8 children. Families with one child registered neglected totalled 29 (35%). This finding supports the association of increased numbers of children in neglecting families (Polansky 1972) but it also implies that it would be a mistake to focus predominantly on families with many

children as 35% of the 'neglected' cases were of a single child in the family. All the control cases were from different families.
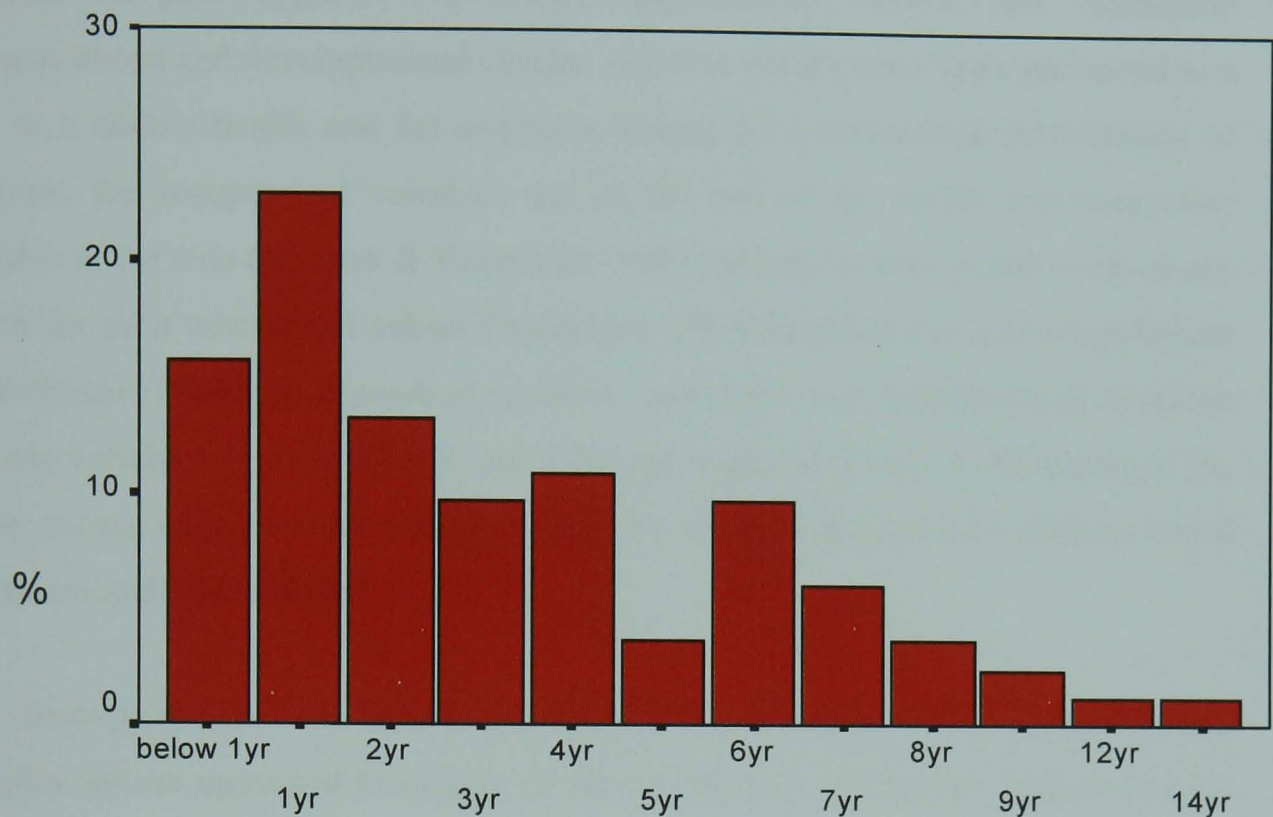
Figure 5.1 Age at registration of child neglect.

5.4 FAMILY HISTORY FACTORS IDENTIFIED AS A CAUSE OF CONCERN

All, thirty two variables of concern were found and supports health visitors taking a multidimensional view into account when working with children and their families. A list of variables and the corresponding codes can be found in Appendix 2 and 3 respectively. Initially, each variable was given several values. These values were labelled as closely as possible to the language used in the professional recording. The group differences between variables were descriptively calculated by cross-tabulation. There were two reasons for using this method. The first was a way of making sense of the ascribed variables by showing the difference in the frequencies of the variables between the two groups. The second reason was to identify the point of divergence in order to dichotomise the variables by dividing them

according to acceptable and more adverse values. The positive values where recorded strengths, combined with the 'not-recorded' values and the values where there was little difference between the two groups, such as 0-2 changes in family address; above 50 percentile and 25 percentile growth (ability to thrive); 1-2 incidents of poor hygiene; 1-2 routine appointments missed; and incomplete immunisations and developmental checks. Adverse values were those perceived as a risk to a child's health and development. Using the conventional presentation of analysis, the independent variables are at the top of the tables and dependent variable at the side (Newton & Rudestam (1999) as can be seen in the contingency tables for each assessment subset (Appendix 12). Following the recommendations of Rothman (1986) the dependent variable, *carestatus* was dichotomised using the dummy variables 1 for neglected and 0 for not neglected cases. Conforming to the same recommendations the dummy values for all the independent variables was 0 for absent and 1 for present.

The descriptive statistics served mainly to show a difference between the two samples and an increased frequency of adverse factors among the neglect sample. However, the relationship between the variables and child neglect offered a more meaningful explanation of health visitors' recordings of the identified variables. Using a two-tailed, non-parametric correlations test (Spearmans' rho) the relationship between neglect and the variables for each of the assessment instrument subsets were determined.

In descending order of strength of the relationship for the variables in the 'Family History' subset to 'Neglect' (carestatus) were moderately associated with *substance misuse* (.592), and *violence* (.561). Each was related to the other (.521). These two variables were also related to crime (*violence* .502; *substance misuse* .482). *Violence* was also related to *structure* (.435).

The family situation that emerges was an unstable family life were there were more than two changes to the family structure (most often a change in paternal parental figure) and where substance misuse, violent behaviour and criminal activities presented. The findings suggest that were one of these variables present other related variables may also presented, especially violence and substance misuse and violence and criminal activities, as presented in Figure 5.2.
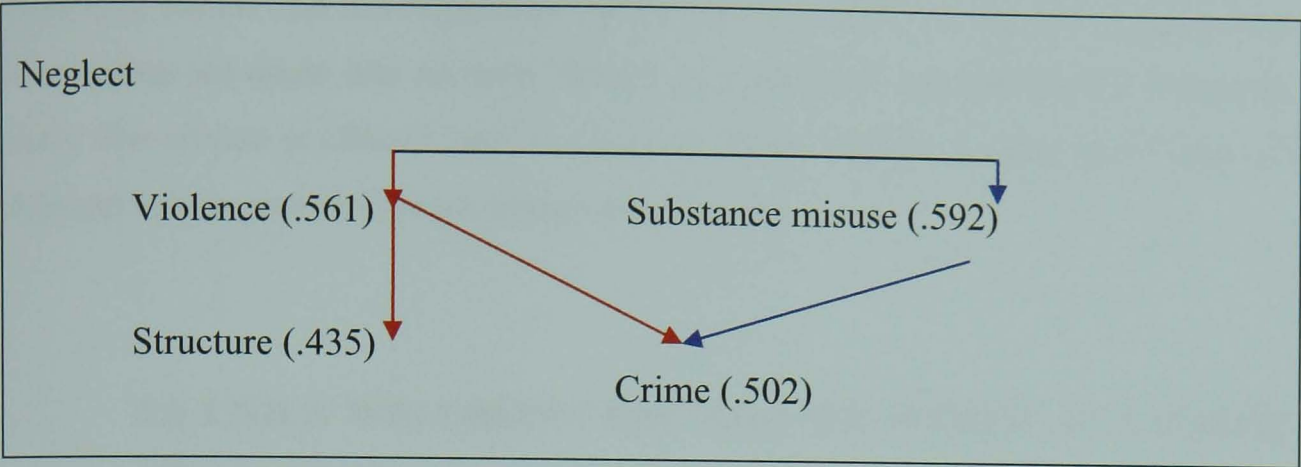
Figure 5.2: Correlations of the Family History subset

5.5 PARENTAL SKILLS FACTORS IDENTIFIED AS A CAUSE OF CONCERN

The variables in the parenting skills subset found to be highly and moderately correlated to neglect were, in descending order of strength of the relationship, *care* (.712), *needs* (.604), *PCrelate* (.448), *help* (.478) and *advice* (.367). An association was also found among these variables. For example, *care* was associated with *needs* (.562), *PCrelate* (.404) and *advice* (.367). What these relationships may suggest is that the quality of care is of importance to health visitors' assessment of the families health needs.
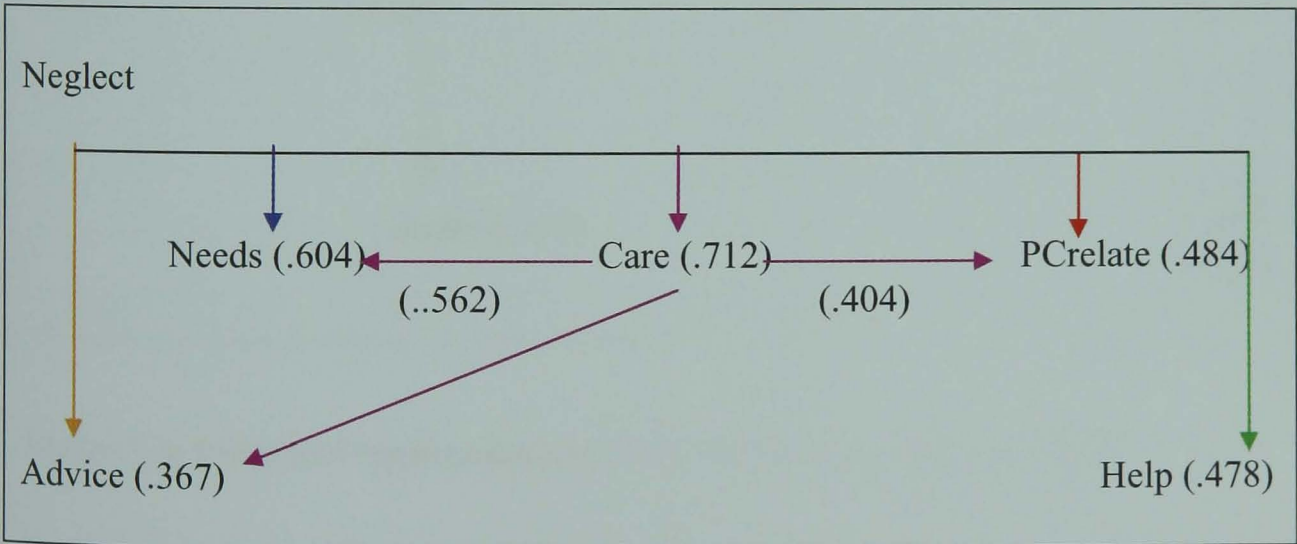
Figure 5.3: Correlations of the Parental Skills subset

When the quality of care is judged to be at a level of concern both the meeting of children's health and developmental needs and the quality of the parent and child relationship are taken into account. Where care concerns are identified it is equally likely that advice is offered and if necessary additional family support in terms of physical help is provided as presented in Figure 5.3..

5.6 CHILD WELLBEING FACTORS IDENTIFIED AS A CAUSE OF CONCERN

From among the child wellbeing subset neglect was associated with *thrive* (.426), *attend* (.526), *behaviour* (.606) and *hospital* (.320). *Thrive* (or the growth at or below the 10th percentile) was associated with *behaviour* (.365) (behaviour perceived a problem) and *incare* (.318) (children taken into local authority care or living with relatives other than their parents). *Attend* (play/school attendance) was associated with *ldiff* (.371) (learning difficulties).
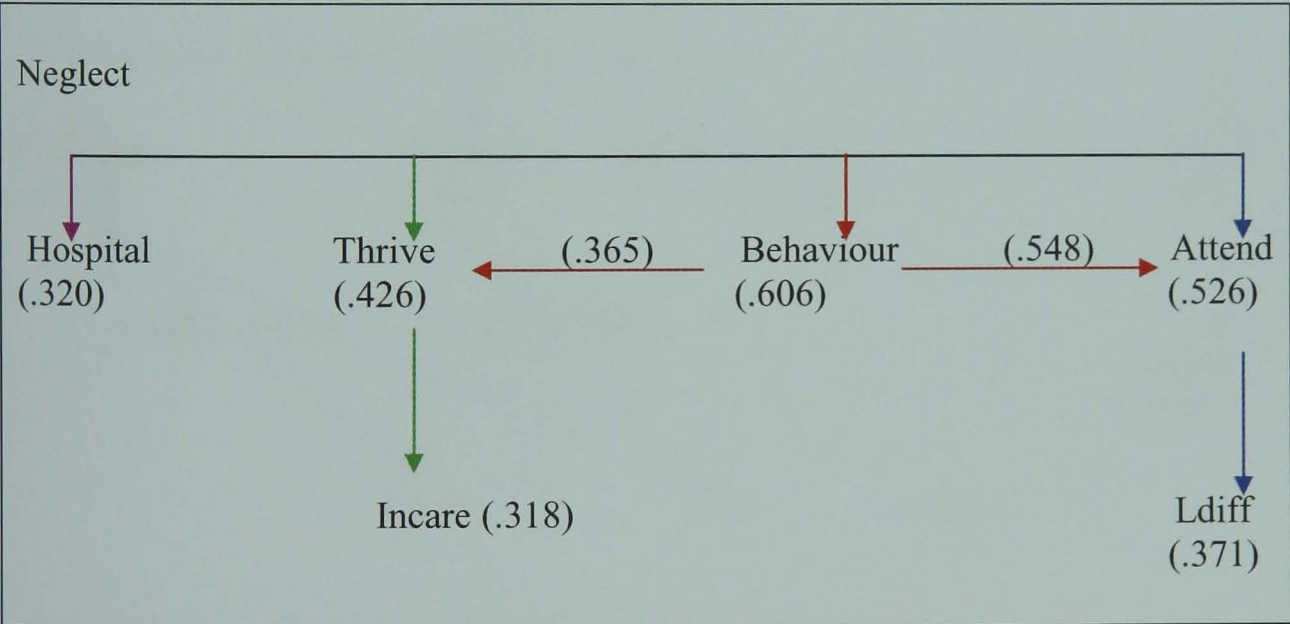
Figure 5.4: Preschool registration and Child Wellbeing subset correlates

An interpretation of these relationships might suggest behaviour perceived to be a problem was related to low growth and poor play school or school attendance. Difficulties with children's behaviour may either contribute to poor attendance at play school or school or poor attendance predisposes children to behaviour that was perceived a problem. More than three attendances and the raising of suspicion

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for injuries presented at hospital were also more likely, though there may be appropriate reasons for some children attending hospital frequently. Figure 5.4 present the Child Wellbeing subset correlations.

5.7 SOCIAL AND ENVIRONMENTAL FACTORS IDENTIFIED AS A CAUSE OF CONCERN

Four social and environmental factor variables were moderately associated with neglect. They were attendance *engage* (.468) (reluctance to engage with services), *housing* (.447) (poor housing conditions), *impappo* (.409) (attending important appointments), and clothing (.322). *Housing* was associated with *engage* (.307) and *impappo* (.348). Not attending important appointment was related to not attending routine appointment, *routine* (.310). *Engage* was associated with *employment* (.312), *play* (.304) and *food* (.304). *Clothing* was also related to *food* (.388) *play* (.318). These findings are presented diagrammatically in figure 5.5.
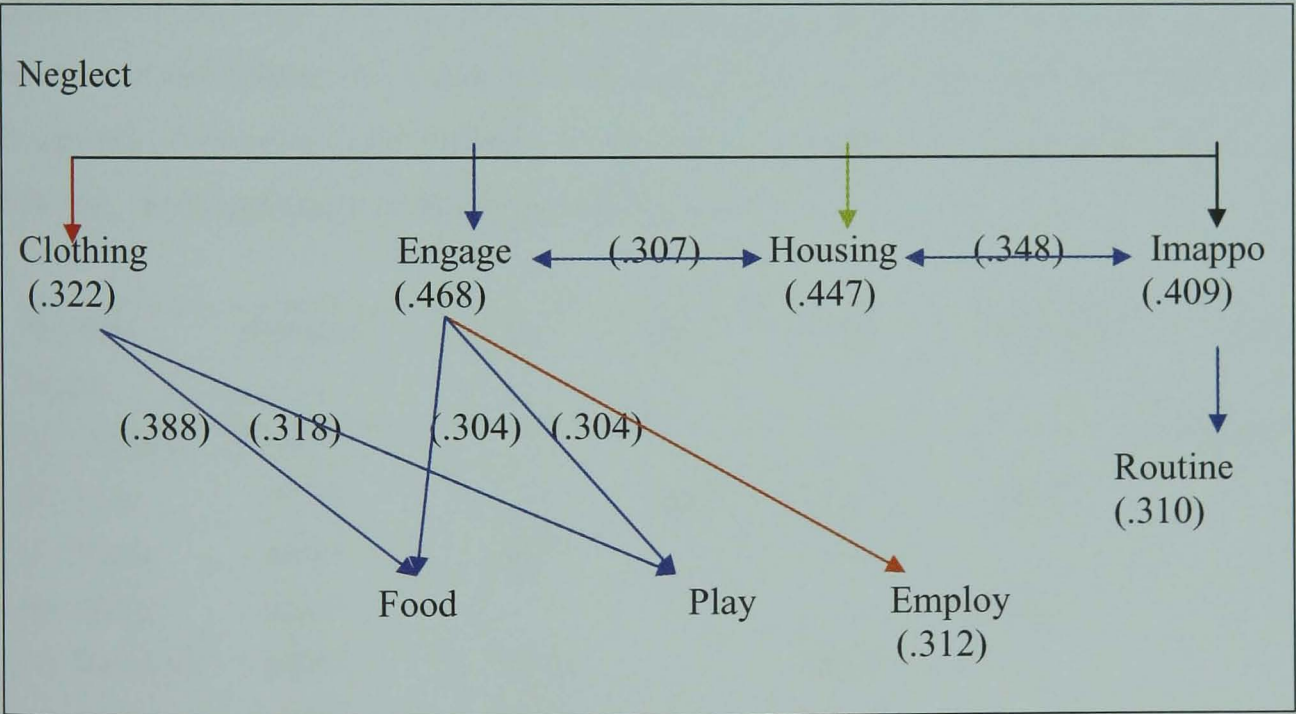
Figure 5.5: The Social & Environmental subset correlates

An interpretation of these findings may support a parental ineptitude that other studies of child neglect have identified (Polansky 1992, Christiansen et al 2000, Dubowitz 2005, Chapple et al 2005). However, in this case the ineptitude may be summed up as being manifested in the poor circumstances of the house and unemployment. For children the ineptitude was inappropriate clothing, food and

interactive play or play generally. From the reluctance to attend either important or routine appointments and engage with supportive childcare services it is impossible to tell if the reluctance to engage with services is a deliberate act due to a negative belief system about the services or other reasons. Alternative explanations could be that mothers may be either ashamed they cannot provide better provision for their children or they may not want to place their housing, clothing and feeding skills and accessing medical care shortcomings under the scrutiny of authoritative services. Hence they are reluctant to attend or make contact with persons perceived as inquisitive. Also, it is feasible to conceive of employment being a barrier to engaging with services.

5.8. THE STRENGTH OF VARIABLES TO CHILD NEGLECT

Of the 32 variables reported six show strong correlation to *neglect (carestatus)* and other variables. These are aggression and violence *(violence)*, management and handling of the child *(care)*, unmet needs *(needs)*, attendance at playgroup, nursery because of developmental delay and school *(attend)*, behaviour that was a problem to parents *(behaviour)* and children living with other than their parents because of concern, such as family or foster parents *(incare)*.

Measures Incare	Carestatus	Care	Needs	Attend	Behaviour	Crime
(1) Violence	.561**					.502**
(2) Care	.712**		.562**	.516**	.590**	
(3) Needs	.604**	.562**				
(4) Attend	.526**				.548**	
(5) Behaviour	.606**	.516**		.548**		
(6) Incare	.675**	.590**				

**p<*.001*

Table 5.2: Spearman's (rho) correlations between measures of perceived child neglect and family factors

Using a two tailed, non-parametric correlations test (Spearman's rho) because the data is "non-normally distributed" (Lang & Secic 1997), and applying Cohen's (1988) guidelines of .50 for highly associated variables, all six variable were

significant to a p value (.000) that is lower than the alpha used (0.01) as shown in table 5.2.

Caution is taken in accepting at face value the above statistical significances of the relationship between variables on such a relatively small matched sample. Hence, the amount of shared variance is calculated to confirm that a significant relationship does exist between the variables. This was done by following Pallant's (2001) instructions. The highly correlated variables were squared and multiplied by 100. For example, the correlate of *care* and *carestatus* (neglect or not neglect) is .712, that is (.712 x .712) x 100 = 50%. In other words:

- Not providing adequate *care* helps to explain 50% of neglect cases.

- Experiencing periods when living with other than parents helps to explains 45% of neglect cases

- Problem behaviour helps to explain 37% of the recorded neglect cases

- Unmet need helps to explain 36% of the recorded neglect cases

- Violence helps to explain 31% of the recorded neglect cases

- Poor attendance at playschool, nursery or school helps explain 28% of the recorded neglect cases.

- Likewise poor care helps to explain 35% of children living with other than their parents, 31% of unmet needs and 27% of problem behaviour.

- Not attending playschool, nursery or school helps to explain 30% of behaviour problems

- Violence helps to explain 25% of reported crime. These findings are interpreted as having what Pallant (2001:121) calls "quite a respectable amount of variance".

Also significant at a confidence level of 0.01 level are variables with moderate association (.3-.49) (Cohen 1988) that together with the strongly correlated variables make more explicit a relationship between variables of parental capacity and outcomes for children. Those most noteworthy, in terms of frequency, were *help* (additional help needed with childcare) (.478); *engage* (reluctance to engage with services) (.468); *crime* (criminal convictions) (.458); *hygiene* (poor hygiene) (.452); *p-crelate* (inappropriate parent-child relationship) (.448); *housing* (poor home circumstances) (.447); *thrive* (10% percentile or less) (.426); *drugs* (drug

misuse) (.421); *incare* (child looked after by other than their parents) (.411) and *alcohol* (alcohol misuse) (.377). Their relationship to highly correlated parenting and child variables are summarised in Figure 5.2.
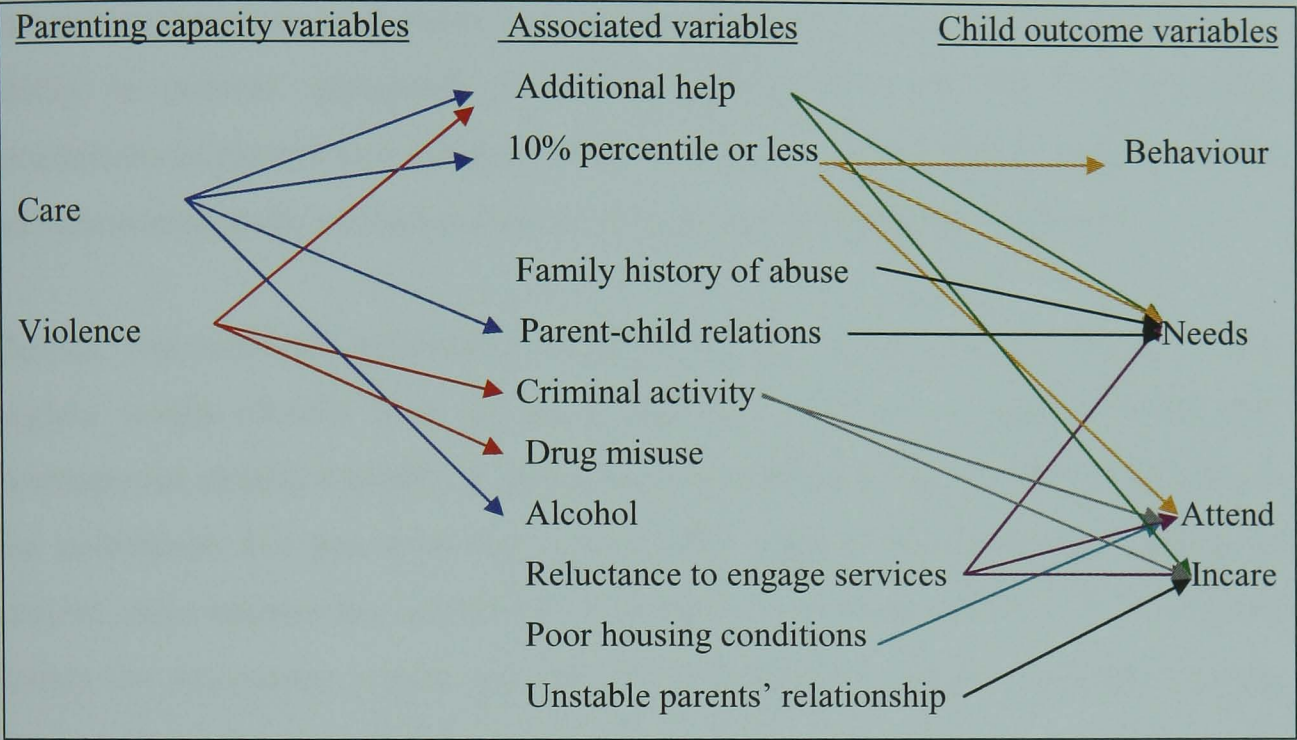
Figure 5.6: Model of the strong and moderate relationship of variables to parental capacity and outcome for children.

5.9. VALIDITY AND RELIABILITY OF THE ASSESSMENT INSTRUMENT

Though this moderate correlation is encouraging, and certainly fits the picture of child neglect I have experienced in professional practice, it does not give the degree to which the study assessment instrument is measuring neglect. That is to say, that although one variable may have a strong correlation to an outcome described as child neglect the variable may not be, alone, a cause of neglect but a contributing factor among many variables. The multi-variable instrument as a whole and the individual subsets of the instrument were calculated for reliability using the most widely used practice, alpha reliability coefficient. Pallant (2001) suggests that a coefficient of .7 indicates greater reliability. As a whole the instrument was calculated to be reliable after calculating an alpha of .8910. However, a consistently

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high alpha was not found for all four subsets of variables. The highest alpha is the subset *Family history* (.7488), followed by *Parenting Skills* (.7156), *Social and Environmental Factors* (.6999) and finally, *Child Wellbeing* (.6600). Nevertheless, the assessment instrument does confirm health visitors identifying numerous factors and, thereby applying a comprehensive knowledge, relevant to child neglect. These can be summarised as patterns of family behaviours that impacted on parents' ability to provide adequately for their children; the relationship and caring interactions of parents and children; children's health, development, unmet physical and emotional needs and behaviour; and social and environmental factors.

Despite this relatively persuasive reliability of the instrument the reality is that neglect would already have occurred, and the effect on children's health and development already manifest if 'diagnosed' according to the numerous variables in the instrument. For practices that aim to offer early child and family support to prevent child neglect the instrument is limited as an early warning. In its current format the instrument would certainly be unhelpful as a guide to health visiting practice that aims to recognise, assess for and intervene in order to address early health needs.

5.10. FACTORS PREDICTIVE OF CHILD NEGLECT

Taking a public health perspective, what might prove a more useful assessment guide is the identification of variables that when combined allow some degree of predictions of the neglect of children's health and development. This concept requires a return to the association between variables and in particular the joint effect of many independent variables on the one categorical dependent variable carestatus. Logistic regression was the statistical technique of choice (Polit 1996; Tabachnick & Fidell 1989) for categorical outcomes (Polit 1996). Regression analysis is the statistical attempt to predict the value of neglect occurring from the explanatory variables. As there was more than one explanatory variable simple regression was not appropriate. Regression of multiple explanatory variables was an option but as the variables were dichotomised regression test of choice is logistic regression (Lang & Secic 1997). In this study logistic regression is used to verify

firstly, the association of variables, and secondly to confirm the variables with the best predictive ability.

The first step towards building a model of predictive variables is to identify the variables that explain a relationship to neglect and that are significantly related to neglect. Cross-tabulation analyses presented above have gone some way to confirming a difference between the two groups. Correlation analysis confirms the strength of association of variables significantly related to *care status*. Although the analysis of correlation confirmed a high confidence level (p <0.01) this was also supported by univariate analysis (GLM General Factorial). However, to assess the likelihood of an event occurring and certainly something as disturbing as child neglect, only the variables significant at a level of confidence of 0.01, that indicates the result is not due to chance alone, and with a high correlation at alpha .5 or above, were selected for logistic regression. Six variables were selected; *care, incare, behaviour, needs, violence and attend.*

Predicted	not neglected	neglected	Percent Correct
	1	2	
Observed	+--------------+--------------+		
not neglected 1	75 I	8 I	**90.36%**
	+--------------+--------------+		
neglected 2	9 I	74 I	**89.16%**
	+--------------+--------------+		
			Overall 89.76%

Table 5.3: Classification table of predictive model of neglectful circumstances

The second step in model building involved entering all these variables into a Forward stepwise logistic regression until stopping when a set of variables was reached with a value of .50. The result is a set of variables with the best predictive ability. As anticipated the number of variables was reduced but this was also disappointing as none were statistically significant. Numerous regression combinations followed to find a set of these variables with the best Goodness of Fit to the sample data, with the highest overall percentage of correct predictions and a

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high degree of sensitivity (to predict true positives) and specificity (to predict true negatives). The results shown in tables 5.7 and 5.8 are of a predictive model that includes *care, needs* and *attend* with the closest value between the -2 Log Likelihood (89.896) and Goodness to Fit (121.156).

The ratio of odds helps determine the percentage of correctly selected cases using the resulting model which in this study is an 89.76% overall likelihood of neglect occurring if the identified variables are present against the odds of not-neglect occurring in the absence of these variables. In the classification table (Table 5.7) the number of predicted true positives (TP) is 89.16% (74) and the true negatives (TN) 90.36% (75). False positives and false negatives are also identified as 8 and 9 respectively. A higher predictive true positive is preferred for a screening instrument. This criterion is met and although it is not intended as a diagnostic instrument it does give direction for assessment of factors most frequently found among cases of children with unmet needs. What is of particular importance is the small number of variables with a significant relationship to each other and the greatest prediction of neglect or not neglect occurring.

Logistic regression found three variables *care, attend* and *behaviour* retained in the analysis as predictive variables, positively related (B) to each other and all significantly related (Sig) to the likelihood of neglectful situations. Care is by far the most predictive indicator of neglect when combined with the other two variables followed by behaviour and then poor attendance. The output from the logistic regression for the variables is presented in Table 5.8 below.

Variable	B	S.E.	Wald	df	Sig	R	Exp(B)
Care	4.2774	.8127	27.6975	1	.0000	.3342	72.0495
Behaviour	2.4524	.6654	13.5821	1	.0002	.2243	11.6159
Attend	3.4773	1.1472	9.1875	1	.0024	.1767	32.3720
Constant	-2.1603	.3526	37.5380	1	.0000		

Table 5.4: Logistic regression output of predictive model of neglectful circumstances

It would, of course, be inappropriate to propose a model without the model being tested. Therefore, from the study one sample of 75% of the cases were randomly selected and in a separate second sample of 25% of the cases were randomly selected for logistic regression. As can be seen from the table below (Table 5.9) of a comparison of the two test models there are similarities. Care is strongly confirmed in both samples. 'Poor attend' is also present but not in the same degree of frequency as 'care' and 'behaviour' Hence, this study supports the quality of management and handling of children and behaviour problems to be variables with predictive ability of child neglect. More specifically, this finding is representative of significant harm (DH 2000: 7) in that "the child is suffering...and that harm or likely harm is attributed to a lack of parental care or control".

75% random sample			25% random sample		
Variable	B	Sig	Variable	B	Sig
Care	3.9495	.0000	Care	4.2341	.0003
Attend	3.3652	.0034	Attend	10.6221	.7990
Behaviour	2.1621	.0017			

Table 5.5: Comparison of random samples using the predictive model.

5.11. PRE-SCHOOL RECORDINGS TO FACILITATE PREVENTATIVE ACTION?

The overall findings do not necessarily relate to pre-school age cases and thereby health visiting specifically. With registration of children under the category of neglect ranging from months to 14 years this suggests many of the same variables will present across the age range. However, the strength of variables for preschool and school age may be the same. To differentiate between the two age ranges, preschool and school age (5 years) two logistic regression analyses were performed, one with preschool age cases and one with school age cases. The results are outlined in table 5.5.

In both of these analyses the same three variables were found as resulted in the predictive model for child neglect cases generally. *Care and behaviour* are the variables with predictive ability in both age group analyses. Once again, *care* is the

most predictive variable among preschool neglect cases whereas *attend* is the variable most predictive among school neglect cases. Overall the predicted percentage of cases using the predictive model *care* and *behaviour* for preschool age cases is 87.84% (65 of 74) and using the predictive model *care, attend,* and *behaviour* for school age cases is 91.30% (84 of 92).

Preschool age cases							
Variable	B	S.E.	Wald	df	Sig	R	Exp(B)
Care	4.3399	1.1121	15.2281	1	.0001	.3591	76.6975
Behaviour	2.5145	.9467	7.0552	1	.0079	.2220	12.3602
Constant	-1.7525	.4422	15.7033	1	.0001		
School age cases							
Variable	B	S.E.	Wald	df	Sig	R	Exp(B)
Care	3.9141	1.2437	9.9046	1	.0016	.2490	50.1028
Attend	3.9366	1.2360	10.1435	1	.0014	.2527	51.2424
Behaviour	2.7939	.9525	8.6040	1	.0034	.2276	16.3443
Constant	-2.6845	.5986	20.1117	1	.0000		

Table 5.6 Logistic regression of preschool and school samples

In summary, statistical analysis of 32 variables found six variables with a high confidence level and with a strong relationship to child neglect. They are, *care, incare, behaviour, needs, violence* and *attend.* From these six variables there are three, which, when combined were found to have predictive ability; *care, behaviour and attend.* A difference was found for variables with predictive ability between the preschool and school age cases. *Care* and *behaviour* are the variables most predictive of preschool cases of child neglect and *attend* is the most predictive variable for school age cases.

5.12. CHAPTER SUMMARY

Statistical analysis of 32 variables found six variables with a high confidence level and with strong relationship to child neglect. Three of these were found to have predictive ability *care, behaviour* and *attend. Care* and *behaviour* are the variables of preschool cases of child neglect and *attend* is the most predictive variable for school age cases. A breadth of knowledge is demonstrated from the numerous factors deemed relevant to preventing child neglect and promoting children's health and development. A more accurate 'parental' focus would follow if more information about fathers was included. Parental capacity or mainly mothers' capacity is emphasised. The implications for health visiting are to continue to identify early parenting capacity detrimental to providing adequate child care and child behaviour problems. The following narrative study is intended to gain an understanding of health visitors' meanings of their work when concern is raised about the possibility of a child being neglected.

CHAPTER SIX

HEALTH VISITORS' NARRATIVES OF WORKING WITH

NEGLECTED CHILDREN AND THEIR FAMILIES:

STUDY TWO

6. 1. BACKGROUND

Study one, outlined in chapter five, demonstrates the application of risk and resilience factors by health visitors before the implementation of the assessment framework for children in need. However, access to health visitors' knowledge through child health records was lacking in its representation of the 'practice' of health visitors with families whose children are categorised as neglected and that lack recorded professional judgements. As such to explore further health visitors' knowledge and practice it is necessary to use a complementary, different approach to comprehend the work. This narrative study provides a number of stories that act as guides to health visitors' interactions with the family each offered as an exemplar for the research. As McLoad (1997) suggests these stories are sufficiently ambiguous to encourage the reader to actively construct meaning and interpretation from them. In this context meaning is the claims implicitly or explicitly described in the stories that are the taken-for-granted understandings of the participants (Dreyfus 1991). Interpretation is coming to understand the true condition of the story (Outhwaite 1994) and in that sense it can be considered the result of a rational process.

To elicit an interpretation of contemporary health visiting practice in relation to child neglect, seven of 24 experienced health visitors provided a narrative. They were invited in early 2002 to recall one family they were professionally involved with over the last five years. All the participants were female aged between 32 to 51 years of age. Four of the participants had a degree level qualification, two a diploma level qualification in health visiting and one declined to share this information. Their years of experience spanned 5 to 28 years. The names of the participants and family members in the study have been changed to protect their identity. The characteristics of the families recorded in the narratives, are similar to those

described by others (Zuravin 1987; Polansky et al 1992). The families had a large number of children, with an average of 3.4 children. Unstable 'marital' relationships were reported and all could be described as disadvantaged or vulnerable (Aday 1993) due to the existence of multiple problems.

The analysis was conducted in two stages. The first stage involved a consideration of the process of assessment and initiation of interventions and the second stage involved a consideration of the interests and inequalities reflected in the narratives. The analysis draws on recognised models of health visiting, professional guidelines (NAfW 2001) and Habermas's critical theory and especially his theory of communicative action. Findings are reported in two stages. In the first stage of the analysis the more public nature of health visitors' work is illuminated which describes four major themes in health visitors' assessment of needs. The second stage is a more private nature of health visiting. Validation of my interpretations can be undertaken by tracing the participants' pseudonym and paragraph of the narrative (e.g. Julie, P2). The four stages in the assessment of needs are:

- Establishing relationships that facilitate an opening into the context of the family,
- Access to the context of the family,
- Clarifying and revising interpretations of risk to children's health and development, and
- Determining when a build up of problems and patterns of behaviour has occurred that are barriers to appropriate change and thereby become a threshold for protective intervention.

6. 2. ESTABLISHING RELATIONSHIPS

Establishing a relationship with families (usually mothers) was the first stage in the health visiting process that embraces the concept of partnership (Chalmers 1992). First of all, the relationship was enhanced through familiarity. For example Sue wrote "For the past 8 years or so, [she] has always had access to the home and the family" (P124). By comparison Catherine has "known the mother of these children for four years" whilst Dianne "first met [the family] in December 1998" (P11) (four years ago). When contact is broken with one health visitor another relationship can

commence. Transfer into a new geographical location and through involvement with general practice, maternal, education and social services will lead to the 'appropriate' health visitor in the new locality being made aware of the families' presence. 'Appropriate' in this context refers to the organisation of participants' work be it geographically allocated or attachment to General Practice, or specific health and social care allocated (e.g. Sure Start, child and adolescent mental health, paediatric liaison). Both Julie and Sue were introduced "when [the families] transferred into the local area" (Julie P4). Otherwise renewed contact with the health visiting service might be in times of stress or crisis such as homelessness and Linda's "weekly visit to the Homeless Hostel" (P4), or when "The school had expressed concerns" (Rachel, P13).

Continuity of contact between families and health visitors was determined mainly by the families. This was problematic when participants became concerned about children's health or development and, in particular, when families did not understand the health visitors' concern or denied there was a need or problem. As such, no matter how hard health visitors try they are unlikely to establish a mutually reciprocal relationship with all the families on their caseload. Three of these narratives (Rachel, Linda and Julie) reflect this. Moreover, a sense of distance is sensed when Rachel notes that the advice she had given the family had been ignored, and parents were "repeatedly fail[ing] to act on advice given by professionals" (L70). Other examples include Linda (P 10) who was met with resistance and denial of their parenting difficulties. When "laying down the ground rules" Linda was confronted by a "rather morose and uncommunicative" father and a mother who denied the concerns that hostel staff had observed and expressed.

Julie describes a family with 6 children with multiple unmet needs. An "anticipated [relationship of] trust and honesty...didn't progress in a straightforward manner" (P4). The father of the family has played a substantial role in maintaining a distance from professionals through his being verbally abusive, especially to accident and emergency staff when one child was taken for treatment following an injury and he senses some uncertainty about the validity of the accident. Julie was seemingly intuitively picking up a 'hostile environment' that no one would take seriously "until there was evidence of domestic violence" (P28). Throughout her contact with

the family Julie's "visits became uncomfortable and even downright unpleasant" (P12).

Parents' acceptance of the health visitor is an important component in the relationship that seemingly arises from the parents perceptions of the health visitor as sensitive to mother's emotional feelings (Sue) and needs (Catherine); or productive response to mother's help seeking behaviour (Dianne). These participants gave of themselves emotionally by supporting the families though troubled times such as a child protection issue and family break down (Sue), the death of maternal mother and abortion counselling (Catherine) and the death of a baby (Dianne). Emotional support was also important in Ester's narratives but the emotional sharing may also have been due to the frustrations of working alone and unsupported by the multi-agency team.

Attempting to establish a reciprocally agreeable relationship was "the normal health visiting process [that facilitates] sharing information and anticipated trust and honesty developing between [health visitor] and the mother" (Julie, P4). One example of trust was one mother who "trusts [Sue] now to be alone with her children and they enjoy that contact" (P89). The relationship not only contributes to the job satisfaction that Sue implies but this relationship building can be essential when the health visitor is the only professional "to obtain access to the family" (Ester, P42). However, when children's needs compete with parents' needs the relationship may necessitate health visiting to be "done against a background of rising anxiety and unresolved issues" (Julie, P4) and when mothers are "not too keen" (Linda, P20) to retain Linda as the family health visitor. Linda had it seemed been too conscientious in the identification of serious unmet need (failure to thrive) and limitations in parental capacity (terminating feeds before finished) compounded by drug use. Hence, a trusting relationship can sustain health visitors through "a long haul of contact visits and a gradual return home" (Sue, P72) after a crisis. However, the reluctance of some families to engage with health visitors is particularly challenging to the promotion of health for both adults and children alike.

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6.3. ACCESS TO THE CONTEXT OF THE FAMILY

Access to the context of the family supports the pattern of contact proposed by Goodwin (1988), an initial universal contact followed by a targeted service, but that also maintains universality at specified developmental stages in a child's life. Essential to supporting targeted families was access to the family in the family home. The family home was deemed to be more than exposure to the physical environment it is the context where care and nurture takes place and where family values and beliefs are laid down (Roberts 1996). Together the physical environment, personal health of family members, relational and value systems form the groundswell of opinion upon which to judge families in need of additional support or filtered from the service until a later developmental stage. Catherine assesses and judges for herself that a child was not likely to suffer harm even when knowing a single mother who is using drugs. She judges that additional family support to the family is not necessary because this mother "relied heavily upon her mum to look after [the 7 year old] fulltime" (Catherine, P12). Another filtering process occurs during developmental checks when a health visitor "didn't see the family again (except in passing) until the 18month check" (Rachel, P25). The final targeting stage was at a time of crisis such as a child's death, as indicated by Sue when she "supported the family in their grief" (P66); potentially life threatening accidental "ingestion of a bag of heroin" (Catherine, P22) and harm to children such as "a large fresh bruise down the left side of the baby's head which extended right down to the top of the shoulder" (Linda, P24).

6.3.1 Initial and health promotion concerns

From these narratives, the premise of the universal service was seemingly healthy children experiencing a healthy parenting model to prevent adverse intergenerational concerns. Children's health needs can be categorised as (1) adequate provision, (2) expected development, and (3) socialisation through new experiences. Participants considered carefully where they notice examples of inadequate provision, delay in development or lack of socialisation opportunities. Examples of identified inadequate provision include inappropriate or insufficient clothing (Dianne, Sue); lack of personal hygiene (Rachel, Dianne); poor nutrition (Linda, Sue); inadequate emotional attachment (Ester, Sue); medical care needs – 60% burns, suspected childhood cancer (Julie); prevention of childhood infectious

diseases (Ester); inadequate supervision (Catherine, Rachel, Julie, Dianne) and the need for protection (Catherine, Rachel, Linda, Julie, Dianne, Sue). Identified delay in childhood development compromised speech (Rachel, Ester, Dianne) soiling (Rachel, Dianne), multiple developmental delay (Sue) and education (Ester, Dianne). Socialisation impairment was seen as declining pre-school services (Ester, Sue); poor educational attendance (Ester, Dianne, Sue) and unsocial behaviour – temper tantrums (Dianne).

When identifying healthy parenting, participants consider the parents' parenting capacity in terms of three issues (1) ability to provide for their children, (2) relative absence of marital disharmony and (3) the social support available. Participants, in the sample, describe parents' inability to cope with reference to:

- Parental misconception that children's needs are met (Catherine);
- Conditions affecting parental capacity, for example, learning disabilities (Sue), mental illness (Sue), Depression (Rachel, Linda), and dependency on alcohol and drugs (Catherine, Linda);
- Physical environment, for example, overcrowding (Ester, Dianne), homelessness (Linda) and poor housing conditions (Rachel, Sue);
- Parental choice, for example, parents also made a choice not to provide in the case of an unplanned pregnancy (Catherine), not to attend important health and development appointments (Rachel), and encouraging children of an inappropriate age to act as young carers to their siblings (Ester);
- Marital disharmony, for example, domestic violence (Julie);
- Social support, for example, absence of support from other family members or friends (Linda, Julie, Ester, Dianne).

Intergenerational concerns were also the focus of the universal services because there was the potential that the "cycle of limited parenting capacity will continue though the generations" (Ester, P 40). Poor attendance at antenatal clinics was perceived as "a pattern established by her mother, who rarely attended school events, parents' events or medical assessments" (Rachel, P11). Poor school attendance was one need where either intergenerational or familial traits are found. In the case of Miss C it was implied that it was not surprising to find multiple unmet needs among her children as "new socialisation experiences and education...she

hasn't had that in her own parenting" (Ester, P38). Mrs F also failed to send her children to school regularly. What both these mothers have in common was larger than average families, poor housing and a lack of social support. Perhaps not wanting "to discuss asking family or friends for more practical support" (Ester, P33) may be indicative of a family pattern that does not involve others (Egeland 1991; Polansky 1982). On the other hand, the young mother may have come to the conclusion that to ask would be futile as her "mother is more interested in "Come Dancing" than helping her daughter meet her grandchildren's needs" (Ester, P38) as Coohey (1995) found of neglecting maternal mothers. Conversely, Sue who has learning disabilities and for whom one incident was recorded of her not sending the children to school, was fortunate to have "a twin sister and 4 other siblings all of whom were reported to have a great deal to do with each other" (P5). This level of social support may have been sufficient to sustain the mother at a level of coping that was not a concern to the "differing professionals supporting and assessing this family's needs" (P54), other than the health visitor. Delayed educational progress was explained for the 16 year old with autism, but it is not clear whether the delayed educational development of the 17 year old, the 13 year old or the 9 year old were due to learning disability or poor school attendance.

From the maternal grandmother's perspective there was certainly some expectation of a continuity of family values. These were evident in the frustration of one maternal mother when her daughter does not conform to accepted family values. Catherine tells of the maternal mother who recognises her daughter "would be unable to cope", wanting her "to have an abortion" and wishing she would "come off drugs completely to set up a stable home for [the children]" (P20). Accepting responsibility rather than stability was more pressing for the maternal mother in Rachel's narrative. The maternal mother thought her daughter "was taking more and more advantage of her 'babysitting' services" (P50) and spending more and more time with her boyfriend and frequently spent the night away (P52). Expecting her daughter to accept responsibility was tinged with sympathy for the single mother's needs for companionship having "friends to see, and now a new boyfriend" (Rachel, P 34). Being burdened by taking on the added responsibility was expressed about the time the baby was 18 months old, but 18 months later the maternal mother was suffering depression and hypertension. The young mother's response was to blame her mother for "taking over with {the toddler}" (P52) but the health visitor foresaw

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a time when the young mother would "move out, then [she], would have to learn to take responsibility for the [baby's] care" (P36).

6.3.2 Promotion actions

Whether human needs or generational or intergenerational concerns it was the promotion of children's needs that dominated the work of health visitors. Promotional actions for health visitors were continuity in assessment and support, advice and guidance to increase parents' capacity to provide. Action was the operative word. Having identified a health need (repeated failure to attend child development checks) Catherine "checks [the child] up at home". Any concern was then usually followed through until a 'normative' stage was reached such as "slow gains punctuated by some losses" (Linda) or to a point of referral for specialist opinion as in being "shocked to see she had dropped below the 0.4th percentile...it was time to call in the expert as the baby was not gaining weight" (Linda). Both the support agent role and referral agent roles of health visiting outlined by Appleton (1996) were implicit here.

This regular reassessment of vulnerability or of children's needs was often referred to as 'monitoring' but it was far from passive. Rather "quite a while [is spent] advising re: accident prevention, suitable diet and dental hygiene" (Rachel), and much more. Dealing with a situation often necessitates talking to two or more parties. Linda discusses nutrition with both the parents and the hostel staff and "Feeling fairly reassured that I had dealt with the problem I went back to the clinic" (P14). Referral outside the close health visitor, community paediatric consultant and general practitioner relationship, for specialist care includes the developmental assessment clinic (Julie, Dianne), preschool services (Julie) and social services (Julie, Dianne, Catherine, Rachel, Linda, Sue). Declining services and referrals was respected, providing the needs were not perceived as severe (Ester).

The multidisciplinary team regularly included school, midwives, school nurses, social workers and general practitioners or community paediatric consultant (Rachel, Julie, Dianne, Sue) with mental health practitioners and drug and alcohol services where necessary (Catherine, Linda, Sue). For some participants work was in isolation because the families did not want or rejected additional services (Ester).

Participants exposed themselves to criticism from the child protection service if they opted to take action without parental consent. Julie's concern that one mother "did not appear to have the capacity for putting the children first" was later let down by the mother's none attendance to an arranged medical appointment, social services closing the case and a vulnerable woman and children left in a situation where "nobody dares to challenge them" (P30).

Regrettably, inaction was also a choice. Rachel was working alongside the midwife when they noticed "a problem with personal hygiene of both the [young mother] and her mum". Rather, than act upon their observations they decided to "not address this highly delicate matter, at the time" (P15). Approximately 18 months later the same problems were observed and still not addressed. It would seem that discussing children's personal hygiene was easier than discussing adult personal hygiene as Rachel and the school nurse demonstrate by feeling "uneasy about the general standard of hygiene and state of the furnishings. Again I didn't feel able to tackle this with [maternal grandmother]. The school nurse and I confined ourselves to discussion about the head lice and [son's] personal hygiene" (P38).

6. 4 CLARIFYING AND REVISING INTERPRETATIONS OF RISK TO CHILDREN'S HEALTH AND DEVELOPMENT.

Determining a focus for health visiting could be simply a response to parents' help seeking behaviour or intuitively determined. Parents' help seeking behaviour such as "mother would phone health visitor" (Sue) and "mother asked if we have access to warm clothing for children" (Dianne) ensures service provision for expressed needs. Then there were times when *gut feelings* told the health visitor something was wrong. She continued to support the family believing the mother and children needed support even when "visits became uncomfortable and even downright unpleasant" (Julie). This mother was described as "not wanting to be seen as a mother who could not cope". She had also been observed with a black eye and the health visitor suspected domestic violence. The unpleasantness was probably to hide the aggressive partner's actions for it was only once the mother was able to admit to experiencing domestic violence that she agreed to receiving help (Julie). Another hidden problem that was difficult to understand was the faulty water boiler

and washing machine reported by Rachel. The connection between personal hygiene and washing facilities is so obvious and yet it took years before mother or teenage daughter disclosed the problem. It is perhaps also pertinent to inquire why the health visitor, school nurses and educational social workers failed to ask about washing facilities. Could it be that washing problems are not perceived as part of health and social workers' family support, even if they have an effect on children's health and development?

Once needs or problems were identified or perceived, participants continue to clarify and revise levels of severity, until no longer necessary. "It is becoming apparent during health visiting interventions that the mother is relying heavily upon the older boy and girl to help parent the twins" (Ester, P20). Attempts to discuss and arrange additional support services through "Joint visits with educational social worker, school nurse and social services have still not encouraged the older children's attendance at school". (P33). The health visitor was not deterred, however, and gained consent to refer the older boy to young carer support services. The impetus for this was that the mother would not accept practical help from outside the family. Without some alternative source of family help these young carers could not escape the dilemma they were placed in.

Despite some families' reluctance to discuss problems some problems were made more 'visible'. Following on discussion with a responsible family member, a supportive but terminally ill maternal mother confirmed Catherine's suspicion that a mother could not cope. She was failing to attend drug and alcohol services and failing to attend the children's health checks. In additional to routine child health and nutrition advice, this mother was supported by the health visitor in relation to a re-housing request and offered abortion counselling. Unfortunately, the housing request was denied due to previous rent arrears and a series of missed abortion appointments resulted in the birth of a third child, which was promptly taken into care at birth. It was the increasing drug misuse by both parents that precipitated "at risk reports sent to the social services department" (Catherine).

The key principle of professional collaboration was demonstrated in the narratives, with references to multi-agency meetings and the provision of services. However, collaboration did not of itself achieve the desired results, as Rachel points out

"[maternal mother] had done nothing to rectify the lack of hot water and the poor state of the house in terms of cleanliness" (P62). Ester also points to failure of the joint visits to "ensure the older children's attendance at school". One reason may have been inconsistency in professional judgement. In the narrative of Rachel, the same problem of personal hygiene was interpreted with different levels of seriousness but only addressed once. When she failed to comply, she was probably frustrated to be faced with a decision to place the children's name on the child protection register. In Ester's narrative, referrals to social services had not produced any social support so it was no wonder the mother "declined all local statutory and voluntary services" (P 42).

Julie commented that, unlike social services, health visitors "proceeded not on the basis of a single incident, but on the basis of a whole series of incidents, which I felt added up to a serious level of concern". It is possible that the health visitor was aware of patterns of behaviour, that influence her interpretation of the family's response and this understanding of the family was then used to predict similar negative outcomes. To make matters worse, by balancing limitations with strengths such as "mother is very good at playing with the children when they are babies" (P) Sue conveys an air of optimism that appears less likely to have a referral accepted by social services. The 'grey area' of child neglect that Sue writes about was the crux of difficulties with multi-agency collaboration. For example, when was a 'need' not a need? Either four of the children had educational needs or they did not. Not providing adequate food and clothing is either an example of failure to provide physical needs or it is not. A house with refuse scattered throughout could either be defined as adequate housing or it could not and broken windows did or did not constitute safety needs. One child out of eight was "often ignored and not comforted" (Sue) and this was either indicative of emotional needs or it was not. Sue and the other health visitors felt strongly about the professional inconsistency, and it was an issue that requires attention

The narrative provided by Ester tells of a family with multiple problems, that would challenge any child protection team, but she was left unsupported. Ester and Catherine both found "dealing with grey area" (Ester) resulted in social services rejecting cases on the grounds of mothers' non-compliance. In Catherine's narrative the "social worker closed the case as [mother] did not keep appointments".

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However, the burden of supporting families became even greater when team members expressed personal opinions about others e.g. that the health visitors "should not impose middle-class judgemental views [upon mother]" (Sue).

Evidently, some means of defining children's needs as potentially harmful was essential, and, when faced with this dilemma two participants adopted a more objective assessment of parenting. The Graded Care Profile (GCP) (Srivastava & Polnay 1997) was used by Rachel and Julie to substantiate their judgement that social service intervention was necessary. In both cases the GCP showed areas of care concern. In Rachel's case the GCP revealed a faulty boiler and washing machine that contributed to the initial personal hygiene problems of one child. The grading of parental care in this way was effective in that it gained social services' attention. Unfortunately, once the need was agreed the objective measures were interpreted by social services as "the child protection route" (Rachel) and the criteria for compulsory intervention. In Julie's case, a more preventative approach was put forward but without success and as Julie writes "this does not seem to be in the spirit of children in need".

What appears to be emerging from these narratives is that there is enormous scope for identifying opportunities for health and identifying unmet needs of children, but there are few avenues to 'challenge disabling barriers', an aim highlighted by the National Assembly for Wales (2000). In reality, it appears that the only avenue open to health visitors is agencies that advocate child protection but then arbitrarily deny service provision because the families do not meet a spurious criterion for child-in-need referral. What eventually activated service provision, for four of the seven families, was physical abuse, as Ester, Linda, Julie, and Dianne found. For Sue it was the death of a baby. This supports Nye and colleagues' (1994) finding that physical injuries followed children with unmet needs concerns (child neglect). The child protection services that aim to provide for children in need would appear to have a mismatch of contemporary roles and responsibilities that do not always conform to meeting children's needs. Conversely, health visitors worked towards meeting children's needs and preventing impairment to health and development but social workers appeared from these narratives to be acting on evidence of harm or the likelihood of harm that clearly met child protection criterion (Aldgate & Tunstill 2000) – a reactionary, rather than proactive approach.

If the more clearly defined children in need categories (DOH 2003: 1) developed for the biannual census of children's cases to "indicate the main reasons why [social] services are being provided" was implemented as a general guide to need classification, no statutory or voluntary service should be in any doubt about the criteria for services. All the narratives at some time, if not most of the time, would fit neatly into one of the Department of Health 'need codes' (Appendix 13).

According to the children in need categories above, all seven narratives could be coded appropriately. Catherine and Sue's narratives, for example, equate with code N3 for parental illness or disability. Disability of the child (N2) is the focus of Rachel's narrative. On the other hand, Ester, Julie, and Dianne focus on family dysfunction (N5) whilst Linda identifies a family in acute stress (N4). At other times the need when poor personal hygiene affects a child's social development (Rachel), lack of supervision placed a child in danger (Catherine) and bite marks constituted physical injury (Dianne) the code N1 or child abuse and neglect applied. In effect, the 'need' codes might change according to families' ability to cope, why coping is impaired or an acute or chronic crisis but at least one code applied.

Attempting to organise services around the children with multiple risk factors was what these health visitors had tended to do but integration across agencies was not achieved (DOH 2003b). Then again, risk was defined as unmet needs and the likely impaired health and development as the language used in the narratives supports. The word 'risk' was used by only one health visitor and this was in the context of 'at risk' reports and not to indicate parental risk behaviour such as substance misuse or domestic violence as a risk. The preferred language was 'needs' used by all the participants in relation to either the provision of 'help' or 'care'.

6.5 DETERMINING A THRESHOLD FOR PROTECTIVE ACTION

'Protection' was also a word used by all the participants but with three different meanings. First it was the reference to the procedures for protection, e.g. police or emergency protection and interim care orders and case conferences. The second was as a threshold for accessing additional family support. Rachel states her regret at having "no option at this point to go down the child protection route" (Rachel, P54)

and sadness that "Six months prior to the baby's death I referred the family to the team manager for the child protection team, asking for an assessment. The manager tried to hand this back, stating that there was already a social worker involved" (Sue, P60). As a result of battling to draw attention to family plights participants experienced an emotional burden that was the third meaning of protection that was the 'grey area'. Participants observed as part of health screening measures multiple unmet needs with a combination of parental difficulties or environmental vulnerability but these cases did not conform to social services criteria for child protection (Julie). It was the indivisible children in need and child protection threshold that was divisible only when there was a consensus that child abuse and neglect had occurred. Different levels of severity of need were being displayed but perhaps it was the 'at risk' perception that was not shared by agencies.

As Dianne tells, in her narrative, "parents did not receive any positive input from social service until...a child protection issue" developed. When this stage was reached health visitors were not only persuasive by using "the Graded Care Profile to assess the family" (Rachel, P56) but also complicit in "reinforcing the message" (Sue, P 79). Catherine was complicit in child protection decisions when she suggested an emergency protection order after believing a mother might snatch her child from hospital following the cessation of a police protection order. Likewise, Rachel comments that a mother was "taking no steps to replace the boiler or make alternative arrangements for hot water". Interpreting the impact on the disabled child as a social need, with the child "being ostracised at school", both the mother and her daughter were threatened with removal of their children (Rachel).

However, the meaning of 'protection' was ambiguous. In Linda's narrative, registration was synonymous with protection and deregistration with parents' "co-operating with social services". From Dianne's perspective, protection meant legal proceedings whilst for Julie, Linda and Sue, it meant registration with multiple services to provide an early warnings system. Maintaining the family unit was important to Sue and yet what influenced decisions adversely was parents, particularly fathers, who were "verbally abusive". For example, Sue reveals that a second visit to accident and emergency for a second injury in two months with an accompanying brother with bruises to the head found nurses, one doctor and health visitor very concerned. The senior doctor, a registrar, however, was not unduly

concerned, so consequently, no action was taken. The father complained to social services about the process once concerns were raised, who responded by "apologising profusely to the family for any inconvenience caused and they tried to ensure that should the family have to attend casualty again, they would not be put through such an experience". This meant that future judgements about injuries would effectively be preordained as accidental. In trying to explain this behaviour, Julie is of the opinion that "parents' verbal aggression affects our behaviour towards them" and children can be lost in our professional dealings with aggressive people.

Consequently, these narratives illustrate the lack of homogenous criteria for children in need services and definition of protection. The participants were 'promoting' health and development opportunities for positive health, and challenging the perceived barriers to prevent impaired health and development in later years. Social workers appear, from these participants experiences, to aim to prevent re-occurrence of 'significant harm' rather than actively prevent it occurring in the first place. Applying the Department of Health (2003) 'need' codes (Appendix 15) it becomes clearer why these different perceptions occur. The guidance to inclusion in Abuse and Neglect 'need' code refers to children whose names are on the child protection register, where there is either "Evidence of possible neglect or abuse" (p6), or situations that have triggered section 47 inquiries (Children Act 1989) such as domestic violence, prostitution, abuse of other children or abandonment. Needs within the participants narratives depict care that "is impaired by disability, illness, mental illness or addiction" (N3 – Parental illness/disability); where "parenting capacity is diminished" (N4 – Family in Acute Stress); or "parenting capacity is chronically inadequate" (N5 – Family dysfunction). The participants were right to request children in need assessment but perhaps not for child abuse or neglect. Similarly, social services may have been right not to accept a referral for child protection but mistaken in not accepting the referrals for children in need assessment. By utilising the 'need' codes to create a shared criterion for children in need it is possible for a more integrated system to be develop rather than the tension creating, emotionally charged ambiguities that currently exist.

6. 6 INTERESTS AND INEQUALITIES

Although children's needs have been identified as the primary interest for health visitors the process of analysis has to this point embraced a system perspective. That is, there are singular discipline roles, instructional processes and integrated actions that constitute the professional guidance and legislative system for safeguarding children from impairment and harm. Another understanding of the work of health visitors is their attempt, or not, to reach out to children's and their families' worlds to increase their understanding of the family life. Habermas (1981) calls this the lifeworld and links the ability to engage with people's objective, social and subjective worlds as "a cooperative process of interpretation" (p120). It is with the process of communication in mind that a second process of analysis was undertaken. This second process of narrative analysis aims to answer the research questions, what interests or inequalities are reflected in participants work with families and why might inequalities result? The following results first explain the emerging themes from the narratives that are themselves both interests and inequalities. This will be followed by the exploration of why the inequalities might result.

Three communication themes emerge from the narratives. They are (1) normative rhetoric (2) rhetorical persuasion, and (3) coercive rhetoric. A positive meaning of rhetoric as the descriptive use of language that is "pragmatic...its functions ultimately to produce action or change" (Bitzer 1968) is applied rather than the populist understanding of rhetoric as "pejorative, empty verbiage or propaganda" (Hill 2002). Dividing rhetoric into three types further incorporates Habermas's (1990) distinction between strategic action and communicative action. I briefly digress, here, in order to link the rhetorical styles to Habermas's critical theory. Strategic action aims to influence the behaviour of others by means of threat or as a catalyst to the desired outcome whereas communicative action "seeks *rationally* to *motivate* another by relying on the illocutionary binding/bonding effect" (Habermas 1990: 58). Habermas's (1981) explanation and strategic action are similar to coercive rhetoric. He explains communicative action as either normative or persuasive rhetoric. Normative rhetoric is synonymous with the conscious meanings and knowledge of communicators. Rhetorical persuasion is an attempt to make conscious, unconscious meanings to reach a mutual understanding.

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As interests, the rhetorical styles imply a means to an end or intentionality to the work. Inequality may lie within the selection of the type of communication used for the purpose intended. Normative rhetoric is language used towards normative ends. It is the economical short-cut to providing information that is used in response to either a request for information (advice, instruction or direction); or given in the hope that it proves useful, or as a matter of course because it is part of the strategic action directive of professional guidelines. Rhetorical persuasion is the language used towards reaching an understanding. It is the aforementioned establishment of a relationship between professionals and family members but one that aims to reach a true understanding of the health needs of the family. Mayhew (1997; 21) suggests rhetorical persuasion requires "participants to engage in sincere, two-sided exchanges and to accept good arguments as grounds for decisions". Coercive rhetoric aims to achieving conformity. It is the language of force used to elicit compliance in situations deemed dangerous or hazardous to children and their families.

To return to the analysis of the narratives, it is easy to draw critical inference with the benefit of hindsight. Unlike the participants who took part in this study, I do not have the interference from workload pressures, guideline constraints, the juggling of multiple needs or concerns. Neither am I faced with uncomfortable family contexts that are more intuitive than explainable (but no less anxiety provoking). Analysis of the narratives attempts to engage with a truth about the social reality of the narratives from both the professional and family perspective. Using a critical theory approach it is inevitable that some level of criticism will result, but any criticism is by no means aimed at the health visitors who bravely exposed their work to the scrutiny of a researcher. Although having health visiting experience I must attempt to be relatively selective about what I interpret from the narratives so they give a rationale for change that might eventually improve the promotion of children and their families' health and improve health visiting practice. Any criticism is directed foremost to those with responsibility for the organisational structures within which health visiting takes place and the unrealistic expectations made of them in relation to social problems. By voluntarily taking part in this study these seven participants have demonstrated a courageous streak of curiosity about what another might think about their work and demonstrate the value they place on reflecting on their professional practice. Most importantly they offer their work as examples of good

health visiting practice given the ambiguities they often have to contend with (Cowley & Appleton 2003).

6. 7 NORMATIVE RHETORIC

Within the narratives there is evidence of one-sided approaches such as advice, direction, education, monitoring and expressing concern. Rachel "suggested...semi-skimmed milk and encourage her to walk" (P44). Linda "explained the importance of enough calcium, fruit and vegetables in the diet" and seems to accept, in actions at least, the mother's view that the hostel failed to provide proper food by "discuss[ing] the supply of food with the manager" (P14). An educational approach was implicit in the "step by step...management of head lice, its initial treatment and how to keep looking out for it" (Rachel, P 46). Monitoring was expected of Julie as described below and Catherine mentions many 'at risk' reports to social services without any reference to consent being sought or given or debate about problems.

Normative rhetoric is formed by 'situation definitions' (Habermas 1981: 121) determined by the perceived status of the actors. A consensus is not necessarily reached, as a truth of what is spoken also requires 'sincerity of the speaker' (p121). This is true whether the communication is with parents or other workers. For the message to be received a shared knowledge is necessary. For example, Dianne "liaised with school nurse who also had concerns about children" (P23) and "a joint visit was done...with the named social worker" (P29). Here three workers concur with their relevant co-workers about children or family needs. Julie refers a maternal mother to her GP. One can assume the referral was acceptable because the maternal mother was in agreement and attends the surgery. Just as it was in reaching a shared knowledge of one situation when Linda "had to explain to mum that "I had to get a doctor to see the baby and call the social worker" (P24). Likewise Catherine (P18) shares her knowledge with others as she recalls "at risk reports were sent to the social service department by the police".

However, to assume a consensus about all needs would be erroneous, as this sharing of information sometimes depicted a difference of opinion or lack of sincerity of the part of one or other actor. A difference of opinion was implicit in the rejection by

parents of themselves and their children having unmet needs as perceived by the health visitor and other agencies refusing health visitors and the family's request for additional family support. Participants' narratives demonstrate sincerity about meeting children's needs but some parents and other workers may not be as sincere. Julie's narrative exemplifies this. Growing concerns had followed attempts to establish mutual "trust and honesty developing between [health visitor] and the mother" (Julie, P4) but to no avail; initial acceptance "for [child with 60% burns] to be referred to assessment clinic" (P6) and then no attendance; discussion of mother "stressed and had her own physical problems" (P8) but unable to follow up due to numerous non-access visits; and offered "proactive family support" that was rejected, (P 12) left Julie with little option but to seek help from the multi-agency team. She requested a multi-agency meeting that gave some relief at having the opportunity to discuss the family with a wider network of potential family supporters. The help she might have expected was not forthcoming and there was a distinct sense of disapproval, more at the lack of parental consent than what might have been interpreted as an inappropriate referral. Instead, even after acknowledging the children were 'in need' no social work involvement was planned because the treatment options were considered to be of a health service nature. There were sufficient observations to indicate a need for services but a letter conveying parental responsibility was not what Julie had in mind.

Perhaps the lesson to be learnt from such an experience was for health visitors to have a clear understanding of the boundaries for their work and those of social services in cases deemed as children in need (including significant harm, child abuse and neglect and looked after children). Social services have the key case management role and any perceived 'at risk' or 'likely to be at risk' must be reported to them, as all the narratives attempted to do. When differentiating between significant harm and child abuse and neglect. Adcock and White (1998: 35) view 'significant harm' as *effects* and 'child abuse or neglect' as *acts* or *omissions*. As Reder and Duncan (2003: 90) explain messages must contain the meaning that is intended because in Julie's narrative "emotional impact may make parts of the message harder to hear".

The difference between informing and activating a service probably lies in the message that stipulates and justifies a perceived appropriate category of child in

need. For example, Dianne made a referral for children in need, and proceeded to visit the family home "in December with a named social worker" (P29). Also "A joint visit was made with educational social worker" (P31) but Dianne is of the opinion that the "parents did not receive any positive input from SS until April and this was after a child protection issue" (P35). At the visit in April behaviour management was seemingly the related problem. School attendance was the problem jointly tackled with the educational social worker. From a social service perspective it is easy to see how one might interpret an appropriate services was provided. The positive involvement following a child protection issue was foster care. Health, school attendance, soiling, speech, behaviour problems are receiving attention or had improved but the family had broken down. A sad indictment was the final sentence that states "it is hoped that one day mum can improve her parenting skills sufficiently to be able to care for her children" (Dianne, P56). The oldest child was 6 years old. The question must be asked about families where improvements are not forthcoming 'How long can the needs of children be addressed by advice without recourse to a change of intervention?'

Emancipatory interests associated with the normative rhetoric were more about mutual involvement when necessary. When introducing herself Linda (P10) tells the homeless, drug taking parents "about what service [she] provided...and where [she] could be contacted". This interaction could be interpreted as respecting parents' responsibility for their children and their right to seek help when necessary as she had "learnt it does not do to judge too quickly [but] give them the benefit of the doubt" (P8). Advice was a typical example of normative rhetoric rather than a persuasive rhetoric. Rachel's narrative tells of her advising a young mother and her maternal mother about many health issues over many different chronological periods of the new baby's life. Even though she "didn't feel that J was very committed to following my advice" (Rachel, P27) a deeper understanding of the presenting need was not elicited. This was because the overriding concern about the neglect of personal hygiene was not discussed in any depth, nor was there exploration of related issues such as support and washing facilities.

Another interpretation may suggest a counselling approach through the "Listening visits". However, it is difficult to accept a counselling approach because the narrative as a whole gives the impression of the health visitor and lay person talking

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about problems rather than sharing values and meanings to reach a true understanding of the family's plight. Both the faulty boiler and the 'exercise by invitation' support this idea of communication style. The suggestion of 'exercise by invitation' was particularly insightful given that the maternal mother with depression and hypertension also had a problem with personal hygiene. This 'prescribed' membership to a sports centre is just that – prescribed. One cannot imagine this mother engaging enthusiastically with the health promotion scheme when she has been reluctant to engage socially with other activities at school or child health clinic.

As most parents provide good enough parenting this normative rhetoric level of communication may be sufficient for the majority of health visitors' clients. The sense or depth of engagement depends upon the need identified, but between health visitors and family members a cooperative and conforming relationship was ostensibly optional. When agencies referred to other agencies there was an expectation that recognised needs would be addressed. This was exemplified by Rachel's disappointment and feelings of frustration and isolation as a result of social service reluctance to accept her referral. Similarly, Rachel explains "I didn't feel able to tackle this" (P38) personal hygiene need referred to her by a special school. In Rachel's case, to communicate personal hygiene is "highly delicate" (P15). She and the school nurse adopt covert advice and health educational approaches about recurring infestation of head lice through teaching "step by step... management of head lice, its initial treatment and how to keep looking out for it" (Rachel, P46). Some success is assumed as "for several months [he] was free of head lice. His personal hygiene has improved slightly" (P46) but the problem repeatedly returns. Overall, normative rhetoric may prove frustrating if the advice given is not taken but it is at least emotionally safe.

6. 8 RHETORICAL PERSUASION

Conversely, rhetorical persuasion is emotional sharing with the aim of emancipation. Steps towards emancipation consist of accessing meanings, coming to an understanding and encouraging reflection. Highly charged emotional involvement that is sad enough that Linda (P24) "cried her eyes out" comes with

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rhetorical persuasion that equates with the commitment to emotional sharing observed by Cowley (1995). Engaging with complex problems certainly took its toll, with participants "getting mentally exhausting" (Linda, P24). It may have come from having a difference of opinion to "Mum feel[ing] that there is no problem" (Ester, P22) and with other professionals' "attitude and their inability to recognise there was a problem" (Linda, P24). The key, for Dianne (P27) was "I managed to persuade mum and dad that a referral to social services as a family in need would get them better housing and also help to get a fulltime nursery place for 3 and 2 year olds".

Persuasion also involves sharing meanings and opinions that are dependent upon reciprocal communication but when a parent "offered no opinion about my advice and seemed totally disinterested" enabling parents to meet children's needs may be complicated. As this father's attitude was partly due to drug taking (Linda, P10), advice about children's normative needs might be all that could be achieved at that early stage of involvement with the family. Julie's observation of normative needs, such as safety concerns, could be perceived as seeking understanding but because the mother "resented" her involvement (P10) a reciprocal, trusting relationship did not exist. Thereby, the family's objection to their family life being exposed to a health visitor was detrimental to reciprocal communication about children's needs. Intuitively, health visitors may also sense reluctance and act accordingly. Rachel was successful in temporarily improving recurrence of head lice. She did not hesitate to engage with needs related to obesity, hypertension, depression and poor housing conditions but did not engage with maternal mother's personal hygiene. She may have intuitively decided it inappropriate at the time, or as with the burden of child care responsibility "felt [she] couldn't interfere with this arrangement" (Rachel, P36).

What can be most beneficial to a good working relationship between health visitors and families is home visiting at a time of stress, especially to reaching an understanding. Once domestic violence had been disclosed engaging with mother to express wanting to help ease her burden of childcare was possible but mother doesn't want the interference (Julie). Despite not wanting help, the interaction created an opportunity to reach an understanding about where a mother's responsibility lay. Mother states she "wanted her relationship with her violent

partner to work and did not appear to have the capacity for putting the children first" (Julie, P12). At the very least, and from a cognitive behavioural perspective, mother's *negative automatic, involuntary thoughts* (NATS) were being accessed. This was an opportunity to encourage mother to reflect on these thoughts without stigmatisation. Persuasion will be easier to achieve if the mother had come to the realisation of her competing responsibilities herself with a little help from her friendly health visitor.

This was an attempt to achieve emancipation through self-reflection. The goal of emancipation "aimed at liberating human being from relations of force, unconscious constraints and dependence on hypostatised power" (Dew 1999: 57) was beginning to be achieved. For Habermas any communication used to explore (e.g. family life) cannot be "confined to the limits of technical control" (Held 1980). This Julie implies with her selection of persistent, persuasiveness in that she "tried many ways of exploring help for her" (Julie, P24). The eventual capitulation to communicate probably followed Habermas's basic values of communication; (1) comprehension that another can understand; (2) communicating truth to enable the sharing of knowledge; (3) truthful expression of intentions; and (4) the selection of rhetoric that was right for the interactive context in order to reach an agreement" (West 1996: 76) that "her partner, who was very controlling, would not allow anyone in the house" (P24). It was likely Julie's, comprehensiveness, truthfulness, and trusted intention of genuine concern about "the difficulties the family would have in getting out of the house with so many immobile children" (P28) that helped change the mother's mind about accepting help.

This level of persuasion was not an easy option. However, the liberation was set among moral imperatives similar to the one Julie presents above; father or children. Sue found "Every visit is time consuming, emotionally challenging but usually positive and enjoyable" (Sue, P92). Sue's "communication with the mother and the children has been crucial" (P88) and along with the social worker successfully involving the father in decisions though "progress is slow [it] is happening" (P127). Slow or not the progress was remarkable. Hence, change that stems from persuasive rhetoric may have a more lasting effect. In Sue's narrative the improvements went beyond the children's developmental needs. A better quality of life was implied. "There is a warm homely atmosphere now, with attention being paid to the main

social room. There are family photographs, trinkets and during the Christmas period, a significant effort had been made to create a child friendly seasonal home" (Sue, P105-106). This contrasted markedly from the early descriptions of a house "having deteriorated into a state of repair" (P35), where there are "No toiletries, toys, trinkets or personal belongings" (P37). Yes, one might ascribe time, children growing up and other factors but I support this proposition with the evidence that Sue, working mainly alone until recently had made a particularly physically helping and emotional challenging contribution to this family.

One contentious issue with persuasive rhetoric is that reaching an understanding can be detrimental to a family's sense of autonomy. For example, when an understanding is reached about a build up of family problems and children's needs that fall within the categories of children in need and child protection, health visitors were, and continue to be, obliged to refer the family to social services. On the other hand, health visitors may fail to apply a persuasive rhetorical approach in referral or they may be ill-prepared to grasp the increased responsibility given them to "lead public health practice and agree local health plans" (DOH 2001: 7). Persuasive rhetoric is to apply justification for referral with the opportunity for debate as the health visitors who applied the assessment of neglect using Graded Care Profile did. They were able to score with parents the areas of concern in order to make explicit to social services the low standard of parental care given that cannot be ignored because of the negative impact on children's health and development. Unfortunately a level of coercion was applied in these cases.

From the perspective of the 'new role for health visitors' (DOH 2001: 8) it seems the government has omitted to provide a parental code (Henricson 2003) whereby the moral imperatives attached to parenting are made explicit. It has also omitted to increase awareness of parents that there is an expectation placed on health visitors to "Deliver child health programmes and work in partnership with families to develop and agree tailored health plans to address their parenting and health needs" (DOH 2001: 8). Little is made of families' right to privacy and thus a right to disengage from the service. In terms of health visiting and family support the moral imperative includes children's rights and needs and parents' responsibility to provide for these. Habermas (1990: 63) drawing on the philosophy of Kant suggests "moral norms must be suitable for expression as 'universal laws'. Children's rights

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and needs are now universal laws. The "elimination as invalid all those norms that contradict this requirement" (Habermas 1999: 63-64) is what the work of health visitors must find suitable expression for. That expression is likely to be rhetorical persuasion.

All the narratives involved the effective parenting interventions, but parenting programmes, advocated by the Department of Health (2001) were rejected or ceased. Parenting programmes would have been available to families if they had accepted community services such as SureStart. Then again, traditional health visiting of "notably listening in a non-directive and non-authoritarian way and giving advice appropriate to a family's circumstances" (Elkan et al 2000: 227) may not be sufficient for some families. The enhanced responsibility of supporting families is not a straightforward one. "Vulnerable or priority groups identified by the community health needs assessment" (DOH 2001: 21), as well as those families within their caseload giving cause for concern, may benefit from not just persuasion for help but persuasion to self-reflect on the nature of their reality. Crittenden (1999) draws attention to the discrepancy between workers' focus for intervention and the nature of reality for some families. Routine interventions, he claims, centre around predicted consequences of behaviour but the disorganised families organise their behaviour effectively. Sue has identified this same tendency in the mother who "expresses anger easily" (P51) and she has "found it essential that [she is] sensitive to the mother's emotional feelings during a particular contact" (P90).

Given the overwhelming failure of services to address children's needs or prevent neglect and abuse in four of the narratives and that the three intact families prefer the health visitor as the main worker (Outlined in table 6.3), it could be concluded that involvement of social services precipitates family break down. Conversely, family break down may be the only way of meeting some children's needs. If health visitors are to be expected to take a lead in family support, persuasive rhetoric and new knowledge and skills will be required to more effectively work with families with a complex set of problems. Where families refuse attendance to community services, an alternative would be home parenting programmes: but neither this nor behavioural approaches as advocated by Hutchins and Nash (1996) were illustrated in the narratives

Narrative	Outcome
Catherine	children placed for adoption
Rachel	family break down and new family arrangements
Ester	intact with continued concerns (HV main worker)
Linda	father left the family, mother and children still in homeless unit
Julie	intact with continued concerns (HV main worker)
Dianne	family break down, children in foster care
Sue	intact with continued concerns (HV main worker)

Table 6.1: Narrative outcomes

6. 9 COERCIVE RHETORIC

Without changes to health visiting practice there will be a reliance on coercive rhetoric that places expectation on others. When defined as a family with children in need the coercive rhetoric applies force in expectation of improvements, or conformity, or punishment where deserved. The relationship between the three communication styles can be interpreted from many of these narratives. Often normative rhetoric and persuasive rhetoric had been attempted and rejected. The only course of action seemingly left open to the health visitors in these circumstances was coercive rhetoric that requires social service involvement. The intention may be genuine concern for children and their families but families' understanding or previous experience of out-dated social services may not coincide. Unfortunately for Sue, social services were not concerned with the enormity of the effort she had exhausted in order to engage this family with health needs. Without improvements to children's health or development, parenting capacity or environments such as housing, a point was required help to exhort some pressure on the parents to change. One expectation of coercive rhetoric is compliance where parents "had to co-operate with all agencies, otherwise it would go to case conference" (Catherine, P14). The threats were not idle. Given sufficient

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provocation non-compliance led to compulsory or voluntary family breakdown. Rachel described how non-compliance led to foster care and new family arrangements for the 9 year old with his father and his partner.

Sometime actual involvement may not be required. Just placing children's names on the child protection register was, seemingly, expected to concentrate parents' actions towards their children, as a treatment plan was mandatory (Linda). This certainly appeared to concentrate parents' minds "to co-operating with social services" (Linda, P28). Referral to health care workers may have had little effect on some families as Linda found when the family avoided seeing a community paediatrician when the baby's weight had fallen to a very low level. Such continued scrutiny was detrimental to continued involvement with the family "When the family decided to leave the hostel with no fixed abode arranged" (P20). Further involvement of a social worker facilitated discussion about safe practices when drug taking and the baby's weight improved.

Social work involvement need not be coercive but someone who "has not given in" but speaks "simply and directly, reinforcing previous messages. The social worker "has been open and honest" (Sue, P 75). Perhaps what was being implied here was someone like the health visitor, whose involvement will be over a long period of time rather than the "four social worker changes before we saw any progress" (P72). This same longevity concern that leads to coercive approaches may reflect the emotional burden of working with families over many years. Progress may be an unrealistic expectation of families and only slow progress is achievable, as Sue found.

Punishment was also an expectation of coercive rhetoric. Linda expects punishment for an injury that causes marked bruising down the baby's face but the "father was not charged" even though he "had been looking after the child at the time" and the consultant paediatrician said it was non-accidental. The dangers of child care by a drug taking couple was becoming too much for Linda and alternative care, such as foster care was viewed as an option to solve the problem for the baby and her. Coercive rhetoric and actions are the last attempt to change what normative values and persuasion could not. Time, effort, money and anxiety had been spent over weeks (Linda) and between 3 and 8 years approximately (Catherine, Rachel, Ester,

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Julie, Dianne and Sue). The longevity of family support seemingly had little bearing on the outcome. However, family break down was more common among the persistent offenders of neglectful behaviour towards children's needs, when social services were involved.

6. 10 INEQUALITY IN THE POWER-RELATIONSHIP

Why any inequality of service happens is thought to be due to three aspects of the work of health visitors. They are (1) the power-relationship between health visitors and parents, (2) the selection of an appropriate rhetoric style for the kind of family support perceived and (3) the lack of advancement in strategies to engage with problem-solving. The power-relationship was between the health visitor (an authoritative figure) and families but more importantly, one that was often without an agreed common goal. Inherently there was a common goal. Health visitors aim to promote the health of all children and their families and challenge, where necessary barriers to this promotion (NAFW 2000). According to the National Family and Parenting Institute (2003: 2) parents are charged with the responsibility for "children's well being, looking after children, feeding and clothing them, making decisions about their schooling, deciding whether to consent to medical treatment, representing then in legal proceedings and making decisions about where to live". Unfortunately, debate to agree a common goal and a strategy to achieving the goal was not demonstrated in the narratives.

This relationship was affected by an increased rise in public health interventions (e.g. immunisations) with the desire to prevent difficulties occurring and the inclusion of parents in a perceived "new democratic relationship" (Moorman & Ball 2001: 5). The result was an increased intrusiveness in the private matters of families that is not endorsed "unless something goes seriously askew". The corollary of this was greater exposure to families with insight into their children's needs (some of whom may actively seek support or who are passively accepting of services), but less access to 'unhealthy families' (Olson et al 1979). In relation to child neglect, disorganised families (inconsistent parenting) and depressed neglect families (passive parents who do not understand their children's needs) were more accepting of health visiting support. Emotional neglect families (who are unable to share

feelings with others) were less accepting of health visiting support. Inclusion of parents necessitates parents knowing there is an expectation they will be involved. One way might be a shared statement when becoming parents that includes the moral imperatives to parenting and family support services - much like the one presented in the 'The Family Health Maze' under parent's rights and responsibilities (Page & Keep 2003: 1). The moral imperatives of parental responsibilities to provide adequate provision, participation and protection (children's rights) and their responsibility to seek help when these are not met.

For their part, health visitors and other "professionals must provide a structured, predictable environment with no surprises" (Crittenden 1999: 56). Crittenden includes dealing with feelings and especially reassuring mothers of their indispensable position within the family as well as maintaining an effective relationship for some time after the family have gained competencies. Concentration of mother's need for help or persuading families to accept community services may be undertaken too early, in that they undermine feelings of self-worth before establishing a shared goal complimentary to mother's abilities. In a similar vein, achieving competencies will need time to establish and become more commonplace before services are terminated. In terms of structured interventions there is a plethora of parenting programmes (Barlow et al 2003; Barrett 2003), none of which were mentioned in the narratives by name or theory. If health visitors fail to make clear the intentions of their work they can expect nothing less of parents' contribution.

6. 11 INEQUALITY IN THE USE OF APPROPRIATE RHETORIC

Varieties of interventions are required for the numerous problems that presented. Using the appropriate communicative style was associated above with different intentions. The more superficial rhetorical engagement was for normative needs. For the more complex family persuasive rhetoric was preferred and when all else has failed coercive rhetoric was the only course of action. However, there is an inherent danger of oppression among those children and their parents with low self-esteem who will view these communication styles as threatening, potentially destructive or antecedents to negative self-perception (Brendgen 2002). The

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difficulties of working with emotional sensitivities and the need for preparation to engage can be seen in Ester's narrative when she is "trying to get parents to identify all their children's unmet needs if they haven't had their own needs met by their parents as children" (P40).

All too often the blame, if perceived as such, was directed at mothers rather than fathers as they are given less attention in the narratives. For example, Dianne was aware of the responsibility of one father for domestic violence and suspected child physical abuse but nowhere was he expected to account for his behaviour. A normative rhetoric was most likely to be used with fathers. On the other hand, mother was expected to accept family support even when there were comprehensible reasons why she might not want interference in her family life. The family context was one that conjures up an image of a violent, hostage-like environment where, not surprisingly children have behaviour problems, poor school attendance and there were concerns about their childcare. It is not unusual for mothers in these circumstances to begin to experience themselves as victims (Dale 2004).

As with most interventions for victims a therapeutic approach is appreciated. In Dale's (2004: 148) interviews with parents to elicit their perceptions of child protection services, he found one mother who valued the opportunity to "download some of the junk". Another mother found a parenting course helpful whereas six families wanted a persuasive rhetorical style of intervention. They "need somebody to **understand** what [they] are going through" (p149). The emotional content over many years that health visitors allude was also a feature of these families' experiences that took "many years to get to this stage" (p149) to seek help. These are calls for rhetorical persuasion that "appeals to social norms, on ties of solidarity and on the cultural strengths of eloquence" (Mayhew 1997: 17).

6. 12 UNEQUAL FOCUS ON PROBLEMS

Of appeals to social norms Mayhew means that communicative messages are not left to "institution and creativity" (p 18) but tap into a body of parent knowledge that could support effective responses to the social problems experienced. It is not

simply the "practice or life versus the practice of research" (Habermas 1968: 369). Rather, a merging of subjective experiences with a trialling of practices that is research-based. For example, home visiting and traditional health visiting is synonymous. Research findings are inconsistent about the contribution of home visiting to the reduction of child neglect and abuse. Barratt (2003) suggests the high rate of identification is due possibly to surveillance bias, in that health visitors monitor vulnerable families more closely. This was certainly the case with all seven narratives. Vulnerability emerged as poverty among the large families, (Ester, Julie and Dianne) poor hygiene and housing conditions (Rachel, Sue and Dianne), drug taking (Catherine and Linda) and health problems (Sue).

Conversely, from a review of domiciliary health visiting, Elkan and colleagues highlight the limitation in using outcome measures, as suspected or potential neglect (as the narratives demonstrate) are a very different group. They continue to suggest that improvements achieved in the mother-child relationship may alter the risk of neglect and abuse (Elkan et al 2000). How that is achieved in the narratives remains unclear, other than by discussing needs and problems. The universal service of health visiting need not be a uniform service (Elkan 2000) but the narratives imply uniformity by virtue of the services offered. All the narratives relay intensive health visiting that was much the same as traditional health visiting, rather than a point at which an evaluation determines the necessity to change direction and offer and provide a more specific, additional, goal oriented structure of interventions. There are many effective programmes that can be implemented and, for the families who are reluctant to accept services interventions might instead begin with aims to increase parents' confidence and sense of control to avoid conformity to specific parenting programmes (Smith & Pugh 1996).

Instead of presenting parenting as building upon parents' confidence, and perceived abilities, the assessment or parenting capacity in five of the seven narratives was delayed until a serious concern or an incident of significant harm was reached. Recognition of parents unable to look after their first child of 7 years and inability to cope when pregnant with a second child was not related to specific aspects of parenting skills or relationship with children. Two years later parenting capacity was objectively assessed, following the birth of a third child and ingestion of drugs by the two year old (Catherine). Assessment of the standard of parenting for Rachel

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took 4 years, approximately, whilst, "intensive help in parenting skills from Social service, SureStart project, NCH [National Children's Home] and educational social worker" follows after the birth of the fourth child and a child injury incident. In a third case, six years after the birth of the first child, the health visitor is discussing "nutrition, personal hygiene, care of children's hygiene, managing behaviour problems" (Dianne, P53). Dianne's involvement with the family was uniquely brief and responds mainly to concerns observed by others. The outcome for these families is family breakdown.

In contrast, Ester and Sue outline parenting and child development needs from the outset and stipulate "discussion about relationships, parenting difficulties and finance" (Ester, P27). Sue identified a distinct period of not coping, to the periods of coping that were followed by the death of the baby. In both narratives needs and problems were identified and "are working through" (Sue, P102). Ester's family was intact and Sue's family was rehabilitated after temporary care proceedings. Taking account of the lone mother's own needs and a mother with learning difficulties and depressed husband, Ester and Sue, respectively, offer a flexible, clear focus to their interventions. Perhaps it is time to rethink conformity to set parenting programmes that are unacceptable to some families. As the narrative families preferred home visiting to community services and health visitors to other workers of statutory agencies, home parenting programmes would appear to be a feasible starting point for families with a set of complex problems.

6. 13. CHAPTER SUMMARY

This chapter provides the two phase process of analysis of health visitors' narratives. The first elicits a four stage process to the assessment of needs. They are (1) the establishment of a relationship that facilitates an opening to the context of the family, (2) access to the context of the family, (3) clarification and revision of interpretations of risk to children's health and development, and (4) determining when a level of concern is reached that requires protective interventions, such as a build up of problems and patterns of behaviour that are barriers to appropriate change. The second phase of the analysis aimed to identify interests and inequalities and why the inequalities happen. Findings support the emergence of

three styles of rhetoric. Normative rhetoric addresses normative views of child development and parenting capacity. Rhetorical persuasion is engaged to reach an understanding about the lifeworld of the family. Coercive rhetoric aims to achieve conformity. The interests relation to the styles of communication imply inequalities in (1) the power of the health visitor and family relationship, (2) inequality in the selection of appropriate rhetoric, and (3) an unequal focus on needs and problem-solving.

CHAPTER SEVEN

HEALTH VISITING AS A PREFERRED SOURCE OF HELP FOR PARENTING AND CHILDCARE NEEDS OR PROBLEMS: STUDY THREE

7.1 INTRODUCTION

Findings from studies one and two are unquestioning of the legitimacy of health visitors as a source of support but running through both findings in chapters five and six is a sense of a reluctance of a small number of families to engage with health visitors. Logistic regression of reported adverse factors that correlated with substantiated child neglect identified *care* and *behaviour* as early predictive indicators of child neglect. Care relates to parents' inability to provide adequately to meet their children's health and developmental needs. Behaviour relates to children's behaviour that parents and others perceive as a problem. Health visitors' accounts of their work, in the narrative study, support the importance placed on parental capacity and to a lesser extent behaviour perceived as a problem. One explanation elicited from health visitors' narratives for the different levels of support required with parental care and child behaviour is the degree to which the health visitor engages with the family context of vulnerability. Given the tensions that were created for some health visitors in their attempt to engage constructively with families another explanation may be that parents are not accepting of the health visitors as helpers for certain needs or problems which they and their children experience.

This latter explanation is also based upon my brief involvement with a pilot study of Mothers of Preschool Children in North Wales (Wenger et al 1998). This study looked at the wider social support context where other sources of help and support might make a difference, other than parents/partners. Social support is viewed as a buffer against stress (Cohen & Willis 1985) that is claimed to have a positive effect on people's ability to face multiple stressors (Hobfall & Stephens 1990) and can reduce the risk of mental illness (Alloway & Beddington 1987). Wenger and colleagues findings support the view that there is a low uptake of community

services by mothers who lived in a deprived area of North Wales. Although social support was explored in terms of the women's relationship to their social support network and where professionals might not be included, it was sobering to realise that none of the women included a health visitor as a source of support. This is very different from the impression given in the narratives where a couple of health visitors are presented as sole sources of family support. Consequently, a critical review of the legitimacy of health visiting was formulated. This chapter reports the findings of this third study the 'Preferred sources of support' questionnaire.

Further good reason for undertaking this third study was evidence that teenage parents "had no confidence at all in the ability of health visitors to understand their lives" (Moorman & Ball 2001: 43). Similarly, teenage parents were "critical of health visitors when their advice did not seem to work" (Cragg et al 2002: 47). On the other hand, it was health visitors among the professionals, who were valued by most parents for their advice and emotional support (Cragg et al 2002). Also viewed positively was the flexibility of health visitors' advice and recommendations that was different for different children.

Resorting to social support from family and friends will be those parents wary of health visitors, or professionals in general. Behind the reluctance to engage with professionals is the realisation that comes with parenthood that "We cannot cope with too close a scrutiny of our shortcomings, so we shut the door to the world, his wife and the 'helpful' advice. Behind the closed door, in the private world of our family, tensions may develop. If the going gets too rough, one of us may break out and leave. The last thing we want is 'help' because now we know we are really 'in the wrong'" (Buchanan 2000: 21). However, it would seem that some 'wrongs' are more easily shared with others. Health visitors' narratives point to parents' reluctance to seek help for themselves, their relationship needs or particular behaviours, such as domestic violence and substance misuse. To test the proposition that some needs or problems are more easily shared than others a questionnaire was devised to answer the following research questions:

- Which childcare and parenting needs are health visitors a preferred source of help?

- Do parents, having experience of health visiting, have a different perception of health visitors as a source of help from none parents?

The findings of this study will first be presented in descending order, according to those needs and problems for which health visitors were the preferred source of support. A comparison between parent and non-parent preferred source of support will accompany this. Chi-square and cross-tabulation were the analysis used to identify the preferences and the descriptive comparison of sources of social support variables (family, friend and neighbour) and agency support variables (health visitor, social worker, voluntary service, school and police). Secondly, a diagrammatic representation of the interpretation of the sources of support will be presented to clarify which services were more acceptable for which needs or problems. Finally, the relationship between the social and agency variables is reported. Spearman's correlation was the statistical analysis of choice for this purpose.

As health visitor and social worker are the only health and social services professionals included as a choice of support, it is possible that they have been chosen as an access point to wider health and social services rather than health visiting and social work being explicitly the preferred source of support. Though this may be seen as a limitation of this study, the results, nevertheless, show a match for the seeking of support for parenting and childcare needs or problems with the key services of which health visitors and social workers are often the primary workers.

7.2 PREFERRED SOURCES OF SUPPORT FOR CHILDCARE AND PARENTING NEEDS OR PROBLEMS.

Returned questionnaires totalled 103. Three were void because they were either incomplete or selected more than one social or agency support. From the biographical data the profile of the respondents was females (n92) and males (n8). Thirty were under the age of 20 years; thirty two were between 21 – 30 years of age; twenty eight were between 31-40 years of age; and ten were forty one years of age or older. Marital status was varied with thirty three married, thirty three

partnered, three separated and thirty one single. In all there were 50 parents and 50 non-parents.

To return to the findings and in descending order, with health visitors as the preferred source of support, and separated into categories that closely mirror the domains of the assessment framework for children in need, the findings will follow the pattern of children's health needs, children's developmental need, parents' health needs, parents' relationship needs, and parents social and environmental needs. When the sample is divided into parents and non-parents these became relatively small (samples of 50) and will be reported in numbers. Bar charts representing both the social (lay) support and agency (professional) support will follow an explanation of the results for each need or problem variable.

7.2.1 Children's health needs and problems

The variables included in children's health needs were asthma, vision and hearing, sleeping and feeding or eating. Health visitors were the preferred source of support for both asthma and vision or hearing. Almost all 98% (n98) would seek help for asthma from a health visitor (n50 parents and n48 non-parents). Family (15) and friends (10) would also feature as perhaps the first social support sought. The only other agency support was the voluntary service that was chosen by two non-parents. With half of parents (25) and three quarters of non-parents not seeking social support (39) it may be feasible to presume an acceptance of health visitors as a preferred support for asthma.
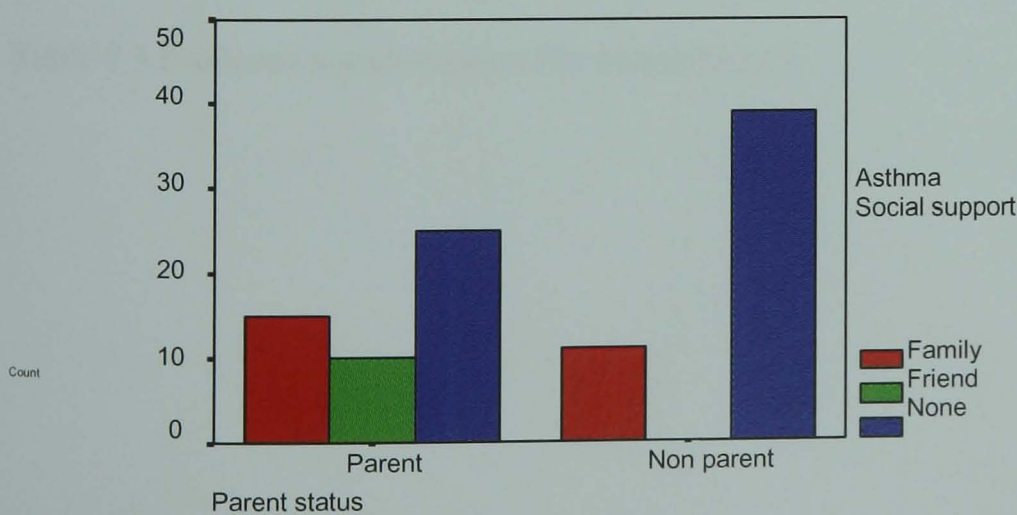
Table 7.1: Preferred social support for asthma
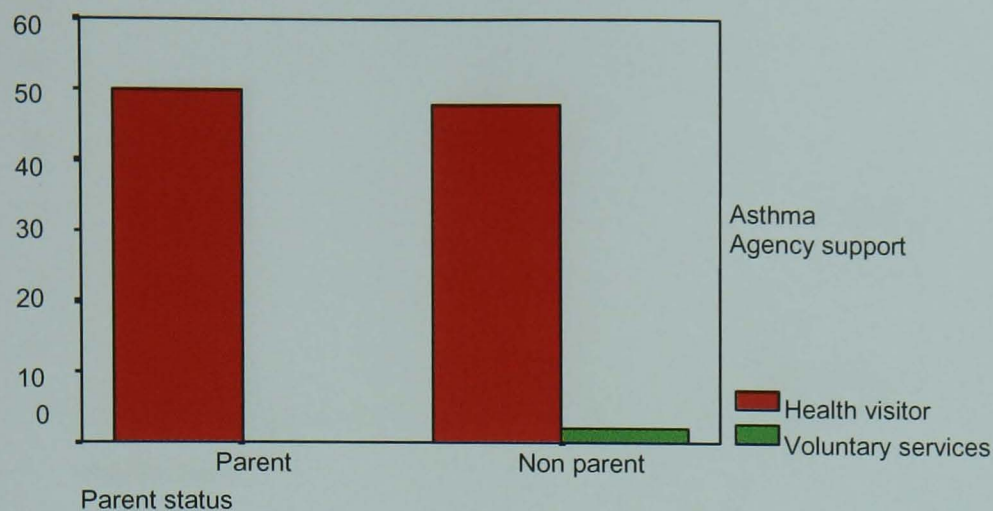
Table 7.2: Preferred agency support for asthma

Similarly, health visiting was a preferred source of support for children with vision and hearing needs for all but one respondent (n50 parents and n49 non-parents). Family came second for fourteen non-parents and thirteen parents. Only one parent and one non-parent would prefer a friend.
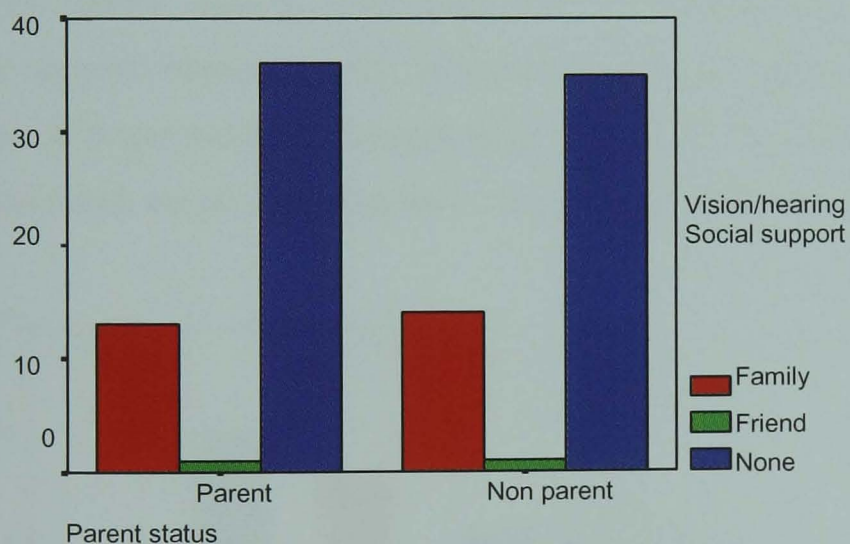
Table 7.3 Preferred social support for vision/hearing
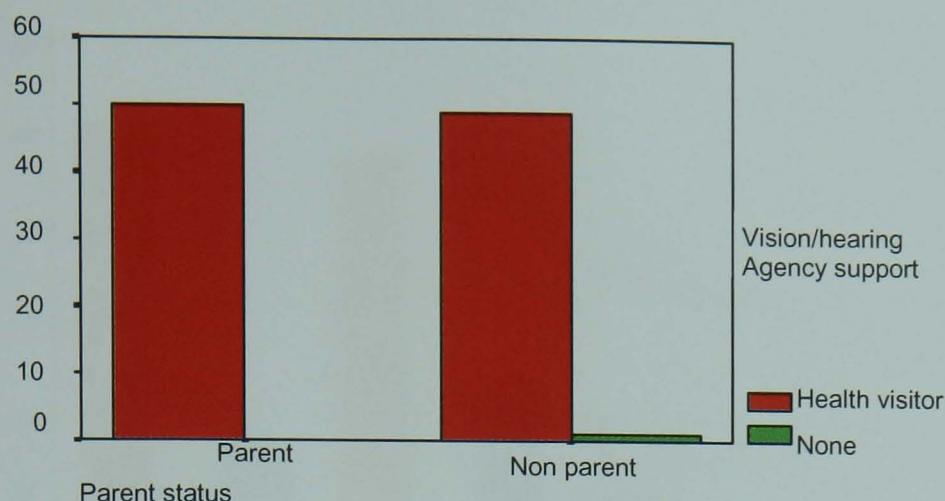
Table 7.4: Preferred agency support for vision/hearing

Sleeping needs of children were also more likely to be shared with health visitors by seventy nine respondents (n41 parents and n38 non-parents) than family. Family was preferred by forty four respondents (n17 parents and n27 non-parents). Five respondents (n3 parents and n2 non-parents) preferred friends with two respondents (parents) preferred voluntary services. Perhaps it is having experienced problems with establishing sleep patterns that has influenced parents to seek social support and then agency support when necessary. Only seven parents would not prefer agency support whereas twelve non-parents perceive they would not seek agency support. A larger number of respondents (n51 – n30 parents and n21 non-parents) would not seek social support which supports the preference for agency support.
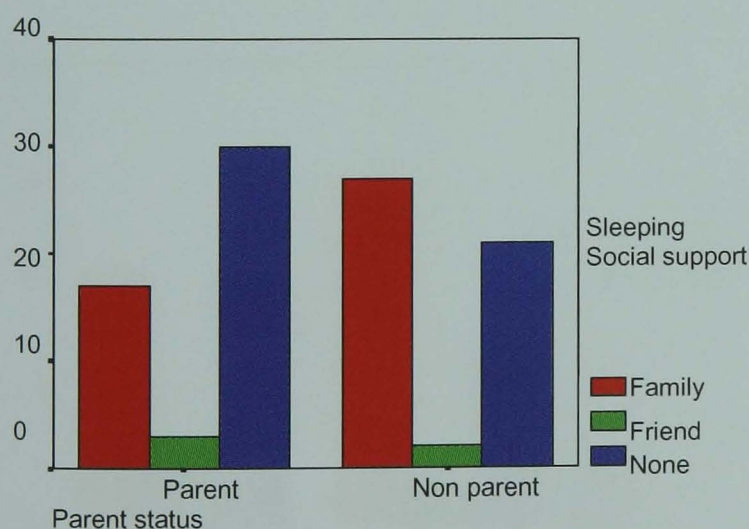
Table 7.5: Preferred social support for sleep problems
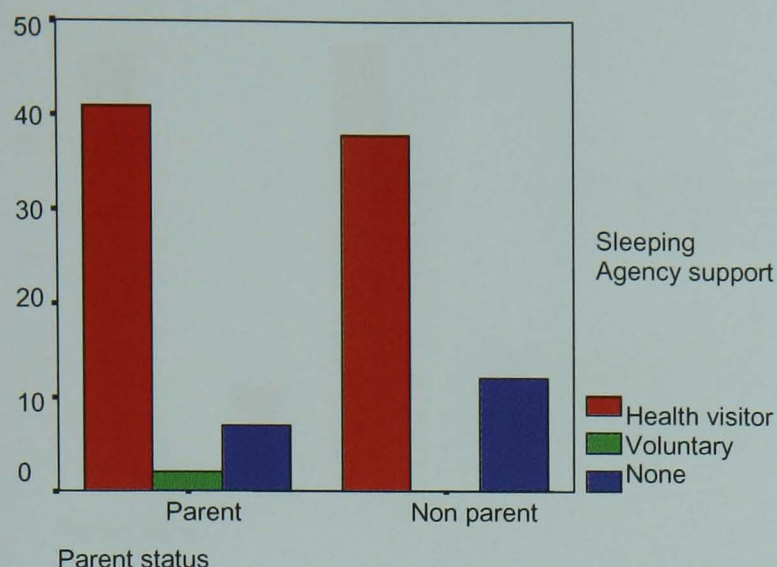
Table 7.6: Preferred agency support for sleep problems

Feeding and eating difficulties were seemingly not problems to discuss with others. A total of 38 respondents (n22 parents and n16 non-parents) would not seek social support nor would 21 respondents (n9 parents and n12 non-parents) seek agency support. Where support was sought the preferred support was health visiting for parents (n37) and non-parents (n38) almost to the exclusion of other agencies barring social work for two parents and voluntary services for two parents. Family was the preferred social support for fifty two respondents (n22 parents and n30 non-parents). Friends featured as a support for ten respondents (n6 parents and n4 non-parents).
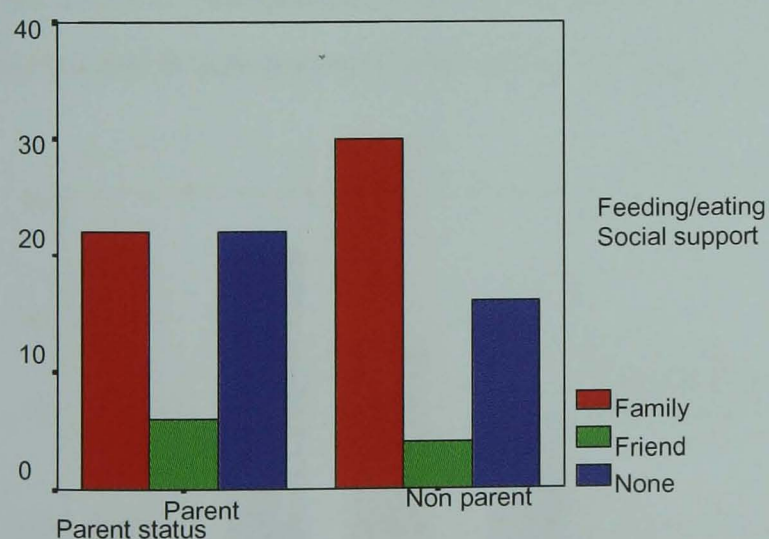
Table 7.7: Preferred social support for feeding/eating difficulties
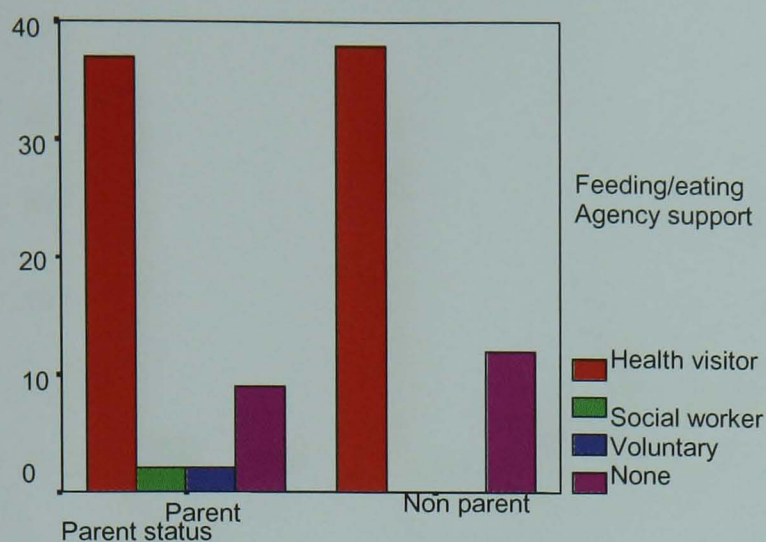
Table 7.8: Preferred agency support for feeding/eating difficulties

7.2.2 Children's developmental needs and problems

Like health needs, problems with the general development of children was an area for support that respondents (n83 – n43 parents and n40 non-parents) gave preference to health visiting. Respondents (n39 – n12 parents and n27 non-parents) preferred family over friends (n3 parents and n2 non-parents). Social work was preferred by six respondents (n4 parents and n1 non-parents) and school by one non-parent. The preference for agency support over social support may be an indication of the seriousness with which parents take responsibility for seeking support for their children's development. A total of fifty six respondents (n35 parents and n21 non-parents) would not seek social support the total number of 11 (3 parents and 8 non-parents) who would not seek agency support.
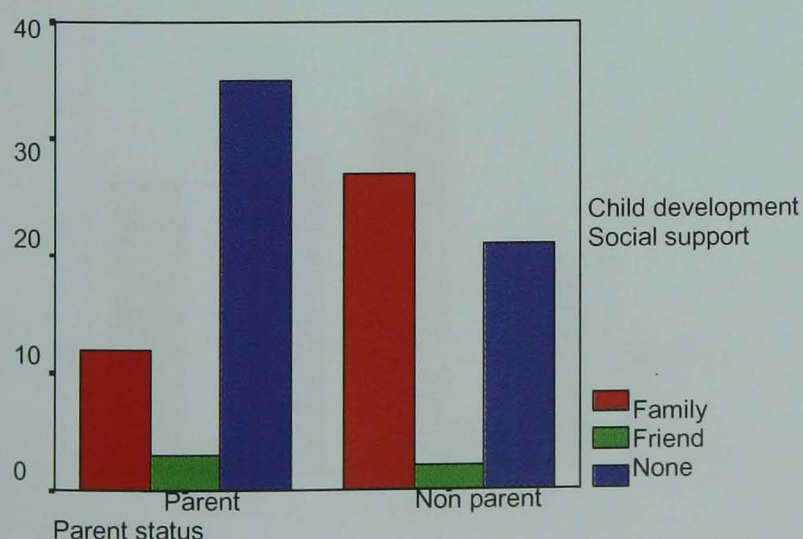
Table 7.9: Preferred social support for child development

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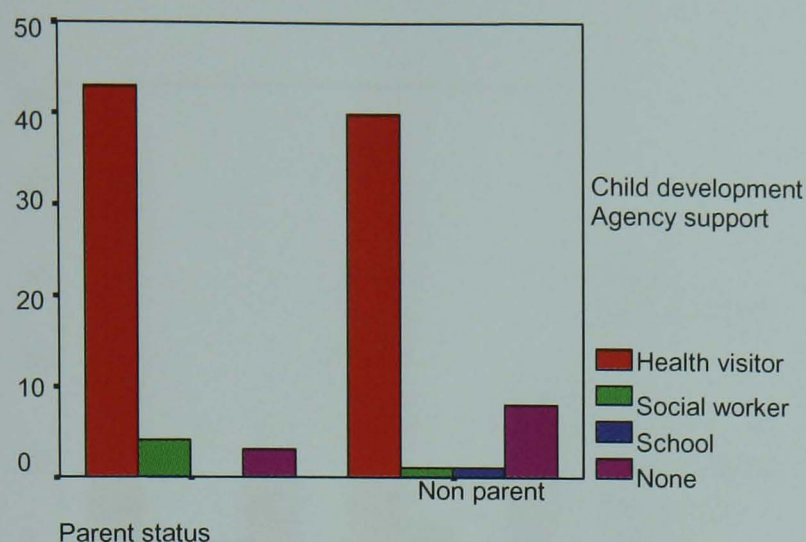
Table 7.10: Preferred agency support for child development

For specific developmental needs or problems the preference differs. The expertise of the agencies was recognised over social support in relation to toileting needs and hyperactivity of children. Preference for social support and agency support was similar for temper tantrums whereas family support was preferred for children who exhibit aggressive behaviour. A health visitor was the preferred support for toileting needs by seventy one respondents (n41 parents and n30 non-parents).Fifty two respondents preferred family (n23 parents and 29 non-parents). Social work was a perceived preference for non-parents and voluntary services for one parent. Of the respondents (n43) preferring no social support twenty-five were parents and seventeen were non-parents. A lesser number of respondents (n25 – n8 parents and 25 non-parents) would not prefer agency support.
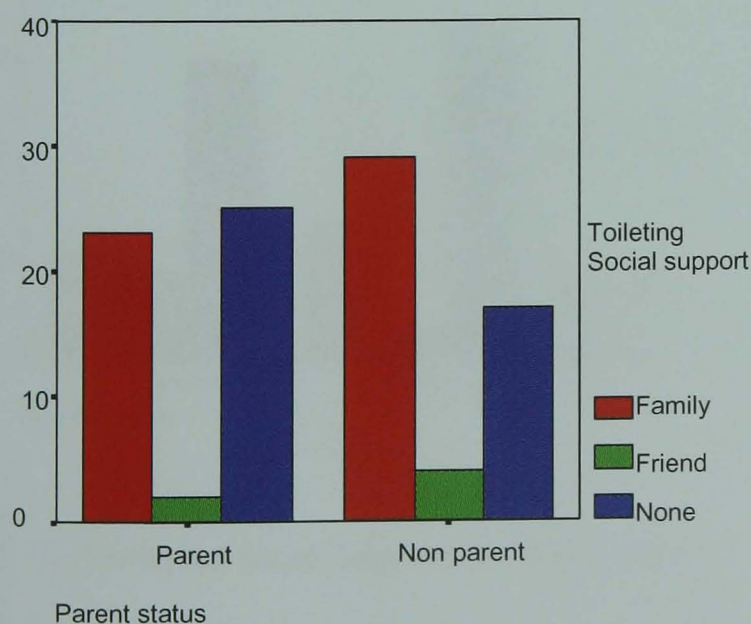
Table 7.11: Preferred social support for toileting difficulties

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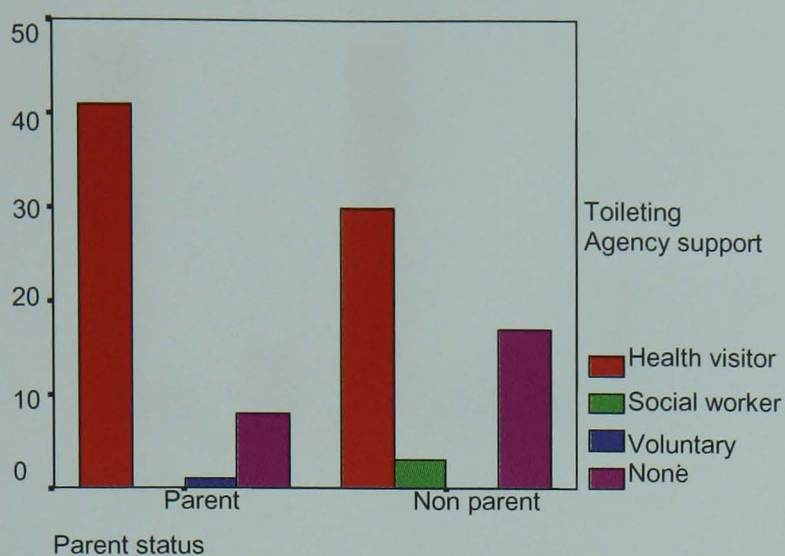
Table 7.12: Preferred agency support for toileting difficulties

Hyperactivity in a child is a problem that health visitors were the preferred source of support for eighty respondents (n40 parents and n40 non-parents). Family was the second preference for twenty five respondents (n11 parents and n14 non-parents). Nine parents would choose friends with only 3 non-parents who might share this problem with friends. Three non-parents might also select the school as a source of support. Only a small number of respondents (n11 – n7 parents and n4 non-parents) would choose not to share this problem with an agency worker but neither would sixty three respondents (n30 parents and n33 non-parents) prefer to share the problem with their social support.
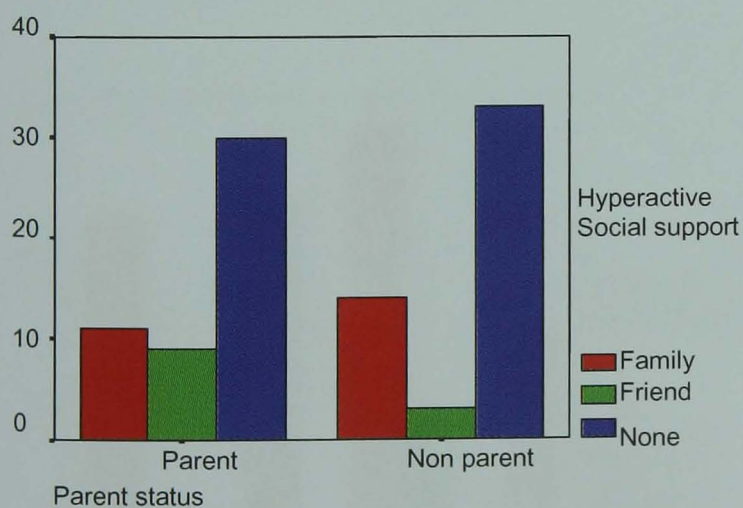
Table 7.13: Preferred social support for hyperactivity
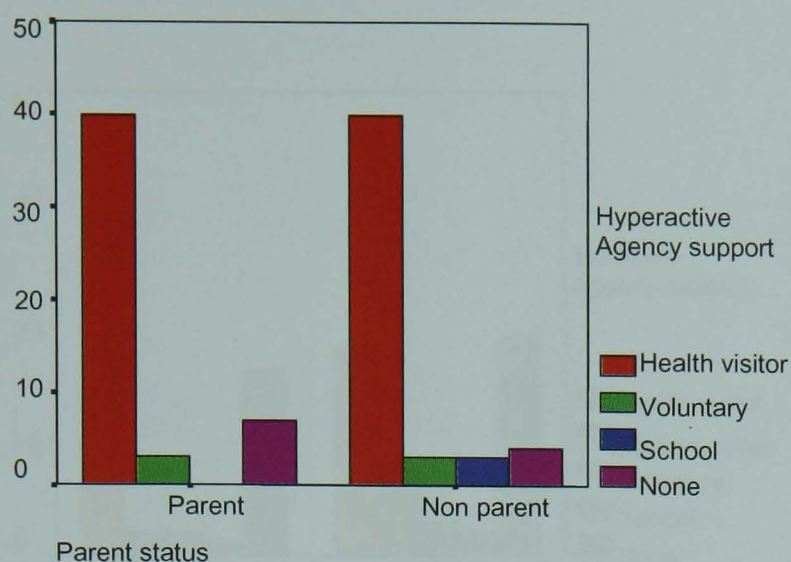
Table 7.14: Preferred agency support for hyperactivity

Health visitor support was preferred for temper tantrums by forty seven respondents (n29 parents and n18 non-parents). A close second preference for respondents (n50 – n22 parents and n28 non-parents) would seek family support. Friends and social work were a third support preference. Ten respondents (n3 parents and n7 non-parents) preferred friends' support and ten (n2 parents and 8 non-parents) preferred social work support. Two parents reported voluntary services as a preference and two parents reported neighbours as a source of support. All the same, a high number of respondents would not seek support for temper tantrums, though agency support was just preferable to social support. Thirty eight respondents (n23 parents and n15 non-parents) would not seek social support and thirty five (n17 parents and n19 non-parents) would not seek agency support.
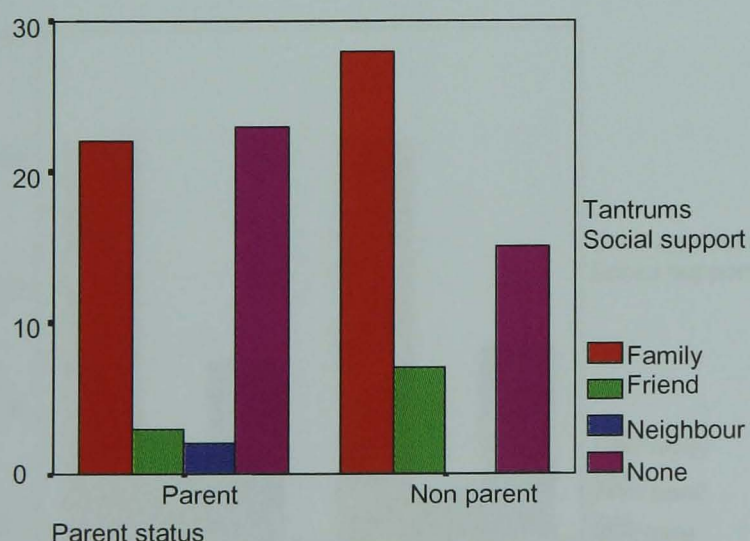
Table 7.15: Preferred social support for temper tantrums
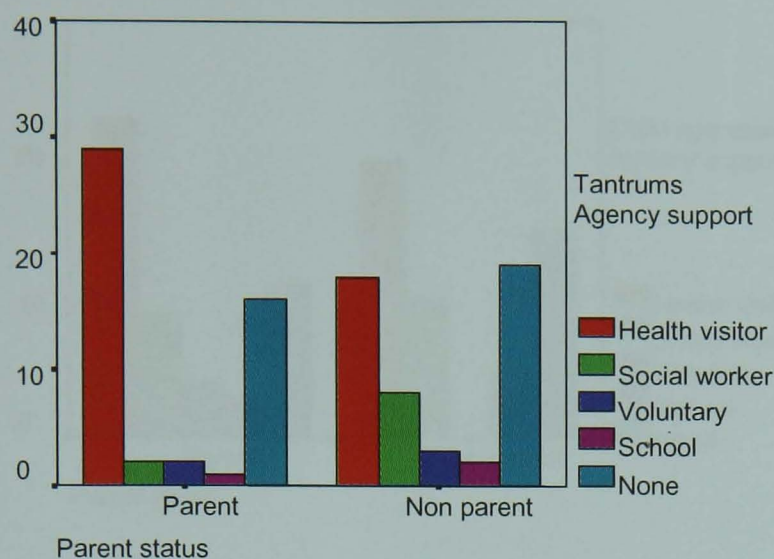
Table 7.16: Preferred agency support for temper tantrums

Behaviour problems were found to be predictive of child neglect in study one but parents may be reluctant to seek support for aggressive behaviour and temper tantrums. For children exhibiting aggressive behaviour sixty two respondents (n31 parent and n31 non-parent) expressed a preference for family as a source of support. However, health visitor support was also a choice for forty three respondents (n23 parents and n20 non-parents). Social work was less likely to be the preferred option and was reported as first choice by ten non-parents and nine parents. Four parents might select voluntary services and three parents perceived school as their preferred agency support. Friends of nine respondents (n5 parents and n4 non-parents) had close preference parity with voluntary services.
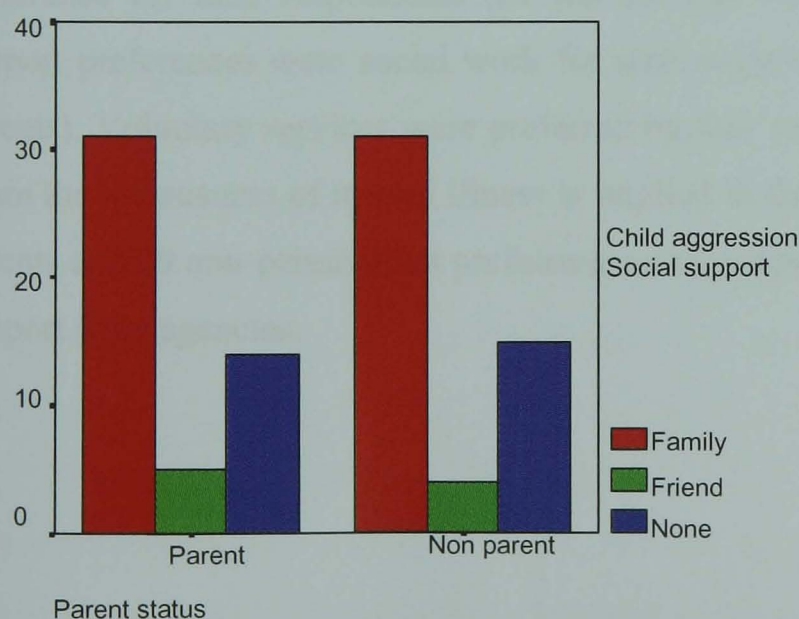
Table 7.17: Preferred social support for child aggression
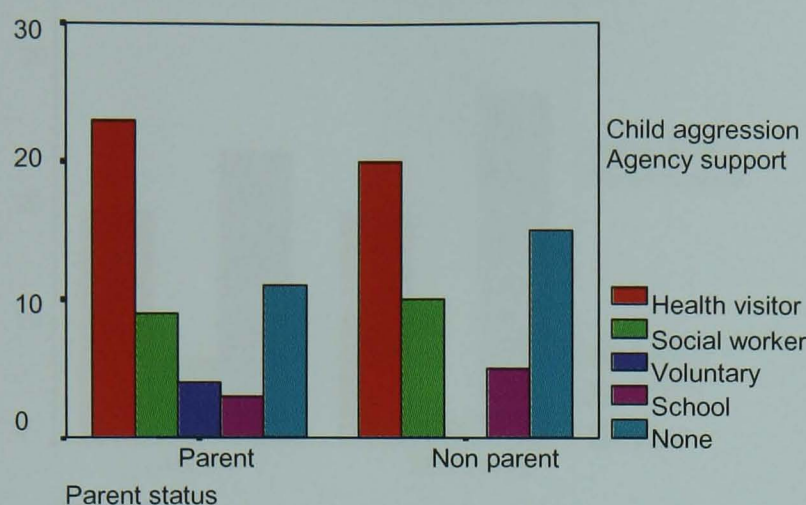
Table 7.18: Preferred agency support for child aggression

7.2.3. Parents' health needs

Parents' health needs include mental illness, alcohol and drug misuse, inability to cope, and feeling inadequate as a parent. Of these, only for mental health problems and alcohol misuse would health visitors be the preferred source of support. Social support was preferred for difficulties that might affect parents' ability to provide adequate childcare such as not coping, drug misuse and feeling inadequate as a parent.

Mental illness is a health problem that eighty one respondents (n40 parents and n41 non-parents) preferred a health visitor as a source of agency support. Nineteen respondents prefer family as their social support with friends reported as a preference for nine respondents (n7 parents and n2 non-parents). Other agency support preferences were social work for nine respondents (n1 parent and n8 non-parents). Voluntary services were preferred by four respondents (n4 parents). Once again the seriousness of mental illness is implied in the total of 53 respondents (n24 parents and 29 non-parents) not preferring social support and only six not preferring support from agencies.
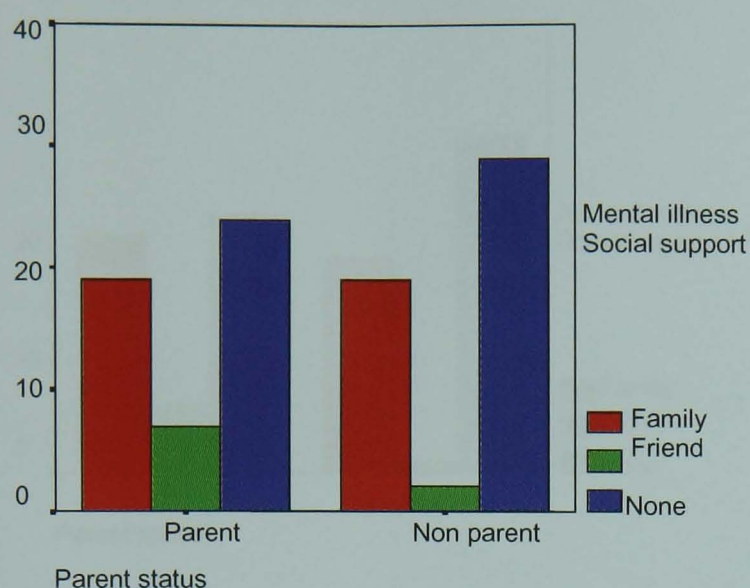
Table 7.19: Preferred social support for mental illness
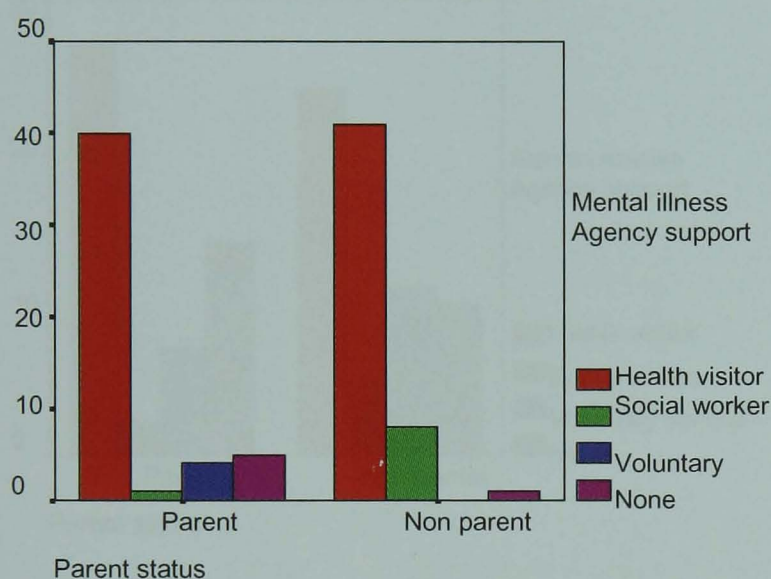
Table 7.20: Preferred agency support for mental illness

Alcohol misuse was most likely to be a problem shared with a health visitor by twenty seven respondents and family by twenty one respondents. Too a lesser extent the problem was likely to be shared with voluntary services (n7), friends (n6) and social worker (n2). Non-parents were marginally less trusting of others, but with health visitors still the preferred source of support for twenty four, family for nineteen, with voluntary services for eleven and social work for five respondents. Non-parents (n30) also reported the likelihood of not seeking social support either, with ten non-parents choosing no support from agencies. This contrasts with no social support reported for twenty three parents and no agency support for fourteen parents. Overall half of adults with an alcohol problem may not seek support.
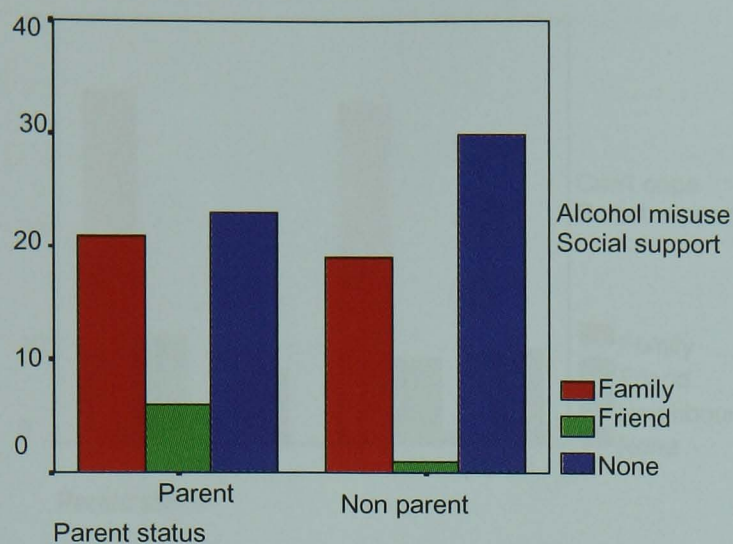
Table 7.21: Preferred social support for alcohol misuse
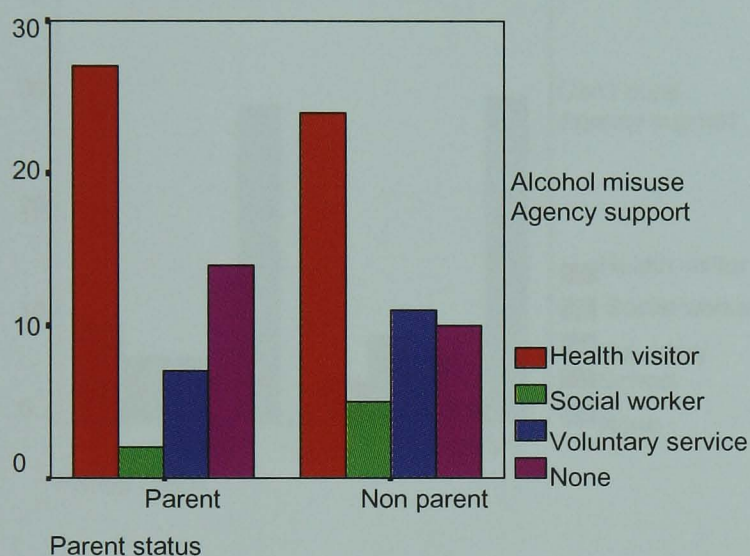
Table 7.22: Preferred agency support for alcohol misuse

Agency support was not preferred for parents who felt they could not cope. Respondents (n65 – n33 parents and n32 non-parents) preferred to share this need with family and ten parents and eight non-parents might seek support from friends. Health visitors were marginally preferred to other agencies by parent (n9) and non-parents (n4). The same number of parents (n6) might also seek support from a social worker or voluntary services. More non-parents (n8) preferred social worker support than voluntary services (n6), with two also preferring school. A considerable number of respondents (n59 –n29 parents and n30 non-parents) would not seek support from agencies.
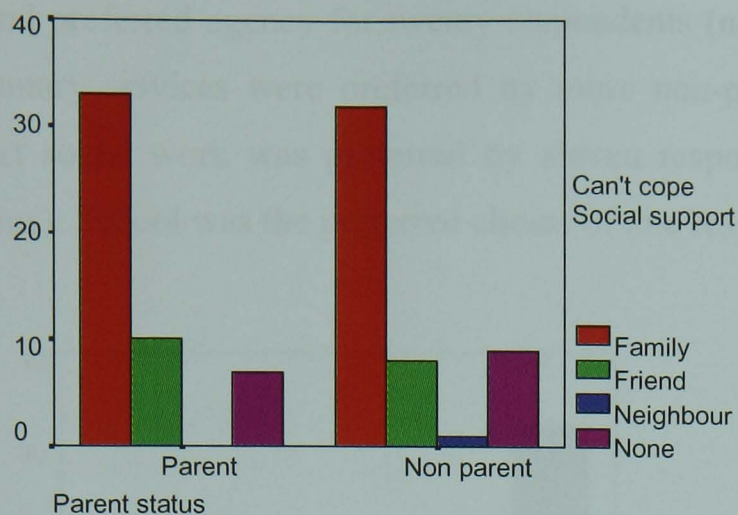
Table 7.23: Preferred social support when parents 'can't cope
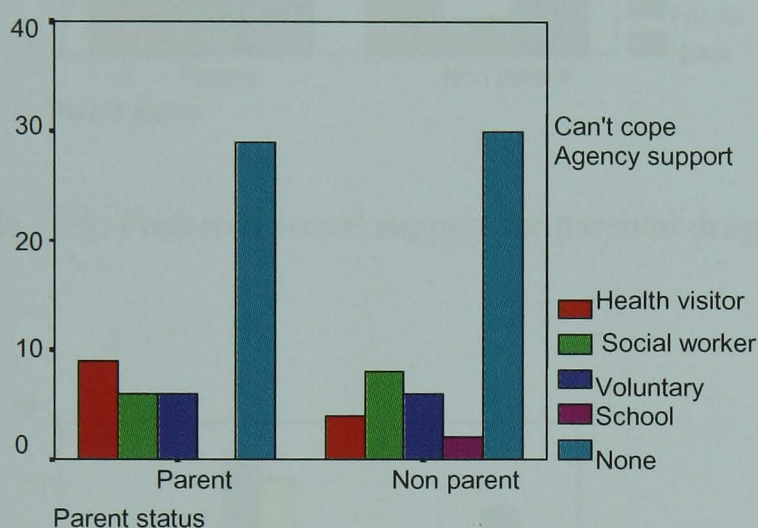
Table 7.24: Preferred agency support when parents can't cope

Similarly, drug misuse may remain a hidden problem for a considerable number of families. A total of fifty five respondents (n21 parents and n34 non-parents) would not seek social support, nor would twenty one (n14 parents and 7 non-parents) seek agency support. Unless registered as drug users parents may, therefore, go undetected. That is, unless family, which was once again the preferred source of support for twenty nine respondents (n16 parents and n13 non-parents) also are inclined to seek support or urge their sons and daughters to seek support. Friends were a close second preference to family for sixteen respondents (n13 parents and n3 non-parents). A more punitive choice of police was reported as the preferred agency support for twenty eight respondents (n15 parents and n13 non-parents). The choice of police as a source of support may be indicative of the seriousness with which some respondents view drug taking as a problem. Health visitors were the

second preferred agency for twenty respondents (n8 parents and n12 non-parents). Voluntary services were preferred by more non-parents (n11) than parents (n8), whilst social work was preferred by eleven respondents (n6 non-parents and n5 parents). School was the preferred choice of one respondent (n1 parent).
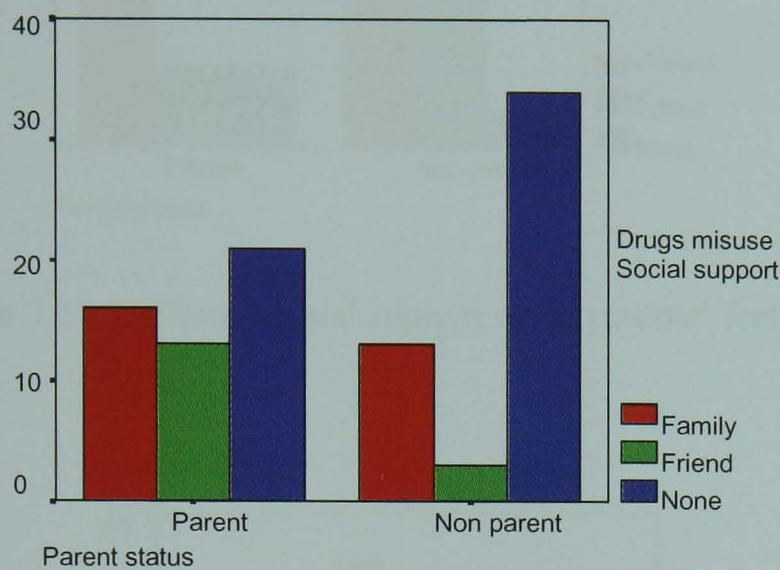
Table 7.25: Preferred social support for parental drug misuse
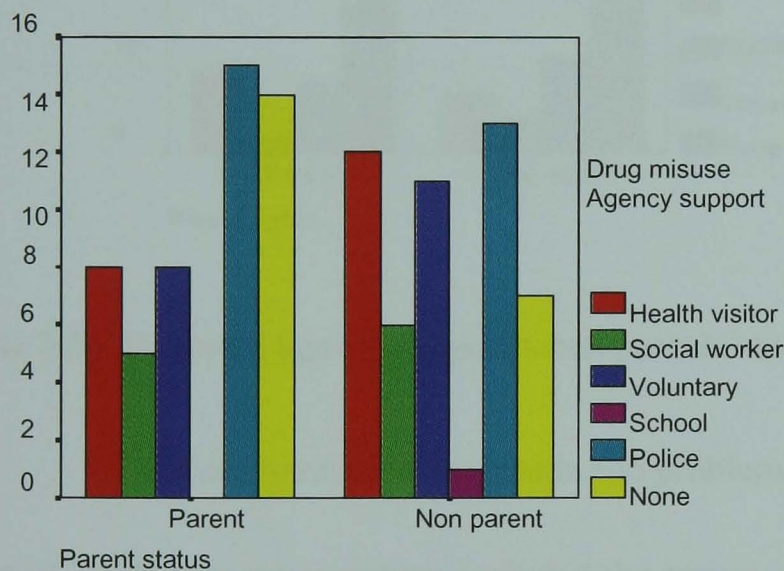
Table 7.26: Preferred agency support for parental drug misuse

Feeling inadequate was not something to be shared with agency support. A total of 70 respondents (n36 parents and n34 non-parents) would not seek agency support. Sixty four respondents (n36 parents and n28 non-parents) choose family support. Friends were the second preference for twenty six respondents (n7 parents and n19 non-parents). Only ten respondents in total (n7 parents and n3 non-parents) would not seek social support either.

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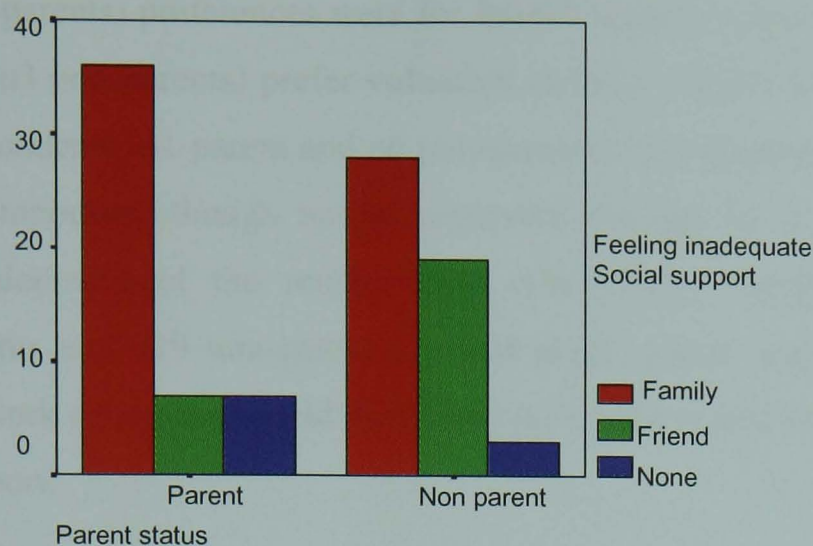
Table 7.27: Preferred social support when parents' feel inadequate
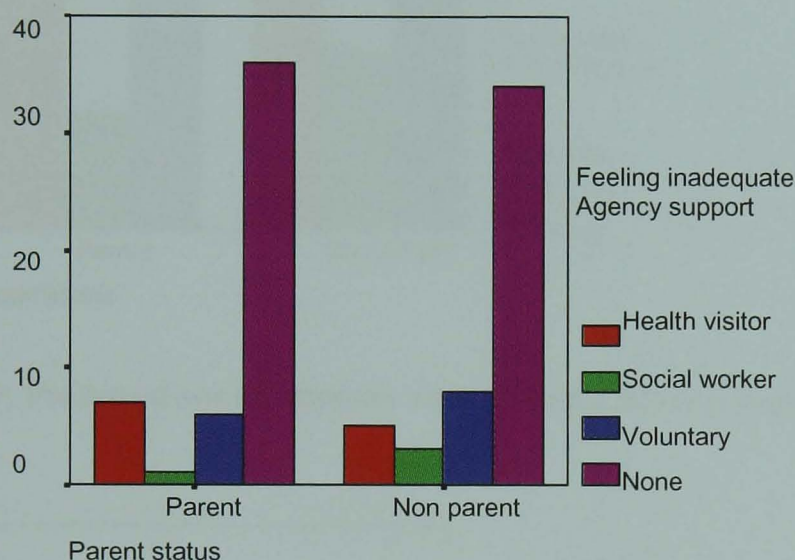
Table 7.28: Preferred agency support when parents' feel inadequate

7.2.4. Family relationship needs and problems

Support for family relationships included the parent and child relationship and the 'parental' relationship. Parent and child relationship difficulties were understood as parents not sensing bonding with a child and perceived discipline needs. The parental relationship included domestic violence and marital support needs. All of which respondents would prefer to keep within the family. Bonding is a sense of attachment between mother and child (Schaffer 1996). Not bonding is a support need that is preferred from the family of forty three respondents (n24 parents and n19 non-parents). A close preference was health visiting for forty three respondents (n23 three parents and n20 non-parents). Twenty respondents' (n8 parents and n12

non-parents) preferences were for friends whereas sixteen respondents (n13 parents and n3 non-parents) prefer voluntary services. Social work was preferred by seven respondents (n1 parent and n6 non-parents). Not seeking support for not bonding is an important, though not a surprising finding, as it might affects the healthy development of the mother-child relationship. Thirty seven respondents (n18 parents and n19 non-parents) would prefer not to seek support from their social network either, nor would thirty four (n23 parents and n11 non-parents) seek agency support.
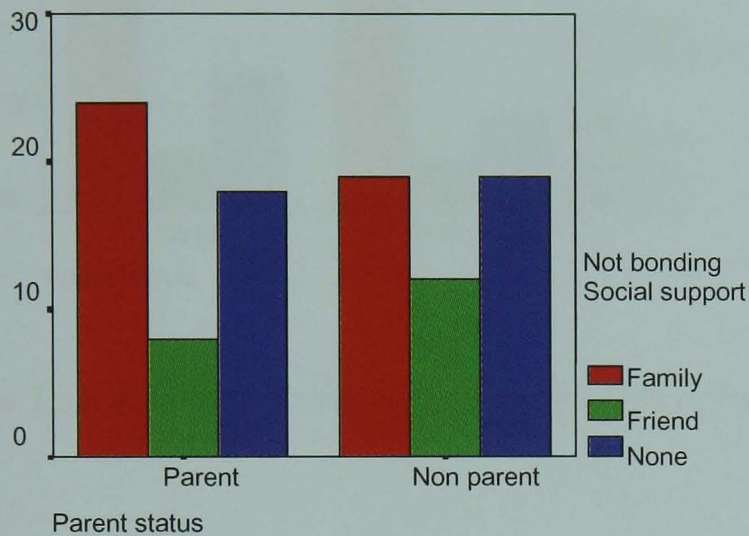
Table 7.29: Preferred social support when parents are not bonding with child
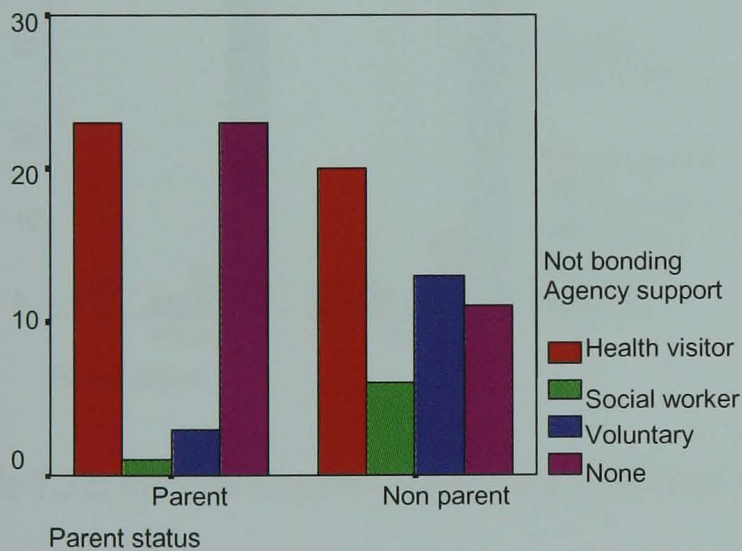
Table 7.30: Preferred agency support when parents are not bonding with child

Discipline problems may seemingly be kept within the family by seventy one respondents (n33 parents and n38 non-parents). Friends were slightly preferred to agencies support by nine respondents (n5 parents and n4 non-parents). Health

visitors were preferred by only seven respondents (n4 parents and n3 non-parents). A total of twenty respondents (n12 parents and n8 non-parents) would not seek social support, nor would over three quarters of respondents (n79 - n39 parents and n35 non-parents) seek agency support.
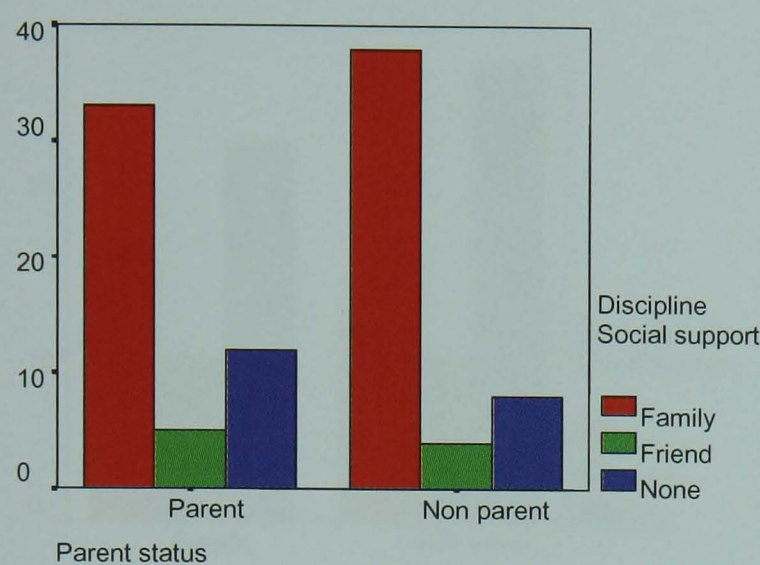
Table 7.31: Preferred social support for discipline difficulties
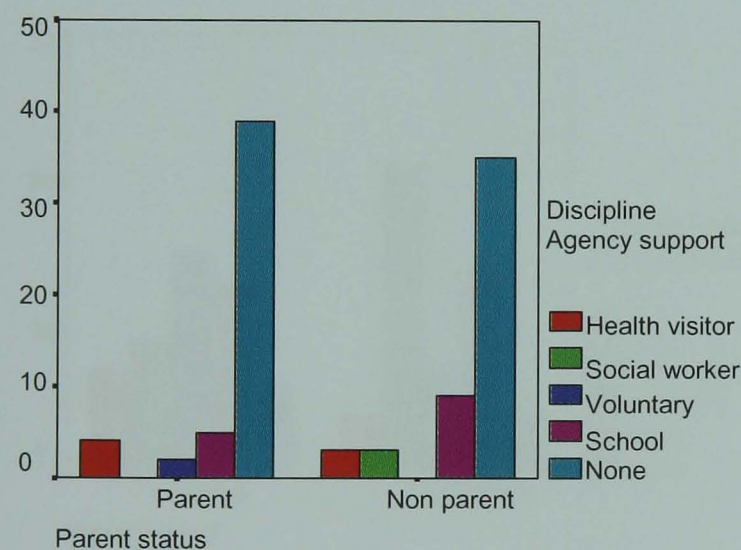
Table 7.32: Preferred agency support for discipline difficulties

Domestic violence was another family characteristic where family support was preferred by thirty seven respondents (n17 parents and n20 non-parents). Uniquely, voluntary services were the preferred agency support for twenty two respondents (n15 parents and n7 non-parents) as well as the police by twenty seven respondents (n13 parents and n14 non-parents). Social workers were preferred by non-parents (n21) to parents (n9) which may imply a singular focus on abuse to the spouse

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rather than taking into account (as parents might) on children also. Overall, 51 (n23 parents and n28 non-parents) not seeking help from social support and only ten not seeking support from agencies implies an acceptance that domestic violence is a problem to be shared.
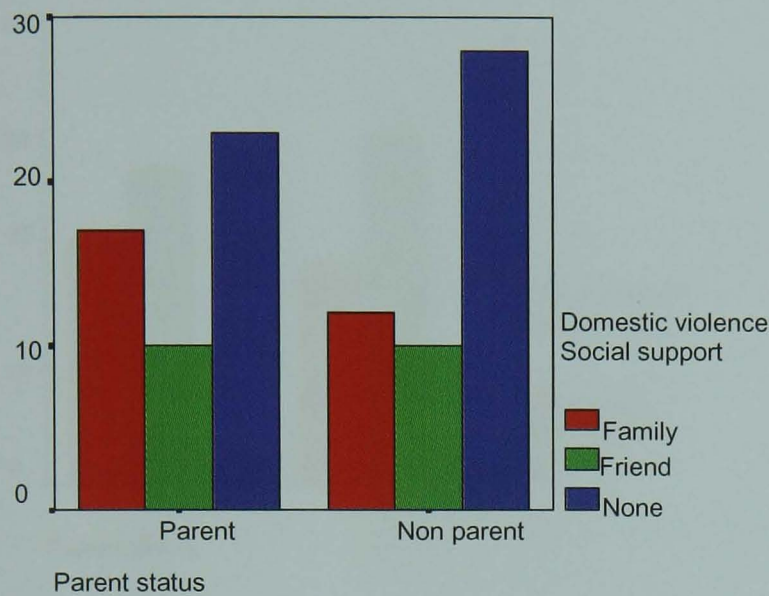
Table 7.33: Preferred social support for domestic violence
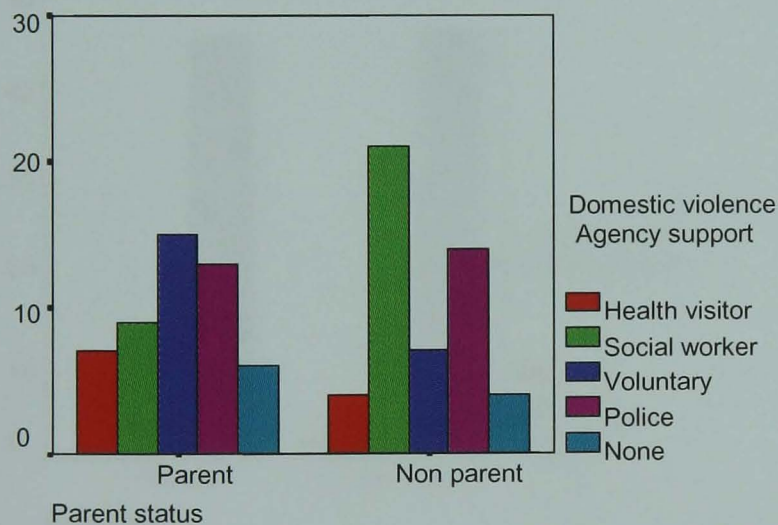
Table 7.34: Preferred agency support for domestic violence

Another, potentially undisclosed need, was marital support where social support was preferred almost to the exclusion of agency support. Friends are the preferred social support for respondents (n58 – n27 parents and n13 non-parents). Family was the second social support preference for forty respondents (n21 parents and n19 non-parents). Only three respondents (2 parents and 1 non-parent) would not seek social support. In contrast, a total of ninety one respondents (n45 parents and n46

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non-parents) would not prefer agency support for marital support needs. One respondent (n1 parent) preferred a health visitor and four (n4 parents) voluntary services, whereas, two respondents (n2 non-parents) preferred a health visitor and two (n2 non-parents) voluntary services.
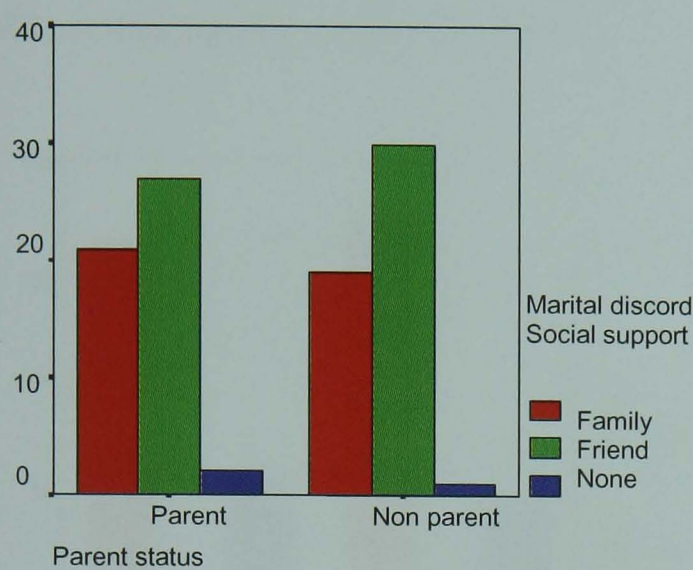
Table 7.35: Preferred social support for marital difficulties
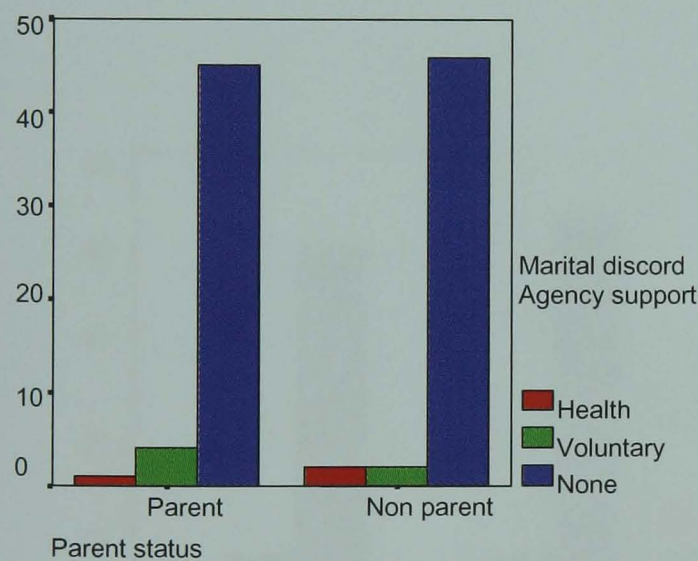
Table 7.36: Preferred agency support for marital difficulties

7.2.5 Families' social and environmental needs

A distinctive choice of agency support was seemingly made respondents. Where health and developmental needs were matched with the health visitor, debt and housing as the two social and environmental needs are social support and social work related. Where debt was experienced only two agencies are given

consideration. They are social work by three respondents (n3 parents) and voluntary services by seven respondents (n7 non-parents). Family would be the primary source of support for respondents (n68 – n33 parents and n35 non-parents). Eight respondents (n4 parents and n4 non-parents) indicated a preference for their friends support. An astounding eighty three respondents (n40 parents and n43 non-parents) would not seek agency support for debt.
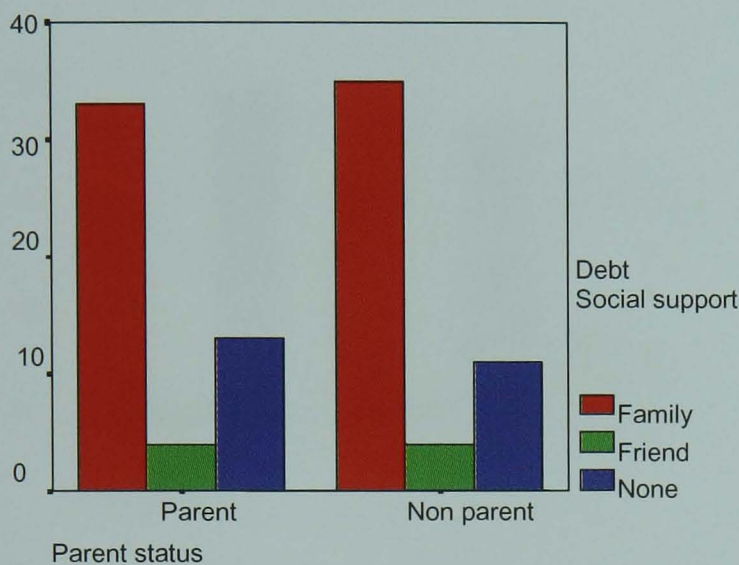
Table 7.37: Preferred social support for debt problems
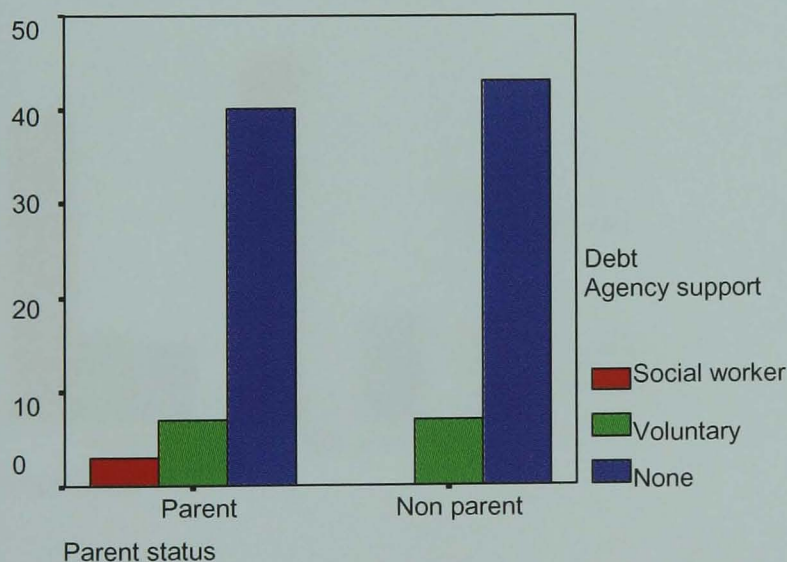
Table7. 38: Preferred agency support for debt problems.

Housing is clearly the province of social welfare where social work is the preferred agency support for seventy two respondents (n33 parents and n39 non-parents). Nine parents would prefer voluntary services. Social support was again the

preference for the family for forty respondents (n19 parents and n21 non-parents). Although a total of fifty five respondents (n29 parents and n26 non-parents) would not seek social support only nineteen (n8 parent and n11 non-parents) would not seek agency support, thus, suggesting that social work support is valued for housing needs.
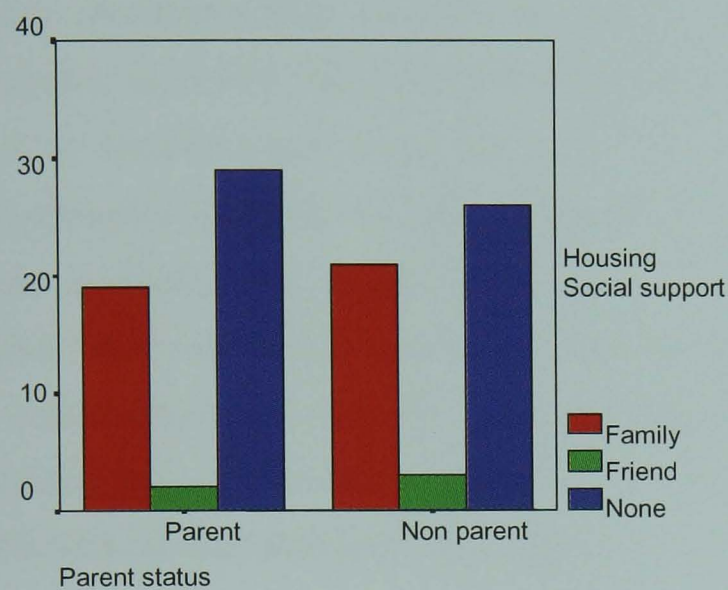
Table 7.39: Preferred social support for housing problems
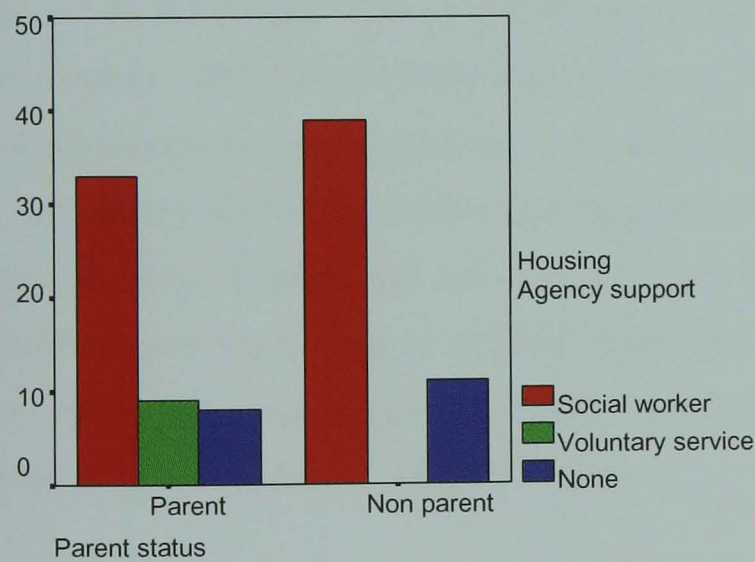
Table 7.40: Preferred agency support for housing problems

7.3 MATCHING NEEDS OR PROBLEMS WITH PREFERRED SOURCES OF SUPPORT

The group of student nurses in their first year of training confirmed, not surprisingly, their preference for social support. Having the required educational qualifications to enter higher education and with professional aspirations towards a helping profession these samples are unlikely to constitute a large number of vulnerable, or 'at risk' individuals from vulnerable families. As such, these findings are more disturbing than might first appear. It is feasible to assume, and as Cragg and colleagues (2002) found, vulnerable and 'at risk' samples might ascribe an even greater preference for social support and a reluctance to engage with agency support. However, such a relatively informed sample might be expected to utilise the services and seek help for any perceived needs or problems but they, too, seemingly share a reluctance to engage with services that can affect the parent-child relationship and the stability of the family.

In respect of mothers with children categorised as neglected, there may be three restrictions to accessing support. One is that neglectful mothers may have only, either, their maternal grandmother's or marital partner's support and even then they might not be necessarily both physically and emotionally supportive (Nelson et al 1996; Coohey 1995; Kelvin 1999) which might leave them inadequately supported. The second restriction is the mothers' lack of confidence to approach others due to a low self-esteem (Dubowitz 1999). The third restriction is their low expectation of support in areas of emotional and behavioural concerns for themselves and their children respectively (Cragg et al 2002: Moorman & Ball 2001). One or more of these characteristics might seriously influence negatively a parent's capacity to seek help for their own and their children's needs.

Overall, the results show some preference for voluntary service, and school but the key support was preferred from family or health visitors depending upon the problem, then social work and police. Health visitors are the preferred source of help for children's health needs, some developmental needs, and parents' needs in relation to mental illness and alcohol misuse. Social workers are the preferred source of support for housing and debt problems and police for drug misuse. For all

other needs and problems family members are the preferred source of support. These findings are presented in Table 7.1.

Need or problem	Health visitor	Social work	Police	Family
Asthma	*			
Vision/hear	*			
Sleep	*			
Feed/eating	*			
Child development generally	*			
Toileting	*			
Hyperactivity	*			
Temper tantrums				*
Aggression				*
Mental illness	*			
Alcohol misuse	*			
Drug misuse			*	
Can't cope				*
Feel inadequate				*
Not bonding				*
Discipline				*
Domestic violence				*
Lack of marital support				*
Debt		*		
Housing		*		

Table 7.41: A match of needs and problems with preferred services

7.4 NEED OR PROBLEM FOR WHICH THERE IS A RELUCTANCE TO ACCESS AGENCY SUPPORT

Furthermore, this preference for social support was analysed to identify relationships between needs and problems to confirm a dependency on social support. Using a 2 tailed, nonparametric correlation test (Spearman's rho) some

highly correlated (.50) support variables were found to determine the relationship between support variables. Linking these are more moderate correlates (.30) of support and agency variables. Each variable is accompanied by the type of support 'social' or 'agency'. All the correlations reported below are significant at the .01 level. The highly correlated variables are grouped into similar needs and these groups are then linked with the highest moderate correlation found between them. The purpose of the diagrammatic presentation below is to isolate those variables which explain a statistically significant preference for social support seeking behaviour of parents and non-parents (or future parents) over agency support; or in many cases over support of any kind.

Three difficulties are of particular importance. They are domestic violence, drug taking and housing. In the case of domestic violence and drug taking the increased preference for social support explained the preferred for social support for the other difficulty (.667). There was also a relationship between domestic violence and housing problems that explain the preference for social support for both (.508). It would therefore not be unexpected to find that where no professional support is sought or support is rejected for one of these variables the same might apply to the others.

Variables relating to children's needs are presented in three groups of high correlates. Firstly, there is child aggression that explains a social support preference with feeding and eating (.587). Feeding and eating in turn explain social support for child development generally (.504). Problems with feeding or eating may seem innocuous but the correlation to child aggression might also explain a reluctance to seek professional help for children's behaviours that others could attribute to the quality of parenting. In child neglect, specifically failure to thrive, feeding and eating problems might explain a delay in development as feeding problems are often accompanied by a lack of emotional nurturance (Iwaniec 2003). A more simple explanation is that feeding problems are not serious and social support may be adequate.

However, health visitors were the preferred source of support for child development generally, so the correlation with child aggression and feeding problems is interesting. For example, a teenage mother in Cragg and colleagues (2002: 47)

interview study stated "My health visitor is a load of rubbish...When my son falls asleep on the bottle she says that I should tickle him to make him wake up and then finish the bottle. But I say, 'No, if he's asleep I don't want to disturb him'". Should a health visitor suspect a lack of nurturance because of ignorance about the nutritional needs of a pre-term baby, weight loss or knowing of 'neglecting' mothers arbitrarily terminating baby's feeds (Iwaniec 2003) this advice may be understandable, although, a tired mother also deserves some respite from her baby's demands. Whatever the reason behind the advice it is clear that no problem is easily explained without further exploration.

A second group of variables; temper tantrums and sleep, show a high correlation to social support between them (.761). Sleep problems should not be ignored as 46% of children with sleep problems as babies continue to have sleep problems at school age (Butler & Golding 1986). The more persistent the problem the more likely it is to be an indicator of a larger behaviour problem (Pritchard 1999). For behaviour that is perceived a problem Pritchard (1999) advises an assessment of the problem and a debate about, and the teaching of, strategies as early as possible. Without adequate social support, sleep problems can lead to extreme tantrum behaviour (Pritchard 1999). It may, therefore, be appropriate to provide information about sleep and behaviour problems, coping strategies and how to seek support, at easily accessible places where parents and their families frequent, such as supermarkets, leisure centres or community centres. Relevant educational resources could be made available on loan from libraries or available for use on personal computers.

The third group of variables relating to children's needs is different in that the relationship between variables is a high correlate between agency supports. That is, where agency support is a preference for temper tantrums this explains a preference for agency support for sleep (.538). Likewise, agency support for sleep reciprocally explains agency support for toileting (.515). Chalmers (1999) is of the opinion that children who wet the bed (enuresis) are not usually associated with behavioural problems unless the bedwetting continues into adolescence. Her argument is based mainly on the association found by Fergusson & Horwood's (1994) from their 15 years longitudinal study. An increased rate of behaviour problems, such as conduct disorder, was found among children over the age of 10 years. These children are arguably entering their most challenging, educational, social and emotional

developmental period of their lives: high school and adolescence. For children to achieve their full potential, as the Government (DOH 1999) and National Assembly (NAfW 2000) pose is the aim of safeguarding children services, then difficulties with sleep, toileting and tantrums must be taken seriously at the earliest possible stage of development.

Moderate correlates that bridge the relationship between the above explained variables are drug taking and child aggression social support (.420), child aggression and sleep social support (.327) and temper tantrum social support and temper tantrum agency support (-.236). Overall, a positive relationship was found for social support. One negative relationship between temper tantrum social support and temper tantrum agency support explains the tendency for an increased preference for social support and a corresponding decreased preference for agency support. The diagrammatic representations of these findings are shown below in Figure 7.1.
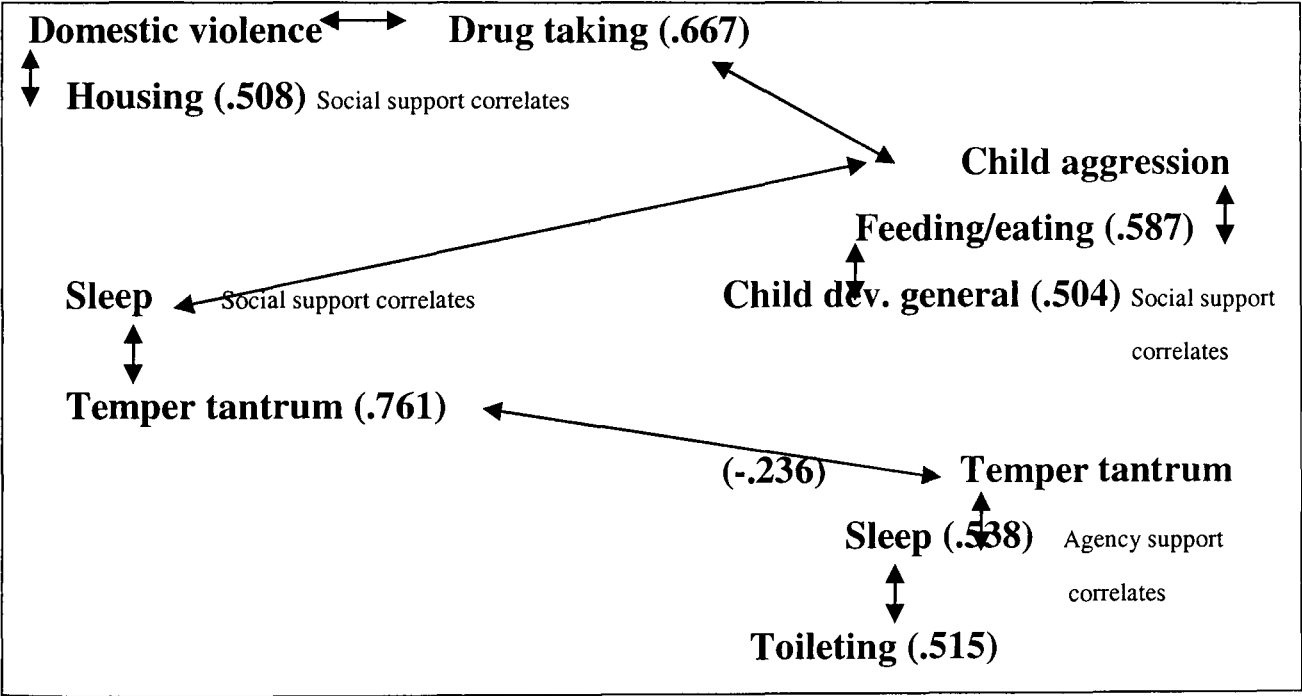
Figure 7.1 Correlates of support preferences.

7.5 DIFFERENCES BETWEEN PARENTS AND NON-PARENTS

Descriptive statistical analysis shows a small difference between parents and non-parents but both show a preference for social support rather than agency support.

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Exposure to health visitors does not seem to inspire more trust in parents than non-parents in relation to drug taking. However, differences were found between parents and non-parents, using the Mann-Whitney U test for asthma social support (.016), child development social support (.003), drugs taking social support (.042), and toileting agency support (.019). These findings can be interpreted as follows:

- Considerably more non-parents than parents would not seek social support from family or friend for asthma. Agency support was preferred.

- More parents that non-parents would not seek social support for drug taking and, worryingly, 14 of 50 parents and 7 of 50 non-parents would also not seek any agency support.

- Likewise, more parents than non-parents would not seek social support for child development but the majority would seek some agency support. Only 3 parents and 8 non-parents would not seek agency support for child development.

- More parents than non-parents would seek health visiting support for toileting and, as the above correlations confirm, a decreased preference for agency support for toileting corresponds with an increased preference for social support.

The difference between parents and non-parents was small. It would seem that engaging with health visitors did not necessarily result in a greater preference for agency support for child development difficulties, drug misuse and toileting. Perhaps there are still parents who view health visitors as health police (Robinson 2000) and are apprehensive about admitting difficulties. Conversely, the difference found was so small that the comparison added little to the general findings that social support is preferred and that health visiting is the preferred agency for parenting and childcare needs and problems.

7.6. CHAPTER SUMMARY

To summarise, the overall impression from this study is that families would seek help but have a preference for different support services for different child care and

parenting problems. For most health related problems respondents referred to the health visitor as their preferred source of agency support. Social problems were directed towards social work, voluntary sector organisations, school and the Police; usually in that order of preference. These respondents were discerning seekers of support. However, a number of problems were unlikely to be shared with others until seriously problematic. They are temper tantrums, children's aggressive behaviour, feeling unable to cope or feeling inadequate, not bonding with child, disciplining a child, domestic violence and drug misuse. Parents' feelings of inadequacy, not coping and lack of bonding may impact adversely on the parent-child relationship. Domestic violence and drug misuse may affect parental capacity and domestic violence will almost certainly adversely affect the parental relationship. Temper tantrums and aggressiveness in children may be the result of children frustration with their childhood experiences. As a result of the association between these factors and child neglect and the reluctance to seek help it would seem that some alternative means of providing information, parenting strategies and support are required. This study did not attempt to isolate any perceived barriers to seeking help nor potential, alterative sources of help but exploring with a sample of parents who have experienced difficulties in meeting their children's needs may be a logical area of exploration for further research.

CHAPTER EIGHT

DISCUSSION: HEALTH VISITING AS COMMUNICATIVE ACTION

8.1 INTRODUCTION

In light of the findings from the three interrelated studies that are described in the previous chapters, the social reality of health visiting with families who neglect their children's needs is, undeniably, relationally complex and of necessity eclectic in communicative approaches. Ostensibly, the social reality is a structured programme of health promotion that includes child development assessment and education and the identification of, and support for, adverse child, parental or environmental circumstances that might impair children's health and development. Occasionally met with negative connotations, health visitors may be construed as government agents set the task of confirming 'good enough' parenting. Parents who ascribed to this view and perceived the contact as unnecessary intrusion into their privacy were experiencing difficulties for which they were wary of professional involvement and they found ways to avoid contact.

The strength of the child health promotion programme was the application of empirical and instructional knowledge, as a universal service, that does enable health visitors to identify vulnerable children and their families and target them for additional services but in an attempt to do so health visitors faced some barrier. The major barriers were (1) professional judgements stated implicitly rather than explicitly that, as a result, often fails to elicit the family support perceived necessary to establish a healthier family, (2) parents' preference for social support over agency support, and (3) communicative actions of health visitors' that did not engage with the 'real' world of the family (their lifeworld). These three barriers will be discussed at 8.2.2; 8.3 and 8.4 respectively. Extrapolated from the findings of this study is a new conceptual framework: *Health visiting as Communicative Action.* This discussion chapter begins with health visitors' application of the empirical knowledge of child neglect, or, their identification and interpretation of presenting factors. This is followed by an interpretation of parents' preference for social

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support and of health visiting as communicative action that incorporates the application of hermeneutic and emancipatory knowledge. The various interpretations will be offered as justification for the proposed conceptual model.

8.2 THE EPISTEMOLOGY OF NEGLECT APPLIED TO HEALTH VISITING

Knowledge of child neglect from empirical evidence and instructional guidelines is tantamount to what Habermas calls technical knowledge or epistemological knowledge. This knowledge informs health visiting which factors are associated with neglect and provides the policies and procedures that direct how to act to prevent or resolve neglect. This epistemological knowledge is also the working knowledge pertinent to the promotion of health, reduction of vulnerability and the protection of children in adversity. One important appreciation of the knowledge of child neglect is that health visitors and families hold differences of opinion about what constitutes adequate childcare and what constitutes neglect. However, the difference of opinion may not be, solely, that lay people apply a higher seriousness to neglect than professionals, as some have identified (Rose & Meezan 1995; Rose & Selwyn 2000) but in recognising the implications of neglecting to meet their children's needs there is the desire to hide perceived neglectful behaviour from health visitors. As a result it is not surprising to find, that the factors strongly associated with neglect (from the case control study) and found to have predictive ability were the very same factors, found in the narrative and survey studies for which parents were reluctant to seek support.

Predominantly, the concerns and subsequent interventions focused on poor management and handling of children and unmet children's needs due to known impaired parental capacity such as learning disabilities (Feldman 1998), drug and alcohol misuse (Rohrbeck & Twentyman 1986; Chaffin et al 1996; Fals-Steward et al 2003; Roditti 2005), mental illness (Folkov 1994) many children (Wolock & Horowitz 1977; Zuravin 1988), their families living in poverty (Roditti 2005) and a maternal and child relationship low in affection (Chapple 2005; Slack 2004). Although these potential impediments to adequate parenting are often referred to as risk factors, in child maltreatment literature, the word 'risk' was not part of the

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language used by health visitors. They preferred to concentrate on 'needs' (6.4). The use of the word 'need' exemplifies the first principle of health visiting – the search for health needs. Application of, and adherence by parents to, the child health promotion programme enabled the identification of developmental competence on which to build protective factors (towards resilience) rather than draw attention to risk, unless professional judgement determined a risk to children. Such a judgement usually followed repeated patterns of adverse parental behaviour and increased impairment of children's development.

It would seem that resilience, and to a lesser extent risk, are parts of health visitors' technical and cognitive professional framework. Health visitors' narratives confirm them seeing and support families as families move from one level of concern to another due to life events. The concerns raised were similar to the four levels of concern suggested by Gelles (2000). One level of concern can be found at all other levels and that is that families either engage with services or they do not. Those who did not usually engage with services where later found to have something to hide (e.g. domestic violence). The second level of concern conformed to others' findings that included parental failure to provide basic needs (Corcoran 2000) and supervision (Coohey 2003; Loeber & Stouthamer-Loeber 1986).

The third level of concern involved a lack of parental involvement with children (Loeber & Stouthamer-Loeber 1986) and subsequent lack of children's involvement with parents (insecure attachment) (Egeland & Soufe 1981; Main & Goldwyn 1984; Schneider-Rosen et al 1985; Carlson et al 1989; Morton & Browne 1998; Crittenden & Answorth 1989). The primary issue at this level was whether the parent-child relationship was sufficient to build protective factors that may protect children from the impact of continued vulnerability. Although the case control study alluded to emotional needs it was health visitors' narratives that illuminated the enormous efforts some health visitors took to encourage parents to understand their children's needs and how the family lifestyle could impact on children. The fourth level of concern was dangerous parental behaviour, identified by many (Loeber & Dishion 1983; Farrington 1989; Henggler et al 1992; Gelles 2000). That is, multiple vulnerable factors such as mental illness, learning disabilities and substance misuse or deliberate neglect or abuse that either impair children's health and development or caused them harm. Where early interventions failed to improve childcare or

dangerous parental behaviour was suspected families were referred to social services.

A frequently encountered difficulty was problems with children's behaviour that needs to be taken more seriously. If early behaviour that is perceived by parents to be a problem is unresolved the problem can escalate. In the case study six children were referred to psychological services for serious behaviour problems. As Coe and colleagues (2003) and Spencer and Coe (2003) found early behaviour problems at 8 months can be predictive of behaviour problems at 3 years. Statistical evidence, from this study supports a strong correlation between child neglect and poor management and the handling of children and behaviour problems and between behaviour problems and poor management and handling of children and poor school attendance. Consequently, the knowledge applied by health visitors is suggestive of a service that assesses children's health and development. Where deficits are identified negotiation with parents takes place to increase awareness of the perceived health need and aim to change behaviour to that conducive to meeting children's basic physical, emotional, educational, medical, social and safety needs and to resolve early childhood behaviour problems. However, the strategies/ programmes used to resolve behaviour were not recorded in either the case records or in narratives.

8.2.1 Reliability of the assessment instrument

An assessment instruments that combines all the, seemingly, relevant factors (as used in the case control study) might be considered appropriate for the general assessment of child neglect but in hindsight such instruments are advocated for research purposes only. Its use assisted in confirming health visitors' identification of multiple factors, relating to families' histories, parental skills, children's health and development and social and environmental factors. Convergent findings from health visitors' narratives support the comprehensiveness of health visitors' assessment of families that, more often than not, considered the aggregate affect of all presenting factors in relation to the impact on children but without making specific and explicit their professional judgement. Moreover, a systematic approach is identified, but rather than describe according to the roles health visitors undertake as Appleton (1994) did, the approach incorporates (1) establishing a relationship

with families, (2) that enabled them to gain access to the context of the family, (3) the clarification and revising of interpretations of need to children's health and development, and (4) determining when a build up of problems and patterns of behaviour had occurred that were perceived as barriers to appropriate change.

Whether using an assessment instrument or not for assessing for health needs rarely was one difficulty experienced by families. It would, therefore, be challenging from the presenting complex set of difficulties to accurately identify a causal factors of child neglect. In almost all of the 'neglected' cases the build up of difficulties was such that the assessment instrument was unlikely to have assisted in a 'diagnosis' of neglect sufficiently early to prevent neglect happening. Consequently, the opinion of Goddard, Saunders and Stanley (1999: 251) that structured risk assessments may be "instruments of abuse" is pertinent given the longevity of neglectful care that some children experience before a 'diagnosis' of neglect was made. Though in reality any fault lies, not with the assessment instruments but, with the inaction of professionals who as Dalgliesh (1998) and Smith (2002) claim failed to be guided by known predisposing difficulties and fail to recognise them as likely to affect the parent and child relationship and then fail to intervene in order to either confirm or address the difficulty. The strong reliability coefficient of the assessment instrument used in this study served mainly to confirm that families with children categorised as 'neglected' experienced similar difficulties and the frequency of those difficulties.

Crucial to predicting adverse influences on children's health and development is likely to be the strength of the relationship between the experienced difficulties. From the original factors assessed six were highly correlated to neglect (inappropriate management and handling children; parental history of residential care; behaviour problems; unmet needs; poor school attendance; and family violence). The strength of the relationships between these suggests a combination of poor management and handling of children and behaviour problems to have a strong predictive ability to child neglect for both pre-school and the school age cases. For the school age cases poor educational attendance also had predictive ability. Hence, the statistical and narrative interpretations of this study support greater weight be given to poor management and handling of children, behaviour problems and poor school attendance. From a health visiting perspective, *child neglect* is *unmet*

children's health and development needs due to inattentive parental behaviour or inattentive supervision; that causes chaotic and unstable family experiences; and that manifestly affects children's development and educational attendance and can result in behaviour that is perceived a problem.

8.2.2 The aggregate effect of neglect

Sharing information with social services and providing summaries of adverse events, parental engagement or failure to engage with interventions or reporting continued concerns about the health and future development of children often led to a request for an assessment of the children (as children in need) and their families. Alas, also frequently, the information provided by health visitors failed to initiate the required level of support from social services. In some cases, the compilation of information provided was ill-defined or was labelled 'grey areas' as others have done (Appleton 1996; Taylor & James 1987; Taylor & Tilley 1990). The expressed concerns were not taken seriously by others

From the body of knowledge of child neglect and supported by this study an aggregate of the effect of neglect guideline can be extrapolated to assist in making a professional judgment. The aggregate effect is the sum of (1) the protective and vulnerable factors, (2) the level of parental failure to provide for children's needs, (3) the types of child neglect; physical, emotional, educational, safety, medical and social neglect and (4) and the chronicity of neglect. Health visitors' narratives and case recordings usually reported at least two of these issues but improvements in professional judgement might follow an analysis of all four elements of neglect of children's needs to predict the potential effects on children. This is not to suggest that the guideline replace other well constructed and trialled and revised means such as the Graded Care Profile but rather as a way of analysing concerns to assist coming to a professional judgement that can then be made explicit to relevant others. According to health visitors' narratives the Graded Care Profile has proved effective in eliciting multi-agency collaboration and services when used as an assessment instrument for serious cases of neglect. Health visitors used the Graded Care Profile in conjunction with parents to agree the level of childcare given and what ought to happen to make improvements. More often it was used as a means of convincing social workers of the need for a child in need assessment rather than an assessment of neglect.

Unfortunately, in some cases, the facts of a case were not always enough to elicit social service support. The attitude of the health visitor to the family and its problems was a more likely catalyst than the facts of the case. It would seem, for example, that a health visitor who takes an optimistic view of children and the family was less likely to receive multi-agency support, even if the family was experiencing severe hardship (Ester's narrative in chapter 6). Contrary to the guidance that a measure of strengths be part of family assessment it was the expression of parental limitations rather than a balance of strengths and limitations that tended to gain the attention of social services and gain perceived desirable resources. Some means of summarising measurements, observations and disclosures relevant to the provision of adequate childcare is required to begin to 'diagnose' what is going wrong so the health and social service interventions are matched specifically. The summary may then inform the professional judgement to more meaningfully argue for a child-in-need assessment and additional family support. An example of the Aggregate Effect of Neglect Guideline can be found as Appendix 16 along with a completed summary of the information provided in one health visitor's narrative.

8.3 PARENTS' PREFERENCE FOR SOCIAL SUPPORT

Unfortunately, the identification of children's needs or family difficulties weighed against protective factors (or strengths of the family) is just the beginning of a process towards change. Implicit in the process is the reciprocal contribution of parents and health visitors. To return to the barriers to effective family support it is the contribution of parents that is discussed first. To begin to address the reluctance of parents to seek professional support for some predictive factors it is important to make sense of why parents prefer social support. When, for example, the Policy Research Bureau for the Department of Health (Rogers 2003:21) explored service users' opinions about resources available to them they found "a high level of need for formal services among parents in poor environments, but that a substantial minority of high-need parents were not in the system". The problem with this interpretation is that families may not have been within the local authority service system but they were plausibly within the health visiting services. As the findings from this study suggests, the health visitors and families may, on request for

additional support, have been denied local authority services. Nevertheless, the families would have been receiving an intensive health visiting service appropriate to children's needs.

Specifically related to parents' reluctance to engage with services is their feeling of a loss of control (Rogers 2003) and a public perception of a link between personal failure and service provision (National Mapping of Family Services in England and Wales - Henricson 2001). Certainly, there was a sense of reluctance to engage with social services by some families in health visitors' narratives but the reason for that reluctance was not investigated. One reason posited by Rogers (2003: 21) is that some services undermined parental autonomy and are thereby interpreted as 'interference'. The difficulty for parents seeking support may not be dislike or like of the service, but as the narratives explain and Collinson & Cowley (1998b) found that some parents do not perceive a need and as such have no reason to demand the service. In such cases, the reluctance to seek help may lie with the type of needs. This begs the question, what is different about the difficulties for which parents were accepting of, and which they were reluctant to access professional support for. An obvious observation about the difficulties related to domestic violence, lack of marital support, discipline, not being able to cope, feelings of inadequacy and not sensing a bond with the baby, is that parents could perceive them as personally responsible to at least one member of the family. Resisting the temptation to smooth over contentious family actions, it has to be said that someone is to 'blame' for domestic violence and lack of marital support. As mothers from disadvantaged areas attending family centres explained the traditional male role disadvantages women by their 'controlling' and acting like 'absolute lords' (Ranson & Rutledge 2005). Certainly from health visitors' narratives, fathers were a crucial influence on the families' acceptance, but more often than not rejection, of services. Some fathers' opinions and behaviour impacted considerably on family decisions hence some way of involving fathers in negotiations about meeting children's needs must be sought.

An unexpected survey response was found for drug taking. Perhaps, it was the illegality of drug taking that was the influencing factor in respondents' preference for the police as a preferred source of support. Neglect in two narratives was associated with drug taking. Involvement with drug services and adherence to

treatment programmes were essential to persuade others that they could cope with their parental responsibilities. Neither family could, seemingly, be trusted to take only the prescribed medication and often failed to attend appointments. Collaboration between the health visitor and drug services constituted more about working with the same family than a shared treatment plan or strategy.

Similarly unexpected was that child aggression and temper tantrums, unlike other health related needs, did not have a clear link to health visiting. It is possible that without information about a wider choice of health services, such as child and adolescent mental health services, respondents were unable to identify an appropriate source of support, especially if the health visitors were not believed to be the right resource for them. Furthermore, it seems equally likely that parents with "remediable suffering of depression, anxious and worried children may not come to the notice of services when help is needed" (NAfW 2000b:15). This inability to access services is particularly relevant for neglectful parents.

Crittenden (1999: 63) described 'Depressed Neglect' parents as "passive and helpless" parents who were not able to perceive their children's needs. In contrast, 'Emotional Neglect' parents tended to meet physical and cognitive needs but not emotional needs. Whereas, 'Disorganised Neglect' parents offered an inconsistent, disorganised form of parenting that is confusing for children. Hence, domestic violence, lack of marital support, discipline, not being able to cope, feelings of inadequacy, not bonding with baby, temper tantrums and children's aggression may present in one or other type of neglectful parenting but without recourse to professional support or family support. That is why a major contentious issue for children receiving a reasonable standard of parenting, and the opportunity to reach their full potential, is the government directive that it is "the decision of parents when to seek help and advice on their children's care and upbringing" (NAfW 2000:1). Some parents will not seek help and even with social or agency support some will not change harmful parenting unless legally required to do so, as Fortin (2003) suggested. The skilled health visitor was able to identify health needs early, perhaps intuitively at first. Having established a trusting relationship there was enormous potential to help parents recognise children's health needs and attempt problem solving using their own resources, as health visitors' narratives demonstrate, but parents must want the help. To endorse this involvement to seek

health needs health visitors must be given the legitimacy to engage with families where there are concerns about children's health and development and not just when there are protection concerns.

8.3.1 Overoptimistic faith in community services

There are those who claim that there is sufficient information available that is relevant to parental needs (Moorman & Ball 2001), but is that information helpful to parents? A simple answer is that some families are not helped because of two limitations. The first is the overoptimistic faith in community developments that families are not ready to access and the second is the high drop out rate among families with the most complex set of difficulties. Firstly, driving the plethora of information are new community developments (NHS Direct, Walk-in Centres, Health Living Centres, Family Centres, Sure Start, Parentline and health-related websites) and the emphasis on parenting information (National Family & Parenting Institute and parents support websites e.g. UK Parenting Information and Advice site for Parents, Shared Parenting Information Group (SPIG) UK).

New community developments are part of the idea of social capital. Laudable as empowering families through community participation (social capital) may be they are less effective for families most in need of family support. There are those who believe such developments principally benefit those with leverage to achieve their particular goals (Bourdieu 1979; Wakefield & Poland 2004) nor are such developments equally beneficial (Lockner et al 2003). Community participation may only be 'good medicine' for those who have a high level of trust in others (Subrananian et al 2001: 31); a characteristic that the study families, seemingly, did not posses. Not even the much acclaimed British Sure Start programme for disadvantaged families, living in disadvantaged communities, can improve the lives of the most disadvantaged (Barnes et al 2002). It cannot improve the lives of those who cannot trust others; do not recognise their children have health or developmental needs; and who are reluctant to engage with health and social services.

Nearly all the families in this study were initially advised and offered community services and refused the services. Hawe and Sheill (2000) argued that with an

advocate vulnerable families may be able to participate in the shift towards community networks and healthier communities. Some health visitors were acting as advocates at the same time as nurturing families to understand their health needs, discussing ways to meet the needs and the purpose of relevant services. Those health visitors who worked to understand the 'real' family were the most successful advocates. They accepted and persisted in serving as the sole advocate, which families favoured, until such time as the families could move on to accepting services.

Caught up in this empowering movement of social capital, the health visitor role of health promoter is to work as a "catalyst and strategist...to lobby for broader social change" (Wakefield & Poland 2004). Many are taking a lead role in Sure Start programmes but this is not about marketing health. Political motivation for widening community services is seemingly so "people will rely less on health professionals as the only source of expertise" (DH 2001b:27). Although, this reliance on other than professionals concurs with parents' preferences for social support, it is unhelpful in preparing those who will not seek help. The government has proclaimed that "by 2010 there will be 3,500 Children's Centres offering education, health and parenting services all on the same site" (Blair 2006). Before vulnerable families can equally participate in their community there is the issue of an imbalance of power between members, a lack of attention to class dynamics and an agreeable means of bridging the social divide between the disadvantaged and advantaged groups (Wakefield and Poland 2004).

Nor will setting policies for families with complex needs be successfully if based on the views of able parents. For example, seeking to establish acceptable health visiting services based on parents' satisfaction with services or their perceived information needs would be a mistake. The key findings from the National Mapping of Family Services (NPFI 2002) may represent the views of the majority of 'good enough' parents but they are unlikely to reflect the views of the more chaotic, apathetic, neglectful parents. The key findings were:

- Parents' anxiety about drugs and alcohol
- Education is major concern

- Less that half the parents wanted more information about help during the teenage years
- Parents' recipe for a successful family life was spending time together and talking with each other
- Some parents wanted information about parenting and children but 48% did not want child development information.
- Parents were more likely to seek help from family and friends first and then local services, and
- Other sources were less popular.

The documented and narrative findings of this study demonstrate a difference between the views expressed in the NPFI (2002) findings and the views of parents of children who were categorised as neglected. Anxiety in the NPFI report is more about children's drug and alcohol use than parents' use. Education is often neglected by neglectful parents and if a concern, it is one they have difficulty improving without intensive support, as both study one and two identified. Although some parents may appreciate information about help during the teenage years and parenting, neglectful parents in common with 'good enough' parents, are more likely to seek help from family and friends. The seeking of information and support, arguably, cannot be left to chance for some families. Common sense suggests that any 'wrongs' will be hidden from the world (Buckanan 2000: 21) but some wrongs need to be explored if children's health and development are not to be impaired. This will take skilful communication, effort and time, considerable effort and time if the health visitors' narratives in chapter six are typical levels of support required to initiate effective outcomes.

8.3.2 Rejection of services

The second limitation is the drop out rate of parents from programmes. The benefits for some families at risk of neglect cannot be denied. Unfortunately, as was found in this study, the retention rate of neglecting families was low. Some community services for parents living in disadvantaged area concede to not transforming every family (Ranson & Rutledge 2005) or were not perceived to have a positive impact (Tisdell et al 2005). Attribute determinants of retention are viewed as programme deliverer's attributes and mothers' attributes (Daro et al 2003). To some extent the

attributes of deliverers is addressed below (8.4) in the match between health visitors interests in supporting families and the communicative style adopted. Consideration of parental attributes follows. A third determinant to retention may be the programme content. Bakermans and colleagues (2003) found clearly defined needs and preferably a single focus rather than a multi-dimensional programme to be more effective. In this study there was no evidence to support either a single or multiple foci. What did appear to drive the health visiting interventions was the immediacy of needs at the time of contact, such as children not ready for school and not having had breakfast, the health visitor sets about providing food for them and transport to school.

8.3.3 Parents' self-efficacy

When all else fails and parents still reject services it may be that they are in the precontemplational stages of change. Emotional readiness to change can be linked to parental self-efficacy. Three factors have been found to be necessary to influence behaviour change. They are the intention to change, possessing the skills required for change and a reduction in environmental barriers to change (Connor & Norman 2005). An absence of these will affect parents' perceived ability to change. Though not a focus of this study but a potential influence on parents' engagement with services (Kendall & Bloomfield 2005); parent self-efficacy (PSE), or parents' belief in their ability to influence their children and environments (Ardelt & Eccles 2001) and to be a successful parents (Hess 2004) may be the missing attribute. By applying Jones and Prinz's (2005) attributions to PSE to the situation of seeking help the important context becomes clearer.

PSE is an *antecedent* in that parents' confidence has an influence over their parenting competence, such that parents with a low level of self-efficacy may not function as competently as parents with a higher level of self-efficacy. Belief in oneself is a motivating factor (Bandura 1982). Coupling a low PSE with socio-economic disadvantage PSE is a *consequence* in that the characteristics of disadvantage may undermine motivation to act. Thus to seek help would require some impulse (e.g. serious behaviour problem) to override the double burden of internal and environmental lack of confidence in self. On seeking help the environmental conditions of the interaction can act as a *mediator* to PSE. A positive

experience may improve parents' perceived competence but a negative experience will, likely, further reinforce a low PSE. As a result parents struggling with parenting, experiencing frustrations and encountering a service that is perceived to be unhelpful or disempowering may compound a low PSE. This *transactional* characteristic of PSE with its confirmation of inability will serve only to avoid seeking help in the future. At the earliest possible opportunity and before problems escalate it may be worth health visitors considering an exploration of parents' level of self-efficacy, into their search for health needs.

8.3.4 Developing self-learning resources for parents

Drop-out rates from community or professional services are mainly in relation to mothers, as few fathers attend because, as Rosen and Rutledge (2005) found most fathers do not perceive involvement as part of their role, at least with family centres. The survey upholds parents do not want to share difficulties with others or only a select few, but they may not have the knowledge or skills to help resolve the problem. A logical alternative is to provide a resource that can be used in the home and serve as a self-learning opportunity. Community and mobile libraries and video stores come to mind for access to resources that can be borrowed for home use or accessed where relevant equipment can be found (e.g. library computer services). All could be accompanied by information of additional support services and contact details. The recommended foci for difficulties are those where less help is likely to be sought. That is, for difficulties with sleep, toileting, temper tantrums, aggressive behaviour in children, discipline, domestic violence, and drug misuse and the need for marital support, bonding with children and feeling unable or inadequate to cope. The British Psychiatric Society has set a precedent by providing information on its website but not everyone would consider accessing a 'medical' society website or have the resources to access the internet.

A summary of the epistemological knowledge of health visitors in relation to children's health and developmental needs ought to take on an assessment mindset. That is, a mindset that incorporates protective and adverse factors; the fact that different definitions of 'neglect' are held by both lay and professional workers requiring some sharing of interpretations; and parents and children hide family shortcomings from outsiders. The mindset ought also to be cognisant of individual

preferences for social support over agency support but plan interventions according to children's health and developmental needs. Interventions may begin with the universal Child Health Promotion Programme but where professional judgements make explicit the actual or likely impairment to children's health and development the programme will be extended to additional interventions. This working knowledge of health visiting is outlined as the first element in the proposed conceptual framework – *Health Visiting as Communicative Action*, in table 8.1.

Epistemological knowledge/practice
Knowledge Knowledge of protective and adverse factors Recognising people hold different definitions of 'neglect' People hide their shortcomings from 'authoritative figures' People have a preference for social support over agency support Establishing an assessment mindset **Practice** Establishing a relationship Adherence to the Child Health Promotion Programme Establishing a mutually trusting relationship Gaining access to the family context Clarifying and revising interpretations of need/risk Determining when a build up of problems constitutes a child protection threshold

Table 8.1: Summary of Epistemological Knowledge

8.4. HEALTH VISITING AS COMMUNICATIVE ACTION

Reluctance of parents to accept health visiting and social services and social workers' reluctance to accept referrals may be part of the rational legitimacy people ascribe to different services. Health visitors' reporting of needs may also be part of their perceived legitimacy. Two factors, for example, that were often omitted from child health records were parenting status, such as single parenting, and unemployment status, despite their association with fiscal need. Where 'low income' or fiscal needs presented the affected families were directed by health visitors towards the perceived, appropriate agency; social services, or benefit agencies. Likewise housing difficulties were directed towards housing departments. Mental ill-health and drug and alcohol misuse were directed to mental health and

relevant voluntary services, providing parents agreed to a referral. Support for the learning difficulties of children and parents were shared with the appropriate key nurse or social worker, and so on. In common with others, but specific to health issues, health visiting practice has been ascribed the roles of advocacy, advising, information giving and supportive roles by Twinn (2000), which were consistent with the findings of this study. However, what was most enlightening about the findings was the identification of three different styles of communication. In effect, *health visiting is communicative action* that is applied differently to different aims (or interests) for intervention.

Rhetorical styles

Normative   Persuasive   Coercive

◄───►

Levels of concern

Universal   Extended interventions   Intensive interventions

◄───►

Focus of interest

Education   Participation/partnerships   Reflection/emancipation

◄───►
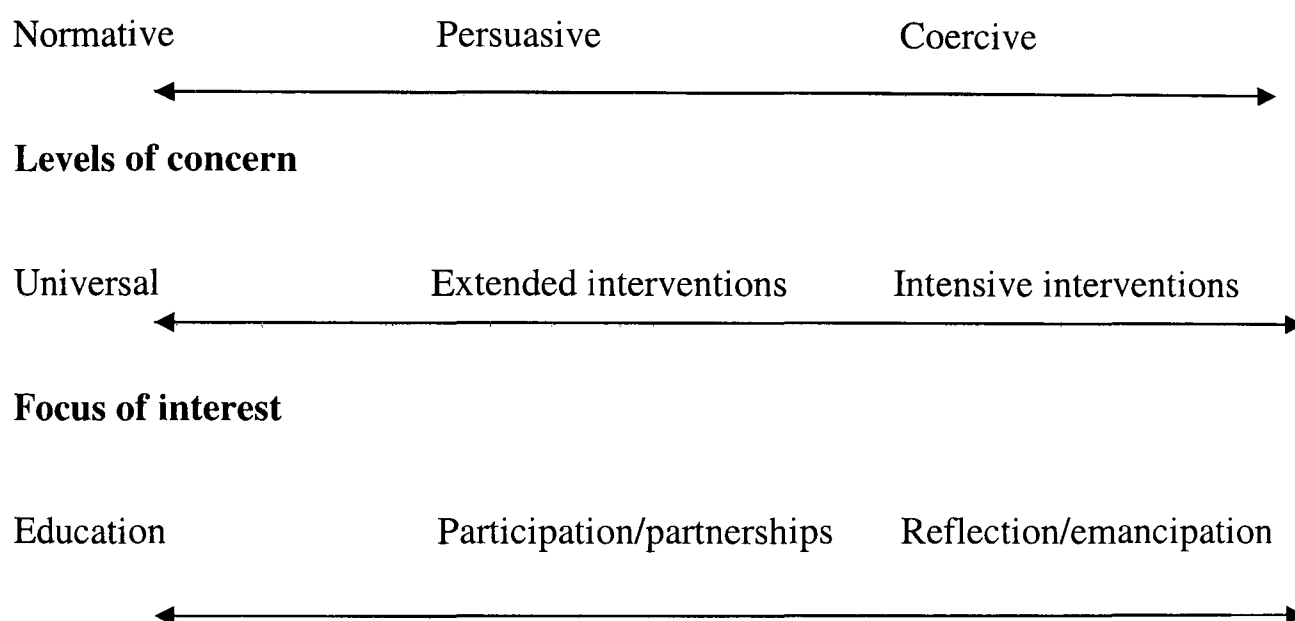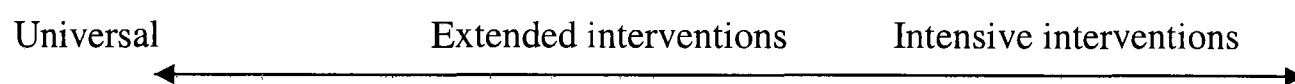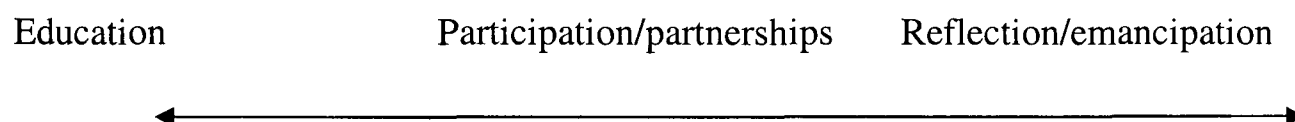
Figure 8.1: Continuum of communicative action and interests

Communicative action is the establishment and continuance of the family and health visitor relationship that is fundamental to successful outcomes at different levels of involvement (chapter 6) and mothers' engagement with services (Moorman & Ball 2001). Underpinning the process of establishing a relationship, accessing the context of the family, clarifying and revising interpretations of need and building opportunities to overcome barriers to health and development, is one or more style of communicative action. Each of the styles of communicative action - normative, persuasive and coercive rhetoric equated with different levels of concern and different foci of interests that together can be considered along a continuum of communicative action. The links between communicative styles, level

of concern and focus of interests are presented in figure 8.1 and explained further in the following sections.

8.4.1 Normative rhetoric

Rhetoric is adopted as the common term for the three styles of communication and is intended to mean "ultimately to produce action or change" (Bitzer 1968). Improved child care is the overall focus with the desired changes related to parental behaviour and family environment. Normative rhetoric is instructional and educational in that it informs health visitors and parents alike about protective and vulnerable factors that impact positively or adversely on children's health and development. These ought to be universal interest and the trend is that the majority of children achieve health and developmental competence due to adequate childcare (DH 2003) appropriate to their chronological age. Most parents are sufficiently autonomous to seek lay support or support from the health visiting service, or others, to meet their perceived needs. This includes families living in lower socio-economic circumstances who perceive a benefit from attending child health clinics (While 1986). Hence, normative rhetoric might adequately suffice to support the educational and instructional needs of the majority of parents, though, child-in-need statistics, which include child neglect and abuse, suggest that some families cannot be left alone.

Children-in-need and their families account for 3.33% of the childhood population (400,000 of 12 million). Although this figure is far too high, the actual number of families may be much smaller. Among the sample of neglected children in the case-control study, only 19 families accounted for 54 of the 83 children (65%). The most disturbing finding was that 17 families (of the 19) received long-term, intensive family support without any marked improvement to the care of their children. For these families a normative communication style was unlikely to have any beneficial effect.

8.4.2 Rhetorical persuasion towards understanding

A totally different approach will be required for some families; in effect, an open and honest approach to motivate and encourage the sharing of sensitivities. In this

way, health visitors and others can achieve, what children desire, and that is for workers to understand what they are going through (Dale 2004). The rhetorical style exemplary of this approach was rhetorical persuasion. The change of position of the word rhetoric is deliberate. It is changed to highlight the rhetorical nature to persuade rather than persuasion being the purpose of the communication. To do so would miss the opportunity to share sensitivities and compare values and beliefs, and miss the opportunity for reflection on individual issues. Rhetorical persuasion, as evidenced in study two, was a two-sided exchange of opinions that attempted to make conscious the participants' meanings of parenting and child care to reach a shared understanding. In contrast to normative and coercive rhetoric, rhetoric persuasion was time consuming, a highly charged, emotional involvement that was able to elicit negative automatic involuntary thoughts; hitherto unshared, unconscious thought. The highly charged, emotional involvement was due to the health visitors' opinions being challenged. Persuasive rhetoric was definitely not an easy option nor was it a quick fix but the outcome probably had a more lasting effect than normative or coercive rhetoric. The narratives with the most emotional sharing resulted in the most positive changes in that the families remained intact and changes were noted.

Guidelines suggest that health visitors need to be clear about the purpose and aims of their planned interventions with families and that "It may be necessary to consider whether [family] needs can better be met in other ways, for example, through Sure Start or community mothers programmes" (DH 2001: 31). Most certainly, clarity of aims and purpose are essential but the in-depth discussions between health visitors and seriously vulnerable families ought not to be limited to an assessment of need matched with an automatic referral to community services. Only a cursory meaning can be achieved in this way as Cowley, Micheson and Houston (2004) found. It would seem that referral to community services for families with a set of complex difficulties should only be made once a shared understanding of needs is reached about service options and the ability of the chosen services to improve the intention to change, develop the necessary skills to change, reduce barriers to change, and overall improve the circumstances for children and their family.

The standard remedy, a structured parenting programme, can only be empowering if not coerced. In the past, attempts to increase the application of structured parenting programmes has increase parents' demands for home visiting (Whittaker & Cornthwaite 2000) which suggests that it is the health visiting, home service that families with complex needs and with children likely to be neglected were mainly accepting of. Expressed pejoratively as health visitors' disliking the increased 'paperwork' as a result of increased home visiting (Whittaker & Cornthwaite 2000), this negativity was not upheld in this study. Although mothers experiencing vulnerability did prefer contact with health visitors, none of the health visitors expressed any regret at the substantial amount of time spent with families. Rather a sense of satisfaction and achievement was expressed, alongside the emotional challenge. Indeed, the pejorative interpretation of an increased demand for home visiting contradicts the expressed main purpose of health visitors - establishing a relationship with families to gain access to the context of the family, when necessary. Situations of necessity might follow clarifying and revising interpretations of intuitive awareness (Ling & Luker 2000) and are supported in the narrative study.

Access to the family context could be described as attempts to reach the 'real' world or *lifeworld* of children and their families in order to increase an understanding of their lives. The depth to which this is achievable is mainly through an environment that enables rhetorical persuasion. Rhetorical persuasion equated with the communicative action described by Habermas (1990: 58) as "when the participants coordinate their plans of action consensually, with the agreement reached at any point being evaluated in terms of inter-subjective recognition of validity claims". In other words, participants seek to *motivate each other to understand their respective views* and negotiate an agreement for action. In some of the health visitors' narratives there was a truthfulness of expression and evaluation of parenting and child care that was achieved without resorting to a power struggle (Deflem 1994) within the health visitor-parent relationship. To engage all three domains of the assessment framework for children in need (children's developmental needs, parental capacity and family and social environment) is unlikely to prove difficult as people's narratives generally relate one domain to another (Fredman & Fuggle 2000). Rhetorical persuasion was distinct from normative and coercive rhetoric by the emotional giving of the health visitor or sharing of meanings to come to a

shared understanding, and is similar to the giving and taking rhetoric described by Chalmers (1995). Rhetorical persuasion that is the means to establishing hermeneutic practice (understanding) is the second element of the *Health visiting as Communicative Action model* summary in Table 8.2.

Hermeneutic practice
Access to the context of the family Engaging with the lifeworld to make conscious family meanings/sensitivities Focus on needs (rather than risks) Clarifying and revising interpretations of needs, protection and risk to children Encouraging reciprocal motivation (worker/family) to reaching an understanding Using truthful expression Emotional involvement with family.

Table 8.2: Summary of the elements of Hermeneutic practice

8.4.3 Coercive rhetoric

When concerns arose and without rhetorical persuasion there was a reliance on normative and coercive rhetoric. In dangerous situations coercive rhetoric was the rhetoric of choice to elicit compliance. Coercive rhetoric aimed to achieve conformity to more normative views or legal requirement than the family seemingly possessed. It was the language of force used to elicit compliance in situations that were either deemed to be dangerous or placed children at risk of further neglect of their needs. Coercive rhetoric equated with the identification of needs that were concerned with children's health and development and that necessitated either extended or intensive health visiting. If all else failed coercive rhetoric or recourse to social services and legal action followed (Fortin 2004).

In most instances, coercive rhetoric was the last resort. To do otherwise would have incurred parental disapproval of professional 'interference' that, as one health visiting narrative implied, could have left victims of domestic violence hostages of a violent man because of professional inertia to confront the violence. Health visitors who became overly concerned with vulnerability such as failure to ensure children attended school, domestic violence, drugs or alcohol misuse and poor hygiene began to loose sight of the 'partnership' aspect of the health visitor and parent relationship. Despite this none lost sight of the impact of the presenting

vulnerabilities on children's health and development. Whilst this ought to go hand in hand with parental skills, the later is a focus that is often used to justify a coercive approach.

Parenting skills assessment and training usually followed a report of serious concern and not a clearly defined parent skills deficit. In one health visitor narrative parents with many children and thereby many years of parenting experience (the oldest child was 7 years old) were required to undergo 'parental assessment'. Another family with a 2 year old daughter who ingested a bag of heroin was immediately taken to the accident and emergency department of the local hospital. It was only then that an assessment of parenting capacity was considered by the multi-agency team. It is possible that an accumulation of concerns were raised that instigated the formal assessment of parenting but this could just as easily have been an opportunity for accident prevention education to prevent reoccurrence of ingestion of harmful substances. Rather, it would seem that assessment of parenting capacity is more about an opportunity to coerce parents to comply with organisational norms than build upon parenting skills. Other narratives told of parental assessment after the death of a family's 4th child. The oldest child was also 7 years old. Numerous times prior to the death of the child the health visitor had expressed concern and requested a child-in-need assessment. Coercion may have, indeed, been justified but it is the lack of honesty in relation to the formal assessment of 'parenting capacity' that sends misleading messages to parents about family 'support'.

Taking a parental perspective of these situations, to impose an assessment of parental skills after 2 to 7 years, and after close observations by a health visitor, with no earlier formal record of parental assessment is surely unethical. Also potentially unethical and a neglect of their duty to care is professionals (both health and social care) knowing about a lack of food, sanitation or supervision and parents' inability to care for their children but preferred to wait until a crisis was reached before offering interventions that address specifically the needs identified. One such example was of health and social services awareness that a primary caregiver, a grandmother, was dying and not preparing an otherwise ill-prepared, drug using mother who had previously abdicated responsibility for her oldest child in the past. Not only was this young mother to look after one child but a second child was also

expected. Assessment may indeed be an ongoing process but, sooner rather than later, a professional judgement ought to be made of parents' ability to provide adequately for their children, especially when serious concerns have been raised. Devaney (2004) found it was not uncommon for children to be registered 24 months after concern was raised. That is not to suggest that not registering children is professional neglect but to allow children to endure inadequate care without evidence of improvement for 24 months or more may constitute professional neglect.

Referral to social services was often as much to do with frustration caused to health visitors and others by the families' non-adherence to advice and information as to clearly identified problems. Skilled though health visitors may have be in assessing health needs (Cowley & Billings 1999; Appleton & Cowley 2003) not all health visitors openly share potential risk and negative aspects. In this study where negative aspects were identified and communicated change happened.

8.4.4. Emancipatory rhetorical persuasion

Fundamental to understanding the need for change is the process of self-reflection that encouraged parents to express how they see themselves, their role as parent and their social expectations. According to Habermas (1981) this critical self-awareness is emancipatory because it allows individuals to recognize the correct reasons for their problems and make desired changes. An example of this 'correct reason' might apply to the narrative where a mother expressed the opinion that she did not need help. Intuitively the health visitor was aware of her difficulties with child care and the possibility of another reason, a violent partner, for not accepting help. 'Being there for' this mother and because of the relationship that developed, the 'correct problem' was able to be disclosed. Perhaps it became clear to the mother that the health visitor did not intend a negative outcome but rather was genuinely concerned to alleviate in some agreeable way the burden of the mother's difficulties.

A wider context of parenting behaviour may be needed; one that involves the social influences on parenting, individual health needs and the different temperaments of both parents according to Corden & Somerton (2004). One narrative was particularly enlightening as to how self-reflection and the application of a wider

context of the family can improve the lives of children. A mother with learning difficulties and her partner with mental health problems were helped to reflect on and share their perceptions of children's needs. The result was a transformation of behaviour towards creating a home for their children that had a warm and homely atmosphere with family pictures and children's processions from a sparsely furnished, non child-friendly environment. Health visitors encouraging parental self-reflection identified more needs and set about meeting the identified needs, with or without the support of other agencies.

What every health visitor ought to bear in mind is that their thoughts and those of family members can be barriers to open styles of communicate. Parental self-interest in drug taking, as highlighted in one narrative was unlikely to elicit change with the health visitor "laying down the ground rules" and the father "totally disinterested" in what she had to say. Conversely, encouraging a mother to reflect on her own childhood and parenting experiences offered new insight into the lack of support. The mother had missed out on socialization experiences and education in her childhood and her mother was more interested in dancing than helping her daughter care for her children. Those health visitors using a rhetorical persuasive approach and encouraging self-reflection did not refer to their actions as counselling but they were able to gain an empathic understanding of maternal needs and difficulties, sufficient to empower parents to make changes.

Health visitors' narratives also demonstrate that the degree of giving and taking of information affects the power that can be shared in a relationship as claimed by Labonte (1994). The more giving and taking of meanings, in particular, the more mutually respectful a relationship would seem to be. Consequently, this raising of consciousness can be a precondition for change (Reder & Duncan 2003). Although Reder & Duncan, as consultant psychiatrists, may be implying a counselling, therapeutic approach, there is, generally, an inherent problem with 'psychologizing' communication to reach an understanding. That problem is the assumption that only 'counsellors' and mental health practitioners, or similarly trained people can undertake such interactions. Communication is said to encourage reflection, the eliciting of meanings and the opportunity to build empowerment awareness, skills and opportunities (Reder & Duncan 2003) and as some health visitors narratives demonstrate this can also be achieved by rhetorical persuasion.

Emancipatory practice
Encourage parents and children (of appropriate age) to self-reflect
Avoiding coercive rhetoric and coercive actions where possible
Use of honesty in expression of own or others reflections
Behaviour should not be a barrier to open communication
Reaching empathic understanding
Discuss perceived health needs or risks when recognised
Invite opinion about how health needs can be addressed

Table 8.3: Summary of the elements of Emancipatory practice

The emancipatory goal of freedom from oppression to empowerment is a theme that runs through health visiting literature but for some health visitors, information sharing is more conversational than rhetorical persuasion. Robinson's (1982) 'chats', Littlewood's (2000) negotiation of sensitivities and Twinn's (1991) emancipatory care are interactional through education and caring to achieve the goal of empowerment (Cowley 1995). Cowley (1995) further describes health visiting as a therapeutic relationship that facilitates a mutual learning experience and that raises consciousness of people's sense of empowerment. However, it is questionable if subtle sharing of information described by Appleton & Cowley (2003) is empowering. The evidence of emancipatory practice from this study supports the encouragement of self-reflection; the avoidance of coercive rhetoric; and honesty in the expression of own and others reflections. The elements of emancipatory practice are proposed as the third element in *Health visiting as Communicative Action model* and is summarised in table 8.3.

8.4.5: Elements of Critical Practice

The findings of this study demonstrate health visitors' application of empirical knowledge and variation in practice interests towards achieving desired goals for children's optimum health and development and emancipation of family members. Long-term involvement with families ought at least, to be periodically evaluated and an outline of parental strengths and limitations observed, discussed and recorded. Evaluation was implicit in the revision of the family issues when concern arose. The referral processes, case conference and review conference requirements seemed to sharpen the presentation of factors but rarely was a formal evaluation undertaken. Working with families and not 'paperwork' is what most health visitors

came into the job to do, but for reasons of openness and honesty some formal family health plan (DH 2001) is desirable in order to set goals for change where there are concerns about children's health or development. Otherwise, health visitors' cannot be surprised if they find parents mistrusting them when one-sided decisions are made about parenting without taking into account earlier negligence of primary workers to address crucial family needs.

As with all processes for health and social care evaluation of interventions is an expectation. When the quality of children's health and development are concerned adding a critical or evaluative component to family support is essential. Different levels of involvement with families can result in different outcomes. Applying coercive rhetoric is tantamount to judging the family against acceptable parental and children's behaviour and their level of compliance to these. Rhetorical persuasion that is termed hermeneutic practice will likely reach an understanding between parents (or child) and health visitor about the family's complex difficulties and the interests of the service. Further rhetorical persuasion that encouraged self-reflection (emancipatory practice) will engage with the 'real' world of the family. Where rhetorical persuasion is used there is, seemingly, greater potential for change. Finally, critical practice is reflection on the applied knowledge and practice of health visiting to determine the extent of success achieved to improvements in children's health and development. Such reflection, as health visitors' narratives demonstrated, enabled insight to be gained into what worked and what did not and to question why the particular outcome. Critical practice ought to be health visitors reflections on the match between the identified health needs, the communication style used, what was communicated and the outcome for children and their families. The criteria for critical review to inform change are proposed as, whether or not interventions achieved the following:

1. A child care focus throughout interventions;
2. Improvements in children's health and development;
3. Improvements in parental insight and skills to meeting children's need;
4. An understanding about the problems of the family;
5. Self-reflection on problems that were barriers to empowerment.

These criteria for evaluation or critical practice are together proposed as the fourth element of the conceptual model as presented in Figure 8.4.

Critical practice
Evaluation of :   Practice as child focussed   Improvements in children's health and development   Improvements to parental insight/skills   Engaging in persuasive rhetorical   Engaging in emancipatory (empowering) practice

Table 8.4: Summary of the elements of critical practice

In summary, professionals and parents must accept equal responsibility for seeking help or providing help when vulnerabilities are likely to or when impairment to a child's health and development is manifest. Attention is drawn to the recommendations that:

- Parents should be helped to understand that, although seeking help is their responsibility, seeking help is interpreted as strength and not a limitation.

- Services should respond to all needs but especially to the potentially predictive factors - management and handling of children, behaviour perceived a problem by parents and poor play/school attendance.

- Providing information about services and problem solving strategies needs to be closer to the social network of families.

- Health visitors adopt a persuasive rhetorical style of communication when working with families with complex needs or problems

8.5. CONCEPTUAL FRAMEWORK: HEALTH VISITING AS COMMUNICATIVE ACTION

Essential elements of the combined knowledge and practices of health visiting were associated with outcomes for children and their families, as outlined above (Tables 8.1 to 8.4). Different levels of involvement and different communication styles

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achieved different outcomes. Levels of involvement or interests extended from normative information or advice giving to reaching a mutual understanding, engaging with the real world of families and critical review of their own or others family support in terms of the impact on children. The relationships of practice and outcomes that constitute the conceptual framework *Health visiting as communicative action* are diagrammatically presented below in Figure 8.2.

PRINCIPLES AND PRACTICE OF HEALTH VISITING

Child Health Promotion Programme

Routine health visiting

Extended & intensive health visiting

(Targeted interventions)

Empirical knowledge of neglect   **Communicative practice**

Normative rhetoric   **Rhetorical persuasion and Hermeneutic practice**   Coercive rhetoric   **Family judged by compliance**

Reaching an understanding

Emancipatory practice

Engaging with the 'real' world of families

Critical practice   Critical review of practices to improve child health & development through family support

POTENTIAL OUTCOMES

Figure 8.2: Health visiting as Communicative Action: conceptual framework

The framework principally acknowledges the **person** as an individual with a unique *lifeworld* with meaning and understandings of parenting, family and childcare that

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may differ from those of workers. As such a family can hold multiple sets of unique needs that are not necessarily met within the family context. Whatever difficulties they experience they prefer social support to agency support and in some cases choose to hide, from agency workers, needs that reflect personal negative attributes. The **environment** of health visiting may be physical, caring, supportive or emotionally challenging. On the one hand, the physical environment is wherever is appropriate for the person to explore their or other family members health needs such as the family home, clinic setting or community environment. On the other hand, caring, supportive and emotionally challenging environments will necessitate access to the context of the family as this is were the care and nurturing takes place and where relational and value systems form the groundswell of family opinions about health needs and how to promote them. A safe environment is essential to nurture self-reflection and part of the safety is a health visitor who is willing to accept the emotional challenge that complex family problems beset them.

Health is a continuum from healthier to less illness throughout the life cycle when increased opportunities and barriers occur to becoming healthier. In relation to child neglect, specifically, barriers are a lack of resources related to family planning, management and handling of children, children's behaviour perceived a problem by parents and poor school attendance. **Health visiting** is communicative action that aims to support families in reaching optimum health for all children and building resilience. The most appropriate style of communication for all health visiting, especially, extended and intensive health visiting is rhetorical persuasion. That is reciprocal motivation to reach a shared understanding with the aim of emancipation towards behaviour change conducive to healthy families and childhoods. Attempts to influence change without actual discourse between themselves and families is strategic action rather than emancipatory interest. It is more likely to result in a coercive approach, or at least those disinclined to participate with the health visiting service might perceive any pressure to change them as coercive.

8.6: CHAPTER SUMMARY

The social reality of health visiting was relationally complex both with some families and other key agencies. Nevertheless, their universal application of the

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Child Health Promotion Programme enabled the identification of health needs generally and the identification and targeting of more vulnerable children and families. Where multiple factors from family history, parental capacity, children's health and development needs and social and environmental factors were identified action was taken to reduce difficulties in order to improve the opportunities for optimum health and development. However, the most effective outcomes were, seemingly, related to health visitors engaging with the 'real' needs or difficulties of families.

Major barriers were identified that limited the potential for effective healthy outcome for children and their parents and for emancipation from disempowering circumstances. The first barrier was health visitors not making explicit their professional judgements in order to elicit a core assessment of a child in need and family and thereby gain access to appropriate resources. To aid this process an Aggregate Effect of Neglect Guideline is proposed. The second barrier was parents' preference for social support. Although the expansion of community services may appear to acknowledge parents' preference for social support, it is possible that the drive towards community participation belies the power balance of members. The third barrier was the application of an appropriate communication style for the level of concern about the neglect of children's needs and health visitors' interest in the personal development of families.

Collectively, these barriers and the opportunities for creating healthy families and the practice knowledge of either normative communication or hermeneutic and emancipatory communication constitute the challenges of health visiting. Evaluation of that practice might appropriately adopt a critical review to determine whether or not the aims and interests of practice are conducive to promoting the health of children.

CHAPTER NINE

SUMMARY

9. 1. INTRODUCTION

Child neglect continues to be the most prevalent type of child maltreatment recorded for children named on Child Protection Registers. A substantial number of children are known to have experienced multiple types of maltreatment and it has been suggested that 'pure' forms of maltreatment are atypical. However, the argument that neglect may be the precursor to other forms of maltreatment is too important a possibility to ignore. Especially given the evidence provided in chapter one of neglect occurring earlier than other forms categorised as abuse; early maternal immature (cold, critical and unrealistic) responses to their babies and poverty of internal resources, material resources and relationship resources. All of which were supported in this study. The conclusion was of parents who were economically and temperamentally ill-prepared to care adequately for their children or the burden of their own lack of resilience, lack of material resourcefulness or relationship conflict detracts from the primary purpose of parenting; that of providing adequately for their children's needs.

At the commencement of this study, knowing the social reality of health visiting in relation to child neglect could not come from research evidence as little relevant research, and certainly no rigorous research process, had been undertaken. Although reference is made to the important role of health visitors in professional guidelines there could not be a substitute to sources of authoritative knowing than derived from the knowledge produced from the disciplined process of research, with each stage of the process open to interpretation and critique. Contemporary knowledge (from chapter one) supports a vulnerability (or risk) and protective (resilience) framework that protects against adversity and promotes health respectively. Since individuals and families swing back and forth along a health and illness continuum they can experience adverse social trajectories and different social contexts at different stages in life. Individual social trajectories of parents and their children have been found to be important to the assessment of their cumulative

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vulnerabilities and strengths that present when needing support. In order to turn limitations into strengths lists of traits have been developed that point towards external support and resources along with internal personal strengths and social interpersonal skills.

Change to health visiting practice (from chapter two) is anticipated and criticism of their ability to change is equally unmistakable. In terms of empirical findings research has not been able to establish the cost effectiveness of health visiting nor could conclusive evidence be drawn concerning the effectiveness of home visiting in reducing incidents of child abuse and neglect. What is sometimes overlooked is that effectiveness is not, necessarily, related to the actual parenting programme or home visiting but to the quality of the relationship between families and health visitors. When working with concepts of children in need and child protection health visitors were, not integral to but, referring *into* the child protection system. Health visitors were found to be less dependent upon research evidence, reluctant to communicate risk but accepting of intuitive awareness of child protection issues. Notably, the main tension in child protection work was associated with child neglect cases. Another was the 'supervisory role' imposed on them by social services. Misunderstanding each others roles was viewed as the foundations of such professional tensions with clearer divisions of responsibility recognised.

Theoretical lead for the study did not come from either the ecological model advocated to underpin the assessment framework for children in need. Nor did it come from health visiting theory as neither was considered an adequate framework to explore both the knowledge and practice of health visiting. As natural science has been the main source of empirical knowledge about child neglect and hermeneutics a source for understanding practice a combination of the two was contemplated. Habermas's critical theory was therefore justified (in chapter 3) as uniquely providing just such a framework with the added advantage of exploring the potential for emancipation

The results of this study offer new insights, which are:

- The application of empirical knowledge that found three factors with the ability to predict child neglect

- Health visitors' use of three styles of communication
- Inequalities in service provision seemingly stemmed from the use of an inappropriate communication style for the seriousness of concerns
- That there is the potential for inequality of power within the health visitor and parent relationships when a coercive communication style was employed, and
- Parents were reluctant to admit to issues related to the predictive factors and thereby were likely to delay the seeking of support.

From these new insights a conceptual framework was proposed in chapter eight: *Health Visiting as Communicative Action*.

9.2 IMPLICATIONS FOR HEALTH VISITING PRACTICE

Health visiting has been described as a profession in transition (Brocklehurst 2004). The findings of this study do not suggest a major transition, for health visiting has stayed true to its ecological approach to social problems and steadfast in its promotion of health and the prevention of ill-health and impaired development. Mainly a re-evaluation of priorities and a match of priorities with appropriate communicative styles are required. The first priority has to be a rethink of interventions for long-term neglectful childhood circumstances. In many ways the transition has already begun but what must not be lost in the redesign of family services is the focus on improving the quality of the lives of children living in adverse circumstances. The results of this study suggest the priorities for health visiting practice are to (1) incorporate communicative action suitable for complex family circumstances; (2) accept the lead responsibility for assessing health needs for vulnerable children, those categorised as children-in-need and abused and neglected children and creating opportunities for family health needs that impact on children's health and development; (3) the earliest possible making of a professional judgement, and recording of that judgement, about parental capacity when there are concerns about children's health and development; and (4) training in behaviour problems.

This proposed transition is further explored here. Firstly, as the relationship between families and health visitors is so important to gaining access to the context of the family and to supporting families working towards self-empowerment the appropriateness of the style of communication becomes crucial. An assessment instrument may be less an issue for identifying health needs if more rhetorical persuasion was adopted. Professional judgement would then begin to be shared, openly and honestly, whether positive or negative aspects. Rhetorical persuasion is essential for parents who fail to meet children's needs because, as empirical evidence has found, passivity and low self-esteem are associated with mothers who neglect their children. By encouraging a two way process of communication from the antenatal to postnatal period parents may feel more comfortable discussing sensitive issues. Rhetorical persuasion could more easily incorporate parental self-efficacy and social competence of mothers whose children have unmet needs without recourse to social service intervention that is seemingly unwanted by so many families. On the one hand, the aim would be to reduce children and family vulnerability by exploring knowledge and expectations of children and the professed ability to meet children's needs. Alternatively, it could increase mothers' social competence and parental competence towards building protective factors for children.

The second priority is for health visitors to accept that they have, not only the responsibility of identifying health needs for vulnerable children, but also the responsibility (with other key workers) to help create opportunities for families to meet their children's health needs. A measure of children's needs (or neglect) is inherent in the child health promotion programme and, therefore, physical neglect should be easy to recognise. From this study it is clear that health visitors identified a range of different needs and assessed children's developmental competence regularly. Compared with other agencies health visitors were, seemingly, more attuned to children's needs than some social workers who were neither accepting of, nor had the resources to deal with, children in need referrals (potentially child neglect). In many cases, social services rejected health visitors' referrals because the focus for interventions was the health and development of children. Consequently, as the NHS has responsibility for children's health and development and social service departments take lead responsibility for children's welfare it seems eminently reasonable to begin to contemplate a more skills based division of these

responsibilities. Where health and development of children is the main concern health visitors should be allowed to take a lead responsibility.

Improving the health and development of children was the primary remit of health visiting. Exploring meanings, life trajectories of family members and negotiating the need for change in order to improve children's lives and their potential constituted the communicative actions of health visiting. Families with complex difficulties were more accepting of the health visiting service than social services and with a reciprocal relationship were willing to plan change. Measured progress was recorded for children's health and development but measured progress for parental risky behaviour was left to other involved agencies. When no progress was achieved or there was deterioration in the adequacy of childcare the concerns were passed to social services but an assessment for a child-in-need was not always forthcoming. Health visitors deserve a greater degree of legitimacy to provide flexible, creative services, using all statutory and community resources as necessary for improving parenting and children's health and development. Community resources may include setting up self-directed learning packages for loan, access to parenting online information in public libraries, and more availability at home or group-based parenting programmes relevant to the identified children and parenting needs. Accrediting parenting programmes might even encourage some parents into child care employment. This recommendation does not negate social service involvement. Assessment and an audit of children-in-need and the level of service provision could still be carried out under the auspices of social services but the plan of action ought to remain with those with the relevant skills, committed to reducing vulnerability and who provide non-stigmatising family support that is acceptable to families; namely health visitors.

Thirdly, the assessment of parenting after many years of known, inadequate child care that led some health visitor to become frustrated with the lack of progress tended to deflect from the 'real' needs of children. Only recently have standards of parenting been directly assessed but ones with a direct measure of the impact on children's need, might, more effectively bridge the divide between parenting and children's needs. One such assessment used by some health visitors (in their narratives) was the Graded Care Profile. Used mainly in serious cases the Graded Care Profile could be applied at a much earlier stage of concern and could serve as a

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benchmark for future assessment of the quality of child care. Where dangerous parenting continues the Graded Care Profile would provide a more objective measure of attempts to improve or persistent harmful parenting to inform legal proceedings were warranted.

Finally, the prevalence of child behaviour that was perceived to be a problem demands an appropriately early response. Accredited training is recommended for all practitioners working intensively with children and families. Of the 83 neglected children in the case control study 17 (20.5%) developed behaviour problems requiring the intervention of mental health services. To prevent an escalation to such serious levels of behaviour early identification and interventions are essential for all childhood problems such as sleep, eating, toileting, biting, etc. One-to-one, group-based interventions or age specific behaviour training should be made available. Additionally, the use of Family Health Plans (DH 2001) could prove invaluable for both further research and serve as a reminder of the needs identified, behaviour of children, and the actions and inaction of parents and professionals alike to identify what works and what does not..

9.3 RECOMMENDATIONS FOR EDUCATION, PRACTICE AND RESEARCH

Whatever the implications for health visiting practice, practice, education and research are so intrinsically linked that neither can function adequately without the support of the others. To begin with education three recommendations are made. They are to:

1. Call for a debate about the theoretical base for practices aimed at safeguarding children from impairment and harm. The current ecological model is untested in relation to safeguarding children practices and is predominantly assessment oriented. Habermas's critical theory with the combined sciences of epistemology, hermeneutics and emancipatory knowledge, with the aim of determining what ought to happen rather than what does happen, may have greater value for an evidence-based service that aims to improve children health and development through parental and child empowerment.

2.   Training health visitors to adopt a rhetorical persuasion style of communication when working with vulnerable families who fail to meet their children's needs and reject community services, and

3.   Increasing health visitors' knowledge and empathic supervisory skills to their teaching of the management of behaviour problems.

In relation to practice, and in particular, with so much speculation about the metamorphosis of health visiting practice, the time could not be better for examining practice priorities and trialling new ways of working. Practice related recommendations are

4. Improved documentation of interventions (e.g. using Family Health Plans). Without a structured framework for planned interventions there is the distinct possibility of families being 'monitored'. The results of which were often repetition of services over many years with a passive acceptance of child care that is less than acceptable. This language change to emphasise recording of interventions rather than communication, may seem disingenuous to an empowering approach but the purpose is to make explicit the commitment of parents and health visitors to children's health and development.

5. Develop a 'respectful uncertainty' and 'health scepticism' of their own and others contribution to safeguarding children from impairment of health and development and harm. Justification for this recommendation stems, firstly, from the rejection of some health visitors and some parents requests for social work support. Secondly, the concepts were recommendations made by Lord Laming to underpin social workers and police. They should, realistically, apply to all workers charged with the responsibility to safeguard children.

6. Make explicit serous level of concern by using suitable frameworks. The current poor quality of shared information, when referrals to social services were made, could be indicative of a lack of desire to *act* on the behalf of children. Something must be done, urgently, to mend the ambiguity and misconceptions that surround the category of children in need between health visitors and social workers. Whether it is application of the 'Aggregate of Neglect Effect' guideline or

the Grades Care Profile or the Child Concern Model, matters not, but the clarity of the seriousness with which concerns are perceived is essential.

7. Health visitors should accept the lead responsibility of supporting families with children-in-need where the main concerns are for health and development. In this respect, there is some sympathy with the social work view that less serious cases do not meet the criteria for social service intervention. However, evaluations of child protection services have consistently found that available resources are not used effectively (Mostyn 1997) and that the majority of Social Service Departments (55 of 67) do not serve children well (Social Service Inspectorate 2006).

Specifically related to the educational and practice developments further research recommendations are made. They are:

8. To replicate the narrative study. However, rather than sample only health visitors the narrative study should include social work narratives of working with families who do not meet their children's health and developmental needs. A small number of additional observations are also recommended in order to offer an 'objective' view of the communication styles used and whether the two disciplines have similar or different interests and communication styles.

9. Trial the use of the Aggregate Effects of Neglect Guideline by comparing the assessment of the level of concern without and with the guideline. Tentative exploration of the guideline in the classroom setting has indicated the guideline to be beneficial to making a professional judgement but the exploration lacked rigour.

10. Trial the setting up, and access to a local library for parenting information, training packages, videos, and internet sites. With the collaboration of a local NHS Trust primary health care workers could decide on the type of resources to be purchased by the library. Primary care workers and the library service could then inform and/or recommend the library's parenting service to parents and their social network. Where empowerment or self-help is the stated aim of services it seems inappropriate for access to such resources to be allocated only by professionals and not be easily available to the public.

9.4 LIMITATIONS OF THE STUDY

As with any piece of work it is possible to look back in hindsight and identify any areas which could have been improved or elements which limit the utility of the study. Awareness of the ways in which a research study could have been strengthened is also part of the process of establishing research expertise and developing a critical approach to research. Limitations of this study were

(1) Maintaining a focus on health visiting and child neglect;

(2) An ambitious attempt to embrace the three interests of Habermas's critical theory;

(3) Some research questions may have blurred the investigation;

(4) Data analysis that lack statistical generalisation, and

(5) Difficulty in maintaining a blinkered view of health visitors' contribution when assessing the broader scope of their practice from prevention through to protection from neglect.

Firstly, the attempt to narrow the focus to child neglect and health visiting proved difficult because of the scarcity of relevant research literature. Nevertheless, the number of small studies available did provide a rudimentary understanding of the complex nature of working with families and attempting to secure family support and protection services. Case records, health visitors' narratives and parents' (and potential parents) survey combined to illuminate some of the social reality of health visiting but the phenomenon of child neglect was less in focus once the study moved from the epistemological knowledge to practical experience of working with families with children categorised as neglected. A major influence was probably the, initial, over reliance on child health records to provide the date required to identify health visitors' knowledge and their 'ways of working'. As the case-control study proved the records did not shed as much light on health visitors' practice as anticipated, hence the inclusion of health visitors' narratives. Perhaps the survey

was a spurious link to the reality of health visiting in that little is gleaned from the respondents about health visiting or child neglect other than the nature and importance of health visiting as a source of support.

Secondly, the attempt to embrace the three interests of Habermas's critical theory was overly ambitious. The emphasis of research evidence on contemporary health care practice seemed to support the inclusion of an epistemological method. However, the epistemological study served only to recognize recorded knowledge and not any positive or negative influence on health visiting practice. As Habermas more recently came to conclude, an epistemological framework could not speculate on distortions in social reality as any distortions can only be explored through 'communicative competence'. To some extent the study does embrace all three 'interests' but with one main fix on each interest rather than multiple fixes on the interests. It could be argued that the use of multiple methods is inappropriate when based on different theoretical positions but by using Habermas's critical theory, multiple positions were already integrated, or rather, they were until his change of direction to a process of self-reflection but that surely need not omit the more explanatory reasoning of practice that flows from empirical knowledge.

Thirdly, there is a consensus that asking the right question is the hardest discipline in the research process. The solution taken to compensate for the difficulty of concentrating on only one small part of the much larger issues was to attempt to unite a number of smaller questions, some of which may have blurred the investigative lens to the social reality of health visiting when working with child neglect. Three questions fall into this category: (1) how valid and reliable are the assessment instrument, (2) which factors are predictive of child neglect, and (3) do parents, having experience of health visiting, have a different perception of health visitors as a source of help from none parents.

Fourthly, in relation to sampling and collection of data the case-control method controlled by age, sex and locality rather than treating the samples equally. It was the different characteristics that one sample (neglected children) experienced that differentiated them from the control sample. Not using validity and reliability tested instruments may be perceived as a limitation of the study but it was the right decision. Instruments utilised for research purposes were mainly based on risk

factors and protective factors, though well documented, have only recently entered child neglect assessment in the Framework Assessment of Children in Need.

A clear limitation of the case control study was the reliance upon documented evidence that is subject to the knowledge of relevant factors and subject to the quality of record keeping. For example, unemployment and single parenting that may contribute to families' fiscal poverty are factors rarely recorded, perhaps because they were either not considered important factors or viewed within the remit of health care provision. This is inopportune, as actions are usually implemented according to the factors defined as needing interventions. Conversely, factors documented could be noteworthy to health visitors, and thereby an indication of the knowledge of child neglect.

Another clear limitation was the small size of the case control sample, narrative sample and survey sample for which the results cannot be generalised to the population and some sampling error was likely. As explained in 4.3.2 sampling for the case control study fell short of the required number, though in some respects it was a fairly large sample (60 or more) (Newton & Rudestam 1999). In the case control and survey studies it sometimes felt like statistical overload. Rather than using the bivariate analysis of cross-tabulation, in the case control study, to demonstrate a difference between the two groups on some characteristics a Factorial ANOVA test would have summarised more succinctly support or rejection of the null hypothesis. Indecision stemmed from the uncertain assumption that nominal data, non-normal distribution and small sample sizes were tested by non-parametric tests. Instead the advice of Newman & Rudestam to use both methods and if the results are the same to use the parametric findings should have been taken.

A limitation of the narrative study may be perceived in not analysing the narratives as a whole rather than in two stages but the latter allowed for the application of a more attuned lens to the health visiting process and the empowerment aims of the process. There are probably limitations in the views expressed and to how close they came to making sense of sensitivities of what happened to the health visitors in neglectful events that tellers wanted to convey. On the other hand, from a critical theory perspective it was essential to clarify the aims for change and a surprising number of differences, as well as similarities were found. Accordingly, the

limitations of this study are my limitations in critical appraisal. Computer aided analysis was commenced but it soon became clear how easy it was to lose sight of the overall context when trying to stay afloat in a sea of NVivo attributes, nodes, node sets and links. It was imperative, after some direction from NVivo, to return, in the final analysis, to the context of the narratives. Hence, the narratives in Appendix F are not coded.

Finally, taking time to reflect on limitations is always helpful. What would change if the study was to be repeated? Just this question is a realisation that the decisions made were always the result of compromise. The overall design was a compromise between applying a theory with three main interests (technical-cognitive interests (natural science), practical interest (hermeneutic science) and emancipatory interest (critical science) and a concentration on the work of health visiting with families vulnerable to neglecting their children's needs. Empirical considerations (of what is acceptable knowledge) balanced alongside ontological considerations (the nature of social entities) were reasonably successful in highlighting the knowledge associated with child neglect.

The narratives were far more revealing about factors 'real' to families and how families where perceived to deal with them as well as how health visitors responded. Social constructs of risk and protective factors, in hindsight, almost demands a purely narrative perspective, but not from just health visitors, from all involved parties. More narratives may have assisted in the construction of the meanings of the social actors (parents and health visitors) encountering the phenomenon (child neglect) under investigation. Change issues might more appropriately then have addressed more fully the process of protection and empowerment for parents and related essential resources.

In some ways the survey was a compromise to accessing the views of parents. One limitation was that the construct for empowerment was ill-defined. Intended to serve to demonstrate some legitimacy for health visiting as a helping agency for child care and parenting needs the legitimacy did not represent the matter of empowerment of parents and their responsibility to seek help when necessary. As a result of the reflection, a similar investigation would probably take a grounded theory or hermeneutic phenomenological approach. Sampling would attempt to

embrace the meanings of parents (mother and father) and health visitor. Taking into consideration the complexity of interagency collaboration, highlighted in the narrative study, it may even be fitting to include the meanings of social workers to working with families with children neglected.

9.5 CHAPTER SUMMARY

Child neglect is, conceptually at least, preventable if attention is given to (1) parents' management and handling of children and (2) all children's behaviour perceived a problem by parents. When a concern about children's health and development is raised health visitors are required to make professional judgements for which a rationale can be produced in order to justify their concerns and support from other agencies. As parents are charged with the responsibility of caring for their children the main aim of the health visiting service must be to support and where necessary engage in a rhetorical persuasive relationship with the view of encouraging parents to examine their sense of power to act autonomously. To achieve this four implications for health visiting practice are perceived. First is the recommendation for widespread adoption of Family Plans. Second is the adoption of an assessment mindset. Third is the use of concern frameworks to make the level of concern more explicit. Finally health visitors are urged to take the lead responsibility for children in need when health and development are the main concerns.

Both educational and research recommendations draw upon these implications to suggest how continuing professional development might be implemented. With the benefit of hindsight limitations to the study are observed and the potential for improvements recognised. Much of this self learning has been applied to the research recommendations in an effort to demonstrate the desire for the value of health visiting to be tested and shown to be of value, believing health visiting to be of value to the most vulnerable families when all else fails.

REFERENCES

Abidin, R.R. (1990) *Parenting Stress Index* (3rd Ed) Charlottesville, VA: Pediatric Psychology Press.

Axelsson, L. & Ejlertsson, G. (2002) Self-reported health, self-esteem and social support among young unemployed people: A population-based study. *International Journal of Social Welfare*, 11, 2, 111-119

Aday, L.A. (1993) *At Risk in America: the Health and Health Care Needs of Vulnerable Populations in the United States*. San Francisco, CA: Jossey-Bass

Adcock, M. (2002) The Process of Assessment: How to synthesise information and make judgement, In: *The Child's World – Assessing Children in Need, Training and Development Pack,* Leicester: NSPCC & University of Sheffield

Adcock, M. & White, R. (1998) *Significant Harm* (2nd Ed) Croydon: Significant Publications

Agger, B. (1991) Critical theory, poststructuralism, postmodernism: The sociological relevance. *Annual Review of Sociology*, 17, 105-131

Aggleton, P. (1992) *Health*, London: Routledge

Albee, G.W. & Ryan, K (1998) An overview of primary prevention. *Journal of Mental Health*, 7, 5, 441-449

Aldgate, J. & Statham, J. (2001) *The Children Act Now: Messages from Research (Studies in Evaluating the Children Act 1989)* London: Stationary Office

Aldgate, J. & Tunstill, J. (1995) *Making sense of Section 17*. London: HMSO

Allen, R.E. & Oliver, J.M. (1982) The effects of child maltreatment on language development. *Child Abuse & Neglect*, 6, 3, 299-315

Alloway, R. & Beddington, P. (1987) The buffer theory of social support: A review of the literature. *Psychological Medicine*, 17, 1, 91-108

Andrea, D. (1996) Systems theory and social work treatment, In: F. Turner (Ed) *Social work treatment*, (4th Ed) New York: Free Press.

Anson, O. Carmel S., Leverson, A. & Banneh, D.Y. (1993) Coping with recent life events: The interplay of personal and collective resources. *Behaviour Medicine*, 18, 4, 159-166

Antonovsky, A. (1980) *Health, stress and coping,* San Francisco, CA: Jossey-Bass Publishers

Antonovsky, A. & Sagy, S. (1986) The development of a sense of coherence and its impact on responses to stress situations. *Journal of Social Psychology*, 126, 2, 213-225

Antonovsky, A. (1987) The salutogenic perspective: Towards a new view of health and illness. *Advances*, 4, 1, 47-55

Antonovsky, A. (1996) The salutogenic model as a theory to guide health promotion. *Health Promotion International*, 11, 11-18

Appleby, L., Hirst, E., Marshell, S., Keeling, F., Brind, J., Butterworth & Lole J. (2003) The treatment of postnatal depression by health visitors: impact of brief training on skills and clinical practice. *Journal of Affective Disorders*, 77, 261-266

Appleton, J.V. (1994) The concept of vulnerability in relation to child protection: health visitors' perceptions. *Journal of Advanced Nursing*, 20, 1132-1140

Appleton, J.V. (1996) Working with vulnerable families: a health visiting perspective. *Journal of Advanced Nursing*, 23, 912-18

Appleton, J. V. & Cowley, S. (2000) *The Search for Health Needs.* Houndmills, Basingstoke, UK: Palgrave Publishers Ltd.

Appleton, J.V., (2000) using Guidelines to Prioritise Families Who Need Additional Health Visiting Support. In: J.V. Appleton, & S. Cowley *The Search for Health Needs: Research for Health Visiting Practice.* Houndmills, Basingstoke, UK: Palgrave

Appleton, J.V. & Cowley, S. (2003a) Valuing professional judgement in health visiting practice. *Community Practitioner*, 76, 6, 215-220

Ardelt, M. & Eccles, J.S. (2001) Effects of Mothers' Parental Efficacy Beliefs and Promotive Parenting Strategies on Inner-City Youth, *Journal of Family Issues*, 22, 8, 944-972

Arsham, H. (2004) *Statistical Data Analysis.* http://obelia.jde.aca.mmu.ac.uk

Ashton, J. & Seymour, H. (1988) *The new public health.* Open University Press; Milton Keynes

Aveson, J. (1987) Biblewomen and Sanitary ladies, *Health Visitor*, 60, 156-161.

Bacchus, L. Mezey, G. & Bewley, S. (2003) Experiences of seeking help from health professional in a sample of women who experienced domestic violence. *Health and Social Care in the Community*, 11, 1, 10-18

Bacon, H. & Richardson, S. (2001) Attachment theory and child abuse: An overview of the literature for practitioners. *Child Abuse review*, 10,6, 377-397

Baggaley, S. & Kean, S. (1999) Health visitors as Family Nurses: A Discussion of Research, Policy and Practice in the United Kingdom. *Journal of Family Nursing*, 5, 4, 388-403

Bakermans-Kranenburg, M.J., van Ljzendoorn, M.H. & Juffer, F. (2003) Less is more: Meta-analysis of sensitivity and attachment interventions in early childhood. *Psychological Bulletin*, 129, 3, 195-215

Bandura, A. (1982) Self-efficacy mechanism in human agency, *American Psychologist*, 37, 2, 122-147

Bandura, A. (1997) Self-efficacy: Towards a unifying Theory of Behavioural Change. *Psychological Review*, 84, 191-215

Barker, W. (1984) *Child Development Programme,* Early Childhood Development Unit, Bristol: University of Bristol.

Barker, W. (2005) Health visiting to families at home, *Community Practitioner*, 78, 2, 61-65

Barlow, A., Duncan, S. & James, G. (2002) New Labour, the rationality mistake and family policy in Britain. In A. Carling, S. Duncan & R. Edwards, *Analysing Families: Morality and situationality in policy and practice.* London: Routledge

Barlow, J. & Parsons, J. (2002) *Group-based parent-training programmes for improving emotional and behavioural health adjustment in 0-3 children* (Cochrane Review). In The Cochrane Library, Issue 2, Oxford, Update Software

Barlow, J., Steward-Brown, S., Callaghan, H., Tucker, J., Brocklhurst, N., Davis, H. & Burns, C. (2003) Working Partnership: The Development of a Home Visiting Service for Vulnerable Families, *Child Abuse Review*, 12, 172-189

Barnes, J., Belsky, J., Broomfield, K.A.., Dave, S., Frost, M., Melhuish, E., Harper, G., Layland, A., & McLeod, A. (2004) Disadvantaged but different: Variation among deprived communities in relation to childhood and family well-being. *Journal of Child Psychology and Psychiatry*, 46, 9, 952-962

Barrett, H. (2003) *Parenting Programmes for Families at Risk: A source book.* London: National Family & Parenting Institute.

Barry, C.A., Stevenson, F.A., Britten, N., & Bradley, C.P. (2001) Giving voice to the lifeworld: More humane, more effective medical care? A qualitative study of doctor—patient communication in general practice, *Social Science & Medicine*, 53, 487-505

Bates, J.E., Freeland, C.A., & Lounsdbury, M.L. (1979) Measurement of infant difficulty, *Child Development*, 50, 794-803

Beaglehole, R., Bonia, R., & Kjellstrom, T., (1993) *Basic Epidemiology*, World Health Organisation, Geneva

Beaves, W. R., & Hampson, R.B. (1990) *Successful families: assessment and intervention.* New York, NY, US: Norton & Co, Inc

Becker, J.V., Alpert, J.L., Bigfoot, D.S., Bonner, B.L., Geddie, L.F., Henggeler, S.W., Kaufman, K.L. & Walker, C.E. (1995) Empirical research on child abuse treatment: Report by the Child Abuse & Neglect Treatment Working Group, American Psychological Society. *Journal of Clinical Child Psychology*: Special Psychological Issues related to child maltreatment, 24, (Suppl), 23-46

Belsky, J. (1993) Etiology of child maltreatment: A developmental-ecological analysis. *Psychological Bulletin*, 114, 413-434

Bengel, J., Strittmatter, R. & Willmann, H. (1999) *What keeps people healthy? The current state of discussion and the relevance of Antonovsky's salutogenic model of health*. Research & Practice of Health Promotion, Volume 4, Cologne: Federal Centre of Health Education

Benner, P. (1994) *Interpretive phenomenology: Embodiment, Caring and Ethics in Health and Illness*. Thousand Oaks, California: Sage Publications, Inc.

Benner, P., & Wruber, J. (1989) *The primacy of caring: Stress and coping in health and illness*. Reading, MA: Addison-Wesley

Bennett, P. (1998) Quality of life: A phenomenological perspective on explanation, prediction and understanding in nursing science. *Advances in Nursing Science*, 8, 1, 1-14

Ben-Zur, H., Duvdevany, I., & Lury, L. (2005) Associations of social support and hardiness with mental health among mothers of adults with intellectual disability, *Journal of Intellectual Disability Research*, 49, 1, 54-62

Berkley, K.M. & Hanson, S.M.H. (1991) *Pocket Guide Family Assessment and Intervention*, St.Louis, Missouri: Mosby-Year Book

Berry, W.D. (1993) Understanding regression assumptions, In: W.D. Berry, *Qualitative applications in social sciences*, Volume 92, Sage University Paper Series. Newbury Park, CA: Sage Publications Inc.

Bhasker, R. (1986) *Scientific Realism and Human Emancipation*, London: Verso

Bidmead, C., Davis H. & Day C. (2002) Partnership working: what does it really mean? *Community Practitioner*, 75, 7, 256-259

Billingham, K. (1991) Public health and the community, *Health Visitor*, 64, 371-372

Birchall, E. & Hallett, C. (1995) *Working Together in Child Protection. Studies in Child Protection*, London: HMSO

Bitzer, L.F., (1968) The rhetorical situation. *Philosophy and rhetoric*, 1, 1-15

Black, M.M., Cox, C.E., Dubowitz, H., Litrownik, A.J., Pitts, S.C. & Runyan, D. (2005) Defining child neglect based on child protection services data. *Child Abuse & Neglect*, 29, 5, 493-511

Black, M.M., Hutcheson, J.J., Dubowitz, H.& Berenson, H.J. (1994) Parenting style and developmental status among children with non-organic failure to thrive. *Journal of Pediatric Psychology*, 19, 689-707

Black, M. (2000) The roots of child neglect. In: R.M. Reece (Ed) *Treatment of child abuse: Common ground for mental health, medical and legal practitioners* (pp157-164). Baltimore, MD, US: Johns Hopkins University Press.

Blair, T. (1996) *Speech to the CPU conference,* Cape Town, 14th October

Block, J. & Block, J.H. (1980) *The California Child Q-set,* Palo Alto, CA, US: Consulting Psychologists Press

Blumer, H. (1969) *Symbolic interationism,* Englewood Cliffs, NJ: Prentice-Hal

Boehm, B., Katz-Salamon, M., Smedler, A-C., Lagercrantz, H., &.Forssberg, H., (2002) Developmental risks and protective factors for influencing cognitive outcomes at 51/2 years of age in very-low-birthweight children. *Developmental Medicine & Child Neurology*, 44, 8, 508-516

Boles, S.M., & Miotto, K. (2003) Substance abuse and violence – A review of the literature, *Aggression and Violent Behaviour,* 8, 2, 155-174

Bolger, K.E., & Patterson, C.J. (2002) Sequalae of child maltreatment: vulnerability and resilience. In: S. Luthar., *Resilience and vulnerability: Adaption in the context of childhood adversities.* New York, NY, US: Cambridge University Press (pp156-181)

Bousha, D.M. & Twentyman, C.T. (1984) Mother-child interactional style in abuse, neglect, and control groups: Naturalistic observations in the home. *Journal of Abnormal Psychology*, 1, 106-114

Bowes, A.M. & Domokos, T.M. (1998) Health Visitors' Work in a Multi-ethnic Society: a Qualitative Study of Social Exclusion. *Journal of Social Policy*, 27, 4, 489-506

Bowlby, J. (1958) The nature of the child's tie to his mother. *International Journal of Psycho-Analysis*, 39, 350-373

Bowlby, J. (1969/1982) *Attachment and loss, Vol. 1, Attachment*, New York, US: Basic Books

Bowlby, J. (1988) *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books

Bowns, I.R., Croft, D.J., Williams, T.S., Rigby, A.S., Hall, D.M.B. & Haining, R.P. (2000) Levels of satisfaction of 'low-risk' mothers with their current health visiting service. *Journal of Advanced Nursing*, 31, 4, 805-811

Boychuk, Duchscher, J.E. (2000) Bending the habit: critical social theory as a framework for humanistic nursing education, *Nurse Education Today*, 20, 453-462

Bradley, R.H., Whiteside, L., Mundffrom, D.J., & Casey, P.H. (1994) Contribution of early intervention and early care giving experiences to resilience in low-birthweight, premature children living in poverty. *Journal of Clinical Child Psychology*, Special Issue: Impact of poverty on children, youth and families, 23, 4, 425-434

Bradley, R.B. & Caldwell, B.M. (1979) Home observation for measurement of the environment: A revision of the preschool scale. *American Journal of Mental Deficiency*, 84, 235-244

Brendgen J. (2002) Overcoming low self-esteem: A cognitive behaviour approach. *Stress News*, 14, 3, 1-7

Briggs C.J. & Garner P. (2006) *Strategies for integrating primary health services in middle- and low-income countries at the point of delivery*. Cochrane Database of Systematic Reviews, Issue 2, Art. No. CD003318

Briggs, H.E., Leary, J.D., Briggs, A.C., Cox, W.H, Shibano, M. (2005) Group Treatment of Separated Parent and Child Interaction, *Research on Social Work Practice*, 15, 6, 452-461

Brocklehurst N., (2004a) Is health visiting 'fully engaged' in its own future well-being? *Community Practitioner*, 77, 6, 214-218

Brocklehurst, N. (2004b) Embodying modernization: corporate working. *Community Practitioner*, 77, 8, 292-296

Brocklehurst, N. (2004c) The new health visiting: thriving at the edge of chaos. *Community Practitioner*, 77, 4, 135-139

Bronfenbrenner, U. (1977) Towards an experimental ecology of human development. *American Psychologist*, 32, 513-531

Bronfenbrenner, V. (1979) Context of child rearing: problems & prospects. *American Psychologist*, 34, 10, 844-850

Bronfenbrenner, V. (1989) Strengthening family systems. In: Zigler E.F. & Meryl F. *The parental leave crisis: Towards a national policy* (pp143-160) New Haven, Yale University Press.

Brown G (2006) *Family Service Units*, http://www.fsu.org.uk/home/Newsstory2. php.

Brown, G.W. & Rutter, M. (1966) The measurement of family activities and relationships: A methodological study. *Human Relations*, 19, 241-263

Bruner, J. (1992) Another look at New Look 1. *American Psychologist*, 47, 780-783

Bryman, A. (2004) *Social Research Methods* (2nd Ed) Oxford, UK: Oxford University Press.

Buchannan, A. (2000) You're Walking on Eggs: Findings from Research into Parenting. In: A. Wheal, *Working with Parents: Learning from other people's experience*. Lyme Regis, Dorset: Russell House Publishing

Buckinghamshire Health Authority (2000) *Parenting Education and Support in Milton Keynes*, Buckingham: Buckinghamshire Health Authority.

Burke J., Chandy J., Dannerbexk, A. & Watt, J.W. (1998) The Parental Environment Cluster Model of Child Neglect: An Integrative Conceptual Model, *Child Welfare League of America*, LXXVII, 389-405

Burton, M., & Kegan, C., (1998) Complementarism versus incommensurability in psychological research methodologies, In: M. Cheung-Chuung (Ed) *Current*

Trends in History ad Philosophy of Psychology, Leister, British Psychological Society.

Burton, R. & Macdonald, G. (1992) *Health Promotion: Disciplines and Diversity,* London: Routledge

Butler, N.R. & Golding, J. (Eds) (1986) *From birth to five: A study of the health and behaviour of British 5-year-old* (1ˢᵗ Ed) Oxford, New York: Pergamon Press

Byrne, M. (2001) *Hermeneutics as a methodology for textual analysis,* AORN Journal, 73, 5, 968-970

Calder, M.C. (2003) The assessment Framework: A critique and Reformulation, In: M. C. Calder & S. Hackett, *Assessment in Child Care: Using and developing frameworks for practice,* Lyme Regis, Dorset: Russell House Publishing

Calder, M.C. & Hackett, S. (2003) Part One: The DoH Framework for the Assessment of Children in Need and their Families: Overview and Critique, In: M. C. Calder & S. Hackett. *Assessment in Child Care: Using and developing frameworks for practice,* Lyme Regis, Dorset: Russell House Publishing

Calhoun, C. & Karaganis, J. (2001) Critical therapy, In: G. Ritzer & B. Smart, *Handbook of Social Theory,* London: Sage (pp179-200)

Callahan, L.E. & Pincus, T. (1995) The Sense of Coherence Scale in patients with rheumatoid arthritis. *Arthritis Care & Research,* 8, 1, 28-35

Cantwell, H B (1997) (4ᵗʰ edition) The neglect of child neglect. In: Helfer M.E., Kempe R.S., & Krugman R. D. *The Battered Child,* Chicago: The University of Chicago Press

Carlson, V., Cicchetti, D., Barnett, D. & Braunwald, K (1989) Finding order in disorganization: Lessons from research on maltreated infants' attachment to their caregivers, In: D. Cicchetti & V. Calson (Eds) *Child Maltreatment: Theory and research on the causes and consequences of child abuse and neglect,* New York: Cambridge University Press (PP494-528)

Carmel, S., Anson, O., Levenson, A., Bonneh, D.Y (1991) Life events, sense of coherence and health: gender differences on the kibbutz, *Social Science and Medicine,* 32, 10, 1089-1096

Carnwell, R. (2000) Models of specialist and higher level health visiting, In: A. Robotham & D. Sheldrake *Health Visiting: Specialist and Higher Level Practice*, Edinburgh, Churchill Livingstone (pp85-108)

Carpenter, D.R. (1995) Phenomenological Research Approach, In: H.J. Streubert & D.R. Carpenter, *Qualitative Research in Nursing*, Philadelphia, Pennsylvania: Lippincott Company.

Carper, B. (1978) 'Fundamental patterns of knowing in nursing', *Advances in Nursing Science*, 1, 1, 13-23.

Carper, B. (1992) 'Philosophical inquiry in nursing: an application'. In: J. Kikuchi & H. Simmons (Eds) *Philosophic inquiry in Nursing*, Newbury Park, California: Sage.

Carson, A. & Fairburn, G. (2002) The Whole Story: towards an ethical research methodology. *Nurse Researcher*, 10, 1, 15-29

Carter, J.D., Joyce, P.R., Mulder, R.T. & Luty, S.E. (2001) The contribution of temperament, childhood neglected abuse to the development of personality dysfunction: A comparison of three models. *Personality Disorders*, 15, 2, 123-135

Cederblad, M. & Hansson, K. (1996) Sense of coherence – A concept influencing health and quality of life in a Swedish psychiatric at-risk group, *Israel Journal of Medical Sciences*, 32, 194-199

Chaffin, M., Kelleher, K., Hollenberg, H. (1996) Onset of physical abuse and neglect: Psychiatric, substance abuse and social factors from prospective community data, *Child Abuse and Neglect*, 20, 191-203.

Chalmers, K. I. (1992) Giving and receiving: an empirical derived theory on health visiting practice. *Journal of Advanced Nursing*, 17, 1317-1325

Chalmers K. & Kristajanson, L. (1989) The theoretical basis for nursing at the community level: a comparison of three models. *Journal of Advanced Nursing*, 14, 569-574

Chamberlain, K. (2000) Methodolatry and qualitative health research, *Journal of Health Psychology*, 5, 285-296

Chamberlain, K., Petrie, K. & Azariah, R (1992) The role of optimism and sense of coherence in predicting recovery following surgery. *Psychology & Health*, 7, 4, 301-310

Chazan, M. et al (1980) *Some of our children: the early education of children with special needs.* London: Open Books

Christiansen, C., Seidl, T. & Carvoone, F. (2000) Initial treatment of neglect: medical, psychological and legal. In: R.R. Reece *Treatment of Child Abuse: Common Ground for Mental Health, Medical and Legal Practitioners*, Baltimore: The John Hopkins University Press. P165-1182

Cicchetti, D. & Lynch, M. (1993) Towards an ecological/transactional model of community violence and child maltreatment: Consequences for children's development. *Psychiatry: Interpersonal & Biological Processes.* Special Children and Violence, 56, 1, 96-118

Classical Liberal Comment on the News and Current Affairs (Civitas) (2004) *Why 'Sure Start' is a Sure-Fire Way of Not to Start Caring for Our Young,* http://www.civitas.org.uk/blog/archives/2004/09/why asurestart.html.

Clarke-Carter, D. & Marks, D.F. (2004) Intervention studies: design and analysis. In: D.F. Marks & L. Yardley *Research methods for clinical and health psychology.* London: Sage Publications, Inc. (pp 166-184)

Cody, A. (1999) Health visiting as therapy: a phenomenological perspective. *Journal for Advanced Nursing*, 29, 1, 119-127

Cody, A. T., Iphofen, R., Clarke, G. & Kelly, A. (1999) *Audit of Child Neglect Cases and the Development of the Likelihood of Neglect Assessment (LONA),* University of Wales, Bangor and North East Wales NHS Trust

Cody, A. & Squire, A. (1998) *Nurses' perceptions of good nursing care*, Professional Nurse, 13, 9, 578-582

Coe, R.M., Miller, D. K. & Flaherty, J.H. (1992) Sense of coherence and perception of care giving burden. *Behaviour, Health and Aging*, 2, 2, 93-99

Coe, C., Spencer, N., Barlow, J., Vostanis, P. & Laine, L. (2003) Services for pre-school children with behaviour problems in a Midland city, *Child: Care, Health and Development*, 29, 6, 417-424

Cohen, J. (1988) *Statistical power analysis for the behaviour sciences*, Hillsdale, NJ: Erlbaum

Cohen, S. & Wills, T.A. (1985) Stress, social support and the buffering hypothesis, *Psychological Bulletin*, 98, 2, 310-357

Collinson, S. & Cowley, S. (1998) An exploratory study of demand for the health visiting service, within a marketing framework. *Community Practitioner*, 71, 244-247

Colton, M. J., Drury, C. & Williams, M. (1995) Children in need: family support under the Children Act 1989, In: J. Aldgate, & J. Stratham, (2001) *The Children Act Now: Messages from Research (Studies in Evaluating the Children Act 1989)* London: Stationary Office

Community Practitioners' and Health Visitors' Association (2001) *National mapping of family services in England and Wales*: NFPI consultation document, London: CPHVA

Connor, N. & Norman P. (2005) *Predicting Health Behaviour*, Maidenhead, Berkshire: Open University Press.

Conrad, M. & Hammen, C. (1993) Protective and resource factors in high and low-risk children: A comparison of children with unipolar, bipolar, medically ill and normal mothers. *Development & Psychopathology*: Special Milestones in the development of resilience, 5, 4, 593-607

Coohey, C. (1995) Neglected mothers, their mothers and partners: The significance of mutual aid. *Child Abuse & Neglect*, 19, 8, 885-895

Coohey, C. (2003) Making judgements about risk in substantiated cases of supervisory neglect, *Child Abuse & Neglect*, 27, 821-840

Cooper, C. (1985) 'Good enough', border line and 'bad enough parenting', In: M. Adcock & R. White (Eds), *Good Enough Parenting* (pp58-80). London: British Agencies for Adoption and Fostering.

Cooper, A. (2003) Risk and the Framework for Assessment, In: M.C. Calder & S Hackett, *Assessment in Child Care: Using and developing frameworks for practice*, Lyme Regis, Dorset: Russell House Publishing

Corden, J. & Somerton, J. (2004) The Trans-Theoretical Model of Change: A Reliable Blueprint for Assessment in Work with Children and Families? *British Journal of Social Work*, 34, 7, 1025-1044

Cormack, D. (2000) *The Research Process in Nursing*, Oxford: Blackwell Science Ltd.

Cornwell, J. (1984) *Hard earned lives: accounts of health and illness from East London*, London: Tavistock

Corcoran, J. (2000) Family Interventions with Child Physical Abuse and Neglect: A Critical Review, *Child and Youth Services Review*, 22, 7, 563-59

Cottrell, R. R., Cottrell, J. T., Girvan, J.F. & McKenzie, M (1999) *Principles and foundations of health promotion and education*. Boston, US: Allyn & Bacon

Council for the Education and Training of Health Visitors (1977) *An investigation into the principles of health visiting*. London: CETHV

Cowley, S. (1994) Health-as-process: a health visiting perspective, *Journal of Advanced Nursing*, 22, 3, 433-441

Cowley, S., (2002) Public health practice in nursing and health visiting. In: S. Cowley (Ed) *Public Health in Policy and Practice: A Sourcebook for Health Visiting and Community Nurses*. London: Bailliere Tindell

Cowley, S., Mitcheson J. & Houston A. M. (2004) Structuring health needs assessments: the medicalisation of health visiting. *Sociology of Health & Illness*, 26, 4, 503-526

Cowley, S., Buttigieg, M., & Houston, A. (2002) *A first steps project to scope the current and future regulatory issues for health visiting*, London: Kings College

Cowley, S. (2003) Modernising health visiting education: potential, problems and progress. *Community Practitioner*, 76, 11, 418-422

Cowley, C. & Billings, J.R. (1999) Resources revisited: salutogenesis from a lay perspective. *Journal of Advanced Nursing,* 29, 4, 994-1004

Craft, J.L. & Staudt, M.M. (1991) Reporting and founding of child neglect in urban and rural communities, *Child Welfare,* 70, 3, 359-370

Cragg, A., Dickens, S., Taylor, C., Henricson, C. & Keep, G. (2002) *Reaching parents: Producing and delivering parent information resources.* London: National Family & Parenting Institute.

Craib, I. (1992) *Modern Social Theory.* Harlow: Pearson Education Ltd

Cragg Ross Dawson (1999) *Information and support needs of disadvantaged parents during pregnancy and early childhood,* London: Health Education Authority

Creighton, S. (1992) *Physical abuse,* London: NSPCC

Crisp, B. R. & Lister, P. G. (2003) Child protection and public health nurses' responsibilities, *Journal of Advanced Nursing,* 47, 6, 656-663

Criss, M.M., Pettit, G.S., Bates, J.E., Dodge, K.A. & Lapp, A.L. (2002) Family adversity, positive peer relationships and children's externalizing behaviour: A longitudinal perspective on risk and resilience. *Child Development,* 73, 4, 1220-1237

Crittenden, P.M. (1985) Maltreated infants: Vulnerability and resilience, *Journal of Child Psychology and Psychiatry and Allied Disciplines,* 26, 85-96

Crittenden, P.M. (1987) Non-organic Failure to Thrive: deprivation or distortion? *Infant Mental Health Journal,* 8, 51-64

Crittenden, P.M. (1997) Truth, error, omission, distortion and deception: The application of attachment theory to the assessment and treatment of psychological disorder. In: P.M. Crittenden, S.M. Dollinger & Clancy D.L. F. *Assessment and intervention issues across the life span.* Mahwah, NJ, US: Lawrence Erlbaum Associates (pp35-76)

Crittenden, P.M. (1999) Child Neglect: Causes and contributors. In: H. Dubowitz (Ed) *Neglected Children: Research, Practice and Policy.* Thousands Oaks, CA: Sage

Crittenden, P.M. & DiLalla, D.L. (1988) Compulsive compliance: The development of an inhibiting coping strategy in infancy. *Journal of Abnormal Child Psychology*, 16, 5, 585 -599

Crouch, J.L. & Milner, J.S. (1993) Effects of child neglect on children, *Criminal Justice & Behaviour*, Special Child Neglect, 20, 1, 49-65

Culp, R.E., Culp, A.M., Osofsky, D.J. & Osofsky, H.J. et al (1991) Adolescent and older mothers' interaction patterns with their six months old infants. *Adolescence*, 14, 2, 195-200

Dale, P. (2004) 'Like a Fish in a Bowl': Parents' Perceptions of Child Protection Services. *Child Abuse Review*, 13, 137-157

Dalgleish, L. (1998) Risk assessment: computer learning, diagnosis and Bayes: A commentary. *Child Abuse Review*, 7, 3, 189-193

Dalgleish, L. (2003) Risk, Needs and Consequences, In: M. C. Calder & S. Hackett. *Using and developing frameworks for practice*, Lyme Regis, Dorset: Russell House Publishing

Daniel, B. (2000) Judgements about Parenting: What do Social Workers Think They are Doing? *Child Abuse Review*, 9, 2, 91-107.

Daniel, B. (2004) An overview pf the Scottish multidisciplinary child protection review. *Child and family Social Work*, 9, 247-257

Daro, D. (1988) *Confronting child abuse*, New York, NY: Free Press.

Daro, D. & Donnelly, A.C. (2002) Charting the waves of prevention: Two steps forward, one step back. *Child Abuse & Neglect*, 26, 731-742

Daro, D., McCurby, K., Falconnier, L., & Stoanovski, D., (2003) Sustaining new parents in home visitation services: Key participants and programme factors, *Child Abuse & Neglect*, 27, 10, 1101-1125

Davis, H. & Spurr, P. (1998) Parent Counselling: an evaluation of a community child mental health service. *Journal of Child Psychology and Psychiatry*, 39, 365-376

Deave, T. (2003) Mothers' views on the First Parent Health Visitor Scheme. *Community Practitioner*, 76, 7, 251-256

Deaves, D. (2001) Prevention and management of postnatal depression, *Community Practitioner*, 74, 7, 263-267

De Bellis, M.D. (2005) The Psychobiology of Neglect. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children*, 10, 2, 150-172

De la Custa, C. (1994) Relationships in health visiting: enabling and mediating. *International Journal of Nursing Studies*, 31, 451-459

Demaris, A. (1992) *Logit Modelling: Practical application*. Series: Quantitative Applications in the Social Sciences Newbury Park, CA: Sage

Dennis, N. & Erdos, G. (1992) *Families without fatherhood*, Choice in welfare, No. 12. Oxford, England: LEA

Denscombe, M. (2003) *The Good Research Guide*. Maidenhead, UK: Open University Press

Dent, J.R. & McIntyre, C. (2000) Health visitors, children and parental mental health problems, In: P. Reder, M. McClure, (Eds) *Family matters: Interfaces between child and adult mental health*. New York, NY, US, Routledge (pp180-191)

Denzin N.K. (1994) The art and politics of interpretation. In: N.K. Denzin & Y.S. Lincoln (Eds), *Handbook of qualitative research*. Thousand Oaks, CA, US: Sage Publications, Inc

DePanfilis, D. & Zuravin, S.J. (1998) Rates, patterns and frequency of child maltreatment recurrences among families known to CPS, *Child Maltreatment*, 3, 27-42

Department of Education and Employment (1997) *Quality Protects: Early Years Development Partnerships and Plans in Guidance for 1995-1999*, London: HMSO.

Department of Health, *Children & Young Person Act 1963*, London: HMSO

Department of Health, *Children & Young Person Act 1969*, London: HMSO

Department of Health (1987) *Report of the Committee on Child Health Services 1976*, London: HMSO (MB/0439a)

Department of Health (1988) *Public Health in England: The report of the Committee of Inquiry into the Future Development of the Public Health Function*. London HMSO

Department of Health (1991) *Children Act 1989*, London: HMSO

Department of Health (1995) *Child Protection: Messages from Research*. London: HMSO

Department of Health (1997) *The New NHS - modern, dependable*, Cmnd 3807, London: The Stationary Office

Department of Health Department of Health (1998) *Supporting Families*, London: The Stationary Office, London.

Department of Health, Home Office, Department of Education and Employment and the National Assembly of Wales (1999) *Working Together to Safeguard Children: A guide for inter-agency working to safeguard and promote the welfare of children*. London: The Stationary Office.

Department of Health (1999a) *Saving Lives: Our Healthier Nation*. London: The Stationary Office

Department of Health (1999b) *Sure Start*, London: The Stationary Office

Department of Health (2000) *Framework for the Assessment of Children in Need and their Families*, London: The Stationary Office

Department of Health (2001a) *The Children Act Now: messages from research*. London: The Stationary Office

Department of Health (2001b) *The Health Visitor and School Nurse Development Programme: Health visitor practice development resource pack*. London: The Stationary Office

Department of Health, (2002) *Safeguarding Children: A Joint Chief Inspectors Report on Arrangements to Safeguard Children*. CI (2002) 15, London: The Stationary Office.

Department of Health, (2003) *Children in Need 2001*, London: DH Publications

Department of Health (2003a) *Emerging Findings: Getting the right start: The National Service Framework for Children, Young People and Maternity Services*. London: DH Publications

Department of Health (2003b) *Tackling Health Inequalities: A programme for Action*, London: DH Publications

Department of Health, (2004a) *National Service Framework for Children, Young People and Maternity Services*, London: DH Publications

Department of Health (2004b) *Core Document: National Service Framework for Children, Young People and Maternity Services*, London: DH Publication

Department of Health, (2004c) *Children Act 2004*, London: Stationary Office.

Derrida, J. (1976) *Of Grammatology*. Baltimore, MD: Johns Hoskins University Press.

Devaney, J. (2004) Relating outcomes to objectives in child protection, *Child and Family Social Work*, 9, 27-38

Dews, P., (1999) Introduction: Habermas and the desublimation of reason, In: P Dews *Habermas: critical reader*, Oxford: Blackwell

DiLeonardi, J.W. (1993) *Families in poverty and chronic neglect of children*, Families in Society, 74, 9, 557-562

Dingwall, R. (1977) Collectivism, regionalism and feminism: health visiting policy 1850-1975 *Journal of Social Policy*, 6, 3, 291-315

Dingwall R. (1987) No need to panic, (Myths about family violence) *Nursing Times and Nursing Mirror*, 83, 4 Feb. 28-30

Dingwall, R (1989) Some problems about predicting child abuse and neglect. In: O. Stevenson (Ed) *Child abuse: public policy and professional practice*, London: Harvester Wheatsheaf

Dingwall, R., Eekelaar, J. & Murray, T. (1995: 232) *The protection of children: state intervention and family life*. Aldershot, UK: Avebury

Doggett C. Burrett S. & Osbourn D.A. (2005) *Home visits during pregnancy and after birth for Women with an alcohol and drug problem.* Cochrane Database of Systematic Reviews, Issue 4, Art. No. CD004456

Dowling, M. (2004) Hermeneutics: an exploration, *Nurse Researcher,* 11, 4, 30-39

Dreman, S. (2000) The influence of divorce on children, *Journal of Divorce & Remarriage,* 32, 3-4, 41-71

Drennan, V.M. & Joseph, J. (2005) Health visiting and refugee families: issues in professional practice, *Journal of Advanced Nursing,* 49, 2, 155-163

Dreyfus, H.L. (1991) *Being-in-the-world: A commentary of Heidegger's "Being and Time".* Cambridge: MIT Press

Dubowitz, H. & Newberger, E. (1989) Pediatrics and child abuse, In: D. Cicchetti & Calson V. *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect.* New York, NY, US: Cambridge University Press. (pp76-94)

Dubowitz, H., Black, M., Starr, R.H., Zuravin, S. (1993) A conceptual definition of child neglect. *Criminal Justice and Behaviour,* 20, 1, 8-26

Dubowitz, H. Klockner, A., Starr, R.H.Jr. & Black, M.M. (1998) Community and professional definitions of child neglect. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children,* 3, 3, 235-243

Dubowitz, H. (1999a) *Neglected Children: Research, practice and policy.* Sage; Thousand Oaks

Dubowitz, H. (1999b) Neglect of children's health care. In: H Dubowitz (Ed) *Neglected Children: Research, practice and policy,* Thousand Oaks: Sage, (pp1109-1131)

Dubowitz, H., Pitts, S.C. & Black, M.M. (2004) Measurement of Three Subtypes of Child neglect. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children,* 9, 4, 344-356

Dunn, J. (1993) *Young children's close relationships: Beyond attachment, Sage series on individual differences and development,* Volume 4, Thousand Oaks, CA, US, Sage Publications.Inc.

Dunst, C.J., Jenkins, V. & Trivette, C.M. (1984) The Family Support Scale: Reliability and validity. Wellness Perspectives, *Journal of Individual, Family and Community Wellness,* 1, 45-52

Dunst, C.J., Trivette, C.M., Carol, M. & Deal, A.G. (1988) *Enabling and empowering families: Principles and guidelines for practice,* Cambridge, MA, US: Brookline Books.

Edmond, A. Pollock, J., Deave, T., Bonnell, S., Peters, T.J., Harvey, I. (2002) An evaluation of the First Parent Health Visitor Scheme. *Archives of Disease in Childhood,* 86, 150-157

Edwards, J., & Polay, J., (1994) Contradictions of support and self-help: views from providers of community health and social services to families with young children. *Health and Social Care in the Community,* 2, 1, 31-40.

Edwards, A., Shipman, K. & Brown, A. (2005) The Socialisation of Emotional Understanding: A Comparison of Neglectful Mothers and Their Children, *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children,* 10, 3, 293-304

Edwards, M (1994) The rationale for the use of risk calculators in pressure sore prevention, and the evidence of the reliability and validity of published scales, *Journal of Advanced Nursing,* 20, 2, 288-296

Edwards, A., Matthews, E., Pill, R & Bloor, M. (1998) Communication about risk: diversity among primary care professionals, *Family Practice,* 15, 4, 296-300

Egeland, B. (1991) A longitudinal study of high risk families: Issues and findings. In: R.H.Jr.Starr (Ed) & A. Wolfe, *The effects of child abuse and neglect: Issues and research,* (pp33-56) New York, NY, US: Guildford Press

Egeland, B. Carlson, E & Sroufe, L.A. (1993) Resilience as a process, *Development and Psychopathology,* 5, 517-528

Egeland, B. & Farber, E.A. (1987) Infant-mother attachment: Factors related to its development and changes over time. *Child Development*, 55, 3, 753-771

Egeland, B., Pianta, R. & O'Brian, M.A. (1993) Maternal intrusiveness in infancy and child maladaptation in early school years. *Development & Psychopathology*, 5, 3, 359-370

Egeland, B. & Sroufe, L.A. (1981) Attachment and early maltreatment, *Child Development*, 52, 1, 44-52

Elliott, S.A., Gerrard, J., Ashton, C. & Cox, J.L. (2001) Training health visitors to reduce levels of depression after childbirth: An evaluation. *Journal of Mental Health*, 10, 6, 613-625

Elkan, R., Kendrick, D., Hewit, M, Robinson, J.J.A.., Tolley, K., Blair, M., Dewey, M., Williams, D. & Brummell, K. (2000) *The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British Literature.* Health Technology Assessment, NHSR & DHTA Programme

Elkan, R; Kendrick, D., Dewey, M., Hewitt, M., Robinson, J., Blair, M., Williams, D., Brummell, K & Egger, M.(2001) Effectiveness of home based support for older people: Systematic review and meta-analysis. *BMJ: British Medical Journal*, 323, 7315, 719-714

Elstad, J.I. (1998) The Psycho-social Perspective on Social Inequalities in Health, *Sociology of Health & Illness*, 20, 5, 598-618

Emery, R. E. (1999) *Marriage, Divorce and Children's Adjustment* (Developmental Clinical Psychology and Psychiatry), Thousand Oaks, CA, US: Sage Publications, Inc

English, D.J., Thompson, R., Graham, J.C. & Briggs, E.C. (2005) Towards a Definition of Neglect in Young Children, *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children*, 10, 2, 190-206

Erickson, M. & Egeland, B. (1996) Child Neglect, In: J. Briere, L. Berliner, J. Buckley, C. Jenny & T. Reid (Eds) *The APSAC handbook on child maltreatment* (pp 4-20) Thousand Oaks, CA, US: Sage Publications, Inc.

Erickson M. & Egeland B. (1997) A developmental view of the psychological consequences of maltreatment, *School Psychology Review*, 16, 2, 156-168

Erickson, M., Egeland, B., & Pianta, R. (1989) The effects of maltreatment on the development of young children. In: D. Cicchetti & V. Carlson (Eds) *Child Maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp647-68). New York: Guildford Press

Etter, J-F. (2005) Comparing the Efficacy of Two Internet-Based, Computer-Tailored Smoking Cessation Programmes: A Randomised Trial. *Journal of Medical Internet Research*, 7, 1, e2

Evans, P. (1996) Government action, social capital and development: reviewing the evidence on synergy, *World Development*, 26, 6, 1119-1132

Ewles, L. & Simnett, I. (1995) *Promoting Health*, London: Scutari Press

Fairclough, N. (1993) Critical discourse analysis and the marketization of public discourse: The universities, *Discourse and Society*, 4, 2, 133-168.

Falmer R., Miller D., & Lawrenson R. (1996) *Lecture notes on: epistemology and public health medicine.* Oxford: Blackwell Scientific

Fals-Stewart, W., Golden, J. & Schumacher, J.A. (2003) Intimate partner violence and substance use: A longitudinal day-to-day examination. *Addictive Behaviours: Special Interpersonal Violence and Substance Use*, 28, 9, 1555-1574

Farrington, D.P. (1994) Early developmental prevention of juvenile delinquency. *Criminal Behaviour & Mental Health*, 4, 3, 209-227

Feagans, L. & Manlove, E. (1994) "Parents, Infants and day care teachers: Interrelations and implications for better child care". *Journal of Applied Developmental Psychology*, 15, 585-602p112

Feldman, M.A. (1998) Parents with intellectual disabilities: Implications and interventions. In: Lutzer J.R. (Ed) *Handbook of child abuse, research and treatment, Issues in Clinical Child Psychology.* New York, NY, US: Plenum Press (pp401-420)

Ferguson, H. (2001) Phenomenology and Social Theory, In: G. Ritzer & B. Smart *Handbook of Social Theory*, London: Sage (pp232-248)

Fergusson D. M. & Horwood L. J. (1995) Early disruptive behaviour, IQ, and later school achievement and delinquent behaviour. *Journal of Abnormal Child Psychology*, 23, 183-199

Festenstein, M (1997) *Pragmatism and political theory from Dewey to Rorty*, Chicago: University of Chicago Press.

Field, A. (2005) *Discovering Statistics Using SPSS* (2nd Ed) London: Sage

Finkelstein, N., Rechberger, E., Russell, L.A., VanDeMark, N.R., Noether, C.D., O'Keefe, M., Gould, K., Mockus, S. & Rael, M. (2005) Building Resilience in Children of Mothers Who Have Co-occurring Disorders and Histories of Violence: Intervention Model and Implementation Issues, *Journal of Behavioural Health Services and Research*, Special Issue: The Impact of Co-occurring Disorders and Violence on Women, 32, 2, 141-154

Finlayson, J.G. (2005) *Habermas: A Short Introduction*, Oxford: Oxford University Press

Fitzgerald, J. (1996) Fifty years of neglect: an overview. In M. Pritchard (Ed) *Neglect: A Fifty Year Search for Answers*, The Bridge Child Care Development Service and Islington Area Child Protection Committee.

Flavell, J.H. (1968) *The development of role-taking and communication skills in children*, Oxford, England: John Wiley & Sons.

Fluke, J.D., Yuan, Y-Y. T. & Edwards, M. (1999) Recurrence of maltreatment: An Application of the National Child Abuse & Neglect Data System, *Child Abuse & Neglect*, 23, 7, 633-650

Foley, P. (2001) The Development of Child Health and Welfare Services in England (1900-1948). In P. Foley, J. Roche, S Tucker, *Children in Society: Contemporary Theory, Policy and Practice*. Basingstoke: Palgrave

Ford, R. & Millar, J. (1997) *Private lives and public responses: lone parenthood and fiscal policy*, Joseph Rowntree Foundation.

Fortin, J. (2003) *Children's rights and the developing Law* (2nd Ed) London: Lexia Nexia

Foucault M. (1973) *Birth of the Clinic: Archaeology of Medical Perception*, London: Routledge

Fox, L., Long, S.H. & Anglois, A. (1988) Patterns of language comprehension deficit in abused and neglected children, *Journal of Speech and Hearing Disorders*, 53, 239-244

Frank, D.A., & Drotar, D. (1994) Failure to Thrive. In: R.M. Reece (Ed) *Child abuse: Medical diagnosis and management* (pp298-324)

Fraser, M.W. & Galinsky, M.J. (1997) Towards a resilience-based model of practice, In: M.W. Fraser (Ed), *Risk and resilience in childhood: An ecological perspective* (pp.265-276). Washington, DC: NASW Press.

Fredman, G. & Fuggle, P. (2000) Parents with mental health problems: Involving the children. In: P Reder, M McClure, A Jolley, *Family matters: Interface between child and adult mental health*. New York, NY, US: Routledge (pp 213-226

Freisthler, B. (2004) A spatial analysis of social disorganization, alcohol access and rates of child maltreatment in neighbourhoods, *Children & youth Services Review*, 26, 9, 803-819.

French, J. & Adams, L. (1986) *"From analysis to synthesis"*, Health Education Journal, 45, 2

Frenz, A.W., Carey, M.P. & Jargensen, R.S. (1993) Psychometric evaluation of Antonovsky's Sense of Coherence Scale, *Psychological Assessment*, 5, 2, 145-153

Freud, A. (1956) *Safeguarding the emotional health of our children: An inquiry into the concept of the rejecting mother*, National Conference of Social Workers, Casework papers 1954, Oxford, England: Family Service Association of America (pp5-17)

Frid, I., Ohlen, J. & Bergbom, I. (2000) On the use of narratives in nursing research. *Journal of Advanced Nursing*, 32, 3, 695-703

Friere, P. (1970) *Pedagogy of the Oppressed*. New York, US: Seabury Press

Gallagher, T.J., Wagenfeld, M.O., Baro, F. & Haepers, K. (1994) Sense of coherence, coping and caregiver role overload, *Social Science & Medicine*, 39, 12, 1615-1622

Gallaghe,r F. & Jasper, M. (2003) Health visitors' experience of Family Group Conferences in relation to child protection planning: A phenomenological study. *Journal of Nursing Management*, 11, 6, 377-386

Garbarino, J. (1991) The context of child abuse and neglect assessment. In: J.C. Westman (Ed) *Who speaks for the children? The handbook of individual and class child advocacy*, Sarasota, Fl, US: Professional Resources Exchange. Inc. (pp183-203)

Garbarino, J. (1995) The American was zone: What children can tell us about living with violence. *Journal of Developmental & Behavioural Pediatrics*, 16, 6, 431-435

Garmezy, N. (1993) Children in Poverty: Resilience despite risk. Psychiatry: *Interpersonal and Biological Processes*. Special Issues: Children and Violence, 56, 1, 127-136

Garmezy, N (1994) Reflections and commentary on risk, resiliency and development, In: R.J. Haggarty; L.R. Sherrod; N. Garmezy & M Rutter (Eds), *Stress, Risk and Resiliency in Children and Adolescents: Process, Mechanisms and Interventions*. Cambridge, UK: Cambridge University Press.

Gaudin, J.M. (1993) *Child Neglect: A Guide for Interventions*, US Department of Health and Human Services, The Clearing House on Child Abuse and Neglect Information

Gaudin, J.M. & Polansky, N.A. (1986) Social distancing of the neglectful family: Sex, race and social class influences. *Children & Young Services Review*, 8, 1, 1-12

Gaudin, J.M., Polansky, N.A. & Kilpatrick, A.C. (1992) The Child Well-Being Scale: A field trial. *Child Welfare*, 71, 4, 319-328

Gavin, L.A., Black, M.M., Minor, S., Abel, Y., Papos, M.A. & Bentley, M.E. (2002) Young, disadvantaged fathers' involvement with their infants: An ecological perspective, *Journal of Adolescent Health*, 31, 3, 266-276

Gelles, R. J. (2000) Treatment resistant families, In: R.M. Reece, *Treatment of Child Abuse: Common Ground for Mental Health, Medical and Legal Practitioners*. Baltimore: The Johns Hopkins University Press (pp304-312)

George, V.D. (1996) Field workers' sense of coherence and perception of risk when making home visits, *Public Health Nursing*, 13, 4, 244-252

Gerrshater-Molko, R.M., Lutzker, J.R. & Sherman, J.A. (2000) Interventions in child neglect: an applied behavioural perspective. *Aggression and Violent Behaviour*, 7, 103-124

Gibbs, G.R. (2002) *Qualitative Data Analysis: Explorations with NVivo*. Buckingham, Open University Press.

Gibbens, A. (1984) *The Constitution of Society*, Berkeley, US: University of California Press

Gillham, B., Tanner, G., Cheyne, B, Freeman, I., Rooney, M. & Lambie, A (1998) Unemployment rates, single parent density, and indices of child poverty: Their relationship to different categories of child abuse and neglect. *Child Abuse & Neglect*, 22, 2, 79-90

Gill, O. (1992) *Parenting under pressure*. Bristol: Barnardos

Giovannoni, JM. & Becerra, RM. (1979) *Defining Child Abuse*, Free Press: New York.

Giovannoni, J. (1989) Definitional issues in child maltreatment, In: D. Cicchetti & V. Carlson (Eds) *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect*. New York, NY: Cambridge University Press.

Giovannoni, J.M. & Bererra, R.M. (1979) *Professionals view child maltreatment. Defining child abuse* (pp77-156), New York, NY, US: The free Press

Glaser, D. (2002) Emotional abuse and neglect (psychological maltreatment): A conceptual framework. *Child Abuse & Neglect*, 26, 6-7, 697-714

Goldberg, D. (1989) Screening for psychiatric disorder, In: P. Williams, G. Wilkinson (Eds) *The scope of epidemiological psychiatry: Essays in honour of Michael Shepherd*. Florence, KY, US: Taylor & Frances/Routledge

Goldthorpe, L. (2004) Every Child Matters: A Legal Perspective. *Child Abuse Review*, 13, 115-136

Gomby, D.S., Cultross, P.L. & Behrman, R.E. (1999) Home0visiting: Recent programme evaluations – analysis and recommendations. *The Future of Children*, 9, 4, 4-26

Goncalves, O.F. (1995) Hermeneutics, constructivism and cognitive-behavioural therapies: from the object to the project. In: O.F. Goncalves, R.A. Neimeyer & J.M. Mahoney. *Constructivism in psychotherapy*, Washington, DC, US: American Psychological Association.

Goodwin, S. (1988) Whither health visiting? *Health Visitor*, 61, 379-382

Gorin, S (2004) *Understanding What Children Say: Children's Experiences of Domestic Violence*. Barkingside, UK: Children's Bureau & Joseph Rowntree Foundation

Green, L.W., Richard, L. & Potvin, L (1996) Ecological foundations of health promotion, *American Journal of Health Promotion*, 10, 4, 270-281

Green, LW., & Kreurer, MW., (1991) *Health Promotion Planning: An Educational and Ecological Approach* (3rd Ed). Palo Alto, CA: Mayfield Publishing Co.

Green, J. & Thorgood, N. (2004) *Qualitative methods for health research*, London, UK: Sage Publications, Inc

Greenhalgh, T. (1997) Getting your bearings (deciding what the paper is about) *British Medical Journal*, 315, 243-246.

Grotberg, E. H (1997: 1) The International Resilience Project. In B. Bain *Psychology and Education in the 21st Century*.

Grotberg E. H. (2003) *Resilience in the family with children who are exceptional*, Delica, SC, US: Greenwood Publishing Group

Guba, E.G. (1981) Criteria for assessing the trustworthiness of naturalistic inquiries, *Educational Communication and Technology Journal*, 29, 75-92.

Guba, E.G. & Lincoln, Y.S. (1994) Competing paradigms in qualitative research. In: N.K. Denzin & Y.S. Lincoln (Eds) *Handbook of Qualitative Research*, Thousands Oaks, California: Sage

Guterman, N. B (2001) *Stopping child maltreatment before it starts: Emerging horizons in early home visitation services*. Thousand Oaks, CA, US: Sage Publications, Inc.

Guterman, N.B. & Lee, Y. (2005) The Role of Fathers in Risk for Physical Child Abuse and Neglect: Possible Pathways and Unanswered Questions. *Child*

Maltreatment: Journal of the American Professional Society on the Abuse of Children, 10, 2, 136-149

Habermas, J. (1968/1998), (6th Ed), *Knowledge and Human interests*, (Trans. Jeremy J), Shapiro. Boston: Beacon Press.

Habermas, J. (1973) *Dogmatism, Reason and Decision: On Theory and Praxis in our Scientific Civilisation* (Trans. J. Viertel), Boston: Beacon Press

Habermas, J. (1979) *Communication and the Evolution of Society*, Edited and translated by Thomas McCarthy, Boston: Beacon

Habermas, J. (1981) *The theory of communicative action, Vol 1, Reason and the rationalization of Society*, Translated by Thomas McCarthy [1984], Boston: Beacon.

Habermas, J. (1986) *The New Obscurity: The Crisis of the Welfare State and the Exhaustion of Utopian Energies.* (Trans. P. Jacobs) Philosophy & Social Criticism, 11, 1-17

Habermas, J. (1987) *The theory of communicative action, Vol 2, Lifeworld and System: A critique of functionalist reasons*, translated by Thomas McCarthy. Boston: Beacon

Habermas, J. (1989) *The Structural Transformation of the Public Sphere: An inquiry into a category of Bourgeois Society.* Trans.Thomas Burger. Cambridge, Mass.: MIT Press

Habermas, J. (1990) *Moral Consciousness and Communication Action* (Trans by C. Lenhardt & S. Weber-Nicholson, Cambridge: Polity Press

Habermas, J. (1995) *Moral Consciousness and Communicative Action*, Cambridge, Cambridge University Press

Habermas, J. (1998) Communicative Ethics. In: J. Habermas, *The inclusion of the other studies in Political Theory* (Trans. A Blunden) MIT Press

Habermas, J. (1999) *On the Pragmatics of Communication* (trans. M. Cooke) MA: MIT Press

Hair, J.F., Anderson, R.E., Tatham, R.L. & Black, W.C. (1995) *Multivariate data analysis* (4th Ed), Englewood Cliffs, NJ: Prentice-Hall

Hall, D.A. (1989) *Health for all children* (1st Ed) Oxford: Oxford Medical Publications

Hall, D.M.B. (1991) *Health for all children: a programme for child health surveillance. Report of the Joint Working Party on Child Health Surveillance*, (2nd) Oxford, UK: Oxford University Press

Hall, D. (Ed)(1996) *Health for all children: a programme for child health surveillance, Report of the Joint Working Party on Child Health Surveillance*, 3rd (Ed). Oxford: Oxford University Press

Hall, W. A. & Callery, P. (2003) Balancing personal and family trajectories: an international study of dual-earner couples with pre-school children. *International Journal of Nursing Studies*, 40, 401-412

Hall, D.M.B.& Elliman, D. (2003) *Health for all children*. (4th Ed) Oxford, UK: Oxford: Oxford University Press.

Hall, C. & Webster, R. (2002) Traumatic symptomology characteristics of adult children of alcoholics, *Journal of Drug Education*, 32, 3, 195-211

Hamilton, C.E. & Browne, K.D. (1999) The repeated victimization of children: Should the concept be revised? *Aggression and Violent Behaviour*, 3, 1, 47-60

Hammersley, M. (1995) Deconstructing the qualitative-quantitative divide. In: J Brannan (Ed) *Mixed methods: Qualitative and quantitative research*. Aldershot: Averbury

Hampshire, A.J., Blair, M.E., Crown, N.S., Avery, A.J. & Williams, E.I. (2002) Assessing the quality of preschool child health surveillance in primary care: a pilot study in one health district, *Child: Care, Health and Development*, 28, 3, 239-249

Harbour, R. & Miller, J. (2001) A new system of grading recommendations in evidence based guidelines, *British Medical Journal*, 323, 334-336.

Harper, D.G.C. (1991) Communication, In: J.R. Kneles & N.B. Davies (Eds.) *Behavioural Ecology: An Evolutionary Approach*. London: Blackwell Scientific Publications (pp388-396)

Harrington, D., Black, M.M., Starr, M.H.Jr. & Dubowitz, H (1998) Child neglect: Relation to child temperament and family context. *American Journal of Orthopsychiatry*, 68, 1, 108-116

Harvey, L. (1990) *Critical Social Research*, London: Unwin Hyman

Hawe, P. & Sheill, A. (2000) "Social Capital and Health Promotion: A Review". *Social Science & Medicine*, 51, 6, 871-875

Health Visiting Association (HVA) (1994) *A Cause for Concern: An Analysis of Staffing Levels and Training Plans in Health Visiting and School Nursing*. London: HVA

Hegel, G.W.F. (1991) *Elements of the Philosophy of Right* (Trans, A. Ward & H. Nisbert, Cambridge: Cambridge University Press

Heidegger, M. (1927/1962) *Being and Time* (Trans. J. Staumbaugh) NY, US: Harper Row

Held, D. (1980) *Introduction to Critical Theory: Horkheimer to Habermas*, Berkeley, CA, US: University of California Press

Heller, S.S., Larrien, J.A., D'Imperiod, R, & Baris, N.W. et al (1999) Research on resilience to child maltreatment: Empirical considerations. *Child Abuse & Neglect*, 23, 4, 321-338

Henricson, C. (2001) *Government and Parenting*, York: National Family & Parenting Institute & Joseph Rowntree Foundation

Henricson, C. (2003) *Government and parenting: Is there a case for a policy review and a parents' code*. York: National Family & Parenting Institute & }Joseph Rowntree Foundation

Herrenkohl, E.C., Herrenkohl R.C. & Egolf B. (1994) Resilient early school age children from maltreated homes: Outcomes in late adolescence. *American Journal of Orthopsychiatry*, 64, 2, 310-309

Heyden, C (2004) "Parental substance misuse and child care social work: Research in a city social work department in England" *Child Abuse Review*, 13, 1, 18-30

Hildyard, K.L. & Wolfe, D.A. (2002) Child neglect: Developmental issues and outcomes. *Child Abuse & Neglect*, 26, 6-7, 679-695

Hill, P.S., (2002) The rhetoric of sector wide approaches for health development. *Social Science & Medicine*, 54, 11, 1725-1737

Himelein, M.J. & McElrath, J.A. (1998) Resilient child sexual abuse survivors: Cognitive coping and illusion. *Child Abuse & Neglect*, 20, 747-758

Hinde, R.A. (1979) *Towards Understanding Relationships*. London, UK: Academic Press

Hobfall, S.E., & Stephens, C. (1990) Social support during extreme stress: consequences and intervention. In B.A. Sarason & Pierce I.G. (Eds) *Social support an international view*. Chichester: Wiley.

Hogg R. & Worth A. (2000) Parents' view of health visiting and child development, *Community Practitioner*, 73, 11, 835-838

Holdin, E.W., Willis, D.J., Foltz, L. (1989) Child abuse potential and parenting stress: Relationships in maltreating parents. *Psychological Assessment*, 1, 1, 64-67

Holloway, I & Wheeler, S (1996) *Qualitative Research fro Nurses*, Oxford: Blackwell Science

Holmes, J. (1996) Attachment theory: A secure base for policy, In:: S Kraemer & J. Roberts, *The Politics of Attachment: Towards a Secure Society*, London: Free Association Books Ltd. (pp27-42)

Home Office (1998) *Supporting families: A consultation document*. London: The Stationary Office

Home Office (1999) *Supporting families: Summary of the Consultation Document*. London: The Stationary Office

Hong Y-Y. & Hong L.K. (1991) Comparative perspectives on child abuse and neglect; Chinese versus Hispanics and Whites, *Child Welfare*, 70, 4, 463-475

Horwath, J. & Morrison, T. (2000) 'Identifying and implementing pathways for organisational change – using the Framework for the Assessment of Children in Need and their Families as an example', *Child & Family Social Work*, 5, 245-254

Howe, D. (2000) Attachment. In J. Horwath (Ed) *The Child's World*, Department of Health/NSPCC/University of Sheffield.

Howe, D. (2003) Assessments Using an Attachment Perspective, In: M.C. Calder & S. Hackett, *Assessment in Child Care: Using and developing frameworks for practice.* Lyme Regis, Dorset, UK: Russell House Publishing Ltd.

Howing, P.T., Wodarski, J.S., Kurtz, P.D. & Gaudin, J.M.Jr. (1993) *Maltreatment and the school-age child: Developmental outcomes and system issues.* Harworth health and social policy, New York, NY: Haworth Press, Inc.

Hoyt, M.F. (1994) *Constructive therapies*, New York, NY, US: Guildford Press.

Huckin, T.N. (1997) Critical discourse analysis, In: T.Miller (Ed) *Functional approaches to written text*, http://exchanges.state.gov/education/engteaching/pubs/BR/ functionalsec3_6.htm

Hunter, R.S. & Kilstrom, N. (1979) Breaking the cycle of abusive families> *American Journal of Psychiatry*, 136, 1320-1322

Hussey, J.M., & Marshall, J,M., English, D.J., Knight, E.D., Lau, A.S., Dubowitz, H. & Kotch, J.B. (2005) Defining maltreatment according to substantiation: Distinction without a difference? *Child Abuse & Neglect*, 29, 479-492

Hutchins, J. & Nash, S. (1998) Behaviour therapy: what do Health Visitors know? *Community Practitioner*, 71, 11, 364-367

Hyde, A & Roche-Reid, B (2004) Midwifery practice and the crisis of modernity: implications for the role of the midwife. *Social Science & Medicine*, 58, 26133-2623

Iwaniec, D., Herbert, M. & McNeish, A.S. (1985) Social work with failure-to-thrive children and their families: 1. Psychosocial factors. *British Journal of Social Work*, 15, 3, 243-259

Iwaniec, D. (1995) *The Emotionally Abused and Neglected Child: Identification, Assessment and Intervention.* Chichester: Wiley

Iwaniec, D. & Sneddon, H. (2002) The quality of parenting of individuals who had failed to thrive as children. *British Journal of Social Work*, 32, 3, 283-298

Iwaniec, D., Sneddon, H. Allen, S. (2003) The outcomes of a longitudinal study of non-organic failure to thrive. *Child Abuse review*, 12, 4, 216-226

Jack, S.M., DiCenso, A. & Lohfeld, L. (2004) A theory of maternal engagement with public health nurses and family visitors, *Journal of Advanced Nursing*, 49, 2, 182-190

Janus, B. (2002) Therapeutic conversations ion the looking glass: Sharing reflective case writings. *Journal of Systemic Therapies*, 21, 2, 55-66

Jimenez, B. (1996) Participant action research: myths and fallacies. In: I Parker & R Spears (Eds) *Psychology and Society: Radical theory and practice*. London: Pluto Press pp220-229

Johansen, JD. (1986) Habermas. In E Devine, M Held, J Vinson & G Walsh (Eds) *Thinkers of the twentieth century: a biographical, bibliographical and critical dictionary*. London: Firethorn Press.

Johnson, A., & Ashurst, H. (1990) Screening for sensotineural deafness by health visitors, *Archives of Disease in Childhood*, 65, 841-845

Johnson, S. (1999) *"Doing Critical Organisational Research: An examination of Methodology"* The First Conference on Critical Management Studies, Manchester: University of Manchester

Johnson, Z., Howell, F. & Molloy, B. (1993) *Community mothers' programme: randomised controlled trial of non-professional interventions in parenting,*

Jones, T.L., & Prinz, R.J. (2005) Potential roles and parental self-efficacy in parent and child adjustment: A review. *Clinical Psychological Review*, 25, 341-363

Jurich, A. & Johnson, L.N. (1999) The process of family therapy: Defining family as a collaborative enterprise. *Marriage & Family Review*, 28, 3-4, 191-200

Kadushin, A. (1988) Neglect in families. In: E.W. Winnally, C.S. Chilean & F.M. Cox *Mental illness, delinquency, addictions and neglect* (pp147-166) Newbury Pack, CA: Sage

Kar. S.B., & Alcakay, R. (2001) *Health Communication: A multicultural perspective,* Thousand Oaks, CA: Sage

Kaufman, J. & Zigler, E. (1989) Do abused children become abusive parents? *American Journal of Orthopsychiatry*, 57, 2, 186-192

Kearney, P., Levin, E., Rosen, G. (2000) *Alcohol, Drugs and Mental Health Problems: Working with families*. London: National Institute of Social Work.

Keep, G. (2000:2) *Is Britain Family-Friendly: The Parents' View*. London: National Family and Parent Institute

Kempe, H. (1976) *Child abuse and neglect: The family and the community*. Cambridge, MA: Ballinger

Kempe, R.S. & Kempe, C.H. (1978: 17) *Child Abuse*, Cambridge, MA, Harvard University Press

Kendall, S. (1998) *Health and empowerment: Research and Practice*, London: Arnold

Kendall, S., & Bloomfield, L. (2005) Developing and validating a tool to measure parental self-efficacy, *Journal of Advanced Nursing*, 51, 2, 174-181

Kendall-Tackett, K.A. & Eckenrode, J. (1996) The effects of neglect on academic achievement and disciplinary problems: A developmental perspective. *Child Abuse & Neglect*, 20, 3, 161-169

Kendall-Tackett, K.A., Lyon, K.T., Taliaferro, G & Little, L. (2005) Why child maltreatment researchers should include children's disability status in their maltreatment studies. *Child Abuse & Neglect*, 29, 2, 147-151

Kendrick, D., March, P., Fielding, F., & Miller, P. (1999) Preventing injuries in children: cluster randomised controlled trial in primary care. *British Medical Journal*, 318, 980-983

Kent, R. (2001) *Data Construction and data analysis for survey research*, Houndsmills, Basingstoke, UK: Palgrave

Kinard, E.M. (1998) Methodological issues in assessing resilience in maltreated children. *Child Abuse & Neglect*, 22, 7, 669-680

Kingree, J.B., Phan, D., & Thompson, M. (2003) Child maltreatment and Recidivism Among Adolescent Detainees. *Criminal Justice & Behaviour*, 30, 6, 623-643

Kirisci, L., Dunn, M.G., Mezziah, A.C., Tarter, R.E., (2001) Impact of Parental Substance Use Disorder and Child Neglect Severity on Substance Use in Male Offspring. *Prevention Science*, 2, 4, 241-255

Kleiman, S. (2004) Phenomenology: to wonder and search for meanings, *Nurse Researcher*, 11, 4, 7-19

Kabasa, S. (1979) Stressful life effects, personality and health: An inquiry into hardiness. *Journal of Social Psychology*, 37, 1-11

Koch, T. (1994) Establishing rigour in qualitative research: the decision trail, *Journal of Advanced Nursing*, 19, 976-980

Loeber, R. & Dishion, T.J. (1987) Antisocial and delinquent youths: Methods for their early identification. In: J.D. Burchard, S. N. Burchard (Eds) *Prevention of delinquency behaviour*. Thousand Oaks, CA, US: Sage Publications, Inc.

Koenig, A.L., Cicchetti, D. & Rogosch, F.A. (2000) Child compliance/non-compliance and maternal contributions to internalization in maltreating and non-maltreating dyads, *Child Development*, 71, 4, 1018-1032

Kotch, J.B., Browne, D.C., Ringwalt, C.L. 7 Stewart, P.W. (1995) Risk of child abuse or neglect in a cohort of low-income children, *Child Abuse & Neglect*, 19, 9, 1115-1130

Kravetz, S., Drory, R., Flomain, V., (1993) Handiness and sense of coherence and their relation to negative effect,. *European Journal of Personality*, 7, 233 - 244

Kreuter, M.W., & Lezin, N. (2002) *Social Capital Theory: Implications for Community-based Health Promotion*, San Francisco: Jossey Bass

Krishnan, V., & Morrison, K.B., (1995) An ecological model of child maltreatment in a Canadian province. *Child Abuse & Neglect*, 19, 1, 101-113

Kuhn, T.S. (1962) *The Structure of Scientific Revolutions*, Chicago: University of Chicago Press.

Labonte, R. (1994) Health promotion and empowerment: *Reflections on professional practice*, 1, 21, 253-268

Lacharite, C., Ethier, L. & Couture, G. (1996) The influence of partners on parental stress of neglectful mothers. *Child Abuse review*, 5, 1, 18-33

Lachenmeyer, J.R., & Davidovicz, H. (1987) Failure to Thrive: A Critical Review. In: B.B. Lahey & A. E. Kazdin (Eds) *Advances in clinical child psychology*. New York, NY: Pleneum Press (pp335-358)

Laforge, R.G., Rossi, J.S., Prochaska, J.O., Velicer, W.F., Levesquire, D.A. & McHorney, C.A. (1999) Stage of regular exercise and health related quality of life: *Preventative Medicine: An International Journal Devoted to Practice and Theory*, 28, 4, 349-360

Laing, G. J., Law, J., Levin, A. & Logan, S. (2002) Evaluation of a structured test and a parent led method for screening for speech and language problems: prospective population based study. *British Medical Journal*, 325, 1152-1154

Laming Lord (2003) *The Victoria Climbie Inquiry. Report of an inquiry*, London: Department of Health

Lang, T.A. & Secis, M. (1997) *How to Report Statistics in Medicine: Annotated Guidelines for Authors, Editors and Reviewers*. Philadelphia: American College of Physicians

Languis, A., Biorvell, H., Antonovsky, A. (1992) The sense of coherence concept and its relation to personality traits in Swedish sample. *Journal of Marriage and the Family*, 49, 857-873

Larrson, G. & Kallenburg, K.O. (1996) Sense of Coherence, socioeconomic conditions and health, *European Journal of Public Health*, 6, 175-180

Lawler, J. (1991) *Behind the Screens: Nursing, Somology and the Problem of the Body*. Melbourne, Australia: Churchill Livingstone

Layden, D. (1994) *Understanding Social Theory*, London: Sage

Leddy, S. K. (2003) *Integrative Health Promotion: Conceptual Bases for Nursing* Practice, Thorofare, NJ: SLACK Inc.

Lee, J. A. B. (1994) *The Empowerment approach in social work*, New York, US: Columbia University Press

Leiter, J. & Johnsen, M.C. (1994) Child maltreatment and school performance, *American Journal of Education*, 102, 2, 154-189

Lemmer, B., Grellier, R. & Steven, J. (1999) Systematic Review of Nonrandom and Qualitative Research Literature: Exploring and Uncovering an Evidence Base of Health Visiting and Decision Making. *Qualitative Health Research*, 9, 3, 315-328

Lengua, L. J. (2002) The Contribution of Emotionalist and Self-Regulation to the Understanding of Children's Response to Multiple Risk. *Child Development*, 73, 1, 144-161

Leonard, V.W. (1994) A Heiddeggarian Phenomenological Perspective on the Concept of Person, In: P.Benner (Ed) *Interpretive Phenomenology: Embodiment, Caring and Ethics in Health and Illness*, Thousands Oaks, California: Sage

Letzring, T.D., Block, J., Funder, D.C. (2004) Ego-control and ego-resiliency: Generalisation of self-report scales based on personality descriptions from acquaintances, clinicians and the self. *Journal of Research in Personality*, 39, 395-422

Leverton, T.J. & Elliott, S.A. (2000) Is the EPDS a magic wand? A comparison of the Edinburgh Postnatal Depression Scale and health visitor report as predictors of diagnosis on the Present State Examination, *Journal of Reproductive and Infant Psychology*, 18, 4, 279-296

Lightfoot, J. (1995) Health Visitors identifying needs and setting priorities: issues of theory policy and practice, *Health and Social Care in the Community*, 3, 2, 105-111

Ling, M. S. & Luker, K. A. (2000) Protecting children: intuition and awareness in the work of health visitors. *Journal of Advanced Nursing*, 32, 3, 572-579

Littlewood, J. (2000) Managing health: ambiguity as a theory of health visiting. *Community Practitioner*, 73, 5, 597-599

Lloyd, J. C. & Sallee, A. L. (1994) The challenge and [potential of family preservation services in the public child welfare system. *Protecting Children*, 10, 3, 3-6

Lochner, K.A., Kawachi, I., Brennan, R.T., Buka, S.L. (2003) Social capital and neighbourhood mortality rates in Chicago, *Social Science & Medicine*, 56, 1797-1805

Loeber, R. & Stouthamer-Loeber, M. (1987) Prediction, In: C.Herbert (Ed) *Handbook of juvenile delinquency*, Oxford, England: John Wiley & Sons.

Loesel, F., (1992) *Resilience in childhood and adolescence, A summary for the International Catholic Child Bureau*, Geneva, Switzerland

Loughlin, M. (2000) 'Quality' and 'Excellence': meaning versus rhetoric. In: A. Miles, J. Hampton & B. Hurwitz (Eds) *NICE, CHI and the NHS Reforms: Enabling Excellence or Imposing Control?* London: Aesculapius Medical Press (pp 1-12)

Lowenfeld, V. (1954) *Your child and his art: a guide for parents.* Oxford, England: Macmillan

Luthar, S.S. & Cicchetti, D. (2000) The construct of resilience: A critical evaluation and guidelines for future work. *Child Development,* 71, 3, 543-562

Lutzer, J.R.C. (1990) Behaviour treatment of child neglect, *Behaviour Modification,* 14, 310-315

Maccoby, E.E., Dowley, E.M., Hagen, J.W. & Degerman, R (1965) Activity level and intellectual functioning in normal preschool children, *Child Development,* 36, 761-770

Magura, S., & Moses, B.S. (1986) *Outcome measures for child welfare services: Theory and application,* Washington, DC: Child Welfare League of America.

Marris, P. (1996) *The politics of uncertainty: Attachment in private and public life.* Florence, KY, US: Taylor/Routledge.

Macdonald, G.M. (2000) *Effective Interventions for Child Abuse & Neglect: An Evidence-based Approach to Planning and Evaluating Interventions.* London: John Wiley and Sons Ltd.

Mackner, L.A., Starr, R.H. & Black, M.M. (1997) The cumulative effect of neglect and failure to thrice on cognitive functioning. *Child Abuse & Neglect,* 21, 7, 691-700

Madison, G.B. (1988) *The hermeneutics of post modernity.* Indianapolis: Indiana University Press

Maggs-Rapport, F. (2001) 'Best research practice': in pursuit of methodological rigour, *Journal of Advanced Nursing*, 35, 3, 373-383

Magura, S. & Moses, B.S., (1986) Clients as evaluators in child protection services, *Child Welfare*, 63, 2, 99-112

Main, M. & Goldwyn, R. (1984) Predicting rejection of her infant from mother's representation of her own experience: Implications for the abused-abusing intergenerational cycle. *Child Abuse & Neglect*, 8, 2, 203-217

Mangolin, L. (1990) Fatal child neglect. *Child Welfare*, 69, 4, 309-319

Mansour, M. (2002) Systems Theory and Human Science, *Annual Reviews in Control*, 26, 1-13

Marden, M., & Nicholas, D. (1997) Information needs of parents, *Child Language & Teaching Therapy*, 13, 3, 279-285

Margalit, M., Raviv, A. & Ankonina, D.B. (1992) Coping and coherence among parents with disabled children, *Journal of Clinical Child Psychology*, 21, 3, 202-209

Marks, D.F. (2004) Questionnaire and surveys, In: D.F. Marks & L Yardley, *Research Methods for Clinical and Health Psychology*, Thousand Oaks, CA, US; Sage Publications, Inc

Masten, A.S. & Coatsworth, J. D. (1998) The development of competence in favourable and unfavourable environments: Lessons from research on successful children. *American Psychologist*, 53, 205-220

Masten, A.S, Garmezy, N., Tellegen, A. & Pellegrin, D.S. (1988) Competence and stress in school children: The moderating effects of individual and family qualities. *Journal of Child Psychology & Psychiatry*, 29, 6, 745-764

Masten, A.S. & Wright, M. O'Dougherty (1997) Cumulative risk and protection models of child maltreatment. *Journal of Aggression, Maltreatment & Trauma*, 2, 1, 7-30

Masten, A., Best, K., & Garmezy, N. (1990) Resilience and developments: contributions from the study of children who overcome adversity. *Developmental and Psychopathology*, 2, 435-444

Mayhew, L.H. (1997) *The New Public*. Cambridge, UK: Cambridge University Press.

McCarthy, T (1978) *The Critical Theory of Jurgen Habermas*. Cambridge: MIT Press

McClure, M. (2000) An integrative ecology. In: P.Reder, M. McClure & A. Jolley *Family Matters: Interface between child and adult mental health*. Routledge; London

McCullogh, G.F., & Boxer, J. (1997) *Mental Health Promotion – Policy, Practice and Partnership*, London: Bailliere Tindall

McHugh, G. & Luker, K.A. (2001) 'Parent Positive': evaluating a new health visiting programme. *Community Practitioner*, 74, 12, 461-464

McHugh, G. & Luker, K.A. (2002) Users' perceptions of the health visiting service, *Community Practitioner*, 75, 2, 57-61

McLeod, J. (1997) *Narrative and psychology*, London: Sage

McSherry, W.C. & Holm, J.E. (1994) Sense of coherence: Its effects on psychological and physiological processes prior to, during and after a stressful situation. *Journal of Clinical Psychology*, 50, 4, 476-487

Mertens, D.M., Farley, J., Madison, A. & Singleton, P. (1994) Diverse voices in evaluation practice: feminists, minorities and persons with disabilities, *Evaluation Practice*, 15, 123-9

Milburn, K., Fraser, E., Secker, J. & Pavis, A (1995) 'Combining methods in health promotion research: some considerations about appropriate use, *Health Educational Journal*, 54, 347-356

Ministry of Health, *Children Act 1891, Custody of Children*, London: HMSO

Ministry of Health, *Children Act 1908, Protection of Children and Young Persons*, London: HMSO

Ministry of Health, *Maternal and Child Welfare Act 1925*, London: HMSO

Ministry of Health, *Children & Young Person Act 1933*. London: HMSO

Ministry of Health (1956) *An enquiry into the Health Visiting: The Jameson Report*. London: HMSO

Minty, B. & Pattinson, G. (1994) The nature of child neglect. *British Journal of Social Work*, 24, 733-747.

Minuchin, S. (1974) *Families and Family Therapy*, London: Tavistock Publications

Mistry, J., Chaudhuri, J.H. & Diez, V. (2005) Ethnotheories parenting, In: R.M. Lerner, F. Jacobs & D. Wertlieb (Eds) *Applied Developmental Science: An Advanced Textbook*. Thousand Oaks, CA, US: Sage Publications, Inc. (pp201-226)

Mitcheson, J. & Cowley, S. (2003) Empowerment or control? An analysis of the extent to which client participation is enabled during health visitor/client interactions using a structured health needs assessment tool. *International Journal of Nursing Studies*, 40, 413-426

Mohan, J., Barnard, S., Jones, K., & Twigg, L. (2004) *Social capital geography and health*, London: Health Development Agency

Monsour, M. (2002) Systems theory and Human Sciences, *Annual reviews on Control*, 26, 1-13

Montigay, F. de. & Lacharite, C (2004) Perceived parental efficacy: concept analysis, *Journal of Advanced Nursing*, 49, 4, 387-396

Moorman, A & Ball, M (2001) *Understanding parent's needs: a review of parents' surveys*. London: National Family & Parenting Institute

Moran, P.B. & Eckenrode, J. (1992) Protective personality characteristics among adolescent victims of maltreatment, *Child Abuse & Neglect*, 16, 5, 743-754.

Morgalit, M., Raviv, A., Ankonina, D.B., (1992), Coping and coherence among parents with disabled children. *Journal of Clinical Child Psychology*, 21, 202-209

Morrow, R.A. & Brown, D.D. (1994) *Critical Theory and Methodology: Contemporary Social Theory*, Thousand Oaks, California: Sage

Morton, N. & Browne, K. D.(1998) Theory and observation of attachment and its relation to child maltreatment: a review. *Child Abuse and Neglect*, 22, 1093-1104.

Mostyn, Lord Williams of. (1997) *National Commission of Inquiry into the Prevention of Child Abuse: Childhood Matters: Vol. 1: The Report*, London: The Stationary Office

Mrazek, P.J., & Mrazek, D.A. (1987) *Resilience in child maltreatment victims: a conceptual exploration*. Denver, US: University of Colorado School of Medicine

Muir, R.C., Monaghan, S.M., Gilmore, R.J. & Clarke, J.E. (1989) Predicting child abuse and neglect in New Zealand, *Australian & New Zealand Journal of Psychiatry*, 23, 2, 255-260

Munro, E. (1999) Common errors of reasoning in child protection work. *Child Abuse & Neglect*, 23, 745-758

Munty, B. & Pattinson, G. (1994) The nature of child neglect. *British Journal of Social Work*, 24, 733-748

Murphy, M. & Wang, D. (1999) Forecasting British Families into the 21st Century. In Mcrea, S. *Changing Britain, Families and Households in the 1990's*, Oxford: Open University Press, pp100-138.

National Assembly for Wales (2000) *Working Together to Safeguard Children from Harm*, Cardiff: NAfW

National Assembly for Wales (2001) *Framework for the Assessment of Children in Need*, Cardiff: NAfW

National Family & Parenting Institute (NFPI) (2001) *Listening to parents, their worries, their solutions*. London: NFPI

National Family & Parenting Institute (2002) *The Future for Family Services in England and Wales – Consultation response to the Mapping Report*. London: NFPI

National Society for the Protection of Children from Cruelty (NSPCC) (1999) Child Protection Statistics, *http://www.nspcc.org.uk/html/home/news_and_campaigns/factsandfigures.htm*

NSPCC (2003) Summary of Child Protection Register Statistics 2002, *http://www.nspcc.org.uk/inform/statistics/protect2001.asp*

NSPCC (2005) Summary of Child Protection Statistics 2004 *http://www.nspcc*
org.uk/inform/OnlineResources/Statistics/Child Protection.

Navarro, G (2003) The factors of resilience contributing to the academic success of adult survivors of child maltreatment, *Dissertation Abstracts. International Section A: Humanities and Social Science 61* (1-A)

Neale, J.M. & Liebert, R.M. (1986) *Science and Behaviour: An introduction to Methods of Research*, (3rd Ed), New Jersey: Prentice-Hall

Nelson, K.E., Saunders, E.J. & Landsman, M.J. (1993) Chronic child neglect in perspective. *Social Work*, 38, 6, 661-671

Nelson, K., Cross, T., Landsman, M.J., & Tyler, M. (1996) Native American Families and Child Neglect, *Child and Youth Services Review*, 18, 6, 505-521

Nettleton, R.J. (1991) *The Support and Supervision of Health Visitors dealing with Child Abuse*, Unpublished MSc. Thesis, Manchester: University of Manchester.

Newman, T. & Blackburn, S. (2002) *Transitions in the lives of children and young people. Resilience Factors*, Edinburgh: Scottish Executive.

Newton, R.R. & Rudestam, K. E. (1999) *Your Statistical Consultant: Answers to your data analysis questions.* Thousand Oaks, CA: Sage Publications, Inc.

Neuman, B. (1982) *The Neuman systems model: Application to nursing education and practice*, Norwalk, CT: Appleton-Century-Crofts.

Ney, P.G., Fung, T. & Wickett, A.R. (1993) Child Neglect: The Precursor to Child Abuse. *Pre and Perinatal Psychology Journal*, 8, 2, 95-112

Ney, P.G., Fung, T. & Wickett, A.R. (1994) The worst combination of child abuse and neglect. *Child Abuse & Neglect*, 18, 9, 705-714

Niccols, A. & Sword, W. (2005) "new Choices" for substance using mothers and their children: preliminary evaluation. *Journal of Substance Use*, 10, 4, 239-251

Normandale, S. (1995) Using a Nursing Model to Structure Health Visiting Practice. *Health Visitor*, 68, 6, 246-247

Normandale, S. (2001) A study of mothers' perceptions of the health visiting role. *Community Practitioner*, 74, 146-150

Oakley, A (1996) Gender, methodology and people's way of knowing: some problems with feminism and the paradigm debate in social science, *Sociology*, 32, 707-731

Oakley, A. (2000) *Experiments in knowing: gender and method in the social sciences.* Cambridge, UK: Polity Press.

Oakley, A (2004) The Researchers' Agenda for Evidence, *Evaluation and Research in Education*, 18, 1&2, 12-27.

Oakley, A. & Oliver, S (2001) Looking to the future: Policies and opportunities for better health. In S. Oliver & G. Peersman, *Using Research for Effective Health Promotion,* Buckingham: Open University Press.

Oates, R.K. (1996) *The spectrum of child abuse*, New York, NY, US: Brunner/Mazel Publishers

O'Donnell, D.A., Schwab-Stone, M.E., & Muyeed, A.Z. (2002) Multidimensional Resilience in Urban Children Exposed to Community Violence. *Child Development,* 73, 4, 1265-1282

Office of National Statistics (2001) *www.census.gov.uk*

Olds, D.L., Eckenrode, J., Henderson, C.R. Jr., Kitzman, H., Powere, J., Cole, R., Sidora, K., Morris, P., Pettit, L. & Luckey, D. (1997) Long-term effects of home visitation on maternal life course and child abuse and neglect: fifteen years follow-up of a randomized trial. *Journal of the American Medical Association*, 278, 637-643

Olds, D.L., Robinson, J., O'Brien, R., & Luckey, L.M. (2002) Home visiting by paraprofessionals and by nurses: A Randomised Controlled Trial. *Pediatrics*, 110, 486-496

Olson, D.H., Sprenkle, D.H. & Russel, C (1979) Circumplex model of maternal and family systems 1: Cohesion and adaptability dimensions, family types and clinical applications. *Family Process*, 18, 3-28

Olsson, M. B. & Hwang, C.P. (2002) Sense of coherence in parents of children with different developmental disabilities. *Journal of Intellectual Disability Research*, 46, 7, 548-559

Orbell, S. & Sheeran P. (1998) Regulation of behaviour in pursuit of health goals, *Psychology & Health*: Special Self-regulation and health, 13, 4, 753-758

O'Reilly, C., Morrison, T., Sherrin, D., & Carr, A. (2001) A group based module for adolescents to improve motivation to change sexually abusive behaviour, *Child Abuse Review*, 10, 150-169

Orr, J., (1981) Feminism and health visiting, *Health Visitor*, 54, 4, 156-157

Outhwaite, W. (1994) *Habermas: A critical introduction*, Oxford: Polity Press

Padgett. D.K. (1998) *Qualitative methods in social work research: Challenges and rewards.* Thousand Oaks, CA: Sage

Page. A & Keep, G. (2003) *The family Health Maze.* London: National Family & Parenting Institute.

Paget, K.D., Phillip, J.D. & Abramczyk, L.W. (1993) Recent developments in child neglect. *Advances in Clinical Child Psychology*, 15, 121-174

Pallant, J. (2001) *SPSS: Survival Manual: A step by step guide to data analysis using SPSS.* Buckingham: Open University Press

Parker, P. (1995) Introduction, In: E. Farmer & M. Owen. *Child Protection Practice: Private risk and public remedies – decision-making interventions and outcomes in child protection work.* London: The Stationary Office.

Parsons, T.(1971) *The System of Modern Societies*, Englewood Cliffs, NJ: Prentice-Hall

Parsons, T.(1964) *Social structure and personality.* New York, US: Free Press of Glencoe

Parton, N. (1997) *Child protection and family support: tensions, contradictions and possibilities.* London: Routledge.

Pawson, R. & Tilley, N. (1997) *Realistic Evaluation*, London: Sage

Peckover, S. (1998) Domestic violence: on the health visiting agenda? *Community Practitioner*, 71, 12, 408-409

Peplau, H. (1952) *Interpersonal relations in nursing*, New York, USA: GP Putman

Perry, A., Douglas, G, Murch, M, Bader, K, & Borkowski, M (2000) *How parents cope financially on marriage breakdown.* Family & Parenthood, Policy in Practice, Family Policy Studies Centre, Oxford: University of Oxford.

Perry-Jenkins, M., Repetti., R. L. & Crouter, A.C. (2000) Work and family in the 1990s. *Journal of Marriage & the Family*, 62, 4, 981-998

Pianta, R., Egeland, B., & Erikson, M.F. (1989) The antecedents of maltreatment: results of the mother-child interaction project. In: D Cicchetti & V. Carlson (Eds), *Child Maltreatment: Theory and research on the causes and consequences of child abuse and neglect.* New York, NY, US: Cambridge University Press.

Platt, D. (2006) Threshold Decisions: How social workers prioritise referrals of child care. *Child Abuse Review*, 15, 1, 4-18

Polansky, N.A., De Saiz, C., Wing, M.L. & Patton, J.D. (1968) Child neglect in a rural community, *Social Casework*, 49, 8, 467-474

Polansky, N.A. (1972) The process of infantilisation. *American Journal of Orthopsychiatry*, 42, 1, 92-102

Polansky, N.A., Hally, C. & Polansky, N.F. (1975) *Profile of neglect: A survey of the state of knowledge of child neglect.* Oxford, England: US Department of Health, Education & Well-Being.

Polansky, N.A. (1979) Help for the help-less. *Smith College Studies in Social Work*, 49, 3, 169-191

Polansky, N.A., Gaudin, J.M. & Kilpatrick, A.C. (1992) The Maternal Characteristics Scale: A cross validation. *Child Welfare*, 71, 3, 271-280

Polit, D.F. (1996) *Data analysis & Statistics for Nursing Practice*, Stamford, Connecticut: Appleton & Lange.

Polit, D.F. & Beck, C.T. (2004) *Nursing Research: Principles and Methods* (7th Ed). Philadelphia, PA: Lippincott, Williams & Wilkins.

Polnay, J. (2000) General Practitioners and child protection case conference participation reasons for non-attendance and proposals for a way forward, *Child Abuse Review*, 9, 108-123

Popay, J. & Williams, G. (1992) "Involving local people in health gain: the contribution of lay epistemology", *Health for All 2000 News*, 19.

Porter, S. (2000) Qualitative analysis. In: D. Cormack (Ed) *The Research Process in Nursing*, (4th Ed) Oxford: Blackwell Science

Powell, J (2000) The economics of health visiting, In: A. Robotham & D. Sheldrake, *Health Visiting: Specialist and higher level practice.* London: Churchill Livingstone

Priest, H. (2004) Phenomenology, *Nurse Researcher*, 11, 4, 4-6

Prochaska, J. O., & DiClemente C.C. (1983) Stages and processes of self-change in smoking: Towards an integrative model of change. *Journal of Consulting and Clinical Psychology*, 5, 390-395

Prochaska, J.M., Paiva, A.L., Padula, J.A., Prochaska, J.O., Montgomery, J.E., Hageman, L. & Bergort, A.M. (2005) Assessing emotional readiness for adoption using the transtheoretical model. *Child and Youth Services Review*, 27, 2, 135-152

Puura, K., Davis, H. Papadopoulou, K., Tsiantis, J., Ispanovic-radojkovic, V., Rudic, N (2002) The European Early Promotion Project: a new primary health care service to promote children's mental health. *Infant Mental Health Journal*, 23, 606-624

Quas, J.A., Bottoms, B.L. & Nunez, N. (2002) Child maltreatment and delinquency: Framing issues of causation and consequences. *Children's services: Social Policy, Research & Practice*, 5, 4, 245-248

Quinton, D., Rutter M., & Rowlands, O. (1976) An evaluation of an interview assessment of marriage. *Psychological Medicine*, 6, 577-586

Ranson, S. & Rutledge, H (2005) *Including families in the learning community: Family centre and the expansion of learning.* York: Joseph Rowntree Foundation

Rasmussen, D.M. (1996) Philosophy and History, In: D.M. Rasmussen *The Handbook of Critical Theory.* Oxford: Blackwell Publishers Ltd

Ray, M.A. (1994) The richness of phenomenology: philosophic, theoretic and methodological concerns. In: J.M. Morse (Ed) *Critical Issues in Qualitative Research Methods.* Thousand Oaks, CA, US: Sage Publications, Inc.

Reade, E. (1987) *British Town and Country Planning,* Buckingham: Open University Press

Reder, P. & Duncan, S. (2003) Understanding communication in child protection networks. *Child Abuse review,* 12, 2, 82-100

Reece, S.M. (1992) The parent expectations survey. *Clinical Nursing Research,* 1, 4, 336-346

Riceour, P. (1981) *Hermeneutics and the Human Sciences,* Edited and translated by J,B. Thompson, Cambridge: Cambridge University Press.

Riessman, C.K. (1993) *Narrative analysis: Qualitative research methods, Volume 30,* Thousand Oaks, CA, US: Sage Publications

Roberts, B. (1996) Health at Home, In: S. Twinn, B. Roberts & S.Andrews (Ed) *Community health care nursing.* Oxford: Butterworth-Heinemann

Robertson, A., & Minker, M. (1994) New health promotion movement: A critical examination, *Health Education Quarterly,* 21, 295-312

Robinson, J. (1982) *An evaluation of health visiting.* London: Council for the Education and training of Health Visitors

Robinson, J. (2004) Health Visitors or Health Police? *AIMS,* 16, 3, 1-10.

Robinson C.A., (1995) Unifying Distinctions for Nursing Research with Persons and Families. *Journal of Family Nursing,* 1, 1, 8-29

Robotham, A. & Sheldrake, D. (2000) Domiciliary health visiting and some intervention strategies. In A. Robotham & D. Sheldrake (Eds) *Health Visiting: Specialist and higher level practice.* London: Churchill Livingstone

Robson, C. (2002) *Real World Research: A Resource for Social Scientists and Practitioners-Researchers.* (2nd Ed) Oxford, UK: Blackwell Publishers

Rocher, G (1974) Talcott Parsons, the problem of order in society and the programme of analytic sociology, *American Journal of Sociology,* 81, 320-334

Roditti, M.G. (2005) Understanding Communities of Neglectful Parents: Child Caregiving Networks and Child Neglect. Child Welfare: Special Community Building and 21st – century *Child Welfare,* 84, 2, 277-298

Rogers, C. (2003) Children at Risk 2002-2003: *Government initiatives and commentaries on Government Policies.* London: National Family and Parenting Institute

Rohrback, C.A. & Twentyman, C.T. (1986) Multimodal assessment of impulsiveness in abusing, neglectful and non-maltreating mothers and their pre-school children, *Journal of Consulting & Clinical Psychology,* 54, 2, 231-236

Rose, S.J. (1999) Reaching consensus on child neglect: African American mothers and child welfare. *Children & Youth Services Review,* 21, 6, 463-479

Rose, S.J. & Meezan, W. (1993) Child neglect: A study of the perceptions of mothers and child welfare workers. *Children & Youth Services Review,* 17, 4, 471-486

Rose, SJ. & Meezan, W. (1995) Variations in perceptions of child neglect. *Child Welfare,* 75, 139-160.

Rose, S.J. & Selwyn, J. (2000) Child neglect: An English perspective. *International Social Work,* 43, 2, 179-192

Rosenberg, M. & Repucci, M.D. (1985) Primary prevention of child abuse. *Consulting Clinical Psychology,* 52, 5, 576-585

Rothman, K.J. (2002) *Epistemological: An introduction.* Oxford, NY, US: Oxford University Press, Inc.

Rutter, M. (1981) Stress, coping and development: Some issues and some questions. *Journal of Child Psychiatry*, 22, 4, 323-356

Rutter, D. & Quine, L. (2002) *Changing health behaviour: intervention and research with social cognition models,* Philadelphia: Open University Press.

Ryburn, M. (1997) Dilemmas in working in partnership with the parents and relatives of children involved in child protection planning, *Early Child Development & Care*, 129, 79-93

Sagy, S. & Dotan, N (2001) Coping resources of maltreated children in the family: A salutogenis approach, *Child Abuse & Neglect*, 25, 11, 1463-1480

Salzinger, S., Feldman, R.S. Stockhammer, T. & Hood, J. (2002) An ecological framework for understanding risk for exposure to community violence and the effects of exposure on children and adolescents. *Aggression & Violent Behaviour*, 7, 5, 423-451

Sammallahti, P.R., Holi, M.J., Komulainen, E.J. & Aalberg, V.A. (1996) Comparing two self-report measures of coping: The sense of Coherence Scale and the Defence Style Questionnaire. *Journal of Clinical Psychology*, 52, 5, 517-524

Sanderson, D., Wright, D., Acton, C. & D. Duree (2001) *Cost analysis of child health surveillance,* Health Technology Assessment, 5, (36).

Saunders, E.J., Nelson, K. & Landsman, M.J. (1993) Racial inequality and child neglect: Findings in a metropolitan area. *Child Welfare*, 72, 4, 341-354

Sayer, R.A. (1992) *Methods in social science: a realistic approach,* London: Routledge

Scambler, G. (2001) *Habermas, critical theory and health,* London: Routledge

Scannapieco, M. & Connell-Carrick, K. (2002) Focus on the First Years: An Eco-Developmental Assessment of Child Neglect for Children 0 to 3 Years of Age. *Children and Youth Services Review*, 24, 8, 601-621

Shaffer, H. R (1996) *Making decisions about children: Psychological questions and answers.* Oxford, Cambridge, Mass: Blackwell

Schneider-Rosen, K. Cicchetti, D. (1984) The relationship between affect and cognition in maltreated infants: quality of attachment and the development of visual self-recognition. *Child Development*, 55, 2, 648-658

Schoon, I. & Parsons, S. (2002) Competence in the face of adversity: The influence of early family environment and long-term consequences. *Children & Society*, 16, 260-272

Schumacher, J.A., Slep, A.M. & Heyman, R.E. (2001) Risk factors for child neglect, *Aggression and Violent Behaviour*, 6, 231-254

Scottish Executive, (2005) *The Independent Evaluation of 'Start Well' Final Report.* http://www.scotland.gov.uk/Publications

Seedhouse, D. (1986) *Health: the foundations for achievement.* Chichester, UK: Wiley

Seedhouse, D. (1997) *Health promotion: philosophy, prejudice and practice.* Chichester, UK: Wiley

Seidman, S. & Alexander, J. (2001) *The New Social Theory Reader*, London: Routledge

Sharma, A., Lynch, M.A. & Irvine, M. L. (1994) the availability of advice regarding infant feeding to immigrants of Vietnamese origin: a survey of families and health visitors. *Child: Care, Health and Development*, 20, 5, 349-354

Sheppard, M. (1996) Poverty, health and health visitors, *Health Visitor*, 69, 4,141-143

Shpancer, N. (1999) Caregiver-parent relations in day care: testing the buffer hypothesis. *Early Child Development*, 156, 1-14

Sicher, P., Lewis, O., Sargent, J., Chaffin, M., Friedrich, W. N., Cunningham, N., Thomas, R., Thomas, P., & Villani, V.S. (2000) Developing child abuse prevention, identification, and treatment systems in Eastern Europe. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39, 5, 660-667

Sidebotham, P.D. (2001) Culture, stress and the parent-child relationship: A qualitative study of parents' perceptions of parenting. *Child: Care, Health & Development*, 27, 6, 469-485

Sidebotham, P.D. & Heron, J. (2003) The ALSPAC study team. Child maltreatment in the 'children of the nineties': Deprivation, class and social networks in a UK sample. *Child Abuse & Neglect*, 27, 337- 352

Sidell, M., et al (1997) *Debates and dilemmas in promoting health: a reader*, London: Macmillan

Silverman, S (2000) *Doing Qualitative Research: A Practical Handbook*. London: Sage

Skuse, D.H. (1993) Epidemiological and differential issues in failure to thrive, *Child & Adolescent Psychiatric Clinics of North America*, 2, 37-59

Skuse, D.H., Pickles, A., Wolke, D. & Reilly, S (1994) Postnatal growth and mental development: Evidence for a 'sensitive period'. *Journal of Child Psychology & Psychiatry*, 35, 3, 521-545

Slack, K.S., Holl, J.L., McDaniel, M., Yoo J. & Bolger, K. (2004) Understanding the Risks of Child Neglect: An Exploration of Poverty and Parenting Characteristics, *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children*, 9, 4, 395-408

Smetana, J.G., Toth, S.L., Cicchetti, D., Bruce, J., Kane, P. & Daddis, C. (1999) Maltreated and non-maltreated pre-schoolers' conceptions of hypothetical and actual moral transgressions, *Developmental Psychology*, 35, 1, 269-181

Smith, R. (2002) The wrong end of the telescope: child protection or child safety? *Family Law*, 24, 3, 247-261

Smith, C. & Pugh, G. (1996) *Learning to be a parent: a survey of group-based parenting programmes*. London: Family Policy Studies Centre.

Smokowski, P.R., Reynolds, A.J. & Bezruczko, N. (1999) Resilience and Protective Factorsin Adolescence – An Autobiographical Perspective from Disadvantaged Youth, *Journal of School Psychology*, 37, 4, 4250448

Social Service Inspectorate, (2002) Commission for Health Improvement, Her Majesty's Inspectorate of Constabulary, Her Majesty's Crown Prosecution Service Inspectorate, Her Majesty's Inspectorate of Prisons, Her Majesty's Inspectorate of Probation, *Safeguarding Children: A Joint Inspector's Report on*

Arrangements to Safeguard Children, London: Commission for Social Care Inspection.

Social Services Inspectorate, (2004) *Building a Better Future for Childcare: Key Messages from Inspection and Performance Assessment*, London: Commission for Social Care Inspection

Solomon M. E. (1976) *Population Dynamics*, London: Arnold.

Spaccarelli, S. & Kim, S. (1995) Resilience criteria and factors associated with resilience in sexually abused girls. *Child Abuse & Neglect*, 19, 9, 1171-1182

Speight, N., & Wynne, J. (2000) Is the Children Act failing severely abuse and neglected children, *Archives of Disease in Childhood*, 82, 192-196

Spencer, N. & Coe, C. (2003) Social patterning and prediction of parent-reported behaviour problems at 3 years in a cohort study. *Child: Care, Health & Development*, 29, 5, 329-336

Squires, T. & Busuttil, A. (1995) Child fatalities in Scottish house fires 1980-1990: A case of child neglect? *Child Abuse & Neglect*, 19, 7, 865-873

Srivastava, O.P. & Polnay, L. (1997) Field trial of Grades Care Profile (GCP) scale: a new measure of care. *Archives of Diseases of Childhood*, 76, 337-340

Stevenson, O. (1998) *Neglected children: issues and dilemmas*. Oxford: Blackwell Science

Stevenson, O (1996) Emotional abuse and neglect: a time for reappraisal. *Children and Family Social Work*, 1, 13-18.

Stokols, D. (1992) Establishing and maintaining healthy environments: Towards a social ecological approach. *American Psychologist*, 47, 6-22

Stone, L. & Campbell, J.G. (1984) 'The use and misuse of survey in international development: an experiment from Napal' *Human Organisation*, 43, 27-37

Stone, B. (1998) Child Neglect: Practitioner's Perspectives. *Child Abuse Review*, 7, 2, 87-96

Straus, M.A. & Kantor, G.K. (2005) Definition and measurement of neglectful behaviour: Some principles and guidelines. *Child Abuse & Neglect*, 29, 1, 19-29

Streubert, H.J. & Carpenter, D.R. (1995) *Qualitative Research in Nursing: advancing the humanistic imperative*. Philadelphia: J.B. Lippincott Company

Stroebe, W. (2000) *Social psychology and health*, Mapping social psychology series, Buckingham, England: Open University Press.

Stuteley, H. (2002) The Beacon Project – a community-based health improvement project, *British Journal of General Practice*, 52, (Suppl) S44-S46

Subramanian, S.V., Kawachi, I., & Kennedy, B.P. (2001) Does the state you live in make a difference? Multilevel analysis of self-rated health in the US, *Social Science & Medicine*, 53, 9-19

Sumner, J (2001) Caring in nursing: a different interpretation, *Journal of Advanced Nursing*, 35, 6, 926-932

SureStart (2006) Why was SureStart set up? *http://www.surestart.org.uk*.

Sutton, S. (2005) Another nail in the coffin of the trans-theoretical model? A commentary on West (2005), *Addiction*, 100, 8, 10443-1045

Svavarsdottir, E.K., McCubbin, M.A. & Kane, J.H. (2000) Well-being of parents of young children with asthma, *Research in Nursing & Health*, 23, 5, 346-358

Swift, K. (1994) *Manufacturing 'bad mothers': A critical perspective on child neglect*. Toronto: Toronto University Press.

Swift, K. (1995) An outrage of common decency: Historical perspective on child neglect. *Child Welfare*, 74, 71-91

Tabachnick, S.G. & Fidell, L.S. (1996) *Using multivariate statistics* (3rd Ed), New York: Harper & Row

Tannahill, A. (1985) "What is health promotion?" *Health Education Journal*, 44, 4

Tanner, K. & Turney, D. (2000) The role of observation in the assessment of child neglect. *Child Abuse Review*, 9, 5, 337-348.

Tanner, K. & Turney, D. (2003) What do we know about Child neglect?: A critical review of the literature and its application to social work practice, *Child & Family Social Work*, 8, 25-34.

Taylor, J. & Daniel, B. (1999) Interagency practice in children with non-organic failure to thrive: Is there a gap between health and social care? *Child Abuse Review*, 8, 5, 325-338

Taylor, S. & James, D. (1987) Children at Risk: The Changing Role of the Health Visitor. *Health Visitor*, 60, 329-330

Talyor, S. & Tilley, N. (1989a) Inter-agency conflict in child abuse work – reducing tensions between social workers and health visitors. *Adoption & Fostering*, 14, 4, 13-17

Taylor, S. & Tilley, N. (1989b) Health visitors and child protection: conflict, contradictions and ethical dilemmas. *Health Visitor*, 62, 273-275

Taylor, C. & White, S. (2001) Knowledge, truth and reflexivity: The problem of judgement in social work. *Journal of Social Work*, 1, 1, 37-59

Teicher, M.H., Dumont, N.L., Ito Y., Vaituzis, C., Giedd, J.& Anderson, S.L. (2004) Childhood Neglect is Associated with Reduced Corpus Callosum Area. *Biological Psychiatry*, 56, 2, 80-85

The United Kingdom Parliament (2000) *House of Lords Select Committee on Science and Technology*. Sixth Report, London: The Stationary Office

Tiet, Q. Q. Wasserman, G. A., Loeber, R., McReynolds, L.S. & Miller, L.S. (2001) Developmental and Sex Differences in Types of Conduct Problems. *Journal of Child and Family Studies*, 10, 2, 181-197

Tiet, Q.Q., Hazing, D. (2002) Dimensions of the construct of resilience and adoption among inner city youth. *Journal of Adolescent research*, 17, 3, 260-276

Tisdell, K., Wallace, J., McGregor, E., Millen, D. & Bell, A. (2005) *Seamless services, smoother lives*, York: Joseph Rowntree Foundation.

Tisdelle, G. (1996) Child neglect: A systematic problem – a child/youth care worker solution. *Journal of Child & Youth Care*, 11, 4, 25-36

Todorski, J. (1995) Attachment and divorce: A therapeutic view. *Journal of Divorce & Remarriage*, 22, 3-4, 189-204

Tones, K. (1990) Why theorise? Ideology in health education, *Health Education Journal*, 49, 1, 2-6

Tones, K., Tilford, S., & Robinson, Y.K. (1991) *Health Education – Effectiveness and efficiency*, London: Chapman & Hall

Tones, K. & Tilford, S. (2001) *Health promotion: effectiveness, efficiency and equity*. Cheltenham: Nelson Thornes

Trocme, N. (1996) Development and preliminary evaluation of the Ontario Child Neglect Index, *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children*, 1, 2, 145-155

Tudge, J.R.H., Odero, D.A., Hogan, D.M. & Etz K.E. (2003) Relationships between the everyday activities of preschoolers and their teachers' perceptions of their competence in the first five years of school. *Childhood Research Quarterly*, 18, 1, 42-64

Tudor, K. (1996) *Mental health promotion*. London: Routledge.

Tunstill, J. & Aldgate, J. (2000) *Services for Children in Need: From Policy to Practice*. London: The Stationary Office.

Twinn, S.F. (1991) Conflicting paradigms of health visiting: a continuing debate for professional practice, *Journal of Advanced Nursing*, 16, 966-973

Twinn, S.F. (1993) Principles in practice: a re-affirmation. *Health Visitor*, 66, 9, 319-321

Twinn S.F. (2000) Professional Artistry: The Contribution to the Search for Health Needs, In: J.V. Appleton & S. Cowley *The Search for Health Needs: Research for Health Visiting Practice*, Basingstoke, Hampshire: Palgrave.

Twinn, S.F. & Cowley S. (1992) *The principles of Health Visiting: A Re-examination*. London: HVA/United Kingdom Standing Conference.

Twomey, J.E., Soave, R.G., Gil, L. & Lester, B.M. (2005) Permanency Planning and Social Service Systems: A comparison of Two Families With Prenatally Substance Exposed Infants. *Infant Mental Health Journal*, 26, 3, 250-267

Underdown, A. & Dewell, D. (2001) *National mapping of family services in England & Wales: A response to the Children's Society*, London: The Children's Society

Underwood, M. (2000) *Randomised Controlled Trials, In Y. Carter, S. Shaw & C. Thomas (Eds) Randomised Controlled Trials and Multi-Centre Research*, London: The Royal College of General Practitioners (pp10-19)

United Kingdom Central Council (1992) *The Scope of Professional Practice*. London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Van Dijk, T.A. (2000) Critical discourse analysis. *http://discourse-in-society/Old Articles/The%20reality%20of%oracism. PDF.*

Van Maden, M. (1990) *Researching lived experience: Human science for an action sensitive pedagogy*, Ontario, Canada: Althouse

Velicer, W.F., Hughes S.L., Fava J.L., Prochaska J.O., DiClemente C.C. (1995) An empirical typology of subjects within stage of change. *Addictive Behaviour*, 20, 299-320

Velleman, R. (2001) *Counselling for alcohol problems* London: Sage Publications, Inc

Verghese, J., valley, A., Derby, C., Kuslansky, G., Katz, M., Lann, C., Buschike H., Lipton, R.B. (2006) Leisure activities and the risk of amnestic mild cognitive impairment in the elderly. *Neurology*, 66, 821-827.

Vincent, S. & Daniel, B. (2004) An analysis of children and young people's calls to Childline about Abuse and Neglect: A study for the Scottish Child Protection Review, *Child Abuse Review*, 13, 158-171

Von Bertalanffy, L. (1975) *Perspectives on General Systems Theory*. Braziller

Wakefield, S.E. & Poland, B. (2004) Family, friend or foe? Critical reflections on the relevance and role of social capital in health promotion and community development, *Social Science and Medicine*, 60, 401-411

Wall, A.E. & Barth, R.P. (2005) Aggressive and Delinquent Behaviour of Maltreated Adolescents: Risk Factors and Gender Differences. *Stress, Trauma & Crisis: An International Journal*, 8, 1, 1-24

Wang, M.C., Hartel, G.D., Walberg, H.J. (1994) Educational resilience in inner cities. In: M.C. Wang & E.W. Gordon (Eds) *Educational resilience in inner city America: Challenges and prospects*. Hilldale, NJ: Lawrence Erbaum Associates. Inc. (pp45-72)

Waterhouse, L. & Cornei, J. (1992) Assessing child protection risk, *British Journal of Social Work*, 22, 1, 47-60

Watson, D. & Williams, B. (2004) Introduction to the theory of Enforced Systems: A tutorial on Reductionism versus Holism, *http://www.wnformy.com/ tesiintro.htm*

Watzlawick P., Weakland J. & Fisch R. (1974) *Change: Problems formulation and problem resolution*. New York, NY: W.W.Norton.

Weir, R.C. & Gjerde, P.F. (2002) Preschool personality prototypes: internal coherence, cross study replicability, and developmental outcomes in adolescence. *Personality & Social Psychology Bulletin*, 28, 9, 1229-1241

Weir, I.K. & Dinnick, S. (1988) Behaviour modification in the treatment of sleep problems occurring in young children: A controlled trial using health visitors as therapists. *Child: Care, Health & Development*, 14, 5, 355-367

Weist, M.D., Freedman, A.H., Paskewitz, D.A. & Proescher, E.J. (1995) Urban youth under stress: Empirical identification of protective factors. *Journal of Youth & Adolescence*, 24, 6, 705-721

Wells, Y.D. & Kendig, H.L. (1999) Psychological resources and successful retirement, *Australian Psychologist*, Special Issue: Psychology and the older person, 34, 2, 111-115

Wenger, G.C., Scott, A., Patterson, N., Robinson, C.A. & Cody, A (1998) *Report of a Pilot of Mothers of Pre-school Children in North Wales*. Bangor, Centre for Social Policy Research and development, University of Wales, Bangor.

Werner, E. E. (1993) Risk resilience and recovery: Perspective from the Kauai longitudinal study. *Development and Psychopathology*, Special Issue: Milestones in the Development of resilience, 5, 4, 503-515

Werner, E.E. & Smith, R.S. (1992) *Over-coming the odds: High risk children from birth to adulthood*. Ithaca, NY, US: Cornell University Press.

Werner, E.E. & Smith, R.S. (2001) *Journey from childhood to midlife: Risk, resilience and recovery*. Ithaca, NY, US: Cornell University Press.

West, P. (1990) 'The status and validity of accounts obtained at interview: a contrast between two studies of families with a disabled child', *Social Science & Medicine*, 30, 1229-39

West, D. (1996) *An Introduction to Continental Philosophy*. Cambridge: Polity Press

Westlake, D. & Pearson, M. (1997) Child protection and health promotion: whose responsibility?, *Journal of Social Welfare*, 19, 2, 139-158

Westman, J. C. (1999) Children's rights, parents' prerogatives and society's obligations, *Child Psychology and Human Development*, 29, 4, 315-328

While, A. E. (1986) The early history of health visiting: a review of the role of central government (1830-1914). *Child: care, health and development*, 1986, 127-136

Whitbeck, C. (1995) Truth and Trustworthiness in Research, *Science and Engineering Ethics*, 1, 4, 403-416

White S.K. (1995) *The Cambridge Companion to Habermas*, Cambridge, USA: Cambridge University Press.

White, M. & Epston, D. (1990) *Narrative Means to Therapeutic Ends*, New York: Norton

Whittaker, K.A. & Cornthwaite, S. (2000) Benefits for all: outcomes from a positive parenting evaluation study. *Clinical Effectiveness in Nursing*, 4, 189-197

Wiggins M, Oakley A, Roberts I, Turner H, Rajan L, Austerberry H, Mujica R & Munford M (2004) The Social Support and Family Health Study: a randomised controlled trial and economic evaluation of two alternative forms of postnatal support for mothers living in disadvantaged inner-city areas. *Health Technology Assessment*, 8, 32

Wills, T.A., Vaccaro, D. & McNamara, G. (1992) The role of life events, family support and competence in adolescent substance use: A test of vulnerability and protective factors. *American Journal of Community Psychology*, 20, 3, 349-374

Williamson, G.R. (2005) Illustrating triangulation in mixed-methods nursing research, *Nurse Researcher*, 12, 4, 7-18

Window, S., Anderson, L. & Vostanis, P. (2004) A multi-agency service for child behaviour problems, *Community Practitioner*, 77, 5, 180-184

Winnicott, D.W. (1950) Some thoughts on the meaning of the world Democracy. *Human Relations*, 3, 175-186

Wolfe, D.A. (1993) Prevention of Child Neglect: Emerging issues. *Criminal Justice & Behaviour*, Special Child Neglect, 20, 1, 90-111

Wong, B.Y.L. (2003) General and specific issues for researchers' consideration in applying the risk and resilience framework to the social domain of learning disabilities, *Learning Disabilities Research & Practice*, 18, 2, 68-76

Wong, O.T. & Daro, D. (1998) *Current trends in child abuse reporting and fatalities*, The Results of the 1997 Annual Fifty State Survey, Chicago, IL: Prevent Child Abuse America.

Wolfe, D.A. (1993) Prevention of Child Neglect: emerging issues. *Criminal Justice & Behaviour*, Special Child Neglect, 20, 1, 90-111

Wolin, S.J. & Wolin, S. (1993) *The resilient self: how survivors of troubled families rise above adversity*. New York: Villard Books

Wolock, I. & Horowitz, B. (1994) Child maltreatment as a social problem: The neglect of neglect. *American Journal of Orthopsychiatry*, 54, 4, 530-543

World Health Organisation (WHO) (1984) *Health Promotion: A Discussion Document on the Concepts and Practices*, WHO, Regional Office for Europe, Copenhagen: WHO.

World Health Organisation (1986) *Ottawa Charter for Health Promotion*, Geneva: WHO

World Health Organisation (1997) *New players for a new era: Leading health promotion into the 21st Century*. 4th International Conference on Health Promotion, Jakata, Indonesia: Conference Report, WHO, Geneva/Ministry of Health, Indonesia

World Health Organisation (1997a) World report on violence and health. *http://www.who.int/entity/violenceinjuryprevention/violence/worldreport/en/full.en.pdf*

World Health Organisation (1997b) *Report of a Technical Working Group: Care of Mother and Baby at the Health Centre: A Practical Guide* (WHO/FHE/MSM/ 94.2 REUZ), Geneva: WHO. Division of Family Health

World Health Organisation (2005) Child Abuse and Neglect, *http://www.who.int/violence_injury_prevention/violence/neglect/en*

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Worth, A & Hogg, R (2000) A qualitative evaluation of the effectiveness of health visiting practice, *British Journal of Community Nursing*, 5, 5, 221-228

Wright, L.M. & Leahey, M. (2000) *Nurses and families: a guide to family assessment and intervention*. Philadelphia, US: F.H. Davies

Wyness, M.G. (1996) Policy, protectionism and the competent child. *Childhood: A Global Journal of Child Research*, 3, 4, 431-447

Zuravin, S.J. (1987) Unplanned pregnancies, family planning problems and child maltreatment, Family Relations: *Journal of Applied Family & Child Studies*, 36, 2, 135-139

Zuravin S.J. (1988) Fertility patterns: Their relationship to child physical abuse and child neglect, *Journal of Marriage & the Family*, 50, 4, 983-993

Zuravin, S.J. (1989) The ecology of child abuse and neglect: Review of the literature and presentation of data. *Violence & victims*, 4, 2, 101-120

Zuravin, S.J. (1991) Research definitions of child physical abuse and neglect: Current problems. In: R.H. Jr. Starr, Wolfe D.A. (Eds) *The effects of child abuse and neglect: Issues and research*. New York, NY: Guildford Press (pp100-128)

Zuravin, S.J. & Shay, S. (1992) Preventing child neglect: In: D. DePanfilis & T. Birch (Eds) *Proceedings: National Child Maltreatment Prevention Symposium*, Washington, DC: National Centre on Child Abuse and Neglect.

Zuravin, S.J. & Taylor, R. (1987) The ecology of child maltreatment: Identifying and characterizing high-risk neighbourhoods. *Child Welfare*, 66, 4, 497-506

APPENDICES

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APPENDIX 1:

RESEARCH AND DEVELOPMENT COMMITTEE AND FUNDING

APPROVAL FOR CASE CONTROL STUDY

WALES OffICE OF
RESEARCH & DEVELOPMENT
FOR HEALTH £ SOCIAL CARE

OurRef: SG98/146

24June1998

Mrs Ann Cody
Lecturer in Nursing
School of Nursing and Midwifery
Clan Clwyd District General Hospital NHS Trust
Bodelwyddan
Rhyl   LL18 5U)

Dear Mrs Cody

Re: Health and social services response to abuse and neglect (HASSRAN)

Thank you for the above application to the Small Grants Scheme. This has now been considered by a Panel consisting of the Assistant Directors of the Wales Office of R&D together with four external assessors. The Panel would like to offer the following feedback on your application.

The Panel considered this to be **an** important area and were impressed by the application submitted. However, considering the small amount of money requested, the Panel agreed that the number of objectives cited were too numerous and it was unlikely that they could all be met.

The Panel suggested that a revised application be submitted taking into consideration the following matters:

- an application for ethical approval should be made for the project;
- the number of children involved should be estimated in order to identify the scale of the problem-
- the questionnaire needed to be validated;
- collaboration from social services personnel;
- concentrate on one or other of the geographical areas.

The Panel agreed that a revised application along these lines could constitute a pilot study which in turn could lead on to a larger project.

I realise that this decision will cause some disappointment but hope that you will not be deterred from submitting applications in the future, using the comments contained in this letter as constructive advice.

Yours sincerely

Professor Richard H T Edwards
Director of Research and Development in Health and Social Care for Wales

DirectoWCvfanwvddwr· Professor Richard HT Edwards

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Ysbyty Cymuned Bae Colwyn
Ffordd Hesketh,
Bae Colwyn,
Conwy LL29 8AY.
Ffôn: (01492) 515218
Ffacs: (01492) 518103

Colwyn Bay Community Hospital
Hesketh Road,
Colwyn Bay,
Conwy LL29 8AY.
Tel: (01492) 515218
Fax: (01492) 518103
Direct Dial (01492) 807503

Ref: VJK/TC/R&D/ACODY

16 July 1998

Mrs Ann Cody
In-Service Training
Post Graduate Centre
Ysbyty Glan Clwyd

Dear Mrs Cody

Re : Project Validation of a Risk Assessment Instrument for Child Neglect

I am pleased to say that in principle The Research & Development Committee for the CCC NHS Trust felt that the project should be supported. However, as you know there are a number of issues which need to be clarified, e.g. the actual tool which you will be using was not included with the proposal, it was felt that a clear definition of neglect should be included and that the numbers of children for example should now be included in the proposal. It would be most helpful if you could proceed to a more detailed proposal to clarify issues. Your mentor from The R&D Committee will be me and I am very happy to meet with you and the principle members of your research team to help in clarifying issues.

Other suggestions which were made were that a literature review should be included on the measurement of neglect and that a clear description of how the assessment tool was arrived at should be included (I was not quite sure whether you had decided to use the assessment questionnaire compiled by the named doctors for child protection or to use a compilation of this and the questionnaire in your small grants application).

A clinical supervisor for the project should be identified who has a well established research background and members of the R&D Committee wondered whether Mr R Iphofen would be an appropriate person to fulfill this role.

The funding you had applied for is £1,400 and The R&D Committee have agreed to this provided that the research protocol is clarified as above.

Have you submitted the protocol to the ethical committee?

Best wishes

Yours sincerely

Dr Valerie J Klimach MD FRCP
Chair R&D Committee - Clwydian Community Care NHS Trust

CC: File

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APPENDIX 2:

CHILD NEGLECT – CASE NOTE ASSESSMENT INSTRUMENT

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Child neglect assessment instrument

Case number _____ Dare of birth _____ Sex _____ Locality _____	Adverse (or risk) factors Age at registration 1. _____ 2. _____ 3. _____ 4. _____	Positive (or protective) factors
Family history		
Change in family structure		
Change in family address		
Aggression & violence		
History of abuse of family members		
History of family members in care		
Members with mental illness		
Members with learning disability		
Parental substance misuse		
Criminal activities		
Parental skills		
Additional parenting help provided		
Management & handling of child		
Understanding child's needs		
Parent and child relationship		
Parental relationship		
Professional advice given		
Child wellbeing		
Ability to thrive		
Developmental delay		
Attending play/school		
Learning disability		
Behaviour problems		
Poor hygiene, infestation, infection		
In-care		
Known illness		
Attandance at hospital		
Social & environmental factors		
Employment		
Housing circumstances		
Play provision, interactive play		
Food consumption		
Clothing		
Attendance for important problems		
Attendance for routine appointments		
Engaging with services		

APPENDIX 3:

CODES OF VARIABLES AND VALUES

Variable name	Variable label	Variable values
Family history		
Neglected or not neglected	Carestatus	1= Neglected 0= Not neglected
Change of family structure	Change	1= 0-2 changes 2= 3-5 changes 3= 6+ changes
Change of family address	Address	1= 0-2 changes 2= 3-5 changes 3= 6+ changes
Aggression and violence	Violence	1= adult aggression 2= child aggression
History of Abuse of family members	Histabus	1= sibling abuse 2= mother abused as a child 3= partner's child abused
History of family members in care	Histcare	1=siblings in care 2= mother in care as a child 3= father in care as a child
Member with metal illness	Histmill	1= siblings with mental illness 2= mother with mental illness
Member with learning difficulties	Hisldif	1= sibling with learning difficulties 2= mother with learning difficulties
Parental substance misuse	Subabuse	1= alcohol misuse 2= drug misuse
Criminal activities	Criminal	1= less serious 2= serious 3= most serious
Parental skills		
Management and handling of children	Care	1= good care 2= lay concern 3= professional concern 4= 2+ sources of concern
Understanding child's needs	Needs	1= needs met 2= one nor met 3= two+ not met
Parent & child relationship	PCrelate	1= satisfactory 2= concern 3= serious concern
Parents' relationship	Prelate	1= supportive 2= critical 3= unstable
Professional advice given	Advice	1= sought 2= given 3= rejected
Additional parenting help provided	Help	1= agency support 2= family support, no improvement 3= help++ no improvement
Child wellbeing		
Ability to thrive	Thrive	1= normal (expected0 2= >50 percentile 3= 25th percentile 4= 10th or less percentile
Development & delay	Development	1= normal (expected) 2= delay at 6-18 month 3= delay at 2-5 months 4= delay at school age

Attending play/school	Attend	1= poor attendance 2= serious problems 3= special needs 4= referral to psychologist
Child with learning difficulties	Learndiff	1= no learning difficulties 2= learning difficulties 3= special unit required
Behaviour problems	Behaviour	1= satisfactory 2= childhood problems 3= inappropriate behaviour 4= serious behaviour problems
Poor hygiene	Poorhyg	1= 1-2 incidents 2= 3-5 incidents 3= 6+ incidents
Child in care	Incare	1= 1-2 times 2= 3-5 times 3= 6+ times
Known illness	Illness	1= congenital illness resolved 2= short term 3= long term
Attendance at hospital	Hospital	1= 1-2 times 2= 3-5 times 3= 6+ times 4= suspicious injuries or explanation
Social & environmental factors		
Unemployment	Employ	1= one or both parents 2= both unemployed 3= single parent unemployed
Housing circumstances	Housing	1= satisfactory 2= inadequate 3= seriously inadequate 4= lay report
Play	Play	1= lacking 2= improved with advise
Food consumption	Food	1= satisfactory 2=inadequate
Clothing	Clothing	1= appropriate 2= inappropriate 3= anonymous concern
Attendance for important appointments	Impappo	1= all attended 2= 1-2 missed or late 3= 3+ missed or late
Attendance for routine appointments	Routine	1= all attended 2= 1-2 missed or late 3= 3+ missed or late 4= developmental checks or immunisations incomplete
Engagement with services	Engage	1= accepted 2= avoided 3= rejected 4= 6+ non access visits

APPENDIX 4:

DATA COLLECTION PROTOCOL

Data collection protocol

Preparation of care and control records

Only cases registered as child neglect in or prior to August 1998 are to be included in the study.

Cases are prepared by the special needs coordinators by requesting the relevant documents to be forwarded to the special needs department. When all documents relating to a 'case' are available they will be stored in a large file box. Each neglect case is numbered with the same number as that recorded on the case list e.g. 12 and the control case will be identified by the same number followed by the letter C e.g. 12C. Neglect cases and related control are bound together. A colour code is used to check that the relevant documents are available. The code is:

Orange = neglect case record

Pink = control case record

Yellow = senior nurse-child protection records

No colour coding = special needs file.

Controls and some neglect cases will not have a special needs file.

Research preparation

Researchers will require:

- 11/2 to 2 hours to read one neglect and one control case record

- The list of neglect cases and controls. This is the list of all known cases registered as 'child neglect' by the local social service department and taken from the health authority's database held by the special needs department. The control cases have been matched with the neglect cases by age, sex and district as closely as is possible.

- Risk assessment tool – pages are numbered 1-4. One tool for each neglect case and one for each control case. Researchers are advised to familiarise themselves with the assessment tool. The assessment tool has four sub-sets – family history, parenting skills, child wellbeing and social and environmental factors and indicators/attributes can be negative or positive.

- A general observation page numbered 5. This page is for any observations made about the documentation, clarity of information or any other factors found to be of interest in determining child neglect.

- Pens rather than pencils
- Paper clips

.

Procedure

First select a set of cases and tick against the name on the case list

Begin the assessment by completing the information at the top of page 1 of the assessment. That is record the case number, researcher number, child's sex and date of birth on the lines provided. A neglect case may have one or more child health records and a family card compiled by health visitors. A record of special needs reports and case conference minutes are kept in a separate file. Some of this information may be duplicated in the senior nurse-child protection notes.

As the records are carefully read record in the assessment all attributes that relate to any of the indicators in the four subsets. The space on the assessment sheet is limited so state the attribute recorded followed by the date, the baby/child's age in brackets and subsequent dates when the same attribute is recorded.

APPENDIX 5:

CODING OF THE CASE CONTROL RECORDS

MEMO

To:

From: Mrs Ann Chesterman, Team Leader Child Protection/Special Needs

Ref:

Date:

Subject: **RESEARCH INTO NEGLECT**

NAME **D.O.B**

ADDRESS

SCHOOL

This Department is currently conducting a Research into Neglect.for all children who have been registered on the Wrexham/Flintshire Child Protection Register during the period 01/01/97- 31/08/98 under the Neglect Category.

The above named has been selected as a "Control" case

Please would you let me have the CHR/10M/CONTACT CARD as soon as possible.

Many thanks.

PLEASE RETURN THIS LETTER WITH THE CHR/10M/CONTACT CARD.

C.C Senior Nurse - Child Protection.

Please would you also make your Nursing records available for this audit.

Colour code — ORANGE

AUDIT OF

NEGLECT

NEGLECT
CASE

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Colour code — PINK

AUDIT OF

NEGLECT

CONTROL

CASE

AUDIT OF

NEGLECT

Senior Nurse - Child Protection's notes

PLEASE RETURN THESE NOTES TO ANN CHESTERMAN - CHILD PROTECTION
ADMINISTRATOR FOR THE ABOVE AUDIT

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APPENDIX 6:

CONTINGENCY TABLES OF VARIABLE SUBSETS

Cross-tabulation of 'Family History' variables

Case status	**Change in** 0-2	**Family** *3-5*	**Structure** *6+*		Not recorded	Total
Neglected	22	17	3		41	83
Control case	4				79	83
	Change in 0-2	**Family** *3-5*	**Address** *6+*			
Neglected	18	22	8		35	83
Control case	14	6	1		62	83
	Aggression *Adult*	**&** *Child*	**Violence**			
Neglected	47				36	83
Control case	3	1			79	83
	History of *Sibling*	**Abuse** *Mother*	*Partner's child*			
Neglected	20	2	2		59	83
Control case	1				82	83
	History of *Sibling*	**'incare'** *Mother*	*Partner's child*			
Neglected	15	3	6		59	83
Control case					83	83
	History of *Sibling*	**Mental** *Mother*	**Illness**			
Neglected	1	24			58	83
Control case		6			77	83
	History of Sibling	**Learning** *Mother*	**Difficulties**			
Neglected	4	6			73	83
Control case		1			82	83
	Substance *Alcohol*	**Misuse** *Drugs*				
Neglected	22	23			38	83
Control case	1				82	83
	Criminal *Less serious*	**Activities** *Serious*	*Most serious*			
Neglected	7	14	10		52	83
Control case		1			82	83

Cross-tabulation of 'Parenting Skills'

Case status	Additional	Parenting *Agency provided*	Help *Family provided – no improvement*	Provided *Help++ - no improvement*	Not recorded	Total
Neglected		14	4	17	48	83
Control case		1		1	81	83
	Management Good care	**& Handling** *Lay concern*	**Of Child** *Professional concern*	*2+ sources of concern*		
Neglected	2	12	15	32	21	83
Control case	4	1	1		77	83
	Understood Met	**Child's** *1 not met*	**Needs** 2+ not met			
Neglected	1	14	34		34	83
Control case	3	1	1		78	83
	Parent Satisfactory	**& Child** Concern	**Relations** Serious concern			
Neglected	12	23	7		41	83
Control case			1		82	83
	Parents' Supportive	**Relationship** *Critical*	*Unstable*			
Neglected	3	5	5		70	83
Control case			2		81	83
	Professional Sought	**Advice** *Given*	**Given** Rejected			
Neglected	2	23	5		53	83
Control case		4			79	83

Cross-tabulation of Child- Wellbeing variables

Case status	Ability Normal	Of Child >50th percentile	To Thrive 25th percentile	10th of less percentile	Not recorded	Total
Neglected	6	19	5	43	10	83
Control case	12	36	9	10	16	83
	Development Normal	& Delays 6/18mths	2-5 years	School age		
Neglected	17	25	23	7	11	83
Control case	48	5	13	4	13	83
	Attending Poor	Playschool, Serious problems	Nursery Special needs	& School Psych referral		
Neglected	19	7	9	3	45	83
Control case			1		82	83
	Child with No	Learning Yes	Disabilities Special unit			
Neglected	5	11	2		65	83
Control case		1	1		81	83
	Behaviour Satisfactory	Problems Childhood	Behaviour Inappropriate	Serious		
Neglected	20	29	7	17	10	83
Control case		2	1		80	83
	Poor Hygiene 1-2 incidents	Infestation 3-5 incidents	Repeated infections 6+ incidents			
Neglected	23	19	25		16	83
Control case	22	8	1		52	83
	Child 'in-care' 1-2 times	(including 3-5 times	Living with 6+ times	Relatives)		
Neglected	43	8	1		31	83
Control case		1			83	83
	Known Illness Congenital Resolved	Short-term	Long-term			
Neglected	15	1	6		61	83
Control case	14	1	6		62	83
	Attendance 1-2 times	at 3-5 times	Hospital 6+ times	Suspicious		
Neglected	26	8	5	15	29	83
Control case	28	11	2		42	83

Cross-tabulation of Social and Environmental variables

Case status	Unemployment *1-2 parents*	Status of *Unemployed*	Parents *Single parent*		Not recorded	Total
Neglected	8	21	1		53	83
Control case	37	5			41	83
	Housing Satisfactory	**Circumstances** *Inadequate*	*Seriously inadequate*	*Lay concern*		
Neglected	3	15	22	2	41	83
Control case	5	6			72	83
	Play *Lacking*	Improved with advice				
Neglected	13	3			68	83
Control case					83	83
	Food Satisfactory	*Inadequate*				
Neglected	1	12			70	83
Control case	1	1			81	83
	Clothing Appropriate	*Inappropriate*	*Anonymous concern*			
Neglected	7	17	1		58	83
Control case		1			82	83
	Attendance All attended	**For Important** 1-2 missed/late	**Appointment** 3+ missed/late			
Neglected	34	25	15		9	83
Control case		6	3		74	83
	Attendance All attended	**For Routine** 1-2 missed/later	**Appointment** 3+ missed/late	Incomplete checks/immune		
Neglected	7	27	31	12	6	83
Control case	38	22	10	10	3	83
	Engagement Accepting	**With** *Avoiding*	**Services** Rejecting	6+ No access visits		
Neglected	32	16	10	6	19	83
Control case	23	1			59	83

APPENDIX 7:

MANAGEMENT APPROVAL FOR NARRATIVE STUDY

Mr E Edwards,
Director of Nursing,
Conwy & Denbighshire NHS Trust,
Glan Clwyd Hospital,
Bodelwyddan,
Denbighshire.
LL 18 5UJ

Dear Mr. Edwards,

Research project: Health visitors' response to child neglect and primary prevention opportunities.

I am writing to you to seek your approval to invite health visitors in your Trust to participate in my research project.

In 1999 I completed an audit of child neglect cases and found that the documented information did not give, what I believe to be, an accurate or in-depth understanding of the health visitors work with families who do not meet their children's needs. I, therefore would like a small number of health visitors to reflect upon a case they have been involved with and tell the story of that involvement. A copy of the letter to health visitors and the recommendations for inclusion in the narrative are enclosed.

At a meeting with the Named Nurses for Child Protection, on 25th September 2000, the nurses agreed they would send letters to health visitors to invite participation in the study, to two health visitors for each unitary authority in their work area. However, to do this they too require your approval to collaborate in this way.

The narratives are part of a wider study that continues themes from the audit of child neglect cases. An outline of the research design is enclosed in order that you may place the narratives in the context of the study as a whole.

Ethical approval is being sought from the North Wales Ethics Committee. The submission date is 21st December 2000 and the meeting date for the Ethics Committee in Glan Clwyd Hospital is 4th January 2001. Provided approval is granted I wish to commence the study as soon as possible.

Thank you for considering this request.

Yours sincerely,

Ann Cody

Ms Ann Cody
School of Nursing & Midwifery Studies
Post Registration Department
Glan Clwyd Hospital

Ein cyf/Our ref: ECE/SH
Eich cyf/Your ref:
Dyddiad/Date: 2 January 2001
Wrth ffonio gofynnwch am/if telephoning ask for
Mr E C Edwaids
Llinell Uniongyrchol/Direct Line:
01745-534579
E-Mail Address
eddie.edwards@ cd-tr.wales.nhs.uk

Dear Ann

Research Project: Health Visitors' Response to Child Neglect and Primary Prevention Opportunities

Thank you for your letter seeking approval for Health Visitors to participate in your research project.

As you advised me when we met briefly today, you have already spoken to Sue Owen, Head of Nursing, Child Health Directorate and she is fully appraised of this project.

On the understanding that you have Sue's agreement, I am pleased to approve your study. I hope it goes well.

Kind regards.

Yours sincerely

Mr E C Edwards DIRECTOR OF NURSING

Cc   Mrs Sue Owen

Mr. Tony Jones,
Director of Nursing,
North West Wales NHS Trust,
Ysbyty Gwynedd,
Bangor.

Dear Mr. Jones

Research project: Health visitors' response to child neglect and primary prevention opportunities - Narrative study

I am writing to seek your approval to invite health visitors in your Trust to participate in my research project.

In 1999 I completed an audit of child neglect cases and found that the documented information did not give, what I believe to be, an accurate or in-depth understanding of the health visitors work with families who do not meet their children's needs. I therefore, would like a small number of health visitors to reflect upon a case they have been involved with and tell the story of that involvement. A copy of the letter to health visitors and the recommendations for inclusion in the narrative are enclosed.

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Thank you for considering this request.

Yours sincerely,

Ann Cody.

23 February 2001

Ms A Cody
Lecturer
School of Nursing, Midwifery & Health Visiting
Glan Clwyd Hospital
Bodelwyddan
LL18 5UJ

Dear Ms Cody

Re: Request for Support for Research Project: Health Visitors' Responses to Child Neglect and Other Primary Prevention Opportunities: in North Wales

Thank you for your letter requesting support for the above research.

I have passed the proposal to the Head of Nursing and Directorate General Management of Women and Families for their perusal.

I can confirm our support of your application and wish you every success with this research project.

Please accept my apologies for the delay in my reply.

Yours sincerely

Mr R A Jones
Executive Nursing Director

Mr M. Jones,
Director of Nursing,
North East Wales NHS Trust,
Ysbyty Gwynedd,
Bangor.

Dear Mr. Jones

**Research project: Health visitors' response to child neglect and primary
prevention opportunities - Narrative study**

I am writing to seek your approval to invite health visitors in your Trust to participate
in my research project.

In 1999 I completed an audit of child neglect cases and found that the documented
information did not give, what I believe to be, an accurate or in-depth understanding of
the health visitors work with families who do not meet their children's needs. I
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in Glan Clwyd Hospital is 4th January 2001. Providing approval is granted I wish to
commence the study as soon as possible.

Thank you for considering this request.

Yours sincerely,

Ann Cody

20th February 2001

Ms Ann Cody
Lecturer
School of Nursing
Ysbyty Glan Clwyd
Bodelwyddan, Denbs
LL18 5UJ

Dear Ms Cody

Re: *Request for support for research project; Health Visitors'
responses to child neglect and other primary prevention
opportunities in North Wales*

Thank you for your recent letters relating to the above research project and
thank you also for informing me of the position regarding ethical committee
approval.

I am pleased to confirm that we can support the study in principle and,
providing you are successful with your application for funding, I will leave it to
you to negotiate with your selected Health Visitors and their managers, as to
who assists you in this project.

Yours sincerely

Maldwyn E O Jones
Director of Nursing

Cc
*Yvonne Harding, CSM, Catherine Gladstone House, Mancot
Sue Roden, CSM, Grove Road Clinic, Wrexham
Joyce Hughes, Childrens Services, Maelor Health Centre
Wendy Turkie, Senior Nurse NEWT*

Mr. P. Pye,
Head of School,
School of Nursing, Midwifery & Health Studies,
Fron Heulog,
Bangor

14th December 2000

Dear Mr. Pye

Research project: Health visitors' response to child neglect and primary prevention opportunities.

I am seeking your approval to invite the new intake of Common Foundation Programme students to complete the enclosed questionnaire before I meet them at my usual Child Protection Workshop planned for March 2001.

After the completion of the Audit of child neglect cases in 1999 I met and discussed some ideas with young mother in both the School of Nursing and in Abergele Health Centre. They made it clear they dislike any form of covert assessments of their parenting abilities or self-assessment questionnaires that include sensitive questions.

Mothers were anxious about admitting parenting difficulties to health visitors and social workers in case they were labeled inadequate parents. The alternative to these methods would seem to be to identify the preferred sources of help and target them with the relevant information and skills to be effective in their support and advice to parents. Therefore, it would seem expedient to try to elicit, from a groups of adults their, preferred sources of help for parenting and childcare problems (related to the four predictive indicators isolated in the audit of child neglect cases).

With this in mind, I have already tested, as a pilot, one questionnaire with a group of Common Foundation Students. The result demonstrated how unsuitable some part where and the potential of other parts if revised. The enclosed questionnaire is the result of those revisions. The relationship between this questionnaire and the other activities for this stage of my research project are outlines in the enclosed sheet 'Overview of study design'.

Some of the student group will be parents and easily able to complete the questionnaire based on their experience. Others may have some idea of the help they might prefer. Either way their perception of helping agencies is important as the pilot study suggested family and friends were the most likely source of help. This finding has implications for primary prevention by professionals and possibly a greater dissemination of relevant information to communities.

Ethical approval is being sought from the North Wales Ethics Committee. The submission date is 21st December 2000 and the meeting date for the Ethics committee

in Glan Clwyd Hospital is 4th January 2001. Providing approval is granted I wish to commence the study as soon as possible.

I would, therefore, appreciate an early response to this request so that I may be ready to act, and arrange to distribute the questionnaire, as soon as ethical approval is granted.

Yours sincerely,

APPENDIX 8:

REQUEST FOR SUPPROT FROM SPECIALIST NURSES FOR

CHILD PROTECTION

Specialist nurses for child protection
Individual named and addressed

Date

Midwifery

Prifysgol Cymru • University of Wales
B AN G 0 R
Ysgol Astudiaethau Nyrsio, School of Nursing,

Bydwreigiaeth ac lechyd and Health Studies
Adran ol-gofrestru Post Registration
Department
Ysbyty Glan Clwyd Glan Clwyd Hospital
Bodelwyddan, Sir Ddinbych Bodelwyddan,
Denbighshire
LL18 5UJ LL18 5UJ

Ffon: 01745 583910 Tel: 01745 583910
Ffacs: 01745 534960 Fax: 01745 534960

Dear (Christian names)

Re: Health visitor's narrative study.

I have attempted to contact either yourself of some of your colleagues only to find, that in some cases, we cannot meet to discuss the 'Health visitor's narrative study' until almost Christmas. I therefore, beg your indulgence, and ask if you could begin the study without us formal meeting.

Clearly, should there be any questions of clarity or about the study in general, I am willing to meet first if you prefer. The change of tactic is mainly due to the time left to complete the study and to ensure that sufficient time is going to be available to debate the findings and implications for practice.

I enclose with this letter a file for your information that includes
- A copy of the letter to health visitors inviting participation;
- The narrative sheets;
- The study protocol;
- 4 un-addressed envelopes for the health visitors; and
- A disk for those health visitors wanting to type their narratives.

Thank you for your continued support.

Yours sincerely,

Ann Cody
Lecturer in Nursing Studies - Post Registration Studies

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APPENDIX 9:

INVITATION TO PARTICIPATE IN NARRATIVE STUDY

Sample of narrative letter to health visitors

Date:

Prifysgol Cymru • University of Wales
BANGOR

Ysgol Astudiaethau Nyrsio,	School of Nursing,
Bydwreigiaeth ac Iechyd	and Health Studies
Adran ol-gofrestru	Post Registration
Ysbyty Glan Clwyd	Glan Clwyd
Bodelwyddan, Sir Ddinbych	Bodelwyddan,
LL18 5UJ	LL18 5UJ
Ffon: 01745 583910	Tel: 01745
Ffacs: 01745 534960	Fax: 01745
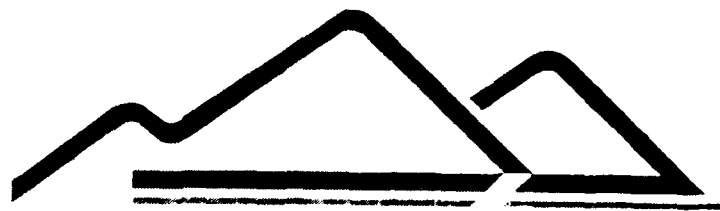
Midwifery

Department

Hospital

Denbighshire

583910

/ 534960

Dear Health visitor,

Research project: Health visitors' response to child neglect and primary prevention opportunities.

This letter is an invitation to participate in a research project that follows on from an audit of child health records in one unitary authority in North Wales. However, I feel sure you will agree with me that documented evidence cannot provide an accurate picture of health visitors' work with children and their families. Only health visitors can do that.
Should you agree to participate your involvement will be to provide a narrative of your work with one family whose child has been neglected or that there is sufficient concern about parents not meeting their children's needs to warrant reporting the situation to a significant child protection practitioner. No information should be included in the narratives that might compromise the families' identity, such as names or dates of birth. As primary prevention is the underpinning concept of the study the child should be 12 months or younger.
The study aims to explore health visitors' self-reflections of identification, response and ways of working with families who do not meet their children's needs (neglect children). Two health visitors in each of the six unitary authorities in North Wales will be invited to participate in this study. This should provide a reasonable representation of work across North Wales and a rich amount of data from which to construct a thematic presentation of their work. Should you be interested in validating the researcher's interpretations of your narrative please write your name and contact address and telephone number at the end of the narrative. However, the information contained within the interpretations must remain confidential to the researcher.
You have been selected by your Trusts 'Named Nurse for Child Protection' because she is aware of your involvement with a family that meets the research criteria. Only the named nurse is aware which health visitors have been contacted and which families the narratives relate to, in order to maintain confidentiality and anonymity. Should you agree to this please read carefully the enclosed sheet. However, if for any reason you are unable to participate in this study please contact your named nurse for child protection. She will then reallocate this task.
Thank you for considering this request and in anticipation thank you for agreeing to complete a narrative and I look forward with interest to reading your narrative.

Yours sincerely,

Ann Cody
Lecturer in Nursing Studies - Post Registration Studies

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APPENDIX 10:

INSTRUCTIONS FOR NARRATIVE STUDY

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Research project: Health visitors' response to child neglect and primary prevention opportunities

Thank you for agreeing to help with this study by providing a narrative. Please use this sheet (and the additional sheet, if necessary) to outline your involvement with a case where there is serious concern about a child's needs not being, or likely to be met, or the child has been categorised as neglected. The child should, ideally, be 12 months old or younger.

The narrative should include an outline of the family members, (but remember to exclude any information that may compromise the families identity), any significant factors, and your feeling, thoughts and actions that relate to your involvement with this family.

If you are interested in reading and commenting on the researcher's interpretation of your narrative please write your name and contact address and telephone number at the end of the narrative. However, do not feel obliged to do this. Signing the narrative is an option.

On completion please send your narrative to Mrs. Ann Cody, Education Centre, Glan Clwyd Hospital, Bodelwyddan, Rhyl, Denbighshire. LL 18 5UJ

Biographical data:

Age:_____

Level of qualification (please tick as appropriate):

Certificate	☐
Diploma	☐
BN/ BSc	☐

Date qualified as health visitor:_____

Signature (optional): _____

Contact address (optional):

_____

_____

Tel. No. (optional): _____

APPENDIX 11:

REMINDER TO SPECIALIST NURSES FOR CHILD PROTECTION

Wales

Prifysgol Cymru • University of

B A N G O R

Ysgol Astudiaethau Nyrsio,   School of Nursing, Midwifery
Bydwreigiaeth ac Iechyd   and Health Studies
Adran ol-gofrestru   Post Registration
Department
Ysbyty Glan Clwyd   Glan Clwyd Hospital
Bodelwyddan, Sir Ddinbych   Bodelwyddan,
Denbighshire
LL18 5UJ   LL18 5UJ

Ffon: 01745 583910   Tel: 01745 583910
Ffacs: 01745 534960   Fax: 01745 534960

To:
Eirlys Jones,   Bryn Seiont Hospital, Caernarfon
Alwen Ingledew,   Royal Alexandra Hospital
Jan Williams,   Catherine Gladstone House, Mancot, Deeside
Gail Barton Davies,   Bryn Seiont Hospital, Caernarfon
Rachel Shaw,   Health Premises, Argyle Road, Llandudno
Judy Snelling,   Wrexham Child Health Centre, Wrexham

Dear

Health visitors' narratives about working with a neglectful family
Happy New Year. By now you and I are probably already automated to the work treadmill.
My major concern at this time is whether or not I will have a sufficient number of narratives to
analyse, and what time-scale I should rearrange. Consequently, this letter comes with a request for
information. Since returning to work after the Christmas holidays I have received only one
narrative. I am not sure if this is due to a lack of interest in participating in the study, if the task
seems complex, or if health visitors would rather tell their story than write it.

I would, therefore, be grateful if you could let me know if I can expect any narratives by the
end of February. Alternatively, for those health visitors who are finding it difficult to allocate time
to writing and would prefer to tell their story, I will willingly arrange to visit them, at their
convenience, to tape their story. Those interested in telling their story instead of writing it need
only ring or e-mail me on these numbers 01745 534301 (direct line - work), 01745 853828 (home)
or e-mail acody@bangor.ac.uk.

Obviously, this approach negates any likelihood of anonymity. Nevertheless, this option is
available but it must keep to the original plan not to influence the content of the story (as an
interview might). I would, therefore, not be asking any questions but merely recording the story as
told.   My only contribution might be to remind them of the information specifically requested.

Thank you for your continued support and I look forward to sharing some interpretations with
you as soon as possible.

Kind regards.
Yours sincerely,

Ann Cody (Mrs)
Lecturer in Nursing Studies - Post Registration Studies

APPENDIX 12:

HEALTH VISITOR NARRATIVES

Narrative 1: Health visitor – Catherine

Health visitor 1 is educated to degree level and has been a health visitor for 10 years. She is 37 years of age.

Family:
C mother
J grandmother
J 7 years
Jenny 2 years
Linda 2 years
New pregnancy

I have known the mother of the above children for 4 years. Caren their mother originates from Manchester. Caren's mother Judy used to live in a village near Rhyl with her sister. Caren got involved with illicit drugs in Manchester and because of her lifestyle around them relied heavily upon her mum to look after Joe fulltime. Joes' father lives in Manchester and is not in contact with his son.

However, Judy was chronically sick with cancer. On moving to Rhyl Caren became involved with a new relationship. John at this time was not involved with abusing drugs, but later became involved with them. When Caren was pregnant with Jenny social services convened a strategy meeting with the parents present. The overall outcome was that they had to cooperate with all agencies otherwise it would go to case conference.

Caren was a poor attendee at clinic with Jenny and I had to check her up at home for the 8 week assessment and subsequent immunisation appointments. Caren did not keep her appointments with the drug clinic or with her named social worker. Caren was in arrears with the housing association in Manchester hence the local authority would not reconsider her for housing in Rhyl. Caren's social worker closed the case as she did not keep appointments.

During the ensuing mothers 'at risk' reports were sent to the social service department by the police following incidents. Firstly, Caren got involved in a fracas in the local railway station. Jenny was about 6 months old and in the middle of it. Unfortunately, Jenny was not injured. Secondly, Jenny was found wondering on the street alone without adult supervision by the police, with no shoes on. A parent support worker visited the family and organised Jenny to go to a local nursery three days a week. This was paid for by social services.

Judy's health was beginning to fail and Joe went to live with his mother and partner fulltime. Caren's lifestyle got more involved with drugs and selling them on the street. I made more referrals to social services. Caren got pregnant and Judy felt she would be unable to cope with either child. Judy's wish for Caren was to come off drugs completely and to set up a stable home for Joe and Jenny. Judy wanted Caren to have an abortion. However, Caren missed two appointments at the nursing home for the abortion. Her pregnancy then went beyond the dates for a vacuum termination. However, then Judy died from cancer. Caren took this very badly herself for not having an abortion and her mum's subsequent death.

A few months after this a professionals only meeting was convened at Glan Clwyd Hospital to discuss the way forward with Caren's pregnancy. However, this turned into a case conference. Jenny had been admitted the previous day following a possible ingestion of a bag of heroin. Her father John called the ambulance after finding a baby of heroin in her mouth. The police took out a police protection order for 72 hours, which ran out on a Sunday afternoon. I pointed out to the case conference members that Caren, mother, could come into hospital on the Sunday and remove Jenny. Hence, I recommended an emergency protection order be applied for. So that Friday afternoon I gave evidence in court to enable the local authority to get the emergency protection order. Caren, the mother was present. Following this event Caren maintained a warm relationship with me.

After the birth of Linda, the interim care order was obtained. A case conference was convened and it was arranged for John and Caren to have their parenting skills assessed over a 4 hour period at the foster carer's home under supervision of a social worker. However, John and Caren did not comply with the former arrangements, although they were set up again on another two occasions.

The court has now released all 3 children for adoption. Caren is pregnant again with her fourth child due in May. A Case conference has taken place. However, Caren is not attending her antenatal appointments or drug appointments. I am no longer the named health visitor for Caren but feel greatly for her. Apparently, John and Caren continue to be involved with illicit drugs.

For confidential reasons I have changed the names of my clients. Should you need any more information Ann or you cannot understand my winning please contact me on the following numbers.

Narrative 2: Health visitor - Rachel

Health visitor 2 did not provide whether she holds a health visiting diploma or degree qualification, nor her age or how long she has worked as a health visitor.

Mrs S
J 17 years
P 9 years
Baby M

When I first knew the family, Mrs S lived with her daughter J and son P in a private house. P had learning disabilities and attends a specialist school in the next town

J was pregnant and was not a good attender antenatal. This followed a pattern established by her mother, who rarely attended school events, parents' evenings or medical assessments with P.

The school had expressed concerns about P's poor hygiene and standards of dress.

During the latter part of the antenatal period J accompanied by her mother attended a couple of antenatal classes at the local clinic. It was noted by the community midwife and myself that there was a problem with the personal hygiene of both J and her mum. We did not address this highly delicate matter at the time.

J chose not to name the father of her baby saying that she was not in contact with him.
Michelle was born by normal delivery at term. She was a normal healthy baby.

J and Michelle continued to live with Mrs S and P. The primary visit and several subsequent visits uncovered no particular concerns about J's care of Michelle. She had the continued support and guidance of her mother, who didn't work outside the home. I noted that the house was in a poor state of repair (paper coming off the walls, threadbare carpets and very little furniture). I noted that there was a fridge to store bottles (it was in the hall, by the front door).

J didn't attend clinic with Michelle, after the initial home visits, although it was only two minutes walk away. Initially, I phoned fairly frequently and visited a further few times although I observed nothing to cause concern. J was not good at attending the surgery for checks or immunisations with Michelle, although she would always report how important she thought these services were, and assured me that she would attend.

By the time Michelle attended her '8 months' check at 11 months of age, she had just completed her primary course of immunisations. Her development was normal for her age, but I noted that she was grubby and her groin area was not cleaned well. As she had no sore areas I didn't bring up this issue. I spend quite a while advising re accident prevention, suitable diet and dental hygiene. Michelle appeared a 'happy' baby. She was dressed appropriately for the weather, her measurements were within normal limits and J listed several play activities and toys that she provided for Michelle. Her mother accompanied her to the clinic. I

invited them to contact me for advice etc. whenever they need to and reminded them of the drop-in clinic facilities.

I didn't see the family again (except in passing) until the 18 month check, which was attended on the second invitation. Prior to that, I often saw J pushing Michelle around the area in her pushchair, often in the dark, as I was leaving for home. J was invariably smoking and sometimes sitting on a bench by a bus stop. She was always accompanied by other young people, usually female, some with babies or toddlers.

At the 18 months check I noted that Michelle was becoming overweight in relation to her height. We discussed diet at length (Mrs S didn't attend this time). J admitted that she found it difficult to know what to give Michelle to eat, and it seemed that the family didn't have regular mealtimes or much in the way of home cooked foods. By now J was in receipt of income support for herself and Michelle and said she was giving her mum a regular sum towards household bills. However, J left all the food shopping to her mum. I advised J to give Michelle less milk (she was having about twp pints a day) and suggested foods that were easy to prepare, such as sandwiches and pasta with sauces. I didn't feel that J was very committed to following my advice.

Soon after this, I saw J in the phone box outside the clinical and Michelle was outside the box by a busy main road. Some other young girls were with her, but not supervising her very closely. She ran out into the road, which was thankfully clear. I asked J to come into the clinic when she came out of the phone box, on the pretext of wanting to see how she was getting on with Michelle's diet. However, my true motive was to address the fact that Michelle had been able to run into the road and discussed ways to prevent this happening again, such as reins.

I asked J if she had any problems with Michelle's behaviour, and she said she wasn't sleeping well. We made an appointment for J to return to the clinic at a later date and J said she would like to bring her mum, as she often put Michelle to bed.

Mrs S came to the appointment on her own. This was when I first felt some concern over J's relationship with Michelle. Mrs S reported that she felt that J was giving her more responsibility for Michelle's care. She reported that it was she who normally put Michelle to bed. She admitted that it was often late, because of P's learning disability it frequently took a couple of hours to get him settled and she felt it worked better if he went to bed first before Michelle. Mrs S said she was getting quite tired but didn't mind as J had her friends to see and now a new boyfriend.

I felt I couldn't 'interfere' with the arrangement but offered advice to Mrs S about her daughter and grand-daughter relationship. I also pointed out that if J and Michelle ever moved out, then J would have to learn to take responsibility for Michelle's care.

At this time, P's school were expressing increased concerns about the level of hygiene and frequent infestation of head lice. Because of my involvement with the family I undertook a joint visit with a school nurse. It was the first time I had been in the house since Michelle was a baby. I was uneasy about the general standard

of hygiene and state of the furnishings. Again (as antenatal) I didn't feel able to tackle this with Mrs S (J wasn't present). The school nurse and I confined ourselves to discussion about the head lice and P's personal hygiene. It wasn't easy, but as tactfully as possible, we reported that the school has stated that P often arrives in 'dirty smelly' clothes and had hardly been free of head lice in the last few weeks. Mrs S didn't seem unduly upset, but denied that he was dirty. The school had been unable to approach Mrs S directly as P travelled to and from school in a taxi, and their phone had been cut off several months previously. They has sent her letters, and invited her to visit the school, but hadn't heard from her.

We had been unaware that P was enuretic as Mrs S hadn't asked for help and didn't attend and of the regular medical reviews held at the school. P had been allocated a social worker from the children with disabilities team, so we suggested to Mrs S that we contact her and discuss the best way forward to tackle P's enuresis, also that I would supply some plastic mattress covers.

Over the next few months, I visited the house regularly now it had been decided that P was unlikely to be able to respond to a reward system, or to use an alarm for his enuresis. He was prescribed Desmopressin and this had begun to work well. However, reports from the school were not favourable. P continued to turn up at school in grubby clothes, with an offensive odour and with head lice. Now our task was made slightly easier, in one way, as the class teacher had reported that she had to open windows and that children didn't wan to sit by P. We now had evidence that P's self-esteem could suffer, as he was being ostracised by the other children.

Michelle had by now been infested by head lice. The surgery was noticing that J and Michelle were requesting frequent prescriptions for head lice treatment. Michelle was gaining weight, so by 2 two and a half years I suggested J put her on semi-skimmed milk, and encourage her to walk as much as possible.

The school nurse and myself did another joint visit to the home. We went step by step over the management of head lice, its initial treatment and how to keep looking out for it. For several months P was free of head lice. His personal hygiene improved slightly. He was mixing okay with other school children.

At Michelle's 3 year check I noticed that she has problems with speech pronunciation, was very over weight (over the 90th percentile while her height was around the 50th) and again had head lice.

Around this time, Mrs S went to see her GP with depression, and was noted to have hypertension. The GP asked me to see her to help with a healthy diet and she agreed to 'listening' visits. We began to monitor her weight and the GP stated that when her blood pressure was more stable, she would be referred for 'exercise by invitation'; a scheme being funded locally which was running at several leisure centres including the one in her town. Mrs S depression seemed to be aggravated by the fact that she felt J was taking more and more advantage of her 'babysitting' services for Michelle. Michelle's behaviour became more difficult to control and she still wasn't going to bed until late.

The house was beginning to deteriorate further in terms of cleanliness and sheer mess. As I could appreciate that Mrs S was depressed I asked whether she felt she

needed help with the housework. Michelle was now in part-time school, so this gave her more time to herself. J was spending more and more time with her boyfriend and frequently spent the night away. Mrs S often complained about her daughter, and on the odd occasion when I saw J on her own on the house, she complained about her mother. J said that her mum was taking over with Michelle and that she was trying to find somewhere to move to on her own with Michelle.

By now I had several reports from speech therapy and the dietician that J had failed to attend appointments. Both schools reported that the children had head lice again and P's hygiene was becoming a problem.

I contacted Mary, a social worker with the disability team and as we had recently become a pilot area for a new tool to measure neglect we decided to use the 'Graded Care Profile' to assess the family in terms of standards of parenting. The tool broadly explored hygiene, nutrition, safety, environment and parent-child interaction. It provide an overall score and a mechanism by which targets could be set for improvements. With this tool, we were able to persuade Mrs S to let us see the whole house. We were appalled by what we saw. There was a mountain of dirty crockery and pans in the kitchen, and it was swarming with flies. Every surface was covered in layers of grime and crumbs. The floor was concrete, with no other covering and this was also filthy. There was no bedding on any of the beds and clothes were in piles over every available floor space. The windows upstairs and in the kitchen were too dirty to see out of. The back garden was also swarming with flies as there was rubbish all over it. The grass was waist high.

The children were graded in separate forms. Both their scores come out very badly, which meant we had no option at this point to do down the child protection route. Mrs S to her credit was very cooperative. It was at this point that she told us that they had had no hot water for several years. The boiler had broken down and was irreparable. She had made no steps to replace the boiler or make alternative arrangements for hot water. They were all able to have baths at a neighbour's house once a week. As the washing machine was also broken they had been taking a few clothes to the laundrette when they could.

It seems that J had allowed her mother to take responsibility for all this and Mrs S had allowed J to carry on as if she had no responsibilities. At this point I reflect on what I could have done previously. Had I facilitated discussions with Mrs S and J about parenting responsibilities things might have improved before getting to this state? If I had previously tackled Mrs S about the state of the house and the levels of personal hygiene in the family as a whole would things have deteriorated to this extent?

We held a child protection conference. Concerns included P being ostracised as school because of poor levels of personal hygiene and the likelihood of the same thing happening to Michelle who was soon to start school fulltime. The fact that Mrs S had done nothing to rectify the lack of hot water and the poor state of the house in terms of cleanliness and the lack of bedding was not excused by her depression as J also had a responsibility. She was now an adult and a mother. It was felt that J had neglected Michelle's health and development by failing to attend appointments re speech and diet. It was also noted that Michelle had several visibly decayed front teeth. Despite numerous reminders and prevision of the community dentist number, J had failed to get Michelle an appointment.

The children's names were placed on the child protection register – category: neglect.

This action did not in itself improve the situation, despite massive input from health, education and social services. This included helping arrange finance for a new boiler, having the house cleared and cleaned from top to bottom, cleaning the garden, provision of good quality second hand furniture, continuing support for Mrs S with her depression and facilitating J to write a CV and register for job seekers allowance. The house was marginally cleaner by Mrs S had not obtained a new boiler and reports about the children's hygiene and head lice did not abate. Michelle did lose some weight by the next conference was again at a weight which could adversely affect her health.

After 6 months, at a second review conference, it was decided that the core group felt that they had little option but to recommend care proceedings in respect of the children. Michelle nor supposed to attend school fulltime, was frequently off and only occasionally was an adequate explanation given. The head teacher and the school nurse had made attempts to facilitate J's application for free school dinners for Michelle, and thus, it was felt, would be at least ensure that she has a proper meal.

The family had repeatedly failed to act on advice given by professionals and the children therefore continued to suffer in terms of emotional well-being (being isolated at school and physical health (persistent head lice infestation and poor nutritional state).

P's dad had recently moved back into the area and tried to see him more often. He felt that he and his girlfriend could offer him a permanent home. It was also nearer to his school. Mrs S was very depressed by this and said she had 'learnt her lesson' and that everything would now change. J too was very upset at the very real threat of Michelle going to live elsewhere, however short term.

The decision made was that P would go and live with his father for the present time and Mrs S and J would be allowed to see how they could cope with just Michelle. This entailed commitments on their part to getting a new boiler installed in the house and attending Michelle's medical and other appointments. Michelle is now being investigated to exclude any pathological cause for her obesity.

Two months after this conference J and Michelle moved to live with J's boyfriend in England. At that time Michelle remained on the child protection register at her new location.

P remained with his father 6 months on. Mrs S has lost weight and had her hair coloured and styled. However, she has not yet replaced the boiler, despite having a DSS loan to do so. The incentive that she might have P back to live with her if she was to secure hot water again for the house had not moved her into action.

At times I have felt that had I been more 'brutal' and frank with Mrs S early on in my involvement with her family things may have had a better outcome for her. However, having reviewed the case for this piece of work, I doubt that this would have been.

Narrative 3: Health visitor - Ester.

Health visitor 3 is educated to degree level and has worked as a health visitor for 6 years. She is 32 years of age.

Boy 10yrs
Girl 8yrs
Twins 3 yrs
Twins under 3 yrs

Miss X has 6 children, a ten year old boy, an eight year old girl and two sets of twins under 4 years of age. They all live in a 3 bed roomed housing association property on the outskirts of a deprived area. Miss X is unmarried, and receives no support from previous male partners who have fathered her children. Her only support network is seeing her mother briefly once a week and her friend D 2-3 times a week.

Following ongoing assessment of the family by the health visitor, numerous unmet needs have been identified. These unmet needs are as follows: lack of socialisation, parenting capacity and childhood new experiences, health needs and educational needs.

Lack of socialisation, parenting capacity and childhood new experiences - Miss X had declined the offer of social services nursery sponsorship support, to allow the older twins play development with children of their own age, and also the offer of Home Start, enabling mother more free time to play with the younger twins.

Health needs
The unmet health needs are non-attendance for clinics and hospital immunisation appointments. The twins are not registered with any dentist. Also Miss X states that she is not depressed and therefore declined medical and psychiatric interventions. The only professional liaison with this family is the health visitor. Housing and overcrowding are further issues that may become an unmet need as the children get older.

Educational needs.
The two older children in the last 6 mths have had a 28% attendance rate at school consequently the 10 year old boy has a reading age of 6 and is in danger of social exclusion. It is becoming apparent during health visiting interventions that the mother is relying heavily upon the older boy and girl to help parent the twins, resulting in them missing out on important years of their childhood.

It is also important to note that the health visitor has failed to hear either of the two 3 year old twins speak, and therefore, is unable to assess whether their speech is within normal limits and age appropriate. Mum feels that there is no problem with this area of their development or any other.

These are the following interventions, which have been attempted to put in place in order to meet the outlined multi-factorial needs.

Lack of socialisation, parenting capacity and childhood new experiences

Arranged Homestart, social services nursery support, transport to local playgroups and active listening support visits. These active support visits have encouraged discussion about relationships, parenting difficulties and finance. Local Gingerbread groups and drop-in clinics also have been discussed

Health needs
Clear explanations of the needs for health screening and immunisations have been explained and Miss X always says she will try and come. Numerous transport facilities (taxi, money for bus, or friend's car) have been arranged jointly with social services and local surgery. However, Miss X has only attended 8 week medical for twins at surgery. All children still need certain immunisations and the youngest twins require paediatric monitoring. Miss X's local GP and I have even attempted to give immunisations at home address, but no access even after Miss X stated to come at the time.

Educational needs.
Joint visits with educational social worker, school nurse and social services have still not ensured the older children's attendance at school. As previously mentioned before Miss X declined Homestart, nursery and social services parental support workers support in helping the children have a better attendance at school. Miss X is not keen either to discuss asking family or friends for more practical support. The oldest boy was also referred to young carers, but no intervention has occurred.

Two referrals to social services local children in need team has been implemented and a third is to take place soon.

Reflections
Psychological theories would confirm that Miss X is attached to her children for she makes good eye contact with all of them and responds outwardly appropriately to their needs, i.e. Cuddles when upset, praises good behaviour and kisses to reassure. However, psychologists and sociologists would argue that Miss X doesn't value her children's needs for health checks, new socialisation experiences and education for she hasn't had that in her own parenting. In fact, Miss X's mother is more interested in come dancing that helping her daughter meet her grandchildren's needs. Miss. X's friend also has difficulties meeting her own children's needs.

On reflection, this case was chosen for this research study, as it wasn't cut and dry case of neglect like my other children in need cases. As a health visitor it is very difficult emotionally dealing with the 'grey areas' of children in need/child protection, which social services do not value as a high priority. It can be physically and emotionally stressful trying to get parents to identify all their children's unmet needs if they haven't has their own needs met by their parents as children. This cycle of limited parenting capacity will continue through the generations, with future health visitors experiencing the same or worse issues of need and neglect. This is reflective of many similar cases working in an area of multi-need and deprivation.

In conclusion, Miss X and her family have declined all local statutory and voluntary service provision to help meet her children's emotional and physical needs. In fact, the only professional obtaining access to the family home is the

health visitor who is becoming increasingly concerned at the emotional neglect of the older children's developmental needs.

Narrative 4: Health visitor - Linda

Health visitor 4 is educated to degree level and has worked as a health visitor for 5 years. She is 50 years of age.

I first met the family I am about to discuss when I paid my weekly visit to the Homeless Hostel where I care for the health and well being of about 40 adults ad 43 children. They are placed there for a variety of reasons and from a wide are of the country.

The family I was asked to see comprised of a baby of 6mths, a child of 8, the mother and her partner who was the father of the baby. They had been referred to the hostel from Chester because they had been evicted for non-payment of rent and wrecking the property. There was also the issue of drugs use by both parents. Both children were on the child protection register in Chester because mum has been seen striking the children whilst out in Chester ands then seen to be drink in change of the children.

I have become quite used to this type of family being re-housed in the hostel but still find it quite sad for the children's sake. The parents seem to think that their needs are paramount ands have little regard to the feelings of the children. I find this so difficult to comprehend being a mother myself, but I have learnt it does not do to judge too quickly and I always, initially, give them the benefit of the doubt.

At the initial visit the mother came across as a very articulate and reasonably intelligent individual but the father was rather morose and uncommunicative, he offered no opinions about my advice and seemed totally disinterested. I felt like giving him a good shake but I realise his attitude was partly due to drug taking. I gave them both my usual speech about what service I provided for the families ate the hostel and where I could be contacted. I feel that by laying down the ground rules at the time can prevent any misunderstanding later on if I have to refer back to this initial interview. I saw the family in passing for the next couple of weeks but received no request for help from them.

On one of my visits I was asked by the staff if I could have a word with the family because there were concerns about the way mum fed the baby in the dining room and the fact that the baby was left to feed herself at such a young age. The staff also claimed that the mother took the baby's food away if she hadn't finished feeding herself, this limited the amount the baby was receiving. There were also concerns about the effect of the parent's drug taking was having on the care for their children.

I went to see the family and discussed the staff's concerns as well as enquiring about the baby's diet. I explained the importance of enough calcium, fruit and vegetables in the diet, mum stated that it was the hostel's fault because they failed to provide the proper food for the parents to give to the children. They denied that the baby was ever left on her own to feed herself. They also denied drug taking whilst in charge of the children. Feeling a bit like a squashed ball bouncing back and forth I went to discuss the supply of food with the manager who claimed that the food provided was adequate, she did however promise to give extra yoghurts to the family. Feeling fairly reassured that I had dealt with the problem I went back to the clinic. I had arranged to return and weight the baby the following

week even though mum didn't feel it was necessary. I found this attitude odd because most mums like their baby's weighed regularly.

When I weighed the baby and plotted her weight on the centile chart I was shocked to see she had dropped below the 0.4thccentile, which was well below the previous weight charted in Chester. Her general physical appearance was poor she looked very 'scraggy'. I voiced my concerns to the parents who seemed quite unconcerned about the weight; mum said the baby was just like her - a slight build! I was getting quite frustrated by their attitude and their inability to recognise there was a problem. Once again I discussed feeding techniques and diet. I was beginning to feel like an old record that had got stuck.

After 2 further visits and more discussions about diet I felt that it was time to call in the expert as the baby was not gaining weight and I needed to eliminate organic disease. Both parents seemed to accept my decision, a little to easily I felt considering the negative vibes I had been receiving for weeks. When the consultant community paediatrician arrived to see the baby 2 weeks later the families behaviour was very odd because they said they were unable to stay for the appointment because they had a taxi booked to go to Chester for the older child to see her dad. I was astounded at their attitude especially as they were aware of the appointment and its importance. I also felt it showed me in bad light in front of the doctor. I agreed to continue to monitor the weight and keep the doctor informed. I went home feeling very angry and frustrated.

The situation took a new turn the following week when the family decided to leave the hostel with no fixed abode arranged. They ended up being housed in the next county. I was asked to stay as their health visitor but mum was not too keen, the senior nurse for child protection gave them no choice at the review case conference where it was decided to remove the children's name from the CPR.

The situation with the baby's feeding got a little better and her weight did start to improve, unfortunately they didn't have a dining room table for the children to eat off. I eventually got mum to take baby to the local clinic to be seen by the community medical officer who gave her advice about feeding routines and the importance of a healthy diet. The weight continued monthly with slow gains punctuated by some losses which mum always has an explanation for. I discussed this with the social worker who voiced concerns about the parents drug taking habits, a scheme was suggested where the parents took turns with the drug taking so that there would always be someone alert to take care of the children. The condition of the flat was also giving staff cause for concern, it was a bit untidy and dirty.

By now I felt I was taking one step forward and two steps back. It was getting mentally exhausting caring for this family. Things came to a head when I visited one afternoon to weight the baby yet again, I immediately noticed a large fresh bruise down the left side of the bay's head which extended right down to the top of the shoulder. I felt sick and my heart was pounding. It was difficult to stay calm when all I wanted to do was dash out and call social services. I had to explain to mum that I had to get a doctor to see the baby and call the social worker. The reason given for the bruise was that the baby had stumbled against the skirting board whilst trying to walk (a likely story I thought). Dad had been looking after the child at the time. The baby ended up in hospital for 3 days and

dad was interviewed by the police. A case conference was called and the children put back on the CPR. Even thought the consultant paediatrician said it was non-accidental the father was not charged. I was devastated, I felt let down by the system. This small child had received a terrible blow, which was non-accidental, but no one was held responsible. I really began to question my ability to do the job and remain neutral. I always thought the health and well being was paramount. I went home and cried my eyes out.

As the children were on the CPR the family received more input from various services which I felt was good, as anything unusual would be reported immediately. The baby started to gain weight at this point, whether it wad because she was now walking and could raid the fridge or because the family were being more closely monitored I will never know.

At the next review conference it was decided to take the children's names off the register as all was well and the family was co-operating with social services. However, I was not convinced but had no grounds to ask for their names to be kept on, only previous concerns which didn't count. A month after this conference the family moved back to Chester but from what I heard from a colleague mum and dad had gone their separate ways with mum and the children living in a new flat which was used to house the homeless. Mum was seen walking around the town sometimes later with the children looking gaunt. Since that day I've heard nothing about them I only hope the children are doing OK as I often think about them. You put in all the hard work but I feel you never receive recognition - after all, its all in a days work.

Narrative 5: Health visitor – Julie

Health visitor 5 is age 51 years, with a BSc in community Studies and has worked as a health visitor for 24 years.

The family described in this narrative was brought to my attention when they transferred into the local area at the same time as the arrival of their newborn twins. They had a complicated family network consisting of two adults, newborn twins, a two year old with unmet needs, two older siblings 5 years and 7 years who has a different family, and this father's own three children who stayed with the family group at weekends. There were the normal health visiting processes of relationship forming, sharing information and anticipating trust and honesty developing between myself and the mother, but this didn't progress in a straightforward manner. The routine health visiting to the family was being done against a background of rising anxiety and unresolved issues, and general health decisions, all of which enhanced my gut feelings about the care of the children. It is a case characterised by health and social service working together but not finding a satisfactory middle ground – what may appear black and white on paper does not always result in a practical, safe solution for the children involved.

In terms of unmet needs, the boy of 2 years had obvious problems. He already had an incident in his history involving 60% scalds, which occurred at 16 months, requiring him to be ventilated in intensive care. There was no documentation whatsoever about the circumstances surrounding the incident in the notes, the only reference being the health visitor care following discharge. He presented as a miserable, tearful child, with severe speech delay, a dummy permanently in place and his upper clothes were soaked to umbilical level with dribble. Both his forearms were obviously scarred, and his mother was openly pleased to observe that he put his own moisturiser on, as she did not have the time herself. Mother appeared delighted for him to be referred to assessment clinic in order to start addressing these problems.

At the review visit a week later mother was stressed and had her own physical problems. She was referred to her GP, but agreed also to weekly support visits. She was out for 3 of these visits by appointment, and then cancelled the 8 weeks check for the twins. I was becoming increasingly aware of my growing concern about this family. At 10 weeks the twins attended their assessment with their mother, who had a black eye and a high postnatal score. She consequently commenced medication. Her GP told her he wanted me to visit her weekly, and she agreed. To add to my concern, she refused an emergency appointment for one of the twins with an ophthalmologist over a possible retinoblastoma, but agreed to one some 3 weeks later. My need to stick to supposedly non-judgemental feelings was becoming difficult.

I visited her the day after the assessment, at the agreed time, to find the 5 and 7 year olds in the house unattended for the 5-5 minutes prior to mother turning up in the car, then cross a busy road with her 2 yr old running beside her. The twins also had not been strapped into the car seats. Mother was always able to give reassuring responses when I questioned her about these instances, but resented my concerns. Further information then started to come to my attention. We received a letter confirming that a child had not attended the pressure garment clinic on 6 occasions, and also that the 2 yr old's violent behaviour at the PACES group was

causing the staff concern. Over the period of time working with this family it became obvious that we needed a multi-agency assessment. There were frequent episodes of her not taking up medical help for recognised medical problems; there was domestic violence which mother had admitted to. Safety issues were a big problem, but the mother did not see what my problem was; she felt it was part and parcel of living in a large family, and failed to act on any safety suggestions made. Visits became uncomfortable and even downright unpleasant. She refused offers of proactive family support, not wanting to be seen as a mother who could not cope. She wanted her relationship with her violent partner to work and did not appear to have the capacity for putting the children first.

The multi-agency meeting was helpful in some respect, but frustrating in others. I did not have the mother's consent to refer; she felt she was a good mother and that her children were well cared for. I proceeded on the basis of a single incident, but on the basis of a whole series of incidents, which I felt added up to a serious level of concern. At the meeting I felt I had the support and understanding of my senior nurse for child protection and the educational social worker. It was agreed that the 2 yr old was a child in need, but then there was no grounds for child protection. School felt the older boys were model pupils. As most of the concerns were from a single agency, social services felt that all the children should be reviewed by a medical officer and monitored by a health visitor. Social services agreed to write to the family to outline their responsibility to take the children to appointments for recognised conditions.

The medical review was a disaster. The mother was furious at having to attend and the medical officer felt that I was over cautious, and even unfair towards a busy parent. Social services subsequently closed the case in January 2001, without a review meeting.

In February, the 2 yr old sustained a spiral fracture to the tibia, with a delay of 4 hours in attending casualty. The hospital staff were so concerned at he mother's lack of sympathy towards the child in the waiting room that they phoned a health visitor colleague. The medical staff decided that the history given was consistent with the injury, and the mother's attitude to her son and the delay in seeking help were overlooked. A joint health and social service follow up visit was arranged to address supervision and safety issues. As the mother agreed to a Homestart referral, which had still not been activated 10 months later, the case was closed again. The rationale was that they have a consistent history and a family who agreed to cooperate. For the health visitor, we are building up a bank of knowledge from other workers who are concerned about the family; PACES staff regarding the child's aggression, staff in casualty regarding lack of empathy and consultant clinic defaulting.

In April that year, there was a 4 day delay in seeking attention for a finger injury to the same child after he trapped it in a car door. When the family attended casualty, the father was so verbally abusive that the police were put on standby. The house officer referred the child and his twin brother to the registrar because of the presenting injuries, the extensive bruising around the twin's heads and the medical history. As the registrar was satisfied with the history given she effectively ruled out any concern about physical abuse.

As a health visitor I felt that my initial feelings about this family were correct even though the medical causes of concern had been ruled out by the physicians. Social services' response was to apologise profusely for any inconvenience caused, and they tried to ensure that should that family have to attend casualty again, they would not be put through such an experience. There remains a huge gap here in our different perceptions of this family. The hospital staff were following their procedures and, of course, should continue to do so. Unfortunately, the case was again closed by social services.

Although the mother was initially very friendly and cooperative regarding help for the children, she refused from day one to consider support for herself. "Other mothers at school think I'm marvellous. They don't know how I do it". I tried many ways of exploring help for her, explaining that she had a greater parenting challenge than most. The bottom line was that her partner, who was very controlling, would not allow anyone in the house. Social services felt that the family didn't meet their criteria for help and nothing was offered.

Although the 'Neglect tool' was not officially launched, staff were using it as an aid to assessment. I felt that health visitors used the tool in a more holistic, long-term fashion, building up a picture of the family, and out concerns. Social services appeared in this case to consider each incident separately, ignoring it completely as soon as it was proven not to be a child protection issue. This did not seem to be in the spirit of children in need. I felt even more strongly after using the tool in the child's assessment that the experience of this child was very much that of a child in need.

In terms of support, the next pregnancy, enhanced the need for the whole family. An antenatal discussion established the difficulties of the family would have in getting out of the house with so many immobile children, but still nothing was forthcoming. At least by this time we had mother's agreement to request help for her. It was not until there was evidence of domestic violence in the nearly postnatal period that we eventually secured a referral to the Family Service Unit. They have, and continue to express, immense concern about the unfolding safety issues and unmet needs of the children. The longer they are involved, the more they are finding.

There are many issues around engaging others to meet the child's needs. As the parents don't recognise the problem, and can see we are not united in our approach to the family, they still fail to meet the children's needs, still missing appointments, and the domestic violence continues. I feel that this mother cannot and won't protect their children, but unless there is multi-agency agreement that they are in need, we have no ability to insist on an improvement in standards of care and supervision of the children. It has taken countless letters and phone calls to get this far. I feel that the parents' verbal aggression also affects our behaviour towards them. We are so aware of our own vulnerability that it is extremely difficult repeatedly to raise issues, which the parents are failing to act on. Nobody dares to challenge them.

I have had several families where I have thought the use of the 'Neglect tool' would have been invaluable. It has helped me to collect and categories my thoughts and to share these with the family in a more structured way. In each case the parents have not considered themselves neglectful, and have not felt that their

children are in need of services. In spite of using the 'Tool' as a basis of referral there have been times when no reply has been forthcoming for periods of over 2 months, which needs to be improved. There remains obvious differences in the way we use the 'Tool', but multi-agency training should bridge some of the gap, and the rest of the gap allows for us all to reflect on the complex nature of the families and agencies we work with.

Results of Graded Care Profile assessment:

Physical environment – overcrowding

Health – frequently missed specialist appointments
   Not following procedures for recognised problems
   2 serious accidents
   Parents need constant prompting regarding children's needs
   Intermittent rejection of health visitor input

Developmental/educational aspects – 21/2 years none of own toys
   Speech delay? Lack of stimulation
   Aggressive behaviour

Social presentation – mother not empathetic

Family/social relationships – frightening outbursts from parents
   Child a young carer

Emotional/behavioural development – developing in an atmosphere of conflict
   Smacking pre-school child

Narrative 6: Health visitor - Dianne

Health visitor 6 is educated to diploma level and has worked as a health visitor for 12 years. She is 40 years old.

Mum 21yrs
Dad 28yrs
Jason 6yrs
Carol 3yrs
Adam 2yrs
Libby 3mths

This is a young family of six. Mum 21 years, Dad 28 years. Jason 6 years, Carol 3 years, Adam 2 years and Libby 3 months. Family moved to the area from Wolverhampton. I first met then in December 1998. On 'transfer in' visit family of 6 were all sleeping in living room on a mattress with a Calor gas heater. Bedroom was not in use as it was too cold. They has a 2 bedroom flat up 2 flights of stairs.

My initial concern was one of safety - worried in case children might burn themselves or flat could go on fire.

Jason 6 years poor attender at school, didn't like going as he was bullied. Jason also had a soiling problem.

Libby 3 months second immunisation outstanding, very chesty. Both parents smoking.

Carol Ann 3 years very quite, would get my attention by pulling at my skirt. Poor attendance at nursery. Developmental and speech delay also behaviour problems

Adam very noisy and boisterous - had temper tantrums frequently. All children appear appropriately dressed. Hygiene was poor for Libby, Adam and Carol. Jason's hygiene appeared better.

I liaised with school nurse who also had concerns about children. A joint visit was done with educational social worker. Baby attended surgery on one occasion - inappropriately dressed, no hat, no blanket. It was winter.

Parents both smoked despite having a 2 year old with asthma and a baby with chesty cough.

Mother asked if we had access to warm clothing for children and baby needed bedding. I managed to persuade mum and dad that a referral to social services as a family in need would get them better housing and also help to get a fulltime nursery place for 3 and 2 year olds.

A referral was made to social services as a family in need. A joint visit was done in December with a named social worker. I worked closely with the family - giving advice on behaviour management, safety in the home.

A joint visit was made with educational social worker to see if they could help with a scheme for getting 6year old and 3 year old to school on a daily basis on time. Liaison with head teacher was most helpful. One of the teachers had actually bought the young girl 3 years a pair of boots as she was wearing pumps in school in the winter - she told mum a parent had given them - would she like them for her daughter. Teachers would watch out to make sure the children had a good dinner - sometimes they would use some of their own food.

Carol 3 yrs was seen by CMO after a referral from health visitor for speech delay and behaviour problems. Carol spent time at a child development unit and she stills receives speech therapy.

The parents did not receive any positive input from SS until April and this was after a child protection issue. Then Adam was put in nursery and Libby. Children were all put on CPR in April and put into foster care. Carol had attended school with bite marks by both arms - adult bites - forensic - said they were mums. Crown prosecution said there was insufficient evidence to support this - case did not go to court.

To date.
Jason in foster care - attending school regularly, self esteem improved, enjoying school, and learning ability improved. Still soiling - had help from CMO for soiling

Carol - foster care (different from Jason) Developmental and speech delay. Referred to CMO. Referred to Child Developmental Team. Attending school regularly.

Adam - in foster care with Libby (but with another different family).Under review with child psychologist for behaviour problems.

Libby - in foster care with Adam. Diagnosed asthmatic. Development is age appropriate. Both Adam and Libby now have new health visitor since moving to ... in January.

Children to be in long term foster care at present.
Since July last year (2001) mum and dad have spilt up. Dad does not visit children. Mum sees children twice a week for 2 hours.

Intensive work is being done with mum, organised by social services.. Mum having intensive help in parenting skills from:
Social services - Sure Start project
NCH
Educational social worker
Health visitor - discussed have been nutrition, personal hygiene, care of children's hygiene, managing behaviour problem

Also attending literacy classes
It is hoped that one day mum can improve her parenting skills sufficiently to be able to care for her children.

Narrative 7: Health visitor - Sue

Health visitor 7 is age 36 years, educated to diploma level and has been health visiting for 10 years

Mrs G 32 years has borderline learning needs but has never been formally assessed. Extended family lives in England. She was brought up by maternal grandmother from the age of 3 years. Query why. Only contact with extended family is with an aunt and uncle. She has a twin sister and 4 other siblings all of whom are reported to have a great deal to do with each other.

Mrs G father age 33 years has depression. He is a local and has 5 siblings. He is well known in the community. He suffers with depression and has support from the mental health team.

A male 1986 (seventeen years old has been 'educationally statemented' He is quiet and stays close to mother.

B Male 1987 (Sixteen years old had been diagnosed with autism and attends school for learning disabilities. Has 2 residential nights at the school.

C Female 1989 (13 years old has started educational statementing process. Will attach herself to adults who show affection and care

D Male 1993 (9 years has commenced statementing process. Is clingy to mother

E Female 1994 (8 years was born prematurely and diagnosed with haemolytic anaemia. Quiet, show affection to other adults known and unknown to her.

F Female 1997 (5 years)

Baby **died** at 7 weeks with a congenital malformation of the brain. Initially the death was thought to be non-accidental, the first post-mortem reported blunt trauma causing cerebral bleed.

G Female (twin 2 year old) Taken into care from birth

G Female (twin 2 yearold) Taken into care from birth.

Documented unmet needs

Food and nutrition: inadequate and poor quality. The cupboards, fridge and freezer were frequently empty. The mother would phone HV reporting no food and no money. On one particular occasion I visited the home at 9 am to find mother in tears (which is not a common feature). The children were in dirty nightwear and wanted to go to school. There was no food at all. I purchased breakfast and packed lunches from the corner shop. On my return I attempted to make breakfast but there were no crockery and only 1 spoon. I then visited the neighbours for a loan of the above. The children have been observed in school to appear hungry e.g. D and E were seen fighting over an apple core.

Dress and hygiene: Poorly clad and unkempt. There are always many black bin bags of clothes...damp, crumpled, torn, etc. The washing machine is in constant use but this does not benefit the children.

Housing: The family have moved council house a number of times within the same town. All of the houses have deteriorated in to the same state of disrepair. This includes – refuge scattered throughout the house, no carpeting, partially stripped walls, broken furniture, bricks and planks of wood cluttering the hallway and bedrooms, toilet leaking, doors hanging of hinges, broken windows, glass in floor. Graffiti on front door. Yard full of furniture and bikes, theirs and others.

Personal belongings: no toiletries, toys, trinkets or personal belongings. The children's rooms have no identity. The beds are often broken, inadequate bedding and the children share when beds break. No safety equipment...gates.

Play and stimulation: the mother is very good at playing with the children when they are babies or toddlers. She clearly enjoys their affection and cuddles, kisses and sings to them. However, as they get older she appears to find it increasingly more difficult to respond to their emotional needs. There is very little evidence of stimulation or praise. She often brushes away their request for attention

Emotional health...attachment: The mother and her elder son appear to be very close and loyal. He seems to take on the male adult role and colludes with her. He is sent errands and expected to look after the younger siblings. Whilst the baby was alive he used to get up and feed her and then tragically found her dead one morning. The mother's relationship with the next two children does not present any significant concerns.
Her attachment to D is close and until recently she would openly state he was her baby. He now challenges her with tantrums, non-compliant behaviour and running away. His emotions 'visible', he can cry and become terribly distressed.
The relationship with E is of concern. She is often ignored and not comforted. When there is an increase in stressors at home she refuses to talk or look at others and will turn and curl her body away. When she is relaxed she will want to be cuddled and given attention.

Communication: Mum fabricates happenings, actions and intentions, but then appears to believe what she has just said. The eldest will support her stories. The children are frequently 'let down' and it is as if they expect this. Mum is flighty and easily distracted. She does not present as if she is listening. She expresses anger easily and is not trusting of professionals.

Professional support: Over the years there have been differing professionals supporting and assessing the family's needs. This has progressed from no social work input other than specifically for children B in relation to his learning disabilities. At this time there were significant input from health...child development team and myself.
This progressed to input from a change of social worker but again from the learning disabilities team, but was expected to support the family generally. At this time the mother's coping skills were poor and there were obviously signs of her not coping. I was assured by the social worker that the mother loved her children and therefore we should not impose our middleclass judgemental view upon her. This view did not change even though the mother was asking social services for support and continued even at the time of the baby's death. Six weeks prior to the baby's death I referred the family to the team manager of the then child protection team, asking for an assessment. The manager tried to hand this back, stating that there was already a social worker involved.

Following the baby's death, a murder enquiry was opened and the parents were kept in the cells overnight and the other children taken into care. I was called to the police station to make a statement. As already stated this was a result of the initial post mortem. It was 3 weeks before the results of the

second post mortem from the Home Office were released. During this time I supported the family in their grief. To go back slightly I attended the A & E department to support the mother at the time of attempted resuscitation and then to go home and tell the children. I could only do this because I had already established a close relationship with the mother. At times I found it difficult not just because of the enormity of the baby's death but rationalising this with…her parents may have murdered her, and if they didn't they may have known how or why. This latter thinking is still with me and others as it may well have been an accident with the other children responsible that set the bleed off.

From this point all the agencies were called together. A full assessment was carried out and the children placed on the child protection register and interim care orders taken out. It was then a long haul of contact visits and a gradual return home. Social services involvement varied and no working relationship with the mother established. There were four social workers changes before we saw any progress. The social worker involved now has had a long slow heavy time trying to work with the mother and had to break the bad news to her too…the birth of the twin girls that were taken into care from the hospital, the announcement that unless she "got her act together"…the twins would be adopted. As a result mother is responding and had now started to work at keeping her twins. We are now on a rehabilitation programme and the twins spend 2 nights per week and daytime hours for 5 days per week.

The reason that we believe that we have started to see some progress are:
- The social worker has not given up or given in. She has spoken to her simply and directly, reinforcing previous messages. She has been open and honest.
- The social worker had involved the father figure as much as has been possible
- The social worker has organised a team approach with very close communication and frequent meetings to reflect and change the support package.
- The team has reinforced the message
- The mother was given a shock regarding the twins but has since been rewarded for good progress.
- The social worker had found support workers who will relate to the mother and to the ch8ildren.
- The team had ensured that management in all agencies but particularly social services have been informed and updated regularly.
- From a health perspective the school nurse and I have worked closely and ensure that the GP's are involved in the needs of the whole family.

From a personal perspective my communication with the mother and the children has been crucial. Apart from two maternity leaves for me, I have been involved throughout, whether there have been preschool children or not. This has given continuity and stability to the whole case for the family and the professionals.

I have found it essential that I am sensitive to the mother's emotional feelings during a particular contact. At times she would want physical comfort at others a distance was and is needed. To ensure she's listening I need eye contact. I take on the role of visitor to her home and do not overstep that mark. This has usually resulted in my being able to access the whole house when others haven't. She trusts me now to be alone with her children and they enjoy that contact.

Throughout all this intense awareness of my communication skills I am needed to assess the children's health and well-being, the state of the house and the family dynamics. Every visit is time consuming, emotionally challenging but usually positive and enjoyable.

The present: Confidential reports for professionals only meeting regarding the family.

Growth and development: Both girls are developing normally and are reaching age appropriate milestones. They are walking, climbing and are confidently mobile. Speech and language…they are both mimicking and are interactive.

Social development: Both are visibly attached to their mother, are clingy to her in the presence of unknown adults which is appropriate. Both respond very positively to their mother and clearly play simple games, e.g. peek-a-boo, hiding and clapping games. They respond by participating and laughing. Growth is normal.

Care and parenting: Daily routine appears to be reasonably structured to their benefit. Personal hygiene and dress is reasonable. Diet and nutrition is adequate, there is a need to support mother in providing a nutritionally balanced and age appropriate meals e.g. there is tendency to use jars and baby food or to mash family food rather than encourage finger foods from the family meals. Bottles of milk are also offered which is unnecessary. This is an area that we are aware of and are working through.

Family home: There has been an improvement in the general state of the home. There is a warm homely atmosphere now, with attention being paid to the main social room. There are family photographs, trinkets and during the Christmas period, a significant effort had been made to create a child friendly seasonal home.

The twins' room is warm and again an effort has been made to make it homely. There are wall hangings, a sofa, furniture for the twin' clothes and two cots with adequate bedding.

The other bedrooms are not as well catered for with limited furniture or storage for toys. There are very few personal belongings for the older children leaving the rooms with little identity. There are few toys.

Family relationships: there has always been a close attachment between the children and their mother. They "look out" for each other and there is normal sibling rivalry. The twins have a significant place within the family, the older children are attached to them and his bond appears to be reciprocated. We do not fully understand the impact the loss of their baby sibling had on them, but the relationship with the twins may be helping them with this loss. The twins appear to enjoy playing with their siblings and appear to have established an attachment with them.

The parents have been together now for 4-5 years. The father's mental health has at times been as stressor for the family but during the past year this has been less a concern.

Protection: The parents' ability to protect from harm from others does not give concern. They have demonstrated their ability to protect the children from those who may be a risk to them. None of the children have been involved in crime or social disturbances even when they have been in close proximity to this.

Housekeeping…financially: This appears to be in a much better state latterly. There have not been the previous concerns regarding debt, no electricity or food, The children are receiving Christmas and birthdays present. This is an area that needs continued support and monitoring.

Accessing support and advice: Historically there has been a reluctance to accept input from social services or from new professionals. Trust with agencies has always taken time and is often fraught with a poor take up of support. As a health visitor from the past 8 years or so. I have always had access to the home and the family seek out my support. Medical appointments are requested and kept. Compliance with advice and treatment is usually carried out with support.

General thoughts: Progress is slow but is happening. To enable this to progress the family will need sustainable package of support from the multi-agency team. I would not want to see this family unit broken up whilst there is an opportunity to support the development of a family where there are recognisably strong attachments and an understanding of their roots, family dynamics and a stability that is often lacking in many families.

I do not under estimate the demands this will put the multi-agency team, it will require a long term plan to continue working collaboratively to enable these children to develop to their full potential within their family home.

I believe that we should recognise the progress that has been achieved by the team in particular the social worker's ability to communicate with the family and the work of the support workers.

APPENDIX 13:

ETHICAL APPROVAL

NORTH WALES HEALTH AUTHORITY
RESEARCH ETHICS COMMITTEE (CENTRAL)
Committee Services, Room 1038, Glan Clwyd DGH NHS Trust, Bodelwyddan, Denbighshire. LL18 5UJ
Tel. No. 01745 – 534132 - Fax 01745 583143

Chairman: Dr. R. J. Meara   **Secretary: Mr. U. M. Chouhan**

Mrs. A. Cody,
Lecturer in Nursing,
School of Nursing,
Ysbyty Glan Clwyd.

COPY

Our ref: RJM/JW
Date: Tue 8 September 1998

All correspondence and enquiries
to be directed to:
Mrs. Julie Whitmore
01745 534132

Dear Mrs. Cody,

Re: Validation of a risk assessment instrument for child neglect

Thank you for attending the LREC meeting on the 3rd September 1998. Members always find it most helpful to have the nature and purpose of the study explained by the Investigator.

Following discussion three main concerns were expressed by members as detailed below:

How would the control group be identified?

There would be lack of information in the notes of the control group. This would be insufficient to merit comparison with the study group.

If whilst extracting data from the notes of the control group, and the subject required intervention then how would Mrs. Cody deal with the issue.

During the discussions you did assure the members that databases – from neglect / non neglect and abused databases – were available and the control group will be identified.

You also agreed to seek further statistical advice and increase the numbers to be recruited to account for possible lack of information in control.

You also agreed that the data will be made anonymous.

With your acceptance of these comments the members were able to grant ethical approval for the study to proceed, on condition that:

- the protocol is followed as agreed
- the project commences within 3 years of the date of this letter
- the committee is notified of all protocol amendments and serious adverse events as soon as possible
- the committee receives annual progress reports and/or a final report within 3 months of completion of the project.

<div align="right">Continued ....</div>

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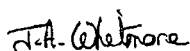
Approval from the Trust Research & Development Committee (Ext. 3624) must be sought before the study can proceed locally.

The Committee reserves the right to audit local research records relating to the above study. Ethics approval is granted on this basis.

The Committee aims to be fully ICH/GCP compliant. Please find attached a copy of our working constitution and a list of members, for your information and retention.

Yours sincerely,

J.A. Whetmore

Mr. U M Chouhan
Secretary
NWHA Research Ethics Committee (Central)

MEMBERS OF THE NORTH WALES HEALTH AUTHORITY
RESEARCH ETHICS COMMITTEE (CENTRAL) @ SEPT 1998

Dr. R. J. Meara, **Chairperson** / Honorary Consultant - Care of the Elderly - Clinical Representative

Mrs. J. Humphrey, **Vice Chairperson** / Lay Member (Health Authority)

Mr. U. M. Chouhan, **Secretary** / Principal Clinical Pharmacist - **North Wales Pharmaceutical Committee representative**

Dr. T. D. Yuille, Consultant Paediatrician - **Clinical Representative**

Mr. C. N. Penfold, Consultant Oral & Maxillofacial Surgeon - **Clinical Representative**

Mrs. J. Leadbetter, Senior Midwife - **Nursing representative**

Dr. N. P. Archard, Consultant Radiologist - **Clinical Representative**

Dr. D. L. Williams - General Practitioner - **Primary Care Representative**

Dr. I. Wilson - **Junior Doctors representative**

Dr. M. E. Evans, Retired GP - **Lay Member**

Mr. J. B. Hughes, County Coroner - **Lay Member**

Dr. T. R. Trevelyan, Consultant Psychiatrist - **Mental Health representative**

Mrs. G. D. H. Hack, Lay Member / **Community Health Council representative**

Canon R. Byles, **Lay Member**

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CENTRAL SUB - COMMITTEE

All correspondence and enquiries to: Mrs. Julie Whitmore, Gweinyddwraig Etheg / Ethics
Administrator at Glan Clwyd Hospital, Ystafell 1038 / Room 1038, Ysbyty Glan Clwyd, Rhyl.
Denbighshire. LL18 5UJ
☎ Direct Line: 01745-534132   Ffacs / Fax: 01745 583143
Website: www.conwy-denbighshire-nhs.org.uk   E-Bost/ E-Mail: Julie.Whitmore@cd-tr.wales.nhs.uk

Thursday, 25th January'01

Mrs. Ann Cody,
School of Nursing,
Conwy & Denbighshire NHS Trust,
Glan Clwyd Hospital

Dear Mrs. Cody,

Re: Health Visitors' response to child neglect and primary prevention opportunities: in North Wales

Thank you for attending the recent meeting of the NWHA Research Ethics Committee (Central) held on 4th January 2001 and for presenting this study.

Following extensive discussion the following points were raised:

i) Nursing Students Questionnaire - approved by members present

ii) Health Visitors to have the option to have their name included in the narrative, although members felt that it must be stressed to them that the contents of the narrative must remain confidential to the Researcher only.

iii) Health Visitors must <u>not</u> include any information in the narrative which may compromise the patients identity e.g. Patients Name or Date of Birth.

iv) Mrs. Cody informed members that Appendices A, B & C no longer form part of the study requirements and should be removed. This was agreed.

v) The personal attendance of the women would constitute consent and no written consent was therefore felt to be required. This was agreed by members present.

vi) An Information Sheet needs to be formulated for the Women's Group.

Approval for this study was therefore withheld until such time as the amended / additional documents are received and reviewed by an Officer of the Committee.

Yours sincerely,

Mrs. J. Leadbetter,
Acting Secretary, NWHA Research Ethics Committee (Central)

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Ethical approval

Pwyllgor Moeseg Ymchwil Awdurdod Iechyd Gogledd Cymru
(Is-bwyllgorau'r Gorllewin y Canol a 'r Dwyrain)

North Wales Health Authority Research Ethics Committee
(West, Central & East Sub-Committees)
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••••••

CENTRAL SUB - COMMITTEE
All correspondence and enquiries to: Mrs. Julie Whitmore, Gweinyddwraig Etheg/ Ethics
Administrator at Glan Clwyd Hospital, Ystafell 1038 / Room 1038, Ysbyty Glan Clwyd, Rhyl.
Denbighshire. LL18 5UJ 8
Direct Line: 01745-534132   Ffacs/Fax: 01745 583143
Website: www.conwy-denbighshire-nhs.org.uk   E-Bost/ E-Mail: Julie.Whitmore(g)cd-
tr.wales.nhs.uk

Tuesday, 01 October 2002
Our ref: 01/94 (iii)/jw

Mrs. A. Cody,
Nurse Lecturer-
School of Nursing,
Conwy & Denbighshire NHS Trust,
Glan Clwyd Hospital

Dear Mrs. Cody,

**Re: Health Visitor's response to child neglect and other primary prevention opportunities
in North Wales**

The above project was approved by the NWHA Central Research Ethics Committee on 4th
October '01.

Members of the Committee would appreciate some follow-up to the project and would therefore
be grateful if you could complete and return the enclosed questionnaire.

The Committee would also be grateful for a brief summary of the conclusions reached. Yours
sincerely,

Mrs. Julie A. Whitmore,
Ethics Administrator
NWHA Central Research Ethics Committee

Enc.

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Preswylfa, Ffordd Hendy, Yr Wyddgrug, SirYFflint, CH& IPZ. Ffon: 01352 700 227 Ffacs: 0135 754 649

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APPENDIX 14:

SURVEY QUESTIONNAIRE

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Ysgol Nyrsio, Bydreigiaeth

Ac Iechyd

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Sources of support for parenting and childcare difficulties

Questionnaire

Most parents experience difficulties at some time. Without adequate help any difficulty might increase to a more serious stage. It is possible that some difficulties are easier to discuss with certain people and other difficulties with a different group of people. Your help is needed in order that we (the researchers) can identify whom these particular people are and for what problems you might seek help for.

In addition research has shown that there are some difficulties that can affect a child's health and development. Four such concerns are included in question 6. We seek your help in suggesting how parents with these concerns can be better helped.

Before beginning the, brief, specific questions about parenting and childcare difficulties please completing the following information:

Q1. Sex: 1.1) Female   ☐

                      1.2) Male   ☐

Q2. Age: 2.1) less than 20   ☐   2.2) 21-30   ☐

                      2.3) 31-40   ☐   2.4) 41+   ☐

Q3. Parental status: 3.1) Mother   ☐

                          3.2) Father   ☐

                          3.3) Not biological parent   ☐

Q4. Marital status: 4.1) Married   ☐   4.2) Partnered   ☐

                          4.3) Separated   ☐   4.4) Divorced   ☐

                          4.5) Single   ☐

Q 5 If you were to experience any of the following parenting and childcare difficulties whose help might you seek? If you would <u>not seek help</u> from anyone please <u>tick the</u> <u>column 'None'</u>. Please tick **only one social support** and, if appropriate, **only one agency support** for each concern.

Key for social support:
1 = Family, 2 = Friend, 3 = Neighbour.

Key for agency support:
4 = Health visitor, 5 = Social worker, 6 = Voluntary services, 7 = School, 8 = Police, 9 = None

Social support				Agency support							
Difficulties	1	2	3	4	5	6	7	8	9	Research Only	
Asthma (& similar concerns											
Alcohol problems											
Hyperactive child											
Vision/hearing											
Can't cope with multiple demands											
Child's aggression											
Debt											
Disciplining child											
Growth & Development											
Domestic violence											
Drugs (illegal)											
Feeding & eating											
Feeling inadequate as a parent											
Housing											
Marital partner											
Mental illness											
No loving, binding feelings for child											
Sleeping											
Temper tantrums											
Toileting/ Bedwetting											

Thank you for completing this questionnaire and for supporting this research project.

Please return the completed questionnaires, as soon as possible, in the stamped addressed envelope provided to:

Mrs. A Cody, University of Wales – Bangor, Education Centre, Glan Clwyd Hospital, Denbighshire, LL18 5UJ.

APPENDIX 15:

CHILD-IN-NEED CATEGORIES

Definition of 'Need' codes (Adopted from DOH 2003b: 6-20)

Need code	Definition of need for service	Possible sub-categories
N1 - Abuse or Neglect	As a result of, or at risk of, abuse or neglect	As listed on the Child Protection Register statistical return
N2 – Child's disability	Arises out of the children's disabilities, illness, or intrinsic conditions	Children with physical disabilities, sensory disabilities, learning disabilities, emotional and behavioural difficulties, and mental health conditions
N3 – Parental illness/disability	Arises because the capacity of their parents or carers to care for them is impaired be disability, illness, mental illness or addictions	Children with alcoholic parents, drug taking parents, acutely ill parents (short-term) parents with learning disabilities, and parents chronically disabled or chronically mentally ill but who are not taking responsibility for them, and children assuming caring responsibilities for chronically ill or disabled parents
N4 – Family in Acute Stress	Arise from living in a family going through a temporary crisis such that parenting capacity is diminished and some of the children's needs are not being adequately met.	Homeless families, single parents, or death of parent/carer
N5 – Family dysfunction	Arise mainly out of their living in families where the parenting capacity is chronically inadequate	Child's poor attachment to carer, low stimulation for child, erratic relationship between carers, Chronic violence between carers or low boundary control
N6 – Socially unacceptable behaviour	Arise primarily out of their children's behaviour impacting detrimentally on the community	Disorderly behaviour, offending, truancy or unsafe sexual behaviour
N7 – Low Income	Arise mainly from being dependent on an income below the standard state entitlements	Asylum seeking families, non-habitually resident status, or 'independent' young people
N8 – Absent Parenting	Arise mainly from having no parents available to provide for them	Parents died, unaccompanied child asylum seekers, or separated from parents by natural or civil disaster or political events
N9 – Cases Other than Children in Need	Casework which required legal and administrative reasons only and there is no child in the case who is in need	Step-parent adoptions, inter-country adoptions, court reports, subject access to files, historical allegations/complaints
N0 – Need code 'Not stated'	Data is not yet completely entered on the system and whose 'need' code is yet to be determined.	

APPENDIX 16:

THE AGGREGATE EFFECT OF NEGLECT GUIDELINE

Duration of concern and presenting information							
Chronicity Early referral Continuing concern (less than 3 years) Long-term case (more than 3 years)							
Protective and vulnerable factors **Protective factors (* for areas of concern)** **Children's health and development** (internal personal strengths/limitations)	Accepting of services	Rejecting of services	Parental failure to provide basic needs	Lack of parent/child involvement	Lacking potential for change	Subtotal of strengths & limitations	Professional judgement of likelihood of neglect
Sense of being loved Self-esteem Sense of autonomy, and Sense of being trusted Social communication Intellectual skills Seeking trusting relationships Humour Persistence and Problem solving ability **Parental capacity** (external support) Trusting relationships Providing emotional support Provide structure Provide stability Encourage towards achievement, and Provide access to relevant services **Vulnerable factors** Children's health and development Growth and developmental impairment Poor school attendance Children's temperament perceived to be difficult, and Unhappy child **Parental capacity** Lack of family planning Maternal lack of affection Parental lack of support **Social and environmental factors** Substance misuse Violence in the home Poor housing conditions General lack of social support							

Duration of concern and presenting information							
Chronicity Early referral Continuing concern (less than 3 years)　　　　　* Long-term case (more than 3 years)	**Continued educational and medical concern for approximately 2 years without notable improvements**						
Protective and vulnerable factors **Protective factors (* for areas of concern)** **Children's health and development** (internal personal strengths/limitations)	Accepting services	Rejecting services	Parental failure to provide basic needs	Lack of parent/child involvement	Lacking potential for change	Subtotal of likelihood of strengths & limitations	Professional judgement of likelihood of neglect
Sense of being loved　　　　　　　　　* Self-esteem Sense of autonomy, and Sense of being trusted Social communication　　　　　　　　* Intellectual skills　　　　　　　　　* Seeking trusting relationships Humour Persistence and Problem solving ability **Parental capacity** (external support) Trusting relationships Providing emotional support Provide structure Provide stability Encourage towards achievement, and Provide access to relevant services　　* **Vulnerable factors** Children's health and development Growth and developmental impairment Poor school attendance Children's temperament perceived to be difficult, and Unhappy child **Parental capacity** Lack of family planning Maternal lack of affection Parental lack of support　　　　　　* **Social and environmental factors** Substance misuse Violence in the home Poor housing conditions General lack of social support　　　　*	Accepting of health visitor and educational social worker	Not attending support groups Not attending important medical appointments No contact with father Infrequent contact with maternal mother	Twins 28% school attendance 10 year old reading age of 6 years.	Cuddles and kisses Lack of social experiences		Children loved Accepting of services that go to the home Less accepting of other services Lack of medical care for important appointment Lack of social support	Types of neglect: Physical　　* Emotional Educational　* Safety Medical　　* Social　　　* **Judgement** **These children cannot reach their potential due to lack of education.** **Potential behaviour problems when oldest child enters high school and cannot cope**