The identification and reporting of child neglect among professionals and the general public

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Thesis submitted to the University of Nottingham for the degree of Doctorate in Forensic Psychology (D. Foren. Psy.)

March 2018

Abstract

Background: Child neglect remains a challenge for professionals and the general public to identify and effectively respond to. This thesis provides a broad investigation into professionals and the public's ability to identify and respond to child neglect. In particular exploring how different facets of child neglect impact on identification/taking action.

Aims and Objectives: The main aims of this thesis was to explore and expand the current understanding of factors that impact on professionals and the public identifying and responding to child neglect. The four questions were;

1. What is the current literature on factors that impact on professionals' reporting/responding to child neglect? (Chapter two).
2. What factors impact on family support workers, primary school teachers, and public's ability to identify and respond to child neglect and are they any differences dependent on participant group? (Chapter three).
3. What are the experiences and difficulties of working with child neglect identified by family support workers and primary school teachers? (Chapter four).
4. Is the Family Star (Early Years) (Burns, MacKeith and Greaves, 2015) a suitable tool to support family support workers in identifying and responding to child neglect? (Chapter five).

Method: To answer the first research question a systematic review was completed to explore current literature on what factors impact on professionals' reporting of child neglect (Chapter two). An empirical research study using quantitative measures was used to explore and compare the general public, family support workers and primary school teacher's identification and reporting/taking action when presented with child neglect vignettes (Chapter three). An empirical research study using qualitative measures was used to explore family support workers and primary school teachers' experiences and attitudes towards reporting or taking action when neglect is identified (Chapter four). When professionals have concerns about neglect a framework for assessment can be used to help identify neglect and support them in the most appropriate response. A methodological critique was therefore conducted to explore the psychometric properties of the Family Star (Early Years), a tool commonly used by family support workers to help identify child neglect and signpost where appropriate intervention is necessary (Chapter five).

Overall findings: The systematic review (Chapter two) identified both positive and negative factors that influenced reporting tendencies. Perceived seriousness, correct identification of neglect, and correct knowledge and understanding of mandatory reporting laws have consistently been found to improve reporting tendencies. Negative factors affecting reporting were a lack of knowledge about child neglect, or perceived lack of evidence to report. Results were

however inconsistent across papers (e.g. training impacting on reporting tendencies).

The results from the quantitative primary study (Chapter three) showed that overall professionals were significantly more likely to report than the general public, physical neglect was seen as significantly more serious and likely to be reported by all participants compare to emotional neglect. Factors that increased the likelihood of reporting were perceived seriousness and how worrying the vignette was.

The results from the qualitative primary study (Chapter four) showed that early intervention when child neglect was identified was not common practice. Emotional neglect was often deemed 'not serious enough' to report, professionals struggled with policies/funding and multi-agency working that made it difficult for them to respond in every case of child neglect.

The methodological critique of the Family Star (Early Years) identified theoretical support for the outcomes used to identify areas of child neglect, however there remains very little evidence to support its validity and reliability.

Conclusion: Professionals and the general public continue to find child neglect, in particular emotional neglect, difficult to identify and are less likely to respond when it is identified. A better understanding into the serious consequences of emotional neglect, as well as better support for professionals to be able to respond

effectively are needed to ensure the continuing protection of children vulnerable to neglect.

Preface to thesis

Background to the study

For my Masters dissertation I completed a study on the identification of child neglect in comparison to physical and sexual abuse. Child neglect has been an area I have been interested in since reading a paper by Gilbert et al., (2009) on child maltreatment in high-income countries. It identified the lack of research in to child neglect and the lack of understanding into its serious short and long-term consequences. The results of my Masters study identified that participants rated child neglect significantly less serious and less worrying compared to both physical and sexual abuse, and were significantly less able to identify it as maltreatment compared to physical and sexual abuse. These findings were in line with previous literature within the field, with Wilding and Thoburn's (1997) research in to referrals to children's social services, finding concerns about neglect were given less priority than other forms of maltreatment: 61% of referrals for neglect received no further action in comparison with 30% of referrals for physical or sexual abuse. Similar findings were apparent in a survey of 242 social workers, where 60% said they felt pressure to "downgrade" neglect and emotional abuse cases and 59% said that it was "quite" or "very" unlikely that children's social care would respond swiftly to children suffering neglect (Community Care, 2013). The lack of research in child neglect compared to other forms of abuse is well established within the field (McSherry, 2007; Kaplan, Pelcovitz, and Labruna, 1999; Wolock and Horowitz, 1984). With this in mind I

wanted to build off my Masters study and continue to develop my research idea. I wanted to learn more about the attitudes of specific professionals, more about the decision to report or take action if neglect is identified, and what supported/ hindered professionals in this process.

Publications and conference presentations

The following publications and presentations have been produced from work within this thesis:

Publications

***Chapter four*:** Bullock, L., Stanyon, M., Glaser., G & Chou, S. (in press) Focus groups exploring primary school teachers and family support workers' professional experiences of identifying and responding to child neglect. *Child Abuse Review*.

Presentations

2018 Bullock, L., Glaser, D. & Chou C. *A systematic review on the factors that influence and impact on professionals' taking action/reporting in cases of suspected or actual child neglect.* Oral presentation delivered at the *International Society for the Protection of Child Abuse and Neglect*, Prague, Czech Republic.

Bullock, L., Glaser, D. & Chou C. *Perceptions, opinions and experiences of child neglect within Great Britain. A professional and public comparison.* Poster presented at *International Society for the Protection of Child Abuse and Neglect*, Prague, Czech Republic.

2016 Bullock, L., Glaser, D. & Chou C. *Perceptions, opinions and experiences of child neglect within Great Britain. A professional and public comparison.* Oral presentation delivered at *The British Association for the Study and Prevention of Child Abuse and Neglect*, Birmingham.

Structure of the thesis

This thesis follows the imposed structure for a Doctorate in Forensic Psychology at the University of Nottingham, which includes the following:

- A systematic review
- Two empirical studies
- A methodological critique of a measurement tool discussed within the thesis
- An introduction and discussion chapter.

Although each chapter is separate there is a narrative and theme that runs through all chapters and ensures that the thesis is a unified whole. This thesis' theme focuses on the identification and

response to child neglect, each chapter looks at a slightly different aspect of this theme. The systematic review looks at factors already identified within the literature that impact on professionals taking action. The subsequent two chapters look at professionals' own ability to identify child neglect, whether they would report child neglect, and identifies reasons why they may or may not respond. The fifth chapter focusing on whether a specific assessment tool (used by professionals within this thesis) is effective in helping and supporting professionals recognise and respond to child neglect.

Acknowledgements

Firstly, I would like to thank my academic supervisor, Dr Shihning Chou for her supervision and support throughout all parts of my thesis. I am extremely grateful for your patience and thorough guidance. I am especially grateful for your interest in my development as a psychologist and professional as a whole. You have spent time and effort offering me advice and helping me develop my professional identify, taking an interest in me, as well as my research. Thank you!

I would also like to thank Dr Danya Glaser my second academic supervisor, she provided me with invaluable insight into the application of research, and how best to apply my finding to effectively inform policy and practice.

I would also like to thank the whole department for your continuing support and words of encouragement when I needed them most.

A big thank you to all my placement supervisors and mentors, Dr Stan Renwick, Paul Mooney, Mark Hoyland, Sara Mackenzie, and Kerry Kehoe for proving me with fantastic support and guidance throughout my placements. I hope to continue to develop as a professional and learn from the fantastic examples you provided.

I am forever grateful and appreciative of all my friends and family for their support and patience throughout my training, and whom I have neglected somewhat in the last few years. My friends, siblings, colleagues, housemates, parents, and grandparents, thank you for always being there. I appreciate your patience and

understanding when I have had to cancel on plans, or turned up stressed and not my usual self. Thank you!

I would also like to thank all the dogs and puppies that I have had the pleasure to meet and sometimes look after. They have all given me so much happiness and have consistently been the perfect way to help me de-stress. Sirius, Isaac, House, Lady Penelope, Audrey, and every other dog along the way – thank you.

Finally, I would like to express my appreciation to the patients and clients I have worked with. I thank them for sharing their experiences with me.

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Chapter One

Overview

1.1. Introduction

Neglect remains the most common form of child maltreatment within the UK, with one in ten young adults reporting they experienced severe neglect as a child (Radford et al., 2011). Neglect is also the most common reason for a child to be on a Child Protection Plan[1] (Department for Education, 2016). Research from the NSPCC found reports of child neglect to the National Society for the Prevention of Cruelty of Children (NSPCC) had risen by more than 60% in the last five years (Bentley et al., 2016). Despite the rises in reporting and neglect being the most common CPP category, potentially indicating an increased public awareness and improvement in reporting from professionals, it does not reflect the true prevalence of neglect. Many more incidents of neglect remain unrecognised, or unreported by professionals witnessing them, and so fail to receive support from the appropriate services (Munro, 2011)

Child neglect can result in the most damaging developmental deficits (Egeland, Sroufe & Erickson, 1983) however despite the prevalence neglect consistently has the least amount of literature and media coverage designated to it (Burgess and Daniel, 2011). The apparent lack of research into neglect has resulted in the concept of the 'neglect of neglect' (Wolock & Horowitz, 1984) and more recently the 'absurd paradox' (McSherry, 2007).

[1] A child protection plan is a plan drawn up by the local authority. It identifies the likelihood of a child suffering harm and look at ways that the child can be protected. It also clarifies people's responsibilities and actions to be taken and outlines ways of monitoring and evaluating progress.

1.2. Defining child neglect

Compared to both physical and sexual abuse, there is far less agreement over what constitutes neglect, including a universal definition and thresholds for neglect (Munro, 2011; Naughton et al., 2013; McSherry, 2007).

Neglect can be defined as a concept, where a child's developmental needs are not being met or as a more operational policy label. The definition used depends on what basis it is needed for, e.g. criminal proceedings, research on child development, local policy etc. Using definitions for policy making may include a broad definition of neglect, for professional practice (and therefore compulsory action the definition is often narrower and more specific (Daniel et al., 2011). Different professional disciplines may use different definitions dependent on their background, training, and use of definition (Dubowitz et al., 1998). The definition an individual uses can therefore impact on their understanding and decision making on what constitutes neglectful behaviours.

Another difficulty in developing a general definition of child neglect is the problem in deciding what the threshold for adequate parenting is. As McSherry (2007) explain, there is a general consensus into what inadequate care is, such as lack of clothes, food etc. However, agreement on establishing thresholds for minimal care, is far more challenging and may be influenced by other factors including the professional's culture, ethnic group, profession type, age of child, and moral beliefs.

Horwath (2007) in an attempt to develop a clear definition of child neglect collated a range of definitions within the literature and developed a detailed breakdown of different forms of neglect, which were; medical neglect, nutritional neglect, emotional neglect, educational neglect, physical neglect and lack of supervision and guidance. These categories are helpful in distinguishing between forms of neglect and understanding the wide-ranging areas of child development that neglectful behaviours can impact.

In the United Kingdom (UK) child neglect is defined in the 'Working Together' guidelines (2015) as:

'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

1) *Provide adequate food, clothing or shelter;*
2) *Protect a child from physical and emotional harm or danger;*
3) *Ensure adequate supervision;*
4) *Ensure access to appropriate medical care (including antenatal care, dental care);*
5) *Be responsive to a child's basic emotional needs*

(pp. 07)

This is the definition this thesis uses throughout the chapters as recommended by HM Government to professionals when working

to safeguard and support children. Alongside this definition, the typologies identified by Horwath (2007) are also used to identify and describe specific neglectful behaviours. As this thesis is mainly focusing on professionals' responses to child neglect and understanding child neglect operationally this definition was viewed as most appropriate, (compared to a potentially broader definition that previous research in the field may have used).

The definition above is to be used operationally by professionals and researchers, and thus is appropriate to use in this thesis, which marries research and professional practice. However, the definition clearly aligns neglect as a 'caregiver omission', and is parent focused, not locating the primary caregiver(s) within the wider socio-economic context. The definition focuses on the parental responsibility and culpability not on the children's needs, and thus may be seen as a narrower definition.

This in turn can impact on a child's access to services or support, as professionals using this definition may focus on the parental aspects and whether these behaviours constitute a 'neglect' label, rather than focusing on the needs and impact these behaviours have on the child and their development. In Scotland, it has been proposed to remove the requirement of a category of concern when placing a child on a protection register, and instead focus on whether a child has suffered or will suffer significant harm. Here, using a very broad definition focusing on the child's needs allows for professionals to act, regardless of whether they believe the actions of the parents meets certain definition criteria. Despite

the difficulties outlined above the definition was felt most applicable to the participant group, as well as offering a focused definition of neglect so that the specific types of neglect could be identified and explored.

1.3. The effects and impact of child neglect

As research develops in the area, child neglect is consistently found to be as damaging as other forms of child abuse (Naughton et al., 2013; Gilbert et al., 2009; Action for Children, 2013). Child neglect although rarely life threatening impacts on many areas of a child's development, including impaired cognitive functioning, emotional wellbeing, behavioural difficulties, identity, social skill development and early attachment (Hildyard and Wolfe, 2002; Naughton et al., 2013; Hughes & Cossar, 2016).

Research also indicates the longer impact of childhood neglect, including mental health difficulties in adulthood including anxiety disorders, suicide attempts, substance misuse, major depressive disorders and risky sexual behaviours (Norman et al., 2012; Widom et al., 2007). Long-term physical neglect has also found to be associated with an increased risk of hypertension and chronic pain syndromes (Anda et al., 2006).

1.4. Noticing and helping the neglected child

Despite the high prevalence of child neglect and detrimental and long-lasting effects, research shows that there is under-recognition of neglect and tendency to prioritise other forms of child

abuse by professionals (Wilding and Thoburn; 1997 Gardner, 2008). Evidence also points to professional continually failing to recognise the severity of child neglect or its negative consequences (Community Care, 2013).

There is an important distinction to be made between identification and responding, both are required for a child to receive support but identification does not necessarily ensure that professionals will act.

Difficulties in identifying/recognising child neglect can be partially attributed to difficulties in the definition of neglect. Neglect is seen as the omission of behaviours by a parent/carer, often without intention to harm the child. This is in comparison to other forms of maltreatment, i.e. physical and sexual abuse where in certain situations can be seen more commonly as an act of commission (Connell-Carrick, 2003). Identifying what has not happened can be harder than what has happened (Allnock, 2010).

Despite the difficulties in defining child neglect the recognition of child neglect has been described as relatively straight forward (Daniel, Taylor and Scott, 2010), with indicators and risk factors shown by both the parents/carers of the child, and the child itself (Cash and Wilke, 2003; Appleton and Cowley, 2004; Glaser, 2007). Responding to child neglect however, is seen as far more complex.

There is a lack of research identifying specific factors associated with difficulties in reporting or tacking action when neglect specifically is of concern. Much of the research focuses on other forms of abuse, or more commonly conflates child abuse and

neglect as one form of maltreatment. Despite this, research shows that professionals' personal attitudes and perceptions of perceived severity or seriousness of neglect (Rose and Meezan, 1996; Shor, 1998, system characteristics, such as a very high case load, lack of training (Haynes, 2015; Adair et al; 1997; Fraser et al., 2010), and family characteristics, such as false compliance (Haynes, 2015) can impact on professionals reporting or acting on suspicions of child neglect.

Research has tended to rely on Serious Case Reviews [2] (SCRs), which provide an insight into how professionals respond in serious cases but do not provide an insight into the day-to-day work of professionals. Brandon et al., (2009) highlight that more needs to be known about routine child protection work and its effectiveness.

The importance of early intervention has been highlighted as an important focus for the prevention of child maltreatment (Wolfe et al., 1988; Guterman, 1997). Professionals are advised to respond and act as soon as there are concerns for a child's welfare, focusing on more preventative rather than reactive services. More recently early intervention has also been the focus of research and guidance for professionals to successfully support children at risk of maltreatment (Allen, 2011; Haynes, 2015). Professionals in universal services (such as family support workers and primary school teachers) are in such a position to provide this kind of

[2] A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. Local Safeguarding Children Boards (LSCB) follow statutory guidance for conducting a serious case review.

support. The aim being that intervention at an early stage will ensure the child and family receive support and guidance, preventing chronic neglect and the on-going suffering of the child(ren) (Haynes, 2015).

1.5. Mandatory reporting

Although there is a growing body of literature on the identification and reporting of child neglect, much of this research is completed in countries with mandatory reporting laws, in particular America and Canada (Adair et al., 1997; Canella, 2008; Ashton, 1999).

Mandatory reporting refers to legislation that identifies who are required by law to report suspected cases of child abuse and neglect. This law is practiced in countries including America, Australia (dependent on state), Canada, Sweden, Israel, and Northern Ireland. Despite a growing number of countries adapting this law, Great Britain does not have mandatory reporting laws. Within Great Britain individuals voluntarily report their concerns guided by professional policy.

Much of the evidence on the impact of mandatory reporting appears to be conflicting, within the USA, Australia and Canada reporting significantly increased with the introduction of mandatory legislation (Harries and Clare, 2002). However, this reporting increase appears to plateau and decline as time progresses. As Wallace and Bunting (2007) highlighted there was no difference in reporting or referrals in jurisdictions in Canada where there was no

mandatory reporting law. Research on professionals understanding and attitudes to mandatory reporting is limited and little is known on its impact or influence on reporting tendencies compared to countries with no mandatory reporting laws.

1.6. The present thesis

This thesis aims to explore and expand on factors that impact on professionals and the general public identifying and responding to child neglect. It aims to explore different aspects of child neglect and provide a clearer and more detailed understanding into how these aspects impact on identification and reporting. Additionally these thesis will look at whether specific assessment frameworks can help support professionals in identifying and helpfully responding to child neglect.

Chapter two presents a systematic review on factors already identified in the literature that impact on professionals acting when child neglect is suspected. Both positive factors that improve reporting/helping neglected children, and those factors that may negatively impact on reporting tendencies were found in the review. However, results were found to be inconsistent across studies.

Leading on from the findings in Chapter two that there remains little research conducted in Great Britain specifically on child neglect, Chapter three is a quantitative primary study exploring the identification and reporting attitudes of family support workers (FSWs), primary school teachers (PST) and the general public.

Both these professionals have a professional responsibility to be able to identify and respond to suspicions of child neglect. Despite this they are two professional groups who have had less research dedicated to them (Daniel, Taylor, Scott, 2010). The general public, do not have a professional responsibility to report child neglect however are equally important in identifying children in need and reporting or taking action on their concerns.

An online questionnaire was developed using six vignettes describing two aspects of child neglect (physical, emotional and a control scenario), as well as an additional factor indicating recent but not current domestic violence within the family.

Chapter four is a more in depth qualitative research study exploring the specific factors that may impact on FSWs and PST's responding and helping when neglect is identified. Two in-depth, semi-structured focus groups were conducted to explore the experiences of the two separate professions and the difficulties they felt they faced within their day-to-day practice.

As chapters two, three, and four evidenced, professionals can struggle to identify child neglect, and indeed do not always respond, or know when and how to respond if neglect is identified. Structured assessments have been proposed as a way to support professionals in noticing and helping children who may be suffering from neglect. Chapter five therefore presents an overview and methodological critique of the Family Star (Early Years) (Burns, MacKeith and Greaves, 2015). The chapter explores the tools suitability in identifying child neglect indicators, the theoretical support for the

scales used, its measurable properties, as well as considering its clinical use by FSWs when working with families in need.

Finally chapter six concludes the thesis providing a discussion on the findings of each chapter, the overall limitations of the thesis are presented as well as implications for practice and potential future research.

Chapter Two

A systematic review on the factors that influence and impact on professionals taking action/reporting in cases of suspected or actual child neglect

Abstract

Background: Child neglect remains a challenge for professionals and the public to identify and effectively respond to. Research consistently evidences that neglect is not consistently acted upon once identified.

Aims and Objectives: This systematic review sought to identify existing quantitative research into factors that influence professionals responding or reporting suspicions of child neglect.

Method: Eleven databases, three grey literature databases and five child protection websites were searched. Five experts within the field were also contacted. The number of hits was 17,782, of which 4,417 duplicates, 11,746 irrelevant, and a further 1,604 not meeting inclusion criteria, including qualitative studies, or papers not distinguishing between child abuse and neglect were removed. This resulted in 17 publication and 16 studies for inclusion. The quality of each paper was assessed using a pre-defined checklist. Data from 7,588 students and professionals contributed to the review.

Overall findings: Findings indicated both positive and negative factors that influenced reporting tendencies. Perceived seriousness, correct identification of neglect, and correct knowledge and understanding of mandatory reporting laws have consistently been found to improve reporting tendencies. Negative factors affecting reporting were a lack of knowledge about child neglect, or perceived lack of evidence to report. Results were however inconsistent across papers (e.g. training impacting on reporting tendencies). The different tools used to explore child neglect may explain the

inconsistent findings. 14 studies used non-validated vignettes and did not provide a definition of child neglect or explanation of how these vignettes were developed.

Conclusion: There remains a lack of research focusing on the factors that may or may not impact on professionals reporting child neglect, particularly within non-mandatory reporting countries, and especially among professionals such as the police and educational professionals. Suggestions are made for future research.

2.1. Introduction

2.1.1. Background

Public and professional awareness of child neglect has varied over time (Parker, 1995), impacted by the media and shifts in policy priority over other forms of child maltreatment. Yet neglect within Great Britain remains the most common reason for a child to be on a Child Protection Plan (Department for Education, 2016).

There has been a consistent body of literature emphasising the importance of early intervention, focusing on a proactive rather than reactive stance in policy (Allen, 2011; Haynes, 2015). Professionals must be able to 'notice' and then 'help' (terminology from Daniel et al., 2011) the neglected child, without this the child may continue to be maltreated resulting in chronic neglect.

One clear manifestation of neglect is that children do not always or consistently gain access to universal services (Daniel, Taylor and Scott, 2010). Neglected children are often unable to understand or even recognise that they are being neglected and therefore unlikely to ask for support, additionally the parents are also unlikely to be equipped to make use of informal support services (Cawson et al., 2000). Health and educational professionals therefore play a crucial role in recognising and responding to indicators of child neglect). Professionals and policy makers need to be aware of the barriers to effective intervention and address these when working with cases of child neglect.

2.1.2. Noticing the neglected child

Previous literature in the area has indicated that professionals can identify child maltreatment. Paavilainen and Tarrkka (2003) interviewed public health nurses in Finland and found they were confident in their ability to recognise child maltreatment, and were able to offer risk factors associated with it. Appleton (1996) found that health visitors in England could identify children at risk of vulnerability, and Burgess et al. (2014) found that of universal service staff (in England) 81% had come across children they suspected of child neglect.

As child neglect is the most common category for a Child Protection Plan, indicating that professions can in practice identify child neglect. However, the next stage where professionals decide whether to respond, help, or take action is perceived as more difficult. Serious Case Reviews highlight that often professionals can identify concerns for a neglected child, however their concerns do not always result in meaningful action (Brandon et al., 2011)

2.1.3. Responding to the neglected child

Potential obstacles for effective intervention when tackling child maltreatment has been explored, either through the review of files or Serious Case Reviews, or cross-sectional studies. The vast majority of research within child maltreatment has focused on barriers to child abuse, or has not distinguished between child abuse and neglect. Only a few studies look at neglect specifically and the barriers professionals face.

Barriers to action involve the professionals' mind-set regarding child neglect, including fear of being viewed as judgmental (Brandon et al., 2009), and that intervention may cause more harm than good (Adair et al., 1997; Johnson 1993).

Haynes (2015) study identified system characteristics that can create barriers for professionals in universal services within Great Britain. These included difficulties in multi-agency working and a demanding caseload making it difficult to address every case of child neglect.

Newcity, Ziniel and Needleman (2011) found among American dentists that barriers to reporting child neglect were a lack of adequate history, a lack of knowledge about how to report, a lack of understanding into child neglect, and concerns over the impact it would have on the practice. They found one predictor of reporting child neglect; those who engaged in continued education were 41 times more likely to report. Training has also previously been found to be an effective tool in tackling barriers to responding to child neglect (Adair et al., 1997; Fraser et al., 2010).

Within the literature there are various studies that report on barriers to effective intervention in terms of maltreatment and to a lesser extent child neglect. For professionals to be able to help neglected children, and be able to respond proactively with early intervention, an overview and understanding of the specific barriers related to child neglect is necessary. In addition, information on how to address these potential barriers or identify what encourages reporting should be made clear and utilised in the future.

One similar systematic review of the literature was conducted by Daniel, Taylor and Scott (2010) who looked at three research questions, including 'to what extent are practitioners equipped to recognise and respond to the indications that a child's needs are likely to be, or are being neglected, whatever the cause?'. Conducting their search on 14 databases for primary research studies published in English from 1995-2005. They found through 20,480 references, 63 papers for inclusion to answer their three research questions. They identified three key areas that appeared to increase the likelihood of professionals reporting; child and family characteristics, personal/professional characteristics, and system characteristics. They did include an amalgamation of child neglect and other forms of maltreatment if the findings were particularly relevant. This systematic review will specifically focus on child neglect and will additionally look at both barriers and factors that increase the likelihood of reporting.

2.2. Aims

The purpose of this review was to identify and synthesise factors that influence professionals' decision making to take action/ help or report suspected cases of child neglect.

The findings provide a clearer understanding of some of the barriers professionals with a duty of care for children face as well as factors that may positively influence professionals' decisions to report child neglect.

2.3. Method

2.3.1. Sources of literature

The search strategy did not have a restriction on the year of publication or country of origin. Although papers that were not written in English were not excluded, publications were all searched within English-focused search engines, and so this will have limited the inclusion of papers written in languages other than English that had not been translated.

Relevant publications were sources using the following search techniques:

2.3.1.1. Electronic bibliographic databases (search date: 01.11.2017)

The following electronic databases were included as it was felt, although potentially not exhaustive, that they covered a wide range of journals in related fields:

ASSIA, CINAHL, EMBASE, ERIC, HMIC, IBSS, MEDLINE, PsychINFO, SCOPUS, Social Care Online, and Web of Science Core Collection.

2.3.1.2. Grey literature (search date: 02.11.2017-05.11.2017)

OpenGrey, ProQuest Dissertation, and DART dissertation

2.3.1.3. Websites (search date: 06.11.2017-08.11.2017)

A range of websites were selected that focused on child maltreatment and child protection:

NSPCC

Barnardos

Save the Children

Action for Children

Family-Action

2.3.1.4. Citation Searching (search date: 08.11.2017)

Using the 'cited reference' function within Web of Science, searching was conducted on 10 key references. These were references that were most highly duplicated and relevant to inclusion.

2.3.1.5. Experts contacted (emailed: 04.07.2017)

Five experts within the field of child neglect were contacted; Jane Scott, Cheryl Burgess, Brigid Daniel, Marian Brandon, and Julie Taylor who were selected due to having a high number of publications within this area. They were asked if they had any unpublished data that may be relevant for this review, and if they knew of any published or unpublished work that would be unlikely to be obtained from electronic bibliographic databases.

All professionals responded and two additional grey literature papers were offered and subsequently included in the review.

2.3.1.6. Inclusion and exclusion criteria

Inclusion and exclusion criteria were applied to studies that were retrieved through the searches; those that did not meet these

criteria were excluded (see Appendix 2.2 for inclusion/exclusion criteria. See Figure 2.1 for study selection process).

Population: Professionals or those in training who were likely to be exposed to signs of any form of child neglect (e.g. emotional neglect, physical neglect etc.) A child was defined as under the age of 18.

Exposure: Factors impacting on professionals reporting or taking action when child neglect is suspected

Outcome: Decision of action (i.e. reporting, referring etc.)

Study design: RCT, controlled before and after, cohort, cross-sectional, case control. RCT's, controlled before and after, and cohort studies were included if they measured whether a certain intervention specifically increased/decreased the likelihood of reporting child neglect.

Exclusion Criteria: Single case studies, studies that do not distinguish between types of maltreatment and therefore do not allow analysis on child neglect specifically, studies that did not explicitly look at factors that impact (negatively or positively) on reporting tendencies. Qualitative findings were also excluded this was due to this review specifically looking at measurable views that could be compared across countries and potentially across professions.

2.3.2. Search strategy

The following search terms are a guide to the terms that were used and applied to all database. These were modified due to the requirement of the database. The search terms were informed by similar systematic reviews completed by Daniels et al. (2010) and Matthews et al. (2015) who conducted a systematic review on whether training improves the reporting of child maltreatment.

(See Appendix 2.1 for search syntax for PsychINFO):

(maltreat*, mistreat*, child abus*, child neglect*, neglect* negligent, neglect* parent*, emotion* neglect*)

AND

(child*, adolescen*, infan*, baby or babies, toddler*, preschool*, boy*, girl*, newborn*)

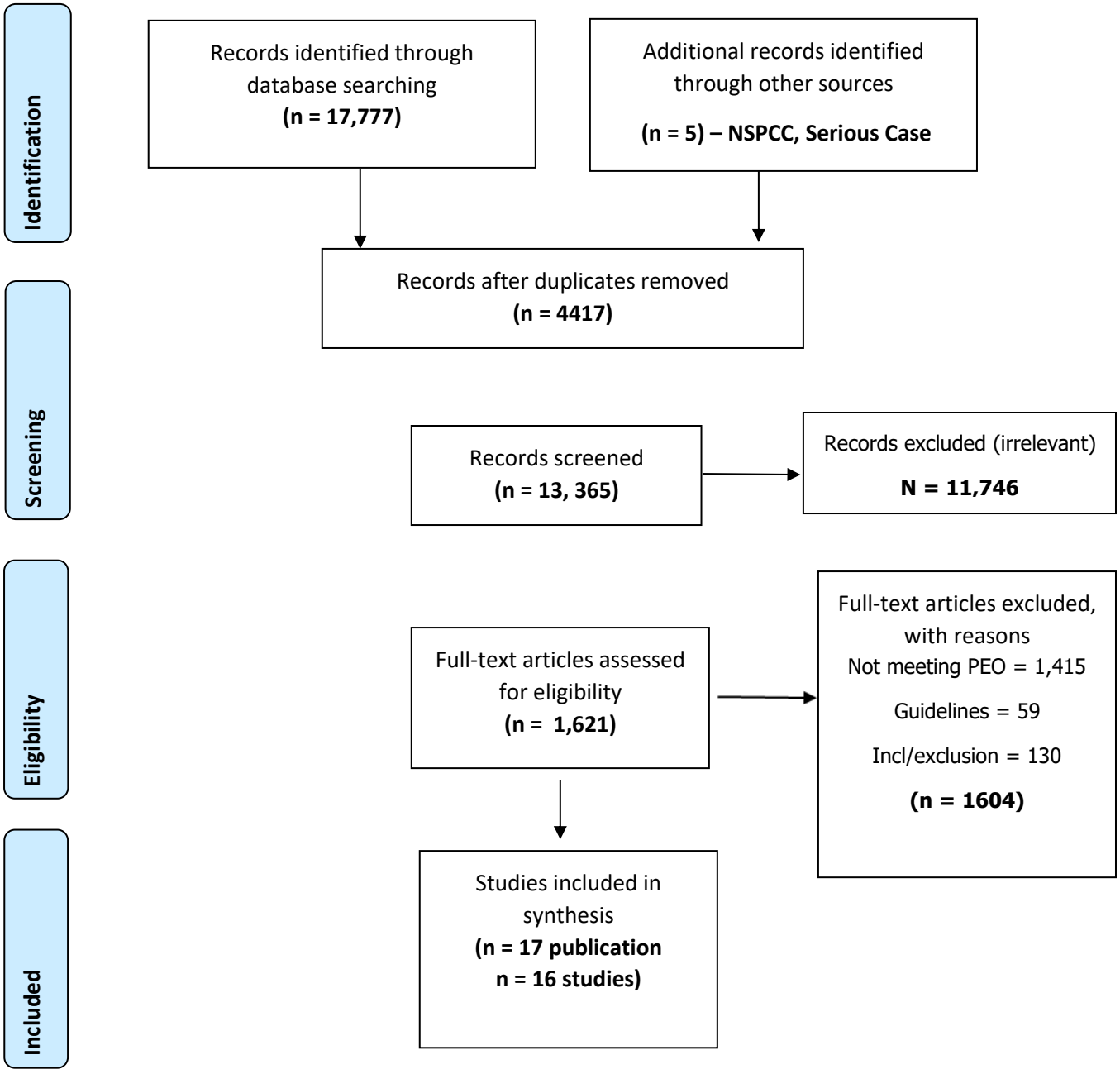
AND

(profession*, social worker*, physician*, doctor*, general practitioner*, paediatrician*, nurse*, school nurse*, teacher*, clinician*, psychologist*, psychiatrist*, police*, health visitor*, social services, school counsellor*, protective services, medical personnel*, caseworker*)

AND

(abuse reporting, child abuse reporting, report*, professional referral*, decision making, refer*, intervention*, professional intervention* identi*, notic*, recogni*)

Figure 2.1 Study selection process



2.3.3. Quality Assessment

The quality of papers were assessed using pre-defined checklists adapted from the Critical Appraisal Skills Programme (CASP, 2013) and CRD Report 4 (Khan et al., 2001, see Appendix

2.3). The quality appraisal form included questions that helped identify different categories of potential bias (e.g. sampling and selection bias, exclusion bias, measurement bias, reporting bias etc.). The papers were rated on a scale of 2 (yes), 1 (partial), 0 (no), and U (unclear) (Appendix 2.4 and 2.5).

The researcher assessed the quality of included studies, with a second reviewer independently assessing 20% of the included studies (a trainee forensic psychologist). An Inter-class Correlation Coefficient (ICC) of 0.871 was achieved. Using Fleiss' (1986) Inter-class Correlation Coefficient (ICC) classification values (ICC ≥ .75 = excellent, ICC between .60 and < .75 = good, and ICC between .40 and .60 = moderate) this was rated as 'excellent'

2.3.4. Data Extraction

Data extraction was performed by the researcher using a pre-defined form relating to the study design, sample demographics, the assessment process and data (See Appendix 2.6). If further information was required authors were contacted and given a month to respond (this was due to time constraints).

Table 2.1 Studies included in the Systematic Review – studies on identification and reporting decisions of professionals

	Authors, Publication Year, Design Country (Reporting law)	**Tool used**	**Participant characteristics (inc. profession)**	**Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)**	**Variables affecting reporting: Non-significant findings**	**Descriptive statistics (totals or percentages of participants reporting**
1	Adair, Wray, Hanes, Sams, Yasrebi, Russell (1997) Cross-sectional USA (Mandatory)	Self-developed vignettes describing hypothetical neglect and abuse	Dentists from members of Georgia Dental Association: N = 288 Age: not reported Female: 41 (14%) Male: 247 (86.5%) Response rate: 41.10%	Two-tailed Fisher's exact test Training after 1980 + p = 0.03 (83.3%) Female + p = 0.0005 Lived in smaller communities + p= 0.009	Two-tailed Fisher's exact test Year of Dental Degree acquisition (p>0.05)	Associated factors: (difference of more than 10% between reporters and non-reporters) Exposure to continuing education Seen suspected cases in practice Filed at least one report in past
						Descriptive statistics for yes response

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
						(%) Serious incident 72.6 Is it abuse (yes response) 57.6 Are they required to report? 7.3 Would report negative impact on child 51.4 Would Report negative impact family 70.8

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
						Likely to report 9.7
				+ Perceived as serious *+ Defined as abuse* *+Required to report* *- Negative impact on child*	*Negative impact on family*	
2	Alnasser, Albijadi, Abdullah, Aldabeeb, Alomair, Alsaddiqi, Alsalloum (2017) Cross-sectional	Self-developed, self-report questionnaire on child abuse and neglect	Paediatricians, paediatric trainees, medical students: N = 127 Age: *M* = 35, *SD:* not reported Female: 61 (48%)	Multivariate logistic regression (95% CI for Odds Ratio) + Sig more likely if: More senior professionals *p* = 0.0004 + Med school prepared well: YES	Multivariate logistic regression (95% CI for Odds Ratio) Gender (female) OR = 2.382, L = 0.714, U = 7.950, Wald =	

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
	Saudi Arabia (Mandatory)		Male: 66 (52%) Response rate: 84.6%	OR = 11.049, L = 1.027, U = 118.930, Wald = 3.927, *p* = 0.048 + Total no. of CAN consequences reported in general OR = 2.045, L = 1.275, U = 3.279, Wald = 8.819, *p* = 0.003 + Other Colleagues hesitate to report: yes OR = 3.720, L = 1.012, U = 13.676, Wald = 3.911, *p* = 0.048 + Recognise local CPS: Yes OR = 1.858, L =	1.992, *p* = 0.158 Definition of CAN subject to culture: YES OR = 2.734, L = 0.688, U = 10.858, Wald = 2.043, *p*= 0.153 CAN is a priority: YES OR = 3.019, L = 0.734, U = 12.414, Wald = 2.347, *p* = 0.126 Total no. risk factors mentioned	

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
				=0.357, U = 9.670, Wald = 0.542, *p* = 0.462 + Senior professionals: Yes OR = 10.457, L = 1.612, U = 67.838, Wald = 6.054, *p* = 0.014 (Constant) OR = 0.0006, Wald = 9.644 *p* = 0.002	OR = 0.940, L = 0.766, U = 1.154, Wald = 0.347, *p* = 0.556	
3	Ashton (1999) Cross-sectional USA (Mandatory)	Adapted vignettes describing child abuse and neglect. Likert scale answering	Graduate social work students working towards masters: N = 86 Age: M = 32, SD: not reported Female: 72 Male: 13 (one	Regression, B weights (*p*<.01.) + Seriousness .49 R^2 for Model .29	Regression Age -.13 Gender .17 Marital status -0.00 Parenthood .11	

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
			missing data) Response rate: not reported			
4	Beck and Ogloff (1995) Cross-sectional Canada (Mandatory)	Questionnaire adapted and developed by authors; questions and vignettes on child abuse and neglect	Registered psychologists specialising in clinical, counselling, and school psychology: N = 198 Age: M = 48, SD = 7.6 Female: 97 (54%) Male: 80 (44%) Unknown: 4 (2%) Response rate: 48%	Regression + Personal opinion about the law and certainty ratings of neglect R^2= .69., F(6, 159) = 59.11, p < .0001	NOTE: Review of data revealed that certainty ratings accounted for the entire variance, although personal attitudes about the law did not sig predict likelihood.	Descriptive statistics Neglect less likely identified and reported compared to abuse N = 13 (26%) Certainty of abuse occurring for neglect highest for neglect and sexual abuse (M = 6.53, SD = 0.89) and rated most likely to report (M = 6.35, SD

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
						= 1.10)
5	Canella (2008) Cross-sectional USA (Mandatory)	Vignettes from Crenshaw Abuse Reporting Survey (CARS, Crenshaw, 1999).	School psychologists: N = 281 Age: M = 44, SD = 12 Female: 223 (79%) Male: 58 (21%) Response rate: 41.1%		Multiple Regression Consequence for student, concern about legal retaliation by parents, desire to adhere to reporting laws, infringement on parent's rights, damage to professional relationship with family $F(5,264) = 0.48$, $p = .79$) Logistic Regression	

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
					Child age β = 0.12, SE 0.38, OR 1.12, Wald 0.09.	
6	Craft and Staudt (1991) Cross-sectional USA (Mandatory)	30 short case descriptions considered child neglect. 9 extrapolated from CLLS (Polansky and Williams, 1987), 3 point Likert scale answering	Lay citizens and protective service workers: N = 101 (25 workers, 76 citizens) Age: service workers M = 35, S = not reported, citizens age: M = 41.5, SD = not reported Female service workers: 20 Male service workers: 5 Citizens: not reported Response rate	Chi-Square + Parent lost job and too proud to ask for help $\chi 2(1) = 4.5$, $p<0.05$ + Rural respondents more likely to report than urban respondents, (71.8% vs. 70.5%). ($\chi 2$ (1) = 4.5, *P* <0.05).		

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
			citizens: 39%, workers not reported			
7	Crenshaw, Crenshaw and Lichtenberg (1995) Cross-sectional USA (Mandatory)	CARS-S Questionnaire and vignettes on child abuse and neglect, alpha and beta versions used (female and male victim)	Teachers (37%), counsellors (27%), principals (14%), school psychologists (12%), district superintendents (6%) no response (4%) N = 664 Age: not reported Female: 58% Male: 42% Response rate: 42%	Discriminant Analysis of full sample (reporters and non-reporters - Difficulty defining symptoms -0.444, M = 2.78, SD = 1.21 + First line of defence 0.399, M = 3.96, SD = 1.04 - No solid evidence -0.309, M = 2.65 SD = 1.18	Chi-Square Profession χ^2 (4, N = 638) = 2.85, *p* = .58. Age of child r(pb) = .05 Tenure as educator r(pb) = .04.	
8	Fung and Chow (1998)	Questionnaire developed with 21 behaviours	Family physicians, hospital doctors		Chi-Square Profession type	

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
	Cross-sectional Singapore (Mandatory)	potentially perceived as abuse or neglect	and lawyers N = 368 Female:114 (31) Male: 254 (69%) Response rate: 29.5% Parents: 226 (61%)		and 'always reporting concerns' χ^2 (2) = 2.904, p < 0.05	
9	Fraser, Mathews, Walsh, Chen and Dunne (2010) Cross-sectional Australia (Mandatory)	CARIS adapted to include vignettes. Developed the Child Abuse and Neglect – Nurses Questionnaire (CANNQ)	Paediatric nurses: N = 930 Age: M = 40.77, SD = 10.52 Female: 95% Male: 5% Response rate:42%	Multiple logistic regression (*p<.5 **p<.01) + Received training 0.558, 0.344, -0.906, 5.56* + Positive attitudes to reporting 1.06, 1.02-1.10, 9.19**	Multiple logistic regression Parent status (p>0.05) Parent role (p>0.05) Workplace (p>0.05) Age	

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
					(p>0.05) Years experience (p>0.05)	
10	Hawkins and McCallum (2001) Randomised control trial South Australia (Mandatory)	CARS Questionnaire– using five vignettes measuring abuse and neglect	Teachers and school personnel: N = 140 Age: M = 41, SD = not reported Female: 83% Male: 17% Response rate: 33.3%	Chi-Square, MANOVA Difficulty defining symptoms vs poor parenting/poverty Sig greater impact on reporting for non-training compared to training group (M = 4.32, SD = 0.91), t(70) = 4.25, p<0.001) Personal desire to adhere to mandatory	Reporting for training vs non training group	

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
				reporting laws Sig less impact on decision to report in recent training group (M = 4.32, SD = 0.91), t(52.08) = -2.88, p<0.01)		
11	Kvist, Malmberg, Boqvist, Larheden, and Dahllof (2012) Cross-sectional Sweden (Mandatory)	Questionnaire developed for study on child abuse and neglect. Questions regarding general practice	Dentists: N = 590 Age: not reported Gender: not reported Response rate: 95%	Chi-Square + Receive guidelines to report general neglect (34% compared to 14%) p = 0.000 + Receive guidelines to report dental neglect (30% compared to 6%)		

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
				p = 0.008 + Report if belief missed appointment due to: + parental negligence *p* = 0.0004 + Parental avoidance of authorities or public institutions *p* = 0.034 + Parental fear of disclosure of actual abuse *p* = 0.003		

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
12	Newcity, Ziniel, and Needleman (2011) Cross-sectional USA (Mandatory)	Questionnaire developed by authors. Demographic information on the dentists and their practices; knowledge and reporting behaviours of child maltreatment; and educational experiences with child maltreatment.	Dentists; N = 678, Response rate: 19.6%,	Multivariate logistic regression + Continuing education 41 times more likely to report *p* = 0.0002		
						Descriptive reasons not to report Lack of adequate

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
						history 43% (13/30) Lack of knowledge how to report 16.7% (5/30) Lack of knowledge problem of neglect 10%(3/30) Concerns over effect on practice 3.3% (1/30)
13	Shor (1998) Cross-sectional Israel	Questionnaire developed for study 40 vignettes describing child abuse	Paediatricians: N = 135 Age: M = 54, SD = 11.64 Female: 53 (39%)	t-tests Sig more likely to report to welfare department compared to police	t-tests Perception of risk to child and willingness to report	

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
	(Mandatory)	and neglect. Likert scale response	Male: 82 (61%), Response rate: 45%	for educational neglect Educational neglect: M = 3.42 (SD = 1.08) Physical neglect: M = 1.24 (SD = 0.58) *p* <0.001 More likely to report to welfare department compared to police for physical neglect Educational neglect: M = 4.34 (SD = .98) Physical neglect: M = 1.49 (SD = 0.76), *p*<0.01 High perception of risk to child and willingness to	educational neglect to welfare: Risk to child M = 3.32, willingness report M = 3.42, t = -1.05, *p*>0.05	

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
				report physical neglect to welfare: Risk to child M = 4.16, willingness to report M = 4.34, t = -2.2, *p* = 0.05		
14	Walsh, Bridgstock, Farrell, Rassafiani, Schweitzer (2008) Cross-sectional Australia (Partial mandatory laws)	Child Abuse and Neglect Teacher Questionnaire (CANTQ, 2004). Uses vignettes and Likert scale response	Primary school teachers: N = 254 Age: M = 41-50 (36.9%) Female: 86.2% Male: 13.8% Response rate: 23.6%	Multivariable multilevel analysis + correct detection of neglect Pearson's *r* = 0.72, *p* < 0.0001. B Coefficient (standard error) + Teachers in lower school compared to upper school −0.150(0.031), −0.157(0.042)	B Coefficient (standard error) Age of professional −0.022(0.019), 0.037(0.027) parental status 0.006(0.032), 0.005(0.044) Qualification level of	

Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
			+ Those without training 0.174(0.032), 0.128(0.043) + Higher confidence levels in knowledge of neglect 0.097(0.019) , 0.244(0.025) + Teachers who believed (wrongly) in legal duty to report −0.127(0.040), −0.588(0.054) + Previous experience of reporting neglect −0.201(0.030), −0.229(0.042)	professional 0.022(0.038), −0.088(0.052) Regular discussion in work −0.021(0.029), 0.006(0.040)	

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
				+ Larger schools 0.208(0.040), 0.259(0.058) + Teachers rated school higher socioeconomic status 0.163(0.032), 0.118(0.044) + Teachers rated high levels of CAN in school −0.075(0.029), −0.218(0.040)		
15	Zellman and Bell (1990) Cross-sectional USA	Vignettes developed by author describing child abuse and neglect.	Mandated reporters (family practitioners, paediatricians, psychologists, psychiatrics,	Regression + High perceived seriousness 0.23, (p<0.001)		

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
	(Mandatory)		social workers, child care providers, elementary and secondary principles) N = 1196 Gender: not reported, Response rate: 59%	+ Defined as abuse 0.27, (p<0.001) + Belief that law requires a report 0.74, (p<0.001) + Belief that reporting will benefit child 0.19, (p<0.001) + Reporting would benefit rest of family 0.07, (p<0.01) + Type of Professional – paediatricians -2.73, (p<0.01) (sig less likely) + Practice income		

	Authors, Publication Year, Design Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Variables affecting reporting: significant findings (+ increase likelihood,) - decrease likelihood)	Variables affecting reporting: Non-significant findings	Descriptive statistics (totals or percentages of participants reporting
				index -2.32, (p <0.05.) (sig less likely) + Received training 2.31, (p< 0.01.) + Have a review team at work 2.73, (p<0.001)		

Table 2.2 Studies included in the systematic review - studies on barriers to professionals helping children suspected of neglect

	Authors, Publication Year, Design	Country (Reporting law)	Tool used	Participant characteristics (inc. profession)	Descriptive findings
16	Burgess, Daniel, Scott, Dobbin, Mulley and	Great Britain (Not	Online questionnaire developed	Online survey of 1,552 professionals (pre- and primary school teachers,	Percentages given for each profession Most common barriers

	Whitfield (2014) Cross-sectional	mandatory)	with questions related to previous practice regarding child neglect	health professionals, social workers and police officers) across the UK about the frequency with which they recognise a child at risk of neglect, what influences their ability to help and what would make them more accessible to members of the public who are concerned about a child Social workers (n=210) Police officers (n=227) Primary school teacher (n=833) Nursery school teacher (n=100) Health professionals (n=182)	overall: Gap between services for adults and children Lack of services Point at which intervene is too high Percentages given for each profession – most common barriers overall.

2.4. Results

2.4.1. Description of studies

The search yielded 17,782 hits. See Table 1 for a summary of the included studies. 4,417 duplicates were removed and a further 11,746 irrelevant references were also excluded after reviewing the title of the paper. The 1,621 remaining references were further refined by reading the abstract and applying the inclusion/exclusion criteria. Of those references 1,415 did not meet PEO at screening, 59 guidelines on responding to child neglect were excluded due to no new data being used, as well as 130 were deemed not meeting inclusion criteria after a thorough reading of the 'methods' (most due to results not distinguishing and separating between abuse and neglect, papers not looking at factors that impact on reporting). This resulted in 17 publications and 16 studies included, with data from 7,588 students and professionals contributed to the review (this figure does not double count the two publications using the same participants. One paper was included that used an intervention method, this paper met criteria as it was an intervention measuring whether training increased likelihood to report child neglect. Appendix 2.7 outlines reasons for exclusion for references excluded after initial PEO sorting (130).

2.4.2. Characteristics of the studies

Two were conducted in countries without a mandatory reporting law, Australia and Great Britain.[9,16] Note the state of Queensland, in Australia only has mandatory reporting laws for

suspected child sexual and physical abuse. The other studies conducted in Australia in this review had mandatory reporting laws for child neglect. All other studies were conducted where professionals were required by law to report child neglect.

Few were focused solely on child neglect[6,16.] Three studies were conducted in Australia,[,9,10,15] seven in America,[1,3,5,6,7,12,15] one in Great Britain,[16] one in Canada,[4] one in Saudi Arabia,[2] one in Israel,[13] one in Singapore,[8] and one in Sweden.[11]

Most used a vignette-based design with subsequent questions usually using a Likert Scale Response or lists of potentially neglectful behaviours. Two papers used a questionnaire asking questions related to general practice.[11,12]

2.4.3. Quality of included studies

All includes studies were assessed for quality. Quality ratings ranged between 25 and 42 (maximum = 42) with a mean of 30.7 (SD = 3.84). Appendix 2.5 and 2.6 detail the results of the quality assessment process.

The majority of studies (N = 15) used a cross-sectional design, which is an appropriate design for the exploration of reporting factors. Despite this, it is important to identify the potential effect of confounding variables (e.g. other individual factors that may influence reporting tendencies not already measured). Few of the studies discussed the possible impact of confounding variables that may also impact on reporting tendencies. The one study using a randomly controlled trial (RCT) design[10]

measured the impact of training on reporting tendencies. It was the only paper to find no significant relationship between training and reporting tendencies compared to the 4 other papers that found a positive or negative relationship[1,9,12,14,15.] It could be argued that the RCT provided a more objective measure of training with better control of confounding variables (i.e. comparable and specific training given), and thus could be a more reliable finding, despite its conflicting results. However, it is important to also compare the training itself, if it lacked insufficient depth or quality this may also impact on reporting tendencies.

Only 7 papers provided a definition of child neglect or child maltreatment in general (44.4%)[2,3,5,9,11,12,16]. Defining child neglect is important as there are various definitions used dependent on the country of individuals or the profession. The definition used is important as it emphasises the specific forms of neglect that are being researched and thus can make vignettes more comparable. This highlights a particular area for improvement with future papers outlining the specific definition they worked with and how it informed the development of vignettes (if not using pre-developed vignettes).

In terms of selection bias 15 studies (93.75%) had a large number of participants (n ≥ 100), however only two studies (11.1%) provided a power analysis.[3,5,] All studies, bar one[10], did not randomly select the sample, as participants were recruited (dependent on their profession) and voluntarily chose to complete the questionnaire/survey. The samples therefore were likely to be

completed by individuals who already had in interest in the subject, and potentially have a reasonable understanding of the subject area. This increases the selection bias of the studies but is often unavoidable in cross-sectional, survey/vignette style studies.

Measurement bias was considered in terms of using appropriate tools, including vignettes or surveys. The tool used was clearly stated in all studies, 10 studies used vignettes (62.5%), however only 3 papers (18.8%) used validated measure, and thus their findings could be more easily comparable. [5,7,10] The use of non-validated vignettes coupled with the lack of a definition or explanation of how the vignettes were developed impacts on the validity of the findings. Studies need to explicitly explain what form of child neglect they are measuring and professionals' reactions to it. In addition using different facets of child neglect may well result in differing responses due to different levels of severity described in the vignette.

Measurement bias in terms of the outcome was considered in relation to whether the outcome was clearly defined, and whether missing data was discussed. Although the outcome of likelihood to report or take action was clearly defined in all studies, only 1 study[6] (5.5%) discussed missing data. It is unknown whether there was missing data and if there was a pattern as to why this may be. If participants consistently did not answer specific questions it could indicate a lack of knowledge, or willing to answer specific questions. The studies did not explore this and so potential outcome measurement bias was raised for most of the studies.

The results were clearly reported in all studies however two did not perform any statistical analysis on the findings, instead reporting percentages and making conclusions on the differences in percentages.[1,8] These findings cannot then be compared or applied to the wider population as it is unknown what the significant findings are. The author of this thesis therefore computed 2x2 Fischer's exact (due to predicted frequencies less than five), and Chi-Square on the data to show if there was any statistical significance to the.

The results were considered to fit the available evidence in the majority of cases. However, the results were not unanimous, with findings being supported by some papers and not in others. As discussed above this could be due to the cross-sectional design with a lack of ability to control confounding variables such as specific participant characteristics (i.e. being a parent). It could also indicate the lack of consistency across vignettes or measurement tools that may describe different levels of severity or facets of child neglect which again may impact on reporting tendencies. The implications of findings were reported in 91% of the papers and evidenced good application of the findings to future practice.

2.5. Data synthesis

A meta-analysis was not attempted due to the heterogeneity between the included studies; instead a narrative synthesis was conducted. It is important to acknowledge that due to the use of 'vote counting' the review cannot identify whether an effect may have been found if similar findings were combined together

(creating a larger sample size). Comparing five papers that do find an effect, to two papers that do not, does not allow for a statistical sound way of measuring results, potentially allowing for a higher chance of accepting a null hypothesis.

All papers were included in the summary tables (Table 2.1 and Table 2.2), however the total sample represents unduplicated participants from the same data set. Note statistics in *italics* were completed by the author of this thesis.

Table 2.3 Factors impact on reporting/taking action tendencies of participants

	Factor
Positive effect	1. Identified or defined as abuse[1,14,15]
	2. Perceived seriousness (the more severe) [1,3,13,15]
	3. Knowledge and understanding of mandatory reporting laws[1,4,10,11,14,15]
	4. Professional ways of working/policies[1,2,11,13,15]
	5. Belief reporting would have positive impact on family[15]
	6. Parental factors[11]
Negative effect	1. Difficulty defining symptoms of child neglect[7,10]
	2. Lack of knowledge[12]
	3. Lack of evidence to report[7]
No effect	1. Age of professional[3,9,14]
	2. Age of child[5,7]
Mixed findings	1. Training[1,9,10,12,14,15]
	2. Geographic location of professional[1,6,9]
	3. Seniority/experience of professional[2,9,14]
	4. Gender of professional[1,2,3]
	5. Belief reporting would have negative impact on family[1,6]
	6. Belief reporting would have negative impact on professional practice[6,12]

2.5.1. Findings of factors

2.5.1.1. Identified/defined as abuse (Five studies)

Three studies[1,14,15] found that individuals were significantly more likely to report the vignette if they identified it as 'abuse'. Two additional papers[7,10] found that those who had difficulty defining the symptoms of child neglect were less likely to report the scenario.

2.5.1.2. Training (Six studies)

Four papers found a significant and positive relationship between receiving training or on-going education and likelihood to report.[1,9,12,15] Perhaps counter-intuitively one paper[14] found that those professionals who had not had training specific in child neglect were significantly more likely to identify child neglect and subsequently report. One paper[10], found no significant difference in reporting tendencies in those who had received training and those that had not. This paper was the only RCT paper in this review and potentially provided a more objective measure of training with better control of confounding variables (i.e. comparable and specific training given).

2.5.1.3. Perceived seriousness (four studies)

All papers[1,3,13,15] found a significant positive relationship between perceived seriousness and reporting tendencies. Individuals who perceived the vignette as more serious were significantly more

likely to report. Of note, is Adair et al.[1] where of 259 participants only 28 would report the vignette.

2.5.1.4. Knowledge and understanding of mandatory reporting laws (six paper)

Adair et al.[1] found that those who were aware of the law were significantly more likely to report the vignette than those that were not, this finding was also supported by three other studies.[4,14,15] Fraser et al.[9] identified that certainty of reporting law predicted reporting but not attitude to the law. Hawkins and McCallum[10] found that those individuals who received training were significantly more likely to be influenced by knowledge of reporting laws compared to those who had not received training. Kvist et al.[11] found that those who received guidelines on how to report general neglect and dental neglect were significantly more likely to report than those that did not.

2.5.1.5. Professional ways of working/policies (six studies)

The following factors can be grouped into ways of working or professional policy that may improve reporting tendencies. Alnasser et al.[2] identified factors that increase the likelihood of reporting including, the perception that medical school had prepared them well, that a colleague was hesitant to report, and recognising the local CPS. Zellman and Bell [15] found that having a review team at work increased likelihood to report and Kvist et al.[11] found receiving guidelines on what, and how to report increased likelihood to report both educational and physical neglect. Adair et al.[1] also found that

previous experience of suspecting and reporting child neglect significantly increased the likelihood of the professionals reporting the vignette.

Walsh et al.[14] found no significant impact on professionals regularly discussing child neglect and reporting tendencies, but did find that teachers working in larger schools with higher socioeconomic status were more likely to identify and report child neglect.

Shor[13] found that paediatricians were significantly more likely to report to the welfare department compared to the police for both educational neglect and physical neglect.

2.5.1.6. Professional characteristics (10 studies)

Adair et al. [1] found that those professionals living in smaller communities were more likely to report than their urban counterparts, similarly Craft and Staudt[6] found those professionals working in rural areas were more likely to report compared to urban respondents. However Fraser et al.[9] found no relationship between workplace and reporting tendencies.

Three studies found no effect of age of professional on reporting tendencies.[3,9,14] Alnasser et al.[2] found that senior doctors were more likely to report than those with less experience. However, Fraser et al. [9] and Walsh et al.[14] found no relationship between years' experience and reporting tendencies.

Adair et al.[1] found that females were significantly more likely to report suspected cases of child neglect. However, contrary to this

finding both Alnasser et al.[2] and Ashton[3] and found no significant difference in reporting tendencies between the genders.

Kvist et al.[11] found that professionals were likely to report if they believed there was parental negligence, parental avoidance of authorities or public institutions, or parental fear of disclosure of actual abuse. Both Walsh et al.[14] and Fraser et al.[9] found no significant effect of parent status or parent role in reporting of child neglect.

Walsh et al.[14] identified that professionals who were confident in their knowledge of child neglect, and had previous experience of reporting child neglect were significantly more likely to be able to identify and subsequently report child neglect.

Zellman and Bell[15] found that those who believed that reporting would have a positive impact on both the family and the child were more likely to report.

Two papers[5,7] looked at the relationship between age of child and likelihood to report but none found a relationship to reporting tendencies.

Both Walsh et al.[14] and Fraser et al.[9] found no effect on reporting dependent on whether the professional was a parent themselves.

2.5.1.7. Parental factors (one study)

Kvist et al.[11] found that parental avoidance of authorities or public institutions and perceived parental negligence significantly increased the likelihood of professionals' reporting.

2.5.1.8. Negative impact of reporting on child, family, or profession (four studies)

Two studies[1,6] explored whether the belief that reporting may have a negative impact on the child and family would influence reporting tendencies. Adair et al.[1] found that this belief negatively impacted on the likelihood to report, whereas Canella[5] found no such relationship.

Newcity, Ziniel, and Needleman[12] found that a reason not to report was the concern that it may have a negative impact on professionals practice, however Canella[6] did not find a significant relationship between these factors. Adair et al.[1] found no significant difference in those that would report and those that did not and the belief that reporting would negatively impact on the professional. However there was a high level of agreement to this statement from those that would report the vignette (75%) and those that would not (70.3%). Thus, this appears a commonly held view but may not impact on reporting tendencies.

2.5.1.9. Profession type (four studies)

Zellman and Bell[15] found that paediatricians were significantly less likely to report the vignette compared to (family practitioners, psychologists, psychiatrics, social workers, child care providers, elementary and secondary principles) and those with a higher practice income index were also significantly less likely to report. Whereas Crenshaw, Crenshaw and Lichtenberg[7] found no significant

difference in reporting tendencies dependent on profession, or if receiving tenure as an educator. Fung and Chow[9] identified that lawyers were least likely to always report concerns of child neglect, compared to family physicians and hospital doctors.

Walsh et al.[14] found that those teachers in upper school (teaching older children) were significantly less likely to report compared to the lower school teachers.

2.5.1.10. Lack of knowledge (two studies)

Newcity, Ziniel, and Needleman[12] found that a lack of history, lack of knowledge how to report, lack of knowledge into the problems of neglect were all reasons given for not reporting. Crenshaw, Crenshaw and Lichtenberg[7] found that those who felt there was no solid evidence were less likely to report.

2.5.1.11. Professional ways of working (one study)

Burgess et al.[16] (not statistically significant but through highest scored percentages) found that a lack of resources, lack of services and high thresholds of intervention were all barriers to reporting or acting on child neglect cases.

2.6. Discussion

This systematic review identified factors that positively impact on professionals' likelihood to report child neglect and barriers to professional action. Papers tended to focus on universal service professionals including medical and educational professionals, social

workers and psychologists. Factors that increased the likelihood of reporting tended to fall into the following overarching themes; identification, professional personal and working characteristics (including gender, rural community working, additional support at work, training), case characteristics (e.g. parents presentation, perceived seriousness), and knowledge and understanding of reporting laws.

Barriers to effective intervention fell into themes including the belief that reporting would cause more harm than good (to the child, family or professional), certain professional groups were found to be less likely to report (these included lawyers compared to doctors and paediatricians compared to other universal service staff, perceived lack of knowledge about neglect, or reporting neglect and specific professional ways of working that may hamper effective intervention.

Most papers used vignettes in their methods, due to the nature of this type of measure most vignettes were not validated due to the fact that they were developed by the researchers. This may influence the findings of the research and its comparability to other papers. Additionally most papers did not include a definition of child neglect or include a power analysis or attrition rate.

The findings from this systematic review highlighted that there has not been universal agreement on factors that may improve reporting tendencies. An example of this, gender, where Adair et al., (1997) found females were more likely to report, compared to males. This finding was not, however found to be

significant by both Ashton (1999) and Alnasser et al., (2017). This is a pattern found throughout the results with findings differing from paper to paper. This may in part be due to how the studies were designed. Most of the studies in this review used adapted or self-developed vignettes to describe and explain aspects of child neglect. The use of non-validated tools may have impacted on the validity and reliability of the findings. Additionally, using different vignettes potentially describing different facets of child neglect may result in different reporting decisions from professionals.

Only two papers conducted research in countries with non-mandatory reporting laws. From this systematic review it would appear that professionals who are aware of the law, and who have had training on the law are more likely to report, but simply having the law in place did not significantly affect reporting tendencies. A barrier for mandatory reporters from Adair et al. (1997) and Newcity, Ziniel and Needleman (2011) was the concern that it would cause more harm than good to their profession, family, and child. This finding is also supported by Flaherty et al., (2006) whose national survey of paediatricians (within the US) found that 56% of physicians experienced negative consequences from reporting suspected maltreatment, including 40% who lost patients and 2% who were sued for malpractice. There remains a lack of research into the positive (and negative) effects of mandatory reporting and thus it is difficult to ascertain whether it is a positive or negative policy (Jones and Flaherty, 2008). However, the fear that reporting will do more harm than good is a belief of further exploration.

Mctavish et al. (2017) suggest the need for better support for the reporting process, from a personal to institutional and national level including increased training and debriefing.

The understanding and knowledge surround neglect, including identification, perceived seriousness and related to this access to training appeared to have a positive impact on reporting tendencies. Those professionals who were able to identify neglect, and perceived it as more serious were more likely to report or take action on their concerns. This is an area that policy and training can target and use as a means of educating professionals in their skills in identifying but also understanding the seriousness of neglect. As previous research has highlighted professionals can underestimate the seriousness of neglect (Rose and Meezan, 1996). Therefore the necessity of on-going training and education to tackle this is paramount to improve the likelihood of children receiving the support they need.

2.6.1. Limitations

This systematic review did not include qualitative papers in its review due to focusing on quantitative papers. This was to try and identify specific factors that impact on reporting that is representative to the professional population. Thus, the findings should be more generalizable and used to inform policy and potential training needs. Quantitative findings allow for measurable views that can then be objectively measured.

Despite this, quantitative research can be less detailed and a second review using qualitative findings may be of great use to understand in greater detail the experiences felt by specific professional groups.

2.7. Conclusions and recommendations

This systematic review identifies various areas which need to be targeted to improve the response of professionals working with child neglect, both positive factors and barriers were identified and should be used going forward to improve professional practice.

A consistent but limited area of research was the finding that when professionals can identify child neglect they are more likely to report. Professionals need to be confident in their ability to recognise signs and aspects (however subtle) of child neglect to increase the likelihood of further professional intervention. One way to help ensure this is to focus on the development of on-going training for all professionals in child neglect. Findings from this systematic review highlight that training can have a significantly positive impact on reporting tendencies of professionals and is something that should be continually re-visited throughout a professional's career.

This systematic review highlights the lack of quantitative research directly focusing on child neglect and additionally research exploring professionals' reporting tendencies in non-mandatory reporting countries. There is a lack of understanding into the impact

of not having this policy and whether factors are similar than those highlighted in this study.

Additionally there were few papers focusing on primary or secondary school educators, most focusing on medical professionals. It is important that more is known about this professional body. They are professionals who see children every day and build relationships with them. This finding is supported by Daniel, Taylor and Scott (2010) who also highlight this gap in the literature.

As this systematic review identifies, factors impacting on reporting tendencies of professionals are varied in type and between papers. There needs to be more of an emphasis on focusing on the positive factors improving reporting and a better understanding into the specific aspects dependent on profession, that impact on reporting tendencies.

Chapter Three

Perceptions, Opinions and Experiences of Child Neglect within Great Britain. A Professional and Public Comparison

Abstract

Background: Factors that may influence the reporting of child neglect by family support workers, primary school teachers, and the general public are necessary to identify in order to improve the protection of children vulnerable to neglect. Despite this there remains little research on these groups in countries without mandatory reporting laws.

Aims and Objectives: This study aimed to explore the general public, primary school teachers and family support worker's identification, perceived seriousness and reporting tendencies of child neglect (emotional neglect and physical neglect). In addition respondent's gender, years of experience, and perceived seriousness were examined to see if they impacted on reporting attitudes.

Method: A quantitative approach was used where 169 participants consisting of 70 members of the general public, 52 primary school teachers and 47 Family Support Workers completed an online questionnaire consisting of six vignettes (within-subjects design). Three vignettes described emotional neglect, physical neglect, and a control and three contained an additional domestic violence factor. Participants were asked to rate how worrying the vignette was, how serious, whether they would report or take action, to identify if it was a form of maltreatment and to name the maltreatment.

Overall findings: The results indicated that professionals were more likely to report and take action than the general public. Physical neglect was seen as significantly more serious and more

likely to be reported by all participants compared to emotional neglect. Factors that increased the likelihood of reporting child neglect were the vignette being perceived as more serious and more worrying.

Conclusions: There remains a lack of ability to identify emotional neglect and understanding regarding its seriousness amongst professionals and the public, with no difference in their ability to identify emotional neglect or associated perceived seriousness. Professionals were, however, more likely to report or take action when presented with the vignettes compared to the general public.

3.1. Introduction

3.1.1. Background

Child neglect and its harmful consequences are becoming more prevalent in the public and professional consciousness but practitioners remain slow to respond when neglect is apparent (Office of Standards in Education, Children Services and Skills (Ofsted), 2014).

Internationally studies have revealed the difficulties professionals face when identifying and reporting child maltreatment. However, evidence on professionals' ability to identify neglect remains inconclusive. Health care staff and health visitors have previously felt able to identify the signs of child maltreatment (Paavilainen and Tarkka, 2003; Paavilainen et al., 2002). However, these findings are not always supported (Van Haeringen, Dadds, and Armstrong's, 1998; Al-Moosa, Al-Shaiji, Al-Fadhli, Al-Bayed, & Adib, 2003). Nevertheless, the finding that professionals do not always act on suspicions of child neglect remains relatively consistent.

Child neglect remains under-reported within the UK (Ofsted, 2008). Even when reported, it is not prioritised (Wilding & Thoburn, 1997). This may be in part due to neglect not being seen as sufficiently serious as other forms of maltreatment (Rose and Meezan, 1996; Shor, 1998). Research (mainly from Serious Case Reviews (SCR)) has also identified other barriers that may impact on professionals' reporting their concerns. These may include fears of being viewed as judgemental, or that neglect is not their area of expertise (Brandon et al., 2009). Farmer & Luton (2014) identified a

parent-focused attitude to intervention, instead of focusing on the child and their development and well-being. More systemic factors have also been identified such as difficulties in multi-agency working and demanding caseloads (Haynes, 2015).

The majority of research on the difficulties professionals face when reporting child neglect has not distinguish between abuse and child neglect. Research has also tended to rely on Serious Case Reviews (SCRs), which provide an insight into how professionals' respond in serious cases but do not provide an insight into the day-to-day work of professionals.

It has been established that domestic violence and child maltreatment co-occur (Mcguigan and Pratt, 2001). Although the literature has identified characteristics of families where this may be more likely (Hartley, 2002) less is known about how professionals' respond when tackling it. Eckenrode et al. (2000) investigated whether the presence of domestic violence limited home visits from nurses aiming to reduce and prevent child maltreatment. They found that domestic violence may limit the effectiveness of their visits in reducing the incidence of child abuse and neglect. From these results it can be hypothesised that domestic violence may impact on an individual's decision to respond or act in cases of child neglect. It could be argued that the neglectful behaviour will be attributed to the domestic violence, rather than problems with the carer's understanding of parenting. Once it has been understood that domestic violence is no longer within the home individuals may believe that the neglect will also not be an issue for concern.

To the author's best knowledge, there is little to no research exploring the impact a (recent but not current) domestic violence factor may have on participant willingness to take action/report suspected child neglect.

An individual's opinion on what constitutes neglect can affect whether or not to report their suspicions to the authorities (Price et al., 2001). If individuals are unsure of what neglect is, and the seriousness of its effects they are much less likely to inform others. In addition, faulty perceptions may affect the punishment of perpetrators, as well as having a negative effect on support avenues for schools who propose interventions to tackle the neglect of children (Price et al., 2001).

There remains a lack of research within Great Britain into the role of schools in tackling child neglect (Daniel et al., 2011). Primary school teachers (PSTs) are in a position to identify and report their suspicions of child neglect. They see their pupils most days and by the nature of their role develop relationships with the children and parents. They are therefore well positioned to notice changes in behaviour or any apparent lack of care or support from parents.

Family support workers (FSW) within Children Centres provide individual or group support to parents/guardians of children, currently aged 0-5. Parents/guardians voluntarily accept support from the FSWs and may have approached the professionals for help, or support may have been recommended as part of a Child Protection Plan. FSWs provide support as part of universal services

(before a child is formally identified as 'a child in need') up to targeted early help, targeting behavioural difficulties, parenting skills, sleep workshops and domestic violence support. Early intervention involves providing support as soon as the problem emerges, within a given time frame and evidence of positive change (Working Together, 2015). FSWs therefore must be able to identify when a child is in need of additional support, identify what support is necessary, and provide interventions that target the unmet needs.

Having greater insight into professionals' understanding, opinions and experiences (i.e. reporting) of child neglect is crucial to identify the current practice in Great Britain, obstacles in tackling neglect, and support required by different professionals that enable them to approach cases involving neglect more effectively. Previous research has identified the views and practice of specific professionals, including social workers and health staff. Strikingly there is very little on educational staff as highlighted by Daniel et al. (2011) and little on Children Centre workers, including family support workers. These two professional groups have an important responsibility for child protection.

The understanding and perceptions of the general public may help to understand and thus encourage appropriate referrals to relevant agencies (Price et al., 2001). If there is a lack of awareness and understanding the ability to address and reduce the impact of neglect with multi-agency approach is far less likely to succeed. An increase of awareness, from parents through to the agencies working with the families in need and more generally to the wider

public is needed. Also, their expressed opinions and perceptions shape election agenda and policy making in a democracy. At present there is very little research directed towards the public's perception and understanding of child neglect.

While Serious Case Reviews have provided valuable information regarding factors that prevent more effective practice, they are not without limitations. Brandon et al., (2009) stated that Serious Case Reviews are not a typical safeguarding process and 'more needs to be known about routine child protection work and its effectiveness'. Lord Laming (2009) stated that by using Serious Case Reviews retrospectively, individuals often feel that they are being held to account. This could affect what they report and thus threaten learning meaningful information from the process. In light of this, using a fictitious situation to reflect on child neglect where there is minimal scrutiny may result in more honest and open answering from participants.

By comparing the understanding and reporting tendencies of the professionals and general public we can ascertain whether professionals are better equipped to understanding child neglect. This would be expected given their experience and ongoing training in child protection.

3.2. Aims

1. To explore two professional groups (primary and infant school teacher's, and family support worker's) and the general public's ability to identify neglect, their perceptions

surrounding the severity of neglect and factors that affect their decision-making in taking action or reporting potential child neglect.

2. To identify if there are significant differences in responses between professionals, compared to the general public.
3. To explore if an additional domestic violence factor significantly impacts on the likelihood of participants reporting child neglect.
4. To explore if additional factors such as gender of participant or years' experience significantly impacts on reporting tendencies.

3.3. Research questions

1. Can respondents identify two different types of child neglect
2. What are the respondents perceptions surrounding the severity of neglect
3. What factors impact on reporting child neglect
4. Are there differences between the general public and the professionals' understanding and reporting tendencies of child neglect

3.4. Method

3.4.1. Pilot Study

A pilot study was conducted with two subjects, one male and one female to demonstrate the feasibility of the questionnaire. The

average completion time was 17 minutes. Their responses were not included in the analysis.

3.4.2. Design

This online study used a cross-sectional, within-subjects one-way design with six levels. The independent variable was type of vignette; the dependent variable was the response the respondents gave to the vignettes. Participants were recruited dependent on their profession in the following way:

1. General public: The general public were recruited using snowballing technique; the link to the questionnaire was distributed through Social Media accounts Facebook and Twitter. Participants were then asked to forward the link on to friends and family.
2. Primary school teachers: Teachers were recruited through social media networks (Facebook), again given the advert link and asked to complete and forward on the study link. In addition, the link was also posted in specific teacher groups on social media websites (Facebook).
3. Family support workers: The study link was emailed to the Children Centre co-ordinators (with the agreement of the General Manager) of Children Centres (within Nottinghamshire). The co-ordinators then disseminated the link to all relevant family support workers. Primary/infant school teachers were specifically targeted due to their responsibility over younger children. The vignettes used

describe a young child (aged 4), secondary school teachers do not usually have the experience of working day-to-day with younger children and therefore the vignettes would not accurately replicate their experiences of seeing potential neglect in their working practice.

Participants were asked to complete an online questionnaire hosted on Bristol Online Survey (BOS: onlinesurveys.ac.uk). This study was granted ethical approval from both the NHS and the University Of Nottingham School of Medicine Ethics Committee, reference number: 195644.

3.4.3. Participants

In order to be included in the study, participants must be:

- 18 years of age or older.
- Have access to the Internet in order to complete the questionnaire.

However, the following potential participants who meet the inclusion criteria above were excluded from the study:

- Any individual who did not reside in Great Britain. This was to ensure that every individual answering the questionnaire followed the same legal legislations and laws. If a different country has different laws on child neglect (e.g. mandatory reporting) this may affect their responses.

A power analysis was conducted using G-Power 3 (Faul, Lang, and Buchner, 2007) to ascertain the appropriate amount of participants. Conducting power analyses for a Chi-Square, Multiple Regression and an ANOVA. An ANOVA resulted in the highest number of participants required and so this number was used as a necessary recruitment goal (ANOVA: fixed effects, omnibus one-way, A priori, effect size f0.25 (medium), an error of 0.05 and power of 0.8 (as recommended by Cohen, 1998). With three groups this gave a total sample size of 159. Additional participants were recruited to account for missing data, incomplete questionnaires or ineligible responses.

In total, 171 participants completed the questionnaire, two of whose responses were removed because the respondent's country of residence did not meeting inclusion criteria (Germany and Greece). Data from 169 participants, 22 male (13%) and 147 female (87%), with an age range of 21-67 (M= 39, S.D. = 11.72) were analysed. Of these respondents 47 (28%) were family support workers, 52 (31%) primary school teachers, and 70 (41%) the general public. The significantly higher proportion of female respondents may in part be due to the higher percentage of women within the professional fields included, and that women are more likely to respond to surveys than men. (Moore and Tarnai, 2002). See Table 1 for demographics of the professionals and general public groups.

Table 3.1 Demographics of Participant Groups

	Family Support Workers (N = 47)	**Primary and Infant Teachers** (N = 52)	**General Public** (N = 70)
Average Age (SD)	42 (10.21)	35.88 (11.11)	37.96 (12.6)
Gender total (%)			
Male	1 (2)	8 (15)	13 (19)
Female	46 (98)	44 (75)	57 (71)
Ethnicity total (%)			
British	100 (100)	49 (94)	63 (90)
Non British		3 (6)	7 (10)
Average years experience (SD)	10 (7.6)	8.48 (7.9)	N/A

3.4.4. Measures

3.4.4.1. Demographic information

Participants were asked (dependent on their profession) questions relating to their age, gender, profession, ethnicity, highest qualification, profession, and years of experience in current profession (see Appendix 3.2).

3.4.4.2. Questionnaire

A questionnaire was developed consisting of six vignettes. The vignettes described a child aged 4, with no gender specified to

minimise the potential confounding variable. The vignettes either described an example of emotional neglect, physical neglect, or a control. There was also an additional factor of domestic violence within the family home; each neglect vignette was presented once with the domestic violence factor and once without. Each participant responded to all vignettes. The inclusion of recent domestic violence was to ascertain if this affected (positively or negatively) on reporting tendencies.

The vignettes were developed using the definitions outlined by Brandon et al., (2014) and taking guidance from previous research (Zellman and Bell 1990; Crenshaw, Crenshaw & Lichtenberg, 1995). The vignettes were developed to include both the neglectful behaviours of the carer but also the impact on the child. They were also examined by three professionals and experts within the field to ensure they were clear and described accurately what respondents may witness. The inclusion of emotional neglect and physical neglect were included as they are two areas of neglect that may be commonly witnessed by both professionals and the general public. Physical neglect was chosen as it represented a form of neglect that would be seen by both professional groups and the general public. Emotional neglect was also chosen due to there being a considerable lack of research on the identification of this form of neglect, with most research focusing on dental, medical, or physical neglect (as evidenced in Chapter two).

A child of four was described due to family support workers working with children up until five years of age and children within

the UK start school aged four. Therefore both professional groups would have contact and responsibility of a child aged four.

Vignettes have been widely used in previous research for exploring professionals' judgements and actions and for identifying similarities or differences in responses (Dalgleish, 2003; Zellman and Bell, 1990). Taylor (2006) argued that vignettes may produce more valid responses compared to professionals own account of their decision making process. However it is important to recognise that by using hypothetical vignettes the results do not represent the actual decisions of professionals, rather their intention or attitudes towards reporting behaviours.

After each vignette a series of questions were presented;

1. How worrying the vignette was
2. Perceived severity of the vignette
3. Likelihood to take action (and what form)
4. Likelihood to report (and to where)
5. Decision making behind their answers (open-ended question) and
6. Identify what (if any) maltreatment had occurred

For perceived seriousness and likelihood to report or take action participants were asked to answer on a Likert Scale of 1-10, with not labelled 'not at all' and 10 as 'extremely'. A ten-point scale was used rather than a smaller scale as it allows for more variance

and a higher degree of measurement precision (Wittink and Bayer, 2003).

When asked to identify if any maltreatment had occurred respondents could answer yes, no, don't know, and rather not say. The separation between reporting and taking action was deemed necessary to identify if any form of action would be taken. Individuals may feel uncomfortable reporting due to the potential serious consequences, but may take some other form of action i.e. talk to a colleague etc.

Below is an example of the emotional neglect vignette with the domestic violence addition (see Appendix 3.3 for all questions and vignettes).

Emotional abuse with domestic violence vignette example

A 4-year-old child lives with its mother. The father left the home having been served a court order to have no contact with the family due to domestic violence against the mother a few months ago. The child mostly plays by itself and spends little time with its mother. The mother does not tend to interact with the child or offer it praise. The mother does not show much affection to the child or reach out to comfort them when distressed. The child will at times inappropriately attention seek and at other times be withdrawn and choose to play in isolation.

3.4.5. Procedure

Bristol Online Survey was used to collect and store responses from participants. Once a participant clicked on the link they were sent to an information sheet and consent form and asked to read and confirm their agreement to participate (see Appendix 3.1). Bristol Online Survey does not have a randomisation function so to minimise order effect bias 6 separate questionnaires were developed where the vignettes were presented in different orders. When one questionnaire reached a necessary response rate, the link was updated to the new questionnaire.

Participants were first presented with an information sheet and asked to provide consent. They then provided demographical information before being presented with the 6 vignettes and subsequent questions. At the end of the questionnaire participants were debriefed and thanked for their time. Primary school teachers and family support workers were also asked to follow an additional link (separate from their questionnaire) to leave their name and contact details if they were interested in completing a focus group.

Participants were assured that by leaving their name their questionnaire would remain anonymous (see Appendix 3.4 for debrief).

Although it is not possible to identify how many people who saw the link responded due to the nature of the snowballing methodology, of those that clicked on the link there was a 46% response rate. This is a close approximation of the typical return rate of 33% for online surveys (Nulty 2008).

The data was exported from Bristol Online Survey and imported into Statistical Package for Sciences (SPSS) 23.0 for analysis.

3.5. Results

Table 3.2 Descriptive statistics of total vignettes seriousness, total correct identification, total average reporting and professional group correct identification

	Physical neglect	Physical neglect with DV	Emotional neglect	Emotional neglect with DV	Control	Control with DV
Total correct identification (%)	148 (87)	146 (86.4)	98 (58)	130 (76.9)	164 (98)	168 (99.4)
Group correct identification total (%)						
Family support workers	45 (95.7)	43 (91.5)	33 (70.2)	39 (83)	46 (97.9)	47 (100)
Teachers	44 (85.6)	44 (84.6)	27 (51.9)	39 (75)	50 (96.2)	51 (98.1)
General public	59 (84.3)	59 (84.3)	38 (54.3)	52 (74)	68 (97.1)	70 (100)

Total average seriousness (SD)	17.34 (2.68)	17.38 (2.48)	15.91 (3.22)	16.76 (3.01)	7.07 (4.14)	8.57 (4.50)
Total average likelihood to report	8.18 (2.2)	7.98 (2.36)	6.03 (2.75)	6.07 (2.92)	2.65 (2.06)	3.27 (2.44)

3.5.1. Identification

Categorical data was used to identify participants' ability to correctly identify the neglect vignettes. The groups consisted of three categories (family support workers, primary school teachers, and the general public), identification had two variables (correctly identified or not), and there were six vignette categories. However, for identification only the neglect (and not neglect with DV) were analysed so that it was clear whether individuals could identify neglect independently of other additional variables.

As no assumptions were violated a standard Cochran's Q test (due to related, dichotomous data) determined that there was a statistically significant difference in participants ability to identify emotional neglect, physical neglect and the control, $\chi^2(2) = 210.65$, $p < 0.001$.

Dunn's post hoc test was carried out on each pair of groups (a test used for related, non-parametric data). As multiple tests were carried out, a Bonferroni adjustment was also applied by dividing

each Dunn's p-value by the total number of tests being carried out (3).

The findings identified that participants were significantly more likely to correctly identify physical neglect (87%) and the control (98%) compared to emotional neglect (58%).

A Chi-square was used to analyse whether one or more of the professional groups were significantly more able to identify the vignettes (emotional, physical and control) as neglect.

There was no significance association between groups and correct identification of emotional neglect $\chi 2$ (2) = 3.81, $p>0.05$ or physical neglect $\chi^2(2) = 3.99$, $p>0.05$. The control vignette did not meet assumptions (due to a count size of less than five), a Fischer's exact test was completed on the data, and again there was no significant association between the groups and correct identification of vignette.

3.5.2. Perceived seriousness

A one-way repeated measures ANOVA was conducted to identify if there was a significant difference between how serious the participants felt each of the six vignettes were. Two questions were asked regarding how serious respondents perceived the vignette to be, one question relating to how seriously it would affect the child at the time, and another question asking how seriously did they think the experience could affect the child once they are older (a young teenager). These two scores were summed to give a maximum score of 20.

Mauchly's test indicated that the assumption of sphericity had been violated, $\chi^2(14) = 265.57$, $p < 0.01$ and the variance between the different conditions (vignette seriousness) were not equal. This therefore results in a loss of power and a test statistic (F-ration) that cannot be compared to values of the F-distribution. Multivariate tests were reported ($\epsilon = 0.57$) instead of univariate tests (e.g. Monte Carlo) due to a large violation of sphericity ($\epsilon < 0.7$) and a sample size greater than $a+10$ (where a is the number of levels, in this case 6) (Stevens, 2002).

The results show that perceived seriousness was significantly affected by type of vignette V = 0.87, $F(5, 164) = 213.20$, $p<0.05$.

Bonferroni post hoc tests were used due to the test's robustness in controlling both Type 1 and Type 2 error (Maxwell, 1980; Keselman and Keselman, 1988. The tests showed that physical neglect (Mean = 17.34; SD = 2.68) and emotional neglect (Mean = 15.91; SD = 3.22) were seen as significantly more serious compared to the control (Mean = 7.07; SD = 4.14), $p < 0.05$). Physical neglect (Mean = 17.34; SD = 2.68) was also seen as significantly more serious compared to emotional neglect (Mean = 15.91; SD = 3.22), $p < 0.05$).

3.5.3. Reporting and action taking

A one-way-ANOVA was conducted to identify if there were significant differences in reporting tendencies between the respondent groups. Skewness and Kurtosis were considered satisfactory, as each measure had a z-score below 1.96 and so was

non-significant at (p>0.05). In addition, Levene's test was not significant and thus equal variance was assumed.

Table 3.3 Descriptive statistics for respondent group reporting and taking action

	Mean likelihood to report for all six vignettes (inc. control) (SD)	Mean likelihood to report for 4 neglect vignettes (SD)	Mean likelihood to take action for all six vignettes (inc. control) (SD)	Mean likelihood to take action for 4 neglect vignettes (SD)
Family Support Worker	39 (8.32)	35 (5.0)	43.17 (7.74)	32 (6.20)
Primary/Infant Teacher	38 (10.32)	34 (5.3)	42.19 (9.47)	31 (6.50)
General Public	28 (10.03)	27 (8.3)	32.10 (10.45)	23 (8.57)

Analysis indicated that there was a significant difference in reporting tendencies depending on their professional group, $F(2,166) = 24.685$, $p < 0.05$. Post-hoc tests using Hochberg's GT2 were carried out due to differing sample sizes. The results identified that teachers (p<0.01) and family support workers (p <0.01) were significantly more likely to report than the general public. No significant difference were found between teachers and family support workers (p>0.05).

Due to non-parametric data (a skewed dataset with a z score of 2.1) a Krustal-Wallis Test was used to identify whether taking some form of action (but not necessarily reporting) significantly differed depending on the professional group.

There was a significant difference in decisions to act dependent on the respondent group, $H(2) = 38.67$, $p<0.05$. Mann-Whitney tests were used to follow up on this finding. A Bonferroni correction was applied to control the Type 1 error rate due to multiple tests (3) being carried out on the data. To account for this the effects are reported at a 0.0167 level of significance. It appeared that taking action did not differ significantly between teachers and family support workers ($U = 1130$, $r = -0.07$). However when comparing both teachers to the general public ($U = 890$, $r = -0.44$), and family support workers to the general public ($U = 642$, $r = 0.52$), both professional groups were significantly more likely to take action than the general public.

When comparing likelihood to report dependent on type of vignette a repeated measures ANOVA was conducted. The results show that individuals were significantly more likely to report some vignettes compared to others, $F(3.72,625.70) = 270.62$, $p < 0.05$.

Maucley's test indicated that the assumption of sphericity had been violated, $\chi^2(14) = 160.73$, $p<.01$., therefore multivariate tests are also reported ($\epsilon = 0.75$). The results again showed that participants were significantly more likely to report certain vignettes compared to others, $V = 0.84$, $F(5,164) = 176.52$, $p<0.01$.

Bonferonni corrected post hoc tests revealed that both physical neglect and emotional neglect were significantly more likely to be reported compared to the control for both domestic violence vignettes and when this was omitted (p = 0.01) (as expected). In addition, physical neglect was significantly more likely to be reported compared to emotional neglect (p =0.01). This was consistent both when the vignette contained a domestic violence description and when it was omitted.

When comparing type of vignette and inclusion of domestic violence (e.g. emotional abuse compared to emotional abuse with domestic violence) no significant effect on reporting was found for any vignette (p>0.05).

3.5.4. Factors affecting reporting for professionals

Two multiple regression was conducted to ascertain factors that may predict total reporting likelihood of the emotional and physical neglect vignettes (including the domestic violence vignettes) for all participants, and a further multiple regression, specifically looking at factors affecting professionals, which includes years' experience. Table 3 provides a summary of the results for all participants showing that the more worrying and serious a vignette was rated the more likely participants were to report.

Table 3.4 All participants multiple regression co-efficient

	N	B	SE B	β
Step 1				
(Constant)		-7.986	3.960	
Worrying	169	0.487	0.215	0.327*
Seriousness total	169	0.231	0.110	0.302*
Gender	169	3.367	1.990	0.104

Note: $R^2 = 0.65$ *p<0.05, **p<0.01, ***p<0.001,

B = Beta, SE B = standard error of Beta, β = standardised beta

Table 3.5 Professionals' multiple regression co-efficients

	N	B	SE B	β
Step 1				
(Constant)		-6.098	3.924	
Worrying	98	0.822	0.211	0.61***
Seriousness total	98	0.104	0.105	0.16*
Gender	98	1.808	2.216	0.059
Years' experience	98	-0.077	-0.063	-0.063

Note: $R^2 = 0.62$ *p<0.05, **p<0.01, ***p<0.001,

B = Beta, SE B = standard error of Beta, β = standardised beta

3.4. Discussion

The aim of this study was to examine whether individuals can identify different aspects of child neglect, their perceived attitudes on its seriousness and whether they would report the examples given. The study also aimed to identify factors that may influence reporting tendencies as well as look at differences between the

general public and two professional groups (primary school teachers and family support workers).

The findings from this study identified that participants struggled to identify specific aspects of child neglect. Previous research indicated that professionals (in particular) can identify child neglect; the problem however lies in the next step of 'taking action' (Lewin and Herron, 2007; Appleton and Cowley, 2004). The results from this study indicated that participants were significantly less likely to identify emotional neglect than physical neglect. The finding did not differ dependent on participant group highlighting that professionals were no better at identifying emotional neglect or physical neglect compared to the general public. In fact, although not a significant finding, when looking at percentages, the general public were better at correctly identifying emotional neglect compared to teachers (51.90% compared to 55.7%).

The reason for this finding may be due to the differing methods in previous studies. Previous papers directly asked professionals how confident they felt they were at identification as well as asking them to identify signs they would be looking out for (Paavileinen et al., 2002). Potentially when presented with a fictitious scenario with minimal priming they are less able to confidently identify child emotional neglect. With the lack of priming and additionally focusing on a potentially less understood form of neglect they are less likely to identify it as such.

As well as emotional neglect being significantly less identifiable, it was also seen as significantly less serious. These

results indicate that both the public and professionals need a better understanding of neglect, in particular, the identification and seriousness of child emotional neglect.

Due to professionals having a professional duty to care and support children, and who have had training and experience in identifying and understanding child maltreatment and child neglect, it was hypothesised that they would have a better understanding of child neglect, compared to the general public.

If their understanding is no better than the general public it may evidence that further training or supervision is necessary to ensure that neglect is understood among these professionals.

Previous research has identified the confusion around a clear definition of neglect (Hussey et al., 2005) and these results may well support this finding. It could be argued that physical neglect has more well-known and clearer signs, with dirty clothes for example. However, for emotional neglect, (which often will not have physical evidence) there is more of a reliance on an individual's understanding of what neglect is, which can be influenced by other factors (e.g. culture, ethnicity, personal values etc.). Individuals may rely more on their own moral judgement and internal understanding of what is 'acceptable parenting'. When behaviours require various combinations of criteria to be met (necessary for emotional neglect) individuals are more likely to rely on their own 'moral compass' as to what is acceptable and what is not. Helm (2010) highlighting this by stating that it is as much professional's

humanity as their professionalism that will influence recognition of child neglect.

As well as emotional neglect being harder to define and identify as maltreatment it was also significantly less likely to be reported by participants. This indicates that participants may not understand firstly that it is a form of neglect but that also the child is in need of further support. Although it may be more unlikely for emotional neglect to be seen in isolation it still needs to be understood as a serious and important area of child neglect that needs to be responded to.

The results indicate that professionals are more likely to report both physical and emotional neglect compared to the general public; this is supported by previous research in this area (Daniel et al. 2011; Burgess et al., 2014). Professionals are again more likely to take action than the general public (taking action could be telling a friend or colleague). This is a positive finding in terms of the attitudes of professionals who have a duty of care over children and their potential behaviours within their work. The results do however indicate more needs be done to improve the perceptions of child neglect within the general public and to ensure that they understand their responsibility to take action when confronted with potential child neglect.

The analyses found no significant difference in likelihood to report dependent on whether there was a recent but not current domestic violence factor. As there was very little previous research into this specific additional factor the results cannot be compared to

previous literature. Previous research (Brandon et al., 2011) and Chapter four identify the difficulties in evidencing child neglect and so additional risk factors were hypothesised to potentially increase the likelihood of professionals' reporting. This was not found to be the case. It could therefore be argued that for physical neglect participants would report regardless of additional risk factors, but for emotional neglect additional factors did not impact on reporting.

Factors that did impact on likelihood to report were how worrying and serious the participants perceived the vignettes to be. The more worrying or serious an individual felt the vignette was, the more likely they were to report. This is supported by previous research in the area, which identified that those who rated a scenario as more serious were more likely to report (Ashton, 1999; Zellman and Bell, 1990). Gender has had conflicting results in previous research with Adair et al. (1997) finding that females were more likely to report than males. Alnasser et al. (2017) and Ashton (1999) found no such relationship. The results from this regression is in line with Alnasser et al. (2017) and Ashton (1999) with no gender effect found on reporting for any participant group. There was also no effect of years experience in reporting tendencies, which is in line with Alnasser et al. (2017).

3.4.1. Limitations

Vignettes although adequate at looking at attitudes to reporting, or potential behaviours cannot replicate real-life decision making fully. The vignettes used were only short with a simple

description; in practice individuals would have a more detailed understanding of the situation. Despite this, the results do offer an understanding of professionals' intention to report or potential attitudes surrounding child neglect.

The vignettes were developed for this research paper and as such were not validated beforehand. Despite this they were developed using the Working Together guidelines (Brandon et al., 2009) and were examined by three professionals to ensure that they replicated what respondents may witness.

The sample was predominantly female and as such may not be representative of both male and female respondents in the wider public. Despite this, the professional sample could be seen as representative due to the fact that there are (within Nottinghamshire) many more female FSWs than male, as well as more female primary school teachers than male.

By using a snowballing technique participants were, in general, all from a very similar socio-economic group, focusing predominantly on professional individuals, friends or colleagues of the researcher. Future research could involve a more representative sample of differing socio-economic groups. The respondents were also from a convenience sample; therefore the data may also be more vulnerable to selection bias, with those agreeing to take part already having an interest in child neglect.

3.4.2. Future implications

For the general public and professionals there needs to be a greater understanding into the different areas of child neglect, emotional neglect was seen as less serious and less likely to be reported, despite the effects of such maltreatment being very serious. Although it less likely that areas of neglect would occur in isolation individuals may only see one area of child neglect and so understanding and identifying all parts of child neglect is crucial. This is especially important for professionals who may have greater contact and responsibility to help such children.

The general public were less likely to take action or report compared to the professional groups. Although they do not have a professional duty to report it is crucial that the general public can identify and raise concerns if child neglect is suspected as this helps to ensure that children receive support at the earliest stage. Neglect needs to be better understood and represented in the media, as perceptions of the general public can shape election agenda and thus influence policy change and support for early intervention services.

To date there is very little research on the opinions and attitudes of the general public in regards to child neglect and the findings from this study identify a need for more public awareness into its importance.

3.4.3. Future research

Although this research identifies areas that may impact on reporting tendencies including types of neglect, gender and perceived seriousness of the vignettes more detail is needed to identify what does in fact impact reporting in day to day practice. The following chapter attempts to address this question with two focus groups conducted with family support workers and primary school teachers.

In addition there remains a lack of research targeting police officers and their experiences and attitudes towards child neglect within Great Britain. Further research targeting this professional group is crucial to identify if further training or understanding is needed.

3.5. Conclusion

Neglect continues to remain a prevalent and difficult maltreatment to address; this study has identified specific areas that may help to explain some of the difficulties associated with identifying and addressing child neglect. In particular, the confusion or lack of understanding around emotional neglect and its seriousness, and the potential effect of desensitisation with those who have worked longer within the field. These findings provide a basis for a more in-depth exploration of professionals' attitudes and experiences of child neglect within the UK, including what their perceived barriers to different forms of neglect are.

Chapter Four

Focus groups exploring primary school teachers and family support worker's professional experiences of identifying and responding to child neglect

Abstract

Background: Family support workers and primary school teachers are in a position to identify and provide (early) intervention when a child begins to show signs of being neglected. Understanding more about the experiences of these professionals when working with child neglect is necessary to understand why immediate action is not always taken.

Aims and objectives: This study aimed to explore primary school teacher's and family support worker's experiences of working with families and children with suspected or confirmed child neglect.

Method: Two in-depth, semi-structured focus groups explored the experiences of the two separate professions, four primary school teachers and six family support workers. Two hypothetical vignettes describing emotional and physical neglect were used to aid discussion. A qualitative, inductive thematic analysis was used to analyse the focus group data.

Overall findings: Despite professionals wanting to act when neglectful behaviours are first identified (early intervention) this was often not common practice. Professionals highlighted that child neglect, in particular emotional neglect, was often not deemed 'serious enough' to report, and would not be reported until a bigger 'jigsaw puzzle' of evidence had been collated. Professionals struggled with policies and funding that impact on their ability to respond in every case of child neglect, as well as multi-agency

working difficulties, including perceived confidence in their roles and how other professionals view their work and professional opinions.

Conclusions:

Child neglect, especially emotional neglect, must be rated as equally serious and necessary for intervention, and professionals must be given support and funding to achieve this.

4.1. Introduction

Chapter three identified specific variables that impacted on professionals reporting or helping (taking action) when presented with neglect vignettes. Along with the systematic review in Chapter two these findings help to provide an objective understanding of specific factors that influence reporting tendencies that may or may not have been known by the professional. Despite this, it does not allow for an in-depth exploration of the experiences, feelings, and perceptions of professionals. It is of use to understand more about how professionals feel about working with child neglect to further explain why it remains so challenging to address.

Previous research has evidenced some factors that professionals feel may impact on taking action including neglect being seen or understood as less serious than other forms of maltreatment (Shor, 1998), fears of being viewed as judgemental, or perceiving neglect to not be their area of expertise (Brandon et al., 2009). Farmer & Lutman (2014) identified a parent-focused attitude to intervention, instead of focusing on the child and their development and well-being.

More systemic factors include difficulties in demanding case-loads and multi-agency working (Haynes, 2015). Multi-agency working is crucial to ensure that children are successfully identified as in need and effectively responded to (McKeown, 2012; Wills et al., 2008). It allows for a holistic and comprehensive picture of the child, their family, and different aspects of their life that one professional may not be witness to. Despite the necessity for multi-

agency working challenges often arise, including the varying definitions professionals use to identify child maltreatment, different knowledge frameworks used, and varying priorities and interventions (Peckover and Golding, 2017; Glisson and Hemmelgarn, 1998; Rose, 2011). Child maltreatment often overlaps with other issues within the family, including domestic violence, substance misuse and mental health (Hartley, 2002; Ammerman et al., 1999; Brown et al., 1998). Various professionals are therefore likely to be involved with different focuses and priorities, making it difficult to develop a shared goal to safeguard a child (Peckover and Golding, 2017).

As Chapter three identified FSWs and PSTs are both in a position of responsibility to not only identify neglected children, but provide early intervention or indeed signpost the children and their family to further support if this is needed. Both these professionals work within universal services (Children Centres/schools) and will see children/families regularly. This ensures that they can see the progress and well-being of a child (Munro, 2011) but also can provide support with less perceived stigma compared to children's social care. Parents/carers may feel that they can go to these types of professionals without fear that their child will be removed.

As already discussed in Chapter two and three these two professional groups have little research dedicated to the specific barriers they face when working with child neglect. Haynes (2015) has previously identified difficulties these professionals face using focus groups and online questionnaires. Their research did not use

hypothetical vignettes and in addition did not look at specific areas of child neglect (i.e. physical neglect compared to emotional neglect).

These separate forms of neglect may have different responses and barriers associated with them and thus a better understanding of them is important.

4.2. Aims

This study aimed to identify

1. Specific difficulties reported by PSTs and FSWs respectively in how they respond to child neglect. In particular, the barriers they face in responding as soon as neglect has been identified or is suspected.
2. Explore how different forms of neglect may impact on decision-making and the attitudes and responses of the professionals.

4.3. Method

4.3.1. Participants

FSWs were recruited from two districts within Nottinghamshire. The managers of these districts had given agreement for their employees to participate in the focus group. One manager emailed all FSWs within the two districts asking for their voluntary participation. The two districts consisted of 7 Centres and 22 FSWs. Six FSWs (5 female, 1 male) participated, 4 FSWs, 1 Family Support lead and 1 Family Support Manager agreed to

participate with no participants dropping out from the time of agreement to completing the focus group. Ages ranged from 32 to 56 (M = 48, *SD* = 8.2) with years of experience ranging from 5-20 years of experience (M= 11.3, SD = 7.2). Participants came from three Children Centres and all knew each other.

The facilitator of the focus group had worked alongside 5 of the participants in some capacity (group or individual interventions with families) over the preceding six months within the Children Centre. Those participants were aware of the facilitator's interest and research in child neglect.

PSTs were recruited from an online questionnaire disseminated by the researcher as part of their doctoral research. The study had looked into participant's identification and reporting of child neglect using a series of case vignettes. At the end of the questionnaire participants were asked to provide an email address if they were interested in taking part in a focus group on professional experience of working with child neglect.

Two PSTs from the same school expressed an interest in participating in the focus group, they then asked colleagues if they would like to be involved and after gaining approval from the school four PSTs agreed to participate. The group consisted of 2 male and 2 female, ages ranged from 23 to 41 (M = 30, *SD* = 7.9) with average years of experience within their current profession ranging from 2 to 14 (M = 6.25, *SD* = 5.3).

Participants all worked within the same school and knew each other well. The facilitator knew one of the PSTs prior to the study

but met the other three participants for the first time on the day of the focus group.

All participants received no remuneration for their time but were provided with refreshments.

4.3.2. Procedure

This study was given favourable opinions by both the Nottinghamshire NHS local R&D and the University School of Medicine Ethics Committee, reference number: 195644

After confirming their attendance to the focus group through email with the researcher, a pack was emailed to each participant containing an information sheet and consent form, demographic form, vignette examples, and a list of questions (see Appendices 4.1 – 4.4). The information sheet outlined the purpose of the research, the nature of the participation (the focus group would be tape-recorded), how the data would be collected and stored, confidentiality, and how to withdraw. The two vignettes used were sent in advance, see materials below for an outline of the vignettes used.

Both focus groups took place at the participants' place of work, in a meeting room at one of the Children Centres and a classroom at a primary school in Nottingham. Participants sat around a table, were provided with the paperwork to look over again, given the chance to ask any questions, and asked to sign and complete the relevant forms. There was only one facilitator in the room (researcher) who explained the study. Time was provided to

ask questions before the tape recorder was turned on and the focus group began. At the end of the focus group participants were asked if they had any further questions before the tape recorder was turned off. They were then given a debrief sheet with information about further services if they felt affected by any of the topics discussed. The FSW focus group took 57 minutes to complete, the PST group took 49 minutes.

4.3.3. Materials

The vignettes were developed using the definitions outlined by Brandon et al., (2014) and taking guidance from previous research (Zellman and Bell, 1990; Crenshaw, Crenshaw & Lichtenberg, 1995). The vignettes were developed to include both the neglectful behaviours of the carer and the impact on the child, this was to ensure that it identified not just what was seen by the professional but the effect on the child as well. Emotional and physical neglect were described and vignettes included a domestic violence factor to identify if this had an impact on perceived seriousness and likelihood of taking action. Physical neglect was chosen as it represented a form of neglect that would be seen by both professional groups and the general public. Emotional neglect was also chosen due to there being a considerable lack of research on the identification of this form of neglect, with most research focusing on dental, medical, or physical neglect. Hypothetical situations were used to help minimise defensive answering as discussing actual cases may result in professionals feeling the need

to defend their previous decisions. A child of four was described due to family support workers working with children up until five years of age and children within the UK start school aged four. Therefore both professionals would have contact and responsibility of a child aged four.

The vignettes had been used for the online questionnaire (Chapter three) and so all participants had seen them prior to the focus group. The vignettes had been piloted by two lay people to ensure they understood the wording as well as the general manager of Nottinghamshire Children Centres and a PST known to the researcher to ensure that the wording and description was relevant and applicable to the day-to-day experiences of those professionals.

Vignette 1 – Emotional neglect

A 4-year-old child lives with its mother. The father left the home having been served a court order to have no contact with the family due to domestic violence against the mother a few months ago. The child mostly plays by itself and spends little time with its mother. The mother does not tend to interact with the child or offer it praise. The mother does not show much affection to the child or reach out to comfort them when distressed. The child will at times inappropriately attention seek and at other times be withdrawn and choose to play in isolation.

Vignette B – Physical neglect

A 4-year-old child lives with its mother. The father left the home after been served a court order to have no contact with the family due to domestic violence against the mother a few months ago. The child often looks dirty with their clothes looking unwashed and smelling. They are often not dressed for the weather lacking a coat when it is cold. The child is small for its age and frequently complains of being hungry.

4.4. Analysis

The focus group recordings were transcribed verbatim by the researcher. The researcher at the time of data collection and analysis was in the final year of their Doctorate in Forensic Psychology. They had previous experience of analysing data using thematic analysis in their Masters project, and as part of their training as a Forensic Psychologist.

All participants were sent the transcripts for comment and correction. Of those that responded to the researcher, none had any amendments or comment. Responses were analysed using the inductive thematic analysis procedure described by Braun and Clarke (2006). First the data was read by the researcher to identify meaningful codes relevant to the research topic. Once codes had been developed these were compared with a second researcher (independent to the design and development of the study). Units or codes with similar issues were then grouped together in analytical categories and given an overarching title. Once the two researchers had agreed on the distinct themes a code book was developed by

the researcher with a definition and description of each theme, and an example of each sub-theme within that theme, with a definition, description, example of code and an incorrect example. This was then corroborated with the second researcher, amendments made and time spent to ensure the themes were distinct from one another. The thematic analysis resulted in 15 sub-themes, which were grouped into five distinct themes.

The coherence and replicability of the themes were supported by a third independent researcher who re-coded a section of data from both focus groups using the codebook.

Participants were sent a copy of the results and codebook and invited to give feedback on the findings, no requests of amendments to the codebook were received.

4.5. Results

These themes have been developed to identify separate issues surrounding the difficulties identified working with child neglect. Although they can be seen as distinct categories, they are still related to one another in terms of consequences or cause and effect. A code of T (for PST) and F (for FSW) is used to distinguish which theme and subtheme each profession discussed.

Table 4.1 Themes and subthemes of the data

Themes	Subthemes
1. Locating the threshold for action **What influences decision making on where the perceived 'threshold for action' is.**	**1a. Previous experiences working with child neglect (T & F)** The impact previous, repeated experiences of working with cases of child neglect (often with little positive outcome) has on professionals attitudes and decision to report or take action when neglect is identified
	1b. Waiting for the full picture (T & F) Professionals waiting to take action until they feel they have sufficient evidence to demonstrate the seriousness of the neglect for the child. The importance of information sharing from multi-agencies to achieve this.
2. Hands tied with red tape **The policies, laws, and procedures that are in place that can impact on successful referrals and outcomes**	**2a. Targets need to be met (F)** How money and number targets affect professionals ability to help those in need
	2b. Eligibility criteria need to be met (F) Policy which indicates the eligibility criteria of who the professionals are able to help
3. Personal and interpersonal dynamics amongst professionals **Personal and interpersonal aspects that impact on how successfully professionals can, or feel they can, intervene or take action when neglect is identified**	**3a. Can I, and do I, confidently fulfil my job role (F)** Confidence in their professional opinion and how other professionals may view their role and responsibilities that impacts on their ability to tackle child neglect.

Themes	Subthemes
	3b. Using the 'N' (neglect) word (T) When and why do professionals use the word neglect and when or why do they not.
4. Why has nothing changed for the child? (despite intervention) **Situations where professional support is provided to the family however the support is not sufficiently targeting and addressing the neglect to the child(ren).**	**4a. Mum's mental health (F)** Mental health of mother can take priority as focus of intervention without further work to address the mothers neglectful behaviours
	4b. Relationship with the family (T & F) Professionals' relationship with the parents impacting on the intervention
	4c. Human Rights (F) Professionals understanding of the extent of their authority to intervene in family life without impacting on the rights of the family
5. What helps when working with child neglect **What is helpful or is needed to help professionals identify and respond to child neglect?**	**5a. Reflective practice (T & F)** The need for regular supervision, reflective practice, and support in their professional work
	5b. Regular contact with the family (T) Consistent and regular contact with parents/carers so that professionals can get to know the family.
	5c. Mandatory reporting (T)

Themes	Subthemes
	Would mandatory reporting help safeguard children from neglect **5d. Do more 'bottom up' interventions i.e. breakfast clubs (T)** **5e. The use of The Family Star (Early Years) to help decision making** FSW use of this assessment to help guide how to help the parent and child

4.5.1. *1) Locating the threshold for action*

A pre-requisite for this theme is the understanding from professionals that they do not always report or take action when they begin to have suspicions of child neglect within a family. Professionals state that they take some form of action only after they feel a 'threshold' has been crossed. This theme represents the professional decision-making that takes place when working with cases of child neglect and what factors influence their decision as to what is 'serious enough' to report.

1a. Professionals' previous experiences working with child neglect

Previous experiences of working with child neglect was identified as a factor in whether professionals will report/take actions with their concerns. Participants proposed the idea that repeated experiences, potentially with a lack of positive progress, means that professionals are less likely to intervene as the neglect

observed does not appear 'serious enough'. When discussing reporting child neglect a FSW stated:

FSW 3: "I think social care can become densensitised, and your scale moves down on what is important."

One FSW summing up the difficulties of neglect in comparison with other more 'serious' situations:

FSW 4: "They aren't as bad as all the others I have on my caseload… you can't do a good job on every case."

1b. Waiting for the full picture

Participants expressed that they would need multiple examples of neglectful behaviour within the home, as well as evidence of actual harm to the child. They would attempt to collate evidence from multiple sources (i.e. social workers, GPs etc.) as well as look for other potential indicators of ill-treatment that may put the child at risk (e.g. domestic violence, parental drug use), thus adding to the 'whole picture'.

This comes from the understanding that for neglect to be taken seriously and for social services to intervene there need to be additional indicators of harm, or substantial physical evidence to ensure that the situation meets the threshold or is deemed 'serious enough' to report, this includes the need for children to be seen as at 'immediate risk'. Understandably, the development of a "jigsaw

puzzle" takes time, and therefore participants identified that immediate action when child neglect is identified is not always or even commonly the norm in their practice.

When discussing physical neglect in comparison to emotional one PST stated:

PST 8: "It's more obvious, I am not saying I'd feel any more confident to report it… but this is the sort of thing that when you look at the logs are quite common."

PST 9: "As a teacher, there is little there that you could actually report. Not that you'd be reluctant to report something like emotional neglect you'd still do it, but there isn't much of a case there, if it doesn't come along with other things."

FSWs had the same opinion. Firstly, they were confident in their ability to identify neglect:

FSW 3: "It's evidencing it, it's not recognising it, it's evidencing it."

However, they struggled with the fact that neglect was far more difficult to evidence:

FSW 6: "You know neglect is that you need to have evidence and that's the thing…I had a huge amount of neglect cases which were child in need which tippered on the edge of being child

protection…and actually I saw that these children stayed in these situations because professionals were saying there isn't enough evidence, there is some good parenting in place".

FSWs in particular believed that for the emotional neglect vignette it would not meet the 'threshold':

FSW 1: "But I actually don't think it would make the threshold for a Social Care referral…I would be concerned… but actually I know that Social Care wouldn't touch that, but we know services which may be able to."

Again, another professional felt that the vignette described a child that was not immediately at risk, and so would not meet a threshold:

FSW 3: "That child's not significantly at risk now… over time possibly?"

Participants indicated the problematic nature of 'risk'. One could argue that a child may never be in 'immediate risk' due to the chronicity of neglect and the fact that the damage caused is in part due to the on-going treatment by the parents.

In relation to thresholds, information sharing was deemed as crucial in building the full picture. Professionals highlighted the impact information sharing and multi-agency working has when working with child neglect. They highlighted the importance of

sharing information between agencies and to be transparent and honest in providing feedback to agencies and families alike:

FSW 6: "That all agencies are making sure that they are communicating the information that they have. And it's like you know like in meetings…and then telling something else when they walk out of the door. Actually that's not putting the jigsaw together, and that's not supporting the child."

Some professionals felt this was lacking in certain professions:

FSW 4: "I think there are some groups of professionals who don't share information, or go into a family with horse blinkers on."

PSTs in particular felt that using a log-book of incidents was very helpful in sharing information and were more confident in their belief that they would take some form of action in suspected child neglect:

PST 8: "Even if it's the tiniest think… I'd just log."

PST 10: "The other good thing is that everyone can see it."

Professionals emphasised the need for multi-agency working, that sharing information was vital due to the importance of building

the jigsaw puzzle in order for professionals to help children of child neglect.

4.5.2. *2) Hands tied with red tape (systems and processes)*

A consistent theme that was identified across the professional groups was the policies, laws, and procedures that are currently in place that can impact on the outcome of intervention.

2a. Targets need to be met

Professionals identified governmental or service lead targets, including policies and/or funding, that impact on the professionals' ability to help those children that they have identified as 'in need' of support.

Participants identified times when they would not make a referral due to the pressures of meeting specific targets and making what may be perceived as too many referrals by those who manage them:

FSW 1: "So no matter what we think is significant or not, if there is no money you can't do anything… we are targeted on the number of referrals to social care and if you know you are going to make a referral which affects our payment by results contract and your jobs..."

FSW 1: "It's all about targets and budgets, social care can't be taking on all these children… there's not enough money to do that."

This was however met with some disagreement with some professionals stating they would take some form of action or report in such cases:

FSW 3: "It's your duty."

FSW 4: "I'd sleep better at night, and I'd take the consequences of managers telling me I think you are wasting money putting in referrals… do you know what I mean...? I've done what I think is right to safeguard the interest of that child."

2b. Eligibility criteria needs to be met

Professionals also identified policies, which determine whom they are able to help, regardless of whether others are in need of support. FSWs were only able to directly help those families that fit specified criteria (in this case children only ages 0-5). If families did not fit this category the professionals were not able to provide the support themselves.

FSW 6: "It was really, really good in the respect that we were doing all the intervention work with the over 5's, now we don't or

shouldn't be, and there's nothing for those children in terms of early intervention, other than what the schools are providing now."

4.5.3. *3) Personal and interpersonal dynamics amongst professionals*

This theme identified personal and interpersonal aspects of the professionals' work that can impact on how successfully they can, or feel they can, intervene or take action when neglect is identified.

3a. Can I, and do I, confidently fulfil my job role?

Professionals discussed feeling unsure about their own professional opinions, especially when working with other agencies and professionals. This uncertainty increased when working with other professionals who may not know or understand the extent of work they do in relation to the families involved.

Some professionals identified a lack of confidence in their own voice as a professional and ability to challenge others who may have alternative views:

FSW 6: "Sometimes we think we can't challenge professionals and like, you think well, social work has all the answers and actually your professional judgment is as important."

FSW 2: "Because when you go to an RCPC [Review Child Protection Conference] at the end they go round every professional

and ask if you think the child should stay on the plan or be taken off the plan… I think it takes conviction; it takes guts to do that, particularly when you're the only person in the group that is raising that."

There appeared to be reluctance in some cases to take ownership and responsibility for child neglect, especially for the PSTs, not in terms of caring for the child but the additional responsibility without the apparent training or knowledge to accompany this:

PST 10: "I wouldn't feel confident saying that [neglect]... I would personally feel uncomfortable making that judgment…someone else who has all the facts together would make that judgment… I would never say that it's neglect, I would say, well I'd write down what I saw and let them make the decision… Am I really qualified enough to say this child is being neglected?"

This may be associated with the idea of 'passing the buck' and result in children experiencing delays or in fact a lack of overall support. PSTs were aware that they were confident in their school to deal with concerns and that this may not be the case in other schools:

PST 7: "They definitely set a standard of what is you know, every training and inset day we have had say come and speak to someone and if we aren't doing enough, go and do something else."

3b. Using the 'N' (neglect) word

Fear or misunderstanding around using the word neglect was apparent with some professionals. Professionals may have perceived connotations, understanding, and implications of using the word that impact on their likelihood of labelling a situation as neglect, and thus the child getting the appropriate support. As one professional describes:

PST 8: "Neglect comes with quite a heavy meaning and also consequence, and as far as I'm aware if a child is being neglected it can lead to being taken away from the home."

The PSTs in particular did not feel comfortable using the word neglect, despite identifying it within the focus group as neglect. When asked about this they were clear that although they felt it was neglect, they would not give it such a label:

PST 10: "The strength in the system is that you can report that without feeling under pressure to label it."

PST 10: "I wouldn't to be too strong; I may label it as uncaring."

4.5.4. *4) 'Why has nothing changed for the child?' (despite intervention)*

This theme reflects the frustration felt by professionals who work with families where neglect has been identified or suspected and despite professional intervention the support does not sufficiently target and/or address the neglect towards the children. The theme represents that the child is often not at the centre of concern with other factors taking greater priority, potentially masking the fact that neglect is still on-going, with little improvement to the child(ren's) quality of care.

4a. Mum's mental health

The mental health of the mother was seen as a factor that can take priority as a focus of intervention without further work to address the mother's neglectful behaviour. Professionals often target the mental health of the mother as the cause of the neglectful parenting. Once the mental health of the mother improves, it is assumed that the neglectful parenting will stop. Although this may be the case, often the parents need further support to help them develop positive and attentive parenting skills. Due to the professionals focus on the parents, rather than the child, they focus on the progress the mother has made in her mental health and not on whether it has resulted in a better environment for the child.

FSW 4: "I think professionals can get so caught up in the parents issues that they forgot to think where that child's at and the

impact on that child and we talk about parental mental ill health, we talk about substance misuse…hold on we've not talked about the child and we are an hour into this meeting".

4b. Relationship with the family

Professionals also discussed that the parents can themselves cause barriers that stop the child receiving the support that they need. Professionals can become more focused on ensuring a continuing positive relationship with the parents, which can then cloud or impact on their ability to identify on-going neglectful behaviours:

FSW 4: "Also we know that parents are, can be quite manipulative and they are, you know, oh but she is a lovely person, you know we can as professionals get quite sucked into that".

In addition, professionals may value the relationship they have built and fear challenging the parents may damage the relationship in terms of upsetting the parent:

FSW 1: "It could be again about not wanting to upset the parent".

There was also the fear that challenging would result in the parents' disengagement from the services (especially the case in voluntary participation from parents):

FSW 3: ”How often do you get that, when you are working with the family, and you just think if I push too far and they disengage, nobody knows what’s happening, rather than at least if somebody is involved that child is seen and that child is heard…You are playing a game”.

FSW 1: “We are told we don’t challenge parents enough…if someone says I’ve done that and we say, well actually I don’t think you have, we aren’t used to doing that are we…it is quite uncomfortable.”

4c. Human Rights

The FSWs expressed their uncertainty over the extent of their authority to intervene in family life without impacting on the rights of the family:

FSW 1: “Children and families have human rights and should we be probing into their lives and to always remember that actually who are we to have these suspicions about people and to be probing… this family has human rights and actually get your nose out its none of your business”.

This theme was predominately discussed by FSWs, which is logical given their level of involvement with families. FSWs appeared frustrated that they could be involved with a family and still the child not remaining the centre of concern. They discussed the frustration of mental health and potential domestic violence needing

to be addressed to help protect the child but that these factors seem to hold greater priority in intervention rather than the experiences felt by the child. Although the mother's mental health may improve, and the domestic violence may cease, this does not automatically ensure that the child's experiences of neglect will diminish.

4.5.5. *5) What helps when working with child neglect?*

Professionals were able to identify what works in terms of identifying and responding to child neglect and potentially what needs to be put in place to further support children and professionals.

5a. Reflective practice

Reflective practice was identified as important, this could be completed in supervision, individually or in groups but the importance of regularly discussing and exploring safeguarding issues was seen as important in terms of keeping the child as the centre of concern and also to keep in mind desensitisation or potential burn out:

FSW 6: "I think because we have, all FSWs have regular supervision and obviously all their cases are discussed and we have a mechanism in place, I suppose sometimes it concerns me that the early years practitioners… I sometimes wonder if their safeguarding is discussed enough in their supervision".

FSW 6: "It's a really, really tough job isn't it, in regards to safeguarding but then again if you are in any doubt discussing it with someone else can be, you know, what you need to do just to make sure you actually aren't missing anything".

5b. Regular contact with the family

Another aspect was the importance of consistent and regular contact with the parents/carers so that they can identify changes in behaviours, or identify that things have not consistently changed for the better. PSTs especially highlighted this concern:

PST 10: The parents can walk right into the classroom…it is easier to interact with them, whereas there is a school nearby where the parents wait behind the line, unless they have a meeting with the teacher, it's just not how you build a relationship in the community:

PST 7: It is very organic, we would very rarely say to a parent, you need to come in and have a meeting with us, one side of the desk to the other

5c. Mandatory reporting

Professionals also discussed the potential positive or negative impact of mandatory reporting of suspected child neglect. This discussion was not covered with the FSWs, however the PSTs

appeared to believe that it would have little impact on their reporting or logging of incidents/suspicions:

PST 7: "I think there is very little, that we should report that we don't already report so actually if there was mandatory reporting there wouldn't be any difference".

They also discussed feeling that it would be an added responsibility that they (currently) would not feel comfortable accepting:

PST 10: "Teachers have to do so many things… we live in a blame game, kind of society it would be very easy to put blame on the teacher …If it did become mandatory I would expect a lot more [training and support]".

5d. Develop more 'bottom up' interventions i.e. breakfast clubs

Professionals stated the possible benefits of more 'Bottom-up' interventions activities/interventions that are not requiring of child protection services but that may heavily impact on a child's welfare. This could be in the shape of clubs, after school activities or education for children and parents:

PST 8: "At our school we have breakfast club so actually, a lot of those things, you'd still report it and you'd still go through the processes but a lot of those things we could address quite quickly".

5e. The use of the Family Star (Early Years) to help guide decision making

FSWs stated that when they had initial concerns regarding a child who may be neglected one of the first actions they would undertake is to complete the Family Star to help them develop a full understanding of the family and the specific difficulties they have.

FSW 6: "you'd do your assessment and from that you'd see where there are areas that need to be worked on with mum… you'd put some sort of action plan to support mum with the issues that came out of the assessment"

The Family Star was seen as the tool that can then help evidence where the areas of concerns were and develop interventions to support both mother and child.

4.6. Discussion

4.6.1. Key findings

The data highlighted the two professional groups faced similar difficulties when tackling child neglect. Professionals appeared confident in their ability to identify child neglect, and most were able

to correctly identify the vignettes (some FSWs labelled the vignette as emotional abuse rather than emotional neglect). Professionals' discussed at length the difficulties they face in how to successfully tackle child neglect and what they identify as common barriers.

The data evidenced that professionals feel that neglect, emotional neglect in particular, is difficult to address due to the lack of evidence and belief it is not serious enough to report on its own. Although previous literature has evidenced the misunderstanding of professionals' opinions about the seriousness of neglect (Crenshaw et al., 1995) little research has identified how professionals feel about different areas of child neglect and how they target them. However, this finding is in support of results identified in Chapter three. There is also little further research to develop the finding that once other risk factors within the family home have been resolved (including mental health of the mother) no further work is undertaken or perceived to be needed to address the mother's neglectful behaviours. Although neglect can often improve after other issues have been addressed this should not be assumed. Neglectful behaviours must therefore still be assessed and monitored once other risk factors have been addressed.

A key theme throughout the data was the need for evidence and the 'jigsaw puzzle'. In working with cases of child neglect the importance of multi-agency working is clear. Working alongside a variety of professionals can help to develop 'the jigsaw puzzle' quickly without the need to wait for 'enough evidence' to intervene. Although multi-agency working can be challenging, Paavilainen and

Flinck (2014) highlighted ways to address and overcome these difficulties. They recommend joint training on child maltreatment, focusing on identification (including the different and varied definitions professionals may use) and the roles of various professionals. This may help with professionals' uncertainty within their roles but also develop confidence in their professional opinion and ability to effectively intervene.

This research identified that professionals were aware that they knew that child neglect was occurring but felt that they would need to gather more evidence to support their beliefs before reporting would occur. This clearly takes time and results in delays to children receiving the care they need. Thus these behaviours of professionals contribute to the on-going chronicity of child neglect that can be so damaging to a child's development and health (Horwath and Tar, 2015).

Related to this point is the finding of professionals' frustration that despite the identification and willingness to target child neglect they are faced with increasing 'red-tape', which makes this difficult to achieve. The funding and policies in place appear to hamper their ability to help those that they have identified as in need. This appears to be a novel finding, and although is broadly in line with Haynes (2015) findings on difficulties in reporting, highlights a more specific barrier to intervention.

Another finding, specific to FSWs but could well be applied to other professionals is the attitude that they are not able or confident enough to challenge the attitudes of those professionals that may

appear to have more authority over the case. Meetings do not appear to foster an environment where professionals feel comfortable voicing differing opinions. Multi-agency working can only be successful if professionals feel able to openly disagree and offer alternative views and evidence. Without this decisions can be made without all the evidence in place and children left in situations that are still neglectful.

Professionals also highlighted that more needed to be done to help address neglect through other means, apart from reporting. This is similar to Haynes (2015) findings of professionals 'passing the buck' but in addition offers potential solutions. PSTs discussed the importance of breakfast and after school clubs that allow PSTs time to develop a relationship with the children as well as identify and respond to early signs of child neglect.

Some participants identified feeling uncomfortable using the word 'neglect' to describe the scenarios. This could be seen as a barrier if it resulted in the child not being identified as in need, however, the teachers felt describing the situation was more helpful. In fact, describing (if done accurately) may provide other professionals with further detail and more meaning than using a label. Both approaches have their merits and can be used as long as action is taken once the harmful behaviours have been identified.

4.6.2. Limitations

Additional participants in the PST focus group could have allowed for alternative opinions or points of discussion. The

participants were also all part of the same school; PSTs from different schools (and socio-economic areas) may have encouraged more contrasting data and different barriers.

Qualitative data may not be transferrable to broader populations and should be done so cautiously. The findings do however highlight specific difficulties that PSTs and FSWs face that can impact on policy and require further investigation.

The facilitator was known to most of the FSWs and to one of the PSTs and they were broadly aware of their research interests. This might make participants more comfortable describing their views but also make them share what they thought the facilitator was looking for in their answers or would be potentially beneficial to the facilitator and their research.

4.6.3. Implications

The results indicate that professionals want to provide support to families as soon as child neglect occurs and believe that acting in the early stages of identification (early intervention) of child neglect should be the norm. However, they continue to struggle to implement actions that can help and support children at risk, or identified as being neglected. It remains to be normal practice that cases are left until a threshold of seriousness has been reached, often at considerable harm to the child. This is evidenced by the fact that neglect remains the most common category for a Child Protection Plan in the UK (Department of Education, 2016). Support needs to be provided for professionals to report or take

some form of action when they first identify child neglect, and not feel the need to wait until it is 'serious enough'. This is especially relevant for cases of emotional neglect.

Professionals also need to understand that descriptions constitute the evidence and are more salient than the term 'neglect'.

Mandatory reporting could be argued as a tool to target this, taking the responsibility of 'enough evidence' away from the professional. This however comes with the necessity for more resources and individuals to deal with the inevitable increase in reports. Literature within countries with mandatory reporting laws describe similar non-reporting behaviours (Hawkins & McCallum, 2001; Melton, 2005), potentially highlighting that it may not be the necessity of a law that is important but professionals given time and resources to be able to respond to all cases of suspected child neglect.

Specific training on how to confidentially and sensitively discuss with parents how they are not providing appropriate care for their children may help tackle the concerns of damaging professional relationships with the family. This is especially important for professionals with less experience who may not have developed the skills to confidently and successfully challenge parents. More training on the importance of ensuring that the child remains the centre of concern was also a key finding. Professionals see the progress of the mother as sufficient evidence that the child's wellbeing will improve. When a mother makes progress or develops

the focus should still remain on whether that positively impacts on the child.

Previous research has shown the suspicion and lack of trust parents feel towards child protection services (Dumbrill, 2005). Increasing universal services and interventions may reduce the difficulty in acting on child neglect as soon as it is identified. For example, breakfast clubs and groups for parents in need can introduce parenting skills and build relationships with parents in a non-threatening and supportive environment.

One way to try and support professionals with their decision-making is the use of structured assessments. Using a structured assessment can provide professionals with a focus as to what the main areas of concern are, intervention needs, as well as ensure that a decision is not just made from their opinion but supported by a validated, evidence-based tool. The following chapter critiques an assessment used by FSWs in their day-to-day practice of working with cases of child neglect.

Chapter Five

Methodological critique of the Family Star (Early Years)

Abstract

Background: Family support workers (FSWs) as part of universal services have a professional duty to identify and respond to children and families who are failing to thrive. Child neglect is a multi-faceted form of maltreatment, which may affect many areas of a child's life. Assessments have been developed to provide a framework to identify a child's unmet needs in all domains, the parent's capacity and motivation to meet those needs and potential areas to target for intervention

Aims and Objectives: To explore whether the Family Star (Early Years) (Burns, MacKeith and Greaves, 2015) is a suitable tool to support family support workers in identifying and effectively responding to child neglect?

Method: A methodological critique was conducted to explore the development of the outcome scales, the theoretical support for the scales and supporting psychometric evidence (including validity and reliability) of the scales.

Overall findings: The methodological critique of the Family Star (Early Years) identified theoretical support for the outcomes used to identify areas of child neglect, however there remains very little evidence to support its validity and reliability.

Conclusion: The Family Star (Early Years) appears to successfully measure and identify indicators of child neglect and more generally child development, however it may not provide sufficient detail to be used as a sole measurement tool for child neglect. FSWs should be

encouraged or recommended to use an additional tool, potentially the GCP2 when concerns of child neglect are raised.

5.1. Introduction

Family support workers (FSW), as highlighted in Chapter two, are responsible for identifying, assessing, and developing programmes to support vulnerable children. Working in Children Centres they are seen as an early intervention service (Working Together, 2015) providing support to families where there may be concerns about a child receiving adequate care to ensure their healthy development. FSWs provide interventions prior to a child being formally identified as a child 'in need', early intervention involves providing support as soon as the problem emerges, within a given time-frame and evidence of positive change (Working Together, 2015). FSWs therefore must be able to identify when a child is in need of additional support, identify what support is necessary, and provide interventions that target the unmet needs.

As Chapter two and three identified, certain aspects of neglect may be difficult to identify as child neglect, and indeed are seen as less serious. If individuals are uncertain about whether a parental action (or lack of actions) is serious and/or identified as neglectful behaviour, professionals are less likely to take action and put in place support for both parent and child (Adair et al., 1997; Ashton, 1999, see Chapter two).

As already highlighted in chapter three and four when there no clear standard or definition as to what constitutes 'child neglect' professionals will develop their own criteria to judge what is adequate parenting.

Professionals in chapter four identified that they struggled to either know where the threshold for action was, or felt that they would not have the means (funding and/or time) to act on neglect if they did believe it was a form of neglect. This is also supported by previous literature within the field (Haynes, 2011). In order to help professionals in their ability to identify neglectful behaviours, provide interventions and monitor progress, assessments have been developed to help with this process.

Researchers have highlighted that using an assessment for parental adequacy should be based on the parenting abilities and the capacities that are functional and benefit the child (., 1986; Budd and Holdsworth, 1996). This may be knowledge of child development, parenting skills, and responsiveness (Gershater-Molko, Lutsjer and Sherman, 2003). In addition, other researchers focus on the necessity of caregiving skills and their relationship with the child (Grisso, 1986).

These assessments allow for specific criteria and scoring that help to guide the decision making process of the professional. They signpost the unmet needs for a child's healthy development, identify what support is needed and provide data to measure positive change.

5.1.1. Assessing the needs of a child

As FSWs discussed in Chapter four when a FSW is initially concerned about a child's welfare they do not always refer or report their concerns to child protection services. Often the course of action is to develop 'the jigsaw puzzle'. One crucial step in developing the 'jigsaw puzzle' is to complete an assessment called the Family Star (Early Years). The Family Star (Early Years) was described by the professionals as the tool that they use to signpost the areas of concern and help develop an action plan to support both parent and child.

The tool itself has not been developed to specifically identify child neglect but is seen as a holistic tool hoping to capture a wide range of issues that may impact on the development of a young child. The tool is used to identify specific areas of difficulty in parenting, measure, and support change within that family. FSWs in Chapter four highlight that this is the assessment they would use to identify parental neglect and target their intervention around the outcomes.

Daniel et al. (2011) argue that it may be of greater use to identify and focus on a child's unmet needs rather than deciding on a specific label of 'child neglect'. They argue that a narrow definition should only be necessary when compulsory measures are needed. A broader definition would make it more likely that children with unmet needs are noticed and supported, and not just the 'most severe'. Therefore the use of a more holistic and broader measurement tool of child development as opposed to specifically

child neglect may be more useful in identifying parental behaviours indicative of child neglect.

5.1.2. The Family Star and Family Star (Early Years) (Burns, MacKeith and Greaves, 2015).

The original version of the Outcome Star was developed by Triangle Consulting, initially for the homeless sector but since has expanded and been developed to be applicable to support and measure change for a wide range of clients and needs. In 2009 Family Action developed the Family Star, which aimed to measure parental behavioural change using eight core areas of parenting seen as essential for enabling children to thrive. Each area has a ten-point scale, from 'stuck' to 'effective'. Since this original Family Star, further stars have been developed to address specific behavioural changes.

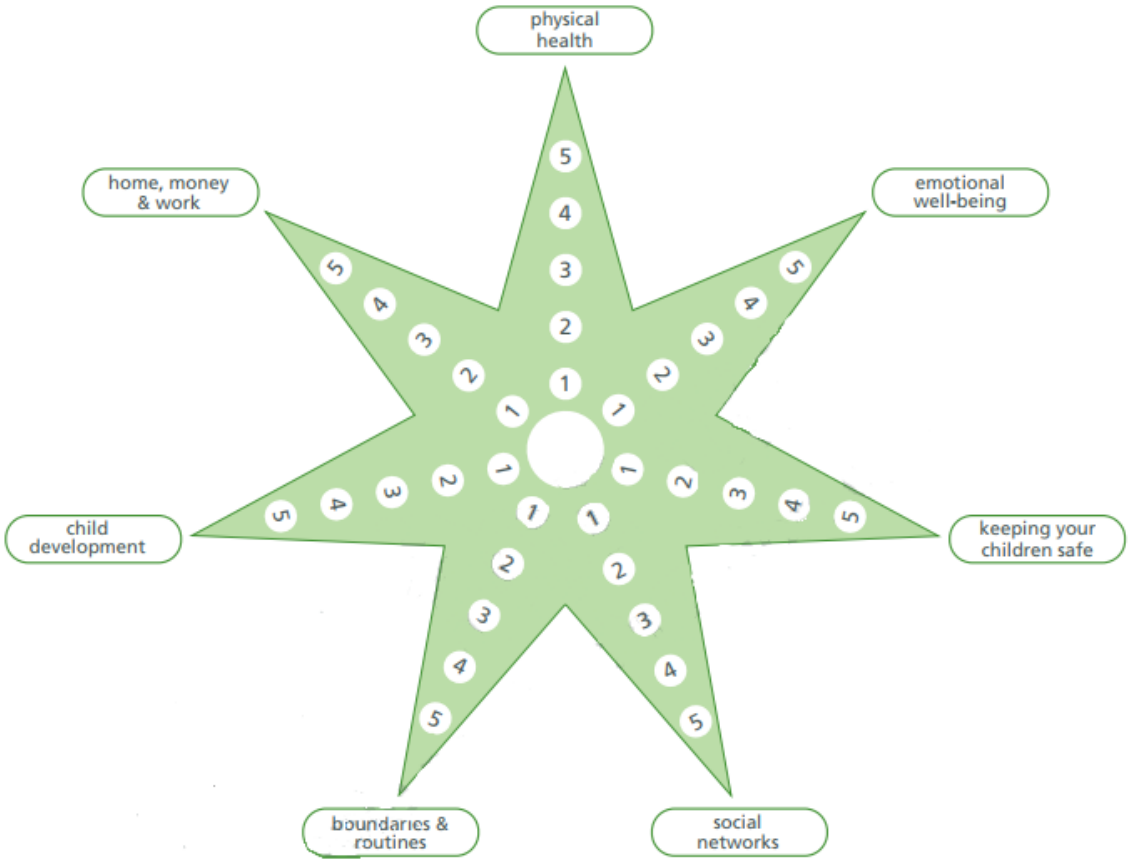
The Family Star (Early Years) was specifically designed to be used for young children (0-5 years), and in early interventions (more specifically Level 2 in a continuum of needs (Nottinghamshire's Pathway to Provision, 2017). This Family Star was developed to be suitable for family support workers, having fewer and shorter scales for ease of use.

The Family Star (Early Years) was developed by Triangle with the Royal Borough of Kensington and Chelsea Early Help and Children Centre Services. The Star consists of seven outcome areas listed below along with a diagram of the Star:

1. Physical health

2. Emotional well-being
3. Keeping your children safe
4. Social networks
5. Boundaries and routines
6. Child development
7. Home, money and work

Figure 5.1 The Family Star (Early Years)



The Family Star (Early Years), is rated using a five step 'journey of change' which are described as follows:

1. Stuck (red) – people are concerned for the well-being including their child's development, behaviour, or health of

the child, however the parent is not acknowledging or attempting to address the problem and are not accepting help.

2. Accepting help (orange) – As above there are problems with the child's well-being, the parents are willing to engage with support however this is led by the worker, with no little or no initiative taken by the parents.
3. Believing and trying (yellow) – Parents recognise it is up to them to make changes, a shift in external locus of control to internal locus of control. At this point have yet to learn the skills or what works to put this into practice.
4. Learning what works (green) - The parent is learning what works and what does not. Parents need a lot of support and guidance to increase confidence and ensure they do not give up.
5. Effective parenting (blue) – The child is thriving in the parent's care, parent does not need specialist service help. They can put their child first, and can reflect on what they have learnt, and continue to improve their skills as their child gets older.

For each outcome the tool identifies specific parental behaviours and attitudes that the professional should be focusing on. For example, for Physical Health, 'stuck' is defined as 'there are concerns about the health of my children. I don't have help with this or accept help'. The manual then proceeds to give specific items as

examples, including not going to medical appointments, lack of food etc. The tool also allows for discussion and scoring of parental factors that may impact on effective parenting (e.g. domestic violence, drug and alcohol use) when it specifically impacts on an outcome (e.g. for 'keeping your child safe' outcome).

The tool is an easy to administer assessment that both the professional and caregiver complete together. The Star is completed within the first few meetings with a parent and the parent's progress is then monitored with a further Star completed within 3-6 months to highlight progress and further work that may be necessary.

5.1.3. Development of the outcome scales

The tool is underpinned by the core principles of Action Research and Participatory Action Research (PAR), which seek to understand and change a difficulty collaboratively and following reflection (O'Brien, 2001; Carr and Kemmis (1986), and research should be done 'with' people and not 'to them' (Chevalier and Buckles, 2013). The Outcome Stars are described as a participatory assessment and measurement (PAM) and seeks to empower, collaborate and integrate in a similar way to PAR (MacKeith, 2011). The tool aims to empower service users by ensuring they are active participants in their behaviour plans, the tool is collaborative in an attempt to build dialogue between both professional and service user hoping to change perceptions and understanding MacKeith, 2011). The Outcome Star is integrative as it sees assessment as part of the 'treatment', with the assessment and measurement of

change integral to help support change, this contrasts with other assessments which sees collection of data as separate to the treatment process (MacKeith, 2011).

The Family Star (Early Years) and its outcomes were primarily developed using a bottom-up, iterative process (MacKeith, 2011), using the knowledge and experience of service users and service providers. The Family Star (Early Years) as with other Outcome Stars was developed following a four-step process used in Existential Phenomenological research, summarised as follows from de Castro (2003):

1. Formulation of the question – what are the main areas service users and services are seeking to create change, what is the end point of the change process.
2. The data-gathering situation - (including interviews with workers, service users, a workshop including managers, frontline workers and service users come to discuss the formulation question, and structured questioning exercises to understand the change steps in outcome areas).
3. Data-analysis – researchers write up the material without preconceptions and develop meanings and common strands.
4. Presentation of findings – Drafts are presented, feedback gathered, and changes made, a six-month pilot to test, and a final workshop where results are reviewed.

5.2. Theoretical support for outcomes

The Family Star (Early Years) was primarily developed, as highlighted above, using discussions and focus groups with practitioner and service users. As such there is little discussion of it being informed from previous literature on child development, or specific areas of concern 'critical in enabling children to thrive' (Family Action, 2013), which would include indicators and risk factors of child neglect.

Assessments for the welfare of children should be based upon the Framework for Assessment and explores the three domains; parenting capacity, family and environmental factors and child developmental needs (Working Together, 2015). Specific to child neglect, Brandon (2008) argues that the transactional-developmental framework is a useful model for identifying factors indicative of child neglect. This model takes into account the environment, culture, structures and different levels of support (psychological, sociological) that can help or prevent care. Additionally, the National Society for the Prevention of Cruelty to Children (NSPCC) identifies three overarching areas indicative of child neglect, and thus areas to focus intervention; poor appearance and hygiene, health and development problems, and housing and family issues. The Star's outcome measures can therefore be assessed to ascertain whether they correspond with the indicators of child-wellbeing and neglect as evidenced by previous literature.

5.2.1. Poor appearance and hygiene

Poor appearance and hygiene can include having smelly or dirty clothing, inadequate clothing for the weather, looking undernourished or seeming hungry. These are more obvious signs of child neglect and as Daniel et al. (2011) state should be easily recognisable and followed up.

The Family Star (Early Years) addresses some of these indicators of child neglect in its 'Physical health' outcome, with a higher rating indicating that a child has adequate food and a healthy diet. It does not however have a specific section for poor appearance and hygiene. It could be argued that this could more widely fall into the umbrella outcome of 'Physical health', however these indicators are not specifically explored in this outcome.

5.2.2. Health and development problems

Health indicators can be seen as a common indicator of a child's needs not being met, this can include untreated injuries or medical issues, missed appointments or delays in getting medical attention. Around a third of children who became subject to a Serious Case Review (SCR) in England and Wales for neglect had a history of missed appointments (Ofsted, 2010).

Literature has evidenced the lack of physical development in children who have been neglected, including stunted growth, lack of neurological development, negatively affecting brain functioning (Glaser, 2007). Cognitive developmental delay has also been found to be an indicator of child neglect affecting, speech, language and

social skills (De Paul and Arrubarrena, 1995; Egeland, 1991).

Emotional development can also be affected when a child's needs are not fully met, Stevenson (2008) highlights the impact of neglect on attachment; parents can have a disorganised attachment to their child, resulting in lack of positive interactions and consistent response to their child. This can result in children developing either a demanding, and fretful pattern of interaction or passive and withdrawn presentation (Stevenson, 2008).

The Family Star (Early Years) has the 'Physical health' outcome to address health needs, which focuses on ensuring a child has sufficient food, sleep, exercise, parents are keeping consistent health appointments for their child, and ensuring child is taking medicine if necessary. It also has an 'Emotional well-being' outcome which targets the emotional attachment and emotional development of the child, with scoring relating to the parents behaviours towards the child including responding positively, consistently, and feeling close and connected to the child. The Star has a further 'Child development' outcome, which identifies cognitive, physical, and emotional development, including behaviours seen by the parent but also specific presentations of the child (e.g. speech and language development). The Star appears to adequately cover the health and developmental indicators of child neglect, including emotional, physical and cognitive development.

5.2.3. Housing and family issues

This indicator of child neglect includes an unsuitable home environment, including a dirty or messy home, or not having adequate heating. It may also include leaving a child for a length of time or the child taking on the role of carer for other family members (NSPCC). Dubowitz et al., (2002) identified this indicator as environmental neglect, defined as risks in the neighbourhood.

Environmental risk factors identified in the literature include parental and child isolation (Spinetta, 1978), parents with fewer parenting skills, and understanding or child development (Coohey, 1998), and living in poverty or unsuitable housing (Thoburn, 2009).

The Early Years Star has 4 main outcomes to cover this aspect of child neglect, 'Keeping your child safe', 'Social networks', 'Boundaries and routine' and 'Home money and work'. All four outcomes look at different aspects of a child's environment and map onto previous literature and understanding of risk factors of child neglect. 'Keeping your child safe' focusing on supervision, a safe-home (clean, tidy, no harmful items left out etc.) as well as ensuring appropriate visitors or those babysitting the child. 'Social network' looks at developing friendships and relationships with others and ensuring parents and child are not isolated. This can include ensuring the child develops friendships with other children, and the parent having help from friends and family to ensure additional support for the family. 'Boundaries and routine' identifies the necessary parenting skills including appropriate bed-times, and parental control/ boundaries necessary to keep a child safe, it also

includes parental involvement with the law. 'Home, money, and work' focuses on the need for steady income, and a safe home to live in, including having enough money to buy food, clothes, heating etc. The Star appears to sufficiently cover the environmental aspects of child neglect, breaking the outcomes down into more specific and detailed factors.

5.3. Psychometric evidence to support the Family Star (Early Years)

There is a lack of research evidencing the psychometric properties of the Family Star (Early Years), the author could not find any research to evidence the psychometric properties of the Family Star (Early Years). There is however, limited psychometric evidence for The Family Star and Family Star Plus, which can be applied to the Family Star (Early Years) due to the same scoring system and similar outcome measures.

5.3.1. Validity

Validity identifies whether a tool measures what it is supposed to, or claims to measure.

York Consulting (2013) carried out an evaluation of the implementation of the Family Star within Family Action, interviewing staff and service users. The study concluded in terms of the tools validity as a key-work tool;

"The Star helped develop service user's resilience and helped workers reflect on their practice, particularly in terms of improving

outcomes" (page 6 of summary report). It also found that "service users engaged with the tool, because it gave them ownership of the change process" (page 6 of summary report)".

York Consulting (2013) also reported it validity as a measurement tool, feedback from managers stating;

"Family Star data can provide valuable insights into the extent and nature of changes occurring, as well as highlighting areas for further investigation…. The Family Star data can be used by services to identify where families are struggling most…as well as where they are evidencing most positive change" (page 3 summary report).

5.3.2. Reliability

Reliability refers to the extent to which an assessment tool successfully and consistently measures a construct. A tool is found to be reliable if it can consistently produce similar results/outcomes when tested in similar conditions.

5.3.2.1. Inter-rater reliability

Inter-rater reliability can be defined as 'a measure of reliability used to assess the degree to which different judges or rater's agree in their assessment decisions' (Phelan and Wren, 2006). MacKeith (2014) found the Family Star to have good inter-rater reliability for the five point Journey of Change (as also used in

the Family Star (Early Years)), with a score of 0.8 inter-rater reliability coefficient. Mackeith does however acknowledge that the sample size of 24 raters is small but argue it is sufficient for an initial test. A paper soon to be submitted (Good, in press) found the inter-rater reliability of the Family Star Plus to have a score of .83 (using Krippendorff's α), indicating very good reliability with a case study sample of 65 workers.

5.3.2.2. Internal consistency reliability

Internal consistency reliability measures the degree to which the tools items measure the same construct. Good (in press) found internal consistency to be very good (Cronbach's α = 0.86). Good et al., (in press) also found no inter-item correlation exceeding the 0.7 threshold (where they used Nunnally's (1978) guidance of 0.7 as an acceptable reliability co-efficient) (using Cronbach's α) indicating no redundancy due to repetition of constructs.

5.4. Limitations of the Family Star (Early Years)

As previously highlighted the Family Star (Early Years) does not have a specific and distinct outcome for poor appearance and hygiene. Although this arguably could be rated in other outcomes (e.g. 'Physical health') it is then difficult to accurately rate this, whilst also focusing on the other areas of the 'Physical health' outcomes. The Star needs a specific outcome to address this, or make the scoring more explicit so that professionals can identify this risk area.

The scoring system for the Early Years star could be more detailed in terms of specific behaviours seen by parents, and also behaviours seen by the child. Although the scoring system does provide examples, these could be more detailed and offer further examples to help professionals accurately rate the outcome. Additionally some of the outcome areas are quite large and may include various indicators of unmet needs (e.g. Physical health includes medical and nutritional neglect). This may result in professionals and parents finding it difficult to identify what exactly the difficulties are. The Star may be more useful if these factors are broken down into smaller factors.

As already highlighted the Family Star (Early Years) currently has no research dedicated to explore its specific psychometric measures, although it is argued that other Family Stars (which are very similar to the Early Years star) have evidenced some positive psychometric properties, even this evidence is limited. The evidence for the validity and reliability of the Family Star is reliant on small samples (the highest sample consisting of 65 respondents). There additionally needs to be further analysis on the predictive validity of this measurement tool. It is necessary to ascertain if the outcomes predict future parental behaviours/lack of behaviours that can result in a child's unmet needs.

The Early Years Star does not focus directly on specific outcomes such as domestic violence or parental drug and alcohol use, which are highlighted as outcomes from the Troubled Families Programme (Day, Bryson and White, 2016). These are necessary to

assess as they have an impact not only on the child's wellbeing but also on the parents ability to make consistent and positive change. Although it is important that the child remains the centre of concern, these indicators or risk factors are closely linked to child neglect, or more broadly troubled families (Osofsky, 2003; McGuigan and Pratt, 2001; McKeganey, Barnard and McIntosh, 2002).

5.5. Alternative Assessments

The Graded Care Profile 2 (GCP2) (Scrivastava and Hodson, 2014) was developed to provide a framework for assessment where child neglect concerns are raised. The tool was developed to be used by a range of professionals for the identification and assessment of neglect, and to support consistent and effective early response. The tool looks at indicators of neglect from three areas; child development, parent capacity, and family and environmental factors. Within these three overarching areas there are detailed and specific sub-areas describing each factor. Each of these sub-areas are graded on a five-point scale from 'all needs met' to 'most or all essential needs unmet'. Within these scales are specific examples of parental actions and child behaviours, which are described in detail. The tool uses the Calderdale Continuum of Need to assess the severity or level of neglect to help professionals understand the severity and level of support needed. In addition to identifying risk factors it also focuses on the positive factors that can be built upon with the family.

The GCP2 is supported and recommended by the NSPCC and has evidence for good validity and reliability (Johnson, Smith and Fisher, 2015). It also uses theoretical evidence for its outcome measures from Maslow's Hierarchy of Needs (Maslow and Lewis, 1987) and the Framework for Assessment (Working Together, 2015).

As the GCP2 has been designed specifically to identify risk factors and indicators of child neglect it provides far more detailed and specific outcomes when compared to the Family Star (Early Years). The GCP2 can be used in conjunction with existing broad assessment frameworks and so may be a valuable tool for FSWs to use after concerns have been identified from the completion of the Family Star (Early Years).

5.6. Conclusion

The Family Star (Early Years) supports professionals in identifying areas of unmet needs in children, identifying developmental, family and environmental factors as well as parenting capacity. It provides an over-view of a child's care highlighting where intervention is needed but also focusing on positive parenting to help parental confidence and engagement. The tool is capable of measuring positive change as well as helping to signpost where and what additional intervention is necessary if sufficient progress is not seen. The tool also measures parental motivation, which Daniel et al., (2011) highlight as an important

factor in the success of professional intervention, and is often over-looked in maltreatment assessments.

The Family Star (Early Years) is not marketed as a tool specifically designed to assess child neglect. However it is used routinely to identify a child's unmet needs which should therefore include indicators of child neglect. As an overall tool of child well-being it appears to identify the main areas crucial for healthy child development, despite not specifically using literature to support these outcomes. Due to the fact that it is not specifically designed for child neglect it does not have the detail necessary to provide a comprehensive picture of the specific facets of child neglect. It could be argued that the tool is sufficient in its ability to identify unmet needs in a child's development with further assessments required to focus directly on specific aspects of child neglect. With the additional use of a further assessment explicitly designed for child neglect (e.g. the GCP) a thorough assessment and understanding can be reached.

The Family Star (Early Years) appears to successfully measure and identify indicators of child neglect and more generally child development, however it may not provide sufficient detail to be used as a sole measurement tool for child neglect. FSWs should be encouraged or recommended to use an additional tool, potentially the GCP2 when concerns of child neglect are raised.

Chapter Six

Discussion

The aim of this thesis was to explore and better understand factors that influence family support workers (FSWs), primary school teachers (PSTs), and the general public's reporting or taking action when child neglect is apparent. The thesis attempted to explore previous research into this area, as well as developing a better understanding into specific difficulties that different types of neglect may have.

This thesis identified through a systematic review (Chapter two) that if professions can identify neglect and rate it as more serious they are more likely to report (Adair et al., 1997; Zellman and Bell, 1990). This finding is also supported by the findings in Chapter three, with those who identified neglect and rated it as more worrying/serious were more likely to report. Although this is not a novel finding, this thesis identified that individuals still struggle to identify certain facets of child neglect (emotional neglect) and may in fact over-estimate their ability to do so (Chapter three and four). This finding is novel to this thesis and is worthy of further exploration. Previous literature has ascertained that professions can identify neglect (Paavilainen and Tarrkka, 2003; Appleton, 1996) leading researchers to believe it is more a problem of response (Daniel et al., 2011). As Chapter one highlighted the identification of child neglect can become more difficult when its definition varies and it is not well understood (Munro, 2011). Additionally the reliance of a more narrow definition, usually used for professionals and those needing a 'threshold to respond' may mean that emotional neglect is not identified as a

serious cause for concern (Brandon et al., 2011). Indeed by focusing on the behaviour of the parent rather than the impact of the child, emotional neglect may well get downgraded or seen as less serious, compared to other forms of maltreatment or neglect. Where parental behaviours are more easily recognised, either due to more readily available physical evidence, or a lesser reliance on professionals own judgement and moral understanding of appropriate behaviours identification action may be more likely. This lends further evidence for the necessity of an assessment that can professionals identify areas of need for a child and whether these needs are being met. The Family Star, as explored in Chapter five, is one such assessment that can provide this additional support, looking at the ecological-transactional development of a child, rather than just the behaviours of the parent.

This thesis also identified factors, other than identification, that may impact on the likelihood for professionals to respond to neglect. Chapter two highlighted a range of factors that can impact on reporting tendencies, however these remained inconsistent between studies. Chapter three identified similar findings to studies in Chapter two, with those perceiving the vignette as more serious were more likely to report (Adair et al., 1997, Zellman et al., 1990). However, novel to this thesis is the finding that emotional neglect was significantly less likely to be acted upon compared to physical neglect. Chapter four identified in more detail why this may be, with particular focus on the necessity for further information to develop the 'jigsaw puzzle'. Indeed it is important that professionals gain an

understanding of whether these behaviours are a 'one off' or are part of a pattern of behaviour. Despite this, research has evidenced the negative impact of the cumulative harm of child neglect (Bromfield, Gillingham and Higgins, 2007), and as Horwath (2007) highlights it is difficult for individuals to be able to distinguish between an accident, and an accident resulting from neglect. In this case the use of assessments as explored in Chapter five may provide support and guidance to professionals to help with this decision.

Another common finding in the literature and evidenced within this thesis was the importance, but also difficulty in multi-agency working. Although this area has previously been highlighted as a barrier for effective response (Haynes, 2015). This thesis identified in further detail why this is the case, in particular the lack of confidence some professionals feel in voicing their own opinions within a wider team, and indeed how the setup of meetings may impede their ability to do so.

Chapter two and Chapter four explored whether mandatory reporting helps in responding to child neglect. Chapter two identified that if professionals were aware of the law they were more likely to report the vignette (Adair et al., 1997; Beck and Ogloff, 1995; Walsh et al., 2008). However the law itself did not increase reporting tendencies. Within Great Britain there is no mandatory reporting laws and indeed the NSPCC (2014) released a report indicating their reluctance to introduce this law. They highlighted that victims may be deterred from confiding in an adult if they know

it will automatically result in an investigation. In some cases they argue that the professional intervening themselves and supporting the family may result in a more successful outcome for the child. This view is supported by the teachers in the focus group who stated that it would potentially do more harm than good, and in fact lead to the blaming of teachers, and not supporting both the child and the teacher. Mandatory reporting laws, as discussed in the introduction, has had conflicting findings into its effectiveness in increasing reporting tendencies (Wallace and Bunting, 2007). Perhaps time and resources given to professionals to respond to suspected child neglect, not the law itself, are the key. Similarly, when working with the family, descriptions constitute evidence and are more salient than the term 'neglect'. This is especially important if professionals are using different terminology and definitions in identifying neglect (Peckover and Golding, 2017).

6.1. Limitations

This thesis has some important limitations and these should be noted.

Chapter two did not include qualitative studies in the systematic review. While these do provide a very valuable contribution to the field, and in fact qualitative data is used in Chapter four it was decided that the systematic review would focus on specific factors that can or may be generalizable across populations and settings (Mulrow, 1994). A narrower search of the literature would help to identify what specific factors affect

reporting/taking action that can then be potentially explored in Chapter three of this thesis.

A meta-analysis was not conducted after the systematic review; this was due to the heterogeneity between the studies. For example papers exploring differing factors that impact reporting tendencies (e.g. training, perceived seriousness, identification etc.).

Chapter three identified specific factors that impacted on reporting tendencies from hypothetical vignettes. The vignettes were developed by the author and so were not validated. Despite this, the vignettes were developed using definitions from Working Together (2015) and specifically identified what neglect was being explored.

By using hypothetic vignettes this type of study indicates the intention or attitudes or reporting behaviour and not actual decision-making or behaviours of professionals. Therefore, it cannot be concluded that these attitudes would definitely predict the same behaviours. Using online questionnaires also increases the likelihood of selection bias, with those already with an interest in the area more likely to engage with the study, therefore the participants cannot be randomly selected.

Chapter four explored FSWs and PSTs experiences and perceptions of working with child neglect. The facilitator of the focus group was also the author of this thesis, and was known to a few of the participants in both groups. This may have affected participation, with some desirable responding, with participants responding or answering how they thought the author/facilitator

wanted them to. There was a small participant number in the PST group (n = 4). This could indicate that there was not a wide range of opinions or differing attitudes given the small number participating.

Selection bias may also have occurred within this study, with those individuals who already have an interest in the area of child neglect more likely to participate. Additionally all participants were recruited from within Nottinghamshire and not Great Britain. Therefore the sample may not be representative or FSWs or PSTs in the wider population.

Chapter five provided a critical evaluation of the Family Star (Early Years) (Burns, MacKeith and Greaves, 2015) it was critiqued in terms of its ability to identify indicators of child neglect, however it has not been developed to specifically address child neglect, but is used to help develop 'effective parenting'. Despite this, it is the only tool used by FSWs (within Nottinghamshire) to identify aspects of child neglect and thus should be critiqued in its clinical application to child neglect.

The assessment being a relatively new tool, and developed by adapting previous Stars has very little research evidencing its reliability and validity. The studies that were included to address the psychometric tools were actually conducted on other Stars, although similar are adapted. Therefore the validity and reliability of the Star cannot be assumed from papers cited in this review.

6.2. Implications for practice

Despite the limitations to this thesis there are a number of implications for practice. The consistent finding from both Chapters three and four was that professionals (and the public) still do not fully understand the seriousness of neglect, emotional neglect in particular. Professionals within the focus group identified that on its own, emotional neglect was 'not enough' to take further action. This was further compounded by the fact that due to recent funding cuts (Hastings et al., 2015) and high thresholds even if they did report or take action their recommendations would most likely be rejected by social services. There are two implications with this finding, the first is that professionals need to be equipped to recognise emotional neglect as equally as seriously as physical neglect, but also that they are supported in their responses and able to report or take action and that the child will be properly supported. Secondly, if funding continues to be cut and social services overstretched, universal services such as Children Centres and after school/before school clubs can be used to address and target the early stages of child neglect. This may then result in a pro-active response to child neglect, instead of waiting for thresholds of seriousness to be met, ultimately resulting in a child unnecessarily suffering. For this to be made a reality however, funding would need be provided for 'early intervention' by professionals.

6.3. Suggestions for future research

The systematic review evidenced little to no research on the identification and understanding of police response to child neglect. The police have access to families and homes and have a responsibility to be able to identify and report child neglect. Further research in this area is necessary to understand their reporting tendencies.

A systematic synthesis into the qualitative findings into the barriers or positive factors that impact on reporting tendencies would also be of great value. Chapter two provided a thorough exploration of specific measurable factors that impacted on hypothetical vignettes. A narrative synthesis looking at professionals' specific experiences would provide a complimentary understanding, looking at the difficulties professionals feel they face in real-life situations.

Future research could also identify other areas of child neglect in addition to emotional and physical neglect (e.g. medical neglect, educational neglect) and whether these have an impact on reporting tendencies. Additionally, there remains little research into the attitudes and behaviours of professionals identifying and responding to older children who are suffering from child neglect. Raws et al. (2016) found that 15% of 14-15 self-reported neglect by their parents/carers however a review by Rees et al. (2010) found little research in this area.

Emotional abuse is a further area of child maltreatment that is significantly under researched (Glaser, 2007). Alongside neglect it

is an area that is worthy of further research to explore individual's ability to identify it and whether they would act once identified.

In terms of application to policy, further research looking at the longer-term effect of Children Centres and early intervention services on the impact of neglectful behaviours by parents and the development of the children is necessary. There remains a small but substantial body of evidence that supports the positive effects of Children Centres (Reynolds, Mathieson and Topitzes, 2009; Evidentiary foundations of Nurse-Family Partnership, 2011), however more research is needed to continue to evidence the positive impact (both short and longer term) this work has on children and their families.

The debate about whether the implementation of mandatory reporting in Great Britain remains, there remains a lack of research into reporting tendencies in non-mandated countries, especially when looking at neglect. A further area of interest would be to compare reporting tendencies of those in mandated reporting countries to those who do not have such laws.

6.4. Conclusion

This thesis aimed to explore and add to the research evidence into factors that impact on attitudes of reporting/taking action of FSWs, PSTs and the general public. The thesis attempted to look more clearly at different aspects of child neglect (emotional and physical) and how these may influence noticing and helping the child. The evidence suggests that emotional neglect in particular is

harder to identify and less likely to be reported on. Reasons for this are explored and understood in terms of attitudes of participants as well as policies or funding impacting on action being taken.

References

**Abrahams, N., Casey, K., & Daro, D. (1992). Teachers' knowledge, attitudes, and beliefs about child abuse and its prevention. *Child abuse & neglect*, *16*(2), 229-238. doi.org/10.1016/0145-2134(92)90030-U.

Action for Children. (2013). *Impact Report*. Retrieved from https://www.actionforchildren.org.uk/media/2158/impact-report-2013.pdf.

*Adair, S. M., Wray, I. A., Hanes, C. M., Sams, D. R., Yasrebi, S., & Russell, C. M. (1997). Perceptions associated with dentists' decisions to report hypothetical cases of child maltreatment. *Pediatric dentistry*, *19*, 461-465.

*Adair, S. M., Yasrebi, S., Wray, I. A., Hanes, C. M., Sams, D. R., & Russell, C. M. (1997). Demographic, educational, and experiential factors associated with dentists' decisions to report hypothetical cases of child maltreatment. *Pediatric dentistry*, *19*, 466-469.

Allen, G. (2011). *Early intervention: the next steps, an independent report to Her Majesty's government by Graham Allen MP*. The Stationery Office.

**Al-Amad, S. H., Awad, M. A., Al-Farsi, L. H., & Elkhaled, R. H. (2016). Reporting child abuse cases by dentists working in the

United Arab Emirates (UAE). *Journal of forensic and legal medicine*, *40*, 12-15. doi.org/10.1016/j.jflm.2016.01.033 1752-928X.

**Al-Dabaan, R., Newton, J. T., & Asimakopoulou, K. (2014). Knowledge, attitudes, and experience of dentists living in Saudi Arabia toward child abuse and neglect. *The Saudi dental journal*, *26*(3), 79-87. doi.org/10.1016/j.sdentj.2014.03.008.

**Al-Moosa, A., Al-Shaiji, J., Al-Fadhli, A., Al-Bayed, K., & Adib, S. M. (2003). Pediatricians' knowledge, attitudes and experience regarding child maltreatment in Kuwait. *Child abuse & neglect*, *27*(10), 1161-1178. doi.org/10.1016/j.chiabu.2003.09.009.

Allen, G. (2011). *Early intervention: the next steps, an independent report to Her Majesty's government by Graham Allen MP*. The Stationery Office.

Allnock, D., & Start, N. F. (2010). Children and young people disclosing sexual abuse: An introduction to the research. *London: NSPCC*. Retrieved from https://s3.amazonaws.com/academia.edu.documents/44699405/children_disclosing_sexual_abuse_pdf_wdf75964_1.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1540987176&Signature=5%2FZOCorZLziLnPXL83xihtYOCZ8%3D&response-content-

disposition=inline%3B%20filename%3DChildren_and_young_people_disclosing_sex.pdf.

*Alnasser, Y., Albijadi, A., Abdullah, W., Aldabeeb, D., Alomair, A., Alsaddiqi, S., & Alsalloum, Y. (2017). Child maltreatment between knowledge, attitude and beliefs among Saudi pediatricians, pediatric residency trainees and medical students. *Annals of Medicine and Surgery*, *16*, 7-13. doi.10.1016/j.amsu.2017.02.008.

Ammerman, R. T., Kolko, D. J., Kirisci, L., Blackson, T. C., & Dawes, M. A. (1999). Child abuse potential in parents with histories of substance use disorder. *Child abuse & neglect*, *23*(12), 1225-1238. DOI.org/10.1016/S0145-2134(99)00089-7.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C. H., Perry, B. D., ... & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European archives of psychiatry and clinical neuroscience*, *256*(3), 174-186.

Appleton, J. V. (1996). Working with vulnerable families: a health visiting perspective. *Journal of Advanced Nursing*, *23*(5), 912-918. doi. 10.1046/j.1365-2648.1996.01028.

Appleton, J. V., & Cowley, S. (2004). The guideline contradiction: health visitors' use of formal guidelines for identifying and assessing

families in need. *International Journal of Nursing Studies*, *41*(7), 785-797. doi.org/10.1016/j.ijnurstu.2004.03.006.

**Ards, S., & Harrell, A. (1993). Reporting of child maltreatment: A secondary analysis of the national incidence surveys. *Child Abuse & Neglect*, *17*(3), 337-344. doi.org/10.1016/0145-2134(93)90056-B.

*Ashton, V. (1999). Worker judgements of seriousness about and reporting of suspected child maltreatment. *Child Abuse & Neglect*, 23(6), 539-548. doi.org/10.1016/S0145-2134(99)00032-0.

**Ashton, V. (2004). The effect of personal characteristics on reporting child maltreatment. *Child Abuse & Neglect*, *28*(9), 985-997. doi.org/10.1016/j.chiabu.2004.03.012.

**Ashton, V. (2007). The impact of organizational environment on the likelihood that social workers will report child maltreatment. *Journal of Aggression, Maltreatment & Trauma*, *15*(1), 1-18. doi.org/10.1300/J146v15n01_01.

**Azevedo, M. S., Goettems, M. L., Brito, A., Possebon, A. P., Domingues, J., Demarco, F. F., & Torriani, D. D. (2012). Child maltreatment: a survey of dentists in southern Brazil. *Brazilian oral research*, *26*(1), 5-11. doi.org/10.1590/S1806-83242012000100002.

**Badger, L. W. (1989). Reporting of child abuse: influence of characteristics of physician, practice, and community. *Southern medical journal*, *82*(3), 281-286.

**Bankole, O. O., Denloye, O. O., & Adeyemi, A. T. (2008). Child abuse and dentistry: a study of knowledge and attitudes among Nigerian dentists. *African journal of medicine and medical sciences*, *37*(2), 125-134.

Brown, J., Cohen, P., Johnson, J. G., & Salzinger, S. (1998). A longitudinal analysis of risk factors for child maltreatment: Findings of a 17-year prospective study of officially recorded and self-reported child abuse and neglect. Child abuse & neglect, 22(11), 1065-1078. DOI.org/10.1016/S0145-2134(98)00087-8.

Budd, K. S., & Holdsworth, M. J. (1996). Issues in clinical assessment of minimal parenting competence. *Journal of Clinical Child Psychology*, *25*(1), 2-14.

**Buljan Flander, G., Tarabić, B. N., & Čuković-Bagić, I. (2015). Child Abuse and Neglect: Croatian Dental Practitioners' Experience and Knowledge. *Alcoholism and psychiatry research: Journal on psychiatric research and addictions*, *51*(2), 127-136.

**Beck, K. A., Ogloff, J. R., & Corbishley, A. (1994). Knowledge, compliance, and attitudes of teachers toward mandatory child abuse

reporting in British Columbia. *Canadian Journal of Education/Revue canadienne de l'éducation*, 15-29.

*Beck, K. A., & Ogloff, J. R. (1995). Child abuse reporting in British Columbia: Psychologists' knowledge of and compliance with the reporting law. *Professional Psychology: Research and Practice*, *26*(3), 245.

**Beck, K. A. (2000). *A decision making model of child abuse reporting* (Doctoral dissertation, University of British Columbia).

**Ben-Arieh, A. (2015). Community characteristics, social service allocation, and child maltreatment reporting. *Child abuse & neglect*, *41*, 136-145. doi.org/10.1016/j.chiabu.2014.08.018.

**Benbenishty, R., & Schmid, H. (2011). Public attitudes toward child maltreatment in Israel: Implications for policy. *Children and Youth Services Review*, *33*(7), 1181-1188. doi.org/10.1016/j.childyouth.2011.02.015.

Bentley, H., O'Hagan, O., Brown, A., Vasco, N., Lynch, C., Peppiate, J., Webber, M., Ball, R., Miller, P., Byrne, A., Hafizi, M. & Letendrie, F. (2017). How safe are our children? London: NSPCC.

**Bonardi, D. J. (2000). Teachers' decisions to report child abuse: The effects of ethnicity, attitudes, and experiences.

**Borres, M. P., & Hägg, A. (2007). Child abuse study among Swedish physicians and medical students. *Pediatrics international*, *49*(2), 177-182. doi.org/10.1111/j.1442-200X.2007.02331.

Brandon, M. (2008). Analysing child deaths and serious injury through abuse and neglect: what can we learn?: a biennial analysis of serious case reviews 2003-2005.

Brandon, M. (2009). Understanding Serious Case Reviews and their Impact: A biennial analysis of serious case reviews 2005-07.

Brandon, M., Sidebotham, P., Ellis, C., Bailey, S., & Belderson, P. (2011). Child and family practitioners' understanding of child development: lessons learnt from a small sample of serious case reviews (Research Report DFE-RR110).

Brandon, M., Bailey, S., Belderson, P., & Larsson, B. (2013). Neglect and serious case reviews. *University of East Anglia/NSPCC: Norwich.*

Brandon, M., Glaser, D., Maguire, S. et al (2014). Missed opportunities: indicators of neglect - what is ignored, why, and what can be done? London. DfE. https://dspace.lboro.ac.uk/dspacejspui/bitstream/2134/18367/1/RR404 Indicators_of_neglect_missed_opportunities.pdf.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101. doi./10.1191/1478088706qp063oa.

Bromfield, L. M., Gillingham, P., & Higgins, D. J. (2007). Cumulative harm and chronic child maltreatment. *Developing practice: the child youth and family work journal*, *19*, 34-42.

Bryant, J., & Milsom, A. (2005). Child abuse reporting by school counselors. *Professional School Counseling*, *9*(1), 63-71.

**Bsoul, S. A., Flint, D. J., Dove, S. B., Senn, D. R., & Alder, M. E. (2003). Reporting of child abuse: a follow-up survey of Texas dentists. *Pediatric dentistry*, *25*(6).

Buchanan, E., Poet, H., Sharp, C., Easton, C., & Featherstone, G. (2015). *'Child Neglect is Everyone's Business': Achieving a Greater Sense of Shared Responsibility for Tackling Neglect: Findings from LARC 6, National Foundation for Educational Research (NFER)*. National Foundation for Educational Research.

Burgess, C., & Daniel, B. (2011). Neglecting the issue: impact, causes and responses to child neglect in the UK: A Briefing Paper for Action for Children.

*Burgess, C., Daniel, B., Scott, J., Dobbin, H., Mulley, K., & Whitfield, E. (2014). Preventing child neglect in the UK: what makes services accessible to children and families? An annual review by Action for Children in partnership with the University of Stirling.

Burns, S., MacKeith, J. and Greaves, S. (2015), Family Star (Early Years) Organisation Guide, Triangle Consulting Social Enterprise, London.

Carr, W. and Kemmis, S. (1986), Becoming Critical: Education, Knowledge and Action Research, Falmer Press, London.

Cash, S. J., & Wilke, D. J. (2003). An ecological model of maternal substance abuse and child neglect: Issues, analyses, and recommendations. *American Journal of Orthopsychiatry*, *73*(4), 392-404. doi.org/10.1037/0002-9432.73.4.392.

Cawson, P., Wattam, C., Brooker, S. and Kelly, G. (2000) *Child maltreatment in the United Kingdom*. London: NSPCC.

**Chadwick, Barbara L., Jane Davies, S. K. Bhatia, Catherine Rooney, and Neil McCusker. "Child protection: training and experiences of dental therapists." *British dental journal* 207, no. 3 (2009): E6. doi.10.1038/sj.bdj.2009.666.

Chevalier, J. M., & Buckles, D. (2013). Participatory action research: Theory and methods for engaged inquiry. Routledge.

**Clark-Jones, F. (1992). *An examination of factors influencing teachers' compliance/noncompliance with the Illinois Abused and Neglected Child Reporting Act* (Doctoral dissertation, University of Illinois at Urbana-Champaign).

Cohen, J. (1988). Statistical power analysis for the behavioral sciences. 2nd.

Connell-Carrick, K. (2003). A critical review of the empirical literature: Identifying correlates of child neglect. *Child and Adolescent Social Work Journal*, *20*(5), 389-425.

Coohey, C. (1998). Home alone and other inadequately supervised children. *Child welfare, 77(3),* 291.

**Coohey, C. (2003). Defining and classifying supervisory neglect. *Child maltreatment*, *8*(2), 145-156.doi. 10.1177/1077559502250786.

**Coope, C. M., & Theobald, S. (2006). Children at risk of neglect: Challenges faced by child protection practitioners in Guatemala City. *Child abuse & neglect*, *30*(5), 523-536. doi.org/10.1016/j.chiabu.2005.11.007.

*Craft, J. L., & Staudt, M. M. (1991). Reporting and founding of child neglect in urban and rural communities. *Child Welfare: Journal of Policy, Practice, and Program*.

**Crowell, K., & Levi, B. H. (2012). Mandated reporting thresholds for community professionals. *Child welfare*, *91*(1), 35.

*Crenshaw, W. B., Crenshaw, L. M., & Lichtenberg, J. W. (1995). When educators confront child abuse: An analysis of the decision to report. *Child abuse & neglect*, *19*(9), 1095-1113. doi.org/10.1016/0145-2134(95)00071-F.

**Cukovic-Bagic, I., Dumancic, J., Kujundzic Tiljak, M., Drvaric, I., Boric, B., Kopic, V., & Welbury, R. R. (2015). Croatian dentists' knowledge, experience, and attitudes in regard to child abuse and neglect. *International journal of paediatric dentistry*, *25*(6), 444-450. doi.org/10.1111/ipd.12151.

**Dalzell, D. P., Bajaj, R., & Hunter, J. (2002). Child abuse and neglect: detection and reporting behaviors of Oklahoma dentists. *Journal-Oklahoma Dental Association*, *92*(4), 28.

Dalgelish, L. (2003) *Risk, Needs and Consequences*, in Calder, M. C. and Hackett, S, (ed) *Assessment in Child Care*, Lyme Regis: Russell House Publishing.

Daniel, B. (1999). Beliefs in child care: social work consensus and lack of consensus on issues of parenting and decision-making. *Children & Society*, *13*(3), 179-191. doi. 10.1111/j.1099-0860.1999.tb00123.

Daniel, B., Scott, J., Taylor, J., Derbyshire, D., & Neilson, D. (2011). *Recognizing and helping the neglected child: evidence-based practice for assessment and intervention*. Jessica Kingsley Publishers.

Daniel, B., Taylor, J., & Scott, J. (2010). Recognition of neglect and early response: overview of a systematic review of the literature. *Child & Family Social Work*, *15*(2), 248-257. doi.org/10.1111/j.1365-2206.2009.00670.x.

**da Silva Franzin, L. C., Olandovski, M., Vettorazzi, M. L. T., Werneck, R. I., Moysés, S. J., Kusma, S. Z., & Moysés, S. T. (2014). Child and adolescent abuse and neglect in the city of Curitiba, Brazil. *Child abuse & neglect*, *38*(10), 1706-1714. doi.org/10.1016/j.chiabu.2014.02.003.

**Davidson-Arad, B., Englechin-Segal, D., & Wozner, Y. (2003). Short-term follow-up of children at risk: Comparison of the quality of life of children removed from home and children remaining at

home. *Child Abuse & Neglect*, *27*(7), 733-750. doi.org/10.1016/S0145-2134(03)00113-3.

**Davidson-Arad, B., & Benbenishty, R. (2010). Contribution of child protection workers' attitudes to their risk assessments and intervention recommendations: A study in Israel. *Health & social care in the community*, *18*(1), 1-9. doi.org/10.1111/j.1365-2524.2009.00868.

**Davidson-Arad, B., & Benbenishty, R. (2014). Child welfare attitudes, risk assessments and intervention recommendations: The role of professional expertise. *The British Journal of Social Work*, *46*(1), 186-203. doi.org/10.1093/bjsw/bcu110.

Day, L., Bryson, C., & White, C. (2016). National evaluation of the troubled families programme: final synthesis report.

De Castro, A. (2003), ''Introduction to Giorgi's Existential Phenomenological Research Method'', Psicologia desde el Caribe, Universidad del Norte, Vol. 11, pp. 45-56. Doi.10.1.1.424.7495&rep=rep1&type=pdf.

Department for Education (2016) Characteristics of children in need in England, 2015-16. London: Department for Education (DfE). Table D4.

de Paúl, J., & Arruabarrena, M. I. (1995). Behavior problems in school-aged physically abused and neglected children in Spain. *Child abuse & neglect*, *19*(4), 409-418. doi.org/10.1016/0145-2134(95)00009-W.

**Dickerson, K. L., Lindner, S., Scurich, N., & Quas, J. A. (2017). When Is Neglect, Neglect?: It Depends on Who You Ask. *Child maltreatment*, *22*(3), 256-264. Doi. 10.1177/1077559517709558.

** Dobrin, L. (2007). Through education and awareness, school nurses can play an integral role in the identification and prevention of child abuse. *School nurse news*, *24*(3), 8-9.

** Dobrin, L., & Rosenzweig, J. (2005). The role of school nurses in recognizing, reporting, and preventing child abuse. *School nurse news*, *22*(3), 12-14.

Dubowitz, H., Klockner, A., Starr Jr, R. H., & Black, M. M. (1998). Community and professional definitions of child neglect. *Child Maltreatment*, *3*(3), 235-243. doi. 10.1177/1077559598003003003.

Dubowitz, H., Papas, M. A., Black, M. M., & Starr, R. H. (2002). Child neglect: Outcomes in high-risk urban preschoolers. *Pediatrics*, *109*(6), 1100-1107. doi. 10.1542/peds.109.6.1100.

Dumbrill, G. C. (2006). Parental experience of child protection intervention: A qualitative study. *Child abuse & neglect*, *30*(1), 27-37. doi. .org/10.1016/j.chiabu.2005.08.012.

**Dyer, C. B., Goodwin, J. S., Pickens-Pace, S., Burnett, J., & Kelly, P. A. (2007). Self-neglect among the elderly: a model based on more than 500 patients seen by a geriatric medicine team. *American Journal of Public Health*, *97*(9), 1671-1676.

Eckenrode, J., Ganzel, B., Henderson Jr, C. R., Smith, E., Olds, D. L., Powers, J., ... & Sidora, K. (2000). Preventing child abuse and neglect with a program of nurse home visitation: The limiting effects of domestic violence. *Jama*, *284*(11), 1385-1391. doi.10.1001/jama.284.11.1385.

Egeland, B. (1991). A longitudinal study of high-risk families: Issues and findings. In R.H. Starr and D.A. Wolfe (eds) *The effects of child abuse and neglect: Issues and research*, 33-56. New York, NY. Guilford Press.

**Eisbach, S. S., & Driessnack, M. (2010). Am I sure I want to go down this road? Hesitations in the reporting of child maltreatment by nurses. *Journal for specialists in pediatric nursing*, *15*(4), 317-323. doi.org/10.1111/j.1744-6155.2010.00259.

English, D. J., Thompson, R., Graham, J. C., & Briggs, E. C. (2005). Toward a definition of neglect in young children. *Child maltreatment*, *10*(2), 190-206. doi. 10.1177/1077559505275178.

**Falkiner, M., Thomson, D., & Day, A. (2017). Teachers' understanding and practice of mandatory reporting of child maltreatment. *Children Australia*, *42*(1), 38-48. . doi.org/10.1017/cha.2016.53.

**Farmer, E., & Lutman, E. (2014). Working Effectively with Neglected Children and Their Families–What Needs To Change?. *Child Abuse Review*, *23*(4), 262-273. doi.org/10.1002/car.2330.

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G* Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior research methods*, *39*(2), 175-191. doi. 10.3758%2FBF03193146.

**Fayez, M., Takash, H. M., & Al-Zboon, E. K. (2014). Combating violence against children: Jordanian pre-service early childhood teachers' perceptions towards child abuse and neglect. *Early child development and care*, *184*(9-10), 1485-1498. doi.org/10.1080/03004430.2014.901013.

**Feng, J. Y., Huang, T. Y., & Wang, C. J. (2010). Kindergarten teachers' experience with reporting child abuse in Taiwan. *Child abuse & neglect*, *34*(2), 124-128. doi.org/10.1016/j.chiabu.2009.05.007.

**Fieten, J. A. (2007). *Facilitators and barriers to pediatric orthopedic physicians' reporting child abuse and neglect*. The University of Texas at San Antonio.

Flaherty, E. G., Thompson, R., Litrownik, A. J., Theodore, A., English, D. J., Black, M. M., ... & Dubowitz, H. (2006). Effect of early childhood adversity on child health. *Archives of pediatrics & adolescent medicine*, *160*(12), 1232-1238. doi.10.1001/archpedi.160.12.1232.

**Flander, G. B., Stimac, D., Bagaric, E. S., & Vinscak, M. (2015). Patterns of and Copying with Cyberbullying in Croatia. *International Journal of Person Centered Medicine*, *4*(4), 251-256.

Fleiss J, L. (1986). The design and analysis of clinical experiments. Wiley, New York.

**Francis, K., Chapman, Y., Sellick, K., James, A., Miles, M., Jones, J., & Grant, J. (2012). The decision-making processes adopted by rurally located mandated professionals when child abuse or neglect

is suspected. *Contemporary nurse*, *41*(1), 58-69. doi.org/10.5172/conu.2012.41.1.58.

* Fraser, J. A., Mathews, B., Walsh, K., Chen, L., & Dunne, M. (2010). Factors influencing child abuse and neglect recognition and reporting by nurses: A multivariate analysis. *International journal of nursing studies*, *47*(2), 146-153. Doi. 10.1016/j.ijnurstu.2009.05.015.

* Fung, D. S., & Chow, M. H. (1998). Doctors' and lawyers' perspectives of child abuse and neglect in Singapore. *Singapore medical journal*, *39*(4), 160-165.

Gardner, R. (2008). *Developing an effective response to neglect and emotional harm to children*. National Society for the Prevention of Cruelty to Children. Retrieved from https://www.nspcc.org.uk/globalassets/documents/research-reports/developing-effective-response-neglect-emotional-harm-children.pdf.

Gershater-Molko, R. M., Lutzker, J. R., & Sherman, J. A. (2003). Assessing child neglect. *Aggression and Violent Behavior*, *8*(6), 563-585. doi.org/10.1016/j.avb.2000.04.001.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment

in high-income countries. *The lancet*, *373*(9657), 68-81. doi.org/10.1016/S0140-6736(08)61706-7.

Glaser, D. (2007). The effects of child maltreatment on the brain. *The link: The official Newsletter of the International Society for the prevention of Child Abuse and Neglect,* 16, 2 1-4.

**Glasser, S., & Chen, W. (2006). Survey of a pediatric hospital staff regarding cases of suspected child abuse and neglect. *Age (yrs)*, *22*(30), 31-40.

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child abuse & neglect*, *22*(5), 401-421. doi.org/10.1016/S0145-2134(98)00005-2.

**Goebbels, A. F. G., Nicholson, J. M., Walsh, K., & De Vries, H. (2008). Teachers' reporting of suspected child abuse and neglect: behaviour and determinants. *Health education research*, *23*(6), 941-951. doi.org/10.1093/her/cyn030.

Good, A. (2018). Assessing family functioning: Psychometric evaluation of the Family Star Plus. *Manuscript submitted for publication.*

Grisso, T. (2006). Evaluating competencies: Forensic assessments and instruments (Vol. 16). Springer Science & Business Media.

**Gunn, V. L., Hickson, G. B., & Cooper, W. O. (2005). Factors affecting pediatricians' reporting of suspected child maltreatment. *Ambulatory Pediatrics*, *5*(2), 96-101. doi.org/10.1367/A04-094R.1.

Guterman, N. B. (1997). Early prevention of physical child abuse and neglect: Existing evidence and future directions. *Child Maltreatment*, *2*(1), 12-34. doi.org/10.1177/1077559597002001003.

**Habib, H. S. (2012). Pediatrician knowledge, perception, and experience on child abuse and neglect in Saudi Arabia. *Annals of Saudi medicine*, *32*(3). Doi.10.5144/0256-4947.2012.236.

Harries, M., & Clare, M. (2002). *Report for the Western Australian Child Protection Council: Mandatory Reporting of Child Abuse: Evidence and Options*. Discipline of Social Work and Work Policy, University of Western Australia.

**Harris, J. C., Elcock, C., Sidebotham, P. D., & Welbury, R. R. (2009). Safeguarding children in dentistry: 1. Child protection training, experience and practice of dental professionals with an

interest in paediatric dentistry. *British dental journal*, *206*(8), 409. doi:10.1038/sj.bdj.2009.307.

**Harris, J. C., Elcock, C., Sidebotham, P. D., & Welbury, R. R. (2009). Safeguarding children in dentistry: 2. Do paediatric dentists neglect child dental neglect?. *British dental journal*, *206*(9), 465. Doi.10.1038/sj.bdj.2009.356.

**Harris, C. M., Welbury, R., & Cairns, A. M. (2013). The Scottish dental practitioner's role in managing child abuse and neglect. *British dental journal*, *214*(9), E24. Doi.10.1038/sj.bdj.2013.435.

Hartley, C. C. (2002). The co-occurrence of child maltreatment and domestic violence: Examining both neglect and child physical abuse. *Child Maltreatment*, *7*(4), 349-358. doi. 10.1177/107755902237264.

*Hawkins, R., & McCallum, C. (2001). Mandatory notification training for suspected child abuse and neglect in South Australian schools. *Child Abuse & Neglect*, *25*(12), 1603-1625. doi. org/10.1016/S0145-2134(01)00296-4.

Haynes, A. (2015). Realising the potential: Tackling child neglect in universal services. *NSPCC, London*.

Helm, D. (2010). *Making Sense of Child and Family Assessment: How to Interpret Children's Needs*. Jessica Kingsley Publishers.

**Herendeen, P. A., Blevins, R., Anson, E., & Smith, J. (2014). Barriers to and consequences of mandated reporting of child abuse by nurse practitioners. *Journal of Pediatric Health Care*, *28*(1), e1-e7. doi.org/10.1016/j.pedhc.2013.06.004.

Hildyard, K. L., & Wolfe, D. A. (2002). Child neglect: developmental issues and outcomes☆. *Child abuse & neglect*, *26*(6), 679-695.

HM Government (2015). Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf.

**Hillman, S. J., & Siracusa, A. J. (1995). The effectiveness of training teachers to identify and intervene with children of alcoholics, abuse, and neglect. *Journal of Alcohol and Drug Education*, *41*, 49-61.

Horstead, A., & Cree, A. (2013). Achieving transparency in forensic risk assessment: a multimodal approach. Advances in psychiatric treatment, 19(5), 351-357. doi. 10.1192/apt.bp.112.010645.

**Horwath, J., & Morrison, T. (2005). *Effective staff training in social care: From theory to practice*. Routledge.

Horwath, J. (2007). *Child neglect: Identification and assessment*. Palgrave Macmillan.

Horwath, J., & Tarr, S. (2015). Child visibility in cases of chronic neglect: Implications for social work practice. *The British Journal of Social Work*, *45*(5), 1379-1394. doi. org/10.1093/bjsw/bcu073.

Hughes, M., & Cossar, J. (2016). The relationship between maternal childhood emotional abuse/neglect and parenting outcomes: a systematic review. *Child abuse review*, *25*(1), 31-45. doi.org/10.1002/car.2393.

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*(5), 479-492. doi.org/10.1016/j.chiabu.2003.12.005.

**Janczewski, C. E. (2015). The influence of differential response on decision-making in child protective service agencies. *Child abuse & neglect*, *39*, 50-60. doi.org/10.1016/j.chiabu.2014.06.006.

**Jedwab, M., & Benbenishty, R. (2017). Israeli paediatricians' attitudes and experiences of reporting child maltreatment and related training needs. *Child Abuse Review*, *26*(6), 439-450. doi.org/10.1002/car.2468.

**Jenny, C. (2007). Recognizing and responding to medical neglect. *Pediatrics*, *120*(6), 1385-1389.

Johnson, C. F. (1993). Physicians and medical neglect: Variables that affect reporting. *Child abuse & neglect*, *17*(5), 605-612. doi.org/10.1016/0145-2134(93)90082-G.

Johnson, R., Smith, E., & Fisher, H. (2015). Testing the reliability and validity of The Graded Care Profile Version 2 (GCP2). NSPCC. http://www.solihulllscb.co.uk/media/upload/fck/file/GCP/graded-care-profile-2-evaluation-report-large-text.pdf. Accessed 15/01/2018.

**Jones, J., & Gupta, A. (1998). The context of decision-making in cases of child neglect. *Child Abuse Review*, *7*(2), 97-110. doi.org/10.1002/1099-0852.

**Jones, R., Flaherty, E. G., Binns, H. J., Price, L. L., Slora, E., Abney, D., ... & Sege, R. D. (2008). Clinicians' description of factors influencing their reporting of suspected child abuse: report of the

Child Abuse Reporting Experience Study Research Group. *Pediatrics*, *122*(2), 259-266. doi.org/https://doi.org/10.1542/peds.2007-2312.

Kagan, C. (2012). Participatory Action Research and Community Psychology. récupéré de< http://compsy. org. uk/PAR% 20kagan% 20final% 20for% 20web. pdf. Chicago.

Kaplan, S. J., Pelcovitz, D., & Labruna, V. (1999). Child and adolescent abuse and neglect research: A review of the past 10 years. Part I: Physical and emotional abuse and neglect. *Journal of the American Academy of Child & Adolescent Psychiatry*, *38*(10), 1214-1222.

**Karadag, S. Ç., Sönmez, S., & Dereobalı, N. (2015). An investigation of preschool teachers' recognition of possible child abuse and neglect in Izmir, Turkey. *Journal of interpersonal violence*, *30*(5), 873-891.

**Kean, R. B., & Dukes, R. L. (1991). Effects of witness characteristics on the perception and reportage of child abuse. *Child abuse & neglect*, *15*(4), 423-435. doi.org/10.1016/0145-2134(91)90026-A.

**Kenny, M. C. (2001). Child abuse reporting: Teachers' perceived deterrents. *Child abuse & neglect*, *25*(1), 81-92. doi.org/10.1016/S0145-2134(00)00218-0.

**Kenny, M. C. (2004). Teachers' attitudes toward and knowledge of child maltreatment. *Child abuse & neglect*, *28*(12), 1311-1319. doi.org/10.1016/j.chiabu.2004.06.010.

**Kenny, M. C., & McEachern, A. G. (2002). Reporting suspected child abuse: A pilot comparison of middle and high school counselors and principals. *Journal of Child Sexual Abuse*, *11*(2), 59-75. doi.org/10.1300/J070v11n02_04.

Kelly, L., & Jackson, S. (2011). Fit for purpose? Post-qualifying social work education in child protection in Scotland. *Social Work Education*, *30*(5), 480-496. doi.org/10.1080/02615479.2010.516430.

**Kim, D. S. (1986). How physicians respond to child maltreatment cases. *Health & Social Work*, *11*(2), 95-106. doi.org/10.1093/hsw/11.2.95.

**Kirankumar, S. V., Noorani, H., Shivprakash, P. K., & Sinha, S. (2011). Medical professional perception, attitude, knowledge, and experience about child abuse and neglect in Bagalkot district of north Karnataka: A survey report. *Journal of Indian Society of Pedodontics and Preventive Dentistry*, *29*(3), 193. doi.org/10.4103/0970-4388.85807.

* Kvist, T., Malmberg, F., Boovist, A. K., Larheden, H., & Dahllöf, G. (2012). Clinical routines and management of suspected child abuse or neglect in public dental service in Sweden. *Swedish dental journal*, *36*(1), 15-24.

Laming, H. B. (2009). *The protection of children in England: A progress report* (Vol. 330). The Stationery Office.

**Lee, P. Y., Fraser, J. A., & Chou, F. H. (2007). Nurse reporting of known and suspected child abuse and neglect cases in Taiwan. *The Kaohsiung journal of medical sciences*, *23*(3), 128-137. doi.org/10.1016/S1607-551X(09)70387-0.

**Levin, P. G. (1983). Teachers' perceptions, attitudes, and reporting of child abuse/neglect. *Child Welfare*, *62*(1).

Lewin, D., & Herron, H. (2007). Signs, symptoms and risk factors: health visitors' perspectives of child neglect. *Child abuse review*, *16*(2), 93-107. doi. 10.1002/car.949.

**Lusk, V. L., Zibulsky, J., & Viezel, K. (2015). Child maltreatment identification and reporting behavior of school psychologists. *Psychology in the Schools*, *52*(1), 61-76. doi.org/10.1002/pits.21810/.

**Lynne, E. G., Gifford, E. J., Evans, K. E., & Rosch, J. B. (2015). Barriers to Reporting Child Maltreatment Do Emergency Medical Services Professionals Fully Understand Their Role as Mandatory Reporters?. *North Carolina medical journal*, *76*(1), 13-18. doi.org/10.18043/ncm.76.1.13.

MacKeith, J. (2011). The development of the outcomes star: a participatory approach to assessment and outcome measurement. *Housing, Care and Support*, *14*(3), 98-106. doi.org/10.1108/14608791111199778.

Mackeith, J. (2014). Assessing the reliability of the Outcomes Star in research and practice. *Housing, Care and Support*, *17*(4), 188-197. Doi.org/10.1108/HCS-11-2014-0027.

**Madera, D. D. (2007). *Effects of Reporter and Child Characteristics on the Identification and Willingness to Report Child Maltreatment* (Doctoral dissertation, University of Florida).

**Manea, S., Favero, G., Stellini, E., Romoli, L., Mazzucato, M., & Facchin, P. (2007). Dentists' perceptions, attitudes, knowledge, and experience about child abuse and neglect in northeast Italy. *Journal of clinical pediatric dentistry*, *32*(1), 19-26. doi.org/10.17796/jcpd.32.1.f920721252jx3614.

**Markenson, D., Tunik, M., Cooper, A., Olson, L., Cook, L., Matza-Haughton, H., ... & Foltin, G. (2007). A national assessment of knowledge, attitudes, and confidence of prehospital providers in the assessment and management of child maltreatment. *Pediatrics*, *119*(1), e103-e108.

Maslow, A., & Lewis, K. J. (1987). Maslow's hierarchy of needs. *Salenger Incorporated*, 14, 987.

**McCallum, F. (2000). Cross-Cultural Perspectives on Educators' Reporting Practices of Maltreatment: An Australian Study.

McGuigan, W. M., & Pratt, C. C. (2001). The predictive impact of domestic violence on three types of child maltreatment. *Child abuse & neglect*, *25*(7), 869-883. doi. 10.1016/S0145-2134(01)00244-7.

McKeganey, N., Barnard, M., & McIntosh, J. (2002). Paying the price for their parents' addiction: meeting the needs of the children of drug-using parents. *Drugs: education, prevention and policy*, *9*(3), 233-246. doi. org/10.1080/09687630210122508.

McKeown, K. (2012). Inter-agency cooperation between services for children and families in Ireland: does it improve outcomes?. *Journal of Children's Services*, *7*(3), 191-200. doi.org/10.1108/17466661211261370.

**McKittrick, C. A. (1981). Child abuse: recognition and reporting by health professionals. *The Nursing clinics of North America*, *16*(1), 103-115.

McSherry, D. (2007). Understanding and addressing the "neglect of neglect": Why are we making a mole-hill out of a mountain. *Child Abuse & Neglect*, *31*(6), 607-614.

McTavish, J., Kimber, M., Devries, K., Colombini, M., MacGregor, J., Knight, L., & MacMillan, H. (2017). Mandatory reporting: An evidence-based overview and meta-synthesis of qualitative studies. *Manuscript in preparation*.

Melton, G. (2005) Mandated reporting: A policy without reason. *Child Abuse & Neglect*, 29(1):9-18.

Moore, D. L., & Tarnai, J. (2002). Evaluating nonresponse error in mail surveys. In: Groves, R. M., Dillman, D. A., Eltinge, J. L., and Little, R. J. A. (eds.), Survey Nonresponse, John Wiley & Sons, New York, pp. 197–211.

**Moreira, G. A. R., Vasconcelos, A. A., Marques, L. D. A., & Vieira, L. J. E. (2013). Training and knowledge of professionals of the health family team on reporting mistreatment of children and adolescents. *Revista Paulista de Pediatria*, *31*(2), 223-230. doi.org/10.1590/S0103-05822013000200014.

Manso, J. M. M., Sánchez, M. E. G. B., Alonso, M. B., & Romero, J. M. P. (2012). Pragmatic-communicative intervention strategies for victims of child abuse. *Children and Youth Services Review*, *34*(9), 1729-1734.

**Morris, J. L., Johnson, C. F., & Clasen, M. (1985). To report or not to report. *Am J Dis Child*, *139*, 194-197. doi.org/10.1001/archpedi.1985.02140040096037.

**Muehleman, J. T., & Kimmons, C. (1981). Psychologists' views on child abuse reporting, confidentiality, life, and the law: An exploratory study. *Professional Psychology*, *12*(5), 631. doi.org/10.1037/0735-7028.12.5.631.

Mulrow, C. D. (1994). Systematic reviews: rationale for systematic reviews. *BMJ, 309*(6954), 597-599.

Munro E. (2011). *The Munro review of child protection. Final report. A child centred system.* London: Department for Education

**Nalepka, C., O'Toole, R., & Turbett, J. P. (1981). Nurses' and physicians' recognition and reporting of child abuse. *Issues in comprehensive pediatric nursing*, *5*(1), 33-44. doi.org/10.3109/01460868109105381.

Naughton, A. M., Maguire, S. A., Mann, M. K., Lumb, R. C., Tempest, V., Gracias, S., & Kemp, A. M. (2013). Emotional, behavioral, and developmental features indicative of neglect or emotional abuse in preschool children: a systematic review. *JAMA pediatrics*, *167*(8), 769-775. DOI :10.1001/jamapediatrics.2013.192.

*Newcity, A., Ziniel, S., & Needleman, H. (2011). Part 3: neglect. *Journal of the Massachusetts Dental Society*, *60*(3), 28-31. Nottinghamshire Safeguarding Children Board (2017).

**Nightingale, N. N., & Walker, E. F. (1986). Identification and reporting of child maltreatment by Head Start personnel: Attitudes and experiences. *Child Abuse & Neglect*, *10*(2), 191-199. https://doi.org/10.1016/0145-2134(86)90080-3.

Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. *PLoS medicine*, *9*(11), e1001349. doi.org/10.1371/journal.pmed.1001349.

**Noyes, D. M. (1989). *School professionals' knowledge and experience with child abuse and neglect*: Impact on reporting. Science Index (1286-1286).

Nulty, D. D. (2008). The adequacy of response rates to online and paper surveys: what can be done?. *Assessment & evaluation in higher education*, *33*(3), 301-314. doi.org/10.1080/02602930701293231.

Nunnally, J. C. (1978). *Psychometric theory* (2nd ed.). New York: McGraw-Hill.

O'Brien, R. (2001), ''An overview of the methodological approach of action research'', in Richardson, R. (Ed.), *Theory and Practice of Action Research*, Universidade Federal da Paraiba (English version), Joao Pessoa.

Ofsted (2008) *Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008*. London: Ofsted.

Ofsted (2010) *Learning lessons from Serious Case Reviews: Interim Report 2009-2010*. London: Ofsted.

Ofsted (2014), *In the child's time: professional responses to neglect.* www.ofsted.gov.uk/resources/140059.

Olds, D. (2011). Evidentiary Foundations of Nurse-Family Partnership. Retrieved from

https://www.nice.org.uk/guidance/ph40/documents/social-and-emotional-wellbeing-early-years-expert-report-42.

**Olive, S. M., Tuthill, D. P., Maguire, S., Chadwick, B. L., & Hingston, E. J. (2015). G422 Dentists, doctors, nurses and neglect: do you see what i see?. *British Paediatric Allergy Immunology and Infection and British Association for Community Child Health, 100*, *A174-A175.*

**Oloumi-Johnson, R. (2016). *The Lived Experiences of Middle School Counselors in Reporting Abuse and Neglect to Child Protective Services: A Phenomenological Study* (Doctoral dissertation, Sam Houston State University).

Osofsky, J. D. (2003). Prevalence of children's exposure to domestic violence and child maltreatment: Implications for prevention and intervention. *Clinical child and family psychology review*, *6*(3), 161-170. Doi.org/10.1023/A:1024958332093.

**O'Toole, R., Webster, S. W., O'Toole, A. W., & Lucal, B. (1999). Teachers' recognition and reporting of child abuse: A factorial survey. *Child abuse & neglect*, *23*(11), 1083-1101. doi.org/10.1016/S0145-2134(99)00074-5.

**Pakis, I., Demir, F., Bektaş, G., Altun, U., & Yildırim, S. (2015). Investigation of the awareness and knowledge about child abuse

and negligence among doctors and nurses working in the east part of Turkey. *Romanian journal of legal medicine*, *23*(2), 151-156. Doi. 10.4323/rjlm.2015.151.

Phelan, C., & Wren, J. (2006). Exploring reliability in academic assessment. *UNI Office of Academic Assessment*. https://www.uni.edu/ chfasoa/reliabilityandvalidity.htm. Accessed 15/1/18.

Paavilainen, E., & Flinck, A. (2014). The effectiveness of methods designed to identify child maltreatment in social and health care: a systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports*, *12*(1), 90-100. DOI:10.11124/jbisrir-2014-953.

Paavilainen, E., Merikanto, J., Åstedt-Kurki, P., Laippala, P., Tammentie, T., & Paunonen-Ilmonen, M. (2002). Identification of child maltreatment while caring for them in a university hospital. *International journal of nursing studies*, *39*(3), 287-294. doi.10.1016/S0020-7489(01)00035-9.

Paavilainen, E., & Tarkka, M. T. (2003). Definition and identification of child abuse by Finnish public health nurses. *Public Health Nursing*, *20*(1), 49-55. doi. 10.1046/j.1525-1446.2003.20107.

Pathway to Provision (2017). *Multi-Agency Thresholds Guidance for Nottinghamshire Children's Services*. Retrieved from http://www.nottinghamshire.gov.uk/media/119798/pathway-to-provision-handbook-march-2017.pdf.

Peckover, S., & Golding, B. (2017). Domestic abuse and safeguarding children: critical issues for multiagency work. Child abuse review, 26(1), 40-50. DOI:org/10.1002/car.2392.

**Pierce, L., & Bozalek, V. (2004). Child abuse in South Africa: An examination of how child abuse and neglect are defined. *Child Abuse & Neglect*, *28*(8), 817-832. doi.org/10.1016/j.chiabu.2003.09.022.

**Portwood, S. G. (1998). The impact of individuals' characteristics and experiences on their definitions of child maltreatment. *Child abuse & neglect*, *22*(5), 437-452. doi.org/10.1016/S0145-2134(98)00008-8.

**Portwood, S. G., Grady, M. T., & Dutton, S. E. (2000). Enhancing law enforcement identification and investigation of child maltreatment. *Child abuse & neglect*, *24*(2), 195-207. doi.org/10.1016/S0145-2134(99)00135-0.

Price, J. H., Islam, R., Gruhler, J., Dove, L., Knowes, J., & Stults, G. (2001). Public perceptions of child abuse and neglect in a

midwestern urban community. *Journal of Community Health*, 26(4), 271-284. doi. 10.1023%2FA3A1010356528082.

Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N., & Collishaw, S. (2011). Child abuse and neglect in the UK today. http://www.nspcc.org.uk/childstudy.

Raws, P. (2016). Understanding Adolescent Neglect: Troubled Teens. A Study of the Links between Parenting and Adolescent Neglect. *The Children's Society: London. Available: http://www. Childrens society. org. uk/what-we-do/research/troubled-teens-understanding-adolescent-neglect [5 December 2016]*.

**Reimer, E. C. (2014). Using friendship to build professional family work relationships where child neglect is an issue: Worker perceptions. *Australian Social Work*, *67*(3), 315-331. doi.org/10.1080/0312407X.2013.815240.

**Regnaut, O., Jeu-Steenhouwer, M., Manaouil, C., & Gignon, M. (2015). Risk factors for child abuse: levels of knowledge and difficulties in family medicine. A mixed method study. *BMC research notes*, *8*(1), 620. doi.org/10.1186/s13104-015-1607-9.

Renninger, S. M., Veach, P. M., & Bagdade, P. (2002). Psychologists' knowledge, opinions, and decision-making processes regarding child

abuse and neglect reporting laws. *Professional Psychology: Research and Practice*, *33*(1), 19. doi.org/10.1037/0735-7028.33.1.19.

Reynolds, A. J., Mathieson, L. C., & Topitzes, J. W. (2009). Do early childhood interventions prevent child maltreatment? A review of research. *Child Maltreatment*, *14*(2), 182-206. Doi. pdf/10.1177/1077559508326223.

Rose, J. (2011). Dilemmas of Inter-Professional Collaboration: Can they be Resolved?. *Children & Society*, *25*(2), 151-163. DOI: .org/10.1111/j.1099-0860.2009.00268.x

Rose, S. J., & Meezan, W. (1996). Variations in perceptions of child neglect. *Child Welfare*, *75*(2), 139.

**Saulsbury, F. T., & Campbell, R. E. (1985). Evaluation of child abuse reporting by physicians. *American Journal of Diseases of Children*, *139*(4), 393-395. doi.org/10.1001/archpedi.1985.02140060075033.

**Shapira, M., & Benbenishty, R. (1993, June). Modeling judgments and decisions in cases of alleged child abuse and neglect. In *Social Work Research and Abstracts* (Vol. 29, No. 2, pp. 14-19). Oxford University Press. doi.org/10.1093/swra/29.2.14/

Shingler, J., & Mann, R. E. (2006). Collaboration in clinical work with sexual offenders: Treatment and risk assessment. *Sexual offender treatment: Controversial issues*, 225-239.

**Shoop, R. J., & Firestone, L. M. (1988). Mandatory Reporting of Suspected Child Abuse: Do Teachers Obey the Law?. *West's Education Law Reporter*, *46*(3), 1115-22.

* Shor, R. (1998). The significance of religion in advancing a culturally sensitive approach towards child maltreatment. Families in Society: *The Journal of Contemporary Human Services*, 79(4), 400-409. doi. 10.1177/1077559504266800.

**Smith, A. F. (2015). "Child maltreatment: What attitudinal factors of commitment, confidence, and concern predict reporting practices of preservice speech-language pathologists?" *Dissertation Abstracts International: Section B: The Sciences and Engineering* 76(2-B(E)): No Pagination Specified.

Spinetta, J. J. (1978). Parental personality factors in child abuse. *Journal of consulting and clinical psychology*, *46*(6), 1409. doi.org/10.1037/0022-006X.46.6.1409.

Srivastava, O.P. and Hodson, D. (2014) Graded Care Profile version 2 Guidance.

Stevenson, O. (2008). *Neglected children and their families*. John Wiley & Sons.

**Sulimani-Aidan, Y., & Benbenishty, R. (2013). Child maltreatment reports in Israel: The intersection between community socioeconomic characteristics and ethnicity. *American journal of orthopsychiatry*, *83*(1), 29-36. doi.org/10.1111/ajop.12009.

**Suzuki, K., Paavilainen, E., Helminen, M., Flinck, A., Hiroyama, N., Hirose, T., ... & Okamitsu, M. (2017). Identifying and intervening in child maltreatment and implementing related national guidelines by public health nurses in Finland and Japan. *Nursing research and practice*, *2017*. doi.org/10.1155/2017/5936781.

**Talsma, M., Bengtsson Boström, K., & Östberg, A. L. (2015). Facing suspected child abuse–what keeps Swedish general practitioners from reporting to child protective services?. *Scandinavian journal of primary health care*, *33*(1), 21-26. doi.org/10.3109/02813432.2015.1001941.

Taylor, B. J. (2005). Factorial surveys: Using vignettes to study professional judgement. *British Journal of Social Work*, *36*(7), 1187-1207. doi.org/10.1093/bjsw/bch345.

Thoburn, J. (2009). *Effective interventions for complex families where there are concerns about, or evidence of, a child suffering*

significant harm. London: Centre for Excellence and Outcomes for Children (C4EO).

**Thomas, J. E., Straffon, L., & Inglehart, M. R. (2006). Knowledge and professional experiences concerning child abuse: an analysis of provider and student responses. *Pediatric dentistry*, *28*(5), 438-444.

**Tilvawala, D., Murray, C., Farah, R., & Broadbent, J. M. (2014). New Zealand dental therapists' beliefs regarding child maltreatment. *Australian and New Zealand journal of public health*, *38*(5), 480-484. doi.org/10.1111/1753-6405.12238.

**Tite, R. (1993). How teachers define and respond to child abuse: The distinction between theoretical and reportable cases. *Child Abuse & Neglect*, *17*(5), 591-603. doi.org/10.1016/0145-2134(93)90081-F.

**Tiyyagura, G., Gawel, M., Koziel, J. R., Asnes, A., & Bechtel, K. (2015). Barriers and facilitators to detecting child abuse and neglect in general emergency departments. *Annals of emergency medicine*, *66*(5), 447-454. doi.org/10.1016/j.annemergmed.2015.06.020.

**Truman, P. (2004). Problems in identifying cases of child neglect. *Nursing Standard (through 2013)*, *18*(29), 33.

**Tufford, L., Bogo, M., & Asakura, K. (2015). How Do Social Workers Respond to Potential Child Neglect?. *Social Work Education*, *34*(2), 229-243. doi.org/10.1080/02615479.2014.958985.

**Turbett, J. P., & O'Toole, R. (1983). Teachers' recognition and reporting of child abuse. *Journal of School Health*, *53*(10), 605-609. doi.org/10.1111/j.1746-1561.1983.tb01119.x.

Turney, D., & Tanner, K. (2005). Understanding and working with neglect. *Research and Practice Briefings: Children and Families*, *10*, 1-8.

**Uldum, B., Christensen, H. N., Welbury, R., & Poulsen, S. (2010). Danish dentists' and dental hygienists' knowledge of and experience with suspicion of child abuse or neglect. *International journal of paediatric dentistry*, *20*(5), 361-365. doi.org/10.1111/j.1365-263X.2010.01070.

Van Haeringen, A. R., Dadds, M., & Armstrong, K. L. (1998). The child abuse lottery—will the doctor suspect and report? Physician attitudes towards and reporting of suspected child abuse and neglect. *Child abuse & neglect*, *22*(3), 159-169. doi.org/10.1016/S0145-2134(97)00172-5.

**VanBergeijk, E., & Sarmiento, T. (2005). On the border of disorder: School personnel's experiences reporting child abuse on

the US-Mexico border. *Brief treatment and crisis intervention*, *5*(2), 159. doi.org/10.1093/brief-treatment/mhi015.

**Vanbergeijk, E. O. (2007). Mandated reporting among school personnel: Differences between professionals who reported a suspected case and those who did not. *Journal of Aggression, Maltreatment & Trauma*, *15*(2), 21-37. doi.org/10.1300/J146v15n02_02.

****Vulliamy, A. P., & Sullivan, R. (2000). Reporting child abuse: pediatricians' experiences with the child protection system. *Child abuse & neglect*, *24*(11), 1461-1470. doi.org/10.1016/S0145-2134(00)00199-.

**Waibel-Duncan, M. K. (2006). Prospective nurses' appraisals of screening for child neglect in primary care settings. *Pediatric nursing*, *32*(1), 13.

Wallace, I., & Bunting, L. (2007). *An examination of local, national and international arrangements for the mandatory reporting of child abuse: The implications for Northern Ireland*. NSPCC Northern Ireland.

* Walsh, K., Bridgstock, R., Farrell, A., Rassafiani, M., & Schweitzer, R. (2008). Case, teacher and school characteristics influencing teachers' detection and reporting of child physical abuse and

neglect: Results from an Australian survey. *Child Abuse & Neglect*, *32*(10), 983-993. doi..org/10.1016/j.chiabu.2008.03.002.

Weaver, I. C. (2009). Shaping adult phenotypes through early life environments. *Birth Defects Research Part C: Embryo Today: Reviews*, *87*(4), 314-326.**:** 10 doi.1002/bdrc.20164.

**Welbury, R. R., MacAskill, S. G., Murphy, J. M., Evans, D. J., Weightman, K. E., Jackson, M. C., & Crawford, M. A. (2003). General dental practitioners' perception of their role within child protection: a qualitative study. *European Journal of Paediatric Dentistry*, *4*, 89-95.

**Wells, S. J. (1994). Child protective services: research for the future. *Child Welfare*, *73*(5), 431. https://doi.org/10.1016/S0190-7409(03)00044-6.

Widom, C. S., DuMont, K., & Czaja, S. J. (2007). A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. *Archives of general psychiatry*, *64*(1), 49-56. doi:10.1001/archpsyc.64.1.49

Wilding, J., & Thoburn, J. (1997). Family support plans for neglected and emotionally maltreated children. *Child Abuse Review*, *6*(5), 343-356. doi. 10.1002/(SICI)1099-0852(199712)6:5<343::AID-CAR356>3.0.CO;2.

Wills, R., Ritchie, M., & Wilson, M. (2008). Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach. *Journal of Paediatrics and Child Health*, *44*(3), 92-98. doi.org/10.1111/j.1440-1754.2007.01276.x

Wilson, C. A., & Gettinger, M. (1989). Determinants of child-abuse reporting among Wisconsin school psychologists. *Professional School Psychology*, *4*(2), 91. doi.org/10.1037/h0090583.

Wittink, D. R., & Bayer, L. R. (2003). The measurement imperative. *Marketing Research*, *15*(3), 19-19.

Wilson, C. A., & Gettinger, M. (1989). Determinants of child-abuse reporting among Wisconsin school psychologists. *Professional School Psychology*, *4*(2), 91. doi.org/10.1037/h0090583.

Wolock, I., & Horowitz, B. (1984). Child maltreatment as a social problem: the neglect of neglect. *American Journal of Orthopsychiatry*, *54*(4), 530. doi.org/10.1111/j.1939-0025.1984.tb01524.x.

Wolfe, D. A., Edwards, B., Manion, I., & Koverola, C. (1988). Early intervention for parents at risk of child abuse and neglect: A

preliminary investigation. *Journal of Consulting and Clinical Psychology*, *56*(1), 40.

Wright, R. J., Wright, R. O., Farnan, L. O. R. I., & Isaac, N. E. (1999). Response to child abuse in the pediatric emergency department: need for continued education. *Pediatric emergency care*, *15*(6), 376-382.

Yehuda, R., Flory, J. D., Pratchett, L. C., Buxbaum, J., Ising, M., & Holsboer, F. (2010). Putative biological mechanisms for the association between early life adversity and the subsequent development of PTSD. *Psychopharmacology*, *212*(3), 405-417.

York Consulting (2013). Family Action Family Star Evaluation: Summary Report. Family Action website www.family-action.org.uk.

Zellman, G. L. (1990). Report decision-making patterns among mandated child abuse reporters. *Child abuse & neglect*, *14*(3), 325-336. doi. org/10.1016/0145-2134(90)90004-D.

*Zellman, G. L., & Bell, R. M. (1990). *The Role of Professional Background, Case Characteristics, and Protective Agency Response in Mandated Child Abuse Reporting*. Rand Corporation, 1700 Main St., Santa Monica, CA 90406-2138.

*References included in systematic review

**References excluded from systematic review

Appendices

Appendix 2.1: OVID PsychINFO search syntax

1. maltreat*.ab,ti.

2. mistreat*.ab,ti.

3. exp Child Abuse/ or child w abus*.ab,ti.

4. exp CHILD NEGLECT/ or neglect*.ab,ti.

5. negligent.ab,ti.

6. (neglect* w parent* or emotion* w neglect*).ab,ti.

7. child*.ab,ti.

8. adolescen*.ab,ti.

9. infan*.ab,ti.

10. pre$school*.ab,ti. or exp PRESCHOOL STUDENTS/

11. exp Elementary School Students/ or school$child*.ab,ti.

12. exp Social Workers/ or exp Medical Personnel/ or exp Health Personnel/ or exp Social Casework/ or profession*.ab,ti.

13. exp Physicians/ or exp General Practitioners/ or doctor*.ab,ti.

14. general w practitioner*.ab,ti.

15. exp PHYSICIANS/ or exp FAMILY PHYSICIANS/ or physician*.ab,ti.

16. exp Pediatricians/ or paediatrician*.ab,ti.

17. (dentist* or dental w practitoner*).ab,ti.

18. nurse*.ab,ti. or exp NURSES/ or exp SCHOOL NURSES/

19. teacher*.ab,ti. or exp TEACHER/

20. exp CLINICIANS/ or clinician*.ab,ti.

21. exp PSYCHIATRISTS/ or psychiatrist*.ab,ti.

22. exp Clinical Psychologists/ or exp Psychologists/ or exp School Psychologists/ or psychologist*.ab,ti. or exp Educational Psychologists/

23. police.ab,ti.

24. exp POLICE PERSONNEL/

25. health w visitor*.ab,ti.

26. exp Social Services/ or exp Social Workers/ or social w worker*.ab,ti.

27. social w services.ab,ti.

28. school w counse$lor*.ab,ti.

Inclusion criteria	Criterion met?	Comment

29. exp PARAPROFESSIONAL PERSONNEL/ or paraprofessional*.ab,ti.

30. protective w services.ab,ti. or exp Protective Services/

31. exp Abuse Reporting/ or exp Child Abuse Reporting/

32. (report* or decision w making).ab,ti.

33. (notic* or recogni* or identif*).ab,ti.

34. exp Professional Referral/ or exp Decision Making/ or refer*.ab,ti.

35. exp Intervention/ or professional* w interven*.ab,ti.

36. 1 or 2 or 3 or 4 or 5 or 6

37. 7 or 8 or 9 or 10 or 11

38. 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30

39. 31 or 32 or 33 or 34 or 35

40. 36 and 37 and 38 and 39

1. Topic: Study addresses child neglect (child: aged between 0-18)	Yes Unclear No
2. Topic: Study addresses individuals likely to be exposed to signs of child neglect	Yes Unclear No
3. Topic: Study addresses internal or external barriers to reporting their suspicions, or factors that increase likelihood to report	Yes Unclear No
4. Topic: Neglect is clearly defined.	Yes Unclear No
5. Methods: Cohort OR case control OR cross-sectional OR RCT	Yes Unclear No
6. Methods: Clear description of method of data collection	Yes Unclear No
7. Methods: Quantitative data collected	Yes Unclear No
8. Methods Neglect not individually analysed	Yes Unclear No

Appendix 2.2: Inclusion Criteria

Appendix 2.3: Quality assessment form

Question	Rating	Comments
Are the results of the study valid?		
Screening/threshold questions		
1. Population – those exposed to CAN		
2. Factors impacting on action/reporting		
3. Definition of child neglect		
4. Criteria for inclusion explicit		
Sampling and selection bias		
5. Participants clearly defined (who and where from)		
6. Cohort representative of defined professional group (age, gender)		
7. Were demographics of participants clear? (e.g. age, gender)		
8. Power calculation reported		
9. Established reliable system to select participants (Surveys, e-mails, phone calls)		
Measurement bias for exposure		
10. Method clearly described		

11. Are the measures appropriate (think vignettes, questionnaires etc)		
12. Are the measures validated		
Measurement bias for outcome		
13. Were the outcomes clearly defined		
14. Was missing data discussed		
Attrition bias		
15. Response rate stated		
16. Withdrawal of data		
Other issues		
17. Was the statistical analysis appropriate?		
18. Assumptions of data tested		
Will the results help locally		
19. Can the results be applied to the local population (generalizable to the same professionals or similar professionals)?		
20. Do the results of this study fit with other available evidence?		
21. Are the implications of this study for practice discussed?		
Quality rating		Y = 2, P = 1, N = 0, U = Unclear
No.		

unclear		

Appendix 2.4: Quality assessment outcome (Part one)

Are the results of this study valid? Screening questions	Selection bias								Measurement bias (exposure)			
Cross sectional	1	2	3	4	5	6		7	8		9	
Adair et al. (1997)	2	2	0	1	2	2	2	0	2	2	2	0
Alnasser et al. (2017)	2	2	2	1	2	2	2	0	2	2	2	0
Ashton (1999)	2	2	2	1	1	1	2	2	1	2	2	0
Beck and Ogloff (1995)	2	2	0	1	1	2	2	0	1	2	2	0
Burgess et al. (2014)	2	2	2	1	2	2	1	0	2	2	2	0
Canella (2008)	2	2	2	2	2	2	2	2	2	2	2	2
Craft and Staudt (1991)	2	2	0	1	2	2	2	0	U	1	2	0
Crenshaw, Crenshaw and Lichtenberg (1995)	2	2	0	1	2	2	2	0	2	1	2	2
Fung and Chow (1998)	2	2	0	1	2	2	2	0	2	2	2	0
Fraser et al. (2010)	2	2	2	2	2	2	2	0	2	2	2	0
Kvist et al. (2012)	2	2	2	1	2	2	0	0	2	2	2	0
Newcity, Ziniel, and Needleman (2011)	2	2	2	2	2	2	2	0	2	2	2	0
Shor (1998)	2	2	0	1	2	2	2	0	2	2	2	1
Walsh et al. (2008)	2	2	0	1	2	2	2	0	2	2	2	2
Zellman and Bell (1990)	2	2	0	2	2	2	2	0	2	2	2	0
Randomised Control trial	1	2	3	4	5	6	7	8	9	10	11	12
Hawkins and McCallum (2001)	2	2	0	2	2	2	2	0	2	2	2	2

Appendix 2.5: Quality Assessment outcome (Part two)

Are the results of this study valid? Measurement bias (outcome)			Attrition bias		Other issues	Will the results help locally?			Total	
Quality Cross sectional rating (42)	13	14	15	16	17	18	19	20	21	unclear
Adair et al. (1997)	2	0	2	0	2	U	2	2	2	1	29
Alnasser et al. (2017)	2	0	2	0	2	U	2	2	2	1	31
Ashton (1999)	2	0	0	0	2	U	1	2	2	1	27
Beck and Ogloff (1995)	2	0	2	0	2	U	2	2	2	1	27
Burgess et al. (2014)	1	0	2	0	1	U	2	2	2	1	28
Canella (2008)	2	2	2	2	2	2	2	2	2	0	42
Craft and Staudt (1991)	2	0	2	2	2	U	2	2	2	2	28
Crenshaw, Crenshaw and Lichtenberg (1995)	2	0	2	1	2	U	2	2	2	1	31
Fung and Chow (1998)	2	0	2	0	1	0	1	1	1	0	25
Fraser et al. (2010)	2	0	2	0	2	2	2	2	2	0	34
Kvist et al. (2012)	2	0	2	2	2	U	2	2	2	1	31
Newcity, Ziniel, and Needleman (2011)	2	0	2	0	2	U	2	2	2	1	32
Shor (1998)	2	0	2	0	2	U	2	2	2	1	30
Walsh et al. (2008)	2	0	2	2	2	2	2	2	2	0	35
Zellman and Bell (1990)	2	0	2	2	2	2	2	2	2	0	32
Randomised Control Trial	13	14	15	16	17	18	19	20	21	Total unclear	Quality rating (42)
Hawkins and McCallum (2001)	2	0	2	0	2	2	2	0	2	0	32

Appendix 2.6: Data extraction form

Reference:	
Tool used	
Country	
Mandatory reporting law	
Study design	
Profession	
Participant no.	
Age	
Gender	
Response rate	
Variables affecting reporting/taking action	
Variables not affecting reporting/taking action	

Appendix 2.7: References excluded after PEO (130)

Reference	Reason for exclusion
Abrahams, N., et al. (1992)	Study design (neglect not distinguished)
Al-Amad, S. H., et al. (2016)	Study design (neglect not distinguished)
Al-Dabaan, R., Newton, J. T. and Asimakopoulou, K. (2014)	Study design (neglect not distinguished)
Al-Moosa, A. et al. (2003)	Study design (neglect not distinguished)
Ards, S. and A. Harrell (1993)	Study design (neglect not distinguished)
Ashton, V. (2004)	Study design (neglect not distinguished)
Ashton, V. (2007)	Study design (neglect not distinguished)
Azevedo, M. S., et al. (2012)	Study design (neglect not distinguished)
Badger, L.W. (1989)	Study design (neglect not distinguished)
Bankole, O. O., Denloye, O. O., and Adeyemi, A. T. (2008)	Study design (neglect not distinguished)
Buljan Flander, G., Nikša Tarabić, B., and Čuković-Bagić, I. (2015)	Study design (neglect not distinguished)
Bavolek, Stephen J. (1983)	Study design (neglect not distinguished)
Beck, K. A. et al. (1994)	Intervention
Beck, K. A. et al. (2000)	Study design
Ben-Arieh, A. (2015)	Study design (neglect not distinguished)
Benbenishty, R. et al. (2011)	Study design and Intervention
Boss. K. A. (2014)	Study design (neglect not distinguished)
Bonardi, D. J. (2000)	Study design (neglect not distinguished)
Borres, M. P. and A. Hagg (2007)	Study design (neglect not distinguished)
Bryant, J. and A. Milsom (2005)	Study design (neglect not distinguished)
Buljan Flander, G., Gordana Nikša Tarabić, B., and Čuković-Bagić, I. (2015)	Study design (neglect not distinguished)
Bsoul, S. A., et al. (2003)	Study design (neglect not distinguished)
Carr, A. (1972)	Study design (neglect not distinguished)

Chadwick, B. L., et al. (2009)	Study design
Clark-Jones, F. (1992)	Study design (neglect not distinguished)
Coohey, C.(2003)	Intervention
Coope, C. M., and Theobald, S. (2006)	Study design
Craig, M. E. et al., 1987)	Study design
Crowell, K, and Levi, B. H. (2012)	Study design and Intervention
Cukovic-Bagic, I., et al. (2015).	Study design (neglect not distinguished)
Dalzell, D. P., Bajaj, R. and Hunter, J. (2002)	Study design (neglect not distinguished)
da Silva, R. A., et al. (2014)	Study design (neglect not distinguished)
Davidson-Arad, B., et al., (2003)	Study design (neglect not distinguished)
Davidson-Arad, B., and Benbenishty, R. (2010)	Intervention
Davidson-Arad, B., and Benbenishty, R. (2016)	Intervention
Dickerson, K. L., et al. (2017)	Intervention
Dobrin, L. (2007)	Study design
Dobrin, L., and Rosenzweig, J. (2005)	Study design (neglect not distinguished)
Dyer, E. M. (2007)	Study design (neglect not distinguished)
Eisbach, S. S. and M. Driessnack (2010)	Study design (neglect not distinguished)
Falkiner, M., Thomson, D., and Day, A. (2017)	Study design (neglect not distinguished)
Farmer. E., and Lutman, E. (2014)	Study design
Fayez, M., Takash, H. M., and E. M. Al-Zboon (2014)	Study design (neglect not distinguished)
Feng, J.-Y., et al. (2010)	Study design (neglect not distinguished)
Fieten, J. A. (2007)	Study design (neglect not distinguished)
Flaherty, E. G., et al. (2006)	Study design (neglect not distinguished)
Flander, G. B., et al. (2015)	Study design (neglect not distinguished)
Francis, K., et al. (2012)	Study design (neglect not distinguished)
Girgus, J. S. (2010)	Study design (neglect not distinguished)
Glasser, S. and W. Chen (2006)	Study design (neglect not distinguished)
Goebbels, A., et al. (2008)	Study design (neglect not distinguished)

Gunn, V. L., et al. (2005)	Study design (neglect not distinguished)
Habib, H. S. (2012)	Study design (neglect not distinguished)
Harris, J. C., et al. (2009a)	Study design (neglect not distinguished)
Harris, J. C., et al. (2009b)	Study design
Harris, C. M., et al. (2013)	Study design (neglect not distinguished)
Herendeen, P. A., et al. (2014)	Study design (neglect not distinguished)
Hillman, S. J., and Siracusa, A. J. (1995)	Intervention
Horwath, J. (2005)	Study design
Janczewski, C. E. (2015)	Intervention
Jedwab, M. and R. Benbenishty (2017)	Study design (neglect not distinguished)
Jenny, C. (2007)	Study design
Jones, J. and A. Gupta (1998)	Study design
Jones, R., et al. (2008)	Study design (neglect not distinguished)
Karadag, S. C., et al. (2015)	Study design (neglect not distinguished)
Kean, R. B. and R. L. Dukes (1991)	Study design (neglect not distinguished)
Kenny, Maureen C. (2001)	Study design (neglect not distinguished)
Kenny, M. C. (2004)	Study design (neglect not distinguished)
Kenny, M. C. and A. G. McEachern (2002)	Intervention
Kelly, L., and Jackson S. (2011)	Study design (neglect not distinguished)
Kim, D. S. (1986)	Study design (neglect not distinguished)
Kirankumar, S. V., et al. (2011)	Study design (neglect not distinguished)
Lee, P. Y., et al. (2007)	Study design (neglect not distinguished)
Levine, P.G. (1983)	Study design (neglect not distinguished)
Lewin, D., and Herron, H., (2007)	Intervention
Lusk, V. L., et al. (2015)	Study design (neglect not distinguished)
Lynne, E. G., et al. (2015)	Study design (neglect not distinguished)
Madera, D. D. (2007)	Study design (neglect not distinguished)
Manea, S., et al. (2007)	Study design
Markenson, D., et al. (2007)	Study design (neglect not

	distinguished)
McCallum, F. (2000)	Study design (neglect not distinguished)
McKittrick, C. A. (1981)	Study design (neglect not distinguished)
Merza, A., et al. (2013)	Study design (neglect not distinguished)
Moreira, G. A., et al. (2013)	Intervention
Moreira, G. A., et al. (2014)	Study design (neglect not distinguished)
Manso J. M. M., et al. (2012)	Study design (neglect not distinguished)
Morris, J. L., et al. (1985)	Study design and Intervention
Muehleman, T. and C. Kimmons (1981)	Study design
Nalepka, C., O'Toole, R., and Turbett, J. P. (1981)	Study design (neglect not distinguished)
Nightingale, N. N., and Walker, W. F. (1986)	Study design (neglect not distinguished)
Noyes, D. M. (1987)	Study design (neglect not distinguished)
Olive, S. M., et al. (2015)	Intervention
Oloumi-Johnson, R (2016)	Study design
O'Toole, R., et al. (1999)	Study design (neglect not distinguished)
Pakis, I. et al., (2015)	Study design (neglect not distinguished)
Paradise, J. E., et al. (1997	Study design (neglect not distinguished)
Pierce A. L., and Bozalekb, V. (2004)	Intervention
Portwood, S. G. (1998)	Intervention
Portwood, S. G., Grady, M. T., and Dutton, S. E., (2000)	Study design (neglect not distinguished)
Ramesh, G., et al. (2014)	Study design (neglect not distinguished)
Reimer, E. C. (2014)	Intervention
Regnaut, O. et al., (2015)	Study design (neglect not distinguished)
Renninger, S. M., Veach, P. M. and Bagdade, P (2002)	Study design (neglect not distinguished)
Saulsbury, F. T., and Campbell, R. E. (1985)	Study design (neglect not distinguished)
Shapira, M. and R. Benbenishty (1993)	Study design (neglect not distinguished)
Shoop, R. J., and Firestone, L. M. (1988)	Intervention
Smith, A. F. (2015)	Study design (neglect not distinguished)
Sulimani-Aidan, Y. and	Study design (neglect not

Benbenishty, R. (2013)	distinguished)
Suzuki, K. et al., (2017)	Study design (neglect not distinguished)
Talsma, M., Bengtsson Bostrom, K. and Ostberg, A. L. (2015)	Study design (neglect not distinguished)
Thomas, J. E., Straffon, L., and Inglehart, M. R. (2006)	Study design (neglect not distinguished)
Tilvawala, D., et al. (2014)	Study design (neglect not distinguished)
Tite, R. (1993)	Study design (neglect not distinguished)
Tiyyagura, G. et al., (2015)	Study design (neglect not distinguished)
Truman, P. (2004)	Intervention
Tufford, l., Bogo, M., and Asakura, K. (2014)	Study design
Turbett, J. P., and O'Toole, R. (1983)	Study design (neglect not distinguished)
Uldum, B. et al., (2010)	Study design (neglect not distinguished)
Van Haeringen, A. R., Dadds, M., and Armstrong, K. L. (1998)	Study design (neglect not distinguished)
Vanbergeijk, E., and Sarmiento, T. (2005)	Study design (neglect not distinguished)
VanBergeijk, E. O. (2007)	Study design (neglect not distinguished)
Vulliamy, A. P. and R. Sullivan (2000)	Study design
Waibel-Duncan, M. K. (2006)	Intervention and Intervention
Welbury, R. R. et al. (2003)	Study design (neglect not distinguished)
Wells, S. J. (1994)	Study design (neglect not distinguished)
Wesley, K. and K. Wesley (2015)	Study design
Wilson, C. A. and M. Gettinger (1989)	Study design (neglect not distinguished)
Wright, R. J., et al. (1999)	Study design (neglect not distinguished)
Yehuda, Y. B., et al. (2010)	Study design (neglect not distinguished)
Zellman, Gail L. (1990)	Study design (neglect not distinguished)

Appendix 3.1: Information sheet and consent form



Participant Questionnaire Information Sheet

Final version 1.0: 31.03.2016

Title of Study: Perceptions and Understanding of Child Maltreatment

Name of Researcher(s): Dr Shihning Chou, Dr Danya Glaser, Lydia Bullock (Student)

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Please read through this information sheet, which will explain the nature of the study as well as what you will be expected to do. If you have any questions regarding the study, please feel free to email the researcher. You will find her contact details at the end of this sheet.

What is the purpose of the study?

The purpose of this study is to explore and have a better understanding of individuals' knowledge and perceptions of child maltreatment. These results can hopefully build a better picture as to whether more education or training is needed to improve the overall understanding and thus protection of children.

Why have I been invited?

You are being invited to take part in the study because you are over the age of 18, have access to the internet (to complete the questionnaire), are able to read English, reside in the UK and are able to give informed consent. We are inviting 159 other participants like you to take part

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, please complete the online questionnaire – completion and submission of the questionnaire will imply your consent. If you decide to take part, you are still free to withdraw from the study at any time and without giving a reason (just close the browser window). This would not affect your legal rights.

What will happen to me if I take part?

If you agree to take part in this study you will be asked to complete an online questionnaire. The questionnaire will be formed of 2 parts and should take no longer than 30minutes.

You will be asked to provide demographic information e.g. your age and profession before continuing to reading vignettes and answering subsequent questions.

At the end of the questionnaire there is a space to leave an email address if you are a primary/infant school teacher or family support worker/health visitor and would be interested in participating in a focus group.
There will be no follow-up questionnaires.

Expenses and payments

Participants will not be paid to participate in the

What are the possible disadvantages and risks of taking part?

Participants will be asked to read and make decisions on vignettes describing child maltreatment. For some individuals the topic of child maltreatment can be distressing to think and read about; however the questionnaire uses fictional vignettes and have been designed not to be too emotive or distressing in their description. If you believe that this will be too distressing for yourself then please do not partake in the questionnaire.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help develop a further and more detailed understanding of individuals' perceptions of child maltreatment and potentially where future research, funding and education is needed.

What happens when the research study stops?

When the study stops, the results will be collected and analysed. The research will be written up as part of an academic thesis. They may also be submitted for publication in an academic journal. Your name will not be associated with any of the results, and only members of the research team will have access to the data.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researcher who will answer your questions. The researcher's contact details are given at the end of this information sheet. If you remain unhappy, you can contact the researcher's supervisor. These contact details are also at the end of this

information sheet. If you continue to remain unhappy and wish to complain formally, you should contact the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, School of Medicine Education Centre, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. Email: louise.sabir@nottingham.ac.uk

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database.

You will not be asked to provide your name so that answering the questionnaire will remain anonymous. If you would like to participate in the focus group and leave a contact email address this will not be attached to your questionnaire ensuring that your answers remain anonymous.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to the data.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected (just close the browser window). If you withdraw after you have submitted your completed questionnaire then the information collected so far cannot be erased (it will be anonymous so won't know which one is yours) and this information may still be used in the project analysis.

What will happen to the results of the research study?

The results of this research will be written up as part of an educational qualification, the researcher's Doctorate thesis. In addition the results may be published within a year or two of completing the research. No participants will be identified in any reports, thesis or publications.

Who is organising and funding the research?

This research is being organised by the University of Nottingham.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by University of Nottingham's Faculty of Medicine and Health Sciences' Research Ethics Committee.

Further information and contact details

Researcher's name: Lydia Bullock
Researcher's e-mail address: lwxlrb@nottingham.ac.uk

Supervisor's name: Shihning Chou
Supervisor's e-mail address: Shihning.Chou@nottingham.ac.uk

Supervisor's name: Danya Glasbrook
Supervisor's email address: d.glaser@ucl.ac.uk

PARTICIPANT CONSENT

Centre for Forensic & Family Psychology
Division of Psychiatry & Applied Psychology
School of Medicine, Faculty of Medicine & Health Sciences

Final version 1.0: 31.03.2016

Title of Study: Perceptions and Understanding of Child Maltreatment

Name of Researcher(s): Dr Shihning Chou, Dr Danya Glaser, Lydia Bullock (Student)

Please, tick each box to continue:

- ○ I confirm that I have read and understood the information on the previous page
- ○ I understand that my participation is voluntary and I can end the study at any time and withdraw my data by clicking the EXIT browser button .
- ○ I understand that my answers will be anonymous.
- ○ I understand the overall anonymized data from this study may be used in the future for research (with research ethics approval) and teaching purposes.

NEXT – to be taken to the survey.

I have read and understood the participant information and consent form, I confirm that I am 18 years old or older and by clicking the NEXT button to begin the online questionnaire, I indicate my willingness to voluntarily take part in the study.

NEXT – I consent to take part EXIT - I do not give consent

Appendix 3.2: Demographic information

1. Gender: Male/female

2. Age:

3. Ethnicity:

4. Occupation:

b) Years in current occupation (if applicable – please write N/A if not)

c) Highest level of qualification relevant to your current profession

5. Current country of residence:

Appendix 3.3: Online Questionnaire

Online Questionnaire

Final version 1.0: 31.03.2016

Title of Study: Perceptions and understanding of child maltreatment

Name of Researcher(s): Dr Shihning Chou, Dr Danya Glaser, Lydia Bullock (Student)

Thank you for taking the time to complete this questionnaire. It is divided into two sections. The first section will ask you some questions about yourself. The second section will contain 8 short vignettes and associated questions. We will be grateful if you can answer all the questions as far as possible.

Section 1: Demographics information

1. Gender: Male/female

2. Age:

3. Ethnicity:

4. Occupation:

b) Years in current occupation (if applicable – please write N/A if not)

c) Highest level of qualification relevant to your current profession

5. Current country of residence:

Section 2: vignettes

There are nine different scenarios described below. Please read each one carefully and answer the questions that follow. It is important to state that the level of information given is limited, and in real life more information would most likely be gathered before a decision is made. Despite this it would be much appreciated if you could make a best decision on the basis of the information provided.

The term *carer* refers to any individual who has a legal and/or parental responsibility to care for the child.

Vignettes

1. *A 4-year-old child lives with his/her mother. The father left the home having been served a court order to have no contact with the family due to domestic violence against the mother a few months ago.* The child mostly plays by him/herself and spends little time with his/her mother. The mother does not tend to interact with the child or offer praise. The mother does not show much affection to the child or reach out to comfort them when distressed. The child will at times inappropriately attention seek and at other times be withdrawn and choose to play in isolation.

2. A 4-year-old child mostly plays by him/herself and spends little time with his/her carer(s). They do not tend to interact with the child or offer praise. They do not show much affection to the child or reach out to comfort them when distressed. The child will at times inappropriately attention seek and at other times be withdrawn and choose to play in isolation.

3. *A 4-year-old child lives with his/her mother. The father left the home after been served a court order to have no contact with the family due to domestic violence against the mother a few months ago.* The child often looks dirty with their clothes looking unwashed and smelling. They are often not dressed for the weather lacking a coat when it is cold. The child is small for his/her age and frequently complains of being hungry.

4. A 4-year-old child often looks dirty with their clothes looking unwashed and smelling. They are often not dressed for the weather lacking a coat when it is cold. The child is small for his/her age and frequently complains of being hungry.

5. *A 4-year-old child lives with its mother. The father left the home having been served a court order to have no contact with the family due to domestic violence against the mother a few months ago.* Occasionally due to unforeseen circumstances both parents are back an hour or so later than planned and so leave the child in the responsibility of its 15-year old sibling.

6. Occasionally due to unforeseen circumstances both parents are back an hour or so later than planned and so leave the child in the responsibility of its 15-year old sibling.

Questions underneath each vignette

1. Based on the information provided how worrying is this scenario?

1 2 3 4 5 6 7 8 9 10

Not at all
Extremely

2. How severely do you believe this experience could be affecting the child now?

1 2 3 4 5 6 7 8 9 10

Not at all
Extremely

3. How severely do you think this experience could affect the child in future when they will be a young teenager?

1 2 3 4 5 6 7 8 9 10

Not at all
Extremely

4 a) How likely are you to take action on this situation?

1 2 3 4 5 6 7 8 9 10

Not at all
Extremely

b) What specific actions would you consider taking in this situation

(NOTE: answer N/A if unlikely to take action)

c) What are your reasons for your chosen decision?

(Option to tick rather not say)

5 a) How likely are you to report this situation?

1 2 3 4 5 6 7 8 9 10

Not at all Extremely

b) Which agency would you report this situation to?

(NOTE: answer N/A if unlikely to report)

c) What are your reasons for your chosen decision?

(Option to tick rather not say)

6 a) Would you identify this scenario as maltreatment?

Yes No Don't know

(Option to tick rather not say)

b) If answered yes: please explain and identify maltreatment in situation

Appendix 3.4: Participant debrief sheet

Title of Study: Perceptions and understanding of child maltreatment

Final version 1.0: 31.03.2016

Name of Researcher(s): Dr Shihning Chou, Dr Danya Glaser, Lydia Bullock (Student)

Thank you for taking the time to complete this questionnaire your input has been very much appreciated. This study was looking into child maltreatment and in particular the identification and understanding surrounding child neglect.

Once all the data is collected it will be analysed and written up as part of a Doctorate thesis. If you would like a summary of the results feel free to contact Lydia Bullock or Shihning Chou on the email below. In addition if you have any further questions please do not hesitate to get in contact on the email below:

lwxlrb@nottingham.ac.uk

shihning.chou@nottingham.ac.uk

If you have been negatively affected by the research or require any further information you can contact the following support lines

NSPCC – 08088005000

Action for Children - 01923 361 500

PLEASE NOTE:

If you are a family support worker or primary/infant school teacher in the Nottinghamshire area and would be interested in participating in a short focus group please click the link below for more details.

LINK

Appendix 4.1: Focus group information sheet and consent form



Information sheet

Final version 1.0: 31.03.2016

Title of Study: Perceptions and understanding of child maltreatment

Name of Interviewer: Lydia Bullock
Name of Supervisors: Dr Shihning Chou, Dr Danya Glaser

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Please read through this information sheet which will explain the nature of the study as well as what you will be expected to do. If you have any questions regarding the study, please feel free to email the researcher. You will find her contact details at the end of the sheet. On the day of the focus group time will be given to ask any further questions you have. Talk to others about the study if you wish. Ask if there is anything that is not clear.

What is the purpose of the study?

The purpose of this study is to explore your professional opinions and perceptions in relation to child neglect. This focus group is hoping to gain some information into how you as professionals feel confident in defining, identifying and reporting neglect and the difficulties surrounding this. It is important to stress that this is not an exercise to point blame at professionals but instead highlight if there are difficulties and your opinions on how best to address them.

Why have I been invited?

You are being invited to take part because you work in a profession that involves working with children (and potentially their families). You will have varied experiences in this area and your opinions are very important to help inform a better understanding of child neglect.
We are inviting 8 teachers and 8 family support workers/health visitors to take part. There will be two focus groups, one of teachers and one of family support workers/health visitors.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.
In addition a copy of the questions that will be asked has been emailed to yourself so that you can make an informed decision and ask any questions you may have.

What will happen to me if I take part?

Once you have agreed to take part in the focus group a selection of dates/times will be sent and an attempt made to find the most suitable date/time and location for the focus group so that the least amount of disruption to your day is incurred. This is likely to be at a place of work of the professionals.
The focus group will consist of no more than 8 professionals with a similar profession to yourself. This Information Sheet will be provided again and a consent form that will need to be signed before the focus group will begin.
An initial question sheet will be provided with demographic information (including age, years in current profession). It is important to note that no names will be attached to any information collected.
The focus group will follow a semi-structured interview style using vignettes and more general questions. Although helpful if everyone feels comfortable to participate this is in no way mandatory.
The focus group will take no longer than two hours and the discussion will be voice-recorded for ease of transcription.
When discussing decision making and previous experiences of (suspected) child neglect you must not identify any clients or disclose any identifiable information about them – this is to ensure the confidentiality of all.
On completion of the focus group the recording will be transcribed and analysed by the researcher, Lydia Bullock. Each participant will be identified through a unique code to ensure that all answers and discussions remain anonymous. Once the focus group has ended there will be no follow up focus group or questionnaires.

Refreshments will be provided.

Expenses and payments

Participants will not be paid to participate in the study, however refreshments will be provided.

What are the possible disadvantages and risks of taking part?

For some individuals the topic of child maltreatment can be distressing to discuss and think about. The vignettes used have been designed not to be too emotive or distressing in its description however if you believe it will be too upsetting for yourself then please do not partake in the focus group.
In addition talking about previous experiences of difficult cases of suspected or actual child neglect may be upsetting. It is important that participants only share what they feel comfortable with. The aim of the research is to look more into what helps and what hinders successful intervention and not too much focus on the child neglect itself.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help develop a further and more detailed understanding of professionals experiences of child neglect and potentially where future research, funding and education is needed.

What happens when the research study stops?

When the study stops the tape will be transcribed by the researcher and thematically analysed. The results will then be written up as part of an academic thesis. They may also be submitted for publication in an academic journal. Your name will not be associated with any of the results, and only members of the research team will have access to the data.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researcher who will answer your questions. The researcher's contact details are given at the end of this information sheet. If you remain unhappy, you can contact the researcher's supervisor. These contact details are also at the end of this information sheet. If you continue to remain unhappy and wish to complain formally, you should contact the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, School of Medicine Education Centre, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. Email: louise.sabir@nottingham.ac.uk

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database.

Your name will not be collected and so any contribution you do give will remain anonymous, in addition any quotes taken from the recording will be anonymised and a code given.

Your personal data (in this case email addresses) will be kept for no more than 3 months after the end of the study. All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain confidentiality, only members of the research team will have access to your personal data.

Although what you say in the focus group is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected.
It is important to be aware that should you withdraw the data collected until that point cannot be erased and may still be used in the final analysis.

What will happen to the results of the research study?

The results of this research will be written up as part of an educational qualification, the researcher's Doctorate thesis. In addition the results may be published within a year or two of completing the research. No participants will be identified in any reports, thesis or publications.

Who is organising and funding the research?

This research is being organised by the University of Nottingham.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by University of Nottingham's Faculty of Medicine and Health Sciences' Research Ethics Committee.

Further information and contact details

Researcher's name: Lydia Bullock

Researcher's e-mail address: lwxlrb@nottingham.ac.uk

Supervisor's name: Shihning Chou

Supervisor’s e-mail address: Shihning.Chou@nottingham.ac.uk

Supervisor’s name: Danya Glaser

Supervisor’s email address: d.glaser@ucl.ac.uk

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Consent form

Final version 1.0: 31.03.2016

Title of Study: Perceptions and understanding of child maltreatment

IRAS Project ID: 195644

Name of Researcher: Lydia Bullock (Student)

Name of Participant: **Please initial box**

1.I confirm that I have read and understand the information sheet version numbe

2.I understand that my participation is voluntary and that I am free to withdraw where appropriate.

3.I understand that data collected in the study may be looked at by authorised i these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.

4.I understand that the focus group will be voice recorded and that anonymous di

5. I agree to take part in the above study.

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Name of Person taking consent Date Signature

2 copies: 1 for participant and 1 for the project notes

Appendix 4.2: Demographic information



Focus Group Demographics form

Final version 1.0: 31.03.2016

Title of Study: Perceptions and understanding of child maltreatment

Name of Researcher(s): Dr Shihning Chou, Dr Danya Glaser, Lydia Bullock (Student)

1. Gender:

2. Age:

3. Professional title:

4. Years of experience in your current profession:

Appendix 4.3: Vignette handout



Vignette Handout

Final version 1.0: 31.03.2016

Title of Study: Perceptions and understanding of child maltreatment
Name of Researcher(s): Dr Shihning Chou, Dr Danya Glaser, Lydia Bullock (Student)

Vignette A

A 4-year-old child lives with its mother. The father left the home having been served a court order to have no contact with the family due to domestic violence against the mother a few months ago. The child mostly plays by itself and spends little time with its mother. The mother does not tend to interact with the child or offer it praise. The mother does not show much affection to the child or reach out to comfort them when distressed. The child will at times inappropriately attention seek and at other times be withdrawn and choose to play in isolation.

Vignette B

A 4-year-old child lives with its mother. The father left the home after been served a court order to have no contact with the family due to domestic violence against the mother a few months ago. The child often looks dirty with their clothes looking unwashed and smelling. They are often not dressed for the weather lacking a coat when it is cold. The child is small for its age and frequently complains of being hungry.

Appendix 4.4 Questions asked to participants



Focus Group Questions

Final version 1.0: 31.03.2016

Title of Study: Perceptions and understanding of child maltreatment

Name of Researcher(s): Dr Shihning Chou, Dr Danya Glaser, Lydia Bullock (Student)

1. How would you describe or class the above scenario? If you are asked to give a label, what would it be?
    a. Why do you think this is XXX? How comfortable/confident do you feel with this identification?
    b. (after revealing it is neglect), how confident do you feel identifying neglect?
    c. Are there any problems you find in doing so?
2. How concerning is this to you professionally?
3. What would you do next? (Would you take any professional action in this situation?)
    a. Reasons behind answer
4. How concerning is this to you professionally?
5. What would you do next? (Would you take any professional action in this situation?)
    a. Reasons behind answers

6. In professional terms would you/have you taken action in every suspicion of child neglect?
    a. Reasons behind answer
7. What factors do you feel impact on your decision to take (or not) some form of action?
    a. Socio-economic status of family
    b. Domestic violence
    c. Drug and alcohol
    d. Learning disability
    e. Relationship with the parents
    f. Presentation of the child
    g. Time
    h. Not your job role
    i. Non-compliance
    j. It will get 'bounced back' (not serious enough)