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Who gets ongoing service and why?

An exploration of assessment, judgments and decision making during Initial Assessments in Child Protection and Welfare Social Work in Ireland

Thesis presented by

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for the degree of

Doctor of Philosophy

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2022





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Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism and intellectual property.

Digital signature of the candidate:



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This thesis is also dedicated to the children and families served by Child Protection and Welfare Social Work in Tusla. It is my hope that this research makes a useful contribution to understanding their needs and to providing service responses that are effective in supporting their protection and welfare.

Short Abstract

Background: Deciding whether or not to provide ongoing services following an Initial Assessment of alleged child abuse and or welfare concerns is one of the most important decisions that Social Workers make in Child Protection and Welfare. Despite this, very little is known about this practice or decisions at the conclusion of Initial Assessments or about the characteristics of children and families involved and their service needs. To fill these gaps, this thesis addresses the following issues: (i) current Irish policy for assessment and decision making with reference to international developments; (ii) the organisational context for assessment practice; (iii) judgment and decision making strategies that social workers use to determine eligibility for ongoing service; (iv) the characteristics of children and families who undergo Initial Assessment compared to the general population; (v) factors that are associated with the decision to provide ongoing service following an Initial Assessment; and (vi) comments on the efficacy of the current legislative and policy framework for assessment practice.

Methods: Two empirical studies were informed by an extensive narrative literature review. In the first study, a case study was designed to explore assessment practice in nine social work departments within a large administrative region of Tusla during the first quarter of 2016. Information collected from case file records (n=45) and interviews with SWs (n= 2 teams; n= 7 individuals) was thematically analysed to gain insight into the context for practice and into the sense-making and rationales provided for decisions.

Secondly, a descriptive and analytic cross-sectional study was designed to profile children in Initial Assessments and to identify factors associated with the decision to provide ongoing service. Descriptive and multivariable analysis was applied to a complete sample of 480 children whose Initial Assessments concluded in seven social work departments in Tusla in the first quarter of 2016. That study also explored the use of the California Structured Decision Making© Family Risk Assessment (NCCD, 2017) to support decision making.

Results: The case study revealed that, consistent with the literature, in situations of limited resources, a number of heuristic strategies were used to make decisions for ongoing service provision. Although social workers operate under a dual mandate of welfare and protection, in situations of high demand they prioritised caseload management over individual risk management leading to regret about judgments and decisions made in this specific practice context.

The descriptive findings of cross-sectional study revealed that families involved in Initial Assessments have greater burdens compared to the general population in addition to the specific child abuse and welfare related difficulties investigated. The prevalence of exposures to risk factors is identified. Almost 2 in every 5 children (38.5%, n=185) remained open for ongoing service following Initial Assessment. In a multivariable model, several clinical and organizational factors were associated with ongoing service. In the analysis, the Irish model was compared to the California Structured Decision Making© Family Risk Assessment tool. The latter model would have allocated more children to ongoing service.

Conclusions: The study makes many novel and important contributions to the literature. Through the originality of the study design, the research presents an in-depth exploration of the context for assessment practice and a detailed understanding of how SWs make decisions for ongoing service provision within this situated context. The findings are discussed in relation to their theoretical, practice, and research implications.

Long Abstract

Background: Deciding whether or not to provide ongoing services to children following an Initial Assessment of alleged child abuse and/or welfare concerns is one of the most important decisions that Child Protection and Welfare (CPW) Social Workers (SW) make. This is a complex decision made under conditions of uncertainty. In Ireland the legislative framework for CPW practice, organisational structure and policies for assessment and decision-making have been central to reforms since the 1970s. Despite this, very little is known about the assessment practice, judgments about risk or the decision at the conclusion of Initial Assessments or about the characteristics of children and families involved in the assessments and their service needs.

To fill these gaps this thesis examines the context for Initial Assessment practice and explores how decisions are made. Specifically, it examines the current Irish policy for assessment and decision-making with reference to international developments; it also examines the organisational context for assessment practice. Two studies explore judgment and decision-making strategies that social workers use to determine eligibility for ongoing service. The research describes the characteristics of children and families who undergo Initial Assessment and compares them to the general population; it also identifies factors that are associated with the decision to provide ongoing service following an Initial Assessment; and lastly, it comments on the efficacy of the current legislative and policy framework for assessment practice.

Methods: The study was informed by an extensive narrative literature review that examined developments in Irish and Anglophone child protection theory, research, and practice since mid-1900's and on theoretical and empirical literature on assessment judgment and decision-making with a focus on social work decisions for ongoing service following Initial Assessment. The research adopted a sequential exploratory design.

A case study was designed to explore assessment practice in nine social work departments within a large administrative region of Tusla during the first quarter of 2016. Information collected from case file records (n=45) and interviews with SW's (n=2 teams; n=7 individuals) was thematically analysed to gain insight into the context for practice and into the sense-making and rationales provided for decisions.

A descriptive and analytic cross-sectional study was designed to profile children undergoing Initial Assessments and to identify factors associated with the decision to provide ongoing service. Descriptive and multivariable analysis was applied to a complete sample of 480 children whose Initial Assessments concluded in seven social work departments in Tusla in the first quarter of 2016. The study also explored the use of the California Structured Decision Making© Family Risk Assessment (NCCD, 2017) to support decision making.

Results: The literature review highlighted the extent to which the Irish model of child protection and welfare, like those on other Anglophone systems, is characterised as high-risk strategies that focus on the identification and management of risks in reported cases, and secondary prevention through strategies aimed at reducing recurrence. The 'front door' of the CPW service is characterised by increasing levels of demand and consistently low rates of ongoing service. Reforms to the Irish system aimed at enhancing the child welfare orientation, in a rights-based and strengths-based model have been constrained due to scarce resources and managerialist approaches and insufficient statistical evidence about the needs of the population. It is hypothesized that consensus-based assessment frameworks and structured decision making (SDM) tools operate differently in ascertaining the level of risk and supporting decision-making, but the evidence is somewhat sketchy and has not been examined in Ireland.

The case study revealed that SWs saw the Initial Assessment as a goal-oriented intervention that operated to help clients address concerns directly or with the support from other professionals, sometimes over protracted periods of time, and to decide whether or not services were needed. The categorisation of evidence into typologies of abuse and welfare needs was a problematic and variable practice. Assessments involving multiple exposures including domestic violence were particularly challenging and some were systematically downgraded from abuse to welfare. These findings are discussed with reference to assessment outcomes. Risk operates as mechanisms to identify cases for ongoing service.

Consistent with the literature in situations of insufficient resources, SWs relied on a number of heuristic strategies as follows

- case load management was substituted for risk assessment in individual cases
- urgent needs were prioritised over less immediate need but where there were concerns about ongoing exposures, judgments and decisions were based on readily available evidence
- explanations employed gendered and blaming narratives and
- SWs relied on the idea of a 'closed system' of surveillance of children and families who did not receive ongoing service.

Also in the case study, SWs reported the assessment framework was helpful, but improvements could be made to better highlight or weight risk factors especially related to domestic violence and the context for practice. SWs expressed concern and anxiety that their modified assessment and decision-making strategies were on occasion, based on thresholds shifts that were not compatible with their judgments about protecting children and supporting families.

In the cross-sectional study, compared to the general population, families involved in Initial Assessments have greater burdens and are clustered in areas of relative deprivation compared to a national mean. The prevalence of child developmental concerns in all aspects assessed was over 50% and many were identified with multiple concerns in addition to exposures to identified risk factors for

abuse. One in four experienced domestic violence (24.6%, n=118) a majority of which was male perpetrated (90%, n=106) but a fifth of which was female perpetrated (22%, n=26) so several children experienced bi-directional violence. The prevalence of secondary abuse i.e., not related to the primary concern category, was 33.9% (n=163). A majority of children (69%, n=331) had previous involvement with CPW and one in ten were intergenerationally involved (10.6%, n=51). More than two thirds were involved with other services (67.5%, n=324) at the time of IA. In parents, the prevalence of mental health concerns and substance misuse was substantially higher (55.4% n=226) compared to the general population (18% in 2016). The findings challenge the prevailing orthodoxy that too many referrals progress to Initial Assessment. There were some missing variables in the data sources such as child nationality, ethnicity and parental age which are influential in decisions for referral and assessment.

Almost two in every five children (38.5%, n=185) remained open for ongoing service following IA. In a multivariable model, several clinical and organizational factors are associated with ongoing service. Factors relating to parenting capacity, family resources, prior involvement with CPW and female perpetrated partner violence determined ongoing service; children who were reported by a professional in statutory role were less likely to receive ongoing services and children whose cases were assessed by male SWs compared to female social workers were more likely to receive ongoing service. The profile of children whose cases were closed/NFA indicated there had been sufficient concern to warrant an Initial Assessment. Many who were closed/NFA were previously involved with CPW (61.3%, n=181) and many were involved with a range of other services (62.4%, n=184). Due to the range of exposures, it is unclear for many of these children if their service needs would be met without supportive case coordination.

In the analysis, the Irish model was compared to the California Structured Decision Making© Family Risk Assessment tool. The latter model would have allocated more children to ongoing service. The implications are discussed.

Conclusions: The study makes many novel and important contributions to the literature. Through the originality of the study design, the research presents an in-depth exploration of the context for assessment practice and a detailed understanding of how SWs make judgments and decisions for ongoing service provision within this situated context. The research presents heretofore undocumented evidence of the characteristics of children and families undergoing assessment and compares them to the general population and identifies rates of ongoing service provision. For the first time in Ireland, multivariable analysis was conducted to identify factors associated with ongoing service provision in children who receive Initial Assessment. The study provides evidence for the decision making ecology in the Irish context.

The results reinforced findings in the extant literature, indicating that assessment decisions and process outcomes do not capture the complexity and nuances of SWs 'front door' assessment practice, risk judgments and decision-making and indicates that they should not be conflated with judgments about

the prevalence of abuse, future risks, or child outcomes. The study provides evidence of a system that is inconsistent, and which is dominated by caseload management which entails prioritising the most immediate risks in cases which are often managed through gendered responses. There is a need for a culture of practice that encourages reflexivity and allows for positive discussion of sources of uncertainty and error so real-world problems can be addressed. There are currently, many barriers to realizing the vision of service Tusla and Government policies which encompass duties under the UN Convention on the Rights of Children. Recommendations and implications for potential data collection, SW training and future research are discussed and add to the evidence base in this area.

Abbreviations

AGS	An Garda Síochána
C1	Carer 1 / primary parent or carer
C2	Carer 2 / second parent or carer
CP	Child protection
CW	Child welfare
CPW	Child protection and welfare
DV	Domestic Violence
DVA	Domestic Violence and Abuse
SWD	Social Work Department
HPRelDep	Hasse Pratschke Relative Deprivation Score Index
Int	Intake / Screening
IR	Intake Record
IA	Initial Assessment
IAR	Initial Assessment Record
NFA	No Further Action
PPFS	Prevention, Partnership and Family Support Programme
SA	Small Area
PSW	Principal Social Worker
SW	Social Worker
TL	Team Leader
Tusla	Tusla Child and Family Agency

Overview of aims and structure of thesis

Aim: To provide a detailed overview of the motivation for the research and the context within which the study is conducted.	Aim: To provide a detailed description of the methodology applied in this thesis**.**	Aim: To address the research questions and present the findings of the studies:	Aim: To appraise the studies and comment on their contribution to the national and international literature. To address the theoretical, practical and research implications of the findings for Irish child protection and welfare social work.
Chapter 1 "We are in the business of risk management" setting the scene for researching assessment and decision-making in Irish child protection social work. Chapter 1 provides an overview of the context and motivation for study, the setting, and provides an overview of how the research project developed. The chapter concludes by describing the benefits of the organisational setting and the funding mechanism. Chapter 2 Responding to concerns of child abuse: the development of the current child protection and welfare system in Ireland. This chapter presents a narrative review of the literature relating to the development of the Irish child protection and welfare system with reference to national and international literature. This sets the scene for the research. Chapter 3 Assessments, judgments, and decision-making This chapter continues the review focussing on theoretical and empirical research on decision-making. It presents a critical review of the Irish practice framework. It concludes with the development of eleven research questions.	Chapter 4 Methodology Two empirical studies were designed to address the research questions, a case study, and a descriptive and analytic cross-sectional study. Chapter 4 presents the motivation for, and the philosophical foundations of the research and provides detailed descriptions of the research setting and timing, the study design, data sources, and analytic methods for each of the research studies. Ethical considerations and approval are discussed. The methodological limitations are addressed. Materials used in the research and discussed throughout the thesis, are attached as Appendices to the thesis.	Chapter 5 Explaining judgments and decisions: a case study of initial assessments in Tusla in 2015. This chapter presents and discusses the findings of the case study designed to address research questions 1 and 2. Chapter 6 Cross-sectional study of sequential Initial Assessments concluded in Tusla between January 1st and March 31st, 2016. Descriptive results. This chapter presents and discusses the descriptive findings of the cross-sectional study designed to address research questions 3 to 7. Chapter 7 Explaining decisions to provide ongoing service following Initial Assessment The final results chapter presents and discusses the analytic findings of the cross-sectional study, which was conducted to address research questions 8, 9, 10, and 11.	Chapter 8 Concluding comments and implications of the study findings for practice, policy, and research. In the final chapter of the thesis, the research studies are reappraised as is their contribution to the national and international literature.

Chapter 1 *"We are in the business of risk management"* Setting the scene for researching assessment and decision-making in Irish child protection social work

1.1. Introduction

In 2016 when this research project was beginning, Tusla Child and Family Agency, the national child protection agency in Ireland, was still in its infancy. Tusla was in the process of transforming child protection and welfare services through the development of a new service delivery framework, building on developments to standardise practice that were introduced in Government and agency polices in the previous two decades (Department of Health and Children, 1999; HSE/Tusla, 2009/2014). The focus of the framework was to address the now familiar pattern of practice, both internationally and in Ireland, whereby demand was consistently rising but only a small proportion of reports screened in for Initial Assessment (IA) went on to receive further services (Higgins *et al.*, 2019; Lonne *et al.*, 2009). The incentive to reform practice was also motivated also by the knowledge of pending legislation to introduce mandatory reporting which, it was anticipated, would increase the burden on services (DCYA, 2017; SI.No.470/2017, 2017).

Tusla had devised new service pathways which intended to divert cases from child protection to the newly incorporated family support and prevention services called Meitheal (Tusla, 2013b). In 2015 an internal audit of referral and assessment practices (Tusla, 2015) concluded that social workers felt bound to investigate reported concerns when they were not warranted. That Audit recommended reforming policy for assessments to enable social workers to better use their professional skills to mediate threshold decisions and to reduce the numbers of referrals that progressed along the continuum from referral to IA and beyond. A suite of guidelines had been introduced to improve assessment practice including a *Threshold of Need Guidance Policy* (Tusla, 2014c) and the *Assessment Guidance Framework* (Tusla, 2014a). The policy framework will be discussed in more detail in Chapter 2, but the intention here is to set the scene for the research project. The Assessment Guidance Framework stated

> *The adoption and implementation of this Assessment Framework document will provide uniformity and a standardised approach, nationally … in assessing child need/risk for the purposes of providing for the proper care and protection of children in the community. The framework guide will assist social work practitioners to work more confidently and competently in assessing unmet child need and cultivate more informed decision making in the supports/interventions appropriate to protect children and/or provide for their welfare when unmet need and /or risk is identified (Tusla, 2014a p.8).*

At the same time a different narrative was informing public concerns. Tusla was being scrutinised internally and externally through a number of investigations into the handling of cases (e.g. HIQA,

2016; Shannon, 2017; Tusla, 2015). Risk was the dominant lens that shaped the narrative. The quote in the chapter title *'we are in the risk management business'* is extracted comments made by Fred McBride, then CEO of Tusla in 2016, Speaking to the media in relation to a case highlighted by the national broadcaster regarding a decision taken by social workers to maintain foster placements for two children in a home where a third child had been sexually abused by an 18-year-old family member. McBride said the decision was taken on the basis that the alleged abuser was not to have unsupervised contact with the two remaining children. The media questioned the reasons why, following involvement with Tusla, children had remained in situations where they were exposed to risks in their care environments and about who was responsible for managing such risks (Holland, Fri, Apr 15, 2016). McBride went on to say that Tusla was not *'in the risk eradication business'* which he claimed was an absurd proposition. Speaking to the plans for reshaping the child protection service, he argued that the agency had been 'paternalistic', 'risk averse' and had taken power from families, focusing too much on managing budgets and insufficiently on 'building resilience and wellbeing' in families. The comments, and a subsequent media interview provided insights to Tusla's position in relation to the role the agency and parents in devising solutions to the problems they experienced. In that interview McBride explained,

> *We do want to challenge families more, we want to demand a bit more from families to have aspirations and, as I say, to take ownership of the problem. It's not the State's problem, it's the family's problem, but our job is to try to support them to come up with solutions to their problem (Hennessy, 2016).*

The discourses on risk surrounding Irish policy and practice for child protection are important: they invoke the sense of Tusla's duty to protect children and as outlined above, to encourage families to protect children. They incorporate to concerns about errors in judgment and decisions in child protection that emerge principally, from high profile cases when social workers were criticised for not using the powers of the state more fully when children known to the services were subsequently harmed (Fox-Harding, 1997; Gibbons *et al.*, 2010; McGuinness, 1993). Equally concerning were investigations of children and families when child protection and welfare (CPW) services were not deemed necessary or when abuse is unsubstantiated (Tusla, 2015). This pattern, which has been widespread across Anglophone systems, has resulted in what Mansell *et al.* (2011) refer to as a 'constant crisis of confidence in child protection' emerging from either not doing enough to protect some children or by being too intrusive and not managing demand appropriately. These 'crises' have been addressed repeatedly by reforming how systems are structured and how concerns are evaluated with the aim of avoiding each situation. From an ideological perspective the rationale for a system with a duty to respond to child abuse and welfare concerns is that potential harms associated referral and intrusion into family life are, as Gilbert *et al.* (2009a p.168) suggest, 'outweighed by the benefits of recognition, and therapeutic or protective responses'. But the Irish child protection system, like many other systems (Lonne *et al.*, 2009; Lonne *et al.*, 2020; Parton, 2014b; 2020), has been challenged in managing the liabilities and responsibilities that emerge from this duty (Burns and MacCarthy, 2012; IASW, 2011) and in demonstrating the benefits, as will be shown in the chapters that follow. These themes continue

to feature in public debates in Ireland (e.g. Holland, Thu, Jun 21, 2018, 02:00) and in the national and international literature, and remain central to reform efforts.

Speaking about the launch of the Corporate Plan 2021 – 2023 (Tusla, 2021c) Minister for Children and Youth Affairs, Roderic O'Gorman TD said it is

> *central to the Agency's pursuit of improvement, in the further development and delivery of consistent services for vulnerable children and families. I have set a number of guiding principles for the Agency along with clear priorities, and I look forward to seeing a greater emphasis on more local delivery of services, greater integration, and accountability (Tusla, 2021a).*

The idea of consistency is central to that corporate plan, and it aims to further embed the service pathways first introduced in 2014. The Plan it notes, aims to

> *ensure we intervene in a preventative and timely manner to effectively support the child and family's presenting needs and enhance the family's ability to meet those needs. Our goal is to always build on the family's strengths utilising their own naturally connected family and community supports with the professional supports and services we offer (Tusla, 2021c p.6).*

The plan goes on to say Tusla wants

> *our referral community to know that, based on whatever reason they refer a child to Tusla, we will make an informed, collaborative, and respectful decision about what will assist the child and their family (ibid).*

The metaphor of the 'Front Door' is widely used in CPW to describe a single point of access for referrals and systems designed to respond to them including intake and assessment services whether physical or digital (Jeyes, 2014; Lonne *et al.*, 2020; Tusla, 2021c). Building on this idea, the change programme being implemented in 2022 is based on three-pillars of *practice, culture and structure* (Tusla, 2021b; Gloster, 2022a) which aims to ensure delivery of 'an experience that is consistent in which everybody has the same reasonable chance of the same type of response' (Gloster, 2022b). Here, as will be explored in Chapter 2, attention focuses on how models of practice inform, and are informed by, the value positions that frame and underlie policy and law, determining which cases are screened in for investigation, how assessments are conducted and who receives services.

Policy, law and practice frameworks for assessment and decision-making have been almost consistently under review since I joined the service as a researcher in 2001.[1] An 'outsider' in the field of CPW, I had qualified as a scientist, undertaken postgraduate studies Public Administration, and worked for over

1 By way of context, the Child Care Act, 1991 which mandates the CPW service to promote the welfare of children in its area who are not receiving adequate care and protection (Department of Health 1991) also confers a duty on the responsible Minister for Children and the agency to conduct research into any matter relating to its functions.

ten years in the field of education with a focus on social integration. Later, between 2006 and 2008 while working in CPW, I undertook an MBS in Health Services Management. My work in CPW has largely focused on evaluating models of practice and patterns of decision-making, examining features of variability in practice among practitioners and across CPW teams (O'Leary, 2007a; b; O'Leary *et al.*, 2013; O'Leary *et al.*, 2015b). In 2001, CPW services were delivered under the auspices of regional boards of management, the Health Boards, accountable to the Department of Health and Children. The first set of national guidelines for child protection and welfare based on the 1991 Child Care Act, '*Children First'* had been published by Government (Department of Health and Children, 1999) with instructions they were to be complemented by regional Health Board guidelines specific to disciplines and organisations to ensure consistent implementation (Department of Health and Children, 1999). The Southern Health Board (SHB) convened a cross-sectoral multidisciplinary group to advance this. Elsewhere Health Boards also commissioned and implemented local guidelines (e.g. Buckley *et al.*, 2006a).

Together with a colleague, I edited the first set of practice guidelines based on '*Children First'* (Department of Health and Children, 1999) that were subsequently implemented in five social work departments across Cork and Kerry (O'Leary, 2007b). With a view to monitoring their implementation, I had recommended that practice standards relating to SW procedures for processing and assessing reports be incorporated into the guidelines. This enabled the first audit of practice and survey of professionals involved with CPW social workers to be conducted a few years later (O'Leary, 2007a). The audit generated a number of research questions some of which were subsequently addressed in a research survey with all professionals with an identified role in the CPW process to examine their perception of the guidelines and of their inherent roles (O'Leary, 2007b). Research questions also emerged from analysis of findings from the legally mandated annual *Reviews of Adequacy of Child Care and Family Support Services,* (Department of Health, 1991 Part II, s.8) for which I had responsibility in Cork and Kerry between 1999 and 2010 (until such time as the reports were prepared nationally). These *Section 8 Reports,* so called in reference to that part of the Act which mandated their publication, were conducted with service managers using a combination of administrative data and mixed-methods survey methodology.

These audits and reports suggested that regional managers and social work mangers, throughout the organisation, acted as 'street level bureaucrats' (Lipsky, 1971) who, within their delegated authority, developed and implemented local systems of practice and procedures in the context of national laws and practice frameworks. While this approach may have been effective, as Chapter 2 will show, over the following two decades' constitutional, policy and practice reforms led to major, and somewhat conflicting, influences on how practice was modelled. The Ombudsman for Children investigated the implementation of *Children First* across the country and found variable practice (Ombudsman for Children's Office, 2010) which it argued impinged on the rights of children to equal service. In 2012 the Government delegated the regulatory responsibility for monitoring standards of practice in CPW to the Health Information Equality Authority (HIQA, 2012). At the same time changes meant the rights

and interests of children were more central to the overall system of child protection (Constitution, 2012; DCYA, 2012b) and the state's authority to intervene to protect children were strengthened through the expansion of services and movements to introduce mandatory reporting (DCYA, 2015). For CPW practice it meant that standardisation and, consequentially, risk management became key organisation rationales in the period that followed. It didn't always sit easy with professionals who believed the emerging bureaucratisation conflicted with professional values and practice.

I identified a pattern of practice, when preparing the *Section 8* Reports, indicating differences in rates of children in care between two Social Work Departments (SWDs) that had similar rates of referral. In 2012, I recommended exploring this and a study was sanctioned. I developed a collaboration between my office, the local Child Care Information Unit for Cork and Kerry (CCIU),[2] the School of Applied Social Studies, UCC, the School of Public Health in UCC, and enlisted the support of the office of Health Intelligence, HSE, Dublin. The CCIU had created a unique, child based dataset for the purposes of management oversite for children in care. This served as a rich source of longitudinal data for children in care in the region. That research identified and documented for the first time in Ireland, a social gradient in referrals to CPW, gender differences in relation to involvement with CPW, variations in placement based on geography and evidence about the use of practice knowledge by SWs (O'Leary *et al.*, 2015a; O'Leary *et al.*, 2013; O'Leary *et al.*, 2015b). However, the findings could not explain the basis for the decisions taken to place children in care because of insufficient data (ibid.). That project generated the research questions for the current exploratory studies which examine one of the key practice decisions, whether or not to provide ongoing CPW service following an IA. The collaboration with UCC was further enhanced with a scholarship award from the Irish Research Council under the Employment Based Partnership Programme (IRC, 2015) to fund this doctoral research.

More broadly, my interest in this research was driven by a gap in the existing Irish evidence about how decisions are made by Social Workers for service provision and by the absence of statistical data and knowledge about children and families involved in the Irish child protection and welfare system.

1.2. The evidence gap

Tusla routinely publishes CPW aggregated performance and census-based activity data relating to the number of referrals, as well as the categorisation and responses to referrals in accordance with Agency standards. Metrics include numbers of referrals processed within 24 hours, the number of IA (investigations) completed within 20 days[3] and the actions taken on completion of these IAs (see tusladata, *Annually*). Child-related metrics are limited to the number of children listed on the Child Protection Notification System (CPNS), a register of children assessed to be at risk of significant harm, the number of children in care and related metrics. Up to 2009, CPW policy allowed referrals to include

[2] CCIU responsible for the collation and management of data to generate regional statistical performance and activity data that informed the production of national aggregated activity statistics produced by the CPW system.
[3] In 2017, after the data for this research was collected, policy changed to allow 40 days for IA.

information on multiple children; since 2009, the policy requires that each referral relates to a unique child (HSE/Tusla, 2009/2014). Data is collected quarterly. Because information that is gathered about IAs relates to these performance indicators, statistics about decisions at the conclusion of IA relate only to about half the IAs commenced. Statistics capture the breakdown by category of concern of Referrals but not subsequent Intakes or IAs.

Tusla does not collate or publish any data on the number of children, or the socio-demographic characteristics of children and families involved in IAs. This precludes having any degree of transparency about the nature of demand and responses provided to children and families involved with the service.

As data presented in Chapter 2 will show, evidence has long indicated that a majority of assessments fall under the threshold for on-going service provision and are closed under the heading No Further Action (Buckley, 2003; 2012; 2015; 2017b; Buckley *et al.*, 2010; Thorpe, 1997; Tusla, 2014c; 2015; tusladata, *Annually*). Commentators have long expressed concerns that the Irish statistics provide very little scope for analysis, do not provide evidence on the characteristics of children and families involved in assessments and that, despite the high proportion of referrals that are screened in, the statistics seem to reflect assessment policies that invest considerable resources in filtering out the majority of the reports, raising questions about the nature of concerns eligible for state ongoing service and the basis for decision-making (Buckley, 2003; 2012; 2017b; Buckley and Burns, 2015; Buckley *et al.*, 2010; Burns and MacCarthy, 2012; Ferguson and O'Reilly, 2001; O'Leary *et al.*, 2013; Ombudsman for Children's Office, 2010; Thorpe, 1997; Whelan, 2018). Some commentators suggest that many children and families are required to engage in unwarranted investigations, causing blockages in the system and using resources that could be better allocated to children and families who need them (Buckley, 1996; 2012; 2015; Ferguson and O'Reilly, 2001; Thorpe, 1997; Tusla, 2015). Alternative explanations suggest a high threshold for allocating ongoing services that is influenced by service availability (Buckley, 2012; Buckley and Burns, 2015).

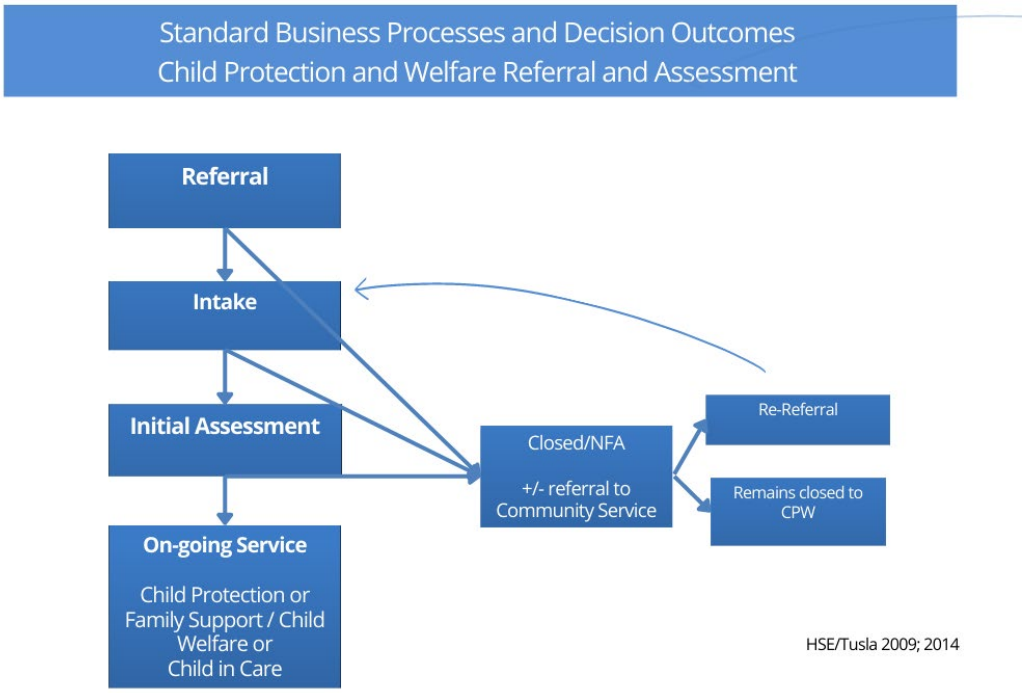
In 2010 an audit of child protection research between 1999-2009, commissioned by the Irish Government stated the 'importance of accurate and comprehensive statistical data cannot be understated' due to its role in demonstrating activities but also the problems and areas where resources should be allocated (Buckley *et al.*, 2010 pp. 37-38). The report noted the absence of epidemiological data, the absence of linkages between social factors affecting families vulnerability and decisions taken by social workers, the prevalence of different types of abuse or the types of child abuse that receive interventions (ibid).

Standard Business Processes (SBPs See Figure 1), introduced in 2009 aimed to ensure a consistent response to referrals across the country (HSE/Tusla, 2009/2014). The SBPs detailed process maps, operating procedures, forms and guidance with a view to creating a standardised and 'integrated child protection system to look after every child and manage every case from first contact with the HSE social

work department through to case closure' (HSE/Tusla, 2009/2014 p. 5) and to provide reliable management information for the National Child Care Information System (NCCIS) an electronic system that was deployed incrementally from 2016 until 2018. The SBPs introduced a number of performance indicators which became the basis for statistics published by Tusla (tusladata, *Annually*). The SBPs have an associated suite of formal records including the Intake Record and Initial Assessment Records (see Appendices 2 and 3) designed for collating information and evidence at the conclusion of each process.

A national audit of referral and assessment practice published in 2015 and mentioned above (HSE/Tusla, 2009/2014), examined practice against the SBPs.

Figure 1 Standard Business Process for Referral and Assessment



The Audit (Tusla, 2015) is important because prior to this research project, it was the only source of evidence about Assessment practice. It found that only 43% of referrals actually proceeded to an IA and of those that did, further action was required in 13.5% of IAs completed (Tusla, 2015), a much lower proportion than is reflected in published statistical data (see Chapter 2). It identified that a welfare approach was adopted in cases of overt neglect to address the limited nature of the current report, whilst 'not viewing the report in terms of the bigger picture in such families'(ibid p.30) noting that managers had reported not having the sufficient resources to address profound neglect or non-cooperation in some families (ibid p.28). The report also noted that the findings could not be generalised as reflecting the 'views or practice of all social workers (ibid p.30).

Of relevance to this research project, the Audit identified that there was good level of compliance with completing records, but also identified a concern that conclusions drawn the analysis provided in the IA record did not accurately reflect the information gathered in terms of risk and need (ibid p.26). The report noted the need for further review using a larger sample size to assess accuracy of this figure but also concluded that a large proportion of referrals were likely not to be eligible for IA in accordance with policy and were incorrectly screened in (ibid).

Tusla and its predecessors have published a significant body of practice guidelines to inform assessments and decisions. In his forward to one such practice handbook published in 2011, Gordon Jeyes, former Chief Officer of Tusla stated it was an aide to 'delivering accountable, consistent and transparent practice in protecting children in Ireland' (HSE, 2011 p.xi). Between 2013 and 2016, as is discussed in Chapter 2, significant additional guidance was introduced to supplement the SBPs to support assessment and decision-making (e.g. Tusla, 2014a; b; Tusla, 2014c). Guidelines require that SWs to engage in evidence-based practice. Although systems for data collection and analysis are continuously improving in Tusla, current statistics lack evidence of the characteristics of assessment and decision-making despite the fact that guidelines and electronic (and formerly manual) case records require SWs to document and analyse a great deal of information about children and families' who are referred to and move through the system, and to provide justification for the various decision thresholds (IASW, 2011; Parton, 2009). Further, there is no knowledge in Ireland about the breakdown by category of concern of cases that receive IA or ongoing services nor is there evidence of the incidence of risk factors or pattern of recurrence among cases undergoing IA. There is no evidence of the stability or accuracy of routine decisions taken in cases, there is no evidence of the incidence and pattern of re-presentation to the service following IA, whether or not services have been provided. Nor does Tusla systematically produce evidence about the progression of children's cases along the continuum of services. Like administrative data collections in many other jurisdictions, this is embedded in information pertaining to case management processes and performance indicators (see Chapter 3).

As a consequence, SWs in Ireland obtain little or no information about the features of their decisions or the accuracy of their judgments and predictions (Buckley, 2012; Buckley *et al.*, 2010). Where it is available feedback is generally in relation to poor outcomes or child deaths, rare events that have significant impact in shaping policy (Buckley and O'Nolan, 2013; Kearney, 2013). This evidence frequently addresses shortcomings in assessments, analysis of information and decisions about future risk and service allocation (e.g. Buckley and O'Nolan, 2013; Munro, 2011a; Parton, 1996; Turney *et al.*, 2011) because in CPW, misdiagnosis in either direction can have devastating consequences for a child, family or professionals involved in a case (Best *et al.*, 2013; Mansell *et al.*, 2011). This is a concern that the current research project aims to go some way to redress.

1.3. Initial Assessments

In Ireland Child Protection and Welfare (CPW) practice is governed by a dual mandate of child welfare and protection from abuse. Decision-making in CPW takes place along a continuum of processes from referral, through intake and IA to ongoing service delivery including alternative care (HSE/Tusla, 2009/2014) as described in Figure 1 above.

Each process requires assessment and a target decision, where 'assessment' refers to both the on-going, informal incremental processes of engagement with clients, gathering information and multiple decisions made in practice, as the gathering and interpretation of evidence to come to target and disposal decisions, choosing among the options available in the policy (Barlow *et al.*, 2012; Baumann *et al.*, 2011; Cash, 2001; HSE, 2011; Hughes and Rycusa, 2006; Macdonald and Macdonald, 2010; Munro, 2019b; Trevithick, 2012; Tusla, 2014a). Disposal target decisions are characterised as threshold decisions (Baumann *et al.*, 2011; Dalgleish, 1988; 2003; Tusla, 2014c) which are essentially, a series of stop/go or eligibility decisions described as, 'the juncture at which certain criteria are met and thereby a specific response is required or specific procedure must be followed' (HSE, 2011 p.9). They include, inter alia, the decision whether or not to accept a referral, whether or not to conduct an IA and, the decision of interest in this research, whether or not to provide ongoing services following an IA as described in Figure 1. At each decision point there is evidence available including client preferences and values, information from consultations and assessment processes and previous decisions and all of these are framed by the context including the policy that set the target decisions and thresholds for action. which in turn, are influenced by social workers' values and preferences and available resources (Baumann *et al.*, 2011; Dalgleish, 1988; Fluke *et al.*, 2016; Kahneman *et al.*, 1982; Shlonsky, 2015) and the knowledge created is used to construct rationales for action or non-action (Buckley, 2003) in accordance with policy and target decisions.

When reported child protection or child welfare concerns are not resolved during the Intake process, they are eligible for IA. During IA, Social Workers are required to determine if there is substance to the concern, to make a preliminary determination of the nature and severity of any risk, the immediate safety needs of a child (DCYA, 2011a; HSE/Tusla, 2009/2014; Tusla, 2014a; c). SWs are required to meet the child and family and to engage with professionals involved with the family (HSE, 2011). The focus of the assessment decisions is on unresolved needs and the likelihood of future harm relating to the reported concern. At the conclusion of an IA, SWs are required to categorise the case as one of the four types of abuse or welfare, and, if categorised as abuse to determine whether or not a child is at significant risk of ongoing harm, and, in all cases, to decide whether or not a child or family requires ongoing CPW services with or without a referral to other services including Tusla prevention and early intervention services (HSE, 2011; HSE/Tusla, 2009/2014; Tusla, 2013a; 2014a; c).

IA practice is an essential element of everyday social work practice, conducted on the basis of professional judgment in accordance with practice guidelines and frameworks, which are explored in greater detail in Chapter 2 and discussed in the context of the national and international literature. As

the overview thus far attests, assessment practice has been central to review policies since the first national guidelines were introduced in 1999 (Department of Health and Children, 1999) and while the focus of reforms have been on standardisation and quality assurance in terms of compliance with SBPs, they have not addressed the deficit of evidence or statistical evidence about assessment practice or those children and families involved and importantly, nor have reforms been informed by such evidence (Buckley, 2012; Buckley *et al.*, 2010).

The absence of evidence on IA includes evidence of the categories of abuse and needs 'investigated', information on the number of children and families involved, the prevalence of risk factors and the prevalence of abuse and prevalence of exposure to risk factors, the decisions taken and indeed, the way these features related to the decisions taken by social workers.

1.4. Overview of thesis, literature review and research design and development

Two exploratory studies were designed to address these evidence gaps and take account of the international literature in what could best be categorised overall as a sequential exploratory mixed method design (Creswell and Plano Clark, 2017). In this thesis I will guide the reader through the research studies, beginning in Chapter 2 by charting the development of the current CPW system and exploring the design in relation to developments internationally. In Chapter 3 I present a review of the theoretical and empirical literature on risk assessment, judgments, and decision-making under uncertainty in CPW assessments that relate to the research topic drawing on particularly influential literature from the fields of economics, organisation science and psychology. Chapter 3 concludes by linking the findings of the review to the development of the research questions. At Chapter 4 the methodology and methods for the studies is detailed and defended. Chapter 5 presents and discusses results of the Case Study. At Chapter 6 the descriptive findings of the cross-sectional study are presented and discussed. Chapter 7 presents the findings of the analytic study which developed a multivariable model of ongoing service, and an alternative model of decision-making is also presented, and the findings are discussed. Chapter 8, the final chapter, reappraises the methodology and explores key empirical, theoretical findings and discuss the implications for policy, practice, and research.

This is the first study to examine assessment and decision-making during IAs and decision-making for ongoing service in Ireland. While there is a developing body of empirical Irish research on decision-making (see Buckley, 1998; 2000a; McCormack *et al.*, 2020; Whelan, 2018) there has been no studies to examine demographic and case related determinants of decisions to provide service. Except for one study led by this author (O'Leary *et al.*, 2015a) there have been no studies that link empirical case data to population based socio-demographic indicators. To my knowledge there have been no studies to date in Ireland that used a sequential mixed methods study design or that included empirical case data in statistical modelling to identify determinants of decisions in child protection and welfare, as the research for this thesis did. This thesis will show that the research fills several evidence gaps.

The literature review for this research, which is presented in narrative form, shaped the design and conduct of the research and interrogation of the research findings. The review was multidisciplinary encompassing the fields of psychology, psychiatry, economics, applied social studies, public health and epidemiology. It included methodological, theoretical, thematic, and systematic approaches. Courses in Biostatistics introduced a body of literature on research and statistical methods. The literature review and systems comparison encompass Anglophone CPW systems, specifically Northern Ireland, England, Scotland, Wales, Australia, Canada, New Zealand, and the United States.

Initially the literature review focused on theoretical and applied research on assessment and decision-making in the field of psychology and economics. Papers that were influential included those distinguishing risk from uncertainty (Knight, 1921), distinguishing decision-making using professional judgment from risk based judgments (Dawes *et al.*, 1989; Meehl, 1954), research on the various perspectives considering the influence of heuristics on decision-making (Dalgleish, 1988; Dhami and Ayton, 2001; Gigerenzer, 1996; Kahneman, 2002; Kahneman *et al.*, 1982; Snook *et al.*, 2011; Tversky and Kahneman, 1974; 1981; 2000) and the development of professional expertise under conditions of uncertainty (Kahneman and Klein, 2009) proved to be both instructive and illuminating. These were particularly helpful when it came to interrogate the empirical research literature and policies for practice.

The study is informed by ecological systems theory (Belsky, 1980; Bronfenbrenner, 1979; Cicchetti and Toth, 1995) which provides a framework for identifying determinants of child abuse but which also recognizes ecological context for practice and the nested nature of cases within an individual CPW system (Belsky, 1980; Mulder *et al.*, 2018; Sethi *et al.*, 2013; Stith *et al.*, 2009). This research is guided by both normative and descriptive theories of bounded rationality (Simon, 1956) which postulate that decision makers use 'satisficing' or heuristic strategies to reduce the complexity of information pertaining to a decision (Helm, 2011; Simon, 1956; Taylor, 2012; Tversky and Kahneman, 1974; Whittaker, 2018) and by theories of risk within the organizational context. And it is informed the development of a number of models for research on decision-making which posit that factors in the wider ecology and the organisation influence decisions at the case level which are also (Baumann *et al.*, 2011; Benbenishty, 1992; Dalgleish, 1988; Helm and Roesch-Marsh, 2016; López *et al.*, 2015; Platt and Turney, 2013).

Comprehensive searches of bibliographic databases included Academic Search Complete, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, US National Library of Medicine NCBI (Bookshelf and PubMed), SocIndex, Web of Science, and Google Scholar. Search terms used varied over the course of the research and according to the topic and phase study.

The archives of a number of social work journals were searched and alerts designed for updates. These included the British Journal of Social Work; Child Abuse and Neglect; the Child Abuse Review;

Children and Youth Services Review; Child and Youth Services; Child Maltreatment; Critical Social Policy; European Journal of Social Work; Research on Social Work practice and The Social Science Review. Irish journals searched were The Irish Journal of Applied Social Studies, Administration and The Irish Social Worker.

Several journals published special issues on risk, assessment, and decision-making in child protection over the past two decades. Hand searches of these volumes proved highly informative. Among these were the Children and Youth Services Review (2000 Vol 22) (see Gambrill and Shlonsky, 2000), Children and Youth Services Review (Special Issue: Decision Making in Child Welfare, 2005); the British Journal of Social Work (2010 Vol 40) (see Warner and Sharland, 2010); and Child Abuse and Neglect (2015 Vol 49) (López *et al.*, 2015). Meta-analyses of risk factors for child abuse (Stith *et al.*, 2009), child abuse recurrence (Hindley *et al.*, 2006; White *et al.*, 2014) and systematic reviews and studies of the use of various risk assessment instruments provided insights into the literature and debates concerning risk assessment practice (Baginsky *et al.*, 2019; Barlow *et al.*, 2012; Bartelink *et al.*, 2015; 2016; Cash, 2001; Dankert and Johnson, 2013; Gillingham and Humphreys, 2010; Johnson *et al.*, 2015; Johnson, 2011; Mendoza *et al.*, 2016; van der Put *et al.*, 2017; van der Put *et al.*, 2016). Papers examining theoretical approaches to measuring the accuracy of child assessments also proved instructive (Mansell *et al.*, 2011; Munro, 2004b) as did literature from outside social work that examined statistical methods of integrating evidence to inform risk assessment for cases of child abuse (Best *et al.*, 2013; Foreman *et al.*, 2015).

Given the evolving policy context for CPW practice it was essential to keep informed of developments in Irish legislation, Government and Tusla policy, Inspection reports (https://www.hiqa.ie/reports-and-publications/inspection-reports) and media commentary, as well as international policy and research developments. As an employee of Tusla, I received policy updates via routine Newscast emails and the Tusla employee hub (http://hsenet.hse.ie/Intranet/childfamilyagency/). Research repositories were used to review policy reports, data and published PhD theses. Among these, the Irish repositories were the All-Ireland Public Health Repository (http://repository.publichealthwell.ie/), the Children's Research Network for Ireland and Northern Ireland (https://childrensresearchnetwork.org/), Lenus (http://lenus.ie), the North South Child Protection Hub (http://nscph.com/), RIAN (http://rian.ie/) and CORA the Cork Open Research Archive (https://cora.ucc.ie/). International repositories included the US Child Welfare Information Gateway (https://www.childwelfare.gov/), the Australian Institute of Family Studies (https://aifs.gov.au/) and the Canadian Incidence Study (https://cwrp.ca/canadian-incidence-study).

I presented a number of papers at national and international conferences which are listed at Appendix 7 (O'Leary, 2017; 2022a; b; O'Leary *et al.*, 2016a; b; c). I am grateful to my colleagues who took the time to review and comment on these papers and to those who took additional time to discuss my research in person. This was very supportive and informed the direction of the work. The conferences also provided space to hear about current research and to build collaborative relationships and networks

which in turn developed publication opportunities (O'Leary, 2021; O'Leary and Lyons, 2021; 2023) some of which are ongoing.

In addition to formal course work, I participated in a number of summers schools, special interest groups and working groups for PhD students organised under the umbrella of international conferences including the 14th European Scientific Association on Residential & Family Care for Children and Adolescents International Conference, Oviedo, Spain, September 2016, the Kempe Research Institute (Online) 2020, the special interest group on Decisions Assessment Risk associated with the European Social Work Research Association online 2021.

I was grateful to many professionals who granted me access to data including Jonathan Pratschke for license to use the Haase Pratschke Deprivation Index data for small areas in Ireland (Haase and Pratschke, 2017a) and the Oranga Tamariki Ministry for Justice in New Zealand for administrative data https://www.orangatamariki.govt.nz/).

1.5. Research setting and funding

The research is conducted in nine social work departments in one administrative area of Tusla. This was particularly important because it provided a unique position from which to develop organisationally situated research. The project would not have been possible without the involvement of many social workers, administrators, data collection officers and managers across the region, in addition to colleagues in a number of other directorates along with senior management. The results are relevant to all disciplines involved. It is hoped that this context will facilitate dissemination of the findings within and outside the organisation. There is a symbiotic relationship between practice, policy, laws, and the overall value perspective of the system that needs to be re-evaluated when evidence is found that might disrupt current beliefs. It is hoped that the evidence from this study will go some way to inform that relationship.

Particularly beneficial also, was the fact that it was supported by a scholarship award from the Irish Research Council (IRC, 2015). In addition to covering university fees, that funding provided travel stipends which enriched the research process as described above.

This concludes the introduction to the research project and the thesis. The next chapter commences the review of policy and the literature.

Chapter 2 Responding to child abuse and welfare concerns: the development of the current Irish child protection and welfare system

2.1. Abstract

The contemporary Irish Child Protection and Welfare system emerges from the 1970s. A number of public inquiries have been influential on reform efforts which have focused on standardisation and quality assurance measures. The developments are traced in this chapter. The review is extended through an analysis of developments in the understanding of child abuse and 'front-door' systems which refer to processes, organised around a single point of entry, in statutory Anglophone child protection systems. Common trends and unique circumstances are identified that impact on practices and decisions along the continuum of service. Concerns about sense-making during IA and the interpretation of reported abuse, need and risk related to decision-making and has received considerable attention in policy and practice reforms in Ireland. Decision-making in IA is simultaneously rules based and reliant on professional judgment but, the relationship between the two and the relationship between assessment, judgment, and choice in CPW is far from simple. The organisational context for practice impacts on professional practice and engenders a sense of anxiety and uncertainty about assessment and decision-making. Irish IA practice is outlined and trends in demand and service provision are presented and analysed in the context of the international literature. In explaining the trends this chapter assesses the current paradigm for CPW practice in Ireland. The issue of current data collection and statistics as an evidence base for practice is discussed.

2.2. Development of the Irish child protection and welfare system

The contemporary CPW system emerges from the 1970s owing to a confluence of pressures that gradually led to a tipping point in political activity. In this section I provide a selective review of factors that were impactful on developments to set the context for current practice and for this research (Buckley *et al.*, 1997; Burns and McGregor, 2019; Skehill, 2003). During the 1800s and early 1900s, Ireland had shared administrative, legislative, and penal systems with the UK. The 1908 Children Act, the children's charter so called, set out the basis for the protection of infants and children from cruelty through institutional residential and foster care, known as boarding out (Buckley *et al.*, 1997). Until the 1990s, child care legislation and policy, based on the 1908 Children Act, remained firmly rooted in the principle of family autonomy and minimal state intervention, because of the 'constitutional and ideological reverence for the family' (Buckley, 2003 p10; O'Brien, 2014b) and the authority delegated by the state to the Church.

The duty of Irish state to ensure, as far as practicable, that the rights of children are protected and vindicated rests in Article 42A.2.1° of the Irish Constitution 1937. This obliges the state to 'endeavour to supply the place of the parents' in 'exceptional cases, where the parents ... fail in their duty towards their children to such extent that the safety or welfare of any of their children is likely to be prejudicially affected.' The role of the family, recognised by the state as the 'natural primary and fundamental unit group of society, and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law' set out in Article 41.1.1° is grounded in the Catholic principle of subsidiarity that supported a privatised and autonomous model of family life, dominated child care policy during this period.

Shortly after the foundation of the Irish Free State (1922), the 1926 Schools Attendance Act, the first legislation passed by the Irish Government, required children between ages of 6 and 14 to attend school. Non-attendance was grounds for committal to Industrial Schools operated by religious authorities. The enforcement of this Act marked a significant level of state intrusion into family life and legitimised the role for the religious congregations in state affairs (Earner-Byrne, 2008; Morgan, 2009). A report on the functioning of these schools (Kennedy, 1970) highlighted the inadequacy of the legislative basis to respond to the needs of children and the need to develop a professional lay system of care managed by the state (Buckley *et al.*, 1997; Gilligan, 2009; Kennedy, 1970; O'Sullivan, 1979). The Kennedy Report was influential in the transfer of responsibility for the delivery of child care from the Department of Education to 11 regional Health Boards under the Health Act, 1970 (Department of Health, 1970) and marked the expansion of the expert system in child protection in Ireland (Buckley and Burns, 2015; Ferguson, 1997).

2.3. Public inquiries into child abuse

Since the 1990s more than twenty-nine state inquiries brought to light horrendous physical, sexual and emotional abuse and wilful neglect of children (Buckley and O'Nolan, 2013; Shore and Powell, 2020). These included inquiries into the historic and systematic abuse of children in the educational and institutional settings operated by the Church on behalf of the State and in sporting organisations that was covered up by those bodies (e.g. Elliott, 2020; Murphy *et al.*, 2005; Murphy, 1998; Power, 2020b; Ryan, 2009). They included five investigations into child abuse in family situations where children were involved with CPW and other services, and where numerous opportunities to intervene effectively to protect them from abuse had been missed (Brosnan, 2008; Bruton, 1998; Gibbons *et al.*, 2010; Joint Committee on the Family, 1996; McGuinness, 1993).

The inquiries had an unprecedented effect on transforming public and professional awareness of the nature of abuse of children and families by the Irish state and awareness of risks posed by perpetrators of abuse to a range of children (Ferguson, 2001; Powell and Scanlon, 2015; Raftery and O'Sullivan, 1999; Shore and Powell, 2020). They also exposed several taboos around familial child abuse in Ireland and a 'disbelief' about the nature of sexual abuse and abusers (Powell and Scanlon, 2015; Shore and Powell, 2020).[4] These exposures, along with evidence of systematic failings of the state and the absence of accountability led to unprecedented public concern and anxiety about protecting children (Ferguson, 2001; McGregor, 2014; Ryan, 2009; Walsh, 1999).

In addition to inquiry reports, current concerns about errors in assessments, decision-making and case management practices by the CPW services were raised in investigations of deaths of children who had been in the care of the state (e.g. Shannon and Gibbons, 2012) and in an audit of case management between the CPW services and other professionals including An Garda Siochána, the Irish police force (Shannon, 2017).

The *Kilkenny Report* (McGuinness, 1993)[5] in its recognition of the complexity of child protection led to what Buckley and Burns (2015) referred to as 'a watershed' in the development of the services as every aspect of policy, particularly inter-agency and inter-professional co-ordination, became the subject of critical analysis and recommendations for change (Ferguson and O'Reilly, 2001; Shore and Powell, 2020). Concerns about the provision of services for children harnessed political will to fund policy developments in child protection and focus on children's rights. Resultant developments

[4] Shore and Powell (2020) say the inquiries into abuse in family settings also illuminated anomalies in legislation, reflective of societies views on the rights of the family over the rights of children, and what Powell and Scanlon refer to as 'disbelief' about the nature of sexual abuse and abusers (Powell and Scanlon, 2015) as the maximum sentence for incest by female perpetrators was less than that for male perpetrator.

5 The Kilkenny Report was the result of an inquiry commissioned to investigate a case that led to the trial in 2003, of a father who was convicted of incest against his daughter. The child had 100 contacts with health and social services before the abuse stopped. The inquiry was the first major child abuse inquiry by the Irish state, and in the same way that the Maria Colwell Inquiry was a catalyst for policy changes in the UK Parton 2004) the Report of the Kilkenny inquiry, more than subsequent inquiries, impacted on the development of child protection policy (Buckley and O'Nolan, 2013).

included the full implementation the Child Care Act, 1991 and the first national policy for child protection and welfare, *Children First National Guidelines for the Protection and Welfare of Children* (DCYA, 2011a; Department of Health and Children, 1999) based on the Act (Buckley and O'Nolan, 2013). *The Ryan Report* [6] (Department of Health and Children, 2009; Ryan, 2009) and the *Report of the Task Force on the Child and Family Support Agency* (DCYA, 2012a) were also instrumental on reforming and developing the current system.

The focus of later inquiries and investigations, commencing with the Roscommon inquiry (Gibbons *et al.*, 2010)[7], reflected the shift in the accountability framework, in their attention to professional failings of social workers and their senior managers to protect children (Gibbons *et al.*, 2010; Powell and Scanlon, 2015; Shannon, 2017) [8] particularly as the perception was that the legislative power, resources and polices had been put in place for the CPW service (Gibbons *et al.*, 2010). Buckley and O'Nolan (2013) noted that successively, the reports of Irish Inquiries recommended improved vigilance, better interagency cooperation, record-keeping, and exchange of information; better practice guidance and the adoption of a children's rights and child-centred approach.

2.4. Impact of inquiries on CPW policy and practice

Higgins *et al.* (2019) suggested that inquiries were almost universally instrumental in expanding the understanding of what constitutes child abuse and neglect and simultaneously broadening the scope of policies as CPW systems aimed to avoid missing potential cases by lowering the threshold for involvement with services. Evolutions in the understanding of causal explanations of child abuse were particularly influential on expanding the scope of child protection policy and practice (e.g. Bronfenbrenner, 1979; 1994; Kempe *et al.*, 1962) and I discuss this in Section 2.3 below. The anxiety generated as a result of such inquiries and the media attention they generated focussed attention on the

6 The Commission to Inquire into Child Abuse was established on 23 May, 2000, pursuant to the Commission to Inquire into Child Abuse Act, 2000 was given three primary functions, to hear evidence of abuse from persons who allege they suffered abuse in childhood, in institutions, during the period from 1940 or earlier, to the present day; to conduct an inquiry into abuse of children in institutions during that period and, where satisfied that abuse occurred, to determine the causes, nature, circumstances and extent of such abuse; and to prepare and publish reports on the results of the inquiry and on its recommendations in relation to dealing with the effects of such abuse. When published in 2009 by the Irish Government the Ryan Report, prompted a seismic change in people's attitudes to the Catholic Church, and to childhood, in Ireland (Shore and Powell, 2020).

7 In January 2009, a mother of six children, was sentenced in Roscommon Circuit Court, Ireland to seven years in prison following her conviction for incest, neglect and ill treatment. The presiding Judge, Judge Miriam Reynolds, (RIP) said the children were failed by everyone around them and that she was concerned that, while the former Western Health Board had been involved since 1996, the children had not been taken into care until 2004. In 2009 the Health Service Executive established the Roscommon Child Care Inquiry to examine the entire management of the case from a care perspective, to identify any shortcomings or deficits to the care management process and make a report on the findings and any learning arising from the investigation. The Report of that Inquiry was published in 2010 (Gibbons et al., 2010).

8 In 2017, a high profile Irish Garda (police officer) was incorrectly categorised on Tusla files as a suspected child abuser. An investigation ensued by the Health Information Quality Authority into the way the Child and Family Agency Tusla handled referrals of child sex abuse allegations found "systemic failures" and a "systems error" (HIQA (unpublished)A review of the child protection service provided by the CFA (Tusla) and the governance arrangements in place to ensure an effective timely and safe service). In addition, a tribunal of Inquiry convened to investigate the matter reported that "Reviewing this account of error upon error, of not attending to duty upon not attending to duty, of not abiding by guidelines...the tribunal is left utterly dispirited." See https://www.justice.ie/en/JELR/Pages/The_Disclosures_Tribunal

need for accountable responses and placed CPW social work in Ireland and elsewhere, under increased scrutiny (Beddoe, 2010; Buckley and O'Nolan, 2013; Cuccaro-Alamin *et al.*, 2017; Featherstone *et al.*, 2012 p.56; Gibbons *et al.*, 2010; Gilbert *et al.*, 2011a; Kearney, 2013; Lonne *et al.*, 2009; see also McGregor and Quin, 2015; Munro, 1999a; 2010b; Thorpe, 1997). However, several commentators suggest that responses to high profile inquiries into child abuse and death during the 1980s in particular served to maintain the focus of policies on managing 'risk of risks' (Kearney, 2013; Mansell *et al.*, 2011; Munro, 1999b). Kearney (2013) argued that such inquiries and media coverage of *single past* child deaths on CPW in the UK had the effect of generating biases in probabilistic reasoning because they reinforced the suspicion that all childcare cases are risky.

More broadly, the general emergence of risk awareness and risk management in all aspects of public life and the ensuing focus on individual responsibility (Beck, 1992b; Giddens, 1990) combined with concerns arising from specific child care and protection contexts to influence the role of the state and the scope and focus of states' CPW policies (Gilbert *et al.*, 2011a; b). According to Featherstone et al., this 'eclipsed concerns to understand **why** children experienced harm or indeed how harm was defined' while simultaneously, the focus on individual responsibility took hold in the context of rolling back state welfare' (Featherstone *et al.*, 2016 original emphasis. p.11).

Since the consequences of underestimating risk are so severe for children, there has been a tendency to overestimate risk (both at policy level and individually) resulting in the overinclusion of cases that appear not to involve serious abuse or, false positives (Jenkins *et al.*, 2017; Mansell *et al.*, 2011; Munro, 1999b). Gibbons *et al.* (1995) identified the 'filter and funnel' system to categorise demand for, and delivery of, CPW services. Their study, which tracked a sample of 1,888 children referred to eight local authorities in the English CPW system for suspected abuse or neglect over a 16 week period, found that 70% of the referrals were screened out (Gibbons *et al.*, 1995).[9] On the whole the process represented a burden of work for already stretched SWs, but also left many families feeling unnecessarily drawn into the system (Gibbons *et al.*, 1995). While that research, like the early research on responses to referrals CPW in Ireland (Buckley, 2003; Ferguson and O'Reilly, 2001) preceded the current legislative, organisational and assessment frameworks, this pattern of demand and response has been persistently identified in this and other jurisdictions (Buckley, 2000a; 2015; Buckley and Burns, 2015; CIS, 1998, 2003, 2008; DHHS, 2018; 2020; Fallon *et al.*, 2022; Hayes and Spratt, 2014; Hood *et al.*, 2016; Mansell *et al.*, 2011; O'Leary *et al.*, 2015a; Spratt, 2001; Thorpe, 1997; Tusla, 2015; Whelan, 2018). However, as I discuss a little later in Section 2.5, it is not the case that screened out children represent those who are not at risk or who do not have service needs.

The necessity to manage demand and to support consistent and accurate judgments about risk and service needs led to an expansion in the formal management structures and to a proliferation of policies and guidelines for assessment and decision-making, interagency cooperation and record keeping

[9] Gibbons found that devices for screening or filtering referrals varied across the local authorities with many moved from one process to another with little information about the rationale applied.

(Buckley and Burns, 2015; Buckley and O'Nolan, 2013; Buckley and O'Nolan, 2014; Christie *et al.*, 2015; Lees *et al.*, 2011; Munro, 2011a; Parton, 1998; Waterhouse and McGhee, 2009). The move in other jurisdictions to develop and incorporate actuarial risk assessments to support decision-making did not occur in Ireland or the UK, which traditionally, have been similar (Baumann *et al.*, 2005; 2006; Johnson, 2006; Mendoza *et al.*, 2016; Schwalbe, 2004; 2008; Shlonsky and Wagner, 2005; Wagner, 2009). In her review of the English CPW system, Munro (2011a p. 6) said that internationally, the blame culture and reform efforts resulted in a clear 'dominance of risk adverse systems' in operations, evidenced by managerialist strategies for assessment and decision-making resulting in systems that are 'over-bureaucratised and focussed on compliance'.

In Ireland, the economic crash in the late 2010s meant increasing demands on a public services operating with fewer resources and the adoption of economic models of practice in CPW to improve accountability (Buckley, 2017b; Buckley and Burns, 2015). The Children and Family Social Workers in the Irish Association of Social Workers (IASW) had cautioned that reforms to Irish policies for assessment and decision-making practice were counterproductive in the same way they were in the UK (Buckley and O'Nolan, 2013; Featherstone *et al.*, 2012; IASW, 2011; Lees *et al.*, 2011; Munro, 2011b; Pithouse *et al.*, 2012; Waterhouse and McGhee, 2009) on the basis they had resulted in a focus on performance monitoring over working with children and families (Buckley, 2012; Featherstone *et al.*, 2012; Howe, 1996; HSE/Tusla, 2009/2014; IASW, 2011; Munro, 2011b p.19). Accordingly, the priority for SWs was to gather, record and exchange information that enabled them to classify clients for purposes of judging the nature of risk and allocating resources and not necessarily relating to client characteristics and needs (Howe, 1996; Parton, 2004; 2008).

Again, more broadly, practitioners argued there was a need to balance the focus on procedural adherence with an understanding of professional judgment and the complex task of analysis in assessments (Helm and Roesch-Marsh, 2010; Munro, 2010b; 2011b). Several authors suggest this activity is complicated by motives and risks that present in the practice environment (Buckley, 2003; 2015; Shlonsky and Mildon, 2017). Researchers found that the very uncertainties and ambiguity inherent in risk-immersed social work that these management systems and working procedures aimed to defend against essentially mediated 'who gets what services and why' (Pithouse *et al.*, 2012 p159) and simultaneously served to enhance social workers' anxieties and uncertainties. These included anxieties about the capacity for developing professional working relationships with clients, the demands of working with increased demand and constrained resources, the desire to provide services that simultaneously support families and protect children concerns while avoiding unwarranted intrusions into people's lives in situations where little could be achieved by their interventions, concerns about partnership with other professionals, and concerns about performance monitoring and increasing regulation (Buckley, 2003; Burns and MacCarthy, 2012; Cooper, 2010; Featherstone *et al.*, 2014a; b; Ferguson and O'Reilly, 2001; Helm and Roesch-Marsh, 2010; IASW, 2011; Lees *et al.*, 2011; Munro, 2004a; 2011b; Peckover *et al.*, 2009; Waterhouse and McGhee, 2009).

Specifically, in Ireland, the simultaneous need to improve accountability and accuracy meant that policies for CPW became increasingly risk averse and legalistic (McGregor and Devaney, 2020a; Mooney, 2018)[10] presenting challenges for working therapeutically with abuse victims (IASW, 2011; Mooney, 2018; Power, 2020a). In 2017 government introduced mandatory reporting (DCYA, 2015) which alongside the continued government under-resourcing of social work services relative to other European countries meant the system struggled to achieve the stated aims (e.g. Buckley and Buckley, 2015; Buckley and Burns, 2015; Burns and Lynch, 2008; Burns and MacCarthy, 2012; Christie *et al.*, 2015; Featherstone *et al.*, 2012; Wayman, 2014). Buckley (2008) argued that the impact of new public management (NPM) ideologies reflected in the introduction in 2009 of Standard Business Processes (see Figure 1) for assessment and decision-making, represented a reductive approach to practice that together with insufficient resources and managerial constraints would leave vulnerable children and families without sufficient support (Buckley, 2017b; HSE/Tusla, 2009/2014). Munro (2010b) said that NPM strategies resulted in increased managerial control of professional behaviour – through prescriptive procedures like the Standard Business Processes (SBPs) - and a greater demand for transparency - achieved through specifying targets and performance indicators relating to them (Tilbury, 2004). This Munro (2010b) argued generated a very biased set of data that omitted some of the key quality aspects of the relationship-based service, a matter that is addressed in section 2.5.5 and which the research in this thesis aims to revise. Mindful of the need to provide a detailed examination of the evolution of Irish policy for assessment practice this review continues with a description of the legislative policy and regulatory framework and the organisation structure, followed by a review of the largely unintended impact of the organisation of services, proceduralisation, and managerialism.

2.4.1. Legislative and policy framework

The Child Care Act introduced in 1991(Department of Health, 1991) replaced the 1908 Act and drew from the 1989 Children Act in the UK. It placed a positive duty on the CPW service to 'identify' and 'promote the welfare' of children who are 'not receiving adequate care and protection' (S.3 (1,2)). Under the 1991 Act, professionally qualified social workers are required to 'take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children in its area" (Section (3)(2)(a)). Subject to respecting the rights and duties of parents and the recognition that it is in the best interests of children to be brought up in her/his own family, the Agency is required to 'provide child care and family support services' (Section (3)(3)). Together with the Child and Family Agency Act (DCYA, 2013), the 1991 Act is the key legislation governing SW assessment and decision-making and has been the basis for elaborating policy and practice guidelines for IAs, discussed in detail at Section 2.4 below.

The Government's substantive policy for child protection is set out in *Children First: National Guidance for the Protection and Welfare of Children* (*Children First*), first published in 1999 and

[10] Policies included the introduction in 2017 of mandatory reporting in addition to a range of guidelines for responding to and assessing referrals.

revised in 2011 and again in 2017 (DCYA, 2011a; 2017; 1999) when they were put on a statutory footing and mandatory reporting of suspected concerns of abuse to Tusla was introduced for a number of professions, voluntary sector organisations in receipt of state funding, and members of the clergy (DCYA, 2015; SI.No.470/2017, 2017).

The Standard Business Processes (SBPs, See Section 1.2 and Figure 1), introduced a decade after *Children First* aimed to ensure a consistent response to referrals across all social work departments in the country (HSE/Tusla, 2009/2014) and generate reliable management information for the National Child Care Information System (NCCIS).[11] The IA process, decisions and information requirements are detailed at Section 2.4 below.

In 2012 the regulation of CPW practice introduced under *Children First* (DCYA, 2011a; Department of Health and Children, 1999) and the SBPs (HSE/Tusla, 2009/2014) commenced with the introduction of *National Standards for the Protection and Welfare of Children* (HIQA, 2012) subject to inspection by the independent, statutory Health Information Quality Authority (HIQA). The standards state that

> *In safe and effective services, practitioners are supported in making appropriate evidence-based assessments and decisions and managing risk to provide interventions and supports that are more likely to protect children not receiving adequate care and protection' (HIQA, 2012 p.18).*

HIQA also has oversight for of a National Review Panel following the publication of *Guidance for the Health Service Executive for the Review of Serious Incidents including the Deaths of Children in Care* (HIQA, 2010). Specific policies for assessment practice are described at Sections 2.8 below.

Also since 2012, the social work profession has been regulated by the Health and Social Care Professionals Council (CORU) of Ireland (CORU, 2017) fulfilling recommendations of the 1970 Kennedy report (Kennedy, 1970). In 2004 the Office of the Ombudsman for Children was established and in 2006 a Special Rapporteur for Children was appointed by Government, to provide input into the development and review of child protection policy and legislation in addition to providing independent observations on the functioning of the Irish system. Ireland is a common law jurisdiction meaning that decisions of the court regarding child protection have implications for national policies. One such implication is the introduction in 2022 of a substantiation policy for allegations of abuse (Tusla, 2022) which is viewed by some as being problematic.[12]

[11] The SBP system was fully integrated into the National Child Care Information System (NCCIS) an electronic case management system in 2017.

[12] The proposed Tusla substantiation policy is viewed as problematic due to the absence of legislative guidance on how competing rights of children and the alleged abuser should be weighed against each other (O'Mahony, 2020). This policy, based on the interpretation of the duty on Tusla by the Irish courts, requires Tusla to investigate complaints of abuse and mitigate any risks that are identified in respect of a reported child and any child who has contact with an alleged abuser, and to disclose the allegation to third parties. As a result of Tusla's proposed policy, discussions about abuse are increasingly framed in legalistic terms in public discourse (O'Mahony, 2020).

More broadly, children's rights and interests were reflected in a range of policy decisions. Ireland ratified the UN Convention on the Rights of the Child without reservation, and it came into force in October 1992 (UN, 1989; UNCRC, 2011). The first *National Children's Strategy* (DHC, 2000) published by Government in 2000 was underpinned by the UNCRC (UN, 1989) and reinforced the 'whole child' perspective in approaches outlined for statutory agencies and the voluntary sector. In 2012 a Constitutional Referendum on the rights of the child led to amendments to Articles on the Family (Article 41) and Education (Art 42) that had been long campaigned for through inquiry reports (e.g. McGuinness, 1993) affirming 'the natural and imprescriptible rights of all children' (Article 42.A.1) independent of their family. Ireland is a signatory to the Charter of Fundamental Rights of the EU, 2012 and to the 9th European Forum, Rights of the Child, in 2015 (Commission, 2015).

2.4.2. Organisation of services

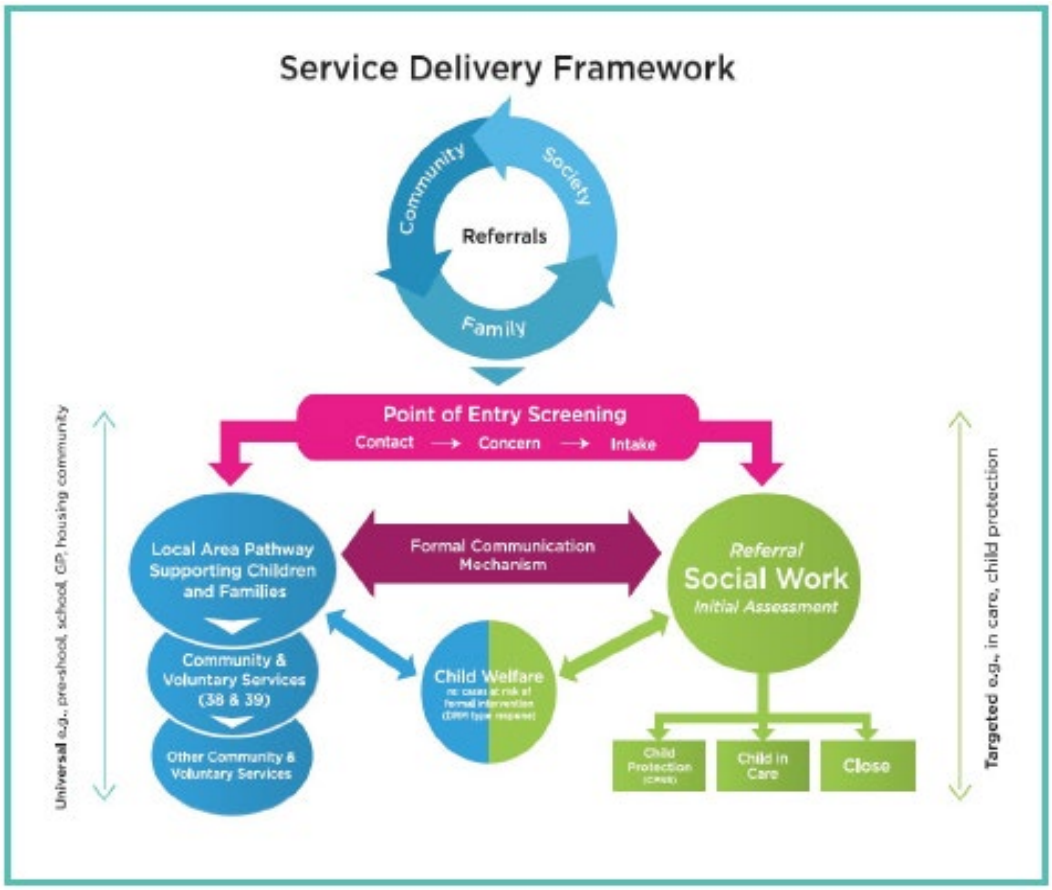
In 2005 management of Health Boards transferred to the Health Service Executive (HSE) in an amalgamation that aimed to increase efficiencies and end the duplication of management positions and inconsistencies in services provided and standardise service delivery (Irish Times Editorial, 2006). Although still delivered under the auspices of the health service, by this time the 'medical domination' of CPW had ended (Buckley and Burns, 2015). From 1999, the framework of practice incorporated roles and responsibilities for AGS and a range of hospital- and community-based health and social-care professionals, delineated under national guidelines (Department of Health and Children, 1999). That framework remained in place until 2014 when Tusla – Child and Family Agency (Tusla) was established as an independent agency. Subject to the legislation, Tusla is accountable to the Department of Children and Youth Affairs, an independent department first created in 2011 as part of the reforms post Ryan (2009) that has been retained in successive Governments, often with additional portfolios.

Following the enactment of the Child and Family Agency Act, 2013 Tusla was established in January 2014 as an independent state agency for *Child Protection and Welfare* and for *Domestic, Sexual and Gender-based Violence*. The Agency describes itself as 'the dedicated State agency responsible for improving wellbeing and outcomes for children' (https://www.tusla.ie/about/ accessed April, 2017). The scope of services was once again, extended as a programme for Prevention, Partnership and Family Support (PPFS) was established in 2015 as part of the continuum of CPW services but, which focuses on early intervention and preventative work through the *Prevention Partnership & Family Support (PPFS) Service* via an interventions called a Meitheal[13] (see Burns and McGregor, 2019; Tusla, 2013a; b). One of the aims of PPFS is its use as a diversion programme from CPW social work (Cassidy *et al.*, 2016; McGregor, 2014). As described in Figure 2 the National Service Delivery Framework has at its central tenet a differential response model, implemented through the establishment of local area

[13] Meitheal is an old Irish term that describes how neighbours would come together to assist in the saving of crops or other tasks. As a national practice model Meitheal is a case co-ordination process for families with additional needs who require multi-agency intervention but who do not meet the threshold for referral to the Social Work Department under Children First or who are diverted from a Social Work Department because their needs do not meet the threshold for intervention (Tusla, 2013b).

pathways and family support services operating with thresholds for referral to the CPW service (Tusla, 2013a).

Figure 2 National Service Delivery Framework, Tusla (2016b)

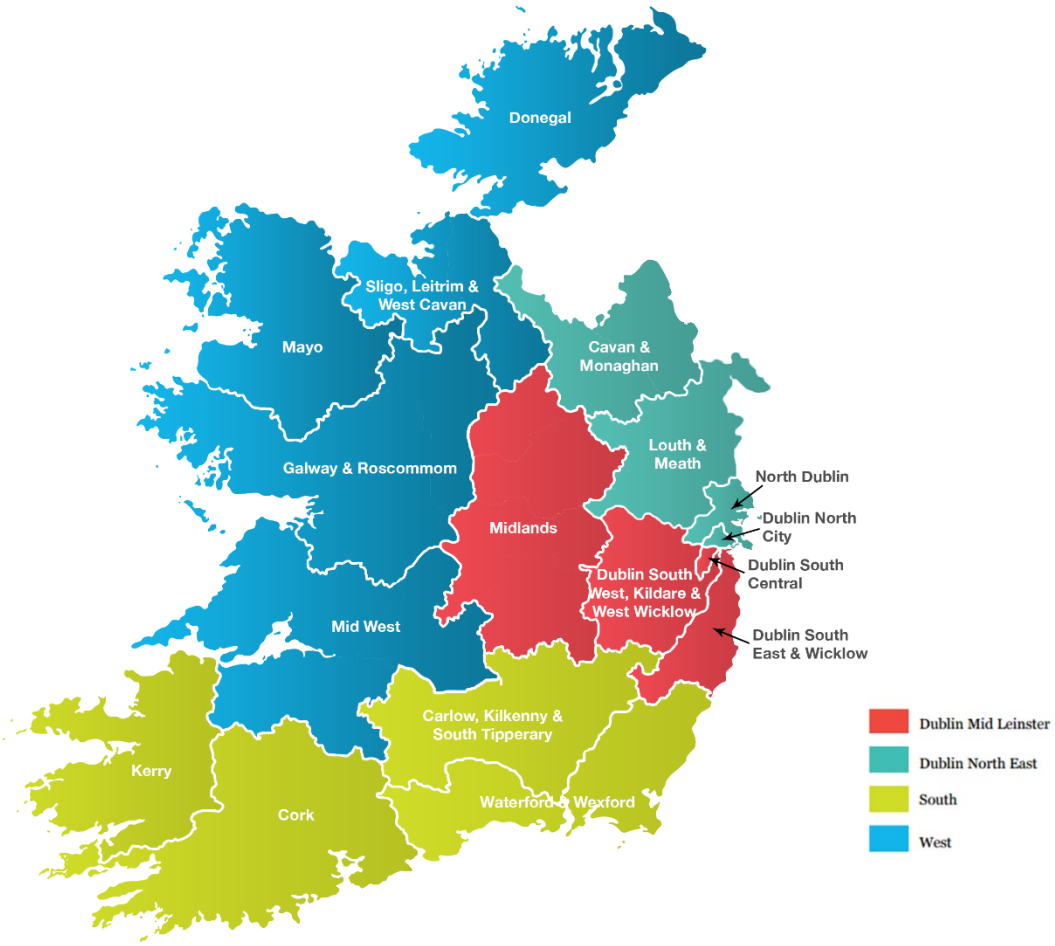


The establishment of Tusla, described as one of 'the most comprehensive reform of child protection undertaken in Ireland'(O'Brien, 2014a) marked the culmination of the developments recommended in the Report of the Task Force (Department of Health, 1980) that had identified an absence of coordination among states bodies with responsibility for children and progressed the development of legislation and resulting associated services for child care. At the launch of Tusla in 2014, Frances Fitzgerald, then Minister for Children and Youth Affairs, commented that Tusla would

> *...set out to fill a profound deficit, as well as dysfunction, duplication and inconsistency within services ... In many cases, we saw how at-risk children were failed by the State, not because the state didn't intervene, but because interventions were uncoordinated and ineffective. Ireland has moved beyond a ritual dance of shock and dismay at recurring exposés of child neglect to practical action ... we're going to transform child protection in Ireland, keep children safe and support Irish families (Fitzgerald, 2014).*

CPW services are provided 32 Social Work Departments (SWDs) operating in 17 administrative areas located within four regions nationally (see Figure 3). Each SWD is managed by a Principal Social Worker, who reports to the Area Manager. Team structure within SWDs vary according to local arrangements and generally include a Duty and Intake Team; Assessment Team and Long Term Team or Children in Care Teams aligned to SBPs for receipt of referral, Intake, IA and ongoing services.

Figure 3 Management Structures as transferred from HSE to Tusla 2014 (source Tusla, 2016)



2.4.3. Standardisation of referral and assessment practice

When *Children First* (Department of Health and Children, 1999) was implemented, according to Irish researchers, neither the design of the system or the bureaucratic infrastructure could facilitate standardisation of CPW practice, nor could it deliver the accountability needed by the system partly due to the range of governance structures and partly because of the range of practice frameworks for assessment and decision-making that were in place (Buckley, 1999; 2003; Buckley *et al.*, 2006b; Department of Health, 2000a; Department of Health and Children, 1999; Ferguson and O'Reilly, 2001; Kemp, 2008; Southern Health Board, 2003; Walsh, 1999).

Initially, *Children First* (Department of Health and Children, 1999) was decentralised to the regional Health Boards for implementation, and although a common approach was agreed among them subsequent audits found practices varied widely across SWDs, even within a single Health Board, reflecting situated cultural professional practices and norms (O'Leary, 2007a; Ombudsman for Children's Office, 2010; PA Consulting Group, 2009). However, through the developments outlined compliance and accountability incrementally became key rationales for the development, delivery and oversight of CPW services (Buckley and O'Nolan, 2013; HIQA, 2012; 2015; 2016; Kemp, 2008; O'Mahony, 2020; Shannon, 2012). Policies for referral and assessment are continuously in development. Section 2.6 provides a review of policies for IA practice in 2015-2016 when this research was undertaken.

Sections 2.2 to 2.4 provided a brief review of the development of the current CPW service highlighting the effects of legacy issues and current failings of the CPW system on the development of the legislative, regulatory, organisational and policy framework for practice. At the same time, policies and practice were influenced by international research on the aetiology and scope of child abuse to which the review now turns.

2.5. Aetiology of child abuse and constructing service responses

The interpretation of presenting concerns and risks and the classification into one of four categories of abuse or welfare concerns, i.e., concerns not meeting the threshold for abuse, is one of the main tasks in IAs (DCYA, 2011a; 2017; Department of Health and Children, 1999; HSE/Tusla, 2009/2014; Tusla, 2014a; b; c). This section briefly explores evolutions in the aetiology and the influence on identifying the 'object of concern' for public child protection systems (Parton, 2017 p.9) and particularly, policies for assessment and decision-making about children and families service needs (Belsky, 1980; DCYA, 2011a; Department of Health and Children, 1999; Ferguson and O'Reilly, 2001; HSE, 2011; Jud *et al.*, 2015; Tusla, 2014c). In particular, through international comparisons, it draws attention to the scope of Irish policy with a view to examining the evidence produced by the Irish system about IAs and situating the research questions addressed in this thesis.

2.5.1. Causal explanations of abuse

Causal explanations of child abuse shifted from a focus in the 1950s and 1960s on individual attributes of offenders and definitions based on medical science, winch came to be known as the battered child syndrome (Kempe *et al.*, 1962), to a social-ecological model that incorporates interacting factors at the child, parent, family and socio-demographic levels (e.g. Bronfenbrenner, 1994; Mulder *et al.*, 2018; Sethi *et al.*, 2013; Stith *et al.*, 2009). This was because research identified that no single risk factor or set of factors provided necessary or sufficient cause for abuse (Belsky, 1980; Cicchetti and Rizley, 1981). The ecological theory of child development and later child abuse, which evolved between the 1970s and 1990s (Belsky, 1980; 1993; Bronfenbrenner, 1979; 1994) explains child development over

time based on multiple interdependent and interacting systems in a process-person-context-time model (Bronfenbrenner, 2001). The ecological–transactional model of child abuse (Cicchetti and Lynch, 1993; Cicchetti and Rizley, 1981) suggests that the probability of abuse, as well as subsequent development, is influenced by a balance among risk and protective factors and their interaction, within any given level of the social ecology. Evidence also points to the intergenerational continuity of child maltreatment and mechanisms that facilitate it (Adams *et al.*, 2019; Savage *et al.*, 2019; Widom *et al.*, 2015).

The premise of ecological models is that interaction between wider ecology and potentiating factors, identified as parental, child or environmental factors and transient challenges are seen to increase risk, and enduring protective factors and transient buffers are seen to reduce risk of abuse (Cicchetti and Rizley, 1981). The model is used to explain the fact that not all children who have been abused are equally impacted developmentally and why children, and families, move in and out of risk (Cicchetti and Lynch, 1993). Ecological theory was central to the development of an Assessment Framework developed by the Department of Health in the UK (Department of Health, 2000a) and adopted as the framework IAs in Ireland as part of the SBPs in 2009 (HSE/Tusla, 2009/2014) and employed as a data source in this research were directly based on this ecological model (See Section 2.4 below). That framework recognises the role of features within and outside the family in child development in addition to their role as causal mechanisms for abuse (Freisthler *et al.*, 2006; Hamilton-Giachritsis and Pellai, 2017; Pelton, 2015; Stith *et al.*, 2009) and their role in designing responses and targeting prevention efforts (Krug *et al.*, 2002; Mulder *et al.*, 2018; Sidebotham and Heron, 2006; Stith *et al.*, 2009).

2.5.2. Scope of policies and definitions of abuse

Definitions of abuse influence the scope of policies for surveillance, referral, response, service delivery and research (Fallon *et al.*, 2010; Gilbert *et al.*, 2009a). During the first few decades of research on child abuse, there was a focus on individual forms of abuse and neglect but, the scope of policies and definitions expanded as evidence and awareness grew about multi-type abuse and polyvictimisation (see Price-Robertson *et al.*, 2013b), online sexual exploitation of children (Quayle and Taylor, 2003) and the effects on child development of exposure to domestic violence (DV) and what is characterised as 'hidden harm' arising from parental drug and alcohol misuse these categories are increasingly recognised as types of abuse (e.g. Fallon *et al.*, 2017b; Gibbons *et al.*, 2010; Gilbert *et al.*, 2009a; Hope, 2011; HSE, 2011; Parton, 2006; Stanley *et al.*, 2011; UNICEF, 2014; WHO, 2016).

In Ireland, up to the 1980s, policy largely focused on Non-Accidental Injures (NAIs) (Department of Health, 1976; Kempe *et al.*, 1962). By 1987 Irish practice guidelines also recognised sexual abuse (Department of Health, 1987; Thorpe, 1997) and over the following decade neglect and emotional abuse were also recognised in policy responses. These changes were reflected in *Children First,* the reference text for CPW practice based on the 1991 Act (DCYA, 2011a; 2015; Department of Health and Children, 1999). The guidelines also included indicators of deficits in child welfare, thus expanded the scope of policies for reporting, assessment, and service provision (Department of Health and Children, 1999;

HSE, 2011; HSE/Tusla, 2009/2014).[14]. When enacted the Child Care Act 1991 was seen as a shift from a residual, reactive system to one with a positive duty to identify and respond to children not receiving adequate care and, a shift from a requirement to have 'evidence' of abuse or harm, principally in relation to NAIs and based on a medical model of intervention, to one focused on 'likely' risk of abuse or harm (McGregor, 2014).

Current definitions of abuse and welfare concerns in Irish policy are listed at Appendix 1. Although DV has been identified as a concern for response in Irish policy and practice, coverage of children specifically victimized by domestic violence is not captured in the Tusla data but policy changes to revise this are under consideration (Buckley, 2018; Buckley *et al.*, 2011b; Department of Health and Children, 1999; Furey and Canavan, 2019; Holt *et al.*, 2008; HSE, 2011; Mulkeen, 2012). In the US, Canada and Scotland exposure to DV is considered a form of abuse that warrants referral to CPW, and in those jurisdictions it is counted among CPW activity data (Henry, 2018; Sheehan, 2019; Victor *et al.*, 2021).

Chapter 3, Section 3.4 picks up this discussion on definitions in reviewing the literature regarding the interpretation of reported concerns during IAs for the purpose of categorising them into one of four abuse categories or as welfare concerns. The next section reviews the framework and policy for conducting IAs as it was in 2015/2016 when this research was conducted.

2.6. Initial Assessment theory, practice, and guidance

2.6.1. What is an initial assessment and what are the target decisions?

The Initial Assessment (IA) is a process that occurs after Intake, when preliminary inquiries into a referral by a professional social worker conclude that there may be child safety concerns or unmet welfare needs (HSE/Tusla, 2009/2014). The purpose of the IA is to reach a preliminary conclusion about unmet need and risk of harm in order to plan and provide an appropriate response within 20 days (HSE, 2011). The importance of good assessment is reflected in national standards and regulation of SW practice (HIQA, 2012).

Processes and thresholds for accepting referrals as cases for assessment vary across Anglophone jurisdictions. In Ireland, Northern Ireland, England, Wales, and Scotland the process following the acceptance of a case is called an assessment. In Australia, NZ, Canada, this process is called an investigation and the USA the term assessment is increasingly employed. In all jurisdictions assessments/investigations can lead to child protection interventions that include alternative care. Most

[14] *Children First* (DHC, 1999) also introduced for the first time a Child Protection Notification System (the CPNS), a register of children deemed to be at risk of significant harm, to be created and managed regionally by CPW SW within the Health Boards and created specific duties and processes for information sharing and case management between CPW SW and AGS.

jurisdictions incorporate some form of differential response mechanism for the direct provision or commissioning of family supports.

The aim of CPW assessment/ investigation across Anglophone jurisdictions, including Ireland is the identification and management of risks in reported cases, and secondary prevention through strategies aimed at reducing recurrence of abuse (Buckley and Burns, 2015; Burns and McGregor, 2019; Gilbert *et al.*, 2012; Scott *et al.*, 2016). This practice is founded on the fundamental principles that the interests of the child are paramount and that and delay in resolving concerns is likely to prejudice the welfare of a child, overall, the potential harms of reporting to child protection services are outweighed by the benefits of recognition and therapeutic or protective responses and that non-intervention is preferred, except in cases where it can be demonstrated that a state intervention is necessary (DCYA, 2011a; Department of Health and Children, 1999; Dixon *et al.*, 2017; Gilbert *et al.*, 2009a). Dixon and colleagues suggest 'these principles are based on practitioners having a thorough understanding of the developmental needs of children; the capacities of parents to respond appropriately to those needs; and the impact of the wider family and environmental factors on parenting capacity and children' (Dixon *et al.*, 2017 p.6).

These principles are reflected in Tusla's *Assessment Framework Guidance* which states "It is important that the practitioner … has a clear understanding of the factors that may impact on individual children and their families, measured against theoretical bases, best practice models, current research, National Business Processes, National Policies and Guidance, and HIQA National Standards for the Protection and Welfare of Children" (Tusla, 2014a p4). The factors, it states, "include child development; attachment and separation; protective factors and resilience; parenting/parenting capacity; socio-economic factors; substance misuse/dependency; domestic violence; mental health; disabilities; behaviour management; Family systems theory." (Tusla, 2014a p.4-5)

The formal target decisions of the IA are

- to categorise the case as welfare or child abuse, and for abuse cases to determine whether or not the child is at risk of significant harm;
- to decide a course of action, from among the following options: Further Assessment; Child Welfare / Family Support Planning; Child Protection proceedings; Child in Care proceeding; or to close the case with or without a referral to another agency or diversion to Tusla family support (PPFS)(HSE/Tusla, 2009/2014; Tusla, 2014a).

In order to progress to a child protection intervention two thresholds must be reached (1) there are grounds for believing that a child is at on-going risk of significant harm and (2) that likelihood of significant harm is attributable to inappropriate or inadequate care from parent/s thus requiring a Child Protection intervention (Tusla, 2015 p7).[15] While this thesis explores and discusses the categorisation

[15] Whereas children may suffer harm for a range of reasons, for the purpose of the child protection conference and the CPNS, the threshold of ongoing risk of significant harm is confined to abuse, including neglect, attributable to

of concerns during IA, the analytic cross-sectional study described at Chapter 7 focuses on factors associated with the decision whether or not to provide service.

According to Calder, the task of assessment is 'the heartbeat of all social work practice' (Calder, 2017 p.279). Turney *et al.* (2011) say that 'good' initial assessments are associated with early interventions and good outcomes for children. Conversely, as detailed above, shortcomings in assessments have been a consistent feature of cases with poor outcomes (e.g. Gibbons *et al.*, 2010; McGuinness, 1993; NRP, 2014; 2016; 2017; Ryan, 2009; Tusla, 2015). Social workers conducting assessments operate in a field pervaded by uncertainty and routinely must decide which children are at risk of future harm and how to manage potential risk (Mansell *et al.*, 2011). In doing so they balance two concerning possibilities; that of overlooking indicators that children are unsafe, i.e. false negative decisions, versus overreacting when children are safe, false positive (Mansell *et al.*, 2011; Munro, 2010b; Shlonsky and Friend, 2007). The consequences may mean that children may be left in situations where they suffer on-going adversity and cumulative harm or alternatively families suffer unnecessary and disruptive intrusion. Thus, correctly detecting from among children referred, the subgroup of children at high risk for future abuse in the absence of intervention is a main concern in assessments (Johnson *et al.*, 2015; Knoke and Trocmé, 2005; Macdonald and Macdonald, 2010). Or, as Parton (2014b) described, the focus is putting into operation the state's legal basis for intervening into some family's while trying to ensure that not all families become clients of the state.

2.6.2. Irish Assessment policy and guidance

The overarching policy for Assessment is *Children First* (DCYA, 2011a) requires social workers 'to identify the nature and severity of any risks, and identify any strengths and protective factors that appear to lessen the risk, such as protective care, support of extended family member or friend, or existing family support service' (DCYA, 2011a 5.4.2. p 31). As the 'full reference text for practitioners' (HSE, 2011), *Children First* was supported by a number of Agency policies. Together, the stated aim of these policies is to support the 'delivery of a consistent, efficient, effective, proportionate and accountable response from our services' (HSE, 2012a) through assessments that identify the likelihood of future abuse and to assign individual clients to the appropriate outcome category (Department of Health and Children, 1999; HSE, 2011; Tusla, 2014a).

The UK based *Framework for the Assessment of Children in Need and their Families* (Department of Health, 2000a) was employed in the design of the formal Initial Assessment Record (IAR) that was required to be completed and held on a child's case file (see Appendix 3). Based on a triangle (see Figure 4 below), the assessment framework provides as systematic way of recording and analysing reported concerns in the context of three broad domains the child's developmental needs, the capacity

inappropriate or inadequate care from parent/s Where a child has suffered harm outside of their family and they are receiving appropriate care from their parent/s, they may well require substantial services and there may be a criminal investigation; however they will not be the subject of a child protection conference. Equally, children who pose a risk to themselves or others as a result of behavioural or mental health issues but who are receiving appropriate parental care will not be the subject of a child protection conference.

of parent or caregivers to respond appropriately to those needs and the impact of the wider family and environmental factors on the child development Each domain consists of several dimensions, each translated into a question with free text entry in the IAR. Social workers are advised to consult with the child and family to reach a shared understanding of the child's needs based on family context and the strengths and difficulties in each of the domains (HSE, 2011; HSE/Tusla, 2009/2014).

Figure 4 Assessment triangle FACNF, DH, 2000



From 2009 onwards, a range of practice guidelines were published specifically to support SW assessment and decision-making that were aligned to the national guidelines *Children First* (DCYA, 2011a; Department of Health and Children, 1999) and the SBPs (HSE/Tusla, 2009/2014). In addition, between 2001 and 2017, four consensus frameworks were approved for assessment practice, so long as practice conformed to national policy (DCYA, 2011a; HSE, 2011; HSE/Tusla, 2009/2014; Tusla, 2014a; c). These were the *Framework for the Assessment of Vulnerable Children and their Families* (Buckley *et al.*, 2006b), *Framework for the Assessment of Children in Need and Their Families* (Department of Health, 2000a),[16], *Signs of Safety* (Turnell and Edwards, 2011), and the *Risk Assessment Framework*, Scotland (Calder *et al.*, 2012). That said, when Tusla was established in 2014, the assessment record based on the *Assessment Triangle* and integrated with the SBPs was retained (Department of Health, 2000a; HSE/Tusla, 2009/2014) along with the existing *Practice Handbook* (HSE, 2011). In 2014 these were supplemented with the *Assessment Guidance Framework* (Tusla, 2014a) and the *Threshold of Need Guidance* (Tusla, 2014c)[17] in addition to a policy for responding to

[16] As mentioned above, this framework was used to develop standard records that were aligned to the Standard Business Processes and formed the formal records of intake and initial assessments during the time this research was conducted (HSE/Tusla 2009/2014).

[17] Two years following completion of the research for this thesis, Tusla introduced the Signs of Safety as a standard approach respond to referrals of child abuse and welfare. This was subsequently aligned to the Standard Business Processes.

retrospective allegations of Abuse and Neglect (Tusla, 2014b) and policies for case load and management and risk escalation (see Text box 2.1).

Text box 2.1 Policy documents that contain guidance for Initial Assessments practice include:

- Children First: National Guidance for the Protection and Welfare of Children (Department of Children and Youth Affairs, 2011)
- The National Standard Business Process (Health Service Executive, 2009)
- Child Protection and Welfare Practice Handbook (HSE 2011/Tusla, 2014)
- The Framework for the Assessment of Vulnerable Children and their Families (Buckley *et al.*, 2006b)
- Framework for the Assessment of Children in Need and Their Families (Department of Health, 2000a)
- Signs of Safety (Turnell and Edwards, 2011)
- Risk Assessment Framework, Scotland (Calder *et al.*, 2012)
- Assessment Guidance and Framework for Tusla (Tusla, 2014)
- Threshold of Need Guidance for Practitioners in TUSLA Social Work Services, (Tusla, 2014)
- Policy and Procedure for Responding to Allegations of Abuse and Neglect (Section 3 Policy) (Tusla, 2014)
- Guidance for Caseload Management for Child and Family Agency Social Work (Tusla, 2014/2015)
- Framework for the analysis of service pressures, Performance and Reporting Social Work Intake Assessment and Allocation Activity (Tusla, 2014)

The *Threshold of Need Guidance* (Tusla, 2014c) was introduced to supplement the *Assessment Guidance Framework* (Tusla, 2014a). Their aim was to support professional judgment, decision-making and communications and to assist consistency of practice, rather than replace or undermine the social work assessment of a child in need or at risk (Tusla, 2014c). The *Threshold Guidance* draws on the hierarchical 'Hardiker Model' of developmental needs (Hardiker *et al.*, 1991) linking a matrix of identified needs or risks to recommended service interventions on a continuum of four levels from universal to high level support (Tusla, 2014c) as described in Figure 5. According to the guidance, relative to the general population, children who are eligible for IA

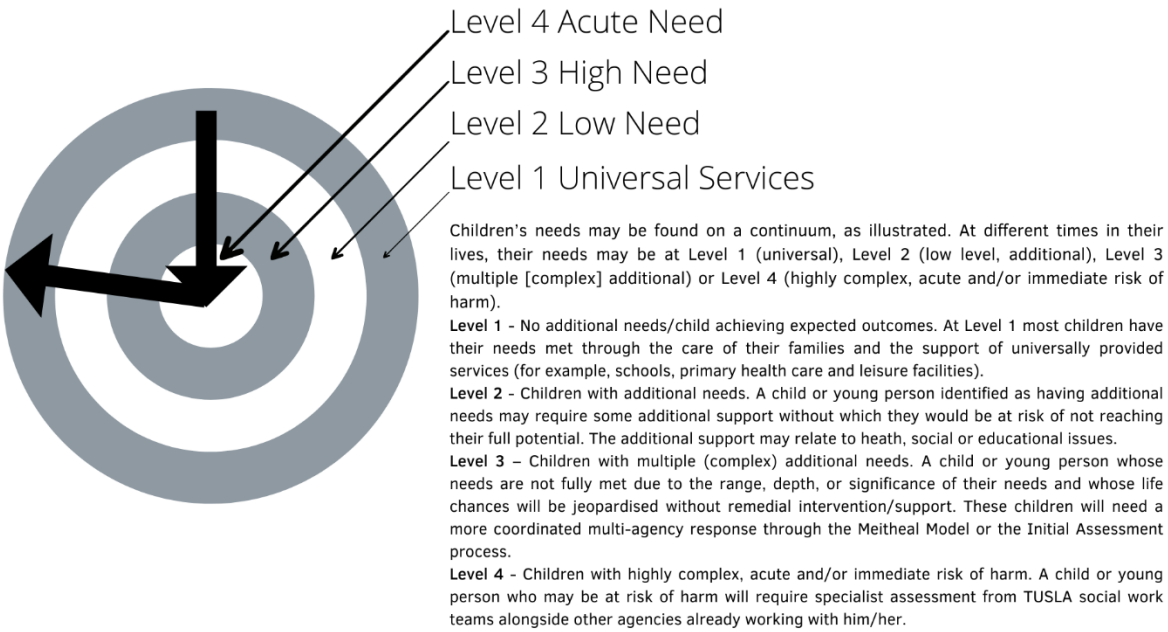
- have multiple, complex additional needs that are presently very significantly compromised, or
- are not receiving adequate care and attention (categorised as Level 3), or
- have highly complex acute needs which includes those who may be at risk of immediate harm (categorised as Level 4)

and those requiring ongoing services following IA were likely to be at Level 3 and Level 4 (Tusla, 2014c). Appendix 4 describes the detail of matrices of need and corresponding business processes.

The *Threshold* guidance advises that it is not intended to provide a rigid set of procedures rather, that

> *it is important that all practitioners understand the needs of each individual child within their own context and realise that each child's situation is unique and specific to them. Nor does it provide an exhaustive list of all the possible situations for children and their families, merely illustrations to assist in decision making. The threshold guidance should also be read in conjunction with the Business Process, Children First, and the Child Protection and Welfare Handbook and Assessment Framework'. (Tusla, 2014c p.1)*

Figure 5 Children's Needs and Levels of Intervention (Tusla, 2014c)



The *Threshold Guidance* aimed to support SWs in the analysis of the information to correctly identify children at risk of harm or in need of service and promote clarity and consistency of response to referrals (HSE, 2011; HSE/Tusla, 2009/2014; Tusla, 2014a; c). While the guidance is prescriptive on what sources to consult, what information should be integrated into assessments and on the characteristics of cases that determine eligibility for different processes (HSE/Tusla, 2009/2014; Tusla, 2014a; c), the process of interpretation or sense-making or analysis of information to reach the decisions required by the policies are based on professional judgment (Tusla, 2014).

The guidelines state that "maximum scope for individual professional and practitioner judgement" is allowed within the rules set out in the framework for assessment (Tusla, 2014a p.1). Elsewhere they state

> *Professional judgment is the sound evaluation of, and response to, the information gathered in the assessment in accordance with the ethical principles of best childcare practice. It is a goal-oriented decision-making or problem-solving process carried out in the interest of the child and family. It is where you give consideration to all relevant information, principles, policies and resources (Tusla, 2014a p.12).*

The *Practice Handbook* (HSE, 2011) elaborates on the evaluation or sensemaking aspect of assessment

> *good risk assessments construct a coherent story about the child's circumstances. They appreciate that there will be ambiguity and uncertainty about some matters; they have been constructed through the testing of hypotheses and a curiosity that sees people in their contexts; they are considered and thoughtful and finally they allow for and enable change (HSE, 2011 p.94).*

and, explains how it relates to judgment, stating,

> *Assessment only has meaning when you apply your professional judgement and analyse the information and evidence that you have gathered in relation to the safety and welfare of the child with whom you are working (HSE, 2011 p.94).*

Guidance documents simultaneously require SWs to rely on professional judgment and to adhere to practice guidance. Research indicates that the wider practice ecology also provides the context for organisational and professional assessment and decision-making at the case level, a matter that is picked up in the review in Chapter 3 (Gilbert *et al.*, 2011b; Gilbert *et al.*, 2009a; López *et al.*, 2015; Maguire-Jack and Font, 2014; Simon, 1997; Wulczyn *et al.*, 2010)[18]. The issue of reconciling the organisational context for practice and professional judgment and sensemaking about a case to come to decisions occurs again and again across the literature and is central to the research undertaken for this thesis.

The range of policy and procedure documents governing SW practice, including referral and assessment practice, was problematic for SWs (Burns and MacCarthy, 2012; O'Connell, 2018). By 2016 there were in excess of 60 policies for front-end SW practice which generated tensions between the need to follow policy guidelines and exercise professional judgement when dealing with specific cases while addressing the demands of continuously rising caseloads (O'Connell, 2018) as previously cautioned by SWs (IASW, 2011) and discussed at Section 2.2.2 above. It meant that cases were frequently closed that otherwise might have received assessments or services, until such time as the risks escalated (Buckley, 2017b; Burns and MacCarthy, 2012; Whelan, 2018). Concurrently, researchers reported that

[18] Simon, 1947 proposes a "general theory of administration" which provides " principles of organization that will insure correct decision-making " and " principles that will insure effective action" (p. 1). Note also Administrative Behavior, 1947, the concept of "satisficing" See also (1976), Administrative Behavior. (3rd Ed.). New York: Macmillan; (1981), The Sciences of the Artificial. (2nd Ed.). Cambridge, MA: MIT Press; 1991 Bounded Rationality and Organizational Learning, Organization Science, Vol. 2, No. 1, Special Issue: Organizational Learning: Papers in Honor of (and by) James G. March (1991), pp. 125-134.

service users involved in CPW assessments reported being failed by the system and blamed for their difficulties (e.g. Buckley, 2017b; Buckley *et al.*, 2011a).

This section of the review has described the context for IA practice and outlined the policies and frameworks to support decision-making, detailing some unintended consequences. As outlined, a range of policies and guidelines describe how social workers are required to make decisions in IA – they incorporate specific threshold and eligibility criteria, frameworks for assessing risks and needs and professional judgment. The research in this thesis goes some way to examine and describe how these operate in practice and to describe the evidence that the assessment process generates about children and families and the decisions required to be made. Several authors suggest that detailed descriptions of practice in individual country's is needed to understand the details of policy and how they relate to responses provided to children and families who undergo assessments (e.g. Garfinkel and Waldfogel, 2012; Gilbert, 2012; Shlonsky, 2015). Although IAs are central to CPW practice, Ireland produces very basic statistics about them specifically, and other aspects of CPW practice, a deficit repeatedly addressed in the literature (Buckley, 2012; Buckley *et al.*, 2010; O'Leary and Lyons, 2021) a matter this research aims to go some way to redress. The review now turns to examine current trends in relating to demand for CPW service and responses.

2.7. Trends in demand and service provision

Tusla publishes aggregated performance and activity data relating to the number of referrals and responses to referrals on a quarterly basis. Metrics include the classification of reports as welfare or one of four types of abuse physical emotional sexual abuse and neglect,[19] the number of referrals processed within 24 hours, the number of IAs (investigations) completed within 21 days (40 days after 2017), and the actions taken on completion of these IAs (see HSE/Tusla, 2009/2014; tusladata, *Annually*).[20] Tusla aggregated statistics are based on the SBPs (see Figure 1) and do not include all referrals which receive IA (HSE/Tusla, 2009/2014). Up to 2009, CPW policies enabled referrals to include information on multiple children; since 2009, the policy requires that each referral relates to a unique child (HSE/Tusla, 2009/2014), but an individual child may reoccur in the data.[21] Since 2010, SWs are not required to determine whether or not their IAs substantiate the occurrence of abuse in relation to the concerns being investigated. As in the UK, the current risk assessment focuses on the likelihood of future significant harm, however a substantiation policy is due to be implemented in 2022 (Tusla, 2022). Child-related

[19] SWs are required to categorise presenting concerns as one of the four types of abuse or welfare at each of the stages outlined in the SBPS referral, Intake processes and at the conclusion of the Initial Assessment (see process map at Appendix 3). Data is published for the categorisation at the referral stage only.

20 Essentially this data item is a performance indicator, providing information relating to the standard of practice for time within which Initial Assessments are required to be completed. Data is not routinely collected on the outcomes of all Initial Assessments that are undertaken by social workers.

21 Repeat referrals are not distinguished in the statistics. Ireland does not produce data on the number of children reported to services or the number of children who receive Initial Assessments and ongoing services.

metrics include the number of children listed on the Child Protection Notification System (CPNS)[22] and the number of children in care. The system does not produce evidence of characteristics of children and family's referred. Given the methodological limitations outlined above, trend analysis of aggregated statistics is limited to the period after 2013.

2.7.1. Demand for service: reports

As shown in Figure 6 the statistics indicate a year on year increase in referrals reflecting a 36% rise in total reports from year 2013 to year 2019 (Tusla, 2012–2019; tusladata, *Annually*) or an increase from 35.0 to 47.5 reports per thousand children aged 0-17 years in Ireland.[23] The rise is attributable to a larger increase in welfare reports (+40%) compared to abuse reports (+31%). Reports of emotional abuse, though small in numbers relative to welfare reports rose considerably (+103%). Reports for physical abuse also rose consistently (+50%). Reports for sexual abuse fluctuated but, rose by 16% overall. Reports for neglect dropped by 33% over the 6 years.

In 2001 Irish research conducted by Ferguson and O'Reilly identified that neglect constituted 21% of reports in their sample (Ferguson and O'Reilly, 2001) whereas in 2019 the proportion of neglect reports nationally was at 8% with welfare constituting 55% of all reports. The suggestion in research and audit of a tendency by SWs to reinterpret and discount concerns of neglect by categorising them as welfare (e.g. Buckley, 2003; Tusla, 2015) may be reflected in the decline in reports categorised as neglect and the simultaneous rise in welfare reports. It is impossible to say whether the substitution actually is occurring absent the evidence of the characteristics that are employed by SWs to construct these categorisations. It has been speculated by SWs that the rise in reports categorised as emotional abuse may be attributed to routine reporting by An Garda Siochána as such of cases of DV where children were present.[24] In a recent publication this author and a colleague examined report data alongside recently published victimisation data gathered by An Garda Siochána (AGS) and published by the Irish Central Statistics Office (O'Leary and Lyons, 2021). That data indicated an increasing trend in reports involving children to both CPW and AGS suggesting that children in Ireland are increasingly victimised.

In 2015 a study by this author and colleagues produced evidence at the population level of a social gradient in referrals to CPW (O'Leary *et al.*, 2015a) [25] indicating that as in other systems, children from

22 The CPNS is a register of children assessed by social workers to be at risk of significant harm during a Child Protection Conference, which occurs following Initial Assessment when cases progress to the Child Protection proceedings (See Process Map Figure 1)

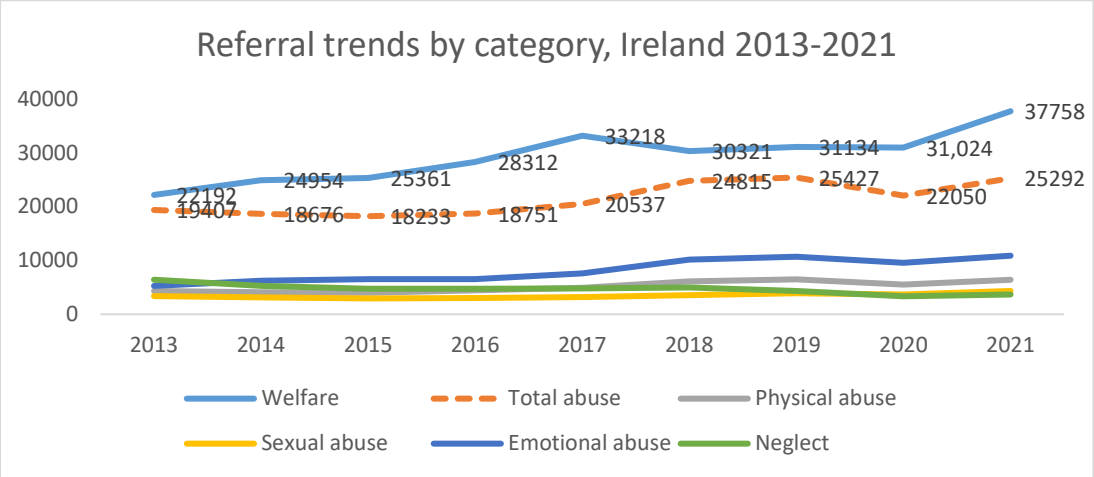
23 All population estimates in this thesis are calculated based on population statistics using https://www.cso.ie/en/statistics/population/ and small area population statistics (CSO SAPS, 2016).

[24] Children First (DCYA, 2011b) and the Joint Working Protocol for An Garda Síochána/ Tusla – Child and Family Agency Liaison (Tusla, 2017b) established guidelines for reporting and joint case management between An Garda Síochána and CPW social workers. The Joint Working Protocol states explicitly that children who witness domestic violence are often traumatised and suffer emotional abuse (Tusla, 2017b).

25 In 2015 the SWDs received on average 23 reports per 1,000 Mean reports per 1,000: Range Mean Relative Deprivation: -10-+15. For each increase in Relative Deprivation (affluence) the rate of reports decreased by 1.93 per thousand children.

disadvantaged areas are disproportionately referred to CPW (Bywaters *et al.*, 2016; Garbarino *et al.*, 1979; Scott *et al.*, 2016; Winter and Connolly, 2005). The expansion of the system since 1999 to incorporate welfare concerns and from 2014 to extend the family support services through the *PPFS* (see Section 2.2.) may have led to an increase in referrals related to families in need of a range of services in addition to abuse and neglect.

Figure 6 Reports by category, trends 2013 to 2021, Ireland



The pattern of reporting in Ireland is different to trends internationally where rates of reported physical and sexual abuse have declined (particularly in the US, see Finkelhor *et al.*, 2021). And while there is no consensus on why rates of different categories of reported and substantiated abuse have changed internationally, changing social conditions and awareness of different types of abuse may play a role (Finkelhor *et al.*, 2021; Gilbert *et al.*, 2011b; Shore and Powell, 2020; Trocmé *et al.*, 2014).

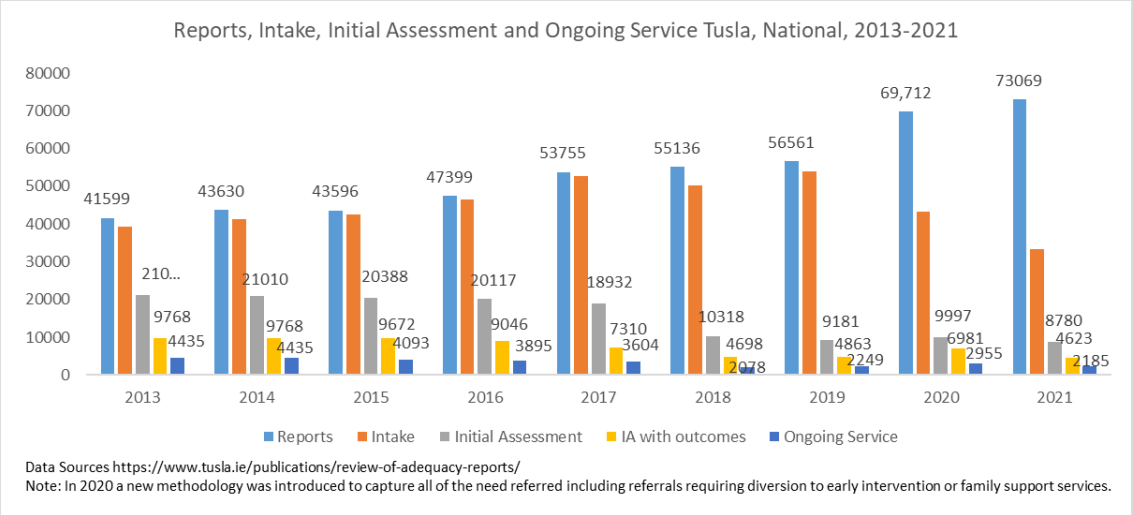
2.7.2. Response to demand: Initial Assessments and ongoing service

As reflected in Figure 7 below, most reports do not meet the threshold of 'reasonable grounds of concern' as per Children First Guidance (DCYA, 2011a), and do not proceed to IA. Of those which do, a consistently low rate of reports, approximately one in five, are deemed to need further interventions. Between 2013 and 2016 approximately half reports received by Tusla had an IA. The proportion fell from 51% in 2013 to 16% of reports in 2019 or from a rate of 18.3 to 7.7 IAs per 1,000 children aged 0-17 years. The trend continued but the gap widened further after 2020 because of changes the methodology used to count reports. Prior to 2020 counts focused on the number of reports that were deemed to require a social work response following screening by CPW services. From 2020, counts include reports requiring diversion to other early intervention or family support services that do not require social work intervention. The proportion of referrals receiving IA fell to 12% by 2021 representing 7.4 IAs per 1,000 children aged 0-17 years.

Figure 7 shows that statistics are published for about half the IAs that commence – this is because the statistic relates to a performance indicator. That data indicates that approximately half IAs result in ongoing CPW service. The trend shows an increase in the proportion of IAs which received ongoing service from 45% of IAs in 2013 to 51% of IAs in 2019. But these rates relate to a reducing number of IAs. In 2013, 3.6 per 1000 children aged 0-17 years received ongoing service following IA and this reduced to 1.8 per 1,000 children aged 0-17 years in 2021. The rate of 'no further action' following IA fluctuated during the time (Tusla, 2012–2019; tusladata, *Annually*) from 3.9 per 1,000 children aged 0-17 in 2013 to 4.9 per 1,000 children aged 0-17 in 2015 and back to 2.0 per 1,000 children aged 0-17 in 2021.

The data indicates that the gap between reports and IA and the gap between IA and ongoing service is growing. A recent audit of SBPs conducted by Tusla found that after IA only 13.49% (39 of 289 IAs) of IAs completed went on to further service (Tusla, 2015). Noting that further investigation using a larger sample size would be necessary to assess the accuracy of this rate, the audit noted the finding correlated with Tusla national statistics for the first quarter of 2014, but concluded 'nevertheless, it does indicate that a large proportion of accepted reports may not meet the threshold for ongoing intervention by the Agency or should be screened out at the point of report (Tusla, 2015 p.33).

Figure 7 Report, Intake, Assessment and ongoing service trends 2013 -2021, Ireland



Data Sources https://www.tusla.ie/publications/review-of-adequacy-reports/
Note: In 2020 a new methodology was introduced to capture all of the need referred including referrals requiring diversion to early intervention or family support services.

2.7.3. Explaining the trends

Researchers have frequently expressed concerns that the Irish statistics highlight policies that invest considerable resources in filtering out without service the majority of children reported to CPW (Buckley, 2003; 2012; Buckley and Burns, 2015; Ferguson and O'Reilly, 2001; Thorpe, 1997) and that in some cases, children and families are left without services that their situations appear to warrant (Holland, Fri, Apr 15, 2016; Shannon, 2017). Furthermore, commentators have criticized the absence of data on the profile of children and families and their demographic characteristics, the prevalence of abuse and welfare concerns and any detailed information about the responses they receive from CPW

services (Buckley, 2012; Buckley *et al.*, 2010; O'Leary and Lyons, 2021) which could provide insights into demand and the propriety of responses to children and families.

Recent comparative analysis of CPW administrative commissioned by the Agency identified that,[26] Tusla receives relatively low rates of referral compared to other Anglophone regions (41,639 in Northern Ireland or 96.8/1,000 and 646,120 in England or 58.7/1,000 children, 355,935 in Australia or 63.1/1,000 and 3,957,000 in the US or 53.2/1,000 children) meaning that a lower proportion of the population is available for 'throughput' in the CPW system (Furey and Canavan, 2019 p.27). However, compared to the other regions a smaller proportion of referrals in the Irish system, also progressed to the assessment stage (42% referrals proceeded to IA compared to 84% in Northern Ireland, 94% in England, 46% in Australia and 84% in US). Accepting that there may be methodological issues that impact on the data, the authors note

> *Ireland's lower rate of referrals proceeding to assessment is notable in that it may say something about how Ireland's system views and manages risk in comparison with other jurisdictions. It may reflect a greater emphasis on the family support or at least a less-interventionist system culture. ... However, the data may simply reflect resource issues. Thus, while there may be cases for which further investigation and intervention would be beneficial, the available resources may influence practice such that the cases that are progressed through the system have higher risk profiles and higher priority in terms of resource use. (Furey and Canavan, 2019 p.27).*

The studies in this thesis aim to shed some light on the queries raised in this report.

In most Anglophone jurisdictions emotional abuse and neglect comprise the highest proportion of reports relative to physical and sexual abuse and several jurisdictions report a decline in the incidence of reported sexual and physical abuse (Fallon *et al.*, 2017b; Finkelhor *et al.*, 2021; Jud *et al.*, 2016; NSCDC, 2012; Sheehan, 2019).

Irish authors have cautioned that the trends, although they reflect sufficient concern by reporters to refer children to CPW, show that service users continue to be eliminated without a service, reflecting a disproportionate amount of resources expended processing reports that ultimately close (Buckley, 2015; Buckley and Burns, 2015; Whelan, 2018). A national audit of Referrals, Intake and IAs conducted by Tusla in 2014 suggested a mechanism to manage demand for scarce CPW resources (Tusla, 2015). The audit noted concern about the rate of IA that closed NFA and criticized SWs for a failure to apply professional judgment to close referrals at the Intake process that precedes IA (Tusla, 2015).[27] It found on average 43% (range 3 to 75%) of referrals proceeded to an IA (n=289) and of these an average of 13.5% of IAs (39/289) received some ongoing service, a rate that equated with the rate reported in statistics for Q1 2014 (tusladata, *Annually*). Given the high proportion of IAs that were closed/NFA

[26] UK and Norway, Australia and USA.
[27] The study examined 670 files, in 34 sites, across the 17 operational Areas of Tusla.

(86.5% IAs) the Audit concluded that many such cases should have been filtered out during Intake (Tusla, 2015).

Questions about trends in assessment outcomes are common across Anglophone systems, and this will be discussed in more detail in the following chapter. A study in 2008 of 1,000 investigations that closed NFA in NZ found they did not represent a wasted effort, because majority of cases contained sufficient concern of child maltreatment to warrant an investigation (Manion and Renwick, 2008). Although the investigation did not find it necessary to invoke a formal, statutory intervention, in many cases where SWs worked with families the support and advice provided tools for change to occur. Manion and Renwick identified that a large portion of the cases needed some form of service to assist the family with the stressors and risks that could otherwise compromise the wellbeing of their children which they say cohered with current national statistics revealing a substantiation rate of 30% for children that received NFA (Manion and Renwick, 2008 p.72).

A study using data from 5 cycles of a cross-sectional study of children and families referred to the Ontario CPW system, the Ontario Incidence Study of Reported Child Abuse and Neglect conducted by Trocmé and colleagues (2014) classified cases as urgent or chronic needs and examined responses. The study found responses were rooted in meeting urgent protection concerns through forensic investigations even though investigations involving urgent protection are much less likely to be recur within 12 months than investigations assessed for chronic need (Trocmé *et al.*, 2014). A subsequent Canadian study that applied the taxonomy (Schumaker *et al.*, 2017) found that greater resources and more specialized services are usually reserved for cases of severe physical harm and sexual abuse but that the higher likelihood of recurrence amongst children investigated for chronic need indicated the necessity of developing service tailored to chronic cases. Fallon et al., (2011c) demonstrated that characteristics of children where abuse was substantiated were similar to those where there was no abuse but there was risk of future harm.

In the US a study by Simon *et al.* (2021) which drew on a growing body of research that examined screened our children or those with unfounded or inconclusive investigations, noted that that 46% of children who are referred to CPS are screened out nationally. The authors suggested that 'screened-out families are similar to "higher risk" families and are at comparable risk for negative outcomes including re-report, homelessness, suicide, developmental problems, emotional and behavioural disorders, and substance use disorders highlighting the importance of addressing their needs with services' (Simon *et al.*, 2021 p.3) factors which may place the children at risk of maltreatment and re-report. The authors argue that screened out referrals represent a missed opportunity for prevention (Simon *et al.*, 2021). The evidence challenges the notion that cases closed at referral and IA reflect the overinclusion of children who do not have service needs.

The focus of this research is on IAs and ongoing service but through an analysis of the evidence and the policy framework it aims also to comment on this question of eligibility for IA particularly among

cases that are closed NFA. It aims to offer insight into the reasons for the trends for service provision by examining the characteristics of cases undergoing assessment and exploring SW rationales for their decisions, as I do in the case study and through an in-depth analysis of demographics and case characteristics of IAs and those that remain open compared to those that close as I do in the cross-sectional study.

This section has identified trends in demand for services and provision of ongoing service. It identified concerns about the pattern of referral and responses to families following IA/Investigation that is exacerbated by the absence of evidence about the characteristics and service needs of children and families. Prior concluding this review, Section 2.7.4 explores what the policy context and trend analysis suggest about the current model of CPW practice in Ireland.

2.7.4. The paradigm of practice for Irish CPW

Paradigms are a means of describing the orientation a system through the assumptions, theories, beliefs, values and methods that underlie and reflect the way it operates (Howe, 1987/2009/2017). The orientation of a CPW system shapes, and is shaped by, the construction of risk and responsibility, and decision-making, because of the inter-related aims, organisation structures and priorities identified in policies including thresholds for intervention (Keddell, 2014a; Križ and Skivenes, 2013; McGregor, 2016). As demonstrated, these features of the system are in constant development. I briefly review the evolution of these paradigms and views on the positioning of the current Irish system. In Chapter 3 I consider how these paradigms are reflected in assessment and decision-making for service provision.

Since the 1990s a number of frameworks have been proposed to describe, scale, and compare state's policies and practices in the context of statutory duties for child protection and welfare (Fox-Harding, 1997; Gilbert, 1997; Gilbert *et al.*, 2011b). Gilbert reviewed systems in nine countries to identify two broad and sometimes overlapping system orientations, a child protection orientation associated Anglophone countries and a family service orientation associated with Nordic and continental European systems, each distinguished on the basis of how abuse was characterised and the relationship between the state and families (Gilbert, 1997). Subsequent to the ratification by many countries of the UN Convention of Children Rights (CRC) (UN, 1989), system wide reforms began to reflect the requirement for children to have formal social, political and legal rights focused on their present and future needs (Gilbert *et al.*, 2011b). More recently, international comparative research into the operation of national systems has identified three main orientations, the child protection orientation focussed on risk and crisis management, family support, which itself has been evolving with prevention now a central aim and the children's rights orientation (Cassidy *et al.*, 2016; Gilbert, 2012; Gilbert *et al.*, 2011b; Lonne *et al.*, 2009) and many systems incorporate features that reflect all three.

Child protection (CP) orientations are seen to frame children's interests narrowly in terms of their protection and regard the needs and circumstances of parents as secondary (Buckley, 2000a). Policies seem to treat abuse as something that can be objectively detected and consequently, may engage

children and families adversarial, legal and investigatory assessments which may result in out of home placement (Fargion, 2014; Gilbert, 1997; 2012; Gilbert *et al.*, 2011b; Parton, 1991; 2017; Wattam, 1996). Some observers suggest this orientation combined with current residualist approaches to wider social policy has resulted in a highly risk averse practice environment where problems are individualised, and the identification of risks dominates the aims of intervention (Buckley and Burns, 2015; Parton, 2020)

Welfare orientations broadly link the interests of children to the interests of the family and to the wider range of a continuum of supports and services for all children and families (Buckley, 2015; McGregor, 2014; Parton, 2017). Generally speaking, state intervention is strengths-based and aimed at maintaining minimum standards through the provision of universal services with a focus on primary prevention and early intervention therapeutic strategies at the community level to reduce indicators of child abuse (Canavan *et al.*, 2019; Department of Health and Children, 1999; Gilbert, 1997; Gilbert *et al.*, 2012; Malone and Canavan, 2021; Parton, 2017). They are premised on the idea of mutuality of *social* risk and encourage *social* responsibility and solidarity (Parton, 2017).

The third, 'child-focussed orientation' based on the rights and wellbeing of individual children, was simultaneously welcomed, because of the attention it brings to children in policies, and critiqued because of its tendency in practice to 'disconnect' children from the context of their social relationships and environments (Buckley, 2012; Featherstone *et al.*, 2014a). For example, in the UK child-focussed early intervention has been hotly debated on evidence that children were removed from parents too readily causing serious trauma for families, and placing their rights at odds with those of their parents (e.g. Axford and Berry, 2018; Featherstone *et al.*, 2014a). Here, discussions centre on which risks are prioritised and the notion of a false dichotomy between protection and family support, as though protecting children separates them from their family context (Featherstone *et al.*, 2014a; Fluke *et al.*, 2016).

Many systems, the Irish one included, are characterised by features of all three and operate under a dual mandate to support families in providing adequate care to children and to intervene to prevent further harm when children need protection (Munro, 2011a). The Irish CPW system was characterised as evolving in two related, and competing, directions - child protection and child welfare (Buckley *et al.*, 2011a). The focus on child welfare in *Children First* (DCYA, 2011a; Department of Health and Children, 1999) was reflected in the recognition of the need for early intervention and preventive services and in the investment in a number of specialist family support services, albeit that they were targeted in specific geographic areas of particular disadvantage and need (Buckley and Burns, 2015).

Recent reforms in Ireland have aimed to balance the move towards risk and crisis management by encouraging principles of prevention, early intervention, children's rights and family support in prioritising service delivery (Burns and McGregor, 2019; Devaney and McGregor, 2017). The establishment of Tusla represented an attempt by government to improve accountability and ring-fence

and raise the profile of child protection and family support by creating an independent system no longer as then chief executive Jeyes said, 'the Cinderella' of the health service (Jeyes in Buckley and Burns, 2015; Fitzgerald, 2014; Wayman, 2014). Despite political commitment and expansion of the scope service, successive chief executives, as reported in the press (e.g. Shanahan, 2015; Wayman, 2014), and observers alike (Buckley and Burns, 2015; Burns and McGregor, 2019) contested the capacity for Tusla to deliver its model as intended within the resources allocated because the expansion was argued to be cost neutral. For example, Ireland only has one social worker per 1,000 children compared with 4.4 per 1,000 in Northern Ireland (Burns *et al.*, 2021).

The central ethos of Tusla's integrative framework and the significant developments in the regulatory side of the state offer an opportunity to embrace a children's rights ethos and focus on strengths oriented and preventive services, but they may be compromised due to the confinement for responsibility for child protection to Tusla's CPW service (Buckley and Burns, 2015; Burns and McGregor, 2019; Canavan *et al.*, 2019). The effect of the increasingly forensic approach to the disposal of referrals has been interpreted as evidence that the child protection orientation has been reified in Irish practice (Buckley and O'Nolan, 2013; Kearney, 2013; Lonne *et al.*, 2020; Mooney, 2018; Shannon, 2017; Whelan, 2018). In a similar vein, reflecting on an analysis of administrative data from the English system Hood *et al.* (2016), suggested that system was managing rather than meeting the demands of children and families reported, indicating the forensic paradigm remains engrained.

Anglophone child protection systems were designed largely to respond to Non-Accidental Injures on the premise that child abuse linked to a syndrome (NAIs) (Department of Health, 1976; Kempe *et al.*, 1962; Melton, 2005; Parton, 1985; 2020). Over time there has been ubiquitous expansion of legislative and organisational responses, driven by advances in understanding the aetiology of abuse but largely, on evidence from inquiries that chid protection systems had failed to understand the scope and complexity of abuse (Lonne *et al.*, 2009; Lonne *et al.*, 2020; Parton, 1985). As described above (Section 2.2), in common with other Anglophone systems, inquiries had the effect of focusing responsibility on CPW systems for protecting children from an ever expanding range of risks (Parton, 2017) while simultaneously maintaining a focus on secondary prevention in 'high-risk' cases (Lonne *et al.*, 2009; Parton, 2017).

As outlined by O'Leary and Lyons (2021) current Anglophone systems have been in crisis necessitating reform because of high and increasing demands for service, the overrepresentation of disadvantaged communities and ethnic minorities, and frequently by poor outcomes linked to fragmentation and high rates of recurrence among those referred (Buckley and Burns, 2015; Buckley and O'Nolan, 2013; Burns and McGregor, 2019; Gilbert *et al.*, 2012; Higgins, 2017; Scott *et al.*, 2016). Where data is available, estimates suggest somewhere between half and 90% of children who experience abuse do not come to the attention of state agencies (Fallon *et al.*, 2010; Gilbert *et al.*, 2009b; Stoltenborgh *et al.*, 2015). It is argued that the current construct of CPW systems which maintain a focus physical emotional and sexual abuse and neglect perpetrated by individuals reinforces social inequalities because it ignores underlying

structural factors (Parton, 2019). Parton (2020 p.31) also suggests that the approach does not 'permit any recognition of the collective harm and exploitation that is caused by institutions, harmful policies and laws, conflicts, failures of governance, and social disruption'.

There have been widespread calls for systems to adopt a preventive public health approach to bring together both child protection and child welfare models through the systematic application of epidemiological methods to understand the patterns causes and effects of abuse, and primary interventions when children display indications of risk (Higgins, 2017; O'Leary and Lyons, 2021; Parton, 2014b). Under the auspices of the WHO Regional Committee for Europe, the Irish Government has pledged to a rights-based and public health approach to reducing the prevalence of child maltreatment (WHO, 2014). This necessitates the development of a systematic surveillance system of child abuse in Ireland, which could complement the current high-risk, investigation-oriented approach to prevention (O'Leary and Lyons, 2021). Both are needed to reduce the burden of suffering in the population but they entail tensions along collectivist versus individualist orientations (Gray and Schubert, 2019; Perry, 2009). In a recent case study of the intake system in Tusla, Whelan (2018 p.252) calls for attention to the wider context of CPW practice in Ireland, suggesting that 'rights based, well integrated network of services at institutional and community levels right across the health, education, justice and welfare sectors' would likely ease the pressure on CPW services and support those involved in it.

As is discussed throughout this review because of its centrality to the motivation for the research, CPW practice is notoriously uncertain because assessments are based on often limited and contested information but also due to the complex and unpredictable circumstance of families (Munro 2011b). This uncertainty is amplified by the absence of evidence on the characteristics of children and families and determinants of decisions at various points along the continuum of service delivery and indeed by the absence of evidence on the efficacy of decisions that social workers they routinely make. It is only through understanding the needs of children and families reported to CPW that effective policies can be developed, and sustainable actions can be taken to systematically respond to children's needs and prevent abuse recurrence (COE, 2017; Gray, 2015; Jud *et al.*, 2016; Meinck *et al.*, 2016; O'Leary and Lyons, 2021; UN, 2015). The availability of data and its implications for policy and practice are reviewed in next in Section 2.7.5.

2.7.5. Data collection and evidence of practice

In recent years, a number of Government strategies have committed to improving data collection to ensure that children's lives are better understood (DCYA, 2011b; 2014). In CPW in particular, several developments are underway within Tusla to enhance the infrastructure and policies for data collection to make information available to support the delivery of better outcomes for children and families and to support a range of interconnected organisational goals such as case management, risk management and regulatory compliance (Furey and Canavan, 2019; HIQA, 2012; HSE/Tusla, 2009/2014; Tusla, 2020a). As part of the reform of the CPW system, there has been significant investment in developing

data and information systems across the organisation (Furey and Canavan, 2019; HSE/Tusla, 2009/2014; Tusla, 2016b; 2020a). The focus of data polices thus far has been on delivering information regarding processes, as opposed to children and their service needs, and performance targets related to these processes. Much of the data collected by SWs remains unused in supporting CPW practice or, in informing polices for assessment and decision-making , despite the fact that it is generally understood that such data is fundamental to delivering client centred services which aim to reduce maltreatment recurrence and that it serves a catalyst for service improvement (Fallon *et al.*, 2017a; Fluke *et al.*, 2021; Jud *et al.*, 2013).

Like many other clinicians and child welfare practitioners, SWs in Ireland obtain little or no information about the features of their decisions or the accuracy of their assessment and predictions about future risks (Dawes *et al.*, 1989; Jonson-Reid *et al.*, 2017; Munro, 2010b). Where it is available feedback is generally in relation to poor outcomes or child deaths, rare events that have significant impact in shaping policy (Buckley and O'Nolan, 2013; Kearney, 2013). This evidence frequently addresses shortcomings in assessments, analysis of information and decisions about future risk and service allocation (Buckley and O'Nolan, 2013; Munro, 2011b; Parton, 1996; Turney *et al.*, 2011) because in CPW, misdiagnosis in either direction can have devastating consequences for a child, family or professionals involved in a case (Best *et al.*, 2013; Mansell *et al.*, 2011).

Researchers have long been calling on the Irish CPW system for better statistical evidence about clients, their service needs and decisions made for service delivery (e.g. Buckley, 1996; 1999; 2009; 2012; Buckley and Burns, 2015; Furey and Canavan, 2019; O'Leary, 2007a; O'Leary and Lyons, 2021; O'Leary *et al.*, 2015b; Whelan, 2018). Buckley (2003) suggested that inherent in the 'official' version of child protection is the belief that the system has the capacity to make definitive judgments about children referred to it. While measures to improve the standard of quality of practice and accountability to this 'crucially important service' were seen as both necessary and commendable (Buckley, 1999) they were questioned because of their focus on 'surface' issues (Howe, 1996; Munro, 2010b; Tilbury, 2004) such as implementing policies and monitoring key indicators relating to business processes, over information and data about cases (Buckley, 2009; Burns and MacCarthy, 2012). And because, on the whole, they were based on very crude information about the nature and number of cases reported to the CPW service and their ultimate disposal or outcomes, reform efforts were ultimately compromised due to lack of 'intelligence' (Buckley, 2009; 2012; 2015).

Ireland is not unusual in this regard: the international literature indicates that although the evidence base is developing, little is known about the characteristics of cases that proceed to on-going service following IA and those that do not (Fallon *et al.*, 2011a; Jud *et al.*, 2012; Lwin *et al.*, 2018b; Smith *et al.*, 2019). However, these factors significantly limit the understanding of client needs and any possibility of evaluating the effectiveness of decisions in responding to them (Jonson-Reid *et al.*, 2017). The lack of evidence limits the potential to draw comparisons to other countries where international evidence is available about responses provided to children and families (Furey and Canavan, 2019). In

2015 in a special edition of an international journal on decision-making and judgments in child protection, Shlonsky said there was 'insufficient empirical attention paid to how decisions are made, the nature and extent of influence of individual biases and preferences, and the way in which context influences decisions at various points in the continuum of child welfare services' (Shlonsky, 2015 p.154). The dominance of information about the performance of the system over that pertaining to children presents a risk he suggested, of conflating outcomes of the system itself with outcomes for children (ibid.). The concerns have resonance for Irish data collections and further, they highlight a risk that incorrect drivers influence policies: without evidence of the scope and nature of abuse and welfare concerns investigated and responded to a system has no way of knowing how well it is doing or how the context has changed or whether structures and policies put in place are adequate in addressing need and risks (Wulczyn et al. 2010; Jud et al. 2013; Buckley et al. 2010).

The current situation is at odds with requirements of the Irish regulatory authority HIQA. The National Standards for the Protection and Welfare of Children (HIQA, 2012) suggest that the delivery of safe and effective services requires Social Workers to be

> *supported in making appropriate evidence-based assessments and decisions and managing risk to provide interventions and supports that are more likely to protect children not receiving adequate care and protection (HIQA, 2012 p.18)*

and further, the standards suggest that safe and effective services are 'open, transparent and accountable' (ibid).

This concludes the review of the policy setting for CPW practice in Ireland. The concerns outlined about the deficits in knowledge and data about assessment practice and decision-making form part of the motivation for the research in this thesis.

2.8. Concluding comments

Chapter 2 described the evolution of current Irish policy for CPW. In doing so it detailed concerns raised in inquiries and audits regarding errors, oversight and variability in assessment practice that became a corner stone of recent policy reforms. It highlighted concerns raised in the literature about the focus in policy and practice on risk and child protection and the low rate of progression of children to ongoing services. It revealed that current Anglophone models of CPW, including the Irish model, are characterised as high-risk strategies as they focus on the identification and management of risks in reported cases, and secondary prevention through strategies aimed at reducing recurrence (Gilbert et al 2012; Scott et al 2016; Buckley & Burns 2015; Burns &McGregor 2019). These approaches are characterised by high and increasing demands for services, overrepresentation of disadvantaged groups and communities, and at times by poor outcomes associated with service fragmentation and high recurrence rates among those referred (Scott *et al.*, 2016). Irish statistics are limited. Where evidence is available regarding Irish practice, from research and audit of professional assessment and decision-

making, it paints a similar picture (Buckley and O'Nolan, 2013; Buckley *et al.*, 2008; O'Leary, 2007a; b; O'Leary *et al.*, 2015a; Shannon, 2017; Whelan, 2018). This chapter presented statistics and trend analysis on reports since 2007 and responses including assessment since 2012. The data reveals consistent rise in demand for services, but a widening gap in post assessment service delivery.

Irish CPW policy has become more regulated, standardised, and bureaucratised, in particular, over the past three decades. Much of this is welcome as it represents a move towards delivering high quality, consistent and transparent services to clients. Critiques of the developments, however, suggest that there are many problems, some of which they claim were predictable, such as the effects of managerialst practices and reduced capacity to work with clients in ways that aligned with professional goals.

Policy reforms in Ireland as elsewhere, have been heavily focused on assessment practice, judgment and decision-making (Mansell *et al.*, 2011; Tusla, 2014a; b; c) with a view to providing consistent and safe responses to children involved with the service. But these reforms have not been based on systematic evidence of characterises the client base, their needs or responses to those needs or on evidence of children's outcomes. By developing the evidence on the characteristics of assessments and decisions for service provision, this thesis aims to provide a basis for proposing some systemic changes in data collection and publication that could support and enhance practice for SWs and clients and policy makers. Chapter 3 continues the review with a focus on current research evidence on assessment practice, judgment, and decision-making.

Chapter 3 Assessments, judgments and decisions making

3.1. Abstract

This chapter presents a review of literature on theoretical and empirical evidence regarding assessments, judgments about risk and decision-making. It is divided into five broad sections linked to the studies undertaken. It begins with a review of key concepts related to judgment and decision-making in child protection and welfare. It considers a selected, influential scholarship on the limitations of decision-making under uncertainty from the fields of behavioural economics, psychology and administration that examines how and why judgments and decisions deviate from a rational model of decision-making. It then presents a review of the empirical evidence that examined influences on judgments and decisions in child protection and welfare. Because the focus in the current research is to explore what drives decisions in IA, the review reflects this by including literature focused on the process of decision-making and determinants of decisions, in contrast with research for example, that explores variability between decision makers (Benbenishty *et al.*, 2015) or sources of errors in decisions. Picking up on themes in Chapter 2, this chapter briefly reviews the role of assessment tools to support judgments and decision-making and considers the evidence on challenges in using consensus frameworks as prescribed for practice in Ireland.

The review considers statistical evidence of the characteristics of children and families reported to CPW services and evidence for categorising presenting concerns. Though growing the empirical evidence on determinants of the decisions to provide service following IA is limited and varies across jurisdictions according to evidence that is routinely produced by the CPW systems. The fifth part of the chapter considers evidence from studies that have employed case data or administrative data related to assessments. Included in the review is evidence from research and audit using a range of methodologies that provide insights into provide factors linked to judgments and decisions. The chapter ends with concluding comments on the entire literature review linking the themes that emerged to the development of the research questions addressed in the remainder of the thesis.

3.2. Key concepts in assessment and research on decision-making

Risk, uncertainty, judgments, and thresholds are key concepts in SW assessment practice that are discussed in Section 3.2. The review begins with a brief discussion of these concepts and the understanding of how they operate in decisions. The discussion draws on influential theoretical and empirical contributions from fields of economics, organisation science and psychology which inform the research on decision-making in CPW currently and specifically, this research.

3.2.1. Risk, uncertainty and judgment

A hundred years ago, Knight (1921), an economist, distinguished the treatment of risk from uncertainty.[28] Under risk the outcomes of alternate options at the group level are known and can be incorporated into predictions and decisions in an individual case, under uncertainty they are not. The way assessments are conducted to estimate the likelihood of outcomes in child protection and welfare (CPW) is far from universal and frequently the subject of debate (Barlow *et al.*, 2012; Connolly, 2017; Gillingham, 2006; Keddell, 2014b; Mendoza *et al.*, 2016; Wulczyn *et al.*, 2010), despite the resounding evidence supporting the superiority in terms of success (validity) and consistency (reliability) of assessment by actuarial means over clinical judgment (Dawes *et al.*, 1989; Grove *et al.*, 2000; Meehl, 1954; Sarbin, 1943). Due to the paucity of evidence about decisions and their outcomes in CPW, decisions are made under conditions of uncertainty.

A further distinction was drawn between judgment, the act of combining or, drawing inferences from, the data to arrive at a prediction of interest, such as the likelihood of future harm, and the decision regarding how to proceed, frequently characterised as a choice between options (Baumann *et al.*, 2011; Dalgleish, 1988; 2003; Helm, 2013; Meehl, 1954; Swets *et al.*, 1955; Taylor, 2017a). However, the terms 'assessment', 'judgement' and 'decision-making' are frequently used interchangeably in the CPW literature (Helm, 2013; Taylor, 2017b; Taylor and White, 2006) and practice guidance (HSE, 2011; Tusla, 2014a). Judgments are influenced by a range of psychological, cultural and contextual factors but in CPW, from theoretical and practical perspectives, judgments are difficult because the known risk factors for abuse are neither necessary nor sufficient for producing adverse outcomes (Munro, 2010a; 2019a; b), and predictions in IA are not linked to a single outcome phenomenon (Keddell, 2014a; Munro *et al.*, 2014). Child abuse, child protection and risks are socially constructed through discursive processes between social workers and their clients, other professionals, colleagues and managers and the knowledge created is used to construct rationales for action or non-action (Benbenishty *et al.*, 2015; Buckley, 2003; Fluke *et al.*, 2016; Parton *et al.*, 1997) that always involve choosing among alternatives available in the policy.

[28] Knight distinguished between decision under risk, situations in which the likelihood of events are known or objective (such as a spin of a roulette wheel), and decision under uncertainty, situations in which the decision maker must assess the probability of the uncertain events and hence the likelihood of events are subjective (such as the outcome of a sports game) Knight's argument rendered insurance attractive and entrepreneurship, in Knight's words, "tragic" 1921.

Complexity and uncertainty arise in assessments and decision-making in CPW from the simultaneous interaction of many factors that include poorly defined problem situations, incomplete or conflicting information, variation in perceptions of need and risks, time pressures, heavy workloads and insufficient resources including access to services and poorly understood targets and variability in views about the implications of decisions (Best *et al.*, 2013; Buckley, 2003; Burns and MacCarthy, 2012; Fluke *et al.*, 2016; Font and Maguire-Jack, 2015a; Foreman *et al.*, 2015; Gambrill, 2005b; Gambrill and Shlonsky, 2000; Graham *et al.*, 2015; HSE, 2012b; Keddell, 2014a; Keddell and Hyslop, 2019b; Kirkman and Melrose, 2014; McLaughlin and Jonson-Reid, 2017; Saltiel, 2015; SIS, 2005; Stoddart *et al.*, 2018).

The view of risk as the probability of an adverse event and the magnitude of the losses and gains that it entails differs from ideas about acceptable risk or socially desirable notions of safety and accountability for risk management which have become central to public politics and public policy generally (Douglas, 1992) and particularly in CPW as reflected in the opening paragraph of this thesis and discussed in the previous chapter.

3.2.2. Risk, accountability, and responsibility

In contrast with the idea of risk as a probability of an outcome, sociological perspectives of risk influence assessments and decisions for service provision. Judgments about what constitutes risk/danger and which inform such responses are culturally and socially selected or constructed and the assessment of risk is consequently biased (Douglas, 1992; Douglas and Wildavsky, 1982; Scourfield and Welsh, 2003). As Douglas (1992)[29] explained, in this way risk is used as a forensic device for deciding what is to be considered dangerous and who should be held to account, or blamed.

There is agreement in the literature that in many Anglophone CPW systems including Ireland, risk has become a dominant rationale for both service provision and non-provision in CPW (Buckley and Burns, 2015; Connolly, 2017; Hayes and Spratt, 2014; Holland, Fri, Apr 15, 2016; Keddell, 2014b; Kemshall, 2010; King *et al.*, 2021; Lonne *et al.*, 2020; López *et al.*, 2015; Munro, 2010b; 2019b; Parton, 2017; Stoddart, 2021; Warner and Sharland, 2010; Whelan, 2018; Wilkins, 2013). The focus on risk has been instrumental in moving from the idea of working with uncertainty to one where risk and risk assessment practices are political concepts that are used to attribute accountability, or blame, by holding both clients and social workers responsible when things go wrong (Beck, 1992a; Buckley, 2017b; Burns and MacCarthy, 2012; Giddens, 1990; Munro, 2019a; Parton, 2017; Stanford, 2010).

The assumption that CPW operates to balance regulation and support is well documented (McGregor, 2016; Parton, 1991; 2014a; Skehill, 2003). Parton argues that CPW mediates across "a series of tensions which occupy the space between the family and the state" (2014a, p. 2053) where it "plays the key role in putting into operation the state's legal basis for intervening into some families where there are

[29] Scourfield & Welsh (2003) suggest this is characteristically different from the risk society perception of risk because of the absence of neutrality: it is a social construction.

concerns about children while trying to ensure that not all families become clients of the state, and in a way that no other occupation is able to do'. According to Parton attention shifted from making the right decision to making a defensible decision, in which process concerns about 'safety' and a 'precautionary logic'[30] come to dominate (Parton, 2017). Writing about risk in relation to the criminal justice system, O'Malley explains,

> *The moment risk is deployed as a technique for governing any problem, it must immediately be given shape by selecting which variables to attend to, determining which risks are to be reduced and which ignored, deciding what 'unacceptable' levels of risk are and what will be acceptable ways of reducing risks, evaluating who should bear risks and who risk should protect. These decisions are always political, even if they are depoliticised due to neutral language of risk (O'Malley, 2008, p. 13).*

These techniques are a source of political and professional power. Parton outlined a similar mechanism in CPW saying that

> *ideas about risk have taken on a strategic significance for rationing services and holding professionals and others to account ... as .... demand is increasing but where there are insufficient resources (2017, p. 3).*

Commentators suggest that current policies and practices embody neo-liberal ideologies wherein subjects are constructed as rational-choice actors or responsibilised users (Featherstone *et al.*, 2014a; Keddell, 2014b; Kemshall, 2010) who, according to O'Malley, like the ideal neo-liberal entrepreneur takes 'opportunity for enrichment where ever they occur' (2008, p. 7). According to Featherstone *et al.* (2016) current policies provide a context where responsibility is conflated with conscious intentionality.

Even when strength-based processes are incorporated through dual mandates and policies for assessments, research from Europe found that the process of individualization persists (Roose *et al.*, 2014). This reinforces social inequality by detracting attention from the influence of structural factors such as poverty and social isolation that are associated with higher rates of childhood adversity, domestic violence (DV) and with contact with CPW services (Featherstone *et al.*, 2016; Featherstone and Morris, 2021; Hood *et al.*, 2021; Jones and Davis, 1965; O'Leary and Lyons, 2021; Parton, 2019; Sidebotham *et al.*, 2016; Sidebotham *et al.*, 2002).

Despite lowered thresholds for referral associated with the expansion of the system (see Chapter 2), individualization has the effect of raising thresholds for allocating services (Buckley and Burns, 2015; Burns and MacCarthy, 2012; Keddell and Hyslop, 2019b; Kemshall, 2010; Lonne *et al.*, 2020; Whelan, 2018) and maintaining narratives promoting the delegation of accountability for risk management, as demonstrated in the opening paragraphs of this thesis (McBride Fred, in interview with Hennessy, 2016).

[30] A precautionary logic denotes a kind of argumentation that urges one to take far-reaching preventative measures.

Developing supportive relationships with clients and supporting parental engagement has long been considered an essential part of practice and is seen to necessitate taking a non-blaming approach to client's problems, even in the face of hostile or aggressive responses from parents (Ainsworth and Hansen, 2015; Buckley *et al.*, 2011a; Crea, 2010; Featherstone *et al.*, 2014b; Keddell, 2016a; Platt, 2008; Taylor and White, 2001). At the same time, attributing responsibility is one of the discretionary judgments that SWs make in order to manage problems and decide on a course of action (Buckley, 2003; Dingwall *et al.*, 1983/2014; Helm, 2013; Parton *et al.*, 1997; Platt, 2005). The literature shows that parent's engagement impacts on the way that families referred to CPW are perceived by SWs (Ainsworth and Hansen, 2015; Buckley, 2012; Hayes and Spratt, 2014; Whelan, 2018) and managers alike (Holland, Fri, Apr 15, 2016) and that it influences SWs views about service needs and decisions about service provision.

Social norms and values which have a powerful role in justifying the victimisation of children and women (Krug *et al.*, 2002) are also evident in sensemaking about the classification of cases and in rationales that section intervention or non-intervention in families involved with CPW (Buckley, 2003; Dingwall *et al.*, 1983/2014; Fallon, 2020; Fluke *et al.*, 2016; Keddell and Hyslop, 2018; Parton, 2018; Parton *et al.*, 1997; Platt, 2005; Platt and Turney, 2013). Risks are frequently addressed through gendered discourses (Buckley, 2002; Christie, 2001; Morris, 2009; Mulkeen, 2012; Parton, 2018; Roy, 2021; Stanley *et al.*, 2011; Stanley *et al.*, 2010) and responses tend to focus on mothering (Daniel *et al.*, 2010; Daniel and Taylor, 2006; Lapierre, 2008). Research repeatedly indicates a tendency among SWs (and other professionals) to blame mothers for their failures to protect children and to attribute responsibility for exposure to abuse to female survivors of DV (Buckley, 2000b; 2003; Buckley *et al.*, 2011b; Coohey, 2007; Featherstone and Morris, 2021; Gibbons *et al.*, 2010; Horwath, 2001; Landsman and Hartley, 2007; Lavergne *et al.*, 2011; Morris, 2009; Rogers and Parkinson, 2018; Victor *et al.*, 2021). Lapierre (2008) said that the dominant discourse in this area has been characterized by a deficit model of mothering. Simultaneously, assessments may fail to take account of the threat that a father/male partner poses or paradoxically, the asset he may be in relation to a child's protection and development (Buckley, 2000b; 2017b; Coohey, 2007; Daniel and Taylor, 2006; Featherstone and Morris, 2021; Holt, 2015; 2017; Landsman and Hartley, 2007; Maxwell *et al.*, 2012; Nygren *et al.*, 2019). Commenting on the gender dimension of findings in the *Report of the Roscommon Child Care Case Inquiry* into intra-familial child abuse and neglect (Gibbons *et al.*, 2010) Mulkeen (2012) attributes the pervasive discourse of 'mother-blaming' which she suggests renders women responsible for matters over which they have little control and the reinforcement of men's power when their abuse remains invisible in professional interventions, to the practice of ignoring the gender dimension in routine CPW work.

Despite the lack of clarity about what constitutes adequate parenting many decisions about service provision are based on SWs perception of parents capacity to respond to or manage presenting concerns (Fallon, 2020; Scott, 2014). Due to this context specific sensemaking, assessments can involve a

reinterpretation of concerns and the roles of mothers and fathers by professionals when they are deciding on responses (Featherstone and Morris, 2021; Kemshall, 2010; Parton, 2018; Roy, 2021). A large-scale study conducted in England by Dingwall *et al.* (1983/2014) that followed cases of child abuse and neglect from identification through case outcomes is enduringly influential in this regard (e.g. Buckley, 2003; Buckley, 2017b; Featherstone and Gupta, 2018; Kettle and Jackson, 2017; Whittaker, 2018). Dingwall et al., (1983/2014) concluded the classification of child abuse resulted from social processes in which SWs considered clinical and social evidence which they combined with an assessment of the moral characteristics to parents. Subsequently, in an Irish study Buckley (2003) found that judgments and decisions made during the assessment phase were similarly based on social evidence (See Section 3.4.2 below on parental cooperation).

In their Irish study of responses to CPW referrals Ferguson and O'Reilly (2001) suggested that the principle of deference to family autonomy meant that risks were taken by SWs in cases where they decided to leave children at home (rather than take them into care) until further neglect, harm or injury could no longer justify the risk of leaving them at home.[31] They suggested this reflected the idea proposed by Dingwall et al., (1983/2014) of a liberal compromise in which family privacy and parental freedoms are balanced with demands of protecting children's rights (Ferguson and O'Reilly, 2001).

These themes are echoed in a recent study of CPW case files involving DV in 22 Local Authorities in England prompted by the 'urgency of exploring possibilities for 'thinking and doing differently' in relation to DV and abuse (DVA) and child protection (Featherstone and Morris, 2021 p.1). The report noted that routine practice focuses on women and while attention was being paid to children's experiences in practice, men were largely invisible as was the effect of their violence on women (ibid.). Featherstone and Morris (2021) said that descriptions of women in the cases (n=166) were confined to value-based commentaries on the effect of the violence on their parenting and protectiveness and that in plans women were assigned unrealistic roles and responsibilities.

3.2.3. Thresholds and decisions under uncertainty

Signal detection theory relates to decision-making under uncertainty. According to the theory, an absolute threshold relates to the minimum stimulus necessary to perceive an action necessary (i.e. the strength of signal or intensity of evidence) but, it's detection is influenced by the degree to which an individual discriminates or pays attention to the evidence, and differentiates a signal of a predictor from surrounding noise (Dalgleish, 1988; 2003; Mumpower, 2010; Mumpower and McClelland, 2014; Swets *et al.*, 1955).[32]

[31] Ferguson and O'Reilly's study did not correlate with the current pattern that only a small proportion of referrals to CPW services received services of any kind. Their study concluded only 26% of the 319 referrals did not receive service even though abuse was evident or substantiated and there remained significant problems of unmet need (Ferguson and O'Reilly, 2001, p.265).

[32] Signal Detection Theory addresses the question of a person's ability to discriminate the presence and absence of a stimulus (or different stimulus intensities) from all the criterion the person uses to develop a response to the criterion. SDT can be applied to analyse the accuracy of decisions in CPW, i.e. the identification of true positives

In Irish policy (see Figure 5, Chapter 2) a formal threshold for each decision is described in terms of eligibility criteria based on legislation and policies and set out in practice guidelines and specifically in the *Threshold of Need Guidance* (DCYA, 2011a; 2015; Department of Health, 2000a; Department of Health and Children, 1999; HSE, 2011; HSE/Tusla, 2009/2014; Tusla, 2014c). The *Child Protection and Welfare Handbook* describes a threshold as 'the juncture at which certain criteria are met and thereby a specific response is required or specific procedure must be followed' (HSE, 2011 p.9). The policies advise SWs to 'tell a coherent story about the child's circumstances' (HSE, 2011) that matches the identified needs and risks to the type of intervention indicated in the *Threshold Guidance* (Tusla, 2014c). These guidelines suggest an automatic response is required to a minimum threshold but, they also stress the importance of the role of professional judgment for the goal-oriented decision-making required in IAs (HSE, 2011; Tusla, 2014a).

Baumann *et al.* (2011 p. 7) suggest a threshold for action 'turns an assessment of a situation into a decision-about action'. It is accepted that the type and weight of evidence required for thresholds and type of intervention varies according to the target decision (Baumann *et al.*, 2011; HSE, 2011; Tusla, 2014c). But, as discussed above, for a case to reach the threshold it is necessary for a SW first to notice factors relevant to the threshold and to discriminate their importance relative to other factors i.e. come to a judgment about risk or categorisation (Dalgleish, 1988; 2003; Mumpower, 2010; Mumpower and McClelland, 2014; Swets *et al.*, 1955).

Ideally, we expect decision makers to use all of the relevant information and combine it appropriately, especially when decisions have significant consequences (Dhami, 2003) such as preventing child abuse or poor welfare outcomes. This ideal model of decision-making, based on rational choice, makes extreme demands on decision makers and this leads to modified decision strategies that results variability in assessments and decisions. The research shows that thresholds in CPW are influenced by a host of factors which are incorporated in to sensemaking and judgments during assessments and which influence decisions (Baumann *et al.*, 2011; Dalgleish, 1988; 2003; Helm and Roesch-Marsh, 2016; Platt and Turney, 2013), which in turn have implications for the client, organisation and the decision maker (Baumann *et al.*, 2011). These influences operate in various ways to the degree that Baumann *et al.* (2011 p.7) described a threshold as a 'line in the sand' that influences case processing at various points along the continuum of services.

3.2.4. Target decisions

Target decisions incorporate disposal decisions and decisions on the categorisation of concerns. These are linked to decisions about the risk of future significant harm (Ireland, NI, England, Wales and

or true negatives from false positives or false negatives (Mansell et al., 2011; Mumpower and McClelland, 2014; Munro, 2004).

Scotland)[33] or substantiation of past abuse and the future risk of future harm (Australia, Canada, NZ, USA) (Cash, 2001; Stoddart *et al.*, 2018) because historically in case study methods the substantiation of prior or current maltreatment presupposed a higher potential for future maltreatment (Hughes and Rycusa, 2006). Even where substantiation is not required in policy certain problems focused on early intervention or preventing recurrence of abuse, such as allegations of retrospective sexual or physical abuse or legal proceedings, may also necessitate substantiation (Best *et al.*, 2013; Tusla, 2020b).

Target decisions have implications for variables required to be integrated in assessments. The identification of past abuse involves attribution or inferring causes of presenting characteristics and behaviours to causal pathways and the prediction of future harm involves the estimation of risk based on certain factors which includes the identification of past harm (Dawid 2013 in Best *et al.*, 2013; Dawes *et al.*, 1989; Keddell, 2016b; van der Put *et al.*, 2016). Christ and Schwab-Reese (2020) suggest that definitions of child abuse mean that maltreatment can be confounded with its causes or consequences for evidentiary purposes in practice. On the whole, data associated with substantiation is widely regarded as being problematic for practical and ethical reasons (e.g. Drake, 1996; Fluke, 2009; Keddell, 2016b). Researchers suggest there may be confusion among risk, safety and substantiation (Fallon *et al.*, 2011b; Hughes and Rycusa, 2006; Jedwab *et al.*, 2017). It is incorrect to equate unsubstantiated cases with an absence of abuse because many studies identify commonalities among substantiated and unsubstantiated investigations (Drake *et al.*, 2003; Jedwab *et al.*, 2017).

The review now turns to the examination of the decision strategies that people use to modify demands of the task of assessment and decision-making for threshold decisions in CPW for assessment generally, focusing also on ongoing service following assessment, drawing on a selective review of influential literature from the fields of organisation theory and again, behavioural psychology.

3.2.5. Search stopping and goal substitution

Simon (1955) provided a theory and empirical evidence for characterising human rationality as 'bounded' in accordance with constraints in the environment/organisation context, in time and workload pressures, and in human rational capabilities. He suggested that under such circumstances individuals accept the first option that minimally meets their needs, rather than search for an opportunity to maximise or optimize the outcome which he called a heuristic or a satisficing procedure (Simon, 1955). This model of bounded rationality does not suggest that decision makers in organisations are naively 'satisficing' rather, decision makers refine their information needs based on the subjective evaluation of requirements of subgoals when the goals of the organisation cannot be connected to practice (Simon, 1955; 1978).

[33] Up to 2012 SWs conducting assessments were required to determine if an abuse allegation was founded or unfounded. Between 2012 and 2022 there was no requirement to evaluate the veracity of allegations except in relation to retrospective allegations of abuse where SWs were required on the basis of probability to determine whether or not abuse occurred. In 2022 Tusla implemented a Child Abuse Substantiation Policy and Procedure (Tusla, 2022).

Reductionist and search stopping strategies have been identified in relation to the sensemaking approaches used by SWs to make various threshold decisions in the context of caseloads and constrained resources and complex and competing rules (Burns and MacCarthy, 2012; Helm, 2013; Whelan, 2018). For example, research has shown that when sensemaking arrived at a threshold for action, the search for information stopped (Benbenishty *et al.*, 2003; Gautschi and Benbenishty, 2020; Helm, 2013; Manion and Renwick, 2008; Munro, 1999a; Platt and Turney, 2013). In an English ethnographic study of safeguarding judgments, Helm (2013) identified that SWs, constrained by time and caseloads, made satisficing decisions (Simon, 1955) coming to decisions when they believed they had gathered sufficient information 'germane to the judgment' (Helm, 2013). The SWs used a limited set of factors from their sensemaking to construct rationales for decisions, which he referred to as 'good enough' judgment (Helm, 2013 p. 33).

The substitution of goals (Simon, 1955; 1978) is seen in a range of local strategies SWs adopt at team or department level to manage caseloads and resources at various decision points, which several researchers suggest shows that SWs operate as 'street level bureaucrats' (Križ and Skivenes, 2013; Lipsky, 1971; O'Leary, 2007a). Strategies adopted include the use of informal wait-lists, bypassing prescribed processes (DePanfilis and Girvin, 2005; O'Leary, 2007a), reallocating work or ranking risks (Gillingham and Humphreys, 2010; Keddell and Hyslop, 2019b) and prescribing local eligibility criteria or less formal practice norms (Broadhurst *et al.*, 2010b; Buckley, 2003; Whelan, 2018). In an Irish study of Intake decisions by Whelan (2018) SWs reported a local policy regarding referrals involving DV to progress a child for IA if and when three referrals had been received. Studies have also shown that where evidence does not equate with eligibility criteria, referrals were closed or abuse categories were reinterpreted as less concerning child welfare concerns receiving less immediate- or no intervention (Buckley, 2003; Ferguson and O'Reilly, 2001; Hayes and Spratt, 2014; Whelan, 2018). In a Scottish study Kettle (2015), echoing Stevenson (1996), suggested that cases reached a 'tipping point' for categorisation or action based on a combination of deliberate strategies and intuition, reflecting the idea of a threshold shift in cases that influences decisions to act (Baumann *et al.*, 2011; Dalgleish, 1988; 2003; Kettle, 2015).

Multiple heuristic approaches have been identified, and they are always efficient and sometimes valid (Goldstein and Gigerenzer, 2011; Kahneman and Klein, 2009; Kahneman *et al.*, 1982). But, they can lead to variability in intuitive judgments and decisions for service provision (Keddell, 2014a; Keddell and Hyslop, 2019b; Platt and Turney, 2013) and to cognitive biases that are large, persistent and serious in their implications for decision-making (Kirkman and Melrose, 2014; Munro, 1996; 1999a; Slovic *et al.*, 1977; Taylor, 2016). The literature also identified that when using such reductionist strategies, SWs may make decisions about which they are professionally unhappy (Burns and MacCarthy, 2012; Keddell and Hyslop, 2019b; O'Connell, 2018; Waterhouse and McGhee, 2009).

Commenting on a case study of responses to referrals to a social work department, Buckley (1999 p. 29 emphases in original text) noted that social workers interpreted *available* circumstantial information and ascribed value to it rather than measuring the degree of 'actual harm' (Buckley, 2000a; Buckley *et al.*, 1997; Keddell and Hyslop, 2019b; Kirkman and Melrose, 2014; Munro, 1996; 1999a; Parton *et al.*, 1997; Skehill *et al.*, 1999; Turney *et al.*, 2011; Whelan, 2018). The basis for intervention was not so much whether or not an abuse allegation had been substantiated, as Parton (2018) explained, because often it was impossible to establish what really happened. He went on to say that

> *methods for resolving practical concerns for agency accountability were substituted and primary focus was that of making judgments about risk – its assessment and management. We discovered that discussions of child abuse were rarely mentioned in the files only by those referring or reporting cases (Parton, 2018 p. 168).*

The selective use of information in case files to affirm an intended decision has been repeatedly discussed in the literature (Benbenishty *et al.*, 2003; Huffhines *et al.*, 2016; Laird *et al.*, 2017; Munro, 1999a; Platt and Turney, 2013; Witte, 2020).

3.2.6. Analysis and decision-making

The focus on professional judgment in polices for IA reflects the importance of theory and expertise in judgments and decisions (DCYA, 2011a; Department of Health and Children, 1999; HSE, 2011; Tusla, 2014a; c). Child safety and development and the importance of relationship are central tenets of CPW policies although they tend to interact with a range of sometimes competing drivers of judgments and decisions (Calder, 1995; Canavan *et al.*, 2019; Coulter *et al.*, 2020; DCYA, 2011a; Department of Health and Children, 1999; Thoburn *et al.*, 1995; Tusla, 2013a).The evidence indicates that professional judgment and decision-making is complex and skilled and that SWs incorporate the theoretical foundations for their judgments, either explicitly or implicitly (Buckley, 2003; Drury-Hudson, 1999; Fluke *et al.*, 2016; Munro, 2019b). But as this review has demonstrated, there have been repeated concerns about SWs analysis and interpretation of evidence particularly in situations where grave errors were made (Munro, 2019a; b; Turney *et al.*, 2011).

In his early research Simon (1945) believed that theory of decision-making had to account for both conscious and unconscious processes and which generated research to explore how they operated (Simon, 1987). Drawing on behaviours of chess masters, Simon developed a hypothesis that these unconscious intuitive processes, in everyday life in addition to professional settings, is nothing more than recognition which, he argued is based on the accumulation of experience (Simon, 1945; 1987). This dual process model of reasoning is now widely evidenced (Kahneman and Klein, 2009; Klein *et al.*, 1993; Klein *et al.*, 1986; Taylor and Whittaker, 2018; Whittaker, 2018) and there is agreement that as knowledge or as professional intuition develops, the processing shifts from conscious deliberate thinking to this intuitive (Kahneman, 2011; Kahneman and Frederick, 2002; Kahneman and Klein, 2009; Simon, 1987; Whittaker, 2018). But, researchers also caution that conditions necessary for

developing accurate intuitive expertise include high-validity environments and adequate opportunity to learn from them (Kahneman and Klein, 2009).

In contrast, CPW systems are 'noisy' (Kahneman *et al.*, 2021) with variable inputs, poor feedback loops and little time for reflection (Crea, 2010; Gambrill, 2005b; Keddell, 2014a; Keddell and Hyslop, 2019b; Munro, 2010b; 2019b). Many examples in the literature suggest the 'relatively straightforward framework outlined in the child protection guidelines' (Buckley, 2003 p. 90) which is bureaucratised and technologically driven, does not account for the informal, situated reasoning that takes place in assessment practice. Assessment practice is emotionally, cognitively and professionally demanding and time constrained and conducted in complex ecological settings characterised by interaction with clients and structural, institutional and operational factors in ways that are not always predictable (Baumann *et al.*, 2011; Benbenishty and Fluke, 2020; Broadhurst *et al.*, 2010a; Broadhurst *et al.*, 2010b; Buckley, 2003; 2015; Burns and MacCarthy, 2012; Featherstone *et al.*, 2014a; b; Ferguson, 2011; Forrester and Harwin, 2006; Helm, 2013; Helm and Roesch-Marsh, 2010; Horwath, 2007a; IASW, 2011; Keddell, 2011; 2021; Mooney, 2018; Munro, 2005; 2011b; O'Connell, 2014; 2018; Pithouse *et al.*, 2012; Platt, 2005; Platt and Turney, 2013; Saltiel, 2015; Shlonsky and Wagner, 2005; Taylor, 2016; White *et al.*, 2010; Wilkins, 2013; Wulczyn *et al.*, 2010).

Research has shown that the role of intuitive and analytic thinking vary according to the nature and complexity of a case (Buckley, 2003; Hackett and Taylor, 2013; Keddell and Hyslop, 2019b). Intuitive decision-making seems to be unproblematic in cases easily categorised as not reaching a threshold or those where there is sufficient evidence of harm and failure to protect in which cases assessments concluded (Buckley, 2003; Hackett and Taylor, 2013; Keddell and Hyslop, 2019b; Kettle, 2015; Stevenson, 1996). Difficult decisions requiring predominantly analytic thinking combined with intuitive thinking, and more time, include new events on chronic cases, emotional and psychological abuse especially in relation to DV and situations where there is uncertainty about future outcomes, substance misuse and parents who despite significant difficulties were coping, because there is rarely unambiguous empirical evidence or guidance to follow, and SWs say they have concerns about their expertise and capacity to respond to children's needs within available resources (Benbenishty *et al.*, 2003; Ferguson and O'Reilly, 2001; Hackett and Taylor, 2013; Keddell and Hyslop, 2019b; Roy, 2021; SIS, 2005; Whelan, 2018). Due to the requirement to follow administrative tasks or manage demand in the frequently adversarial decision-making environments, SWs do not have sufficient time to reflect on practice either in the moment or in supervision to ensure decisions cohere with ethical principles on which they wish to base their practice (Burns and MacCarthy, 2012; Burns *et al.*, 2018; IASW, 2011; Keddell, 2014a; Keddell and Hyslop, 2019b).

General difficulties in professional judgment and decision-making are said to be amplified in CPW assessments because of lack of agreement on what constitutes abuse and because definitions are variously operationalized (Fallon, 2020; Horwath, 2005; 2007b; Parton *et al.*, 1997; Wattam, 1996), due to poor evidence or methods to demonstrate attribution (Benbenishty *et al.*, 2003; Best *et al.*, 2013;

Drake, 1996; Wattam, 1996) and because of the irreducible uncertainty of the environment for practice (Hammond, 1996). All of these, according to Dalgleish (2003), necessitate professional discretion. For SWs this means that interpreting information and having sufficient evidence to demonstrate reaching a threshold that warrants action can be a challenging and subjective endeavour that involves prioritising among a range of variables related to the input and output of decisions (e.g. Buckley, 2003; Devaney, 2019; Drake, 1996; Helm, 2013; Manion and Renwick, 2008; Munro, 2005; 2010a; Platt and Turney, 2013).

The conceptualisation of judgment and decision-making described in Irish guidelines reflects the dual-process model comprising intuitive and rational/analytic thinking (Kahneman and Klein, 2009; Klein *et al.*, 1993; Klein *et al.*, 1986; Taylor and Whittaker, 2018; Whittaker, 2018), which is sometimes in CPW referred to as the 'art and the science' of practice. The 'art' refers to intuitive sensemaking in case work seen in the way SWs 'size up a situation to recognise which course of action makes sense' (Munro, 2019b p152) and the 'science' to the more analytic, deliberate and effortful processes involving the application of eligibility criteria outlined in policy guidelines, assessment tools and checklists to decide a course of action (Cash, 2001; Crea, 2010; Munro, 1999a; 2019b; van de Luitgaarden, 2009). Flyvbjerg (2006) says that context dependent knowledge and expertise are at the heart of expert activity and also at the centre of the case study research method adopted in this research to develop a nuanced understanding of assessment and decision-making in real-life practice (see Chapters 4/5).

This section indicated that assessment and decision-making in CPW entails a number of activities which need to be distinguished. These include the conceptual issues of risk and uncertainty, risk and accountability and formal features including thresholds and target decisions as distinct from informal strategies that are developed by organisations and individual SWs.

3.3. Frameworks for initial assessments

Assessments are designed on the assumptions that interventions support secondary prevention and improve outcomes either through direct service provision or referrals to services within the community (Jonson-Reid *et al.*, 2017). However, as discussed risk and risk screening, assessment and categorisation are central to 'front door' assessment processes which serve to determine whether or not a child and family reaches a threshold for intervention (Lonne *et al.*, 2020).

Decision-making in CPW as in other professional situations, is guided by formal rules and frameworks, models of rational choice, that serve to reduce uncertainty and support consistent and valid assessment and decision-making (Slovic *et al.*, 1977). Practice tools and frameworks, and systems for recording information act as mechanisms to frame thinking and prioritise what noticed, and analysed in support of target decisions and indeed what gets documented in case files (Gillingham *et al.*, 2017; Jud *et al.*, 2016; Tversky and Kahneman, 1974).

3.3.1. Categorizing assessment tools and frameworks

Standardised methods for assessment, judgment and decision-making are classified according to the method by which they are developed (Barber *et al.*, 2008; Barlow *et al.*, 2012; Cuccaro-Alamin *et al.*, 2017; Home and Panel, 2016; Hughes and Rycusa, 2006; Knoke and Trocmé, 2005; Rycus and Hughes, 2003; White and Walsh, 2006). Actuarial risk assessment tools are developed by statistically identifying the factors associated with maltreatment (e.g. Hindley *et al.*, 2006; White *et al.*, 2014), with weights given to specific factors and judgments are based on scoring the factors according to guidance associated with the tools, to arrive at a risk score, which is used to determine a classification and guide a course of action (e.g. Baird *et al.*, 1993; Hughes and Rycusa, 2006). They are considered to be the 'gold standard' for case decisions (Schwalbe, 2008) and they can provide a transparent and accessible evidence base for holding individuals or organisations accountable for actions taken (Bosk, 2018 p.207).[34] However, there are debates about their utility and fairness, because of concerns about training models, the role of static or unchangeable risk factors – which may lead to bias in judgments, with some practitioners preferring consensus models that integrate protective or strength factors (Keddell, 2014b; Mendoza *et al.*, 2016) and some advocating the integration into assessments of dynamic and impactful factors in the wider ecology (Featherstone *et al.*, 2014b; Keddell, 2021). Consensus-based frameworks, as used in Ireland, are based on theoretical approaches and incorporate characteristics that are deemed relevant in terms of risk and protection because of consensus among experts (Barlow *et al.*, 2012; Home and Panel, 2016; van der Put *et al.*, 2017). As described in Chapter 2 Section 2.4 individual items guide practitioners to select and consider their potential link to an outcome i.e. the likelihood that services are needed and the likelihood of future harm, and decide on the course of action (Barber *et al.*, 2000; Barlow *et al.*, 2012; Knoke and Trocmé, 2005) from the options available the end of the IA.

Consensus models are distinguished on the mechanisms that professionals use to judge the likelihood of risk. Some, including the Irish framework rely on professional discretion to determine which characteristics in an individual child's circumstances should be considered and how to combine and weight them to form a judgment on risk (e.g. Barlow *et al.*, 2012; Department of Health, 2000a; Department of Health and Children, 1999; Turnell and Edwards, 1999; Tusla, 2014c). Others, designed to structure decision-making, incorporate numeric scoring systems which are assigned to categories of risk which compute to give an overall risk score, that directs the assessor in choosing between options available in the policy (see Barber *et al.*, 2008; NCCD, 2017). While the aim of these systems is to improve consistency, as Gillingham and Humphreys (2010) reported, this is not the case as staff manipulate scores for a range of reasons including to gain access to services for clients, to prioritise children most in need of services. Some workers stated the tools were not used during decision-making rather, they recorded judgments already reached (Gillingham and Humphreys, 2010). Some tools incorporate the discretionary option to override the rating (NCCD, 2017). Whatever approach is adopted to conduct assessments, the primary objective is to convert uncertainty and ambiguity into expressions

[34] In the US, Canada and New Zealand there has been a focus on developing actuarial models to assess risk. In the US in particular, there is evidence for the validity and accuracy of a number of these models (e.g. W. Johnson et al. 2015).

of relative risk through a complete accounting of the risks confronting children (Camasso and Jagannathan, 2013).

3.3.2. Limitations of consensus frameworks for assessment and decision-making

In a very influential study, Meehl (1954) examined the comparative accuracy of actuarial versus clinical methods of decision-making and dramatically illustrated the unreliability of clinical intuition and subjective judgment (Dawes *et al.*, 1989; Kahneman, 1991). Meehl (1954) believed the inferiority of clinical judgement was due in part to errors such as the systematic neglect of the base rates and outcomes when specific information about individual cases is to hand. Meehl's concerns about intuitive judgments in predicting future behaviours (Dawes *et al.*, 1989) were echoed in research which identified the tendency for people to make judgments on the basis of representativeness, preferring to use individuating information or attributes to answer a similarity question (Kahneman and Frederick, 2002; Kahneman *et al.*, 1982; Kahneman and Tversky, 1972), or evidence from coincidental or smaller samples (Bar-Hillel, 1980) leading to biases in probability judgments.

Tversky and Kahneman (1974) identified that the subjective assessment of probabilities under uncertainty was frequently based on simplifying operations called heuristics or rules-of-thumb, which reduce complex tasks of assessing probabilities and predicting outcomes. Based in experimental settings, their research demonstrated how the subjective assessment of probabilities resembled the subjective assessment of physical quantities like distance or size, all of which are based on data of limited validity, processed using heuristic rules (Tversky and Kahneman, 1974). Essentially, when confronted with a difficult question people often answered an easier question, usually without being aware of the substitution (Kahneman 2002). The research also identified a tendency towards reliance on available information or information easily recalled that served to frame decisions and a failure to revise judgments when judgments have to reach a particular conclusions because people tended to collect and interpret evidence to favour that decision resulting in confirmation and desirability biases (Dawes *et al.*, 1989; Kahneman *et al.*, 2021; Tversky and Kahneman, 1974; 1981).

In CPW patterns of judgment and decision errors are seen in the tendency to rely on dispositionism, in which people overestimate the impact of personality characteristics and underestimated the importance of situational variables external social factors (Benbenishty *et al.*, 2015; Buckley and Whelan, 2018; Enosh and Bayer-Topilsky, 2015; Featherstone *et al.*, 2014b; Keddell and Hyslop, 2019a; O'Leary *et al.*, 2015a; Williams and Soydan, 2005) and representativeness where it appears that a client represents a classic case and where the probability of an outcome is underestimated (Arkes, 1981; Gambrill, 2006b quoted in Regehr et al 2010; Regehr *et al.*, 2010) as discussed above in relation to social norms. Bias also seen in patterns of gendered responses from CPW (Bosk, 2018; Featherstone and Morris, 2021; Keddell and Hyslop, 2019b; Sidebotham *et al.*, 2016) discussed above.

Despite their utility in linking information to case planning through inclusion of a wide range of current and historic risk and protective factors (Home and Panel, 2016) consensus-based models in CPW have been criticized as imprecise, subjective, and inconsistent (Barlow *et al.*, 2012; D'Andrade *et al.*, 2005; Dawes *et al.*, 1989; Gillingham, 2009; Meehl, 1954; Mendoza *et al.*, 2016). This is partly to do with the fact frameworks that inform decision-making are frameworks of social meaning, highly influenced by elements in the social contexts and individual circumstances within which they occur (Baumann *et al.*, 2011; Fallon *et al.*, 2013a; Keddell, 2014a; Kemshall, 2014). Tversky and Kahneman (1981) used the term 'decision frame' to refer to the decision-maker's conception of the acts, outcomes, and contingencies associated with a particular choice. Accordingly, the frame that a decision-maker adopts is controlled partly by the formulation of the problem and partly by the norms, habits, and personal characteristics of the decision-maker. In Chapter 2, I described the effect of rare single events such as those investigated in child abuse inquiries on policy for risk assessment which also influence risk perceptions in individual cases. Drawing on the literature from behavioural psychology Kearney (2013 p.51) argued this risk perception biased thinking so profoundly that there is a need to recognise the rare and "essentially unpredictable nature of future individual non-accidental child deaths" in order to allow CPW professionals to work with children and families in more supportive and less risk averse ways.

The tendency to anchor on a particular formulation of a problem as a starting point for judgments can be problematic, as different anchors yield different judgments (Kahneman *et al.*, 2021; Tversky and Kahneman, 1974). In CPW for example, anchoring on complex and ambiguous constructs such as whether or not DV constitutes emotional abuse has consequences when deciding if children should be the subject of CPW interventions (Cleaver *et al.*, 2011; Gambrill, 2006a; Iwaniec, 2006; Johnson, 2009; Kennedy and Holt, 2020; Landsman and Hartley, 2007). An American study looking at the root cause of decision errors by Rzepnicki and Johnson (2005) concluded that such patterns become so entrenched in routine practice that they have become part of its culture.

SWs conducting IAs are required to make many sequential and impactful decisions that are frequently based on ambiguous and incomplete information (Burns and MacCarthy, 2012; Drake, 1996; Enosh and Bayer-Topilsky, 2015; Fluke *et al.*, 1999; Foreman *et al.*, 2015; Gambrill, 2005b; Helm, 2011; Keddell and Hyslop, 2019b; Kirkman and Melrose, 2014; Saltiel, 2015; Shlonsky and Gibbs, 2004). Practice is complicated by the simultaneous requirement to follow multiple sets of rules or conventions to satisfy and balance often competing and sometimes contradictory, rights and interests of children, parents or carers and alleged abusers (Buckley and O'Nolan, 2013; Burns and MacCarthy, 2012; Gambrill, 2008; Gillingham *et al.*, 2017; Mooney *et al.*, 2021; O'Connell, 2014; Tusla, 2014a; b; c). Recent Irish studies identified conflicting evidence regarding the impact of assessment guidance and threshold guidance on decision-making (McCormack *et al.*, 2020; Whelan, 2018). Together with high levels of demand and the need for rapid case disposal, these uncertain conditions create the 'latent conditions' (Broadhurst *et al.*, 2010b) for error or avoidable mistakes (Broadhurst *et al.*, 2010b; Enosh *et al.*, 2021; Fluke, 2009; Foreman *et al.*, 2015; Gambrill, 2008; Munro, 2019a).

IA policies demand that SWs demonstrate in their records, a coherence between judgments about future risk explanations and decisions whether or not to provide ongoing service (DCYA, 2011a; HSE, 2011; Tusla, 2014c). Studies of CPW practice using SW case files have identified variable quality in record keeping due to the discretionary nature of practice (Roy, 2021; Teater *et al.*, 2016; Tusla, 2015). Information may be under-recorded either because social workers are not aware of an issue (Fallon *et al.*, 2021; Trocmé *et al.*, 2010) or because they do not record it even when they are aware of it because it might not appear relevant to the decision or, due to time constraints or prescriptive recording requirements (Featherstone *et al.*, 2014b; Forrester and Harwin, 2006; Gautschi and Benbenishty, 2020; Hayes and Devaney, 2004; Laird *et al.*, 2017; Roy, 2021; Teater *et al.*, 2016). Conversely, information may be emphasised because of a bias to seek and overweigh evidence that confirms beliefs or the decision taken or because it reflects coherence with organisation values and requirements (Featherstone and Morris, 2021; Gambrill, 2008; Huffhines *et al.*, 2016; Kahneman *et al.*, 1982; McCormack *et al.*, 2020; Roy, 2021; Simon, 1955; 1978; Taylor, 2017b; Witte, 2020). As a consequence the management information and statistics generated from assessment records are criticized also because may represent an oversimplification of the context within which decisions about risks are made (see above) (Baumann *et al.*, 2011; Buckley, 2000a; Burns and MacCarthy, 2012; Platt and Turney, 2013). This limitation has been central to the motivation for the research and to decisions on methods used for the research undertaken for this thesis (see Chapter 4).

Despite the attention to reforming policies for assessment (e.g. Barlow *et al.*, 2012; Tusla, 2017) researchers suggest that any supposition that correct practice frameworks and the application of guidelines reduces uncertainty and complexity or consistently leads to the identification and unambiguous responses to abuse is flawed (Buckley, 1999; 2000a; Drake, 1996; Fluke, 2009; Helm, 2013; Hood, 2014; Kohl *et al.*, 2009; Manion and Renwick, 2008; Munro, 2011b; Platt and Turney, 2013). This is because the focus the role individual client factors overlooks the role that structural and environmental factors play in cause and response, and focus on the role of risk in professional judgment overlooks the role of risk in the environment for practice (Baumann *et al.*, 2011; Gambrill, 2005b; 2010; Gillingham and Humphreys, 2010; Helm and Roesch-Marsh, 2016; Munro, 2010a; 2019a; Platt and Turney, 2013; Shlonsky, 2015) and overlooks the attendant ethical concerns, uncertainties and anxieties for SWs (Keddell, 2014a; Lees *et al.*, 2011; Munro, 2019a; Waterhouse and McGhee, 2009).

This research focusses on revealing the assessment, judgment, and decision-making strategies that social workers use as they describe and document them and to explore their efficacy in the context of the current policies for case management. To support the research, the next section examines the evidence on patterns in judgments and decisions.

3.4. Patterns in sensemaking, judgments and decisions

Exploratory research aimed at tracing decision processes has shown that assessments involve informal processes variously described as office-based sensemaking (Helm, 2013), rationalising techniques or

collegial consensus in decision-making (Buckley, 1999; 2000a), or hypothesis testing (Whittaker, 2018) all of which influence what gets decided and recorded. Cook and Gregory (2020) define sensemaking as a psychosocial process which precedes and underpins professional judgement which, though it may be inherent in the judgments and actions that are recorded by SWs is not reflected in official accounts of social work (Buckley, 2003; Cook and Gregory, 2020; Saltiel, 2015). Having established that individuals may pay different attention to features in a case and that their perception may be influenced by a range of personal and environmental factors, this section presents evidence from empirical studies of factors that influence sensemaking and decision-making processes. This builds on the evidence reviewed in section 3.2.2 about patterns of response related to risk, responsibility, and accountability.

3.4.1. Focus on incidents and recent or available information

Several authors report a tendency in CPW to respond to information relating to episodes or incidents, as opposed to longitudinal or cumulative effects of exposures, which can result in obscuring the experiences and needs of children and of adults involved (Benbenishty *et al.*, 2003; Buckley, 1998; 2003; Howe, 1996; Humphreys *et al.*, 2005; Munro, 2011a; Roy, 2021; Sheehan, 2019; Shlonsky and Friend, 2007; Spratt, 2012; Thorpe, 1994; Trocmé *et al.*, 2014; Whittaker, 2018). Stevenson suggested, that because certain incidents triggered intervention where families were known to CPW, it tended 'to confirm that there may be a dulled response to certain well known families, who are not providing good enough care' (Stevenson, 1996, p. 17). She said that,

> *in long-term cases of neglect, social workers have got used to certain families bumping along the bottom' or 'nearly falling off the edge' As time goes on, there may seem less reason for taking action; … The effect is to tolerate the status quo until 'an incident' necessitates a proper assessment of the contemporary family situation (Stevenson, 1996, p.16).*

Drawing on a number of research studies of social work practice and decision-making conducted by graduate students Buckley (1999; 2002) drew similar conclusions, saying that that responses

> *were focussed on incidents rather than patterns of abuse and did so in an individualistic manner that took little cognisance of the child's ongoing developmental needs or the impact of external factors on the family system … the object of assessment in cases of neglect tended to be parents, not the children, and the work that was done was determined by the structures and services that were available rather than the needs of the children (Buckley, 2002, pp. 87-88).*

She suggested this approach excluded the rehabilitation of 'poorly performing families' through the substitution of child protection in a narrow sense (ibid). In a similar vein, drawing on evidence from Australian SW practice, Thorpe (1994, p. 192) found that interventions in 'neglect' or 'at risk' cases tended to focus on child protection and not 'in a genuine sense' on resolving the problems of families marginalised by poverty and/or addiction problems.

Incident-driven approaches to assessment and intervention persist (Brown and Ward, 2014; Bywaters, 2015a; Featherstone *et al.*, 2014b; Scott, 2014; Sheehan, 2019; Spratt, 2012; Stanley *et al.*, 2010) and mean that frequently opportunities for working therapeutically with children and families to prevent further harm are diminished. Researchers, focused on the necessity to shift thinking in assessments recommend a range of conceptual frameworks including the idea of cumulative harm, which refers to the effects of multiple adverse circumstances and events in a child's life (Bromfield *et al.*, 2007). Sidebotham *et al.* (2016) proposed using the term 'cumulative risk of harm' to encourage consideration of the full range of risks in the family and wider social environment. Murphy and Rogers (2018) use the term 'adult oriented issues' to highlight the importance of responding to parents and children's needs separately and of considering their interaction and impact on individual children during IAs. The concept of 'hidden harm' has been integrated to Irish CPW practice to highlight the necessity of assessing the effects on children of exposure to parental substance misuse (HSE and Tusla, 2019).

Researchers identified that practitioners are good at gathering information about children and families but, their information processing or analytic approaches often meant that judgments and decisions that were based on insufficient or selectively used evidence (Dalgleish, 1988; Kearney, 2013; Munro, 2011b; Turney *et al.*, 2011). Identified shortcomings included tendencies to overweigh recent over historic evidence as discussed above, (Brown and Ward, 2014; Bywaters, 2015a; DePanfilis and Girvin, 2005; Featherstone *et al.*, 2014b; Roy, 2021; Scott, 2014; Sheehan, 2019; Spratt, 2012; Stanley *et al.*, 2010; Stevenson, 1996) to overweigh evidence that supports a particular hypothesis or stereotypes and failure to incorporate sufficient evidence to support or refute claims (Benbenishty *et al.*, 2003; DePanfilis and Girvin, 2005; Gambrill, 2008; Munro, 2008) and failure to use available evidence to explore alternative hypotheses (Benbenishty *et al.*, 2003; Buckley, 2003; DePanfilis and Girvin, 2005; Ferguson, 2016; Gambrill, 2008; Helm, 2011; Munro, 1999a; Platt and Turney, 2013). In her Irish case study on Intakes, Whelan (2018, p. 246) stated that SWs referred to 'dilemmas involved in deciding how much information to gather and how to know when enough has been gathered'.

3.4.2. Focus on parental cooperation

Buckley's Irish research found that compliance, particularly from mothers who were the parents most involved in assessment, was particularly important and that 'as long as parents maintained at least a surface cooperation they were less likely to be the object of compulsory action' (as cited in Buckley, 2000a p.17; Dingwall *et al.*, 1983/2014 p.92). Similarly, in an English case study of decision-making in IA, Platt (2005) found that if SWs believed cooperation from the parent was unambiguous and enthusiastic, there was often a corresponding de-escalation of responses. A Canadian study of CPW decisions in cases involving DV based on administrative and case data by Lavergne et al., (2011) reported that cases in which the parents are considered uncooperative are more likely to involve more coercive intervention.

During assessments the perception of parental cooperation may represent deference to parental autonomy but, also becomes representative of parenting capacity and specifically, protective parenting

and intentions to act protectively (Bartelink *et al.*, 2018; Buckley, 2003; Davidson-Arad and Kaznelson, 2010; Dingwall *et al.*, 1983/2014; Ferguson and O'Reilly, 2001; Hunt *et al.*, 2016; Lavergne *et al.*, 2011; Lwin *et al.*, 2018b; Platt, 2005; Turney *et al.*, 2012; Ward *et al.*, 2014). In assessing parenting capacity and service needs, researchers emphasise the necessity to avoid viewing cooperation and desire to change as expressions of capacity and intention and non-cooperation as the contrary (Ainsworth and Hansen, 2015; Featherstone *et al.*, 2014b; Hunt *et al.*, 2016; Turney *et al.*, 2012; Ward *et al.*, 2014).

Various models for assessing parenting capacity highlight the necessity to develop an understanding in IA of the processes and factors associated with parental 'child-centredness' (Pizzey *et al.*, 2017 p.212), which incorporates parental insight, capacity to understand and take responsibility for difficulties in addition to parental engagement and motivation and capacity to change (Houston, 2016; Jones, 2010; Pizzey *et al.*, 2017; Turney *et al.*, 2012). Researchers highlight the necessity to avoid making early, potentially false judgments about a child's needs, the nature and reasons for the difficulties, the parents capacity to care and the environmental factors that may help or hinder this, and necessity of adopting a chronologic approach in assessments (Jones, 2010; Pizzey *et al.*, 2017).

3.4.3. Categorizing concerns

Child protection agencies typically identify four categories of abuse: physical abuse, emotional or psychological abuse, sexual abuse, and neglect. In Scotland and Canada, DV is also considered a form of abuse that is documented by CPW agencies. Several jurisdictions, including Ireland, also respond to welfare concerns through the dual mandate or differential response framework.

Despite the use of common language and an assumption in policy, that definitions have an 'ontological reality' (Wattam, 1996) that convey an understanding of the problem and induce particular reposes from the system abuse definitions and categorisations have a long, problematic history in child protection (Buckley, 1998; Christ and Schwab-Reese, 2020; Drake, 1996; Ferguson and O'Reilly, 2001; Jud *et al.*, 2016; Scott and Faulkner, 2019; Thorpe, 1997). It is accepted that definitions of maltreatment which sanction intervention change over time but the literature shows also, that they are subject to interpretation and sensemaking by practitioners at the individual case level (Bullock *et al.*, 1995; Fallon, 2020; Ferguson and O'Reilly, 2001; Parton, 2018; Parton *et al.*, 1997; Turney *et al.*, 2011).

Abuse definitions are heterogeneous constructs that are not mutually exclusive, nor do they occur in isolation as abuse sub-types tend to be correlated (Farmer and Owen, 1995; Gilbert *et al.*, 2009a; Higgins and McCabe, 2001; Price-Robertson *et al.*, 2013a).

Meta-analyses of research on risk factors for neglect (Mulder *et al.*, 2018) and physical abuse (Stith *et al.*, 2009) indicate definitions incorporate many dissimilar negative child and family experiences and variously focus on parental behaviours or effects in children.

Findings from a broad church of literature indicates that SWs incorporate a range of variables related to children's experiences in addition to parental risk factors in order to construct or operationalise definitions of abuse and welfare (Benbenishty *et al.*, 2015; Buckley, 2003; Bullock *et al.*, 1995; Christ and Schwab-Reese, 2020; Devaney and Spratt, 2009; Dixon *et al.*, 2007; Drake, 1996; Ferguson and O'Reilly, 2001; Finkelhor *et al.*, 2015; Higgins and McCabe, 2001; Jud *et al.*, 2016; Metzler *et al.*, 2017; Parton, 2018; Parton *et al.*, 1997; Price-Robertson *et al.*, 2013b; Roy, 2021; Scott and Faulkner, 2019; Sheehan, 2019; Spratt, 2012; Stanley *et al.*, 2010; Thorpe, 1997; Turney *et al.*, 2011; Wattam, 1996; Whelan, 2018). Families reported to CPW may present with multiple adversities and distress which may be suggestive of conditions other than abuse so that the prospect of identifying harm that occurred as a result of abuse is challenging (Dawid 2013 in Best *et al.*, 2013; Foreman *et al.*, 2015; Munro, 2010a). Few cases are clearly defined as typical abuse case easily amenable to categorisation and responses by the CPW system (Benbenishty *et al.*, 2003; Broadhurst *et al.*, 2010b; Buckley, 2003; Ferguson and O'Reilly, 2001; Whelan, 2018). There is considerable overlap between partner and child maltreatment, notwithstanding methodological discrepancies across studies and variations in prevalence estimates for both partner and child abuse (Dixon *et al.*, 2007; Knickerbocker *et al.*, 2007; Morris, 2009; Nikolova *et al.*, 2020; Slep and O'Leary, 2005). Incomplete or missing information, as is common in child welfare cases, can lead a worker to draw a faulty conclusion about presenting concerns (Foreman *et al.*, 2015; Gambrill and Shlonsky, 2000; van de Luitgaarden, 2009).

The interpretation and operationalisation of abuse categories varies among reporters (Kesner and Dever, 2015; Whelan, 2018), among professionals who are consulted during social work assessments and between professionals and family members (Buckley *et al.*, 2011b; Holt *et al.*, 2008; Hood *et al.*, 2021; Horwath, 2001; 2005; Jenkins *et al.*, 2019; Shannon, 2017; Stein and Munro, 2008; Thorpe, 1994) and among SW practitioners (Benbenishty *et al.*, 2015; Buckley, 1999; Fallon *et al.*, 2011c; Fluke *et al.*, 2016; Gilbert *et al.*, 2009a; Jud *et al.*, 2016; Thorpe, 1997; Whelan, 2018). Differentiating welfare concerns from child neglect and the line between physical abuse and corporal punishment, pose particular challenges (Ferguson and O'Reilly, 2001; Gambrill, 2005b; Horwath, 2005; Jent *et al.*, 2011; Keddell and Hyslop, 2019b).

Many authors suggest the policy requirement to classify concerns into one single category, driven by a performance management culture, results in the simplification of complex family situations and is seen as reductionist, unhelpful and stigmatising by service users (Broadhurst *et al.*, 2010b; Buckley, 2017b; Buckley *et al.*, 2011a; Buckley *et al.*, 2011b; Buckley *et al.*, 2008; Featherstone *et al.*, 2016; Gillingham and Humphreys, 2010; Macdonald and Macdonald, 2010). The categorisation of a case can mean that some characteristics are prioritized and others are concealed or nested within the definition (Buckley, 2000a; Higgins and McCabe, 2001; Parton *et al.*, 1997; Shlonsky and Friend, 2007). For example, in many jurisdictions including Ireland, exposure to DV and acrimony is a form of emotional abuse (DCYA, 2011a; Department of Health and Children, 1999) but that classification includes multiple other indicators so, statistics on the prevalence of DV among reports to Tusla is not known. In Canada,

since DV was classified as a form of abuse, the rise in demand was largely attributed to referrals involving DV (Fallon *et al.*, 2012).

The way concerns are categorised can impact on subsequent case outcomes (Hayes and Spratt, 2014; Platt and Turney, 2013; Tusla, 2015). This was discussed in Section 3.3.2 above, in relation to the implications anchoring on particular formulations of a problem. Evidence from Irish practice indicates neglect is often poorly understood and variously interpreted by reporters and social workers who conduct assessments (Horwath, 2001; Peyton, 2012; Shannon, 2017). It is frequently interchangeable the welfare category which is precluded from the child protection pathway (Tusla, 2015) and is perceived to be lower priority by courts than cases involving evidence of physical violence and/or sexual abuse (Peyton, 2012 p.83). The classification of DV as emotional abuse can lead to forensic style assessments that may not respond at all or, not respond adequately to the complex needs of children exposed (Buckley *et al.*, 2011a; Connolly, 2009; Kettle, 2015; Stanley *et al.*, 2010; Whelan, 2018). In Ireland longitudinal research using administrative data on children in care and national child death reviews indicate that cases are categorised as child welfare when children have been placed in care and when exposures to abuse and risks have been identified (NRP, 2014; O'Leary *et al.*, 2013).

While the categorisation of a referral on the basis of welfare or abuse is considered useful by many commentators because it might preclude a forensic style approach to cases of need (Hayes and Spratt, 2009; 2014) the converse is also true. Researchers argue that categorisation implies a false distinction between family support and child protection which also paradoxically, endangers the provision of a full range of services to each case (e.g. Buckley *et al.*, 2011b; Featherstone *et al.*, 2014b; Ferguson and O'Reilly, 2001; NRP, 2014). This pattern is particularly pertinent because immediate protection requirements take precedence over welfare assessments and abuse cases where therapeutic and/or preventive work may be indicated (e.g. Featherstone *et al.*, 2016; Ferguson and O'Reilly, 2001; Hayes and Spratt, 2014; Manion and Renwick, 2008; Parton *et al.*, 1997; Thorpe, 1994; Trocmé *et al.*, 2014; Whelan, 2018) the final pattern of decision-making to which the review now turns.

3.4.4. Focus on child abuse and risk

The review thus far has demonstrated the bias towards risk in policy and system design. This section examines the patterns identified in IAs/investigations particularly. There is mounting evidence that families referred to CPW experience multiple adversities that require support to ameliorate wellbeing or prevent further harm, and that many children experience cumulative harm through poverty and lack of access to supports in addition to unintentional and intentional neglect and abuse (Buckley, 2003; Devaney and Spratt, 2009; Featherstone *et al.*, 2014b; Ferguson and O'Reilly, 2001; Finkelhor *et al.*, 2015; Metzler *et al.*, 2017; Price-Robertson *et al.*, 2013b; Roy, 2021; Sheehan, 2019; Spratt, 2012; Stanley *et al.*, 2010; Whelan, 2018). However, where available, the evidence suggests that services are likely to be provided to children when the perception of risk is immediate or unequivocal, prioritising 'child protection' over 'child welfare' or urgent over chronic cases (Brown and Ward, 2014; Buckley, 2003; 2012; 2015; 2017b; Buckley and Burns, 2015; Bunting *et al.*, 2018; Burns and MacCarthy, 2012;

Fallon *et al.*, 2017b; Ferguson and O'Reilly, 2001; Gilbert *et al.*, 2011b; Gillingham and Humphreys, 2010; Hayes and Spratt, 2009; 2014; Hood *et al.*, 2021; Kettle, 2015; King *et al.*, 2021; Nyathi, 2018; Schumaker *et al.*, 2017; Spratt, 2001; Trocmé *et al.*, 2014; Whelan, 2018). In Whelan's Irish case study on the disposal of referrals (2018) social workers said that the more complex welfare cases that comprised a majority of referrals required more individual consideration which was challenging to achieve in the context of high demands, low resources, time constraints and limited information.

The approach is pervasive even though many CPW systems, including Ireland, England and Canada, have a dual mandate of prevention and protection and operate in the context of rising rates of referrals relating to child welfare and abuse (Fallon *et al.*, 2017b; Hood *et al.*, 2021; Trocmé *et al.*, 2014; tusladata, *Annually*). Buckley (2000b) suggested that the forensic approach applied to assessments did little to offer situations that were not amenable to accessible solutions or warnings. And while research shows that SWs are effective in identifying high risk cases (Forrester *et al.*, 2008; Keddell, 2011; Thoburn and Making Research Count Consortium, 2009) the trend left several researchers questioning whether child welfare services are the appropriate mechanism for effectively addressing circumstances that may put children at risk, particularly when the structure and delivery of services have been designed to intervene when children have already been harmed (Keddell and Hyslop, 2019b; King *et al.*, 2021).

Chronic involvement of many families with CPW and high rates of subsequent referrals among children with initially unfounded allegations or NFA following assessment give an indication of the challenge of identifying and providing appropriate responses to those most in need (e.g. Drake, 1996; Ferguson and O'Reilly, 2001; Fluke *et al.*, 2008; Jedwab *et al.*, 2017; Manion and Renwick, 2008; Roy, 2021; Stanley *et al.*, 2010). Ferguson and O'Reilly (2001) reported that such cases can be immensely demanding of energy and resources as they may involve hostile, extremely needy and traumatised children and parents. American researchers found that although assessments of risk of harm were associated with some of the factors that have been shown to predict the recurrence of maltreatment, overall these assessments were often 'only slightly better than guessing' (Dorsey *et al.*, 2008). They reported 'a complex picture of risk assessment in which there were few patterns of risk factors (other than prior reporting) that were consistently associated with caseworker classification of risk and subsequent report' (Dorsey *et al.*, 2008).

3.4.5. Variability, uncertainty, anxiety and ethical implications

Judgments and decisions vary because of eligibility criteria in guidelines (McCormack *et al.*, 2020; Munro, 2010b), the level of harm and the nature and amount of evidence available (Drake, 1996; Kohl *et al.*, 2009; Whelan, 2018), practitioners knowledge, expertise and skills (Barnes and Chand, 2000; Font and Maguire-Jack, 2015b; Keddell and Hyslop, 2019b; Saini *et al.*, 2012), practitioners perception of their role with respect to other service providers (Buckley, 2003; Buckley *et al.*, 2008; Humphreys *et al.*, 2005; Kettle, 2015; Munro, 2011b; Murphy and Rogers, 2018; NRP, 2016; 2018; O'Leary, 2007b; Roy, 2021; Shannon, 2017; Stanley *et al.*, 2010), personal preferences and values such as tensions between child protection focus and family preservation (Fluke *et al.*, 2016; Hayes and Spratt, 2009;

Spratt, 2001) or whether DV constitutes child abuse (Bosk, 2018; Featherstone and Morris, 2021), the value people place on consequences of their decisions (Dalgleish, 2003; Munro, 2011b), relationships with clients (Buckley, 2003; Dingwall *et al.*, 1983/2014), the ethnicity and socio-economic status of clients (Buckley and Whelan, 2018; Bywaters *et al.*, 2015; Fallon *et al.*, 2013a; Graham *et al.*, 2015; Hood *et al.*, 2016; Keddell and Hyslop, 2019a; López *et al.*, 2015; O'Leary *et al.*, 2015a) and the nature and number of cases, resources available to conduct assessments or to operationalize decisions (Buckley and Burns, 2015; Burns and MacCarthy, 2012; Enosh *et al.*, 2021; Fallon *et al.*, 2011b; Hayes and Spratt, 2014; Munro, 2010a; SIS, 2005; Spratt, 2012; Trocmé *et al.*, 2014). When these patterns occur it is their non-compensatory quality that can lead to flawed decisions.

Researchers have shown that the threshold to act in child protection cases varies among practitioners though they may consider and combine case information in similar ways (Rossi *et al.*, 1996). Even when SWs agree on needs or a risk judgment, they may disagree on the course of action required to address them (Baumann *et al.*, 2011; Bosk, 2018; Buckley, 1999; 2003; Keddell and Hyslop, 2019b).

Variation in terms of selected input due to inadequate knowledge, information processing errors or oversights, the environment and time constraints mean that decisions are prone to systematic errors and variability which have clinical, practical, ethical and organisational implications (Biesel *et al.*, 2020; Broadhurst *et al.*, 2010b; Buckley, 2003; DePanfilis and Girvin, 2005; Hackett and Taylor, 2013; Kahneman *et al.*, 2021; Keddell, 2014a; Kirkman and Melrose, 2014; Munro, 1996). Variation in responses on irrelevant grounds such as features relating to the organisation or culture, or through failure to pay attention to their individual needs is unfair and unjust (Keddell, 2014a; Rowson, 2006). While standardisation is a central aim of many systems to support consistency in practice Keddell (2014a) reminds us that some variability is necessary as a duty of care perspective necessitates understanding the context-dependent nature of a case in addition to the relational and caring obligations that derive from it.

The literature has identified that uncertain, erroneous and inconsistent decision-making is a major source of anxiety for practitioners (Buckley, 2015; Buckley and Burns, 2015; Burns and MacCarthy, 2012; IASW, 2011; Keddell and Hyslop, 2019b; Lees *et al.*, 2011; Tusla, 2015; Waterhouse and McGhee, 2009; Whelan, 2018). Researchers have called for learning environments and tools that enhance the development of sound professional discretion, critical reflection and support transparency along with logical decision pathways to be embedded in organisations (Gambrill, 2008; Keddell, 2014a; Munro, 2019a).

On the whole, the research evidence reveals that practices for assessments and rationales for judgments and decisions are based on a diverse range of factors some of which are not reflected in the formal description of practice or in the statistics generated by the systems. The lens of risk dominates practice during IAs in CPW and shapes the various heuristic strategies that SWs adopt when making sense of complex information in a demanding practice setting. This impacts on the interpretation and

operationalisation of risk factors, the categorisation of concerns and decisions regarding service delivery in both patterned and variable ways. The absence of evidence is problematic as it serves to reproduce possibilities for biased judgments and decisions. The review now turns to examining the available evidence on IAs and determinants of decisions to provide ongoing service.

3.5. Characteristics of initial assessments

3.5.1. Introduction

Despite decades of investment in developing assessment and case management systems, statistics on the demographics or case characteristics of children and families undergoing IA services in Ireland are not available at regional or national level. Furthermore, little is known about the movement of children through the system or the basis for decisions whether or not to provide services following IA. Such information is held on case notes, records of assessment and related material. Evidence of the population undergoing IA is gleaned from research studies, audits and reviews of cases of deceased children who are or were involved with CPW (e.g. Buckley, 2003; 2012; 2017a; Buckley *et al.*, 2011a; Buckley *et al.*, 2007; Buckley and O'Nolan, 2013; Buckley and Whelan, 2018; Buckley *et al.*, 2008; Burns and MacCarthy, 2012; Burns and McGregor, 2019; Ferguson and O'Reilly, 2001; Horwath, 2005; NRP, 2016; 2018; O'Leary, 2007a; O'Leary *et al.*, 2013). Although not systematic, this evidence provides insights into a population with complex needs and vulnerabilities. That literature is incorporated into the review that follows.

CPW systems in Anglophone countries produce varying evidence regarding children and families involved with the services. In the US,[35] UK[36] and Aotearoa/New Zealand[37] authorities publish evidence of the number and some characteristics of unique children involved at various stages in the CPW system, including assessments. The Canadian Incidence Study (CIS) and the National Incidence Study (NIS) in the US are representative surveys that produce aggregated information on investigated child maltreatment (Fallon *et al.*, 2022; Public Health Agency of Canada, 2010; Sedlak *et al.*, 2010a; Trocmé *et al.*, 2005; Trocmé *et al.*, 2010; Trocmé *et al.*, 2001). The National Child Abuse and Neglect Data System (NCANDS) in the US is an administrative dataset that utilizes country-wide child welfare data annually. Originally based on key indicators, NCANDS now reports aggregated case-level data on all screened in children and information about child protection service (CPS) responses (AlEissa *et al.*, 2009; DHHS, 2018). Due to the systematic nature of collection and the richness of the data, much of the published evidence on CPW investigations and determinants of assessment decisions is from North America. However, caution is necessary when comparting findings due to variations in definitions and assessment methods (Fallon *et al.*, 2010) and due to demographic differences.

[35] https://www.ndacan.acf.hhs.gov/datasets/datasets-list-ncands-child-file.cfm
[36] https://learning.nspcc.org.uk/research-resources/how-safe-are-our-children/.
[37] https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/cyf/findings.html

3.5.2. Incidence of assessments

In Ireland the proportion of children whose referrals are accepted by Tusla who receive assessment has fallen from rate of 18.3 IAs per 1,000 children aged 0-17 years to 7.7 IAs per 1,000 in 2019 (see Chapter 2). Hood *et al.* (2016) reported a rate of 26.8 IAs per 1,000 children in England for year 2013/14[38]. In Australia in 2015–16, 115,024 children were the subject of an investigation or 21.4/1000 children aged 0-17years (AIHW, 2017). The Ontario Incidence Study of 2018 reported 148,538 investigations were conducted in 2018 or 62.9/1000 children aged 0-15years (Fallon *et al.*, 2021) and the Canada Incidence Study 2008 reported an estimated 235,842 maltreatment-related investigations were conducted, representing a rate of 39.2/1,000 children aged 0-15years (Trocmé *et al.*, 2010) but by 2019 this rate had risen to 299,171 investigations or 48.2 investigations per 1,000 children aged 0-15years, thought to be associated with the inclusion of DV as a category of child abuse (Fallon *et al.*, 2022). In the US approximately 3.2 million referrals were received in 2016 or 55.1/1,000 children and approximately 2.3 million or 31.2 per 1,000 children received dispositions[39] (DHHS, 2018).

3.5.3. Reporters

The source of referrals that progress to IA in Ireland is not systematically documented. In her recent research on referrals Whelan (2018) found those referred by families and members of public most likely screened out before IA and concluded that it might be difficult for families to access CPW services. In Canada, 74% Investigations in the OIS 2018 (Fallon *et al.*, 2021) and 68% of investigations in the CIS 2008 (Trocmé *et al.*, 2010) were from professionals. In New Zealand data from 2015-2016 indicates that 84,228 referrals were received by NZ CPW services of which 44,689 or 53% received further action, and 90.1% of these had been referred by professionals (OrangaTamariki, 2017). Findings might suggest that professionals have knowledge that influences their communications with, and receptivity by, CPW services.

3.5.4. Re-referral and recurrence

In Irish policy 're-referrals' relate to new referrals on cases closed within the previous 12 months (HSE/Tusla, 2009/2014). Re-referral is distinguished from prior involvement on this basis. The rate of re-referrals and IAs involving re-referrals is not routinely published by Tusla but estimates of approximately 18% (n=12,984) were identified for 2021 (Tusla, 2021e).[40] In her research study Whelan (2018) identified that over 60% of referrals (n=327) in a study of 534 intakes were previously known to the service. The re-referral rate in IAs is not known.

Where evidence exists, it indicates a high rate of re-referrals in cases undergoing assessment (Fluke *et al.*, 2008; Trocmé *et al.*, 2010; Trocmé *et al.*, 2014; White *et al.*, 2014; Zhang *et al.*, 2013) some of

[38] Numbers of IA conducted were not reported
[39] A disposition is an investigation or alternative response.
[40] Data provided to the author by the Quality and Regulation Directorate, Tusla.

which is attributed to the chronic exposure to harm or risks (Ferguson and O'Reilly, 2001; Trocmé *et al.*, 2014). Some is due the failures or inability to address concerns due to pressures within the system resulting in 'stop-start' (Roy, 2021; Stanley *et al.*, 2010) or 'revolving door' processes (Lonne *et al.*, 2020) that in turn exacerbate problems for children and families in addition to the system itself.

In Australia, statistics for 2015–16 indicate almost 62% of children receiving CPW investigation were repeat clients (AIHW, 2017). In Canada approximately 48% of investigations in the CIS 2008 involved repeat referrals (Trocmé *et al.*, 2010) and in Ontario in 2018, 49% investigations involved repeat referrals (Fallon *et al.*, 2022). Although there are patterns in factors related to re-referral, and re-referral is associated with ongoing service delivery, re-referral is not necessarily associated with substantiated abuse (Bilson *et al.*, 2015; Jenkins *et al.*, 2019; Jenkins *et al.*, 2017).

Re-referral to CPW may be associated with a surveillance effect of having been previously referred to other services (Connell *et al.*, 2007; DePanfilis and Zuravin, 2002; Jenkins *et al.*, 2017). Exposure to individual or multiple parental risk factors is associated with repeat involvement with CPW (Fluke *et al.*, 2008; Hood *et al.*, 2021) but in order to target interventions effectively requires an understanding of their impact on parenting capacity and factors that have enhanced or impaired this (Bentovim *et al.*, 2009; Pizzey *et al.*, 2017; Schechter and Edleson, 1999).

The relationship between recurrence and service provision is not well understood (Fluke *et al.*, 1999; Jenkins *et al.*, 2017) even though prior involvement is a static factor incorporated in the development and evaluation of risk assessment tools (Johnson, 2011; van der Put *et al.*, 2017). As noted by Jenkins *et al.* (2019) the distinction between children likely to be subject to ongoing or repeated harm from children who are likely to be merely reported is the central task of assessment and the goal is to ensure children at risk of harm are not overlooked while simultaneously avoiding unnecessary CPW inclusion of children not at serious risk of abuse, which can be stressful and stigmatising (Buckley, 2017b). Service provision linked to re-referral may reflect an accumulation of evidence of harm and needs that finally reached a threshold that warranted intervention, as many families are chronically involved with the CPW services (Ferguson and O'Reilly, 2001; Stevenson, 1996; Trocmé *et al.*, 2014; Whelan, 2018).

3.5.5. Social context

Although national policies are based on the principle that all children be treated equally (e.g. DCYA, 2011a; 2015; 2017; Department of Health and Children, 1999; UN CRC, 2011), there is mounting evidence of structural inequalities, and the overrepresentation of the socially disadvantaged children and families and of indigenous and ethnic groups, in patterns of involvement with CPW systems (e.g. AIHW, 2017; Ainsworth and Hansen, 2015; Bywaters, 2015b; Bywaters *et al.*, 2016; Cash, 2001; Drake *et al.*, 2006; Enosh and Bayer-Topilsky, 2015; Fallon *et al.*, 2013a; Fluke *et al.*, 2011; Hood *et al.*, 2016; Jonson-Reid *et al.*, 2009; Keddell and Hyslop, 2019a; Pelton, 2015; Winter and Connolly, 2005) also evidenced in Irish CPW (Buckley and Whelan, 2018; Coulter, 2015; HIQA, 2015; O'Leary *et al.*, 2015a; Shannon, 2012; Shore and Powell, 2020). Deprivation and family poverty are linked to limitations in

safety and security of housing and access to services which impact on the nature of parenting and link to deficits in child welfare and child abuse. An Irish study by this author and colleagues (2015a) and a study in Northern Ireland by Morris et al., (2018) using very different study designs, found that relative deprivation at small community level drives demand but disappears as a factor in SW decisions regarding service provision. Bywaters found an inverse relationship between poverty and admissions into care (2015). Hood et al., (2016) identified areas of higher deprivation had increased demand and patterns of intervention that differed from more affluent areas. In a review of children and families screened out of child protection services (CPS) in the US, Simon *et al.* (2021) recommend that CPS remain involved and collaboratively engage with preventive community services that address the effects of poverty.

3.5.6. Child factors

Children whose referrals progress to IA are those about who a SW believes there exists on-going concerns that may require protection or welfare interventions (Manion and Renwick, 2008; McCormack *et al.*, 2020; Whelan, 2018). As a consequence, the population available for assessment is skewed and heterogeneous, and because the CPW system is constructed on the basis that a child might be both a child in need and a child at risk of significant harm, IAs may focus on risks, needs or both (Bywaters *et al.*, 2016; Cash, 2001; DCYA, 2011a; Gilbert *et al.*, 2012; Hughes and Rycusa, 2006; Keddell, 2016b; O'Leary *et al.*, 2015a; Trocmé *et al.*, 2014; Tusla, 2014c).

Age-groups reported vary across studies. Whelan's study of the disposal of referrals to one of 17 Social Work Departments in Ireland in year (n=794 records), just over a quarter (25.7%) were aged 0-4years, 19.9% 5-8 years, 19.3% 9-12 years and 35.1% 13-17 years old. Children aged 5-8 were referred to IA at a higher rate (68%) than children in the 13-17-year age-group (60%) but findings were not statistically significant.

Evidence from Australia (AIHW, 2017), Canada (CIS, 2010; Fallon *et al.*, 2015) and the US (DHHS, 2018) indicates that infants and young children are more likely to be involved with CPW based on incidence rates that take population data into consideration. In Northern Ireland (Department of Health, 2016), England (Department for Education, 2016) and Scotland (SCRA, 2018) a larger proportion of reports or assessments relate to children in older age groups.

Reasons for assessment and service provision are different for infants and young children compared to older children (Brown *et al.*, 2019; Filippelli *et al.*, 2017a; Gilbert *et al.*, 2009a; Palusci, 2011). Infants and younger children are disproportionately at risk for neglect relative to older children (Harris and Mildon, 2017), are higher risk of impacts of parental substance misuse in reports (Whelan, 2018), are at higher risk for fatality and violent abuse by a caregiver (Brown *et al.*, 2019; Hamilton-Giachritsis and Pellai, 2017) and are at high risk for re-reports to CPW indicating their vulnerability to exposure to ongoing adversities and the potential for exposures to become chronic (Putnam-Hornstein *et al.*, 2015). In Scotland infants were referred on grounds of lack of parental care or having close connection with a

person who perpetrated DV (SCRA, 2018). Sibling or prior family involvement is a risk factor for involvement and interventions with CPW (Fallon *et al.*, 2011c; Featherstone *et al.*, 2014a). The research asserts the imperative of timely and age-appropriate responses because decisions made on behalf of infants and young children during assessments are high stakes as abuse or welfare needs in early childhood can impact a child's emotional development and wellbeing which in turn, can have consequences that can reverberate throughout a child's lifetime (Bentovim *et al.*, 2006; Blumenthal, 2015; Brown and Ward, 2014; Cox and Bentovim, 2000; Featherstone *et al.*, 2014a; Filippelli *et al.*, 2017a; Filippelli *et al.*, 2017b; Filippelli *et al.*, 2021; Harris and Mildon, 2017; Jonson-Reid, 2002; NSCDC, 2012; 2013; Palusci, 2011; SCRA, 2018; Trocmé *et al.*, 2010; Trocmé *et al.*, 2001; Trocmé *et al.*, 2003).

Broadly speaking the risk of sexual abuse increases with age and is more common for girls compared to boys whereas boys tend to experience harsh physical abuse (Krug *et al.*, 2002). A study of assessments that closed/NFA by Manion and Renwick found assessments of older children were associated with behavioural problems and physical abuse in children 13-17 and children 5-8 years old and that emotional abuse was less likely to be a feature of assessments in older age groups (2008).

Findings from investigations in Ontario in 2018 suggest that older teens (aged 12-15) compared to younger children were struggling with academic difficulties and internalising issues (Alman *et al.*, 2020). The Irish Review Panel (NRP, 2016) highlighted the necessity of assessments to address the developmental needs and mental health needs of children in this age group.

Irish research indicates that Irish Travellers, black or black Irish children are over represented on the register of children at ongoing risk of child abuse[41] (Buckley and Whelan, 2018) and Irish Traveller children are over represented in child law proceedings (Coulter, 2015). These processes are generally post assessment and suggest that overrepresentation of minority populations may be a feature of IA also. These findings are consistent with patterns in several Anglophone countries where indigenous minorities are overrepresented in the CPW system and receive higher rates of intervention (Fallon *et al.*, 2013a; Fallon *et al.*, 2022; Font *et al.*, 2012; Keddell and Hyslop, 2019a).

Children who have been abused and neglected may experience parents as unpredictable and dangerous leading to disturbed behaviours and emotional disorders which may include a mixture of low self-esteem depression, difficulties forming and maintaining relationships or recklessness (Finkelhor, 1990; Howe, 2001; Iwaniec, 2006) and consequently they have specific service needs.

The Canadian Incidence Study (CIS) invites CPW workers to identify child functioning concerns that reflect physical, emotional, cognitive, and behavioural issues on 17 dimensions that they become aware

[41] The CPNS is a secure record held by Tusla, the Child and Family Agency, that contains the names of children who have been identified as at ongoing risk of significant harm and are or have been subject to a child protection plan agreed at a child protection conference. A child protection conference may be convened at any stage following a report and is obligatory when children progress to Child Protection proceedings following Initial Assessment.

of during investigations, and reports findings for substantiated maltreatment investigations.[42] In the CIS 2008, 46% of substantiated child maltreatment investigations (an estimated 39,460 investigations or 6.55 investigations per 1,000 children) involved at least one child functioning issue (Trocmé *et al.*, 2010). In the Ontario Incidence Study (OIS) 2018, 37% of substantiated child maltreatment investigations (an estimated 13,966 child investigations or 5.91 investigations per 1,000 children), involved at least one child functioning issue was indicated by the investigating worker (Fallon *et al.*, 2021).

3.5.7. Parent factors

The Irish assessment framework requires SW to assess six dimensions of parenting (see Figure 4 and Appendix 3). The prevalence of parent difficulties in Irish assessments is not known.

As the review thus far attests, families with multiple and complex problems which result in children's needs being unmet or children being at risk of neglect and abuse, have become the primary client group of CPW services (Bromfield *et al.*, 2010; Cleaver *et al.*, 2007). The understanding of factors that impact on parent-child interaction, emotional connection and attachment, and which influence caregiving, are central to assessments of parenting capacity (Bentovim *et al.*, 2009; Cleaver and Horwath, 2001; George, 2017; Houston, 2016; Howe, 2001; Jones, 2010; Pizzey *et al.*, 2017; Turney *et al.*, 2012). Markedly low competence in any of the areas of parenting capacity can impact negatively on child development (Department of Health, 2000a; Houston, 2016; Jones, 2010) making this a central feature of assessments of children's needs.

Assessed caregiver factors vary across practice frameworks and many are interconnected, meaning there are limitations in making comparison across studies. Furthermore, most research has looked at mothers and therefore the risk and protective factors that have been identified may be less applicable to fathers other caregivers or, it may underestimate exposures within the family and may overlook social and environmental factors altogether (e.g. Featherstone and Morris, 2021; Gilbert and Lacey, 2021; Sidebotham *et al.*, 2016; Stith *et al.*, 2009). The literature also suggests that certain caregiver characteristics in addition to being linked the perpetration of abuse, are associated with increased surveillance by services and consequently, with CPW (Fallon *et al.*, 2011c; Sidebotham, 2019).

The CIS 2008 identified that in 78% of substantiated maltreatment investigations (an estimated 66,282 child investigations), at least one primary caregiver risk factor was identified. The most frequently noted concerns were victim of DV (46%), few social supports (39%), mental health issues (27%), alcohol abuse (21%), and drug or solvent abuse (17%) (Trocmé *et al.*, 2010).

[42] The checklist only documents problems that child welfare workers became aware of during their investigations and, therefore, undercounts the occurrence of child functioning problems (Fallon et al., 2021).

A systematic review of risk factors for child maltreatment recurrence identified parental mental health issues as a predictor (Hindley *et al.*, 2006) and potentially, a modifiable characteristics for prevention. Using data from the National Survey of Child and Adolescent Well-Being (NSCAW) Berger *et al.* (2010) suggested that as many as 40%–80% of families involved with CPS may be affected by parental substance abuse.[43]

Administrative data published in England in 2016, indicates DV was identified as a factor at the end of assessment for 49% of children in need, parental mental health problems were a factor in 40%, parental drug misuse was a feature in 20%, and parental alcohol misuse was a feature in 18% of completed assessments in England during 2016-17 (Department for Education, 2017).

It is recognised that DV, parental mental ill-health and/or learning disability, and substance misuse factors feature frequently in CPW cases[44], and individually and in combination can impact on parenting capacity resulting in negative outcomes for children (Brandon *et al.*, 2009; Cleaver *et al.*, 2011). Researchers argue that the supposition that cumulatively, they are central to child abuse is misleading because they are different in nature and effects (Sidebotham, 2019; Sidebotham *et al.*, 2016; Skinner *et al.*, 2021) and due to an absence of an evidence base, as identified in a recent systematic review (Skinner *et al.*, 2021). The supposition of a toxic-trio may fail to consider or control for contextual factors, including parenting dispositions and environmental factors, socioeconomic circumstances or the ethnicity of the families, or children's ages and practice that misrecognises symptom for cause rendering the possibilities of meaningful change less likely (Featherstone *et al.*, 2016; Featherstone *et al.*, 2014b; Jones, 2010; Pizzey *et al.*, 2017; Sidebotham *et al.*, 2016; Skinner *et al.*, 2021).

The prevalence of mental health problems among parents involved in assessments in Ireland is not known but, according to Mental Health Ireland (MHIreland, 2022; OECD and EU, 2016) the prevalence of mental health concerns or substance misuse in adults at the population level in Ireland in 2016 was 18%.

3.5.8. Relationship problems, family functioning and violence

Assessments of abuse and neglect frequently involve children in families characterised by complex relationships resulting from divorces, separations, remarriages, reconstituted families, or single parent households (Ferguson and O'Reilly, 2001; Saltiel, 2013). Many assessments involve acrimonious relationships and conflict which may separations and custody disputes, some of which include DV

[43] Berger et al., (2010) investigated cases of children aged 14 years or younger from the dataset (n=4,156, children aged 14 or younger) to examine a CPS caseworker's perception that a child's caregiver had a substance abuse problem associated with CPW involvement. The study found one in four (23%) children had a caregiver with an alcohol or drug problem. These results were extrapolated to give the finding referred to in the text.

[44] The term 'toxic-trio' entered the CPW lexicon in England arising from the publication of a detailed analysis of 40 children's cases which were part of a review of Serious Case Reviews (n=189) in England between 2005 and 2007 found that nearly three quarters of the children had lived with domestic violence, and parental mental ill-health and/or learning disability, and substance misuse (Brandon et al., 2009). These factors were associated with an increase the risks of harm to the child and often presented a hazardous and frightening home life for the child, and 'a toxic caregiving environment'. The term toxic-trio was coined to describe their role (Brandon, 2009).

(Brandon *et al.*, 2020; Buckley *et al.*, 2011b; Holt, 2015; 2017; Houston *et al.*, 2017; Jaffe *et al.*, 2008; Øverlien and Holt, 2019; Saini *et al.*, 2012; Tanner and Turney, 2000). These circumstances may impact on the continuity of caring relationships between children and their carers.

A meta-analytic review of the interrelatedness of marital relations and parent-child relations by Erel and Burman (1995) identified that parents involved in hostile relationships are more hostile and aggressive to their children and less sensitive and emotionally responsive to their children's needs, which they suggested occurred directly or indirectly through a 'spill over' effect. They identified a robust association between parental conflict and levels of parent child conflict (Erel and Burman, 1995).

The dominant pattern of DV reflected in the CPW literature is of male to female violence and the risk that it poses to women and children (Bernardi and Steyn, 2019; Holt *et al.*, 2008; Humphreys, 2007; Institute of Medicine, 2011; Knickerbocker *et al.*, 2007; Whelan, 2018) although evidence for female to male violence and co-occurring child abuse is developing (Bernardi and Steyn, 2019; Damant *et al.*, 2010; Dixon *et al.*, 2010). In terms of female perpetrated partner violence, data produced by Australian police indicate that women account for up to one in five DV offenders proceeded against by police (Australian Bureau of Statistics 2018 quoted in Boxall *et al.*, 2020 p.1). A national survey conducted in Sweden revealed that men and women engage in similar rates of DV (Swedish Crime Survey, 2014 quoted in Bernardi and Steyn, 2019 p.456). Children living with DV are at greater risk of being directly abused by one or both carers (Dixon and Slep, 2017) and when DV is reciprocal between parents the risk of exposure to it and the risk of abuse increases relative to situations where one parent is violent (Slep and O'Leary, 2005).

Domestic and family violence often occurs alongside a host of other risk factors, such as parental substance abuse, poverty, family dysfunction, other forms of child abuse and neglect, mental ill health and social isolation, which may not receive adequate attention from professionals (Bromfield *et al.*, 2010; Cleaver *et al.*, 2011; Higgins, 2004; Kennedy and Holt, 2020). In England, SWs conducting assessments believed that increased levels of parental conflict and acrimony was due to increased levels of economic hardship among those involved with the service (Hood *et al.*, 2020b).

For children, experiencing DV incorporates exposure to- and witnessing the violence and its consequences (Callaghan *et al.*, 2018; Dixon and Slep, 2017). Research indicates that witnessing violence increases the effect and places children at risk of victimisation and perpetration in later life (Bernardi and Steyn, 2019; Dixon *et al.*, 2005; Forke *et al.*, 2018). Exposure to DV can have severe detrimental impacts on children's health and development (Bernardi and Steyn, 2019; Buckley *et al.*, 2007; Callaghan *et al.*, 2018; Dixon and Slep, 2017; Holt *et al.*, 2008; Noble-Carr *et al.*, 2020; Slep and O'Leary, 2005). The literature shows that children exposed to DV and ongoing disputes have higher reported rates of emotional and behavioural distress than those from households involved in non-parental disputes (Harold and Conger, 1997; Sudland and Neumann, 2021). Children who experience DV experience anxiety and hyper-vigilance to noise and aggression as having adapted to the role of

protector of themselves, siblings or their victimised parent (Buckley *et al.*, 2007; Kennedy and Holt, 2020; Överlien and Hydén, 2009). A study by English et al., (2003) of the effects of DV on children who were abused or neglected during early childhood found they experienced emotional, behavioural and health problems regardless of whether the aggressor was the mother or father (English *et al.*, 2003).

A document recently published by Tusla suggests that in studies of DV the prevalence of co-occurring child abuse is 40% (Rogers, 2015). Whelan (2018) provided the first estimates of the prevalence of DV among referrals in CPW in Ireland under the current administration in her recent study of the disposal of 794 referrals to Tusla. Exposure to DV and parental conflict was the most prevalent reported concern (13%) and was identified for one in every seven children (13.6%, n=108). The majority of instances were perpetrated by males (76%) and a minority by females (7%) and both mothers and fathers were alleged to be responsible in the remaining 17% of referrals (Whelan, 2018 p.119-120). In the US and Canada exposure to DV is considered a form of abuse that warrants referral to CPW and in Scotland is counted among CPW activity data (Featherstone and Morris, 2021; Henry, 2018; Sheehan, 2019; Victor *et al.*, 2021).

Researchers have identified SW's uncertainties in assessments regarding the impact of the experience of DV on child development and its links to abuse and service needs and have identified the necessity to improve responses by CPW (Bosk, 2018; Buckley *et al.*, 2011a; Cleaver *et al.*, 2011; Featherstone and Morris, 2021; Gambrill, 2006a; Howarth *et al.*, 2016a; Iwaniec, 2006; Johnson, 2009; Kennedy and Holt, 2020; Landsman and Hartley, 2007; Saini *et al.*, 2019; Stanley *et al.*, 2011). Several authors say that when professionals are assessing the links between partner- and child maltreatment and considering service needs of children, it is important to consider the role that both mothers and fathers play in the violent interaction and in protecting victims (Buckley *et al.*, 2007; Dixon *et al.*, 2007; Dixon and Slep, 2017; Holt *et al.*, 2008).

3.5.9. Intergenerational transmission of abuse

The prevalence of intergenerational transmission of abuse and welfare concerns in CPW assessments in the Irish population is not known. Parental history of childhood abuse is a risk factor for child involvement with CPW compared to children of parents without a history of childhood abuse (Armfield *et al.*, 2021; Dixon *et al.*, 2005; Widom *et al.*, 2015). Consequently, the increased rate of continuity of child abuse across generations has been researched in the aetiology of child maltreatment (Bartlett *et al.*, 2017; Berlin *et al.*, 2011; Cicchetti and Rizley, 1981; Kempe *et al.*, 1962; Mulder *et al.*, 2018). A recent meta-analysis of the literature (142 studies) on intergenerational transmission of child abuse or neglect found a moderate association of intergenerational transmission in addition to evidence for the intergenerational transmission of specific maltreatment types (Madigan *et al.*, 2019).

In a UK study, Dixon *et al.* (2005) found that parents with a history of childhood abuse (physical and/or sexual) were four times more likely to maltreat their children than families without an abuse history. Fusco (2015) interviewed a random sample of mothers (n = 336) with children younger than age five

in the US child welfare system and identified that 42% of them reported having CPW involvement when they were children. Compared to mothers without a childhood exposure, second generation mothers had less education, more depression and anxiety, and higher rates of DV and they rated lower on measures of engagement (Fusco, 2015).

While evidence indicates that parental history of childhood abuse impacts on physical, psychological and reproductive health throughout the life-course and on life opportunities (Metzler *et al.*, 2017; Sethi *et al.*, 2013) and is a risk factor for child involvement with CPW (Armfield *et al.*, 2021; Dixon *et al.*, 2005; Widom *et al.*, 2015) some researchers suggest that higher rates in families with childhood abuse histories compared to those without, may be due to detection or surveillance bias (Connell *et al.*, 2007; DePanfilis and Zuravin, 2002; Fallon *et al.*, 2011a; Jenkins *et al.*, 2017; Meinck *et al.*, 2016; Widom *et al.*, 2015). And, from a research perspective, the cross-sectional design of many studies means that chronic and re-current cases have a higher probability of being sampled (Alexander *et al.*, 2015). As many other factors in a person's life may mediate the effects, the study of intergenerational transmission of abuse and service needs seeks to identify and understand factors that could confer risk (Broadhurst *et al.*, 2017; Marshall *et al.*, 2011; Widom *et al.*, 2015).

3.5.10. Crime

There is an association between prior parental criminal justice involvement and child abuse (Austin, 2016; Stith *et al.*, 2009) and CPW service involvement (Gifford *et al.*, 2016). Although, the evidence is inconclusive on whether parental criminal justice involvement is an independent risk factor for child maltreatment or of the specific mechanisms through which this association occurs (Austin, 2016).

3.5.11. Categories of concerns in assessments

The current prevalence of child abuse in Ireland is unknown and estimates based on prior national and international studies suggest abuse is underreported in Ireland (McGee *et al.*, 2002; O'Leary and Lyons, 2021). Currently, in Australia emotional abuse and neglect are the most common primary and co-occurring types of substantiated reports (AIHW, 2017). These categories were also most prevalent in a New Zealand study of a population of children who were closed/NFA following IA (Manion and Renwick, 2008). In Scotland, concerns relating to emotional abuse and neglect are the most prevalent among children involved with CPW (SCRA, 2018). The evidence points to a host of child and adult related problems identified during assessment which indicate service needs to address child and adult trauma and child welfare needs, to support parenting and to prevent further harm. The next section examines the analytically identified determinants of service provision.

3.6. Rates and Determinants of ongoing service following assessment

3.6.1. Rates of ongoing service

Ongoing service incorporates any service provided by CPW directly following an assessment or investigation. It excludes services provided by external organisations but, this too is considered in some studies to reflect the identification and response to service needs (e.g. Jud *et al.*, 2012).

Trend evidence from across Anglophone jurisdictions shows that despite rising referral rates in many jurisdictions, consistently few clients receive intervention beyond assessment or investigation (AIHW, 2017; Buckley and Burns, 2015; Department for Education, 2016; Department of Health, 2016; Drake, 1996; SCRA, 2018; Sedlak *et al.*, 2010b; Thorpe, 1997; Trocmé *et al.*, 2010; tusladata, *Annually*). This pattern suggests the overinclusion in assessments of children that appear not to have CPW service needs (Jenkins *et al.*, 2017; Tusla, 2015). The pattern is similar in Ireland (tusladata, *Annually*) but, as noted previously (see Chapter 2), statistics on the incidence of ongoing service relate to a performance indicator that is the proportion of IAs that concluded within the target timeframe in a given quarter.

Albeit it is not possible to compare like with like because of methodological differences between national CPW agencies, it is possible to identify rates of intervention following assessment or investigation in several regions. Estimates for ongoing service following investigation are approximately one in five in Australia (AIHW, 2017), one in four Canada (Fallon *et al.*, 2015; Trocmé *et al.*, 2010), one in three in New Zealand (OrangaTamariki, 2017), one in three in Northern Ireland, although child protection rates (39.8%) were slightly higher than family support transfers (33.8%) (Department of Health, 2016), and one in three in the US (Slack and Berger, 2020).

Featherstone *et al.* (2016) report that investigations in England and Wales increased by 79.4% in the period from 2009/2010 to 2014/2015 during which time rates of children with CP plans rose only by 40.5%. In the absence they say of data on those who moved from investigation to help it is unclear how needs that were uncovered in investigations were addressed (Featherstone *et al.*, 2016). Another English study of demand and service provision by Hood *et al.* (2016) identified that 55.3% of IA progressed to core assessments leading the authors to suggest that IAs performed 'a gate-keeping function with respect to core assessments, which were more comprehensive and took longer to complete' (Hood *et al.*, 2016 p.934).

3.6.2. Case factors associated with service provision

The decision to provide ongoing CPW services to children and their families following IA or investigation is not well-understood (Buckley, 2015; Filippelli *et al.*, 2017b; Filippelli *et al.*, 2021; Hood *et al.*, 2020a; Hood *et al.*, 2021; Jud *et al.*, 2012; Lwin *et al.*, 2018b; Stoddart *et al.*, 2018). The variables included in studies and the cohorts involved vary across studies. The evidence on statistical determinants of ongoing service primarily comes from north America where systematically gathered

information facilitates analytic research (e.g. https://cwrp.ca/canadian-incidence-study, 2021; Sedlak *et al.*, 2010b; Slack and Berger, 2020). Information on the determinants of interventions following IA in Ireland is not available.

Assessments/investigations involve children who have been abused, children whose welfare has been impacted and children whose parents exhibit risk factors for abuse or welfare impairment (Fallon *et al.*, 2011b; Fallon *et al.*, 2011c). Despite the wealth of literature regarding risk factors for child maltreatment (Mulder *et al.*, 2018; Stith *et al.*, 2009; White *et al.*, 2014) the accurate identification among all referred children of those for whom the threat of abuse or welfare impairment is most immediate and impactful has proven difficult.

In various cohorts, clinical case factors, including caregiver risk factors, the amount of caregiver social support, and the type of maltreatment were identified as the strongest predictors of ongoing service provision (Esposito *et al.*, 2013; Fast *et al.*, 2014; Fluke *et al.*, 2010; Jud *et al.*, 2012) with caregiver factors driving models in many studies (Fallon *et al.*, 2013b; Filippelli *et al.*, 2017a; Filippelli *et al.*, 2017b; Filippelli *et al.*, 2021; Lwin *et al.*, 2018a). In an English study Hood et al., (2021) found that child welfare workers used a range of factors at child and parent level and contextual factors to determine the need for ongoing services as opposed to the 'toxic-trio' which alone did not determine ongoing services (Brandon *et al.*, 2009).

In several Canadian studies variables which result in a greater likelihood of referral to ongoing services are mothers age (Fallon *et al.*, 2011a; Jud *et al.*, 2012), children under one, lack of cooperation from parents and household finance difficulties (Lwin *et al.*, 2018b), child and caregiver functioning concerns, few social supports, teen parenting, low socioeconomic status, any type of substantiated or suspected maltreatment, and risk of future maltreatment (Jud *et al.*, 2012). Using administrative data based on substantiated cases in the US researchers identified ongoing service was associated with the number of children in the home (DePanfilis and Zuravin, 2001).

Jud *et al.* (2012) found that children of single caregivers and boys were less likely to receive ongoing services. Using data from the CIS 2008 (CIS, 2010) researchers found that compared to children of parents with no history of involvement with CPW services in childhood, children of parents who had been involved with CP services in childhood were not more likely to receive ongoing services (Fallon *et al.*, 2011a; Filippelli *et al.*, 2017b). Drawing on their retrospective cohort study of intergenerational transmission Armfield *et al.* (2021) suggest that providing services to survivors of childhood maltreatment, particularly female survivors, provides a crucial intervention opportunity to help prevent further child abuse and neglect.

Systematic reviews of evidence have shown that children exposed to parental substance misuse and DV are at risk of suffering abuse and recurrence of abuse (Hindley *et al.*, 2006; White *et al.*, 2014), but provision of service is not always clear-cut. Several studies identified that maternal drug/solvent misuse

is highly significant in decisions for ongoing services (DePanfilis and Zuravin, 2001; Fallon *et al.*, 2011a; Filippelli *et al.*, 2017b). The question of whether exposure to repeat substance misuse determined service delivery was examined in an English study by Roy (2021) using data collected from SW case files (n=299 children). The findings indicate that children affected by parental substance misuse frequently presented with other parental and environmental risk factors including historical and intergenerational abuse to which CPW services were poorly sourced to respond (Roy, 2021). Responses were gendered: while men were more likely than women to misuse substances, maternal substance misuse featured more strongly in records leading to increased scrutiny of mothers, which Roy likened to the 'mother blaming' discourses around responses to DV and abuse (Featherstone and Morris, 2021; Humphreys and Absler, 2011; Roy, 2021).

Jonson-Reid (2002) studied service provision to early adolescents and found that 15% of the sample were referred to ongoing services. The study found that early adolescents, children aged 11 to 14 years, were more likely to be referred for ongoing services than children aged 7 to 10 or older adolescents and that early adolescents who were victims of sexual abuse were of greater likelihood to receive services than those for other types of maltreatment, such as physical abuse and neglect (ibid.).

In a Canadian study Lavergne *et al.* (2011) reported that cases involving DV where the parents were considered uncooperative were more likely to involve coercive intervention. In contexts of male perpetrated DV and abuse, some studies suggested the role of CPW is extricate women and children from possible abuse (Morris, 2009; Rogers and Parkinson, 2018). But, not all children are equally vulnerable to the effects of negative experiences or in the short or the long term (Finkelhor, 1994; Gilligan, 2001) and researchers also argue that not all children or families exposed to DV require the support of CPW services (Øverlien and Holt, 2019).

Several Canadian studies found the decision to provide ongoing service was driven by the risk of harm[45] or the need for urgent intervention (King *et al.*, 2021; Schumaker *et al.*, 2017; Trocmé *et al.*, 2014). But, the higher likelihood of recurrence amongst children investigated for chronic need, the researchers say, provides evidence to support the development of a service specifically tailored to chronic cases (Schumaker *et al.*, 2017). Research shows that substantiation of abuse is associated with the decision to provide ongoing services (DePanfilis and Zuravin, 2001; Drake, 1996; Jud *et al.*, 2012) although the idea of using substantiation as determinant of service provision has also been criticized in the literature for many of the same reasons that prioritizing high risk cases over welfare and chronic cases is criticized (Drake, 1996; Fallon *et al.*, 2011b; Fluke, 2009; Trocmé *et al.*, 2014). Jud *et al.* (2012) identified that investigations involving either substantiated or suspected exposure to DV were three times more likely than cases without DV to be transferred to ongoing services and substantiated risk investigations were four times more likely than those unsubstantiated. In contrast, DePanfilis and Zuravin (2001) found that families who had received a previous substantiated report were 22% less likely to receive ongoing

[45] In Irish, English, Northern Irish, and Scottish policies 'at risk of significant harm' is a warrant for ongoing Child Protection service.

services. A Canadian study by Stoddart *et al.* (2018) found that substantiation influenced the assessment of future risk and that caregiver risk factors, uncooperative parents, older children, and children with emotional or mental health concerns all increased the likelihood of substantiation. But, Manion and Renwick (2008) whose study of cases that closed NFA following IA found that those that received service did not differ greatly from those that closed NFA, and recalled a then growing body of literature indicating that substantiated and unsubstantiated cases are "more similar than different", and that a 'range of other factors' influence social workers' decisions to substantiate some cases rather than others (Drake and Jonson-Reid, 2007).

Several studies using a range of alternate methodologies to multivariable modelling explored service provision in the context of DV and abuse. An Irish study that examined children's experiences of DV (Buckley *et al.*, 2007) highlighted the necessity of providing direct services to these children. Parents in the study reported that suspicion of their children's safety impacted on their own ability to cope that had both direct and indirect consequences for their children's emotional wellbeing and reported they had unmet needs themselves for emotional and practical support (Buckley *et al.*, 2007). Similarly, Munro's review of the English system (2011b) found that CPW responses where DV was a factor tended to focus on parents needs and overlook children, but also identified that where the focus was on children's needs those of parents were often overlooked. As described above (Section 3.2.2) a more recent audit of CPW assessments involving DV in England suggested the needs of children were addressed but very little attention was paid to the effect of violence on mothers whereas responses focused on their roles and responsibilities, while simultaneously ignoring those of fathers who perpetrated violence (Featherstone and Morris, 2021). An English study by Stanley *et al.* (2010) that examined assessments involving referrals relating to DV (n=251 relating to 184 families) identified that only a small proportion of families received IA or further intervention (n=28, 11%). A high recurrence rate among those that had been closed (52%) indicated children continued to be exposed to DV and these children were only receiving a 'stop-start' response (Stanley *et al.*, 2010) which is seen as ineffective in reducing harm to which these children were exposed (Buckley *et al.*, 2008; Stanley *et al.*, 2010).

3.6.3. Cases closed following assessment

Referrals that are closed following IA include those that are directed elsewhere, indicating some services are needed by those children and families but, many authors express concerns that such community services do not succeed because they are difficult to access or service users find it difficult to engage because of their circumstances (Buckley, 2015; Jonson-Reid *et al.*, 2017; Manion and Renwick, 2008) or because these services too are oversubscribed (Lonne *et al.*, 2020) . Some research has shown there may be few differences in characteristics between children and families offered services and those not offered services following IA (Kohl *et al.*, 2009; Manion and Renwick, 2008) and between children who are substantiated and unsubstantiated (Drake *et al.*, 2003; Kohl *et al.*, 2009), indicating possible missed opportunities to prevent abuse and welfare impairment among children screened out (Bywaters, 2015b; Campbell *et al.*, 2010; Simon *et al.*, 2021). An Irish study of responses

to referrals concluded that the main reason for not providing service in substantiated cases was not the absence of services *per se* but the lack of cooperation from parents and some children, the absence of which often shortfall left parents feeling alienated (Ferguson and O'Reilly, 2001 p.265). Ferguson and O'Reilly (2001) recommended skilling practitioners to work with resistant clients.

Several authors note a concern about conflating child outcomes (or the idea of responding to reported children's needs) with rates of intervention because decisions framed by the system such as substantiation, or service intervention, while they may be related to individual functioning, they may focus on adult oriented problems and capabilities, they are not reliable and valid measures of child safety or well-being (Buckley, 2015; Hood *et al.*, 2021; Munro, 2011b; Murphy and Rogers, 2018; Shlonsky, 2015). Several studies reveal a tendency to rely on a protective parent to manage or reduce risks, when the evidence or level of harm does not warrant immediate intervention but also caution about the tendency towards gendered responses and the tendency to delegate responsibility to mothers for factors beyond their control (Buckley, 2003; Buckley *et al.*, 2008; Featherstone and Morris, 2021; Featherstone *et al.*, 2014b; Roy, 2021). Similar findings have lead researchers to conclude that responses in CPW are inadequate both in terms of response and capacity to address the needs of many referred (Devaney and Spratt, 2009; Fallon *et al.*, 2013b; Mooney, 2018; Øverlien and Holt, 2019; Saini *et al.*, 2019; Saini *et al.*, 2012) with many expressing concerns that children and families may fall between services services (Buckley *et al.*, 2008; Humphreys *et al.*, 2005; Kettle, 2015; Munro, 2011b; Murphy and Rogers, 2018; NRP, 2016; 2018; Roy, 2021; Stanley *et al.*, 2010).

3.6.4. Non-clinical factors associated with service provision

The relationship between deprivation and CPW service involvement is uncontested, but the way it operates is less clear. In England Hood *et al.* (2016) found that compared to authorities in affluent areas, those where there was more deprivation experienced higher levels of demand and screened out more referrals and diverted more cases to non-statutory services. An Irish study led by this author identified a strong association between neighbourhood level deprivation and referrals but the association disappeared in decisions to place children in care (O'Leary *et al.*, 2015a).

Some studies have addressed the relationship between clinical and organizational factors and the decision to provide ongoing service provision (Fallon, Chabot, et al., 2013; Fallon & Trocmé, 2011; Fast, Trocmé, Fallon, & Ma, 2014; Jud et al., 2012). Among those factors examined by Jud *et al.* (2012) which included agency location (urban vs. rural), proportion of Indigenous reports, and region, none were influential on the decision to provide services. Researchers say that more research is needed to explore worker and organizational factors that also influence this risk focus and how much of an influence the current risk assessment tools have on the workers' assessment of future risk and substantiation (Jud *et al.*, 2012; Stoddart *et al.*, 2018) because the decision to provide ongoing services after a child maltreatment investigation has implications for both children and their families and the resources of the CPW organisation (Smith *et al.*, 2019).

Several studies identified variability in judgments and decisions for children and families linked to features in the environment such as legal or procedural consequences, the organisational climate and context which may be integrated into assessments or minimised when making claims about future risk and confidence in decisions (Baumann *et al.*, 2011; Burns and MacCarthy, 2012; Camasso and Jagannathan, 2013; Gambrill, 2005a; Keddell and Hyslop, 2019b; McCormack *et al.*, 2020; Mooney *et al.*, 2021; Munro, 2010b; Tusla, 2015).

In a study of practice across several decisions, Buckley (2003) reported that despite the discretion that SWs allow themselves in responding to reported concerns, they felt constrained by the system. In that study SWs discussed disillusionment with the 'service' they were providing, which they believed a lot of the time to be inadequate, misdirected and potentially destructive (Buckley, 2003 p.89-93). The findings were echoed in later Irish research, even though standard business processes (SPBS) had been introduced (Burns and MacCarthy, 2012; Mooney, 2018; Mooney *et al.*, 2021; Whelan, 2018). Research by Whelan (2018) into decision-making for the disposal of reports at the Intake process (which directly precedes IAs) found that reports with 'identifiable abuse' were easily progressed for IA but where there were risks that did not meet 'orthodox' criteria, reports were screened out even when children's safety was compromised and paradoxically, if the outcome could not be decided within the prescribed timeframe, SWs promoted these reports for IA. Studies conducted in Ontario, exploring the impact of risk on the decision to substantiate abuse found that the risk of future abuse in addition to directing attention away from providing services to children who had been harmed, contributed to a focus on blaming parents instead of attending to social issues and reduced opportunities for successfully engaging with families (Stoddart, 2017; 2021).

Another Irish study of factors that influenced decisions for the disposal of reports found the most influential factor on SWs decisions at the organisational level were policies, in particular the *Threshold Guidance* (McCormack *et al.*, 2020; Tusla, 2014c). The researchers concluded that SWs exhibited characteristics of a proceduralised workforce (McCormack *et al.*, 2020; Munro, 2010b). An audit of SBPs conducted by Tusla found similar and conflicting evidence about decisions in IAs and cautioned that 'SBPs should not be seen as an alternative for professional judgement' (2015 p15). The pattern of response echoes findings of study of IAs in an Australian agency by Parton et al., (1997) which found SWs operated a kind of 'risk insurance' rather than conduct comprehensive assessments.

Features such as case load and intensity impact on time available for practice and which impact on decisions about availability to work with clients. on levels of stress, perceptions of risk and SWs decision-making (Burns and MacCarthy, 2012; Enosh *et al.*, 2021; IASW, 2011; Keddell and Hyslop, 2019b; Munro, 1996) though mechanisms vary. In an experimental study Enosh *et al.* (2021) found the perception of heavy work burden meant practitioners assess risk as higher. Whereas other studies report that heavy workloads contributed to the creation of a 'a hierarchy of risk' (Keddell and Hyslop, 2019b p.6) where cases of children in crisis or where risk was perceived highest received SW attention and time (Burns and MacCarthy, 2012; SIS, 2005). As Burns and MacCarthy (2012) explained, the

consequences the ‘saturation effect’ of such cases was that the other children on the caseload become ‘neglected’, either not receiving a service or receiving inadequate service because SWs were spread too thin ‘skimming over’ the case load, or because when they reached a certain threshold of ‘crisis’ they received attention, by which time it is often too late to engage in preventative and supportive work, as reported elsewhere (Keddell and Hyslop, 2019b; Stevenson, 1996). SWs were highly critical of the organisational context and highlighted the stress they experienced because of having had insufficient time to provide quality care and having to lower expectations regarding this care (Burns and MacCarthy, 2012; Keddell and Hyslop, 2019b).

In other studies features in the organisational context that impacted on decisions were the speed at which SWs are expected to make decisions, the lack of agreement on definitions of abuse and neglect, and the ambiguity and uncertainty of much of the information available (Arad-Davidzon and Benbenishty, 2008; Benbenishty, 1992; Parton, 1998; Stoddart, 2017).

Jud *et al.* (2012) found significant variation among child welfare agencies across the regions of Canada in the proportion of cases kept open for ongoing services, from a low of 30% to a high of 70%, but the authors indicated the reasons for these differences were largely unexplained.

SW’s experience and individual values influence judgments leading some to take chances and others to act with caution, resulting in variability in decisions across cases and individuals (Camasso and Jagannathan, 2013; Davidson-Arad and Benbenishty, 2010; Fluke *et al.*, 2016; Holt and Kelly, 2014; Horwath, 2007b; Regehr *et al.*, 2010; Ruch, 2012; Whittaker, 2018). SW’s attitudes towards family privacy and parental freedoms, children’s interests and rights, attitudes about parental engagement and SW’s view of the role of the CPW can drive perceptions about risk and decisions about service needs (Axford and Berry, 2018; Benbenishty *et al.*, 2015; Dingwall *et al.*, 1983/2014; Doherty, 2016; Featherstone *et al.*, 2014a; Ferguson and O'Reilly, 2001; Nikolova *et al.*, 2017). Nikolova *et al.* (2017) found and older SWs more likely to believe that responsibility for child safety lies with the family but, the decision was not influenced by years in service, in contrast with finding’s from an earlier study (Fluke *et al.*, 2016). Research also shows that across the continuum of decisions, SWs judgments are influenced by their relationship with a child and family and whether or not colleagues support their actions (Buckley, 1998; 2000a; 2003; Gilbert *et al.*, 2009a; Helm, 2013; Keddell and Hyslop, 2019b; Parton *et al.*, 1997).

Studies show that uncertainty and decision variability are associated with an overestimation of confidence in judgments and decisions (e.g. Gambrill, 2005a; Regehr *et al.*, 2010). Conversely, lack of confidence in one’s ability to work with issues such as DV or substance misuse can lead to lack of certainty about decisions (e.g. Burns and MacCarthy, 2012; Galvani *et al.*, 2014; Keddell and Hyslop, 2019b; Roy, 2021). Workers’ confidence in their ability to access community services that children and families need influences intervention decisions (Dettlaff *et al.*, 2015; Fluke *et al.*, 2016).

The relationship between service provision and service availability can be straightforward: increased placement rates have been linked to access to services in certain parts of Ireland (HSE, 2012b) and conversely an increase in cases screened out has been linked to decreases in state-level funding to CPW services in the US (McLaughlin and Jonson-Reid, 2017). Variability in service provision can be mediated by individual caseload and the nature of cases and other organisational factors. Access to services, the volume and nature of cases have been cited in several studies as source of variability in decisions whether or not children receive services (e.g. Font and Maguire-Jack, 2015a; Graham *et al.*, 2015; Keddell, 2014a; Keddell and Hyslop, 2019b).

3.7. Concluding comments on the literature review

The review has described how the child protection system provides the framework for case management, assessment and decision-making (Baumann *et al.*, 2011; Munro, 2005). As detailed in Chapter 2, at the macro level, the legal framework, broad policy orientation and national policies for process influence the way that children and families are responded to. Reforms since the 1970s, delivered because of failures to prevent abuse to children involved with services, resulted in expanding the scope of the CPW system through a range of legislative and policy and organisational reforms which impacted significantly on how the services were developed and implemented. The current system, like other Anglophone models, is characterised as a high-risk strategy as it focuses on the identification and management of risks in reported cases, and secondary prevention through strategies aimed at reducing recurrence (Buckley and Burns, 2015; Burns and McGregor, 2019; Gilbert, 2012; O'Leary and Lyons, 2021; Scott *et al.*, 2016).

While there was significant investment in the service, services continued to be under-resourced while demand for services grew, principally from the most disadvantaged areas (e.g. Buckley and Buckley, 2015; Buckley and Burns, 2015; Burns and Lynch, 2008; Burns and MacCarthy, 2012; Christie *et al.*, 2015; Featherstone *et al.*, 2012; O'Leary *et al.*, 2015a; Wayman, 2014).

Policies for assessment and decision-making have been central to reforms and consistently under development over the period of time considered in this review. Chapter 2 also discussed how numerous policies and practice guidelines have been introduced to support consistent assessment and decision-making practice in accordance with regulatory standards, but which also assert the importance of individual professional judgment. The literature has also argued that central to current CPW polices is the idea that risks to children are considered identifiable, measurable and predictable and that once they were identified the system would lend itself to the competent application of a clear solution (Buckley, 2003; Buckley and Whelan, 2018; Parton *et al.*, 1997; Wise, 1989).

Researchers have argued that risk has becomes the dominant concern and mechanism for managing demand and providing services in CPW (Buckley and Burns, 2015; Hood *et al.*, 2016; Keddell and Hyslop, 2019b; Kemshall, 2002; Macdonald and Macdonald, 2010; Spratt, 2001; Trocmé *et al.*, 2014).

Trend analysis conducted in Chapter 2 revealed high and increasing rates of demand with reducing rates of assessment and ongoing service provision to children and families.

The current chapter examined the psychological features of decision-making that distinguish among assessment and judgment and decision-making (Baumann *et al.*, 2011; Meehl, 1954). The literature suggests caseload management, risk management and the delegation of responsibility for risk management have become what Simon (1978 p.353) calls a 'problem representation'. which, as reflected in comments made in 2016 by the former chief officer Fred McBride noted in Chapter 1 (Holland, Fri, Apr 15, 2016), can operate as the overarching *subgoal* or heuristic for organisation strategy in CPW. At the case level, individual SWs engage in similar substitution techniques to manage case load or to simplify complex problem situations.

The review has shown that decision-making in IA is complex and uncertain and contingent on individual sense-making. This is cognitively challenging and problematic because decision makers rely on subjective impressions, which can be flawed, culturally and psychologically biased and available resources (Best *et al.*, 2013; Buckley, 2003; Buckley and Whelan, 2018; Dingwall *et al.*, 1983/2014; Gambrill and Shlonsky, 2001; Kahneman and Tversky, 1972; Keddell, 2014a; Kemshall, 2010; Munro, 2019a; Stoddart *et al.*, 2018). Uncertainty and variability in sensemaking and decisions arise from the simultaneous interaction of static and dynamic features of the case with personal factors related to practitioner and the wider legal and organisational contexts (Baumann *et al.*, 2011; Buckley, 2003; DCYA, 2011a; 2015; Department of Health, 2000a; Department of Health and Children, 1999; Ferguson and O'Reilly, 2001; Helm, 2011; HSE, 2011; Kemshall, 2010; Kirkman and Melrose, 2014; Munro, 2019a; Saltiel, 2015; Taylor, 2012; Tusla, 2014c; Wulczyn *et al.*, 2010) which may result in under- or over-estimating the likelihood of occurrences and service needs. The research shows practitioners find it difficult to distinguish valid and invalid variables and reveal a tendency to develop false beliefs in associations between variables due to unconscious biases and because they receive very little feedback on the accuracy of their predictions, making it problematic to determine the actual validity of the variables on which their judgment relied (Dawes *et al.*, 1989; Jonson-Reid *et al.*, 2017; Kahneman and Klein, 2009; Kearney, 2013; Munro, 1999a).

Despite the high rate of attrition from the service, Irish SWs have been criticized for conducting unnecessary IAs and for adopting too much responsibility for children during assessment processes (Holland, Fri, Apr 15, 2016; Tusla, 2015). An Audit of assessments by Tusla (2015 5.13 p.33) concluded 'that a large proportion of accepted referrals may not meet the threshold for ongoing intervention by the Agency or should be screened out at the point of referral, but also noted the necessity to assess the accuracy of the finding of the low rate of ongoing service following IA (13.49%, 39 of 289 IAs) through further research. At the same time SWs and commentators reported increasing concern about the nature of practice and response to children and families (Buckley, 2015; Buckley and Burns, 2015; IASW, 2011).

As noted recently by Fallon (2020), the decision whether or not to provide ongoing services following IA is one of the most important that a CPW system makes. Assessments are central to risk identification and where it is identified, to the delegation of responsibility for its management, principally through the provision of ongoing services, referral to another service or the provision of advice. The literature reviewed in this chapter identified a lack of transparency with regard to how judgments about need and future risk are made and the basis for decisions in assessments. Absence of evidence impacts the statistics produced by child protection agencies and can have the effect of under-estimating the prevalence of abuse and needs among those seen, whether or not those systems require mandatory reporting of suspected child abuse (Barlow *et al.*, 2012; Best *et al.*, 2013; Fallon *et al.*, 2010; Fallon *et al.*, 2012; Font *et al.*, 2021; O'Leary and Lyons, 2021; Shlonsky, 2015).

3.8. Research questions

Despite advances in Irish policies for information and data (HSE/Tusla, 2009/2014; Tusla, 2016a; 2020a) there is little systematic evidence collated about assessment practice although SWs are required to collect significant demographic and assessment related characteristics . Similarly, despite the fact that SWs are required to detail the basis of their judgments and decisions, we know nothing of the sensemaking or drivers of the decision to provide ongoing services within the current policy framework. The gap in the knowledge base about the profile of Irish IAs and decisions made for children involved with the service became more evident in the context of the literature reviewed in Chapters 1-3. Efforts to improve assessment practice and policy, and case outcomes may be hampered due to the limited knowledge base. The following research questions were identified to address the gaps in the evidence and specifically, to gain insight into the context for assessment practice and explore judgment and decision-making strategies described and documented by social workers and to explore their efficacy in relation to current policies for case management.

1. How do SWs use Initial Assessments?
2. How do SWs explain their judgments and decision-making in Initial Assessments?

Apart from the categorisation of abuse at referral stage, Irish statistics do not reflect the prevalence of child harm or abuse. Tusla systematically publishes *Integrated Performance and Activity Reports* and *Quarterly Management Data Activity Report* (available online at tusladata, *Annually*). Because this data relates to performance of practice in relation to standards for business processes (HSE/Tusla, 2009/2014; Tusla, 2015) it relates to a subset of assessments which concluded within the timeframe of 21 days and the outcomes of these IAs by action which include No Further Action, Child Protection intervention, Child Welfare/Family Support service, Family Welfare Conference or child Admitted to Care. The only published child based data is from a the census of children active at year end on the Child Protection Notification System (CPNS) and those inactive the end year (tusladata, *Annually*).

This research aims to improve the understanding of the profile of IAs and the assessment of reported concerns and service needs with a view to providing insights to case management and policy for case management. Drawing on an ecological systems perspective it aims to analyse available data and evidence to develop a wider understanding of the context within which decisions for service provision are made. Current statistics indicate the trend in low rates of ongoing service persists and the gap between referral and service delivery is widening and questions remain about the knowledge base for service decisions. In order to enhance the evidence base, support policy making and enable comparison with other jurisdictions four questions were posed:

3. What is the demographic setting for the study?
4. What is the number and rate of IA completed and what were the decisions taken? How do rates compare to those in other Anglophone regions?
5. What is the demographic profile of children and families undergoing IA and how does it compare to the general population?
6. What is the scope and nature of assessed concerns and characteristics relating to organisational policy including the rate of recurrence, characteristics of SWs conducting assessments, and recurrence rates?

With a view to commenting on concerns raised about SW's assessment policy, the following question is posed

7. Do children and families undergoing IA meet the threshold for assessment in accordance with Tusla policy?

While several Irish research studies examined decision-making in CPW (Buckley, 2003; Burns and MacCarthy, 2012; Ferguson and O'Reilly, 2001; McCormack *et al.*, 2020; Whelan, 2018) none specifically addressed IA decisions. Internationally little is known about this decision but, the research base growing (Filippelli *et al.*, 2021; Jud *et al.*, 2012; King *et al.*, 2021; Lwin *et al.*, 2018b; Stoddart, 2021). It serves as a rich source of knowledge about investigated children and families and the basis to explain the a basis of service decisions to clients and a means to communicate needs to government and other agencies (Fallon *et al.*, 2017a; Keddell, 2014a; Tonmyr and Martin, 2014; Trocmé *et al.*, 2016). To generate this evidence in the Irish context four questions were posed:

8. Compared to children whose assessments are closed/NFA, what are the characteristics of those that remained open for service?
9. What are the determinants of ongoing service following Initial Assessment?
10. Compared to the current assessment model, what are rates and determinants of service provision based on a structured decision tool and what if any insights can be gained?
11. What do the findings suggest about interventions and where they should be focussed?

A case study was designed to explore social worker's assessment processes and the basis for their decisions to respond to research questions 1 and 2. The findings are presented at Chapter 5.

A cross-sectional study was designed to profile IAs and analytically to identify factors associated with the decision to provide ongoing service. The results of the descriptive study, which address research questions 3 to 7 are presented in Chapter 6. The results of the analytic cross-sectional study which addresses research Questions 8 to 11 are presented at Chapter 7.

Finally, at Chapter 8 the studies are reappraised and the contributions they make to the international literature is discussed. The findings are examined in the context on their theoretical, research and practice implications. Recommendations are offered for future policy developments.

The next chapter presents the Methodology for the research studies.

Chapter 4 Methodology and methods

4.1. Abstract

This chapter details the motivation and philosophical foundations for the research. Two observational studies conducted to address the research questions. The setting, study design, data sources and methods are described for each study. The results are presented in the subsequent three chapters.

4.2. Motivation and philosophical foundations for the research

The development of the research questions outlined in the previous chapter was informed by a comprehensive review of the current national policy framework and the national and international research on CPW and decision-making. The review revealed that we know very little about children and families, and social work assessment practice in Ireland. This being the case even though IAs have been a significant focus of investigations, audit, policy and systems development - due to concerns about variability and errors in judgments and decisions, and despite the fact that IAs are central to whether and what services children and families receive. The review also revealed a disconnect between the official version of IA practice and evidence based on research with SWs (Buckley, 2000a; Buckley and Burns, 2015).

I was interested in exploring practice to understand how SWs used assessments of children and how they explained coming to judgments and decisions about service needs and service provision. I had conducted a regional audit of standardised processes for intake and assessment and consulted with multiple professionals with roles aligned to CPW when *Children First* was first implemented to explore their views about assessment processes (Department of Health and Children, 1999; O'Leary, 2007a; b) and the findings of those studies together with the findings of the recent Audit of SBPs conducted by Tusla in 2015 (Tusla, 2015) persuaded me that there would be variability among SWs in the rationales they used to describe their practice. I was not so interested in the variability *per se*, as one might be in an audit, I wanted to understand what motivated decisions for practice and actions around service provision.

I was also ambitious to use epidemiological methods to develop robust evidence on the characteristics of children and families involved in IA and to identify the determinants of the decision to provide service. In a previous study I had demonstrated the benefit of using systematically collected case level administrative data to explore service provision (O'Leary *et al.*, 2015a) and remained convinced of the underutilisation of routinely collected information in Tusla/HSE. I was also motivated by the principal of fairness in practice and service delivery, in particular, in its conceptualisation in terms of transparency. The literature review demonstrated the preoccupation with accountability across the broad national system, incorporating the legislative, regulatory and policy frames for daily practice, but

also that the system lacks an evidence base to demonstrate accountability in relation to the very purpose for which it was created – the children and families it served. I am passionate about the need to redress this situation and believed I was in a position due to my role within the organisation and because of my interest, to demonstrate a way that this could be done and that it could be beneficial.

Lastly, I wanted to comment on practice in the context of the existing legislative and policy framework and explore how effective or otherwise this framework supported the needs of children and families and supported the SWs involved with them in fulfilling their statutory duties. It became clear addressing the research questions in the context of these aims would necessitate different approaches, methodologies, and designs. Two observational studies were designed and sequentially conducted.

In social research, methodologies and methods are informed by the general philosophical orientation about the world and nature of research that a research brings to research (Creswell, 2017; Guba and Lincoln, 1994) referred to in the literature as paradigms or worldviews. It is necessary to make these explicit in relation to the design and in relation to the analysis and interpretation of findings in a research study (Braun and Clarke, 2006; 2012). A researcher's paradigm reflects their beliefs about what reality is (ontology), what counts as knowledge (epistemology), how one gains knowledge (methodology), and the values one holds (axiology) (Giddings and Grant, 2006). I have outlined above my values base for the research.

Social constructivists that recognises multiple, contradictory and equally valid accounts and research aims to interpret the meanings others have about the world (Creswell, 2017) and what constitutes reality are social constructions derived from perceptions and actions or as a product of social interaction (Bryman, 2016). In this approach, knowledge is gained through making sense of, or interpreting the meanings others have about the world and researchers inductively develop a pattern of meaning about the subject of inquiry (Creswell, 2017). The aims of the first study lent itself to the social constructivist paradigm because the focus was to reveal SWs explanations for their own situated practice decisions. The study design is described below, and the methods, analytical approach and results are presented and discussed in Chapter 5.

Rational risk theories are predominantly associated with a presupposed regularity view of causation (Mohr 1996 in Teddlie and Tashakkori, 2012 p. 147) and variable oriented quantitative statistical approaches. In this approach, evidence can be construed as data that exists 'out there' that are objects of analysis waiting to be discovered which, once integrated can help explain how events come to occur (Sandelowski *et al.*, 2009; Stalker, 2003). Post positivism is a shift from *within* the positivist paradigm (Creswell, 2017; Giddings and Grant, 2006; Onwuegbuzie *et al.*, 2010). It holds a deterministic philosophy but, rather than assuming a linear process of cause and effect, perceptions of reality are the result of a complex array of factors including cultural experiences and worldviews, that interact with each other (Creswell, 2017; Onwuegbuzie *et al.*, 2009; Ryan, 2006).

As demonstrated in the literature review, the framework assessment practice is based on the ecological systems theory (Department of Health, 2000b; HSE/Tusla, 2009/2014; Tusla, 2014a). The review also revealed that interaction between the system and individuals happens in ways that are not always predictable or explicit (Baumann *et al.*, 2011; Buckley, 2003; Dingwall *et al.*, 1983/2014; Parton, 1998; Plsek and Greenhalgh, 2001; Rutter *et al.*, 2017; Wulczyn *et al.*, 2010) with the result that IA practice is highly contextualised (Wulczyn *et al.*, 2010). For these reasons, the cross-sectional study is a mixed methods design within the post positivist paradigm that recognises constructivist views of reality reflected in the empirical data compiled by social workers for the purposes of conducting IAs (Ryan, 2006). Overall, the approach is pluralist (Ryan, 2006; Sandelowski, 2014). In terms of knowledge development, post positivist research is driven by a pre-existing theory and is largely deductive and reductionist as its intent to reduce complexity (Creswell, 2017; Ryan, 2006) which is the aim of the cross-sectional research studies.

The findings from each of these stand-alone; observational studies provide an opportunity to comment on practice in the context of the existing system but, the evidence that each generates is limited by the philosophical underpinnings and by the methods adopted to deliver the research. Taken together, the findings are complementary and offer an opportunity for a more robust analysis taking advantage of the strengths of each design (Greene *et al.*, 1989). To address the third aim of the research, in the final chapter, I draw on the *Decision Making Ecology* framework (Baumann *et al.*, 2011) to bring the findings together dialectally to discuss how the mechanisms like 'why and how' IAs are conducted – evidence garnered from the case study, influence the 'who, what and why' type questions addressed in the cross-sectional study. This offers deeper insight into the meaning and outcomes of IA practice (Ferguson and O'Reilly, 2001) for children and families and the professional social workers who provide the service within the context of the CPW system in Ireland in 2015/2016.

4.3. Theoretical basis for the research

The study is informed by ecological systems theory (Belsky, 1980; Bronfenbrenner, 1979; Cicchetti and Toth, 1995) which provides a framework for identifying determinants of child abuse and which recognizes the ecological context for practice and the nested nature of cases within an individual CPW system (Belsky, 1980; Mulder *et al.*, 2018; Sethi *et al.*, 2013; Stith *et al.*, 2009). The research is also guided by the theory of bounded rationality (Simon, 1956; 1979b) which postulates that decision makers use 'satisficing' or heuristic strategies to reduce the complexity of information pertaining to a decision. And it employs theories of judgments under uncertainty which reveal that heuristics can be useful, but they lead to systematic errors and biases that are large and predictable (Tversky & Kahneman, 1974, Helm, 2011, Munro, 1999, Whittaker, 2018). Drawing on these theories, a number of conceptual frameworks devised for research into decision-making in CPW, variously propose that interaction between the social worker and case factors (including relationships with children and families) and factors in the decision ecology impact on the way that judgments are reached and decisions are made (Baumann *et al.*, 2011; Benbenishty *et al.*, 2015; Dalgleish, 1988; 2003; Helm and Roesch-Marsh,

2016; Keddell, 2021; Munro, 2005; Platt and Turney, 2013; Whittaker, 2018). Aware of this, my approach to data sources and collection sought to ensure the widest, and most representative data to address the research questions.

Building on this rationale, this study draws on the Decision Making Ecology (Baumann *et al.*, 2011) (see Figure 8) which incorporates the General Assessment and Decision-Making Model (Figure 9) (Dalgleish, 1988; 2003) to explore threshold decisions (See Chapter 3) in IAs in the case-study and to assist in the interrogation of the findings of case study and the cross-sectional study in the final discussion. The diagrams are sourced from a conference presentation by Baumann *et al.* (2012).

Figure 8 The Decision Making Ecology

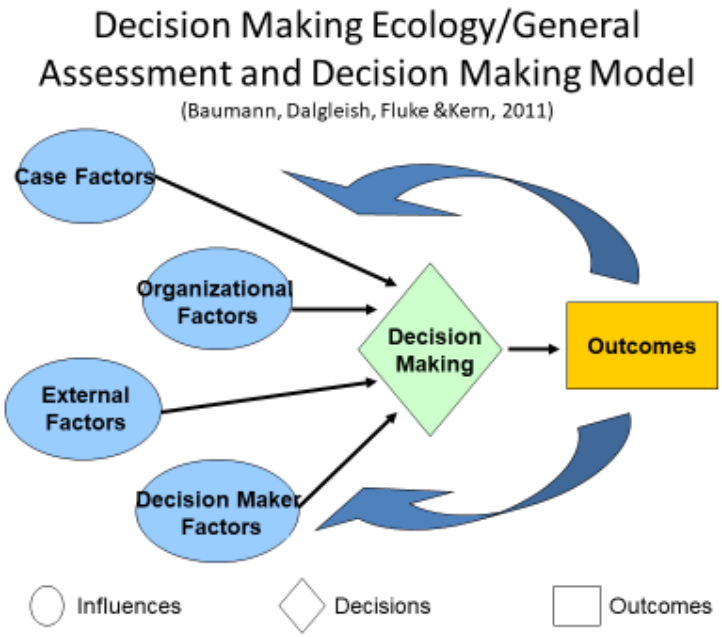
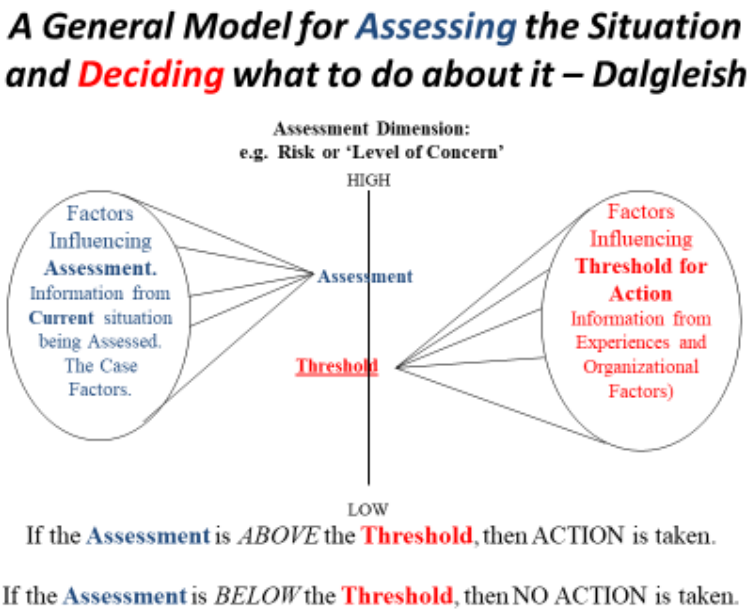


Figure 9 General Assessment and Decision-Making Model (GADM)



4.4. Research methods

Research paradigms were originally associated with particular research methods i.e. constructivist, subjective arguments were held to be associated with qualitative methods and post positivist, objective arguments with quantitative methods (Guba and Lincoln, 1982; Guba and Lincoln, 1994; Pluye and Hong, 2014). Many have argued the incompatibility thesis which posits that qualitative and quantitative research paradigms with different assumptions about the nature of truth and their associated methods, could not and should not be mixed (Guba and Lincoln, 1989; Small, 2011). However, others have argued that these concerns overstate how closely tied epistemological perspectives and every day practice are (Onwuegbuzie and Teddlie, 2003; Teddlie and Tashakkori, 2012). Mixed methods research describes a methodological field (Teddlie and Tashakkori, 2010) that accounts for research that consciously blends approaches within and across the research process (e.g. Johnson and Onwuegbuzie, 2004).

Mixed methods studies seem to have emerged in the 1950s (Pluye and Hong, 2014; Small, 2011) the rationale being that combining research methods was possible and useful because of their complementary strengths and weaknesses, and it yielded increased confidence in results. Methodologically the approach enables researchers to engage with sometimes complex relationships between data sources because it allows one to address tensions or dissonance that might arise in the information (e.g. Creswell, 2017; Johnson and Onwuegbuzie, 2004). Reflecting the epistemological and ontological positions as outlined, and the aims of this research, the concept of mixed methods is central to this project. The data sources are described further along in this chapter and treatment of data is also discussed.

4.5. Research setting and study designs

The research was set in the seven most southerly counties of Ireland in the region known in 2016 as Tusla south (see Figure 10). At the time of publication in 2022 this was organised into two administrative units, Tusla South East and Tusla South West.

The first study, conducted in 2015 was set in all 9 Social Work Department's (SWDs) in the region that collectively serve approximately 25.2% (n=300,064 children aged 0-17 years) of the child population in Ireland in 2016 (n=1,190,502 children aged 0-17 years). The second study, conducted in 2016, involved 7 of these SWDs that collectively serve approximately 22% of the child population in Ireland in 2016 (n=1,190,502 children).

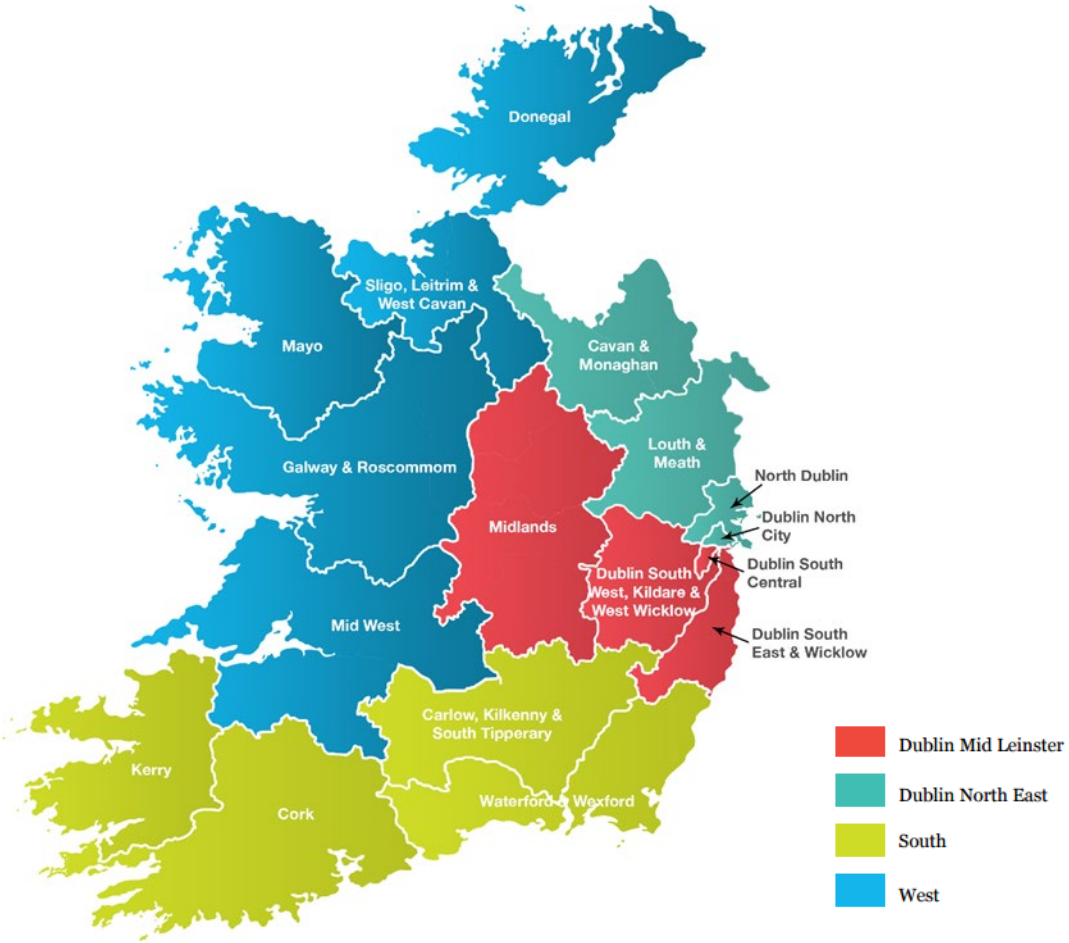
Access to SWDs was facilitated by an agreement between the Regional Manager and Area Managers and Principal Social Workers in each SWD. At the outset of the study, I was invited by the Regional Manager to attend a regional management meeting to explain the motivation for the study, outline the

aims and discuss the plan for data collection and address any questions. Following that, contact was made with individual Principal Social Workers directly to arrange data collection and provide updates.

Two studies, a case study and a cross-sectional study were designed to address the research questions identified at the conclusion of Chapter 3. Benbenishty (1992) identified two types of studies in CPW decision-making, studies that model the processes that lead from input to output, to model relationships between the input and output of decision processes and studies using the 'black-box' approach to model relationships between the input and output of decisions. These two types of studies were suited to the different aims of the studies and research questions.

The study design for each study and data sources, analytic methods and ethical approval for the studies are described below.

Figure 10 Map of Ireland showing boundaries of Tusla operational regions and setting



4.6. The use of case files as a data source for the studies

Case files were used as a data source in both the case study and the cross-sectional study, although they were used differently in each study. Each study used additional data sources. The discussion of data sources for studies would normally falls within the description of methods specific to each study design. Here, to avoid duplication, the discussion of the use of case files for my research purposes is presented in advance of the methods section for each individual study. The way files were employed for data abstraction and the additional data sources used in each study are described within the methods section that follow.

Case files facilitate communication, provide records of interventions, and serve as a basis for actions taken in a case (Huffhines *et al.*, 2016; Witte, 2020). In Irish practice, case files and records serve as a mechanism for supervision and management oversight (HSE, 2011) and as a means for scrutinising practice in accordance with agency and regulatory standards (HIQA, 2012; Tusla, 2015; Witte, 2020). They are seen as a rich source of empirical information for research in CPW assessment and decision-making however, they can be difficult to access and the unstandardized nature of files and ambiguity around the basis for missing data can be problematic (Biehal *et al.*, 2011; Devaney, 2008; Gautschi and Benbenishty, 2020; Hayes and Devaney, 2004; Parton *et al.*, 1997; Roy, 2021; Whelan, 2018).

Social work case files comprise formal records, correspondence and written accounts of interviews and consultations about a case. The formal records include referral documents and summary records for each case process that include Intake Record (IR) and Initial Assessment (IAR) records, as described in Chapter 2. These records serve to capture and organize information derived from the information gathering phase related to each process. As detailed in Chapter 2 (see Appendices 2 and 3) the design of the IAR is based on the 'assessment triangle'. The records contain demographic data, textual accounts and categorical information regarding, communications, aspects of case management, the categorization of a case and decisions taken. The latter form the basis of data that is collated by Tusla for performance and activity statistics.

Some authors suggest that case files, and the administrative data they generate, are not subject to recall or social desirability biases likely found in data associated with self-report studies or survey-based studies (e.g. Brownell and Jutte, 2013; MacMillan *et al.*, 2003). Furthermore, SWs complete the IR and IAR *post-hoc*. Consequently, there is every possibility that information selection and decisions might be affected by unconscious cognitive biases leading to overweighting of information and beliefs that support the decision (Tversky and Kahneman, 1974). On the other hand, the IR and IAR are designed to reflect what is perceived relevant to case management and organisational needs as an account of practice in relation to a particular process (HSE/Tusla, 2009/2014; Simon, 1979a). They may form the basis for supervision, and may be subject to scrutiny in relation to case management strategies, and audit for compliance with agency standards for thresholds and service allocation (e.g. HIQA; O'Leary, 2007a; Tusla, 2015). Parton *et al.* (1997) suggest that case files are a source of information about how

decisions are *accountably* arrived at so, providing evidence of coherence between judgment and decision-making and agency policies. They say

> *… files are constructed for and by organisationally relevant concerns. They provide us with information on what is accountable (to supervisors, clients, colleagues and other practitioners), on what is important to account for in making decisions about child protection matters. … The fact that they do not tell us the full story is essential to their validity as a data source. … Whilst, officially, child protection workers are mandated to detect and prevent significant harm or injury to children, the files tell their own story of what are organisationally relevant actions and reports (Parton et al., 1997, p. 78-79).*

Broadly speaking, this belief can be situated within ecological systems approach described above (Baumann *et al.*, 2011): case information, personal ideologies and beliefs about the role of statutory CPW services influence decisions about what to gather, measure, analyse and publish, and these issues present dilemmas for practitioners and researchers and policy makers alike as they promote one narrative over another (Bywaters, 2015b; Jud, 2018; Keddell, 2013). For the aims of this research and its theoretical foundations, case files are an invaluable source of evidence of the situated context bound assessment practice. Case files have been used in research on decision-making in assessment regarding domestic violence (Devaney, 2008), reunification of looked after children (Biehal *et al.*, 2011) and on research about service provision in assessments involving parental substance misuse (Roy, 2021).

The abstraction of data from case files was driven by an extensive review of current literature and current child protection policy. The approach to data abstraction from case files varied from the case-study to the cross-sectional study due to the purpose and design of the studies. The approaches are described in the respective methods sections below.

4.7. A case-study of initial assessments in Tusla in 2015/2016

4.7.1. Study design and setting

For the first study I adopted a case-study methodology to explore assessment practice, judgments and decision-making regarding service provision. Case-study is research framework or strategy (Taylor, 2013; Yin, 1981; 2003) and the approach has been used in Irish research in CPW (Buckley, 2003; Whelan, 2018). Case-studies are suited to empirical inquiry to examine phenomena in the everyday contexts in which they occur through the use of multiple data sources, be it single case, a multiple-case study or an intrinsic case-study (Flyvbjerg, 2011; Yin, 1981). Whatever the makeup, according to Stake (1995, p. 133) a case ‘is something we do not sufficiently understand and want to - therefore, we do a case study’. Aware of versatility of case-study methods, researchers suggest that it is important to specify the boundaries of the case and ensure congruence between the subject of the research and methods adopted to develop evidence and build theory (Baxter and Jack, 2008; Flyvbjerg, 2006; Taylor,

2013; Thomas, 2011; Yin, 2003) Factors that bind the case can include time and place, activity, definition and context (Baxter and Jack, 2008; Creswell, 2017; Flyvbjerg, 2006).

The case-study in this research is bound by its geographic and institutional setting in Tusla South in 9 Social Work Departments (see Figure 10) in a range of urban and rural settings which served 25.2% of the child population of Ireland (aged 0-17 years) (Tusla, 2012–2019). It was bound by the subject of study and timing, the exploration of assessment and decision-making during IAs by professional social workers in 2015 and 2016. The setting was accessible because I worked in the region which was managed at the time by a single Regional Manager, who was very supportive of the research - I discuss this issue in relation to my role in the research at Section 4.10 below.

4.7.2. Data sources and data collection

The study used two data sources, interviews and case files that were simultaneously gathered over a 5-week period from December 2015 to January 2016. Purposive sampling was used (Creswell and Plano Clark, 2017) driven by an extensive review of current literature and current child protection policy.

The use of case files in the research was described above but, here I elaborate on sampling and data collection. Principal Social Workers (PSWs) were invited to select for on-site review, case files relating to IAs that had concluded in the latter six-months of 2015 (n=45). Some PSWs provided full case files and others the summary Intake Records (IR) and Initial Assessment Records (IAR). Data relating to individual child IARs was collected in Excel using a database designed using variables drawn from the questions on the individual records (see Appendices 2 and 3) and variables that emerged during the data collection. It included demographic data, and information on the categorisation of concerns and target decisions required by the policy. Narrative information transcribed or abstracted into field notes included the SW's assessment of the child and family based on the domains and sub-domains of the IAR (see Appendix 3).

Interviews or conversations are commonly classified in a structural way and are variously denoted in the literature as highly structured or standardized, semi-structured, unstructured or informal, naturalistic or opportunistic (Merriam and Tisdell, 2015; Swain and Spire, 2020). Informal interviewing covers a range of methods including unstructured interviews, casual conversations, chance encounters and observations that remain undocumented until a researcher has an opportunity to recall and document them, and which characterized by a total lack of structure or control and 'unstructured' or 'ethnographic interviewing' also characterized by a minimum of control over the people's responses (Bernard, 2017 p.211). The aim is to get the lived experience of research subjects (ibid; Swain and Spire, 2020). The approach, while common in ethnographic research can be applied to many other forms of qualitative research that take place in everyday settings where they may be used as a source of supplementary data to more formal methods (Swain and Spire, 2020). This is the approach that was adopted in the case-study. Swain and Spire (2020) suggest that situations where researchers are situated in a local context they can take an embedded approach using informal interview approaches that reflects the dynamic

nature of the qualitative research process (Whiteman, 2012 quoted in Swain & Spire) which may be contingent and fluctuating.

From the outset of the case-study there was simultaneous collection of information via case files and unstructured group and individual interviews with SWs. Interviews took place in planned meetings with specific teams (n=2 each entailing approx. one hour) and with individual Principal Social Workers and Team Leaders (n=9) when I attended SWDs to review and collect information from case files. The two team interviews followed a similar format whereby I explained the motivation for the study, discussed the aims and the intention to use case files and the information collected in meetings as data sources. This prompted discussion about the feasibility of research methods and discuss practice for assessment and decision-making, and practical questions about timing and results. Individual interviews which took place onsite at meetings arranged to review case files were less structured as they entailed various discussions about the study (which had been discussed in the regional management meeting), practical issues about where I could situate myself with the files and entailed responding to questions that emerged for me about the case files. These interviews varied in duration, generally involving an introductory chat and then further discussions where questions arose regarding the files. One additional interview with a Team Leader took place at a symposium about CPW SW that was held in the region during the time I was conducting site visits. I used these planned and chance encounters in research environments with a view to creating authentic data which, the literature suggests enables researchers to reflect the everyday context of the research subjects (Bernard, 2017; Swain and Spire, 2020; Whiteman, 2012).

The interviews conducted during case file review were particularly helpful in building relationships with SW managers. They were used to address practical questions about the aims of the research and to discuss issues around data collection for the subsequent cross-sectional study. Sandelowski (2002) suggests that people that people use interviews strategically to present, account for, and even justify themselves and their actions. This was certainly a feature the interviews conducted when I attended SWDs to review and collect information from case files – pretty general topics pertinent across all departments in the region, SWs were keen to explain ‘how things work here’ and to discuss issues pertinent to the current policy framework. As noted in the literature (Murphy and Dingwall, 2007; Swain and Spire, 2020) the significance of this information emerged during the analysis and interpretation phase of the research well after these conversations had taken place.

The aim of the sampling and data collection methods was to achieve comprehensive understanding of IA practices through ‘saturation’, a concept with origins in grounded theory, whereby sufficient information was collected so no new themes or insights were emerging from the information (Charmaz, 2006; Fusch and Ness, 2015; Glaser and Strauss, 1967; Miles and Huberman, 1994; Saunders *et al.*, 2018). During field work I employed the process of constant comparison of the information and themes that emerging from case files and interview (Charmaz, 2006; Creswell, 2009). According to Morse

(2015) this incorporates the scope or comprehensiveness of the data and replication or the deification of common characteristics in the data and the search for explanations when gaps occur.

While this active engagement with the information as it was being collected at individual SWDs and across the different SWDs aimed to ensure rigour, it meant that not all case files made available for review were employed in the research and that the different approaches to interview – individual and group - were not necessitated across the individual SWDs within the research setting and that questions were not necessarily replicated across different interviews. Saturation aimed to ensure all social work departments (SWDs) were represented in the data collected. As Fusch and Ness (2015) observed, the approach meant that one size did not fit all. It also meant that in some cases I needed to check back with SWs to interpret something documented or that I sought an interview after the case file information was collected.

4.7.3. Analysis

The research is situated in the social constructionist paradigm as it aimed to interpret the meaning that subjects have themselves attributed to the evidence and situation to explain the aims of their practice and the basis of their decisions. Information from case files and interviews were analysed separately initially, and findings were then considered together so that patterns of reasoning documented in written records were used alongside insights into the context and conditions for practice to explain IA practice.

Any identifying details relating to individual children and families, Social Work Departments (SWDs) and Social Workers (SWs) were removed. An individual SW reading the text in Chapter 5 might recognise their accounts, but another reader would be unlikely to identify them. Categorical information collected from case records was coded and analysed in Excel to generate descriptive statistics. Textual and categorical information was transcribed into NVivo 10 where it was analysed to identify patterns, or themes, across the data and to develop insights into SW's reasoning processes and explanations of the decision to whether or not to keep a case open for ongoing service.

Case file data was analysed using thematic analysis, following methods described by Boyatzis (1998) and subsequently developed (Braun and Clarke, 2006; Neuendorf, 2017). In this approach themes are patterns found in information that may be manifest (observable directly in the information) or latent (underlying the phenomenon) and can provide a means of transformation of qualitative data to quantitative data (Boyatzis, 1998). Braun and Clarke (2006) outlined a six-phase approach[46] to thematic analysis for systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set, although in practice they stress that thematic analysis is a flexible approach (Braun and Clarke, 2006; 2012). TA enables researchers to use both manifest and latent content analysis at the same time. In this study I employed a hybrid deductive-inductive approach to coding the data

[46] These are 1. Familiarise yourself with the data, 2. Generate initial codes, 3. Search for themes, 4. Review potential themes, 5. Define and name themes, 6. Produce the report.

initially, using both a-priori codes from the case records, i.e. the policy, and literature, and codes that emerged in the text (Boyatzis, 1998; Braun and Clarke, 2006; Creswell, 2017).

The entire text was deconstructed to identify factors and themes that were identified by SW. Once data was entered into NVivo and I began to familiarise myself with it, the first stage of initial coding was straightforward based on the manifest content and involving an 'objective' identification of codes within the data that I had created. That process pretty quickly generated 127 data driven codes drawn from the questions on the records, the literature, and the texts, which I then organised into child related, family related and agency factors. Once the data had been reconstructed in this way, I analysed these codes to find patterns or themes, linked to the decisions taken in the cases, to close an IA or to keep it open for ongoing work. Thus, coding was both deductive, focussed on variables drawn from literature on child abuse and literature on decision-making and inductive, drawing on latent themes and variables that emerged in the texts themselves. This allowed me to map how SW's gave meaning to information in the particular context of the decision taken in the IA.

The coding and analytic process thus involved weaving in and out of the data several times, reworking themes along the way. The constant engagement with the themes aimed to avoid both over- and under-coding the data while at the same time remaining responsive to the data and to theory driving the research.

Information from interviews was reviewed separately initially to gain insights into SW's perception of their role in conducting IAs and the influence of factors related to the practice environment and to understand how the wider context influenced SWs reasoning and actions in IA. This allowed a robust proposition of situated policy and organisationally based reasoning and decision-making during IA to emerge.

The thematic analysis of the case records did leverage insights from the data, but it was in reviewing these along with the data from interviews and in the context of the agency discourse, that a robust proposition of reasoning and decision-making during IA emerged. In this way the data was interpreted to create a rich description of decision-making during IAs (Peel, 2020). This systematic inquiry framework provided an opportunity to deliver a study that reflected a range of views and interpretations of practice which were generalizable to the context at that time (Flyvbjerg, 2006; Peel, 2020). Findings are discussed individually where they relate to specific research question and themes and discussed together where common themes emerged in relation to the research questions.

4.8. A descriptive and analytic cross-sectional study of children receiving initial assessments and ongoing service

4.8.1. Study design and setting

A cross-sectional study was designed to address research questions 3 to 11 (see Chapter 3). Cross-sectional studies are a type of observational study design that are used both descriptively and analytically (Alexander *et al.*, 2015; Ressing *et al.*, 2010). Sometimes called prevalence studies, descriptive cross-sectional studies provide an opportunity to identify the characteristics and exposures in the sample (e.g. demographics, child functioning, parent functioning, risk factors, organisation characteristics) simultaneously with outcomes i.e., decisions about case categorisation and interventions. Descriptively, the aim of this study was to describe the characteristics of children and families undergoing IA and to characterise the prevalence of ongoing service.

Analytically cross-sectional studies are used to describe how these factors relate to an outcome i.e., the decision whether or not to provide ongoing service. The purpose here being to compare the characteristics of children who received any ongoing CPW service following IA to those that did not. The study was used analytically to identify factors associated with the decision to provide ongoing service and measure the relative association between those factors and the decision.

Prevalence studies, and input-output studies examining decisions whether or not to provide services at various stages along the CPW continuum, are a subgroup of cross-sectional studies in which the outcome is dichotomised into those that receive service and those that do not (Gautschi and Benbenishty, 2020). This is the first Irish study to examine and describe demographic and case factors relating to children and families who received an IA. It is likewise the first Irish study that employs regression analysis to examine the relative influence of these factors on the decision whether or not to provide ongoing service intervention following an IA and to explore differences between children who received services and those that did not.

The descriptive findings of the cross-sectional study are presented in *Chapter 6 Children Receiving Initial Assessment for Child Abuse and Welfare Concerns: Clinical and Organisational Characteristics and Decisions Taken.* The results of the analytic study are presented in Chapter 7 *Factors associated with the decision to provide ongoing welfare and child protection services following Initial Assessment*.

Seven of the nine SW Departments that participated in the case-study also participated in the cross-sectional study. The two SWDs that pulled out did so because of difficulties in allocating resources to pulling case files for the purpose of the research.

4.8.2. Sample identification

The eligibility criteria were a child aged 0-17 years whose Initial Assessment concluded during the first quarter of 2016 in six social work departments in Tusla South. These criteria enabled gathering data that would allow classifying children as having received or not received ongoing service (Alexander *et al.*, 2015). A complete sample was identified and used.

Tusla publishes on a quarterly basis, statistics for performance indicators relating to the processing of referrals (https://www.tusla.ie/data-figures/). Among the metrics is the number of IAs completed within 21 working days of receipt of a referral and the actions taken on completion. That data identification strategy was amended to identify any referral that completed an IA during the first quarter of 2016 in seven SWD's in Tusla South. Administrators and regional data collection officers searched physical and electronic case file lists to identify 508 eligible children with unique reference numbers.

4.8.3. Data sources

Manually searching casefiles is a very time consuming practice. During the case-study I identified that the formal Intake and IA records, as opposed to full case files, would provide sufficient information for the purposes of the cross-sectional study. The records are templates for 'structured' collation of information, analysis and decision-making in an organised way as required by policy guidelines. For each child, written referral information, the Intake Record and the Initial Assessment Record were collected from case files amounting to 1,524 hard copy records in all. See Appendices 1 and 2 for the IR and IAR.

A number of additional sources were used to extend the data available for analysis in this study.

Referral and Assessment Administrative Data

Aggregated data sets relating to the processing of referrals[47] were used to generate activity levels and trends for referral and assessments (see Chapter 2, Section 2.7). Some data is available at the SWD level and others at the regional operational level (See Map Section 4.5).

Population Statistics

Population statistics are produced by the Central Statistics Office of Ireland (CSO) for a range of geographical levels, from state to small areas. These include Electoral Districts (EDs) of which there are 3,440 in the country, and small areas (SAs) of which there were 18,488 in 2016. EDs do not provide a homogeneous coverage of all areas in the country, as they contain as few as 76 individuals in some rural areas, but over 32,000 in another. SAs are much more homogeneous in their social composition and have a uniform population size with a mean of just under 100 households (CSO SAPS, 2016; Haase and Pratschke, 2017a).

[47] Published statistics and unpublished reports from SWDs used to generate national statistics

Deprivation Index

The study uses the Pobal HP Deprivation Index 2016, a census-based deprivation index for the Republic of Ireland generated from indicators of three dimensions of affluence/disadvantage (Haase and Pratschke, 2017a). These are Demographic Profile (6 indicators), Social Class Composition (5 indicators) and Labour Market Situation (three indicators) (see Haase and Pratschke, 2017a for details of index construction.). It shows the level of overall affluence and deprivation at the level of the 18,488 SAs for Ireland. It comprises an absolute and a relative score. The Relative HP Deprivation Index Scores (HPRelDep) are derived by subtracting the underlying trend from the absolute HP Deprivation Scores and rescaling them so that they have a mean of zero and a standard deviation of ten at each census wave (Haase and Pratschke, 2017a). The HPRelDep for an area provides a measurement of the affluence/deprivation of a given area relative to the national mean at a specific point in time. Access to the Deprivation Index data at the level of Small Areas (SAs) was granted in 2019 under a licence agreement (Haase and Pratschke, 2017c).

4.8.4. Record management, data extraction and variable evaluation

Once collected, the report, IR and IAR records were physically collated into unique child files and numbered. Then, using demographic data, family groups were identified and numbered. This coding mechanism enabled information to be analyzed at the child and family level, something not available in Irish statistics.

A database was created in Excel, based on variables identified in the records and information from the records was manually extracted and typed into that data set. The initial round of coding generated over 300 variables reflecting the range of data found in the records. Once the draft data-set was completed and quality checked, data was imported into Stata (StataCorp., 2015) and codes were assigned using a number of variable transformation and data reduction techniques as described below.

Records were maintained in accordance with Tusla Information Management and Data Privacy guidelines. Physical files were maintained in a secure filing cabinet. Electronic records and original data sets were maintained on a dedicated secure server maintained by the Tusla ICT directorate.

4.8.5. Variable identification

Variable identification was both deductive, using variables drawn from the Intake and Assessment Records, the extensive literature review, the case study, CPW policies, the national census of population and the qualitative study, and inductive, drawing on features that emerged in the texts themselves.

Based on the *Framework for the Assessment of Children in Need and their Families* (DH 2000), the IAR (Appendix 3 See Figure 11 reproduced from Chapter 2 for ease of reading) provides a systematic way to record and analyse narrative information across 7 dimensions regarding child development, 6

dimensions of parenting capacity to respond to developmental needs and 4 dimensions relating to broader family and environmental factors. The record includes a narrative summary of the child's response, the parent's response to the assessed concerns and a narrative summary of the analysis of the IA and the basis for the decision taken. For welfare assessments, SWs are additionally required to identify by tick box, as appropriate, the presence of 36 factors relating to child (17 factors), parents (10) and households (9 factors). Each of these dimensions was incorporated as a variable in the data set. Assessment outcome variables include categorisation of the concern, the designation of significant harm and case processing decision outcomes. These were recorded as variables. For the analytic study, the decision whether or not to provide ongoing service was identified as the outcome variable. It was dichotomised and 1 represented a child who remained open for ongoing service and 0 a child who was closed/NFA.

Figure 11 Assessment Framework (Department of Health, 2000)



Practice guidelines advise SWs on the scope and characteristics of abuse and welfare concerns, what to look out for, and on the threshold criteria for accepting and progressing reports and providing services (HSE, 2011; Tusla, 2014c). However, with the exception of welfare cases, these characteristics are not distinguished categorically in the IAR. These features were available for coding if they had been noted or described textually in the IAR or as a feature of the referral in the Intake Record.

While aiming to capture and describe as many exposures as possible, variable identification and coding methods aimed to rule out, as effectively as possible, potential covariates and confounding of the association between the independent and outcome variables (Vittinghoff *et al.*, 2011 Ch.5). The full set of variables are presented at Chapter 7.

For the analytic study potential or 'candidate' variables for inclusion in the model were evaluated according to a number of criteria drawn from the statistical literature and described below in Section 4.9.3. Then, multivariable regression analysis controlled for confounding. Potential confounding due to collinearity among predictor variables was also examined as part of the evaluation of the final multivariable model (see Chapter 7).

4.8.6. Coding and measures

Cross-sectional studies require data in the form of numbers but, case file records are textual. The variable identification and coding processes applied here followed a grounded approach. This involved quantitizing the written texts (Driscoll *et al.*, 2007; Jud *et al.*, 2016; Sandelowski *et al.*, 2009), essentially 'coding what I saw' (Huffhines *et al.*, 2016 p257), to extend the understanding of how SWs themselves attached meaning to characteristics and constructed categories of abuse and welfare, and to explore their association in determining the need for ongoing services in assessments (Fallon, 2020; Parton, 2018).

Consideration was given to generating scale variables for exposures from the data. For example, a number of coding strategies have been developed to guide practitioners and researchers in CPW in identifying, describing and measuring the intensity of type of maltreatment exposure that may have been useful (e.g. Chaffin *et al.*, 1997; Cox and Bentovim, 2000; Fallon *et al.*, 2010; Huffhines *et al.*, 2016; Jud *et al.*, 2015) but a number of factors precluded using them. Severity relates to diverse and interactive elements including intensity and extent or injury, as well as duration of exposure, age and vulnerability (Warner, 2003 p344). Descriptions of exposure and extent of harm were varied. Many records referenced the *Threshold of Harm* (Tusla, 2014c) category to which the concerns were attributed, or the term chronic, when describing the context; but again, this was not done consistently across the sample and the claims did not always have accompanying disaggregated evidence to support the categorisation. Due to the cross-sectional nature of the data, and limited or varied accounts of case histories, it was not possible to ascertain the duration exposure. Protective factors were also variously recorded and multifactorial. Together, these limitations meant that consistent application of a scale across 480 individual records would have been impossible. As the study was interested in identifying factors associated with ongoing service, which relates to ongoing needs or the likelihood of future abuse, it was decided to focus on risks.

For the most part, it was not possible to determine whether all clinical characteristics, risk factors and protective factors were equally influential in individual assessments and decisions. Also, the meaning of what constituted concerns about various dimensions of child developmental and parenting capacity varied across different client files. For example, what a SW might consider constituted a concern about a child's educational needs or the emotional warmth from a parent towards a baby would differ from what constituted a concern in relation to a 17-year-old. In this way, definitions on the records lacked reliability and content validity.

To account for the variability across the records and to limit the potential for drawing erroneous conclusions from statistical analysis, binary, or dummy, variables were created for case characteristics, for exposures to risk factors at individual carer level and at the household level and for the categorisation of cases and decisions taken by SWs, where several options were available. Where binary variables were created, 0 accounts for absent, unknown, or missing data. This enabled counting the presence of concerns as determined by the SW in the individual context of each IA, enhanced descriptive analyses and facilitated integration of variables into the regression model (see 6.13). For coding purposes three sub-domains within Family and Environmental Factors, namely *community resources, family's social integration* and *wider family* were collapsed into one variable named *Social Resources*. Some variables were relevant only to certain categories of abuse. For example, the variable 'child witnessed intimate partner violence' (DV) was relevant to cases where DV was present. Excluded from this code were accounts of violence between a parent and another adult and assessments that did not involve DV.

Other data transformations were conducted to simplify the complexity of the data and to reveal organisation policies and for reasons of privacy and data protection. For example, reporters are individually named in the record and in the case of professions, their professional relationship to the child and family is identified. In 2016, the reporting policy operated by Tusla identified three classes of reporters, social workers and An Garda Síochána had a statutory duty to report concerns, professionals were identified as having an ethical duty to report concerns and family members were classified as members of the public. Thus, the reporter role was coded into three categories so descriptive statistics could reveal information about the Tusla's reporting policy. The family address was used to generate the Eircode (zipcode) that in turn facilitated linkage with census demographic data to generate the mean HPRelDep score related to each family. Supplementary CSO and HP Deprivation Index (Haase and Pratschke, 2017a) data were collated for the study at the level of the Social Work Departments. This increased the range of answerable questions and facilitated comparisons with the general population.

When this research was conducted, the Central Statistics Office of Ireland did not produce population statistics using Tusla geography, i.e., boundaries of Social Work Departments or regional operational areas. The ED's and SAs used by CSO were mapped to Tusla geography. Then, Census 2016 population and family demographics were collated at SWD level for those departments involved in the research, and at the regional level for the remainder of the country (see Chapter 2 for Tusla Geography). Using the CSO small area statistics (CSO SAPS, 2016) and HP Relative Deprivation Scores (Haase and Pratschke, 2017a) the mean rates of relative affluence and deprivation were calculated for small areas across the entire country 2016 (n=18,444), also at the level of the SAs (n=4,905) within the geographic boundaries of the SWD in the study (study area) and at the level of SAs (n=272) where families in the sample resided. Family addresses were mapped up to SAs which maintained anonymity but also provided an in-depth picture of the social and economic conditions of small communities where families in the study were living.

4.8.7. Missing data and invalid cases

In total, 28 children were dropped because they were duplicate, incomplete, overage or the completion date of the assessment fell outside study parameters. A number of demographic items, child religion, ethnicity, and nationality, were not routinely gathered, although requested on records (See Table 3, Chapter 6). Information for subdomains of the Assessment Framework were inconsistently recorded (see 'limitations' below). Other variables, important at individual case management level were not valuable at the sample level such as, a parent in prison.

4.8.8. Analysis

Statistical analysis using measures of frequency were used to generate a detailed profile the sample undergoing child abuse and welfare IAs. These were analysed at the level of the child and the family, by socioeconomic characteristics and geography. Results are reported to one decimal place. Bivariate analysis was used to explore the association between variables using two tests of association, Pearson's chi square and fisher's exact test. The threshold for statistical significance was set at $p < 0.05$.

Poisson regression analysis was applied to model the binary decision outcome, whether or not to provide ongoing service with the outcome 1 indicating a child who remained open for ongoing service and 0 a child who was closed/ no further action following IA. Methods are described in Section 4.9.

4.8.9. Limitations and steps taken to modify them

In this study, as often is the case, a cross-sectional study was the only class of observational study that could be conducted, due to restrictions in accessing data for follow-up and time (Ressing *et al.*, 2010).[48] Cross-sectional studies methods are appropriate for examining decision-making but they entail a number of limitations (Alexander *et al.*, 2015; Fallon *et al.*, 2010; Fluke *et al.*, 2020).

Cross-sectional studies are affected by the antecedent-consequent bias, similar to the 'chicken and egg' question, so it is not possible to determine causal relationships, also chronic and re-current cases have a higher probability of being sampled (Alexander *et al.*, 2015). No claims are made about causal patterns in the data. Sampling within the population open to CPW service generates selection bias because the population is skewed. The sample relates to children and families about who concerns have already been identified (Cash, 2001; Huffhines *et al.*, 2016) consequently it is unclear whether concerns about abuse and welfare precede risk factors identified or vice versa. To modify this limitation, techniques

[48] I had intended to conduct a longitudinal study of initial assessments with follow-up at 12 months. However, data collection became for follow up became protracted because of technical issues related to data collection and due to the necessity to conduct a Data Privacy Impact Assessment with Tusla ICT and the Office of Legal Affairs in order to comply with then pending, European General Data Protection Regulation EP & CEU 2016. Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). Official Journal L 119: European Parliament and Council of the European Union. In all these processes took two years to complete. Once the DPIA was complete it was decided to progress with a cross-sectional design.

that are recognised in the literature were applied (Witte, 2020). Secondary and detailed analysis of demographic data was conducted using sample data and regional and national data, and the research findings were compared to research studies employing similar methods, set in jurisdictions with similar CPW systems.

In empirical studies of child maltreatment, records may be coded by two or more research analysts to increase inter-rater reliability (e.g. DePanfilis and Zuravin, 1999). Within the constraints of operating as an independent PhD student, this was not possible. However, as described at Section 6.3 above and based on discussions with my statistics advisor, a number of measures were taken to increase the validity of coding techniques.

Assessment data are based on the interpretation of concerns by professional SWs and their choice to document them and, as in other studies using case file data, are not independently verified (Fallon *et al.*, 2022; Fallon *et al.*, 2021; Forrester and Harwin, 2006; Roy, 2021; Trocmé *et al.*, 2010; Whelan, 2018). Concerns about data validity arose because of variability in the detail recorded in answer to each question on the IAR and evidence recorded for the categorisation of concerns as a sub-type of abuse or welfare, a feature sometimes referred to as clinical heterogeneity, and due to missing data (Gautschi and Benbenishty, 2020; Huffhines *et al.*, 2016; Witte, 2020). To address these potential limitations, candidate variables for descriptive and analytic purposes were examined for face and content validity and for reliability across the data set.

Studies of CPW practice using SW case files have identified variable quality in record keeping (Teater *et al.*, 2016). A consistent feature of the records was that the information that was recorded related to the context of the concerns being investigated, not to child development or parenting capacity generally, or in the case of recurrent cases, to a detailed case history. Also consistent across the records was the way information was recorded. Information about demographics, risk and protective factors relating to each dimension on the *Assessment Triangle* (Department of Health, 2000b) (see Figure 6.2) and family stressors (e.g. resources, relationship difficulties, finances, DV) was not limited to text boxes provided for the respective questions on the IAR. Rather, information available for coding was identified across all sections of the records. Thus, the IAR lacked face and content validity and reliability. To address this, the entire body of text across a referral, intake and assessment record relating to each individual child, was used as a data source. This enabled coding for case characteristics and the presence of more than one type of abuse where it was documented, something not previously available in the Irish statistics.

Consistent with recent research involving IA records in England, information on some domains of the IA record were frequently missing (Roy, 2021) and in some records information was duplicated across several domains. Some information in the records may be overemphasised because it coheres with the decision taken (Huffhines *et al.*, 2016; Kahneman *et al.*, 1982; Witte, 2020). Information may be underreported either because social workers are not aware of an issue (Fallon *et al.*, 2021; Trocmé *et*

al., 2010) or because they do not record it even when they are aware of it because it might not appear relevant to the decision or, due prescriptive recording requirements or time constraints (Featherstone *et al.*, 2014b; Forrester and Harwin, 2006; Gautschi and Benbenishty, 2020; Hayes and Devaney, 2004; Laird *et al.*, 2017; Roy, 2021; Teater *et al.*, 2016). There may be lurking variables that impact on the relationships in the data. For example, factors identified as important when researching assessments and decision outcomes that were not available across the data set were ethnicity (Dettlaff *et al.*, 2011; López *et al.*, 2015), parents age (Fallon *et al.*, 2011a), substantiated (Jud *et al.*, 2012) or previously substantiated maltreatment (DePanfilis and Zuravin, 2001), all factors that are not systematically gathered in IAs. Consequently, figures drawn from files may not be accurate measures of actual prevalence of concerns or abuse and factors associated with decisions. Lastly, information about individual SWs caseloads, professional experience and values, characteristics deemed relevant in establishing thresholds for decision-making were not available (Baumann *et al.*, 2011; Burns and MacCarthy, 2012; Keddell and Hyslop, 2019b; Lwin *et al.*, 2018b; McCormack *et al.*, 2020). These are limitations in the data set (Grove and Meehl, 1996; Kahneman *et al.*, 1982).

In addition to the disposal decision whether or not to provide ongoing service, target decisions in IA include the categorisation of concerns as welfare or as one of four sub-types of abuse (physical, emotional sexual abuse and neglect) and, in the case of any abuse sub-type, to identify whether or not a child is at ongoing risk of significant harm. It would have been insightful to develop a model to identify factors associated with the categorisation of cases, but the interpretation of the findings would have been problematic and particularly difficult given the sample size. It was decided to focus attention for analytic purposes on the binary decision whether or not to provide ongoing services, a decision that was valid in relation to each individual assessment.

Despite the limitations outlined and consistent with other research exploring IAs using casefile records (e.g. Manion and Renwick, 2008; Roy, 2021), this study, compared to officially published findings relating to IAs, provided a wealth of information about the demographic characteristics of children undergoing IA and the a the nature and prevalence of problems they and their families were facing. Importantly, from the perspective of understanding how the state CPW service responds to the needs of children reported, the IA records provide rich evidence of the situated and context based explanations reported by SWs for their decisions taken in IAs.

4.9. Analytic methods for the study of factors associated with ongoing service

4.9.1. Measures

The measures were identified from among the data extracted from the records as detailed above and detailed in Chapter 6 at Table 3.

4.9.2. The outcome variable

At the conclusion of an IA options for action include closing the assessment with no further action (NFA) or progressing the child for one of a number of interventions, depending on the level of need and risk.[49] These interventions are: Child Protection (CP), Child Welfare and Family Support Planning (CWFSP), Further Assessment (FA), Family Welfare Conferencing (FWC) and Admission to Care (AtC). Optional additional actions[50] available to SWs are not included in the study. The outcome variable was dichotomised into children who received any ongoing CPW intervention at the conclusion of the IA with CP, CWFSP, FA, FWC and AtC coded as '1' compared to those that were closed and were closed/NFA coded as '0'.

4.9.3. Evaluating candidate variables linked to service provision

Selecting candidate variables by the measures aimed to ensure as persuasively as possible that they were relevant to the decision outcome and that their selection reduced the potential for confounding of the association between them and the outcome (Heinze *et al.*, 2018; Vittinghoff *et al.*, 2011). Collinearity, the situation when two independent variables are associated with one another, results in the loss of independence in their prediction of the outcome. When both covariates are included in the same regression model, each one becomes less statistically significant because they are explaining some of the same variance in the dependent variable (Enders, 2008). Initially, chi-square analysis was conducted to identify characteristics of IAs that closed compared to those that remained. Then, on the basis of a set of pre-defined criteria (below) variables were incorporated into a multivariable model is to explain the differences in the outcome, whether or not a child received ongoing service, by differences in the explanatory or so called independent variables, and to identify which variables best predicted the outcome (Shmueli, 2010).

The following criteria were applied to screen candidate variables for model development (Greenland *et al.*, 2016; Heinze *et al.*, 2018; Shmueli, 2010; Vittinghoff *et al.*, 2011 Ch. 5). Candidate variables

1. have an established basis in theory i.e. the have face validity
2. are likely to be collected by clinicians
3. have valid measures i.e. have construct validity
4. are not alternative measures of either the outcome or the explanatory variables
5. do not operate as confounders of the association between IV and the outcome

[49] In practice an IA may be instigated on a case already open. At the conclusion of the IA, for business documentation purposes, that IA is integrated into the documentation of the open case. The action recorded on the IA is closed/NFA whether or not the case remains open for ongoing service. For this study any IA with the designation closed/NFA was checked to determine the actual status of the case as closed with no ongoing service or open and in receipt of a particular ongoing service.

[50] As outlined at QH15 on the Initial Assessment Record, these include emergency action, convening an inter-professional strategy meeting, notifying AGS, referral to another agency and providing information and advice (QH15). Also, at the conclusion of an IA, an assessment is categorised as one of four primary types of abuse or welfare or none (see IAR, QH12, Appendix 3). For abuse cases, if the risk status is the presence of 'ongoing significant harm' the IA automatically progresses to Child Protection (QH13). These variables are not examined as explanatory or outcome variables.

6. have (some) statistical power within the sample i.e. there are at least 5 exposures (cases) associated with the outcome of interest (Vittinghoff *et al.*, 2011 Ch.5), and
7. in univariable statistical analysis the cutoff point for association to the decision to provide ongoing services the α level was set in advance, at a $p \leq 0.10$. In the multivariable model this α level was set in advance at $p \leq 0.05$. Establishing the α level is a feature of the study design rather than an effort to dichotomize the continuous measure of p produced by the statistical tests (Greenland *et al.*, 2016).

These are considered liberal criteria that reduce the probability of wrongly rejecting variables of potential clinical importance and potential latent variables, as well as addressing the uncertainty about whether independent variables are mutually important to the outcome across all cases (Vittinghoff *et al.*, 2011 Ch.5). A rule of thumb suggests that having more than ten events per predictor variable might signal potential problems in developing a stable model (Vittinghoff *et al.*, 2011 Ch 5).

4.9.4. Statistical analysis

Initially descriptive bivariate analysis was conducted to explore the characteristics of IAs that remained open for ongoing services compared to those that closed. Univariable analysis was conducted to determine the relationship between the outcome variable and each relevant independent variable.

Measures of association estimate of the relative strength of the association between exposures or independent variables e.g. child developmental concerns, and an outcome, the decision whether or not to provide ongoing service (Boslaugh, 2008). Poisson regression is used for analysing data with count dependent variables and is efficient where the probability of an event is relatively low (Osborne, 2017, Chapter 11). Poisson regression does not assume a linear relationship between the independent and dependent variables (Coxe *et al.*, 2009) such as when children experience events at different rates such as in studies of children in care (e.g. O'Leary *et al.*, 2015b). When applied to binomial dependent data, essentially reducing the count to 0 or 1, Poisson overestimates the relative risk (RR) and produces confidence intervals that are too wide (Zou, 2004). Modified Poisson regression with robust variance provides the modification is required to correct the estimates of data from cross-sectional studies (Barros and Hirakata, 2003; Coutinho *et al.*, 2008; Zou, 2004). The Incident Rate Ratio (*irr*) was specified to generate the measure of association in the analysis to estimate the incidence rate of ongoing service among IAs with a risk exposure compared to those unexposed. The coefficients have an additive effect in the log(y) scale and the IRR have a multiplicative effect in the y scale (UCLA: Statistical Consulting Group).

Firstly, a null model was fitted as benchmark then a single global multivariable model was fitted, containing all accepted candidate variables. On the basis of backward elimination, variables with the most insignificant association were removed until only significant variables with a p value ≤0.05 were retained or variables with a higher p value that had clinical importance were retained (Heinze *et al.*, 2018).

4.9.5. Model evaluation

In addition to the measures used for variable evaluation prior to model development, the final model was evaluated for potential collinearity among predictor variables. Changes in a *p* values for a given independent variable when another covariate is added (i.e. increased or reduced significance) indicates possible collinearity in a regression model. The *p* values for independent variables in the multivariable model were compared to those in univariable analysis. The potential association between characteristics in terms of timing and causal chains was also considered. The interpretation of the results and the final discussion examined the potential role of the IVs and, more broadly, their role in signalling what type of interventions might be indicated and where they should be focussed.

Overdispersion in regression models occurs when the observed variability exceeds the expected variability and can lead to overestimation of significance tests and, the converse is true for underdispersion (Coxe *et al.*, 2009; Crowson, 2019; Osborne, 2017). Having fitted the multivariable Poisson model, departures from equidispersion were assessed by computing the ratio of the deviance to its degrees of freedom and/or a ratio of the Pearson chi-square to its degrees of freedom (Osborne, 2017). A quotient greater than one indicates overdispersion and a quotient under one signifies underdispersion. These were obtained in Stata (StataCorp., 2015) by running goodness-of-fit tests directly using *estat gof* for the estimation sample (Crowson, 2019).

Children undergoing assessments are nested within Social Work Departments. Because estimates of variation are influenced by the distribution of the study population and study design (e.g. sample size) (Cummings and Rivara, 2003) it was necessary to examine potential clustering by SWDs. Once the final model was generated a mixed effect model was fitted, to incorporate fixed or random effects, for cases nested within SWDs. In Stata (StataCorp., 2015) *mepoisson* fits mixed-effects models for count responses. The conditional distribution of the response given the random effects is assumed to be Poisson.

4.9.6. Performance of the model

The provision of ongoing service is a binary variable. Misclassification can be quantified by calculating the proportion of individuals incorrectly classified as either having the outcome or not. These false-positives, or conversely, false-negatives, are a standard measure of diagnostic 'accuracy' in decision performance relative to a decision threshold measured in logistic regression analysis (Vittinghoff *et al.*, 2011 Ch 6). The receiver operating characteristic curve (ROC curve) is a prominent tool for characterizing the accuracy of a continuous diagnostic test. It incorporates the concepts of the "sensitivity" and "specificity" of a diagnostic test to plot the function of the model: sensitivity measures the probability that those IAs identified by the model as needing ongoing service, are indeed those that require ongoing service to address welfare needs or prevent further harm. The specificity is the probability that the model predicts closure for those IAs when children do not have welfare needs and are not at risk of further harm. Post estimation, a logistic regression was run to plot a ROC.

The ROC curve displays the capacity of the model to discriminate between two groups. It plots the sensitivity or true positive rate (those IAs correctly screened in) on the y-axis versus, 1-specificity or false positive rate (those IAs that did not and were correctly screened out) on the x-axis. The diagonal line in the ROC curve represents chance indicating the model is not useful in screening because the true-positive rate is the same as the false-positive rate for a particular cut-off point. The area under the curve (AUC, range: 0, 1) is the measure of how well a model distinguishes between positive and negative outcomes. A good diagnostic or screening model has high sensitivity and high specificity, and the ROC curve lies well above the diagonal line hugging the top left corner of the plot (Hulley *et al.*, 2013; Vittinghoff *et al.*, 2011). The higher the AUC, the better the model is at correctly classifying outcomes.

ROC curves can be used in CPW research on assessment and decision-making for three reasons:

1. to help determine cut off point which optimises sensitivity and specificity for a given test i.e.to set the parameters for an assessment tool
2. to test the overall accuracy for a given assessment model
3. to compare the diagnostic ability of two or more assessment models when used on the same sample

Here, the ROC is used for reasons 1 and 2.

4.9.7. Comparing the Irish consensus-based model for ongoing service with the CA SDM© FRA

The CA SDM© FRA tool is an evidence-based and validated system that assists case workers in assessing the likelihood of future maltreatment to decide whether or not investigations require to be promoted for ongoing service (Dankert and Johnson, 2013; Johnson, 2004; Johnson *et al.*, 2015).[51] The tool (see Appendix 5) contains 16 questions each scored as 0 or 1, that are derived from research on cases with substantiated abuse or neglect, which examined the relationships between family characteristics and the outcomes of subsequent substantiated abuse and neglect. It identifies families at low, moderate, high, and very high risk of subsequent substantiated maltreatment on the basis of the assessment of alleged abuse or neglect, on which basis they are recommended for closure or opening for ongoing services. The policy allows case workers two types of overrides, one on the basis of policy and one discretionary, when the scored risk level determined by the risk assessment is too low.

Due to differences in practice, the tool was modified to reflect the Irish assessment context (see Appendix 6). In the FRA, cases are classified as either Neglect or Abuse with the latter incorporating physical, sexual, and emotional abuse. The approach employed for this sample scored Welfare cases in

[51] The tool is owned under copyright by NCCD. Permission to use the CA SDM© FRA tools for this research project was granted by the Office of the Associate Director of Research and Analysis NCCD, Madison WI, November 2017. It cannot be reproduced.

the sample as Neglect cases in the SDM. The FRA scored either prior abuse or prior welfare cases. Other administrative changes included scoring prior IAs or prior intakes. The scoring system did not match the sample data exactly. Discretionary overrides were not used as the aim was to score the evidence documented by SWs in the IAs rather than evaluate the evidence directly. Otherwise, scoring was in accordance with the guidelines for the tool that was provided for this research (NCCD, 2017).

An Excel spreadsheet was created using the variables from the modified tool. Using the primary case records, the CA SDM© FRA Tool was completed for IAs to determine the risk level and whether or not to promote the IA.

Two variables, the risk score and the decision whether or not to promote the IA were added to the Stata (StataCorp., 2015) data set for analysis. Univariable regression analysis was used to estimate the strength of the association between the decision to provide ongoing service and the decision whether or not to promote the case. On the basis of univariable Poisson regression, the likelihood of ongoing service based on the prediction decision obtained from the modified CA SDM© FRA tool was estimated. The ROC curve was calculated to compare the model with that generated from the IA consensus model.

4.9.8. Alternative approaches

Logistic regression is widely-used modelling approach for studying associations between exposures and binary outcomes and has been applied in research on various decision outcomes in child protection, including the provision of ongoing service (Dettlaff *et al.*, 2011; Filippelli *et al.*, 2017b; Jud *et al.*, 2012; Lwin *et al.*, 2018b; Stoddart *et al.*, 2018). Such studies produce estimated odds ratios (OR) for the effect of covariates for one group relative to a reference group. For rare events (when the incidence of outcomes is < 10%), the OR estimated from logistic regression approximates the RR (Greenland, 1987; Zhang and Kai, 1998). The approach is absolutely appropriate but, when the outcome is common, as may be the case in cross-sectional studies and is the case in the current study (children receiving ongoing service=38.5%, n=185), OR always overestimate RR (also called prevalence ratios in some literature) and OR are often interpreted as the RR. Conversion of OR to RR will provide invalid Confidence Intervals and produce inconsistent estimates for RR which may lead to misinterpretation of study results by readers (Altman *et al.*, 1998; Barros and Hirakata, 2003; Coutinho *et al.*, 2008; Cummings and Rivara, 2003; Greenland, 1987; Zou, 2004). Although methods are described for adjusting OR to give a RR in studies of common outcomes they can be complex, so methods that directly estimate RR are preferable (Barros and Hirakata, 2003; Greenland, 1987; 2004; Nurminen, 1995; Zhang and Kai, 1998; Zou, 2004). For these reasons, Poisson regression analysis directly estimating RRs was selected.

The multivariable approach was selected as opposed to forward multilevel approaches used in similar research studies (Filippelli *et al.*, 2017b; Jud *et al.*, 2012; Lwin *et al.*, 2018b), because the data lacked sufficient evidence on cases across the different levels in the ecology and using multilevel modelling would have required drawing assumptions about a potential hierarchy among them.

4.10. Ethics

4.10.1. Ethical Approval

Ethical approval was sought and granted by Tusla in 2016 when the study began and again retrospectively, subsequent to policy changes, in 2017 under the auspices of the then established Research Ethics Group (REG). Ethical approval was also granted from the Social Research Ethics Committee (SREC) in University College, Cork. Minor changes to the study design were notified to and approved by the REG and SREC.

4.10.2. With the best will in the world! 'Snakes and ladders' with gatekeepers

Gaining access to personal data in any clinical setting can be problematic (Crowhurst and Kennedy-Macfoy, 2013; Green *et al.*, 2015). This study was no different! 'Snakes and ladders' is borrowed from Eldridge (2013) to describe the unpredictable ways in which gatekeepers can influence the research process (Eldridge, 2013).

Research in Tusla is facilitated by the principal legislation governing CPW practice in Ireland, the Child Care Act, 1991, which states that Tusla "may conduct or assist other persons in conducting research into any matter connected with the functions assigned to the board under this Act" (Department of Health, 1991 Part II, s.11, 2). As described in Chapter 1, Tusla was established in 2014 and at the time this research was being conducted, the organisational structure, service delivery framework, and every aspect of policy and practice were being overhauled. Of particular relevance were emerging Information and Communications Technology (ICT) and research policies.

As a researcher employed by Tusla (formerly the HSE and SHB) since 2000, engaging SW managers to participate in the research was a relatively easy process. Throughout the data collection process SW managers and teams were engaged as participants in interviews and facilitators of access to case files.

Tusla requires employees to ensure personal data is processed in accordance with the Data Protection and Privacy Policy (Tusla, 2021d). Staff are responsible for securing data and files related to their practice. Staff are prohibited from unauthorised access to personal data and are required to take all steps to prevent unauthorised disclosures.

In 2016, the General Data Protection Regulation (GDPR) was introduced in across Europe (EP and CEU, 2016). The requirement to comply with GDPR heightened concerns within Tusla at a national level about data protection and regulation. I was required to engage in a Data Privacy Impact Assessment (DPIA) for the project and to develop a detailed data management strategy. This delayed the project by 15 months which could not have been anticipated in advance of the research (Sandelowski, 2002; Swain and Spire, 2020). The DPIA confirmed that my data management strategy complied with the Child Care Act, (1991) and with GDPR (EP and CEU, 2016).

4.10.3. Data anonymization

A number of data anonymization and transformation techniques were used to render individuals indistinguishable and unidentifiable. Individual child records were assigned a number commencing 0001, and not related to any numbering system used by individual SWDs. Parents and carers and SWs were assigned a numeric code in a similar way, according to the order in which they presented in the records. Siblings' files are not systematically ordered within SWDs and nor were they systematically sequentially numbered for this research. Families were identified using demographic and address details. For anonymization purposes, DOB and age were aggregated to age-groups.

Addresses, another potential identifier, were coded to Eircodes (zipcodes) for use in mapping population census data for demographic analysis. These Eircodes were mapped to Small Area geography, as mentioned above. Addresses and Eircodes are not published in the data set.

SWDs were assigned codes SWD1 to SWD7 corresponding with 1 allocated to the SWD associated with the first child file coded. Even if SWDs are identified, the numbering system used mean that any individual in the study could not be distinguished from any other member in the study group. In the case-study an individual Social Worker might identify their comments, but it is unlikely that another reader could attribute comments to individuals.

All source data as well as anonymised data sets were maintained by this researcher, as data controller, throughout the duration of this study.

4.10.4. My role in the research process

Goodwin and Goodwin (1996) say that because a researcher is the one intimately involved in the data collection and analysis, he/she operates as the 'prime filter and interpreter' (p. 111; cited in Peel, 2020). In social research, it is important explicitly identify reflexively features of a personal background, culture, and experiences hold potential to influence and bias information and outcomes (Creswell, 2017). As detailed in Chapter 1, by the time I conducted this research I had worked in this organisation, in its various iterations, as a researcher for almost 20 years. My experience working with SWs collaboratively in various working groups, in auditing practice in SW departments, and in conducting prior research provided me with insights into the practice environment that were instructive and helpful throughout the course of the project. Not being a professional SW I believe afforded me a lens of enquiry through which some possibly taken for granted processes and practices had to be made explicit. But I was also aware of the necessity to clarify any assumptions or biases I may have brought to the project. Throughout all phases of the research project, I availed of opportunities to reflect and discuss any evolving assumptions with my supervisors.

4.10.5. Addressing methodological limitations

Main methodological limitations related to the design of the studies, sampling methods, definitional issues and resulting matters relating to the validity and reliability of variables for descriptive and analytic purposes. These concerns are identified below within the methods sections for each study. The study designs are defended, and the steps taken to reduce biases, i.e., potential systematic errors, that may have arisen as a consequence, are described.

Case-study research has been criticized for its lack of generalizability and the subjective application nature (Flyvbjerg, 2011; Thomas, 2011). The limitations are robustly refuted by Flyvbjerg (2006) who argues that the case-study may be central to scientific development. He suggests that a case-study is ideally suited to generalisation on the basis of 'falsification' – the idea that one observation which does not fit with a proposition stimulates theory building (Flyvbjerg, 2006; 2011). I believe the framework I adopted, and the data sources used enabled me to conduct a valid examination of SW practice and rationales for their decisions and provided the necessary scope to address the first two research questions. For example, themes that emerged from case file analysis did leverage insights, but it was only in reviewing these along with the data from participants interviews and in the context of the agency discourse, that a robust proposition emerged of reasoning and decision-making during IA.

Claims about practice are set within the context for practice at the time the study was conducted in Tusla in 2015/2016. However, drawing on the extensive literature review conducted to support the research, the scope of the research and analytic approach ensured a rigorous approach that supported a theory building approach (Flyvbjerg, 2006) and allowed me to comment more broadly, as I do in the final chapter of this thesis, on the causes behind patterns we see in relation to judgments and decisions in IAs and their consequences.

Cross-sectional studies are influenced by *antecedent consequent bias* which occurs when it cannot be determined whether exposure preceded the effects seen in IAs (Alexander *et al.*, 2015). No claims are made about causal trajectory, but drawing on the ecological theory, enabled me to consider causal mechanisms that may be at play in the patterns identified in the analysis. The limitations of the data source were discussed above. In keeping with other cross-sectional studies in CPW (CIS, 1998, 2003, 2008; Roy, 2021), data recorded in case files were not individually verified. However, the methods did enable me to achieve the goal of describing the situated context based assessment and decision-making practice during IA for children and families involved with Tusla, and to advance the knowledge base considerably.

4.11. Conclusion

In this chapter I outlined the methodological basis for two studies conducted to examine decision-making in IAs in CPW Social Work Departments in the southern region of Tusla during 2015 and 2016. A case-study and a cross-sectional study were designed. I justified the study design and the choice of

data sources, and I detailed the steps taken to ensure the research was conducted in an ethical way in accordance with the principles laid down by Tusla and the Social Research Ethics Committee in UCC.

The research design was informed by a comprehensive review of the literature that established significant gaps in the evidence base about children and families undergoing IA and a lack of transparency about the basis for service provision. The two empirical studies were designed to address that imperative.

The study presented some practical and ethical challenges. These were approached from a perspective that valued the importance of using primary data, situated in the organisation, as a means to develop practice-based evidence.

In Chapter 5 the results of the case study are presented and discussed. In Chapter 6 the descriptive results of the cross-sectional study are presented and discussed and in Chapter 7 the results of the analytic study are presented and discussed. In Chapter 8, I review the methodology and the findings and discuss the implications for policy practice and future research.

Chapter 5 Explaining judgments and decisions: a case study of initial assessments in Tusla in 2015

5.1. Abstract

Background: Initial Assessments require many interpretive acts to identify what is pertinent to judgments about risk and decisions about service provision. Little is known about the interaction of these interpretations and resulting decisions in the current organisation and policy context.

Methods: A case study was designed to examine Initial Assessment practice and decision making in Tusla in 2015/2016. Evidence from case file records and informal interviews with social workers was thematically analysed to explore the context for practice and explore mechanisms for judgments and decisions about service provision.

Results: Initial Assessments were described as a goal-oriented interventions that operated to help clients address concerns, sometimes over protracted periods of time, and as a means to decide whether or not services were needed. Social Workers said the assessment framework was helpful, but recommended changes to better highlight or weight risk factors and support transparent decision making. They reported that published statistics do not reflect practice.

The harm/evidence model was evident in decision strategies (Drake 1996) and policy criteria were used for opening and closing cases. Some problematic heuristic strategies included the nature and volume of cases which led to ranking risks, social workers' perception of their professional role in relation to parents and other professionals, lack of expertise responding to children exposed to domestic violence and the idea of a closed system of surveillance. Parent's cooperation or non-cooperation provided a strong framing effect for explaining judgments and decisions and gendered and blaming narratives were employed to hold mothers accountable for risk reduction in areas over which they have little or no control. Thresholds for intervention varied from day to day and case to case. Social workers expressed professional anxiety and regret that their strategies were frequently based on thresholds shifts that were not compatible with their judgments about protecting children and supporting families.

Conclusions: This case study provides insights into child protection and welfare social work practice in Ireland since the establishment of Tusla. Although social workers assessment practice is focused on resolving concerns, protecting children, and supporting parents, the system prioritises case load management over risk management in individual cases. This negatively impacts the children and families involved but also impacts social work moral and has implications for the wider system. The evidence provides insights into practice and patterns of response and can be used to used develop supports for social work practice, training policies and ultimately, improve advocacy outcomes for clients. The methodology for the research is appraised and findings are discussed in Chapter 8.

5.2. Research questions

The case-study was designed to address two research questions *How do SWs use Initial Assessments?* and *How do SWs explain their judgments and decisions in Initial Assessments?* The methods used (described in Chapter 4) aimed to facilitate exploration and analysis of how SWs use IAs and come to judgments and decisions about service needs and service provision in the context of the legislative and policy framework in Tusla in 2015/2016 (Benbenishty, 1992; Flyvbjerg, 2006; 2011; Yin, 1981).

5.3. Results

Just as there is no one way to design a case-study there is no single way to analyse the findings or report the findings (Baxter and Jack, 2008; Flyvbjerg, 2011). In the approach taken here I present the findings regarding the purpose of the IA, rationales for providing service and rationales for closing cases, the discussion follows the same arrangement. The findings are 'summarised' and discussed the context of the literature and the existing framework for practice and its aims. The implications for policy, practice and research are addressed in the final chapter.

5.3.1. Profile of cases

The file sample comprised 45 Initial Assessments regarding children aged 0-17 years, 52% who were female, and one unborn child. A majority related to child abuse concerns (71%, n=32) and a majority remained open for ongoing service (78%, n=35). See Table 1. Age at the date the assessment concluded, was calculated using date of birth. One in five were infants and children aged 0-4 years (n=9, 20.5%) and half were in the 5-12-year-old age group (n=22, 50%), and the remainder were teenagers (n=29, 5%). See Table 2.

Two thirds of the IAs related to children who were previously open to CPW (64%, n=29). IA's were held open for longer than the 21 days national guidelines recommended (Tusla, 2014a) some up to 112 days.

Table 1 Case categorisation and decisions for action

Case Category at the end of IA	n	%	% categorised concerns
Welfare	13	29	30
Emotional abuse	12	27	28
Neglect	10	22	23
Physical	5	11	12
Sexual	3	7	7
none	2	4	-
	45	100	
Decisions at conclusion of Initial Assessment			
Decision	**n**	**%**	
Child protection	4	9	
Child Welfare Family Support Planning	6	13	
Further Assessment	17	38	
Admission to Care	3	7	
Open Awaiting Allocation	5	11	
No Further Action	10	22	
	45	100	

Table 2 Child age and outcome decision

Age group	Initial Assessments (n =44)	%	Open for ongoir (n=35)	% open within age group
1 to 4	9	20.5	6	66.7
5 to 12	22	50.0	18	81.8
13 to 17	13	29.5	11	84.6

Children's circumstances were complex. SWs accounts revealed historic and current child difficulties, harm and abuse, parental problems of drug and alcohol misuse, domestic violence, mental health, and health problems. In several assessments, parents had been involved with child protection services as children themselves and this was described in relation to either their parenting capacity or to children currently perceived to be at risk from grandparents or family members outside the immediate family. Several accounts detailed neglect and repeated disruption in children's lives due to inconsistent parenting arising from the intersection of these problems but otherwise, explicit accounts of abuse did not feature. Solutions and decisions whether or not to provide services were primarily related to parental awareness of the impact on their children of these risks and whether or not these problems had been resolved.

5.3.2. Purpose of Initial Assessment

In case records and in interview, SWs characterised the IA as an intervention where the aim was to develop solutions and risk management strategies at the level closest to the family. In discussion SWs

described IAs as an assessment *and* a way of working a case, and that the SW felt it was highly important to understand (SW10). Others described it as an opportunity to 'work with families' (SW8).

SWs explained that an IA was used differently in terms of the career of a case. One team explained that an IA on a long-term case would focus entirely on assessing the event causing the risk and aim to 'meet the needs of a critical issue on the day' (SWT2). Others said they may be used as a way 'to provide continuity for children coming into care prior to transferring to the child in care team' (SW5).

In relation to decisions, one SW manager referenced the necessity to document sufficient information in IA records to 'deem an action appropriate' (SW8). Another said the records 'don't capture what we do' (SW912). One team in particular (SWT1), spoke about challenges in addressing allegations of abuse generally. The Principal Social Worker (PSW) said in the 'IA the assessment of needs does not go back to the event to establish whether it happened or not' rather, the event may have happened and based on the evidence to hand SWs have to use their professional judgment to demonstrate if there are unmet needs that might indicate risk (SW10).

Findings indicated that practice varied across SWD's but, the analysis also identified certain common approaches and concerns relating to judgments in IA.

5.3.3. Thresholds for commencing Initial Assessments and for ongoing service

In interview SWs primarily spoke about organisational policies, administrative burdens and time constraints and lack of information that mediated their judgments and decisions. They discussed tensions between what they believed were administrative demands as constructed by the Standard Business Processes (SBPs), their professional interests and local case management practices. Each SW referred to the impact of the new policies on practice and to the tensions experienced in practice trying to balance demand for service, the legislative and policy context and professional values in providing support families and protecting children.

Some SW's found the *Threshold Guidance and Assessment Framework* (Tusla, 2014a; c) useful for framing judgments and decisions. For example, one PSW said,

> *Cases on IA tend to be Level 3. Some are Level 4 but most Level 4 cases are those which require emergency response (SW8).*

Some saw the Intake as an opportunity to work with professionals to 'determine what is going on' (SW5, SW6, SW8). Some teams invested more than others in Intake and often met with and worked with families, whereas other teams suggested, in line with policy, that meeting with the family was a threshold to move to IA (SWT2, SW6, SW8). One PSW said the team has been

> *criticized by the national office for doing too much during Intake – the national office says that much of what happens on intake could form part of the IA. This might explain the small numbers on IA … but unless a child has been visited and seen the case is not on IA. Background checks and calls do not constitute an IA (SW8).*

SWs reported that thresholds for commencing IAs and deciding on ongoing service varied from case to case (*SWT2, SW1*) and week to week depending on the caseload and complexity of cases that were concurrently open (*SW1, SWT2, SW9*). One SW said, 'if the preventive stuff was working the threshold would be higher' (SW1). A Team Leader spoke about weekly allocation meetings at which completed IAs were either allocated for ongoing service or closed off. She said the threshold for the decision to provide ongoing service

> *depends on what's open on a day or the rate of referrals on a given day (SWT1).*

5.3.4. Uncertainty about professional knowledge base and decision-making

The requirement to categorise concerns as welfare or abuse was problematic and had negative consequences on subsequent decisions. Some SWs were concerned about the responsibility conveyed in the IA to assess any allegation of abuse made against a parent (SWT1, SW10). This appeared to narrow the focus of the IA from a broad assessment of children's needs across three domains in the IA to a narrow, forensic type investigation and reduce opportunities to work collaboratively with parents. But, the PSW said 'we owe it to people, when they are accused of abuse to make a judgment about that' (SW10).

In relation to gathering evidence to assessing needs and risk in IA involving DV a PSW suggested there should be 'a box to identify risk factors' of DV (SW10) because SWs are 'doing things that are not explicit … [in] the background… [maybe these] need to be brought forward so other people can understand it more' (SW10).

The following excerpt from a discussion about thresholds for decision-making with a Team Leader demonstrates the effect of uncertainty about professional expertise regarding effects of domestic violence and the interaction of workload on practice on decisions to categorise and close a case.

> *In cases of DV … what is enough [evidence to decide] the threshold between welfare and protection? SWs don't have the time to look into previous reports to count up all the events… [When you] put all the events together and look at them and there's alcohol and drug [misuse] … welfare is ticked far more often than it should be. The statistics [for case categorisation] don't reflect the reality of practice (SW2).*

SW2 also spoke about the anxiety associated with reluctantly closing some cases because of more immediate risks to other children on the caseload and shifting the risk management to the family. She said she routinely worried when returning to work on a Monday following an allocation meeting the

previous week[52] that a crisis would have occurred in a closed case over the weekend leading to the child turning up as an emergency (SW2).

5.4. Rationales for closing cases

Social workers used a number of rationales for closing cases/No Further Action (NFA) drawing on primary observed and/or secondary evidence of harm/abuse sometimes in conjunction with views about the role of statutory CPW services.

5.4.1. Harm and evidence of harm and mitigating factors

Assessments were closed/NFA on the basis that concerns were unfounded, or that they were resolved by parents themselves or together with the support of SW or external services. For example, several records identified parental difficulties including drug and alcohol misuse, DV and acrimonious separations (Cases 9, 44) exposures that could impact on child development needs and may put a child at risk of abuse but, recorded a decision to close/NFA because there was insufficient evidence to keep it open (Case 6), there were no concerns that merited CPW involvement (Case 42, 46) or due to work with other agencies, there was no role for CPW (Case 7, 44).

For example, in an IA that was closed/NFA the SW noted a history of a 'volatile and abusive relationship' and that the mum had issues with the father's behaviour but was not concerned for the children's safety with him (Case 44).

In some cases, explanations show that parental responses or choices were used as rationales for the NFA decisions. Several records referenced both parents in terms of their responses (Case 2, 11, 17, 33, 37) although, mothers' accountability was mentioned more frequently (e.g., Case 1, 2, 11, 15, 30, 31, 44). In one IA, although some aspects of the presenting problems were resolved, the SW had outstanding concerns about a mother's parenting capacity but noted her decision not to accept help. The SW notes the option for her to re-refer to CPW service. This case reflects how involvement with some families is protracted even in the context of an IA which should complete in 21 days. The record states:

> *Dad responded positively to the intervention addressing drinking. He was discharged from addiction counselling… access is re-established. Mum is no longer concerned, she can contact department if so (Case 4).*

[52] Allocation meetings are where SWs and TLs decide which IAs are allocated to a SW or another team for ongoing service.

5.4.2. Limitation of SWs role and delegation of risk management and professional knowledge

The records described situations where a SW had identified concerns about the future safety outcomes for children and families, but due to the involvement of other agencies chose to close the IA. SWs used primary observed and secondary corroborating evidence to support their conclusions and decisions. One such case re-referred to CPW by An Garda Siochána, involved a 14-year-old girl whose reported behaviour which included drug misuse and hitching lifts, was perceived to put her at risk of harm. The SW notes the 'parents prioritise business over daughter' but, 'in light of ongoing work with probation … [SW took] the decision to close the file to SW' (Case 7).

An assessment, referred by the child's preschool due to the young child's reference to sexual activity by the father, concerned a family with a history of involvement with CPW due to a 'volatile' parental relationship, domestic violence that necessitated a barring order against the father, alcohol misuse by both parents and maternal depression that led her to attempt suicide. The record noted the child was exposed to violence, disruption and effects of substance misuse. The SW closed the case on evidence that parents had separated and 'were coping' while awaiting mediation. The record notes that access was established, and the father was attending aftercare following addiction treatment. The SW referred the mother to mental health services and the child to play therapy to address issues relating to the separation (Case 44).

But in several cases, the records indicate uncertainty about the decisions taken. In a welfare assessment involving a report made to AGS regarding a mother who was locking her children out of the home and subjecting them to a 'tirade of [verbal] abuse', the SW noted 'mum denies the allegation' as [the mother] believes the neighbour 'refers everyone' (Case 41, 42). The record read 'the state of the accommodation was not great' but that there was 'a lot of love and time spent on her children'. It noted 'the GP and PHN do not have concerns' and the SW concluded that ongoing service was not warranted. While acknowledging the vexatious nature of the referral, the SW appears to be less sure of the stability of the solutions in place. The SW noted

> *It is open to mum to contact the PHN for advice. Information on family support was sent to mum; mum said she does not wish to pursue either (Cases 41, 42).*

Another closed assessment that resulted in the mother being referred to parenting support, involved a two-year-old and a mother parenting alone who was 'emotionally immature' and lacking parenting skills (Case 47). The SW suspected neglect on reported evidence the mother had been 'hitting the child' and observed evidence of delayed speech development, but concluded the child was not at risk. The record notes the grandmother was supportive, but she and the mother have a tenuous relationship and that 'issues could arise if they have falling out again' (Case 47).

An assessment involving chronic DV where a Barring Order had been issued by the Courts in respect of the father was closed/NFA and the mother was involved with a family support agency. The SW notes

there would be concerns 'if he were to return' and that family support could refer the case again if he did (Case 9). Overall, in seven of the ten IAs closed/NFA (Case 2, 4, 7, 9, 11, 41, 42), the SW noted that a mother or another professional could re-refer to CPW if the concerns re-emerged or there was a risk of child abuse.

As discussed above in Section 5.3.4., SWs had considerable uncertainty about the level of evidence required to make judgments about risk and decisions about service needs in cases involving DV. That particular explanation also revealed a tendency to overlook historic evidence in favour of a rule of thumb to downgrade concerns from abuse to welfare.

5.5. Rationales for decisions to provide ongoing service

Explanations of decisions to provide ongoing service in 35 IAs records detailed evidence of service needs regarding child development, previous and current abuse and neglect and ongoing exposure to risk factors for abuse in conjunction with evidence of parental non-compliance or engagement with plans to prevent abuse and address welfare and development deficits. It appeared that parents' response to identified concerns operated as warrants to keep cases open.

5.5.1. Harm and evidence of harm

In keeping with the premise that the IA served as an intervention, several files detailed attempts to address factors linked to child developmental problems or which led to child abuse or neglect. Some of these detailed parents' acknowledgment of the effects on their children and detail positive engagement with SW, although further services were required (Cases 1, 3, 11, 15, 26). One record concerned a young mother who had been a victim of sexual abuse in childhood and was exposed to chronic DV that was perceived to place her unborn child at risk (Case 1). The decision to provide ongoing service was described in terms of the mother's needs and her interest in protecting her child.

5.5.2. Parental incapacity

Another two IAs that concluded in admitting children into care, involved siblings whose mother who was caring for them alone and who was unable to care for herself or her children due to excessive alcohol misuse and who herself had been admitted to a care facility in childhood (Cases 20, 21). The record notes that the estranged father, who was living abroad agreed to the SW seeking a care order on behalf of the children.

Other explanations focussed on parents' incapacity to manage their children's needs. An IA regarding allegations of emotional abuse, involved a 14-year-old girl with significant behavioural problems, non-attendance at school and drug misuse who had perpetrated 7 incidences against her mother (Case 35). This child and family were involved with multiple services including Child and Adolescent Mental Health Services, which had concerns about the mother's capacity address and manage the child's needs.

The record notes ‘mum will not call Gardaí if [child] is violent towards her’ and ‘is refusing respite care for [daughter]’. The case was held open due to the child’s emotional, behavioural, and educational and social needs not being met.

One case specifically referred to parental learning difficulties. It concerned a 3-year-old child who was grossly overweight referred by a Public Health Nurse and who had previous involvement CPW that had been disrupted due to a relocation. The record noted the mother has ‘limited comprehension ability’ and stated,

> *parents are unable acknowledge the issue or follow through with dietician. … There has been frequent social work contact … family is not participating in [SW] assessment… recommending to transfer to family support (Case 5).*

5.5.3. Parent accountability

Several records cite the parent’s inability to recognise needs or risks and their opposition to- or inability to engage with plans to minimise risks. For example, in sibling records the SW notes ‘mum does not see need further assessment’ (Cases 2 and 3). A case that had three prior IAs due to physical and emotional neglect involved a 9-year-old child who was pricked by a syringe used for injecting drugs by someone in the household (Case 33). The child had mild learning difficulties and poor language skills. The family had a history of poor engagement with CPW and other support services. The current record evidenced physical neglect as ‘inadequate hygiene, lack of appropriate clothing’, housing instability and homelessness, and educational neglect through nonattendance at school and Speech and Language Therapy. The SW decided to ‘transfer to [the child protection team] for further assessment to ensure needs met in an appropriate manner’ (Case 33).

In other IAs where parents were identified as not engaging with CPW plans, SW’s attribute the abuse or risk of abuse to their parents’ failure to act protectively. For example, an IA of a 4-year-old child hospitalised having taken mums medications states mum had ‘not taken steps to ensure meds were out of reach’ (Case 28). One IA involved a 14-year-old boy who was the subject of allegations of sexual abuse by a 20-year-old male and whose behaviour at home was violent towards his siblings. The boy had dropped out of school. The record notes the parents ‘perceive [the child] as a problem’ and were ‘not taking responsibility’ or addressing ‘his challenging behaviour’. It notes the parents did not believe the allegation of sexual abuse and did not wish to care for their child. It concluded it is in this child’s interests to be in care (Case 34).

In assessments involving DV and abuse that remained open (n= 17, Cases 1, 2, 9, 11, 13, 14, 15 17, 19, 22, 23, 24, 26, 33, 35, 37, 38), SWs accounts reveal sometimes protracted and unsuccessful efforts to work with parents to reduce the negative impact of the exposure to DV on the children or to address other difficulties the family was experiencing. In several accounts parents were held accountable for these failures and many judgments and decisions were explained in blaming and sometimes, gendered

discourses. For example, an IA involving a repeat referral of a child and on-going concern about 'physical altercations in the home' the SW notes 'mum is minimising in her response' (Case 10). Another IA arising from 'on-going reports of domestic violence' the child's mother was described as 'putting her children at risk' (Case 11). The SW referenced having met with the parents on several occasions to provide support and noted the parents acknowledged their difficulties and suggested things between them had improved. But, the record notes,

> *The home is unstable due to children being exposed to arguments, physical and verbal abuse. [There is] clutter and rubbish in bedrooms …bathroom is a concern. … Mum is minimising the extent of the neglect – she says its due to work. … [Mum] meets basic care needs.*

> *Children talk to [grandmother] when [parents] are arguing … and [grandmother] calms dad down. [SW questions] the emotional availability when parents continue to argue (Case 11).*

The SW claimed there had been no progress and that the children 'continued to be impacted by the parents' behaviour' (Case 11).

In two IAs involving DV and emotional abuse, the SW record also attributes risk to parents' failure to acknowledge or act to prevent abuse, the record states:

> *Mum denies the level of drinking and dad denies violence. The children are experiencing emotional abuse perpetrated by the parents who are allowing the situation to continue … The parents want to separate. [SW recommends] further assessment and family counselling (Cases 13, 14).*

In a similar case that had recurrent IAs the SW identified risk of future abuse due to chronic neglect, ongoing exposure to DV, parental sexual abuse and mother's mental health issues and financial pressures (Case 15). The record reveals a mixture of empathetic and somewhat conflicting blaming accounts. For example, the SW stated that having been exposed to domestic violence and homelessness as a child the mother 'did not want that' for her children. The SW refers to the mother's psychiatrist reports which stated she has no emotional attachment to her children and that her 'passive avoidant behaviour' means the children 'severely emotionally neglected, medically neglected and educationally neglected'. The record notes,

> *[children's] basic needs not met. The home is totally unacceptable, dirty, unhygienic, disorganised, and chaotic. … [children eat mostly] frozen food, nutritious meals are rarely made…parents are not demonstrating and modelling appropriate behaviour and control of emotions' that they spend all day in bedroom and that any approach receives verbal abuse (Case 15).*

The SW referenced the absence of social connections as a risk factor.

> *The children are not provided any opportunity to develop secure attachments … the family is isolated and the children are not permitted to play outside … [but] the older children provide emotional warmth to the younger ones (Case 15).*

Although the parents appeared compliant and cooperative, the SW cites the parent's lack of insight into the impact of their behaviour on their children as a basis for a threat of potentially more coercive involvement, absent future improvements. It states,

> *parents complied with every consent and consented to every check but have poor insight into reasons for involvement … parents acknowledge need for parenting skills. They were advised unless there are significant changes then care orders would be sought in respect of the children (Case 15).*

An IA involving a mother who presented to a DV refuge with bruising on her face, neck, body with her 7-year-old son and his two siblings notes the 'children witness abuse endured by mother' (Case 38). The record notes one child's account that when the father was fighting the mother, 'she bit him and there was blood on her mouth' but 'she says it's blueberries'. Although the parents were separated, the mother 'lived in fear of' her husband. She was nervous of the referral to CPW because she was fearful of deportation should she be involved with state services. The SW notes 'mum acted protectively bringing children to refuge' and that both 'parents speak of children in loving way' but the children were fearful of their father who was 'reluctant to take responsibility' and was minimising the extent and level of violence. The record notes that the mother was isolated with no social supports. The father was enrolled in an anger management programme and that there would be 'risks if dad were to return to home prior to finishing programme, so access was arranged with [a family member]'. The case was transferred to CPW family support.

In a case where a child had been traumatised by witnessing a serious domestic assault coupled with physical abuse by both parents which 'impact on her emotional development', the record states that 'parents were unable to put child's needs before their own' (Case 26).

Another record cited DV perpetrated by both parents in addition to 'ongoing acrimony' and alcohol misuse by the mother. The family had been involved with CPW for almost a decade and there had been considerable disruption to the family life. The father had been 'physically and emotionally violent' to the mother and had previously left the family home but returned. The record notes recent episodes of violence by the mother to the father and towards the children that had necessitated involvement with AGS and a safety plan by CPW. Following this attack, the SW notes 'dad advised to act protectively' (Case 37).

5.5.4. Timeliness

One case referenced how the practice environment impacted on evidence collection in an IA of physical violence by a father against a child during an DV incident (Case 19). The record states there was a history of physical abuse and domestic violence and in this case a 'credible account of abuse' by the child. The record notes that a delay in response due to lack of resources meant the evidence was compromised as there were 'no bruises on [the child]' and consequently, that there was no need for GP exam. The SW notes that the mother does 'not condone the abuse' and 'has ability to protect' the child but that also she 'denies domestic violence'. The record notes that 'previously abuse stopped for a year after SW involvement' and the case remained open (Case 19).

5.6. Summary

The findings are summarised insofar as they are reducible, because they are incongruous and somewhat conflicting (Flyvbjerg, 2006). SWs described the IA as an assessment and an intervention aimed at developing solutions close to the family. In long term cases IAs focus on events that led to the concern. On the one hand, in the case records, there was coherence between judgments and decisions to provide ongoing service where evidence of harm or risk obviously correlated with guidelines for ongoing service. But reasoning too, was characterised by evidence parental non-engagement, lack of capacity, failure to modify behaviour in order to protect children or non-compliance with plans following efforts to resolve concerns. And there are findings that evidence on case files was overlooked because it was not easily accessible or interpreted in ways that defined problems narrowly using value based explanations of risk and service needs. Cases involving DV and substance misuse were variously assessed. In some situations, parents' histories and involvement with CPW and other services were integrated as causal factors into judgments of risk or child safety and decisions about service provision, and in other situations they were overlooked. In many cases that closed, resources in the community were drawn on in reasoning, where SWs believed there were concerns and risk of need or abuse might arise in the future.

In interviews, SWs referenced the impact of organisational policies on their assessment, judgments, and decision-making. Risk operated as a mechanism to allocate services and mange caseloads.

Analysis of the evidence from case files and interviews indicated social workers used several devices to explain judgments about risk and need, risk management strategies and the decision whether or not to provide services. These were harm and evidence of harm or risk used in conjunction with evidence of parent's engagement (observed and secondary), their accountability for and responses to the identified risks and needs or, plans and solutions put in place. These were used variously in conjunction with SWs interpretation of their professional role and remit and the role of parents and other professionals and their own professional expertise to respond to particular issues and resources available to facilitate assessment processes or enact a preferred decision.

That evidence indicates the use of inconsistent and variable rationales for decision-making. SWs identified professional uncertainty and lack of expertise relating to substantive areas of practice and discussed the burden of anxiety about assessment strategies and regret they carried about some decisions they felt required to adopt. These findings are discussed in the context of the existing policy framework in Tusla in 2015/2016.

5.7. Discussion

This case-study was designed to explore the process of assessment and decision-making by SW's conducting IAs. Key findings which explain assessment processes, judgments, decisions, and their short-term outcomes are reviewed in this discussion section. A number of factors were associated with variability and consistency of practice owing to factors in the practice environment, professional knowledge and expertise relating to substantive case factors, and to factors relating to information processing judgment and decision-making. A striking feature of the case study was the uncertainty and regret that social workers expressed about their assessment and decisions.

In Chapter 8 the methodology is appraised in relation to the aims and findings and the theoretical, policy, practice and research implications of the findings are discussed.

5.7.1. Profile of Initial Assessments

The categorisation of the concerns and the pattern of decision-making in the sample differs from practice trends reported in national statistics. In the study, a majority of concerns were classified as abuse (67%) in contrast with trends in administrative data which indicate that welfare referrals dominated in years 2012-2015 (52.8% 2012 to 58.2% 2015) and 78% of IA's remained open in contrast with 42.2% of IAs in 2015 where evidence was available (See Chapter 2 p.14-16). Among abuse subtypes emotional abuse was most prevalent, consistent with the national profile of referrals, albeit the proportion in the sample was higher.

It may be that SW managers chose cases for the study that warranted ongoing service. Alternatively, open files may have been more accessible to PSWs and easier to produce for consultation. In relation to the profile of concerns, it could be that managers chose assessments that reflected the challenges and complexity of practice. However, it is not possible to know this because the question was not posed to the PSWs.

5.7.2. Purpose of Initial Assessments

Consistent with the *Assessment Guidance Framework* (Tusla, 2014a) it was clear that SWs saw the IA as a goal-oriented intervention that operated to address concerns, help clients address concerns directly or with the support from other professionals, sometimes over protracted periods of time, and to decide

whether or not services were needed. Assessments are conducted differently according to the life cycle of a case and there is variation in practice across teams, and over time.

The study found that Tusla's framework for practice, the Standard Business Processes (HSE/Tusla, 2009/2014) and assessment policies (Tusla, 2014a; c) served as reference points for judgments and decisions. In describing the purpose of the IA, SWs drew attention to the distinction between the Intake process which mostly they suggested involved working with professionals alone (SW5, SW6, SW8) and the IA which additionally involved the need to work directly with families (SWT2, SW6, SW8) in relation to concerns that reflected a higher level of need and risk referred (SW8) in accordance with eligibility criteria in the *Threshold of Need Guidance* (Tusla, 2014c). SWs also identified that IA had different functions according to the lifecycle of a case.

Consistent with previous research, findings indicate that IA decisions have a gate-keeping function (Hood *et al.*, 2016). Available resources impact on assessment processes, judgments and decisions for case categorisation and service provision. The principle of subsidiarity was evident in explanations of decisions where case management or risk management was designated to parents or other agencies involved with a child or family, albeit as I discuss below, SWs were not always certain of the efficacy of plans put in place.

5.7.3. Sensemaking and rationales for decisions

Consistent with the theoretical literature, practice required a series of intuitive and analytic sensemaking process and judgments to arrive at the decisions whether or not to provide ongoing services. Several explanations in case files identified clear warrants for intervention linking evidence of harm and symptoms of abuse, neglect and future risk to exposure to DV, although on occasion the evidence appeared to emerge over prolonged periods of working with families. This approach reflects previous studies of IA decisions using case notes (Manion and Renwick, 2008) and reflects theoretical models for the substantiation decision which suggest that SWs use the degree of harm experienced by a child together with evidence available as proof (Drake, 1996) in addition to estimations of future risk (Cross and Casanueva, 2009) to navigate the threshold for the decision. Accordingly, decisions to close cases were based on insufficient evidence to keep it open (Case6) or the absence of concerns that merited CPW involvement (Case 42, 46) or where children and families appeared to have sufficient strengths or supports even when there was evidence welfare or protection concerns (SW8). In several assessments that remained open SWs used primary observed and reported or secondary evidence of the effects of abuse or neglect to explain decisions (e.g. Case 1,3, 5, 11,15, 20, 21, 26). As demonstrated in a previous Irish study (McCormack *et al.*, 2020), SWs assessed evidence in accordance with criteria described in the *Threshold Guidelines* (Tusla, 2014c) to determine eligibility for service provision.

Consistent with the literature, explanations also hinged on social evidence of parental behaviours including responses to the assessment and plans proposed by SWs some of these employed blaming and gendered narratives, particularly in assessments involving DV and neglect (Buckley, 2003; D'Cruz,

2002; Dingwall *et al.*, 1983/2014; Featherstone and Morris, 2021; Ferguson and O'Reilly, 2001; Gillingham and Bromfield, 2008; Keddell, 2011; Kemshall, 2010; Landsman and Hartley, 2007; Morris, 2009; O'Malley, 2008; Parton *et al.*, 1997; Stanley *et al.*, 2010). However, many such explanations seemed to lack insight to the effect of victimisation and dynamics of power and control in a family and a tendency to attribute to parents, particularly mothers, responsibility for managing risks outside of their control (Featherstone and Morris, 2021; Meyer *et al.*, 2021; Noble-Carr *et al.*, 2020).

5.7.4. Barriers to sound and consistent judgments and decisions

Several barriers to good assessment practices and decision making were identified, which in addition to contributing to potentially poor outcomes, represented violations of agency policies. Consistent with previous Irish studies on practice and decisions the point of referral and intake (McCormack *et al.*, 2020; Whelan, 2018) and case work in general (Burns and MacCarthy, 2012; SIS, 2005) organisational barriers included high caseloads, time constraints and insufficient resources. Personal barriers included poor knowledge or lack of confidence about how to respond to presenting case factors. SWs identified that these barriers constrained assessment practices and impacted on their judgments and decisions. The environment itself therefore served as a barrier to good assessment and information processing resulting in decisions based with poor information or on faulty premises.

The role of professional discretion in developing local strategies or cultural norms within teams to manage demand is frequently documented in the literature (Burns and MacCarthy, 2012; Enosh *et al.*, 2021; Keddell and Hyslop, 2019b; Lipsky, 1971; O'Leary, 2007a; O'Leary *et al.*, 2015b; Tusla, 2015; Whelan, 2018). Those identified in this case study and which resulted in violations of policy included curtailing searches for evidence and failure to incorporate historic case evidence where a pattern of abuse suggested risk, decisions to close cases where there was evidence that a child may be at risk of harm based on risk ranking within a caseload, ambivalence towards domestic violence, attribution of responsibility for abuse or risk management to a parent who may not have control over a situation and not previously described, relying on the premise of a closed system of surveillance when solutions were tenuous.

Risk ranking, which has been previously documented in Irish practice and elsewhere (Burns and MacCarthy, 2012; Keddell and Hyslop, 2019b; SIS, 2005) violates policies and principles on which polices are based as each case is required to be judged on its own merits to ensure the rights of an individual child are upheld (DCYA, 2015; 2017; HIQA, 2012; Parton, 2017; UNCRC, 2011). This practice reflects a classic case of goal-substitution (Simon, 1955; 1978) whereby the goal of caseload management is substituted for child protection. The immediate opportunity costs are apparent in missed opportunities for prevention and the potential for the decision to contribute to re-victimisation and recurrence to the CPW system. Additionally, high-risk cases may not always benefit most from interventions aimed at secondary prevention in fact, lower risk groups might stand to gain greater overall risk reduction from interventions (Featherstone *et al.*, 2014a; Rose, 2001).

What seems to be particularly problematic from a system perspective were findings that this goal-substitution resulted in threshold shifts influenced by factors unrelated to the case being judged *and* consciously, a revision of the assessment findings despite no changes to the evidence available. Furthermore, due to workload, social workers curtailed their assessment processes with the result that both the threshold to act and the judgment of the case were in motion on the basis of workload as demonstrated in the modified GADM at Figure 12. This is discussed in the next section on the mechanisms of decision making.

Although high rates of re-referral in the sample indicate that people in the community identify concerns and re-refer children after cases are closed, it is impossible to know the degree to which a system of surveillance exists as a safety measure. Whelan's (2018) case study on the disposal of referrals indicated that self-referrals were more likely to be closed as the system privileged professional referrals. Consequently, relying on the notion of self-regulation and an individual parent's intention to re-refer to CPW might be a shaky premise on which to close cases and manage potential risks to children (Buckley, 2003; Buckley *et al.*, 2008; Roy, 2021). Prior research and audits in CPW indicate that other professionals consider child protection to be the role of the CPW service and many are overstretched (Buckley, 2003; Lonne *et al.*, 2020; O'Leary, 2007b; Shannon, 2017) which may result in children and families who are closed to CPW not receiving the help they need and falling between services (Buckley *et al.*, 2008; Humphreys *et al.*, 2005; Kettle, 2015; Munro, 2011b; Murphy and Rogers, 2018; NRP, 2016; 2018; Roy, 2021; Stanley *et al.*, 2010) because their needs and exposures to risks are not being actively managed. On this basis, the idea of a closed system of surveillance and re-referral seems like an improbable proposition for accessing CPW services.

There was explicit acknowledgement by SWs of lack of expertise and confidence in responding to domestic violence and abuse (DVA) in addition to accounts in assessment records of ambivalence towards DVA, as frequently cited in the literature (Benbenishty *et al.*, 2003; Bosk, 2018; Buckley, 1999; 2000a; Buckley *et al.*, 2011a; Cleaver *et al.*, 2011; Featherstone and Morris, 2021; Gambrill, 2006a; Helm, 2013; Howarth *et al.*, 2016a; Iwaniec, 2006; Johnson, 2009; Kennedy and Holt, 2020; Landsman and Hartley, 2007; Munro, 1999a; Platt and Turney, 2013; Saini *et al.*, 2019; Stanley *et al.*, 2011). SW's uncertainty and ambivalence led to anxiety about how much evidence to collect to ensure thorough assessment, a feature also identified by Whelan (2018). SWs used heuristic strategies of down grading cases, previously noted in the literature and explained assessments in ways that reflected fixed and gendered views (Bar-Hillel, 1984; Dawes *et al.*, 1989; Jonson-Reid *et al.*, 2017; Jud *et al.*, 2016; Kirkman and Melrose, 2014; Mansell *et al.*, 2011; Munro, 2010a; b; O'Leary, 2007a; O'Leary *et al.*, 2015b; Tusla, 2015). These findings suggest the need for a cultural shift and changes in the way children, women and men are responded to in practice.

5.7.5

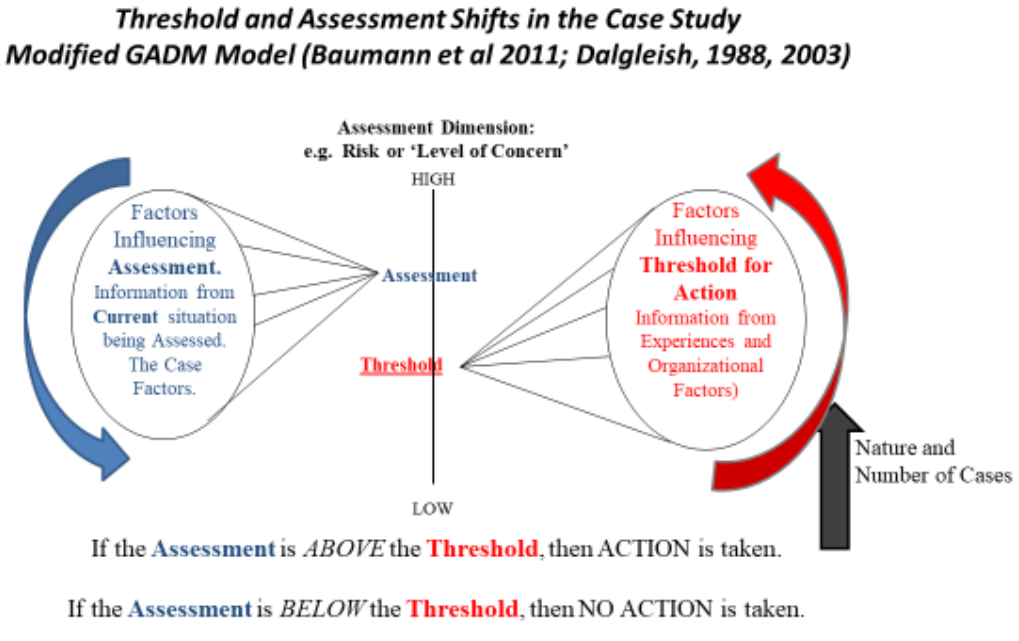
Mechanisms that explain judgments and decisions during Initial Assessments: interactions among influences and outcomes in the Decision Making Ecology

The findings of this case study provide evidence for the General Assessment and Decision-Making Model (GADM) (Dalgleish, 1988; 2003) and the Decision-Making Ecology" (DME) (Baumann *et al.*, 2011 p.7).in the Irish context and extend the understanding of mechanisms that produce decisions and assessment outcomes. In this section they are described.

SWs described what appeared to be routine practice in IA, whereby due to the burden of workload, they curtailed their assessment processes and downgraded the category of the case or they revised their assessment outcome and recommendation to act, with the result that both the threshold to act to provide services and the assessment of the case were in motion. While it is understood in the GADM that a shift in threshold causes the assessment to move below or above it (Dalgleish, 2003), in this study the volatile threshold also initiated revisions in the assessment and in addition to factors individual to the SW influences included workload. This is visually demonstrated in the modified GADM at Figure 12.

In this case study, the downgrading assessments of abuse to welfare or re-weighting risks against factors outside the case misrepresented some SWs initial judgments about risk and service needs (e.g. Dhami, 2003; Fallon, 2020; Featherstone *et al.*, 2014b; Keddell and Hyslop, 2019b; Parton, 2018). In addition to allocating the responsibility for risk management to families where service needs had been identified, the processes result in invalid administrative data which serve as a basis for agency policies: as *SW2* said, '*the statistics don't reflect the reality of practice'*. The implications are discussed below.

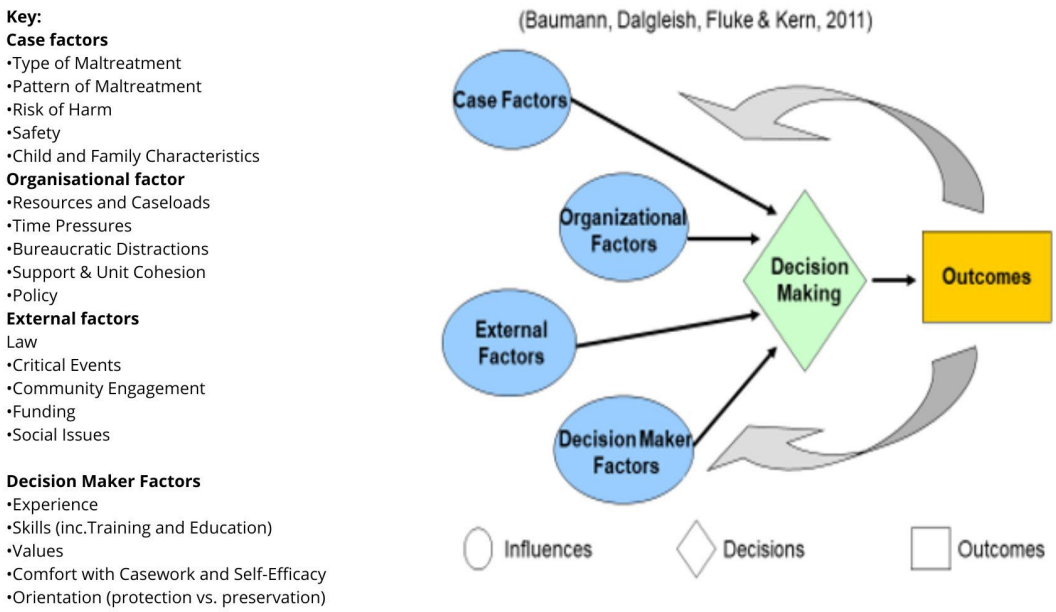
Figure 12 Threshold and Assessment Shifts in the Case Study



In the DME, described in Chapter 4 and reproduced at Figure 13 for ease of reading, four sets of influences represented as ovals, on the decision whether or not to provide ongoing services, represented as a square, within a given system (Baumann *et al.*, 2011). In this case study the decisions whether or not to provide ongoing service after IA were influenced by case factors and other factors within the Irish practice ecology. A straight forward illustration of DME in this study is the impact of organisation factors on decisions, SW8 said cases are eligible for IA because the fit criteria for IA described in policy documents and practice guidance (DCYA, 2011a; HSE/Tusla, 2009/2014; Tusla, 2014c). Starting from this point, the findings of this study also provide evidence of relationships among these influences and the outcome of the assessment process, which are described textually at Figure 13 and visually at Figure 14. While some of these may be assumed, it has been argued in the literature that it important to explain observed individual effects within models because they may not be known and because they may be sources of evidence about judgment and decision making within a particular system (Benbenishty *et al.*, 2015; Fluke *et al.*, 2016; Greenland *et al.*, 1999).

Figure 13 The Decision Making Ecology

The Decision Making Ecology (Baumann, Dalgleish, Fluke & Kern, 2011



As depicted in Figure 14, SWs described interactions between the case factors and individual decision maker factors and between organisation factors and their individual decision maker factors and between external factors, rate of referrals, and their individual assessment practice. SWs also described how particular case factors i.e., DV were linked to assessment practices, judgments and certain outcomes which included downgrading assessment outcomes from abuse to welfare and closing cases, although

the mechanisms included both case load and the individual SW's experience and comfort in working such cases. These mechanisms are graphically depicted in Figure 15. The hashed lines represent interactions among the influences and the dotted lines represent direct interactions between these influences and the outcome of the IA.

Figure 14 Mechanisms that explained judgments decisions and outcomes in the DME

Mechanisms that explained judgments and decisions during Initial Assessments: interactions among influences in the Decision Making Ecology (Baumann, Dalgleish, Fluke & Kern, 2011)

"Cases on IA tend to be Level 3. Some are Level 4 but most Level 4 cases are those which require emergency response" (SW8) ... It is necessary to document sufficient information to "deem an action appropriate" [Organisation Factors and Decision] (SW8).

The threshold [Decision Maker factor, Dalgleish (1988 & 2003)] for the decision to provide ongoing service "depends on what's open on a day [Individual Case Factor AND Organisation Factors] or the rate of referrals [External Factors] on a given day" (SWT1).

In cases of DV … what is enough [evidence to decide] [Decision Maker Factors: experience; casework and self-efficacy] the threshold between welfare and protection? [Outcome]. SWs don't have the time to look into previous reports to count up all the events…[Organisation Factor] [When you] put all the events together and look at them and there's alcohol and drug [misuse] [Case Factors: assessed risk of harm]… welfare is ticked far more often than it should be [Decision Maker Factors]. The statistics [for case categorisation] don't reflect the reality of practice [Outcomes]. (SW2).

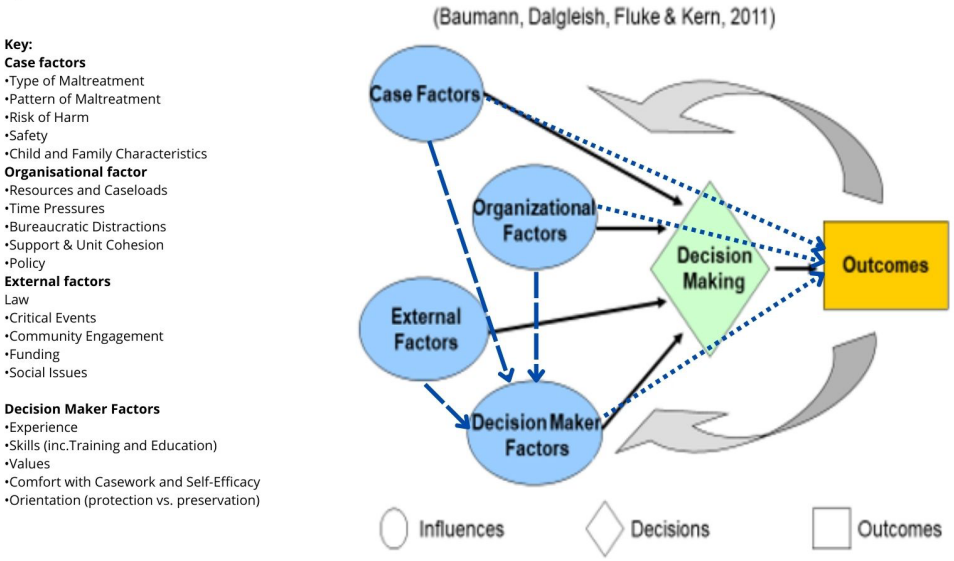
SW2 also spoke about the anxiety [Decision Maker Factors] associated with reluctantly closing some cases [Case Factors and Outcomes] because of more immediate risks to other children on the caseload [Organisation Factors] and shifting the risk management to the family [Outcomes].

Decision regret or anxiety [Decision Maker Factors] was largely explained in terms of the context for practice which produced competition for scarce resources [Organisation Factors] in which situations the goal of workload management was substituted for the wider CPW goal of case management [Case Factors and Outcomes] and operates as a sub-goal for practice [Decision Maker Factors and Outcomes]

Judgments [Decision Maker Factors: assessment of risk AND Decision] 'vary from team to team and day to day' (SW1) depending on 'what's open on a day' [Organisation Factors] (SWT2).

Figure 15 Interactions between influences in the DME and outcomes of Initial Assessments

Graphical representation of mechanisms that explained judgments and decisions during Initial Assessments: interactions among influences and outcomes in the Decision Making Ecology (Baumann, Dalgleish, Fluke & Kern, 2011)



These findings provide evidence of the way that features within the DME interacted to influence decisions and outcomes in IAs. Understanding the mechanisms that lead to judgments and decisions regarding future risk, service needs and service provision has obvious and critical implications for the outcomes for children and families involved in the system. It also has implications for compliance with internal policy guidance and statutory standards, for staff morale as described so emotively by SWs in this case study, for resource management, for the culture of teams and the culture of the organisation and the efficacy of its case management systems and for the validity of information and data outputs, and for interactions with the 'referral community' and other organisations who work with children and families involved with CPW.

5.7.5. Regret and ethical concerns

Decision regret or anxiety was largely explained in terms of the context for practice which produced competition for scarce resources in which situations the goal of workload management was substituted for the wider CPW goal of case management and operates as a sub-goal for practice (Broadhurst *et al.*, 2010b; Buckley, 2015; Buckley and Burns, 2015; Burns and MacCarthy, 2012; IASW, 2011; Keddell, 2014a; Keddell and Hyslop, 2019b; Lees *et al.*, 2011; Simon, 1978; Tusla, 2015; Waterhouse and McGhee, 2009; Whelan, 2018). SW used varying workarounds but also relied on limited or flawed reasoning premises which reflect violations of policy which, as previously evidenced in the literature, resulted in unethical decision-making (DePanfilis and Girvin, 2005; Keddell, 2014a). SWs revealed the categorisation of concerns and decisions do not, as one SW said, 'reflect the reality of practice' *(SW2)* as judgments 'vary from team to team and day to day' *(SW1)* depending on 'what's open on the day' (*SW2)*.

The findings reassert those from previous studies, that the 'formal' model of practice for risk assessment and decision-making represents an oversimplification of the context within which decisions about risks are made (Baumann *et al.*, 2011; Buckley, 2000a; Platt and Turney, 2013).

5.8. Conclusions

A case study methodology was used to explore assessment practice in 9 social work departments (SWDs) within a large administrative region of Tusla during the first quarter of 2016. Information collected from case file records (n=45) and interviews with individual SW's and SW Teams (n= 2 teams; n= 7) was thematically analysed to gain insight into the context for practice and into the sense-making and the rationales provided for decisions. The study found evidence of themes that appear over and again in the literature and reviews indicating that risk operates as a mechanism to identify cases for ongoing service. On the whole, the categorisation of presenting evidence into typologies of abuse and welfare needs was a problematic and variable practice. It was correlated with perceptions of parents' circumstances and disposition. It is impacted by, and impacts on, the filtering of cases during IA. Cases involving multiple exposures including DV appeared particularly problematic for some SWs.

By examining the sense-making and the rationales provided for their decisions, the study found evidence of the social construction of abuse in individualist terms focussed on problems and failings of parents. Due to scarce resources, caseload and workload management is substituted for risk management in individual cases. The principle of subsidiarity promoted in agency discourse was evident: SWs warrants for intervention and non-intervention indicated an expectation that families should by their own initiative, act to reduce risks and protect their children. Not all IAs that are closed where children have ongoing needs and may be re-referred are true 'false negatives' because as the evidence indicated, SWs frequently revised their judgments about service needs on the basis of limited resources. In these cases, explanations of parents' intentions and capability may not always be valid.

SWs concern about their professional expertise in responding to allegations of abuse against a parent and in particular involving DVA indicate specific training needs in this regard, especially in the context of the advent of the Substantiation Policy by Tusla (2020b).

Chapter 6 A cross-sectional study of sequential Initial Assessments concluded between January 1st and March 31st 2016: Descriptive results

6.1. Abstract

Background: Despite the importance attributed to evidence-based practice in Irish CPW policies, much of the information required to be collected by SWs during Initial Assessments is neither systematically collated or available for analysis. Consequently, there is little knowledge of the characteristics of children involved in assessments child abuse and child welfare and corresponding agency responses.

Methods: A cross-sectional study was designed to profile a complete sample of children whose Initial Assessments completed in seven Social Work Departments in Ireland between January 1st and March 31st 2016 and to identify which factors predict the provision on ongoing services.

Results: Compared to the general population, families involved in IAs have greater burdens. One parent families were over-represented (51% compared to the national rate of 21%). The average number of children in families was 2.6 compared to national average of 1.4 and 16% of families had more than 4 children compared to 6.2% of families nationally. Infants and young children were over-represented in assessments as were families with the youngest child under 4 years of age. All differences were significant (χ^2; p<0.00). Both one and two parent families were disproportionately unemployed. Families were clustered in areas of relative deprivation compared to a national mean.

IAs involving children aged 0-4 years were conducted at a higher rate of 2.4 IAs per 1,000 children compared to a rate of 1.8 per 1,000 children aged 15-17years in Q1 2016. Child age was associated with certain types of abuse and assessed service needs. Large family size was associated with neglect. Over 50% of children presented with developmental concerns in addition to exposure to risk factors for abuse. One in four experienced domestic violence (24.6%, n=118) a majority of which was male perpetrated. The prevalence of documented abuse was 43.5% relating to 209 children. A majority of children (69%, n=331) had previous involvement with CPW and one in ten were intergenerationally involved (10.6%, n=51). 67.5% (n=324) were involved with other services at the time of IA. In parents, the prevalence of mental health concerns and substance misuse was higher (55.4% n=226) compared to the general population (18% in 2016). Data on child nationality, ethnicity and parental age, known to be influential in decisions for service provision were missing from the IA Records. Almost 2 in every 5 chlidren (38.5%, n=185) remained open for ongoing service following IA.

Conclusions The study contributes original findings to the Irish and international literature. SWs document a significant body of evidence that is obscured in the statistics published by Tusla: this should be systematically collated to provide an evidence base for practice and policies, to manage risks and to effectively respond to children and family's needs. Efforts should be made to document and collate data

regarding nationality, ethnicity and parent age and socioeconomic data. The findings challenge existing orthodoxies that many IAs are not warranted.

6.2. Aims of the study

This study aims to enhance the understanding of the context for assessment and decision-making in initial assessments and to provide estimates of the scope and characteristics of child welfare and child abuse IAs in 7 SWDs in Ireland in 2016. Specifically, the study was designed to

1. describe the demographic setting for the study
2. determine the number and rates of IA completed and decisions taken and to examine how they compare to rates in other Anglophone regions
3. describe the demographic profile of children and families undergoing IA compared to the general population
4. profile the scope and nature of concerns in IAs and characteristics relating to organisational policy including the source of referrals, characteristics of SWs conducting IA and rate of recurrence and gender of SWs conducting IA
5. and lastly, to comment on the eligibility of children and families undergoing IA to meet the threshold for assessment in accordance with Tusla policy.

6.3. Results

The variables identified for analysis and the coding system are detailed at Table 3. The profile of the assessments and decisions is presented at Table 4. As detailed in Chapter 4, bivariate analysis was conducted to explore relationships between important variables in the data for example, to explore the relationship between assessed child development concerns and identified parenting capacity and parent functioning concerns and assessed factors and the categorisation of concerns. Pearson chi-square (χ^2) and Fishers Exact test and associated *p* values were calculated to test if relationships were statistically significant or due to chance. Pearson chi-square is reported unless otherwise stated.

Table 3 Definition of variables and codes

Variable	Description, content and source of data item	Codes
Demographic characteristics		
Unique child id	Assigned	case001, case002 …
Child age at start of IA	Item required on records. DOB and approx. age Missing two IA start dates to calculate age	Scale variable 0-17 years
Child age group	Age coded as a categorical variable using CSO definitions for age-groups	0-4 years 5-9 years 10-14 years ≥ 15 years
Child gender	Item required on records. Gender of child female, male	0, Unborn, 1 Female, 2 Male 0 Missing / unknown
Child religion	Item required on records – Free text entry.	1 Christian 2 Muslim
Child ethnicity	Item required on records. Insufficient coverage.	1 -16
Family id	Assigned	1-308 fam1 ..fam 117
Family type	Coded from text using CSO categories with additional code, separated parents	1 cohabiting couple with children 2 cohabiting couple with children and others 3 one parent with children 4 one parent with children and others 5 separated parents 6 unclear/no info
Carer 1 relationship to child	Primary carer based on documented relationship to child. Coded from text.	1 mother 2 father 3 extended family / friend 4 foster mother
Carer 2 relationship to child	Second carer based on documented relationship to child. Coded from text.	1 father 2 mother 3 extended family 4 foster carer
Unique mother id	Item required on records. Nominal id assigned to mother	m1 - m303, 1-303
Mother dob	Item required on records. Insufficient coverage	ddmmyyyy
Unique father id	Item required on records. Nominal id assigned to father	f1 - f236
Father dob	Item required on records. Insufficient coverage	ddmmyyyy
Sibs or other children in house	Item required on IR Q4 Household Composition additional information contained in IAR texts.	0 no siblings / other children in household 1 siblings or other children in household
Number of children in household	Number of children documented in the household	Scale, 1-10
Age youngest child	Youngest child in the household	Scale, 0-17
Age group youngest child	Age coded to categorical variable using definitions from CSO Coded using multiple texts.	0-4 years 5-9 years 10-14 years ≥ 15 years
Economic status	Principal economic status Classified from text	0 not in employment / unknown 1 in employment
Principal income source	Primary source of family income. Classified from text	O combination or unknown 1 employment 2 welfare
HP Relative Deprivation Score	Variable generated using family address and HP Relative Deprivation Score index at SA level (Haase and Pratschke, 2017a).	Scale variable -30 to + 30 representing relative deprivation/ affluence

Table 3 continued

Variable	Description, content, validity and source of data item	Codes
Parental/ carer capacity and functioning concerns		
Parental capacity and functioning	The IAR requires SW to document strengths and difficulties across 6 dimensions of parenting capacity, and 4 factors relating to family functioning. These are basic care, ensuring safety, emotional warmth, stimulation, guidance and boundaries, stability, family history and functioning, social resources (wider family, family's social integration, community and social integration) housing, employment, income. For welfare assessments, SW are asked to identify the presence of concerns among 10 parent level and 9 family level factors. As above, text recorded for individual items lacked face and content validity so the entire body of text was used to identify concerns. Content included direct and reported observations.	0 no concern / unknown 1 concern about dimension Income source 0 combination or unknown 1 employment 2 welfare
	Additional parent and family functioning variables drawn from text and the literature include: unemployment, family involved with services at start of IA, carer mental health concern, self-harm/ suicide attempt, drug misuse (heroin, methadone), alcohol misuse, violence to partner, acrimony between carers, involved with CPW in childhood, sexual assault of child, violence to child, involved in crime, carer in prison. Entire body of text used to code each variable.	Dichotomous variable for each factor 0 no concern / unknown 1 presence of concern
Intimate Partner Violence (DV)	Violence between parents or carers was coded as DV. Features aggression, assault, physical violence sometimes causing injury requiring hospitalisation and/or refuge, facial injury, bruising of back and neck, threats of violence, beating, manipulative and controlling behaviour, taunting (coercive control), threat of violence on social media, chronic violence, financial control. Violation of separation and safety and protection orders and partner returning to family home following lapse such orders.	0 No concern / unknown 1 DV
SW perception of parental engagement	Three additional characteristics regarding the parent and carers response to the assessment drawn from the pilot study were: parent recognises risk, parent cooperates and engages and parent has capacity to address concerns/ act protectively	Dichotomous variable 0 no concern 1 concern i.e. does not recognise risk, does not engage, does not have capacity to address concern or act protectively
Assessed child developmental needs and functioning concerns		
Prior involvement with CPW	Item recorded on IR	0 new / unknown 1 known to CPW
Child developmental needs	The IAR requires SW to document strengths and needs across the following dimensions: health, education, emotional and behavioural development, identity, family and social relationships, social presentation and self-care skills. Elsewhere the IAR asks SW to give details of parent and carers capacity to respond to the child's developmental needs, and to summarise the child's response, parent's response and provide an analysis of the IA. Content included direct and reported observations. Some variables lack face validity: texts referred to features of the child or family life not specifically relevant to the question. For welfare assessments, SW are asked to identify the presence among 17 functioning and developmental characteristics. The entire body of text is used to code for presence of concern about each dimension	0 no concern / unknown 1 concern about dimension
Child functioning	Additional child functioning variables were identified from the texts and the literature and coded from the entire body of text. Included: witness DV, mental health difficulty, self-harm/ suicide attempt, known to AGS, drug or alcohol misuse, victim of sexual assault, perpetrates alleged abuse	
Co-occurring abuse and welfare impairment & Findings of abuse – not recorded in administrative data		
Co-occurring welfare needs or abuse recorded	Documented evidence of current or historic welfare concerns, neglect, emotional, physical or sexual abuse, not accounted for by the primary report type.	Five dichotomous variables 0 Other 1 welfare or abuse category
Co-occurring abuse	Documented evidence of current or historic neglect, physical, emotional or sexual abuse recorded i.e. not related to primary category of concern	1 No / not recorded 1 secondary abuse

Table 3 continued

Variable	Description, content and source of data item	Codes
Organisation characteristics		
Reporter category	Reporter details and relationship to child recorded on IR. The information was used to generate the variable which describes the role in terms of Tusla reporting policy	Member of public Professional, statutory duty Professional, other
Department	Variable identifies one of seven departments	
Social worker gender	Social Workers conduct assessments and Team Leaders approve completed IA Records. Gender identified from name.	SW female, TL female 0 other 1 female
Time spent on IA	Dates recorded on IAR	Scale variable, days from start to end of IA
Decisions		
Primary report type / category of concern assigned by SW at end of IA, and characteristics documented in records		
None	Unfounded concerns; fabricated allegations featuring post-separation of parents or carers.	0 Other 1 None
Welfare	Needs/ health care not met due to burden of chronic needs or mental health concern of parent or sibling, lack of income or poverty, lack of social supports, housing instability, poor sanitation and chaos associated with DV, chronic conflict or acrimony, substance misuse – including substance misuse while pregnant, physical chastisement and psychological abuse, intellectual difficulties and poor understanding of child developmental needs, poor understanding of child's complex health needs, exposure to crime, violent partners, parent sexual abuse or prostitution. Child substance misuse, emotional regulation problem, obesity, self-harming and suicidal behaviour, victim of sexual abuse, sexualised behaviour and sexual abuse of sibling, child begging, Court ordered visitation with previously violent carer, carer promotion of inappropriate sexual behaviour and violence.	0 Other 1 Welfare
Emotional abuse	Features psychological taunting, threat of harm and violence, distress arising from parent-child conflict, physical abuse, sexual abuse and neglect, verbal abuse related to exposure to DV and/or chronic substance misuse and / or visitation with violent parent following separation or acrimony, or child in care of violent parent, child protecting siblings during episode of DV, distress arising from carer minimising sexual abuse, involvement in fabricated allegations of abuse, carer manipulating child relating to experiences of violence, sexual abuse and parental substance misuse and violence. Unintentional abuse arising from parental mental health problems, parental loss and parental incapacity and intellectual difficulties.	0 Other 1 Emotional Abuse
Neglect	Features neglect of dental care and medical care particularly in relation to chronic illness, neglect of developmental and safety needs, leaving children alone, exposure to chronic substance misuse, DV and acrimony, exposure to known offenders, exposure to drug paraphernalia, neglect of sanitation and house maintenance. Unintentional abuse arising from parental mental health problems, parental loss and parental incapacity and intellectual difficulties.	0 Other 1 Neglect
Physical abuse	Violence to child including hitting, punching, kicking, biting, assault, fractured bones, head trauma, physical chastisement, threat of aggression, threat of gun use, often occurring with DV and/or substance misuse and acrimony.	0 Other 1 Physical Abuse
Sexual abuse	Sexual abuse by carer, carer's partner, siblings, other children including rape, penetration, touching, coercive sexual incidents between children and circulation of illicit images of children; repeat pregnancy of child, risk of abuse arising from ongoing court sanctioned visitation with former sexual abuser.	0 Other 1 Sexual Abuse
Abuse	Assessment is categorised as physical, neglect, sexual or emotional abuse	0 Other 1 Abuse
Ongoing risk of significant harm	For abuse assessments, SW is required to document whether or not a child is at ongoing risk of significant harm. Includes some historical factors subject of prior assessments.	1 At ongoing risk of significant harm 0 Not at ongoing risk

Table 3 continued

Variable	Description, content and source of data item	Codes
Actions		
Actions recorded on completion of IA	IAR requires SW to identify action taken as one of Child protection, Child Welfare – Family Support Planning, Further Assessment, Family Welfare Conference, Admission to Care, No Further Action Additional options are: Strategy Meeting, notified to An Garda Síochána, Referred to other professional service for alternative/support services, Provision of information and advice only An additional variable, Child in Care was identified as 4 assessments were already in care and remained in care following IA.	Dichotomous variable for each option 0 Other 1 Action type
Ongoing service	Action taken is one of Child Protection, Child Welfare – Family Support Planning, Further Assessment, Family Welfare Conference or Admission to Care	0 Assessment (case) closed 1 Transfer to ongoing service

6.3.1. Complete profile of children in Initial Assessments

Table 4 provides full details of the prevalence of variables created from case file records and mobilized for the study.

Table 4 Profile of chlidrne in Initial Assessments n=480, concluded between January 1st and March 31st 2016, in seven social work departments, Tusla-South

Variable	n	%
Organisation characteristics		
Reporter		
An Garda Síochána	108	22.6
Direct provision	1	0.21
General Practitioner	21	4.4
Local Authority	13	2.7
Member of public	10	2.1
School	62	13.0
Anonymous	26	5.4
Designated officer HSE	120	25.1
SW Tusla	39	8.2
Other	1	0.2
Other family member	19	4.0
Parent/ guardian	28	5.9
Voluntary agency	30	6.3
Reporter category by policy		
Member of public	84	17.6
Professional statutory duty	147	30.8
Professional other	247	51.7
Department (n, % assessments)		
SWD1	94	19.6
SWD2	36	7.5
SWD3	186	38.8
SWD4	32	6.7
SWD5	46	9.6
SWD6	32	6.7
SWD7	54	11.3
Gender of SW (n=68) and TL (n=26) conducting IA		
Social Worker female	51	75.0
Team Leader female	19	73.1
IA by SW Female: Valid total n= 468	350	73.0
IA by TL Female: Valid total n = 462	408	85.0

Table 4 cont.

Variable	n	%
Demographic characteristics (n=480 unless otherwise stated)		
Chid gender total children		
Female	218	45.4
Male	260	54.1
Child age	mean 7.9, SD, 5.1, 0,17	
Child age group, n=447, 93%		
0-4	144	32.2
5-9	126	28.2
10-14	116	26.0
≥ 15	61	13.7
Child religion, n=30, 6.25%	Insufficient data	
Missing / unknown n=451		
Child ethnicity, n=68, 14.2%	Insufficient data	
Missing / unknown 412, 85.8%		
Family characteristics, total families n=305		
Couples with children	361	75.2
One parent family	115	23.9
Family Type by child, n=476, 99.2%		
Cohabiting couple with children	234	48.8
Cohabiting couple with children and other persons	12	2.5
One parent with children	115	24.0
One parent with children and other persons	34	7.1
Separated parents	81	17
Carer 1 relationship to child (n=480)		
Mother	440	91.7
Father	21	4.4
Extended family/friend	10	2.0
Foster mother	9	1.9
		100
Carer 2 relationship to child (n=409, 85.2% total assessments)		
Father	330	80.7
Mother	16	3.9
Partner	44	10.8
Extended family	10	2.3
Foster carer	9	2.2
		100

Table 4 cont.

Variable	n	%
Children with siblings in the house, n=379, 79%		
Number of children in household		
1 to 3	369	76.9
4 to 10	111	23.1
Age group of youngest child in household, n= 477, 99.4%		
0-4	235	49.3
5-9	134	28.1
10-14	80	16.8
≥ 15	28	5.9
Child's primary carer not employed	227	47.3
Income source		
Combination / unknown	169	35.2
Welfare	117	24.4
Employment	194	40.4
Mean HP Relative Deprivation Score, n=480	Mean -5.795891, sd: 9.83574 Minimum -29.97049 Maximum 16.50634	
Parenting capacity concerns, by child assessment		
basic care	122	25.4
ensuring safety	268	55.8
emotional warmth (either parent)	153	31.9
stimulation	66	13.8
guidance and boundaries	242	50.5
stability	235	49.0
family history and functioning	341	71.0
social resources	148	30.9
housing	153	31.9
employment and income	150	31.2
c1 mental health difficulty	145	30.1
c2 mental health difficulty	42	9.0
either carer mental health difficulty	166	34.6
c1 self-harm / suicide	12	2.5
c2 self-harm/ suicide	10	2.1
either carer self-harm suicide	22	4.6
c1 drug misuse	69	14.4
c2 drug misuse	66	13.8
either carer drug misuse	107	22.3
c1 alcohol misuse	88	18.3
c2 alcohol misuse	89	18.6
either carer alcohol misuse	135	28.1
c1 violent to c2	26	5.4
c2 violent to c1	106	22.1
DV (either parent violent to another)	118	24.6
carer violent to child	100	20.1
acrimony	74	15.4
c1 alleged sexual assault of child	1	0.2
c2 alleged sexual assault of child	17	3.5
involved with CPW during childhood	51	10.6
involved in crime	68	14.1
parent or carer in prison	16	3.3
Assessed carer / parental capacity		
recognises risk	296	61.7
cooperates and engages	241	71.0
has capacity/motivation to address concerns/ protect	251	52.3
Service involvement, by child		
Prior involvement with CPW	331	69.0
Involved with other services at time of IA	324	67.5

Table 4 cont.

Variable	n	%
Chid developmental and functioning concerns		
Health	124	25.8
Education	27	5.6
Emotional or behavioural	236	49.2
Identity	111	23.1
Family and social relationships	230	48.0
Presentation	95	19.8
Self-care	68	14.2
Known to AGS	25	5.2
Involved with juvenile liaison office	5	1.0
Witness DV	77	16.0
Mental health difficulties	43	9.0
Self-harm or suicidal behaviour	23	4.8
Uses drugs or alcohol	15	3.1
Victim of sexual assault	20	4.1
Perpetrated alleged abuse	18	3.75
Child view recorded	263	54.8
Secondary abuse OR welfare textually recorded, n=182, 37.9%		
Welfare	27	5.6
Any abuse	163	33.9
Emotional abuse	40	8.3
Neglect	136	28.3
Physical abuse	29	6.0
Sexual abuse	17	3.5

Target decisions		
Primary Report Type / category of concern end of IA		
None	16	3.33
Welfare	220	45.8
Emotional abuse	66	13.8
Neglect	84	17.5
Physical abuse	56	11.7
Sexual abuse	38	8.0
Primary report type: abuse		
Assessment is categorised as one of emotional abuse, neglect, physical abuse or sexual abuse	244	50.8
At ongoing risk of significant harm	82	17.1
Actions		
Child Protection proceedings	44	11.5
Child Welfare - Family Support Planning	46	9.6
Further Assessment	52	10.8
Family Welfare Conference	3	0.6
Admission to Care	25	5.2
Child in Care	4	0.8
NFA	295	61.5
Ongoing service	185	38.5
Additional action	n	%
Emergency action	4	0.8
Strategy Meeting	3	0.62
Information & Advice	28	5.8
Refer to PPFS	29	6.0
Refer to other service	58	12.1

6.4. Setting

The study involved seven SWDs in Tusla south, in southern Ireland. Collectively, these areas are home to 17.8% of the national population and 18.3% of the child population aged 0-17 in Ireland. As Table 5 describes, children aged 0-17 represent approximately a quarter of the population across the study area and nationally.

Two SWDs (SWD3 and SD7) incorporate cities, urban and rural areas. All other SWDs incorporate large or small urban areas and rural areas.

Table 5 Population children 0-17, total population by SWDs, study area and country, 2016

	swd1	swd2	swd3	swd4	swd5	swd6	swd7	study area	country
Tot. Population	92334	54856	192243	94229	136083	149487	130252	849484	4,761,865
MF 1-17, n, %	24275	13461	49086	23787	35213	39109	33359	218290	1190502
	(26.3)	(24.5)	(25.5)	(25.2)	(25.9)	(26.2)	(25.6)	(25.7)	(25.0)
Tot. Age 1-17 F	11982	6606	24020	11543	17163	19036	16220	106570	581717
	(49.4)	(49.1)	(48.9)	(48.5)	(48.7)	(48.7)	(48.6)	(48.8)	(48.9)
Tot Age 1-17 M	12293	6855	25066	12244	18050	20073	17139	111720	608785
	(50.6)	(50.9)	(51.1)	(51.5)	(51.3)	(51.3)	(51.4)	(51.2)	(51.1)

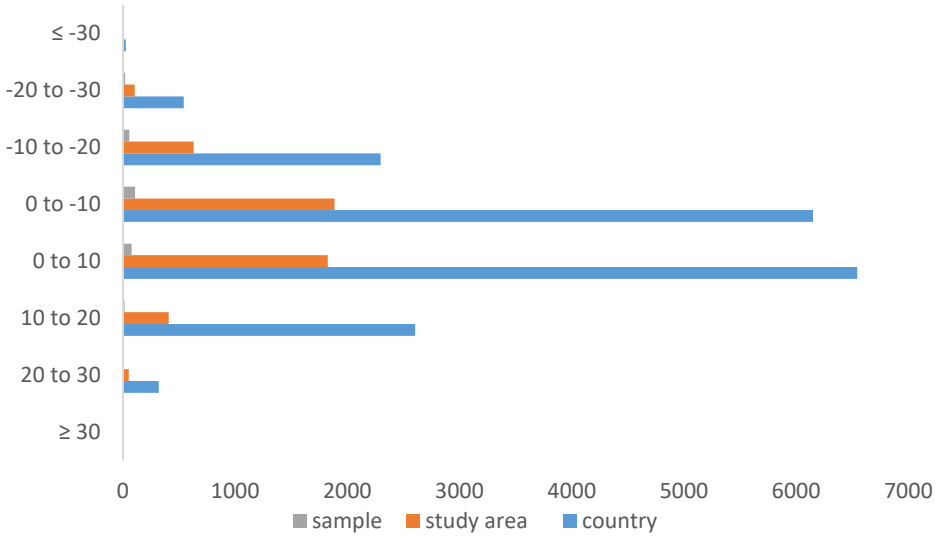
Each family address was mapped up to Small Areas, which are areas of population generally comprising between 80 and 120 dwellings and used by CSO. While maintaining anonymity the analysis at this level provides an in-depth picture of the social and economic conditions of communities where the families in the study reside.

Table 6 describes the distribution of Small Areas (SAs) according to the HPRelDep Scores and classification system (Haase and Pratschke, 2017a) for the country, study area and the sample. Figure 16 presents the same data graphically. Families in the study sample were living in areas categorised as affluent to very disadvantaged but communities were clustered in areas of greater deprivation compared to the study area. There were no families living in SAs categorised as extremely affluent or very affluent, and no families were living in areas categorised as extremely disadvantaged. Compared to families in the study area, fewer families were living in areas marginally above and marginally below average (study area 75.6%, n=3,710; sample 67.6%, n=184). A further 20.6% (n=56) of families in the sample were living in areas categorised as disadvantaged compared to only 12/9% (n=631) in the study area.

Table 6 Distribution of Relative HP Deprivation for small areas, by country, study area and sample, by labels and values, 2016

relative index score	standard deviation	label	SA country 2016, n	SA country, 2016, %	SA study area, n	SA study area, %	SA sample, n	SA sample, %
over 30	>3	extremely affluent	9	0.05	0	0	0	0
20 to 30	2 to 3	very affluent	320	1.7	51	1.0	0	0
10 to 20	1 to 2	affluent	2,603	14.1	407	8.3	13	4.8
0 to 10	0 to 1	marginally above average	6,544	35.4	1,825	37.2	76	27.9
0 to -10	0 to -1	marginally below average	6,151	33.3	1,885	38.4	108	39.7
-10 to -20	-1 to -1	disadvantaged	2,297	12.4	631	12.9	56	20.6
-20 to -30	-2 to -3	very disadvantaged	540	2.9	106	2.2	19	7.0
Below -30	< -3	extremely disadvantaged	24	0.1	0	0	0	0
Total			18,488	100	4905	100	272	100

Figure 16 Number of Small Areas by HP Relative Deprivation classification for Sample, Study Area and Country, 2016



6.5. Number of children in assessments and responses

Between January 1st and March 31st 2016 (Q1 2016), IAs relating to 480 children and 308 families concluded in the seven SWDs. This represents a rate of 2.2 IAs per 1,000 children in Q1or an annual rate of 8.8 IAs per 1,000 children aged 0-17.[53,54]

Among open cases 81.1% (n=150) were recurrent ($\chi^2(1)=20.6662$, $p=0.00$).

Table 7 describes the number of IAs completed in Q1 2016 and responses to the assessments and provides estimates for the annual incidence of completed IAs and ongoing service. The rate of IAs completed per 1,000 children in Q1 varied across SWDs with the highest rate of 1.6 IAs per 1,000 children in SWD1 and the lowest rate of 0.4 IAs per 1,000 children in SWD6.

Table 7 Numbers and rates of Initial Assessments and Ongoing Service and No Further Action. Q1 and Year estimates for IA and Ongoing Service 2016, by SWD

	Initial Assessments Quarter 1 2016							Estimates Initial Assessments and ongoing service for year 2016			
Area	Pop. 0-17	IA n,	IA /1,000	Ongoing service n	Ongoing service /1,000	NFA, n	NFA / 1,000	IA, n	IA/1,000	Ongoing service n,	Ongoing service /1,000*
SWD1	24275	94	3.9	39	1.6	55	2.3	376	15.5	156	6.4
SWD2	13461	36	2.7	7	0.5	29	2.2	144	10.7	28	2.1
SWD3	49086	186	3.8	56	1.1	130	2.6	744	15.2	224	4.6
SWD4	23787	32	1.3	11	0.5	21	0.9	128	5.4	44	1.8
SWD5	35213	46	1.3	33	0.9	13	0.4	184	5.2	132	3.7
SWD6	39109	32	0.8	14	0.4	18	0.5	128	3.3	56	1.4
SWD7	33359	54	1.6	25	0.7	29	0.9	216	6.5	100	3.0
Total 7 SWDs	218290	480	2.2	185	0.8	295	1.4	1920	8.8	740	3.4

**rates are based on the number of children aged 0-17 years in the study area, 2016*

A majority of children were closed NFA (61.5%, n=295) at a rate of 1.4 IAs per 1,000 children aged 0-17 years. As described in Table 6.8 there was variation in the rate of NFA across SWDs with the lowest rate NFA of 0.4 IAs per 1,000 children aged 0-17.

53 Tusla statistics indicates 20,117 IAs or 16.9 per 1,000 children IAs were required in 2016. Of the 20,117 IAs necessitated in Ireland in 2016, 26% of the IAs commenced Q1 i.e. January 1 to March 31st 2016 (n=5153), a further 26% in Q2 (n=5191), 23% in Q3 (n=4,712) and 25% in Q4 (n=5,061). Roughly speaking, distribution is similar across the four reporting periods. Of those IAs 9,046 had recorded outcomes On this basis the rates for Q1 in the study area are multiplied by 4 to generate estimates for annual rates for year (FY) 2016.

54 Tusla Annual Referral and Assessment Data for 2016 indicates the proportion of referrals that proceed to IA are fairly equally distributed across Q1 to Q4 (range 26% to 24%) and those that have recorded outcomes are more varied 30% in Q1 and 26% Q2, 23% Q3 and 25% Q4. The number of IAs with outcomes closely equates to the criteria for sampling used in this study and it is clear that these were less equally distributed over the year. Absent more detailed statistical analysis it seems reasonable to assume that the sample number of 480 IAs reflects approximately a quarter of IAs conducted in the seven SWDs in 2016.

Over one third of chlidren (38.5%, n=185) remained open for service or 0.8 IAs per 1,000 children aged 0-17 years. There was variation in rates across the SWDs with the lowest rate of 0.4 IAs per 1,000 children aged 0-17 years remaining open in SWD 6 and the highest rate of 1.6 IAs 1,000 children aged 0-17 years remaining open at SWD1.

As described at Table 8, of children who received ongoing service (n=185, 38.5%), 29.7% (n=55) received child protection services, 28.1% (n=52) received further assessment and one in four received child welfare family support planning (24.9%, n=46). 13.5% children were admitted to care (n=25) and a further 2.2% remained in care (n=4). Only 1.6% assessments (n=3) were referred to Family Welfare Conferencing.

Children receiving welfare assessments (45.8%, n=220) were disproportionately closed compared to abuse assessments (69.6%, n=153, χ^2= 11.21, χ^2 p=0.00). Assessments for neglect (17.5%, n=84) were more likely to be open (69.0%, n=58, χ^2= 40.0, χ^2 p=0.00) and a majority of these progressed to child protection and admission to care.

Among children who were closed (61.5%, n=295), a majority were not diverted to other services. In this sample 12% of closed cases (n=35) were referred to other services and 11% of closed cases (n=33) were referred to PPFS. The prevalence of abuse in assessments that were closed is 24.4% (n=72) and 61.4% cases that were closed were recurrent.

Table 8 Action taken at end of IA

Category n, %	Welfare 220 (47.4)	Emotional Abuse 66 (14.2)	Neglect 84 (18.1)	Physical Abuse 56 (12.1)	Sexual Abuse 38 (8.2)	Total* 464 (100)
Child Welfare Family Support	31 (67.4)	3 (6.5)	5 (10.9)	6 (13.0)	1 (2.2)	46 (9.6)
Admission to Care	6 (24.0)	6 (24.0)	10 (40.0)	3 (12.0)	0 (0.0)	25 (5.2)
Child Protection	4 (7.3)	9 (16.4)	36 (65.5)	4 (7.3)	2 (3.6)	55 (11.5)
Family Welfare Conferencing	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3 (0.6)
Further Assessment	23 (44.2)	7 (13.5)	6 (11.5)	4 (7.7)	12 (23.1)	52 (10.8)
NFA Closed	153 (51.9)	38 (12.9)	26 (8.8)	39 (13.2)	23 (7.8)	295 (61.5)
Child remains in Care	0 (0.0)	3 (75.0)	1 (25.0)	0 (0.0)	0 (0.0)	4 (0.8)

* not all IA had explicit action recorded

6.6. Demographic characteristics

6.6.1. Family composition

Table 9 describes the number and type of families in IAs (n=308). Just over half the families were one-parent or separated parents with children (51.5%, n=157), the remainder were couples with children. There is some variation in the distribution of families and family type across departments. A majority of families in SWD 2 are cohabiting couples (77.8%, n=14) whereas cohabiting couples comprise a third of families in SWD 6 (32.1%, n=9). The variations are not significant. Most primary carers were mothers (91.7%, n=440) and most second carers were fathers (68.8%, n=330) and mothers' partners (9.2%, n=44).

Table 9 presents comparable data for the country, and this is discussed in Section 6.8 below.

Table 9 Family by family type, study area by population and sample, country, 2016

	Total couples with children 0-17 years (No. of families) n (%)	Total one parent families (No. of families) n (%)	Families with children 0-17, n, 100%
SWD area 1	13,550 (77.5)	3,928 (22.5)	17,478
SWD1 sample	29 (49.1)	29 (50.9)	57
SWD area 2	7,408 (77.5)	2,145 (22.5)	9,553
SWD2 sample	14 (77. 8)	4 (22.2)	18
SWD area 3	26,632 (74.6)	9,079 (25.4)	35,711
SWD3 sample	57 (49.1)	59 (50.9)	116
SWD area 4	12,962 (72.8)	4,848 (27.4)	17,810
SWD4 sample	9 (40.9)	13 (59.1)	22
SWD area 5	19,418 (76.3)	6,046 (23.7)	25,464
SWD5 sample	18 (60.0)	12 (40.0)	30
SWD area 6	17,531 (72.6)	6,632 (27.4)	24,163
SWD6 sample	9 (32.1)	19 (67.9)	28
SWD area 7	20,823 (73.2)	7,608 (26.8)	28,431
SWD7 sample	16 (43.2)	21 (56.8)	37
SWD Areas 1-7	118,324 (74.6)	40,286 (25.4)	158,610
Sample	150 (49.5)	157 (51.0)	308
Country	476935 (79.02)	126637 (21.0)	603, 572

$\chi 2$ $p < 0.000$ for all comparisons except SWD 2; chi 2 $p < 0.00$ for comparison between sample and country

The average number of children per family in IAs was 2.6 (SD 1.3, 1,10). Among the larger families in the study, 16.2% families (n=50) had more than 4 children.

Table 10 describes families in the country and the sample by the age–group of the youngest child. In the sample 44.8% (n=136 families) the youngest child in the household is under 4 years of age. In a further 27.0% of families, the youngest child was between age 5 and 9 (n=83). Only 8.2% of

assessments involved households where the youngest child was ≥15 years of age. One-parent and cohabiting parent families had children of similar age profiles with 48.5% (n=66) and 51.5% (n=70) respectively, under 4 years of age.

Table 10 Families by age group of youngest child, number of families

Age of youngest child	Country, n (%) no. families	Sample, n (%) no. families
0 to 4 years	249,091 (28.9)	138 (44.8)
5 to 9 years	160,952 (18.7)	83 (27.0)
10 to 14 years	123,994 (14.4)	59 (19.2)
15 and over	328,684 (38.1)	25 (8.2)
	862,721	305

χ^2 p <0.000

6.6.2. Characteristics of children

There were more male than female children in the sample (54.1%, n=260). Male children were overrepresented compared to the general population this difference was significant (χ^2; p <0.00).

As described at Table 11 children were aged 0-17 years of age at the time of assessment (n=447, mean, 7.9, sd 5.1, median 8). Almost one third of assessments involved children under 4 years of age (32.2%, n=144 IA or 9.7 IAs per 1,000 children aged 0-4 in the region), 28% were in the 5-9 age group (n=126 IA or 7.7 IAs per 1,000 aged 5-9), 26% in the 10-14 age group (n= 116 IA or 7.8 IAs per 1,000 children aged 10-14) and 13.7% were aged 15 and over (n=61 or 7.1 IAs per 1,000 children aged 15-17).

Table 11 Age of children in Initial Assessments

	Country, n	%	Region	%	IA[1]	%	rate per 1,000 children [2]
0 to 4	331,515	27.8	59196	27.1	144	32.2	9.7
5 to 9	355,561	29.9	65254	29.9	126	28.2	7.7
10 to 14	319,476	26.8	59568	27.3	116	26	7.8
15 to 17	183,950	15.5	34272	15.7	61	13.6	7.1
T: 0 to 17	1,190,502	100	218290	100	447	100	8.2[3]

[1] IA Sample: based on 480 IAs completed in 7 SWDs Q1 2016 for which age was documented
Rate and percentage columns may not add due to totals rounding

[2] Rate per 1,000 children in the region covered by 7 SWDs using Small Area Population Statistics derived from CSO 2016

[3] Actual number of IAs completed was 480. This produces estimated rate of 8.8 IAs per 1,000 children in the region for year 2016

Gender distribution varied by age-group, but the difference was not significant ($\chi^2(3)$ =7.0118, p= 0.072). Male children numbered 59.5% (n=85) in age-group 0-4, 54.8% (n=69) in age-group 5-9 years, 53.5% (n=62) in age-group 10-14 and only 39.3% (n=24) in age-group 15 and older.

Child ethnicity and religion were insufficiently recorded to conduct analysis.

6.6.3. Socio economic factors and relative deprivation

Table 12 describes the distribution of families in the study by SWD and displays and the mean HPRelDep score for the sample within each SWD. Families in the sample are unequally distributed geographically across the SWD's. The largest proportion of families are from SWD3 (38.8%) and the smallest are from SWD2.

The mapping of families' addresses up to small areas shows that HPRelDep ranges from -29.9 (very disadvantaged, SWD7) at the lower end of the scale to 16.51 (affluent, SWD3) at the highest end (mean -5.74, marginally below average, SD 9.6). In SWD2 and SWD3 the most relatively disadvantaged decile is classified as 'very disadvantaged' compared to the other SWDs where it is 'disadvantaged'. Across all SWDs the most affluent decile is 'affluent'.

Table 12 Sample: number of families and SA, HPRelDep by SWD

Family type	SWD1	SWD2	SWD3	SWD4	SWD5	SWD6	SWD7
All families n=307							
n, (%)	57 (19.6)	18 (7.5)	116 (38.8)	22 (6.7)	30 (9.6)	28 (6.7)	37(11.3)
HPRelDep by small area, n=272							
Mean (sd)	-4.02 (8.7)	-5.36 (10.8)	-5.4 (11.1)	-8.2 (6.8)	-9.9 (7.6)	-2.3 (5.5)	-7.4 (9.3)
Range	-24.9, 12.65	-24.7, 12.7	-26.7, 16.5	-17.3, 8.4	-23.4, 5.5	-12.5, 6.9	-29.9, 7.4
10% percentile	-14.0	-24.7	-22.2	-15.8	-19.3	-11.35	-19.5
90% percentile	6.02	7.5	8.4	0.53	1.4	5.6	4.8

HPRelDep Score -20 to -30, very disadvantaged; 10 to 20, affluent

6.6.4. Economic status by family type

Only 23.7% one parent families were in employment compared with 43.3% for heads of two-parent families. Whereas 56.6% one parent families were not in employment compared with 36.6% heads of two-parent families

6.7. Profile of assessments

The second research question asked what is the profile of IAs including the source of referrals, the SWs conducting IA, recurrence, assessed children's developmental needs and identified functioning concerns in the context of assessed parenting capacity, family functioning and exposures to risk factors, the prevalence and category of abuse and welfare needs?

6.7.1. Source of referrals

A minority of assessments were referred by members of the public (17.6%, n=84) comprised of family members (4.2%, n=47) and others (13.3%, n=37). Professional sources accounted for the majority of referrals (n=394, 82.4%), of which 30.6% (n=147) had a statutory duty as Tusla employees (n=39, 8.1%) or members of An Garda Síochána (22.5%, n=108). See Table 4.

6.7.2. Social Workers

IAs were concluded by 94 SWs in the seven SWDs, a majority who were female (74.5%, n= 70) and 26 who were in a Team Leader role. See Table 4.

6.7.3. Recurrent referrals

A majority of children had been previously involved with CPW (69%, n=331). One in ten assessments (10.6%, n=51 or 0.9 per 1,000 children) relating to 11.7% families (n=36) involved a parent who had been involved with CPW during childhood.

6.8. Parenting capacity and functioning concerns

Parenting capacity and functioning concerns are described at Table 4. Over three quarters of assessments involved concerns about at least one aspect parenting capacity to respond to a childs developmental needs (77.5%, n=372 or 6.8 per 1,000 children FY 2016). Most frequently occurring concerns related to family history and functioning (71%, n=341 or 6.2 per 1,000 children), ensuring safety (55.8%, n=268, or 4.9 per 1,000 children) and guidance and boundaries (49%, n=235 or 4.3 per 1,000 children).

At least one parental problem known to be associated with abuse was identified for either parent in 71.5% of assessments (n=343 or 6.3 per 1,000 children FY 2016). The most frequently recorded risk factor was substance misuse in (39.6%, n=190 or 3.5 per 1,000 children). Specifically, alcohol misuse by either carer was noted in 28.1% (n=135), and drug misuse by either carer in 22.3% (n=107). Substance misuse was equally prevalent among primary and second carers, approximately 18% for alcohol misuse and 14% for drug misuse.

Approximately one third of assessments identified a parent with mental health difficulties (34.6%, n=166 or 3.0 per 1,000 children). In 30.1% assessments (n=145) the primary carer had mental health difficulties. Self-harm or a suicide attempt by either parent was noted in 4.6% assessments (n=22). Almost one third of assessments identified concerns about housing (31.9%, n=153), employment and income (31.2%, n=150) and social resources (30.9%, n=148).

Acrimony between carers was recorded in 15.4% of assessments (n=74) or an estimated 1.4 per 1,000 children. Parental DV was recorded a quarter of assessments (24.6%, n=118, 2.2 per 1,000 children) relating to one in five families (20.8%, n=64). Children witnessed violence in two thirds of these assessments (65.3%, n=77). A majority of families in IAs involving DV were cohabiting couples (47.6%, n=30), one parent households comprised a third (34.9%, n=22) and separated parents made up the remaining 17.2% (n=11).

Because textual records were used, it enabled coding the relationship of the perpetrator of domestic violence to the child. In assessments involving DV perpetrated by the primary carer (5.4% of assessments, n=26 children, n=16 families) the child's mother was the primary carer in all 26 assessments. The child's father was identified as the victim in 92.3% of those assessments (n=24) and the mothers' partner in 3.9% (n=1). In assessments involving DV perpetrated by the second carer (22.1% assessments, n=106 children, n=57 families) that carer was identified as the child's father in 84% of the assessments (n=89), as a mothers' partner in 10.4% (n=11) and was not identified in one assessment (3.9%). In all 106 assessments the child's mother was identified as the victim. In 2.9% assessments, involving 14 children and 9 families, both parents perpetrated DV. Lastly, of children exposed to DV, 72.0% (n=85) had prior involvement with CPW.

Carer involvement in crime was recorded in 14.1% of assessments (n=68) and in 3.3% of assessments (n=16) one carer (c2) was identified as being in prison.

Over a third of families (37.7%, n=116) were dependent on welfare as the principal source of income with a further third (36.4%, n=112) relying on a combination of welfare and other sources. A higher proportion of one-parent families were unemployed (53.5%, n=84) compared to families with cohabiting couples (37.8%, n=56). Subjectively, housing was assessed as being problematic (27.5%, n=84 families overall) more frequently for one-parent families (57.1%, n=48) than for families with cohabiting parents (42.9%, n=36).

6.8.1. Assessed parenting capacity in the context of identified risk factors and burdens

Table 13 describes the assessed parenting capacity in the context of problems identified at the parent and family level. Compared to assessments where parental difficulties were not identified, the prevalence of concerns was higher in every dimension of parenting capacity and family functioning where parental risk factors for abuse and functioning difficulties were identified. These included re-

referred reports and those involving parental mental health difficulties (χ^2 p < 0.00). Parental unemployment was linked to increased concerns about basic care and all aspects of the family and environmental factors (χ^2 p<0.00). Parental substance misuse was significantly associated with concerns in basic care, stability, family history and functioning, housing and income (χ^2 p < 0.00). Parental DV was associated with concerns about parenting capacity in domains of basic care, safety, emotional warmth, guidance and boundaries and stability in addition to family and environmental factors in domains of family history and functioning, housing and income (χ^2 p < 0.00).

Assessments based on re-referrals were linked to concerns in all aspects of parenting capacity except stimulation, and to increased level of concerns about housing and income (χ^2 p<0.00). Lastly, intergenerational involvement with CPW was significantly associated with concerns regarding parenting capacity except relating to emotional warmth and guidance and boundaries and significantly associated with concerns in all four dimensions regarding the wider family environment (χ^2 p < 0.00).

SWs perceived that parents recognised risks in 61.7% of assessments (n=296) and engaged with them in 71% of assessments (n=241). Overall parents were viewed as having capacity or motivation to address concerns or, to act protectively in 52.3% of assessments (n=251).

Table 13 Parenting capacity by sample and by assessments featuring parental risk factors DV, substance misuse, unemployment, previously known to SWD, involvement with CPW during childhood

Assessments	Basic care	Ensuring safety	Emotional warmth	Stimulation	Guidance & boundaries	Stability	Family functioning	Social resources	Housing	income
Sample (n=480, 100)	122 (25.4)	268 (55.8)	153 (31.9)	66 (13.8)	242 (50.4)	235 (49.0)	341 (71.0)	148 (30.8)	153 (31.9)	150 (31.3)
Known (n=331, 69.0%)	104 (31.4)*	204 (61.6)*	119 (35.9)*	47 (14.9)**	179 (54.1)*	188 (56.8)*	265 (80.1)*	109 (32.9)**	105 (46.3)*	116 (35.1)*
Unemployment (n=277, 47.3%)	74 (32.6)*	135 (59.5)**	78 (34.4)**	37 (16.3)**	125 (55.1)**	120 (52.9)**	180 (79.3)*	87 (38.3)*	105 (46.3)*	95 (41.9)*
Substance misuse (n=190, 39.6%)	58 (30.6)*	112 (58.9)**	64 (33.7)**	23 (12.1)**	108 (56.9)**	117 (61.6)*	164 (86.3)*	62 (32.6)**	74 (39.0)*	75 (39.5)*
Mental health diff. (n=166, 34.6%)	68 (41.0)*	105 (63.3)*	81 (48.8)*	34 (20.5)*	102 (61.5)*	110 (66.3)*	145 (87.4)*	66 (39.8)*	78 (47.0)*	75 (45.2)*
Acrimony (n= 74, 15.4%)	28 (23.0)*	47 (17.2)**	29 (18.9)**	18 (27.3)*	35 (14.5)**	55 (23.4)*	64 (18.8)*	27 (18.2)**	26 (17.0)**	26 (17.3)**
DV (n=118, 24.6%)	39 (33.0)*	96 (81.4)*	51 (43.2)*	18 (15.3)**	70 (59.3)*	91 (77.1)*	107 (90.7)*	34 (28.8)**	54 (45.8)*	53 (44.9)*
CPW in childhood (n=51, 10.6%)	24 (47.1)*	38 (74.5)*	22 (43.1)**	8 (15.7)**<***	25 (54.9)**	36 (70.6)*	51 (100.0)*	32 (62.8)*	31 60.8)*	24 (47.1)*

*χ^2 p <=0.050
** $\chi^2 p$ > 0.05
*** Fishers exact test p> 0.05

6.9. Child developmental and functioning characteristics and findings of secondary abuse

As described at Table 4, SWs identified concerns about child developmental needs on all subdomains of the Assessment Framework, many which were co-occurring. Three quarters of assessments featured at least one child developmental concern (74.6%, n=358 or 6.6 per 1,000 children) and many were co-occurring. The most prevalent were emotional and behavioural development (49.2%, n=236 or 4.3 per 1,000 children), family and social relationships (47.9%, n=230 or 4.2 per 1,000 children), health concerns 25.8%, n=124 or 2.3 per 1,000 children) and identity related needs (23.1%, n=111 or 2.0 per thousand children). Assessed developmental concerns were not different for females compared to males except in the case of self-care, where it was disproportionately higher for females compared to males (χ^2 p=0.02). One in five children were subject to violence by a carer (21%, n=100) and 16% of children undergoing IA witnessed DV (n=77).

6.9.1. Assessed child needs in the context of identified parent and family level problems

Table 14 describes the results of bivariate analysis conducted to examine assessed child developmental needs where risk factors for abuse among parents or carers were identified. Compared to IAs where known risk factors for abuse are not recorded, there was a significant association between family level risk factors for abuse and concerns about children's emotional and behavioural development, family and social relationships, identity, and self-care (χ^2 p <0.05).

Concerns about children's relationships within the family and socially were higher in IAs where children were known to CPW compared to index referrals (54.4%, n=180; $\chi^2(1)=17.8525$, p=0.00), where parents were unemployed compared to those who were employed (53.7%%, n=122; $\chi^2(1)=5.861$, p=0.025), where parental mental health were recorded compared to no parental mental health difficulties (57.8%, n=96; $\chi^2(1)=9.9952$, p=0.00), and assessments involving parental acrimony (62.1%, n=46; $\chi^2(1)=7.114$, p=0.00) and DV (61.0%, n=72; $\chi^2(1)=10.7595$, p=0.00), when compared to those without.

Concerns about children's emotional and behavioural development were higher in assessments where children were known compared to index referrals (52.6%, n=174; $\chi^2(1)=4.9358$, p=0.03), where parental substance misuse was recorded compared to no parental substance misuse (40.0%, n=76; $\chi^2=10.5731$, p=0.00), where parental mental health difficulties were recorded compared to no parental mental health difficulties (55.4%, n=92; $\chi^2(1)=3.9724$, p=0.05), and assessments involving DV compared to those without DV (50.3%, n=70; $\chi^2(1)=6.4563$, p=0.01).

Child identity concerns were more likely recorded in IAs where children were known to CPW (27.5%, n=91; $\chi^2(1)=11.4412$, p=0.00), where parents were unemployed (30.0%, n=68; $\chi^2(1)=11.3042$, p=0.00),

and where parental substance misuse was recorded (27.9%, n=53; $\chi^2(1)=4.0246$, $p=0.05$) when compared to those IAs without these features.

Table 14 Child developmental needs by parent or family level risk factors, n (%)

Assessments (n, %)	Health	Education	Emotional behavioural development	Identity	Family and social relationships	Social presentation	Self-care
Sample (480, 100)	124 (25.8)	27 (5.6)	236 (49.2)	111 (23.1)	230 (47.9)	95 (19.8)	68 (14.2)
Child female (218, 45.4)	60 (48.4)**	14 (51.9) **	108 (45.8)**	49 (44.1)**	95 (41.3)**	47 (49.5)**	40 (58.8)*
Known (331, 69.0)	87 (26.3)**	21 (6.3)**	174 (52.6)*	91 (27.5)*	180 (54.4)*	72 (21.8)**	54 (16.3)*
Unemployed (227, 47.3)	55 (25.2)**	8 (3.5)**	103 (45.4)**	68 (30.0)*	122 (53.7)*	49 (21.6)**	43 (18.9)*
Par substance misuse (190, 39.6)	39 (20.5)*	10 (5.3)**	76 (40.0)*	53 (27.9)*	98 (51.6)**	30 (15.8)**	20 (10.5)**
Par mental health diff (166, 34.6)	40 (24.1)**	12 (7.8)**	92 (55.4)*	44 (26.5)**	96 (57.8)*	45 (27.1)*	28 (16.9)**
Acrimony (74, 15.4)	21 (16.0)**	9 (33.3)*	42 (17.8)**	13 (11.7)**	46 (20.0)*	14 (14.7)**	8 (11.8)**
DV (118, 24.6)	25 (21.2)**	6 (5.1)**	70 (59.3)*	31 (26.3)**	72 (61.0)*	22 (18.6)**	9 (7.6)*
Par CPW childhood (51, 10.6)	16 (31.4)**	4 (7.8)****	26 (51.0)**	20 (39.2)*	33 (64.7)*	14 (27.5)**	10 (19.6)**

*chi2 $p < 0.05$

**chi2 $p > 0.05$

*** Fishers exact $p < 0.05$

**** Fishers exact $p > 0.05$

In 51 assessments involving 36 families, parents had been involved with CPW during childhood

6.9.2. Categorisation of concerns and assessed needs

Described at Table 15, assessment led to the re-categorisation of the primary report type recorded at Intake across all categories. At the individual case level this may have been impactful as welfare concerns were categorised as abuse and vice versa but the change was not significant (χ^2 $p=0.38$). However, the distribution of cases by category among those that remained open for ongoing service was significantly different to those undergoing IA (χ^2 $p=0.01$) and is described further at Table 6.14 below. On conclusion of the IA, slightly under half the assessments were categorised as welfare concerns (47.4%, n=220) meaning that identified child developmental needs and the risks suggested current or potential development impairment but did not meet the threshold for abuse.

Table 15 Category of assessment at Intake, Initial Assessment and Ongoing Service n (%)

	Intake	Initial Assessment	Ongoing service
Welfare	215 (45.2)	220 (47.4)	67 (36.2)
Emotional abuse	87 (18.3)	66 (14.2)	28 (15.1)
Neglect	75 (15.8)	84 (18.1)	58 (31.4)
Physical abuse	63 (13.2)	56 (12.1)	17 (9.2)
Sexual abuse	36 (7.6)	38 (8.2)	15 (8.1)
Total	476	464	185

Totals vary between intake and IA because categories were not noted in some records

Category at intake compared to IA χ^2 p==0.38; Category at IA to ongoing service χ^2 p=0.01

Identified in 17.5% of assessments (n=84), neglect was the most prevalent primary type of abuse. Emotional abuse was the primary category identified in 13.8% of assessments (n=66), physical abuse

in 11.7% of assessments (n=56) and sexual abuse in 8% of assessments (n=38). A small number of assessments (3.3%, n=16) involving false allegations or resolved concerns, were categorised as having no primary report type. This data reflects the categorisation of the primary concerns in assessments, it does not imply substantiation.

6.9.3. Risk of future harm

In cases categorised as abuse, a SW must determine whether or not a child is suffering, or is at risk of significant harm (HSE, 2011; HSE/Tusla, 2009/2014).[55] In one third of abuse related assessments children were identified as being at risk of future harm (32.0%, n=78) and four children in the welfare category were identified as being at risk of significant harm. See Table 4.

Table 14 describes the child and family characteristics by the category of the IA at the conclusion of IAs. Although assessments for welfare concerns, emotional abuse and physical abuse were more prevalent for males compared to females (66.5%, 60.6% and 58.9% respectively) and assessments for sexual abuse were more prevalent for females compared to males (60.5%), the categorisation of assessment did not significantly differ by child gender, age groups or family type. Relative to children in families with 3 or fewer children, a higher proportion of children in larger families (23.1%, n=111) were assessed for neglect and the relationship was statistically significant (34.5%, n=29; $\chi^2(1)= 7.4418$, $p=0.01$).

Compared to assessments related to index referrals, assessments based on repeat referrals (69.0%, n=320) were likely to be categorised as welfare (63.6%, n=140; $\chi^2(1)=5.3741$, $p=0.02$) and neglect (85.7%, n=72; $\chi^2(1)=13.3546$, $p=0.00$) and sexual abuse (56.6%, n=20; $\chi^2=5.1389$, $p=0.02$), and to involve findings of secondary abuse (38.4, n=127; $\chi^2(1)=9.2479$, $p=0.002$). Overall, compared to the welfare category, assessments involving repeat referrals (69.0%, n=331) were more likely to be categorised as abuse (54.4%, n=180, $\chi^2(1)=5.3687$, $p=0.02$). See Table 6.15.

[55] This being so, a case is automatically follows the Child Protection pathway and is the subject of Child Protection Case Conference (CPC) to determine whether or not to list a child on the Child Protection Notification System (CPNS).

Table 16 Characteristics by category of assessment and abuse findings following IA

	Welfare compared to abuse or none	**Abuse (any) compared to welfare or none**	**Individual sub-types of abuse**				**Finding of secondary abuse**
Characteristic	Welfare n, % (220, 47.4)	All abuse n, % (244, 52.6)	Emotional abuse n, % (66, 14.2)	Neglect n, % (84, 18.1)	Physical abuse n, % (56, 12.1)	Sexual abuse n,% (38, 8.2)	All subtypes n, % 163 (34.0)
Child female (218, 45.4)	96 (44.0)**	114 (52.3)**	26 (39.4)**	42 (50)**	12 (41.1)**	23 (60.5)**	86 (39.5)*
Child age group							
0-4	69(47.9) **	67 (46.5)**	24 (38.1) **	32 (39.5) **	9 (17.3) *	2 (5.9) ***	38 (26.4) *
5-9	47 (37.3)*	73 (57.9)**	20 (31.8) **	22 (27.1) **	18 (34.6)**	13 (38.2)**	45(35.7) **
10-14	52 (44.8)**	62 (53.5) **	14 (22.2) **	22 (27.1)**	17 (32.7)**	9 (26.5)**	44 (37.9)**
≥ 15	33 (54.1)**	28 (45.9)**	5 (7.9)**	5 (6.17)***	8 (15.4)**	10 (29.4)*	27 (44.3)**
One-parent family (230, 47.9)	107(48.6)**	119 (48.8)**	31(46.9)**	42 (50.0)**	25 (44.6)**	21 (55.3)**	82 (35.7)**
Total children in family							
1 to 3 (369, 76.9)	173(48.9)**	185 (50.1)**	54 (81.8)**	55 (65.5)*	47 (89.9)**	29 (76.3)**	114 (30.9)*
Assessed parent difficulties							
Primary income: unemployed (227, 47.3)	103(45.4)**	113 (47.3)**	35 (15.4)**	47 (20.7)**	17 (7.5)*	14 (6.2)**	78 (34.4)**
Parent substance misuse (190, 39.6)	93 (48.9)**	91 (47.9)**	35 (15.4)*	42(22.1)*	10 (5.3)*	4 (2.1)***	65 (34.2)**
Parent mental health difficulty (166, 34.6)	78 (47.0)**	88 (53.0)**	29 (17.5)**	43 (25.9)*	5 (3.0)***	11 (6.6)**	63 (38.0)**
Acrimony (74, 15.4)	32 (43.2)**	42 (56.8)**	16 (21.6)*	20 (27.0)*	6 (8.1)**	0 (0.0)***	36 (49.0)*
DV (118, 24.6)	48 (40.7)**	70 (59.3)*	35 (16.2)*	20 (17.0)**	15 (12.7)**	0 (0.0)***	70 (57.6)*
Prior involvement							
Child known (331, 69.0)	140 (42.3)*	180 (54.4)*	47 (71.2)**	72 (85.7)*	41 (73.2)**	20 (52.6)*	127 (38.4)*
Par. CPW childhood (51, 10.6)	30 (58.8%)*	21 (41.2)**	4 (7.8%)***	7 (13.7)**	5 (9.8)***	5 (9.8)***	21 (41.2)**
Assessed development needs							
Health (124, 25.8)	52(41.9)**	70 (56.5)**	11 (8.9)**	33 (26.2)*	17 (13.7)**	9 (7.3)**	45(36.3)**
Education (28, 5.6)	18 (66.7)*	9 (33.3)**	2 (7.4)***	3 (11.1)***	2 (7.4)***	2 (7.4)***	13(48.2)**
Emotional & behavioural dvt. (236, 29.2)	103(43.6)**	130 (55.1)**	31 (13.1)**	40 (17.0)**	36 (15.3)*	23 (9.8)**	107(45.3)*
Identity (111, 23.1)	49 (44.1)**	59 (53.2)**	16 (14.1)**	23 (20.7)**	18 (16.2)**	2 (1.8)***	46(41.4)**
Family social relationships (230, 47.9)	105(45.7)**	117 (50.9)**	34 (14.8)**	41 (17.8)**	26 (11.3)**	16 (7.0)**	99 (43.0)*
Social presentation (95, 19.8)	39 (39.0)**	57 (60.0)*	9 (9.5)**	29 (30.5)*	14 (11.1)**	5 (5.3)***	41(43.2)*
Self-care (68, 14.2)	30 (44.1)**	37 (54.4)**	7 (10.3)**	22 (32.4)*	5 (7.4)***	3 (4.4)***	26(38.2)**

*χ^2 $p < 0.05$

** χ^2 $p > 0.05$

*** counts too few to produce valid test

As described in Table 16, compared to children whose IAs are categorised as welfare, those whose IAs are categorised as abuse appear to be slightly younger. Otherwise, distributions of demographic features in IAs categorised as welfare are similar to distributions in IAs categorised as abuse.

There was a significant association between parental substance misuse and each of the abuse categories emotional abuse (15.4%, n=35; $\chi^2(1)=5.7858$, $p=0.02$) neglect (22.1%, n=42; $\chi^2(1)=4.6197$, $p=0.03$) physical abuse (5.3%, n=10; $\chi^2(1)=12.5130$, $p=0.000$) and sexual abuse (2.1%, n=4; $\chi^2(1)=14.5692$, $p=0.000$) but the numbers in the sexual abuse category are too small for associations to be considered valid (Frankfort-Nachmias and Leon-Guerrero, 2017).

Parental relationship difficulties (acrimony) were significantly associated with emotional abuse (21.6%, n=16; $\chi^2(1)=4.5710$, $p=0.03$) and neglect (27.0%, n=20; $\chi^2(1)=5.5001$, $p=0.02$). IAs involving parental

acrimony were more likely to involve findings of secondary abuse (57.6%, n=70; $\chi^2(1)=8.4187$, $p=0.00$) compared to IAs where there were no findings of abuse.

Compared to other sub-types of abuse, DV was significantly associated with emotional abuse (16.2%, n=35; $\chi^2(1)=33.4002$, $p=0.00$) and with findings of secondary abuse compared to IAs where there were no findings of secondary abuse (57.6%, n=68; $\chi^2(1)=39.0843$, $p=0.00$). Findings of secondary abuse were higher in assessments involving DV compared to those without DV (57.6% n=68, compared to 34%, n=163).

Compared to assessments without parental mental health concerns, assessments involving parental mental health problems were *less likely* to be categorised as physical abuse (3.0%, n=5; $\chi^2(1)=18.4435$, $p=0.00$) but here also, counts are too small for associations to be considered valid (Frankfort-Nachmias and Leon-Guerrero, 2017). Where parents were unemployed assessments were *less likely* to be categorised as and physical abuse compared to other sub-types (7.5%, n=17; $\chi^2(1)=7.2937$, $p=0.01$).

Repeat involvement was more prevalent in IAs categorised as abuse but was significantly associated with both welfare (42.3%, n=140; $\chi^2(1)= 5.3741$, $p=0.02$) and abuse categories (54.4%, n=180; $\chi^2(1)=5.3687$, $p=0.02$) and was also significantly associated with findings of abuse compared to IAs not involving findings of abuse (38.4%, n=127; $\chi^2(1)=9.2479$, $p=0.002$). Assessments involving intergenerational CPW concerns were primarily categorised as welfare when compared to any abuse (58.8%, n=30, $\chi^2(1)=3.8786$, $p=0.049$).

The prevalence of assessed child development concerns (independent variables) is different in IAs categorised as welfare compared to those categorised as abuse, but bivariate analysis shows that relationship between the independent variables and category of IA are for the most part not statistically significant. This may reflect the finding described in Table 3 of considerable overlap of characteristics across categories of abuse and welfare. There are a couple of notable differences however, for example, concerns related to educational development are more prevalent in welfare assessments and are more likely to be associated with IAs categorised as welfare compared to abuse (66.7%, n=18; $\chi^2(1)=5.0016$, $p=0.03$). Exposure to DV is more prevalent in abuse investigations and is more likely to be categorised as abuse compared to welfare (59.3%, n=70; $\chi^2(1)=4.5111$, $p=0.03$).

Certain identified child developmental needs were associated with particular sub-categories of abuse. Identified health concerns (26.6%, n=33; $\chi^2(1)=9.6169$, $p=0.002$, social presentation concerns (30.5%, n=29; $\chi^2(1)=13.9205$, $p=0.00$) and concerns about child self-care (32.4%, n=22; $\chi^2(1)=12.1056$, $p=0.0$) were significantly associated with assessments of child neglect. Child behavioural and emotional concerns were significantly associated with emotional abuse assessments (15.3%, n=36; $\chi^2(1)=5.7982$. $p= 0.016$). And, though numbers were very small, there was a significant association between child identity concern and sexual abuse (1.8%, n=2, Pearson $\chi^2(1)=7.4061$, $p= 0.007$, Fisher's exact $p=0.004$).

In 2016 Irish policy did not require SWs to substantiate abuse or to confirm the allegations to which the IA relates. Co-occurring abuse and welfare concerns refer to findings of current or past abuse or welfare concerns documented by a SW, that were not accounted for in the current 'primary report type'. One in three assessments involved findings of co-occurring abuse (34.0%, n=163 or 3 per 1,000 children) and the prevalence was higher in assessments involving re-referrals (75.8%, n=127 $\chi^2(1)=9.247$, $p=0.00$) and in assessments categorised at risk of significant harm relating to the 'primary report type' (43.9%, n=36; $\chi^2(1)= 4.46$, χ^2 $p=0.04$).

Where there were findings of secondary abuse, assessments were more likely to involve girls than boys (39.5%, n=86; $\chi^2(1)=5.3699$, $p=0.02$), children previously known compared to index referrals (38.4%, n=127; $\chi^2(1)=9.2479$, $p=0.00$), parental acrimony compared to no acrimony (48.7%, n=36; $\chi^2(1)=8.4187$, $p=0.004$) and DV compared to no DV (57.5%, n=68; $\chi^2(1)=390843$, $p=0.00$).

Compared to older age-groups, documented finding of abuse were less prevalent in the 0-4 age group (26.4%, n=38; $\chi^2(1)=5.2557$, $p=0.02$) and more prevalent in families with more than 4 children compared to those with 1-3 children (44.1%, n=49; $\chi^2(1)=6.6798$, $p=0.010$).

6.9.4. Documented secondary abuse by category

The most prevalent form of secondary abuse was neglect (28.3%, n=136). The prevalence of co-occurring emotional abuse was 8.3% (n=40), physical abuse 6.0% (n=29) and sexual abuse 3.5% (n=17). The prevalence of co-occurring welfare concerns was 5.6% (n=27). See Table 17.

Every second child whose assessment was categorised as physical abuse IA (n=56, 12.1%) involved findings of secondary neglect (51.8%, n=29). Almost every second emotional abuse assessment (n=66) involved findings of secondary neglect (48.5%, n=32). Approximately one in four welfare assessments (n=220) involved findings of co-occurring neglect (24.5%, n=54).

Table 17 Co-occurrence of primary and secondary welfare and abuse

Primary report type	Secondary Welfare (n=27)	Secondary Emotional (n=40)	Secondary Neglect (n=136)	Secondary Physical (n=29)	Secondary Sexual (n=17)	Any secondary abuse (n=163, 34.0%) n, (%)
Welfare 220 (47.4)	1 (0.5)	7 (3.1)	54 (24.5)	12 (5.5)	7 (3.2)	61 (27.1)
Emotional 66 (14.2)	5 (7.8)	14 (21.2)	32 (48.5)	8 (12.1)	1 (1.2)	35 (53.0)
Neglect 84 (18.1)	6 (7.1)	9 (10.7)	10 (7.4)	4 (4.7)	1 (1.2)	18 (21.4)
Physical 56 (12.1)	12 (21.4)	5 (8.9)	29 (51.8)	5 (8.9)	1 (1.8)	30 (53.6)
Sexual 38 (8.2)	3 (7.9)	5 (13.2)	10 (26.3)	0	7 (18.4)	18 (47.4)

Numbers may not round to total when primary report type is not noted

This concludes the findings. The discussion is presented at Section 6.8.

6.10. Discussion

6.10.1. Overview

This study set out to enhance the understanding of the context for assessment and decision-making in IAs and to provide estimates of the scope and characteristics of child welfare and child abuse IAs in 7 SWDs in Ireland in 2016.

The cross-sectional design was useful because it enabled simultaneous examination of national and 'street level' population based data (CSO SAPS, 2016; Haase and Pratschke, 2017a), agency administrative data (tusladata, *Annually*) and empirical narrative case records to explore multiple exposures and decisions.

By translating empirical narrative case records into counts, SWs empirical narrative observations recorded in Intake and Assessment Records but never collated or published, became available for analysis. Recognising the issues around interpretation definitions, efforts were taken in this study to deconstruct and explore the 'content' of typologies of abuse. Although the practice of counting is an interpretive act (Driscoll *et al.*, 2007; Jud *et al.*, 2016; Sandelowski *et al.*, 2009) the approach adopted was to code 'what I saw' (Huffhines *et al.*, 2016). This led to the creation of a rich data set that was strong in information. Importantly, it enabled the production of new knowledge that serves as an alternative to the socially constructed meanings (Fallon, 2020; Parton, 2019) that frequently drive ideas about the necessity of CPW investigations and responses to abuse and welfare concerns. As a result, the study provides a number of new insights into the context for assessment practice and many new findings regarding the children and families involved, their assessed risk exposures and identified service needs. Some key findings are discussed below. The study is appraised in Chapter 8 where limitations of the design and analytic approaches are reviewed in the context of the findings and the theoretical, policy and research implications of the study are addressed.

6.10.2. Demographic context for practice

The study generated for the first time in Ireland evidence of the demographic setting for children and families undergoing IA. The study area is slightly less affluent overall compared to the national profile with fewer Small Areas (SAs) at the affluent levels and a higher proportion clustered around the mean. Consistent with the literature, families undergoing assessments have considerable burdens compared to families in the general population (Hood *et al.*, 2020a; Pelton, 2015). Families were clustered in areas of greater disadvantage relative to the general and local population, living in areas with a mean HPRelDep Score of -5.74 compared to mean -0.0 and -0.8 respectively characterised as 'disadvantaged' and 'very disadvantaged' (Haase and Pratschke, 2017a).

6.10.3. Demand: Rates of IAs and responses and international comparisons

Analysis of Tusla statistics for 2016 indicates that 20,117 referrals nationally progressed to IA equating to 16.9 per 1,000 children. Outcomes were recorded for 9,045 or 45% of these, representing 8.3 IAs per 1,000 children. The outcomes figure equates with the number and proportion if IAs completed in this study i.e., 480 IAs or 2.2 children per 1,000 in Q1 or an estimated 8.8 per 1,000 children in 2016. Acknowledging that there are variations in the rates of IAs conducted across SWDs, it is reasonable to assume this reflects patterns of practice conducted across Tusla.

The incidence of IAs in Ireland (16.9/1,000 children) is considerably lower than incidence rates recorded in other Anglophone jurisdictions and documented in Chapter 3 Section 3.5 (AIHW, 2017; DHHS, 2018; Fallon *et al.*, 2022; Fallon *et al.*, 2021; Hood *et al.*, 2016; Trocmé *et al.*, 2010). But, this may in part be a feature of lower reporting rates compared to other Anglophone regions (Furey and Canavan, 2019; McGee *et al.*, 2002; Whelan, 2018).

The rate of ongoing service in this study was 38.5% (n=185 or 3.4/1,000 children). While it represents a minority of children undergoing IA the figure is higher than the rate reported in the Audit of SBPs conducted by Tusla (2015) (13.5%, range 0, 35%), and at the upper range of the data published in annual statistics for 2016 of IAs with outcomes (see Chapter 2) showing 3,895 IAs or 43% of IAs or 3.3/1,000 children nationally remained open for ongoing services. Almost two thirds of IAs were closed/NFA (61.5%, n=295 IAs or 5.4/1,000 children and a majority of these were not diverted to other services. In this sample 12% of closed cases (n=35) were referred to other services and 11% of closed cases (n=33) were referred to PPFS.

This study reveals that almost one in four IAs remained open for service (38.5%, n=185). Data collections vary across Anglophone jurisdictions, but where comparisons are possible they indicate that the proportion of IAs receiving ongoing service in Ireland is consistent with Canada (Fallon *et al.*, 2015; Trocmé *et al.*, 2010) and New Zealand (OrangaTamariki, 2017), higher than the one in five in Australia (AIHW, 2017) and slightly lower than one in three in the US (Slack and Berger, 2020) and in Northern Ireland (Department of Health, 2016).

Issues relating to potential underreporting of child abuse in Ireland are not the subject of this thesis and have been addressed elsewhere (Buckley and Buckley, 2015; O'Leary and Lyons, 2021; Whelan, 2018). Trend analysis from 2013 to 2021 (see Figure 7) indicates a continuing rising rate in referrals but a widening gap in the proportion that receive IAs and between IAs and ongoing services. Findings from this study which indicate rates of intervention following IA are in line with international trends, suggest that the IA process in Ireland has a similar 'gatekeeping' function to other systems and that the CPW system itself once children are involved, operates as a high risk strategy addressing the highest risk cases in a similar fashion to other Anglophone systems (Buckley and Burns, 2015; Hood *et al.*, 2016; O'Leary and Lyons, 2021).

6.10.4. Profile of families and children

Families with children aged 0-17 years comprise about half (49.9%, n=603,572) of all families in Ireland (CSO, 2017b). Of those families, 79% are couples with children aged 0-17 years (n= 476,935, 79.0%), a profile replicated across the study area. On the whole, one parent families are over-represented in the sample and the difference is significant (sample rate 51.1%, range 22.2% to 67.9%, compared to the national rate of 21.0%, n=126637; χ^2 p <0.00).

The average number of children per family in IAs was 2.6 (SD 1.3, 1,10), almost double the national average of 1.38 (CSO, 2017a; b). Among the larger families in the study, 16.2% families (n=50) had more than 4 children compared to 6.2%, (n=37,568) nationally. The differences are significant (χ^2 p <0.000).

A little over one in three families were reliant on welfare as a source of income. Over half one-parent families were unemployed, which is higher than national rates. Housing instability, which may also be linked to income, was more prevalent among one-parent families than for families with cohabiting parents. As one-parent families were overrepresented in the sample, these findings represent considerable burdens. Two-parent families in the sample were disproportionately unemployed compared to similar families nationally (37.8% compared to 29.8% nationally (CSO, 2017b). These findings highlight the necessity for SWs to consider families' social context when assessing current family difficulties, needs and its role in potentially supporting or compromising interventions.

The prevalence rate of adult mental health concerns or substance misuse was 55.4% (n=266), more than three times the national rate (MHIreland, 2022; OECD and EU, 2016),indicating increased potential burdens and service needs relative to the general population. This is reflected in the bivariate analysis which points to interaction between parental mental health concerns and almost every aspect of parenting capacity in addition to concerns about children's emotional and behavioural development, family and social relationships and presentation in addition to identified child health, education, and emotional and behavioural concern. In sum, the evidence indicates that parents and children undergoing assessment had considerable identified support needs relating to parental mental health and substance misuse.

There was occasional reference to younger parents in records, but overall information on carer age was insufficiently documented to warrant analysis. Another limitation of the data source was the absence of systematically collated evidence on the ethnicity of children and families.

Relative to the general population, infants and young children were overrepresented in assessments (32%; n=144; $\chi^2 p$ <0.05). In addition, as described at Table 10 compared to the national profile, families with the youngest child under 4 years of age are overrepresented (44.8%, n=136 families; χ^2 p <0.00) IAs involving children aged 0-4 years were conducted at a higher rate of 2.4 IAs per 1,000 children aged 0-4 in Q1 or an estimated 9.7 per 1,000 children aged 0-4 in 2016, compared to a rate of 1.8 per

1,000 children aged 15-17 years in Q1 or an estimated 7.1 IAs per 1,000 children aged 15-17 annually (see Table 11). These findings are consistent with age profiles in assessments conducted in Australia (AIHW, 2017), Canada (CIS, 2010; Fallon *et al.*, 2015) and the US (DHHS, 2018) and different to those in Northern Ireland (Department of Health, 2016), England (Department for Education, 2016) and Scotland (SCRA, 2018).

The overrepresentation of infants and young children in IAs suggests their perceived vulnerability for abuse and neglect and impaired emotional development which can endure across a child's live (Blumenthal, 2015; NSCDC, 2012; 2013). By virtue of their age and, relative to older children, infants and young children are at high risk for recurrent involvement with CPW, meaning that decisions made in IA are highly consequential for them (Brown *et al.*, 2019; Featherstone *et al.*, 2014a; Filippelli *et al.*, 2017b; Filippelli *et al.*, 2021; Hamilton-Giachritsis and Pellai, 2017; Harris and Mildon, 2017; Jonson-Reid, 2002; Putnam-Hornstein *et al.*, 2015; SCRA, 2018; Trocmé *et al.*, 2010; Trocmé *et al.*, 2001; Whelan, 2018). Already, two thirds of children aged 0-4 (66.0%, n=95) were previously known to CPW. But findings of secondary abuse were less likely in age-group 0-4 compared to other age-groups (26.4%, n=38; $\chi^2(1)=5.2557$, p=0.02). The findings suggest that this cohort of children requires targeted age appropriate interventions to address their current needs and to support caregivers to respond to their distinctive prevention needs.

In sum, families in IAs have greater burdens relative to the general population. Demographically, one parent families are over-represented in assessments, families have more children and younger children compared to families in the general population. Infants and children up to age 4 are overrepresented in IAs and these children are particularly vulnerable based on their age. Compared to other Anglophone systems demand for CPW services measured in referrals per capita in the child population is lower but response rates, once children are screened in are equal and importantly, equally low. Given the demographic profile of families involved in assessments, the high rate of re-referral in IAs and the low rate of response raises questions for the system. Echoing Featherstone and Gupta (2018); and Weiss-Gal and Savaya (2012) it is my view that families' social context and demographic characteristics should be articulated as part of assessments to develop a robust understanding of service needs for children and parents and as a means to facilitate advocacy with other professionals and services. The gender and age distribution in IA and service provision warrants further research on a larger sample.

6.10.5. Categorisation

The prevalence of abuse subtypes in assessments differs from reporting patterns and IA led to the re-categorisation of the primary abuse type recorded at Intake across all categories (see Table 15). In the sample, welfare was the most prevalent category in IAs (45.8%, n=220) followed by neglect 17.5% (n=84), emotional abuse (13.8%, n=66) and physical abuse (11.7%, n= 56) and sexual abuse (7.9%, n= 38). In reports (see Figure 6) welfare reports are also most prevalent but among abuse subtypes, emotional abuse is reported more frequently than neglect.

Consistent with international evidence, among abuse sub-types (50.83%, n=244), neglect (34.4%, n=84) and emotional abuse (27.1%, n=66) were most prevalent, and sexual abuse least prevalent (15.6%, n=38) in assessments and the pattern was similar where there were findings of secondary abuse (neglect 28.3% n=136; emotional abuse (8.3%, n=40) (AIHW, 2017; Fallon *et al.*, 2017b; Finkelhor *et al.*, 2021; Jud *et al.*, 2016; NSCDC, 2012; SCRA, 2018; Sheehan, 2019).

Welfare cases were disproportionately closed, and neglect cases were disproportionately open. The findings build on the current evidence (Buckley, 2003; Gibbons *et al.*, 1995; Hood *et al.*, 2016; Lonne *et al.*, 2020; Thorpe, 1997; Tusla, 2015; Whelan, 2018) demonstrating that categorisation operates as a mechanism for caseload and demand management across the system.

The categorisation of an IA relates to the *primary* concern, called the primary report type or typology of abuse or welfare, published in administrative data by Tusla. As evidenced in Table 3, the categorisations of concerns into these typologies represented heterogeneous and overlapping harms and exposures, particularly between welfare, emotional abuse, and neglect (Farmer and Owen, 1995; Gilbert *et al.*, 2009a; Higgins and McCabe, 2001; Price-Robertson *et al.*, 2013b). This upholds findings from a broad church of literature indicating that SWs incorporate a range of variables related to children's experiences and parental risk factors to construct or operationalise definitions of abuse and welfare (Benbenishty *et al.*, 2015; Buckley, 2003; Bullock *et al.*, 1995; Christ and Schwab-Reese, 2020; Devaney and Spratt, 2009; Dixon *et al.*, 2007; Drake, 1996; Ferguson and O'Reilly, 2001; Higgins and McCabe, 2001; Jud *et al.*, 2016; Knickerbocker *et al.*, 2007; Metzler *et al.*, 2017; Morris, 2009; Nikolova *et al.*, 2020; Parton, 2018; Parton *et al.*, 1997; Price-Robertson *et al.*, 2013b; Roy, 2021; Scott and Faulkner, 2019; Sheehan, 2019; Slep and O'Leary, 2005; Spratt, 2012; Stanley *et al.*, 2010; Thorpe, 1997; Turney *et al.*, 2011; Wattam, 1996; Whelan, 2018).

While the overlap identified between categories may suggest that the impact of child developmental factors or parent risk factors are variously understood or operationalised, simple bivariate analysis indicates some differences between the categories. For example, child education needs were more prevalent in welfare assessments. Unsurprisingly, relative to other categories of abuse or welfare, neglect was more prevalent in larger families, and children who had identified health, social presentation concerns and self-care needs. Neglect assessments were more likely than other categories to feature parental mental health concerns, substance misuse and significant relationship difficulties, all of which the evidence indicates, are problems that impacted on most dimensions of parenting capacity and suggest particular support needs for children.

Consistent with international evidence, the low number IAs involving primary or secondary sexual abuse concerns (10.0%, n=48) suggest that sexual abuse is under reported (Jud *et al.*, 2016; McGee *et al.*, 2002; Stoltenborgh *et al.*, 2015). There were some gender and age differences in categorisation also. The prevalence of IAs involving a primary sexual abuse concern was higher for girls (10.6%, n=23) than boys (5.8%, n=23) though results were not statistically significant, and sexual abuse assessments

were more prevalent in older age-groups with those over 15 years of age overrepresented compared to younger age-groups (16.5%, n=10; $\chi^2(3)=15.9446$, $p=0.00$; Fisher's exact= 0.02). Although the numbers are small they reflect patterns found in numerous studies (Krug *et al.*, 2002).

As identified by Manion and Renwick (2008) in their study of closed assessments, IAs for physical abuse were most prevalent in the 5-9 age group (34.5%, n=18) and 10-14 age group (32.7% n=17). As is common in cross-sectional studies, the findings also generate some questions such as why welfare IAs were less likely to involve children age 5-9 compared to other age-groups (37.3%, n=47; chi2(1)=5.0092, p=0.02).

Consistent with referral data published by Whelan (2018), relative to older children, children aged 0-4 years had higher rates of exposure to parental drug misuse (29.86% n=43, $\chi^2(3)=15.9795$, $p=0.00$) an issue which may impact on parents capacity to respond to these young children's needs.

Children aged 15 and over, compared to younger children were more likely to have identified needs relating to education, emotional behaviour and identity. However, children aged 10-14, compared to other age-groups were also more likely to present with emotional and behaviour concerns, in addition to health concerns, presentation and self-care issues, suggesting some overlap between this age group and older teens. The findings correlate with findings from investigations in Ontario in 2018 suggesting children older teens (aged 12-15) compared to younger adolescents and children were struggling with academic difficulties and internalising issues (Alman *et al.*, 2020) and findings of the NRP (2016) regarding the need to examine developmental needs and mental health needs of children in this age group.

Although DV is not considered an explicit form of child abuse, it was identified in in one in four assessments (24.5%, n=118 or 2.2 per 1,000 children 0-17) involving one in five families, a majority of which was perpetrated by fathers or male partners (89.8%, n=106). Adding documented parental conflict/acrimony which may well include cases of DV, the prevalence was almost one in three (31.6%, n=152, 2.8 per 1,000 children 0-17). In Canada, where exposure to DV is a category of abuse, it is the most likely form of abuse to be substantiated and rates are higher than in the current study (35% investigations, n=35,867 or 5.78 per 1,000 children) (Fallon *et al.*, 2022).

The only recent comparable Irish data is provided by Whelan (2018) whose study of reports involving 794 children from 547 families identified DV or parental conflict in referrals relating to one in seven children and one in seven families, and which also identified gender differences with males responsible for 76% of conflict or DV. While it is not clear that DV was the reason for opening an IA, the higher prevalence in the current study may reflect the screening in of reports involving DV. In addition the high rate of recurrence in IAs involving DV (72%, n=85) may indicate stop-start responses to children (Buckley *et al.*, 2008; Stanley *et al.*, 2010).

The categorisation of DV and acrimony as emotional abuse in this study is consistent with previous Irish and Australian studies (Buckley *et al.*, 2011a; Connolly, 2009; Whelan, 2018). Bivariate analysis suggests that DV impacted on parenting capacity in domains of basic care, safety, emotional warmth, guidance and boundaries and stability in addition to wider family history and functioning, housing and income. DV was associated with identified needs relating to children's relationships, their emotional and behavioural development and their self-care and needs, and there was a strong association between DV and abuse assessments, particularly emotional abuse. Parental conflict was associated with identified children's education and relationship needs and was also associated with emotional abuse assessments.

The findings update the evidence for the co-occurrence of DV and child abuse (DVA) within the family and provide evidence of patterns of aggression in the Irish CPW practice context (Dixon *et al.*, 2010; Holt *et al.*, 2008; Slep and O'Leary, 2005). The prevalence rate for DVA of 57.6% is higher than reported rate of 40% in studies of DVA cited in a Tusla policy document (Rogers, 2015). The study provides new insights to the impact of exposure to DV and parental conflict on children and on parent's capacity to respond to children's needs. Findings highlight the necessity of providing therapeutic and support services, directly or in collaboration with other services, to parents and children where DV presents.

6.10.6. Repeat and intergenerational involvement

Another new finding from the study relates to rates of re-referral among children undergoing assessments and rates of intergenerational involvement with CPW. Compared to other Anglophone jurisdictions, rates of re-referral among IAs were among the highest (69.0%, n=331). The cross-sectional study design means that chronic and re-current cases have a higher probability of being sampled (Alexander *et al.*, 2015) however, rates are consistent with those identified in referral data by Whelan (2018) and appear to be consistent with rates in an English study of assessments (70%) by Roy (2021), but that study focussed on sub-group of assessments that involved parental substance misuse also using cross-sectional design. They are consistent with rates in Australia (AIHW, 2017) based on administrative data but higher than rates reported in Canada (Fallon *et al.*, 2021; Trocmé *et al.*, 2010) which employed weighted sampling. High rates of recurrence identified in a previous Irish study led Ferguson and O'Reilly (2001) to conclude that a majority of families were chronically involved with CPW.

Re-referral may be associated with a surveillance effect related to involvement with other services (Connell *et al.*, 2007; DePanfilis and Zuravin, 2002; Jenkins *et al.*, 2017) especially among the on ein three children aged 0-4 years (30.4%, n=95) who were re-referred. Three quarters of the children were in families involved with other services (75.6%, n=363) and the rate was slightly higher where children were known to CPW (77.6%, n=257). The strong association between re-referred children and identified concerns across all dimensions of development needs indicating higher risk, suggests the

possibility that abuse, or service-needs had been overlooked or that insufficient supports were provided or that families did not avail of the supports provided.

Intergenerational involvement with CPW is not systematically identifies in IAs and thus, the rate of one in ten children (10.6%, n=51) and one in eight families (12.0%, n=36) may be under- or over-estimates of general patterns. However, the prevalence rate is consistent with rates in the English study of assessments by Roy (2021). Although this measure does not signify substantiated abuse, the findings correlate with the literature which indicates that parental childhood abuse is a risk factor for child involvement with CPW compared to children of parents without a history of childhood abuse (Armfield *et al.*, 2021; Dixon *et al.*, 2005; Madigan *et al.*, 2019; Widom *et al.*, 2015). Intergenerational involvement among children involved with CPW was associated with identified concerns about several aspects of parenting capacity and child developmental needs. IAs involving intergenerational involvement were primarily categorised as welfare.

6.10.7. Findings of abuse and future risk of abuse

The literature on 'front-door processes' in CPW suggests that the categorisation whether or not a child is suffering, or is at risk of significant harm (HSE, 2011) is the closest measure to substantiation in Irish policy in the absence of a standard of abuse confirmation or substantiation (Barlow *et al.*, 2012; Lonne *et al.*, 2020). And among abuse assessments one in three were suffering, or at risk of suffering, significant harm (32%, n=78, 1.5/1,000 children) in addition to 4 children in welfare assessments (1.82%). The outcome for children at risk of future abuse is automatic referral to the child protection pathway to determine whether or not to list a child on the Child Protection Register (CPNS).

SW records provided accounts of past abuse not related to the primary report type which do not necessitate particular responses, and which are not accounted for in agency administrative data. The prevalence of past abuse unrelated to the current report type was one in three (34%, n=163, 3/1,000 children) with co-occurring neglect the most prevalent category (28.3%, n=136). Due to this methodological approach, it is not surprising that the prevalence rate of abuse relating was much lower than in jurisdictions operating substantiation policies (DHHS, 2018; Fallon *et al.*, 2022; Fallon *et al.*, 2021; Trocmé *et al.*, 2010). However, the rate is higher than the rate of 12% (n=1,556 CPNS notifications) last reported in Ireland in 2010 when policy required this (HSE, 2012c).[56]

Findings regarding the co-occurrence of emotional abuse and neglect are consistent with previous studies (e.g. Stevenson, 1996). New findings indicating that co-occurring abuse was more likely where children were previously open to CPW, in IAs involving DV and in larger families provide insights into the scope of children's experiences of abuse and neglect and into families' service needs.

[56] In 2010, the HSE received 29,277 referrals. Of these 12,825 child protection reports were available for substantiation following notification to the Child Protection Notification Management Team/Child Care Manager. 1,556 reports recorded an outcome confirmed.

6.10.8. Policy features - reporters

Consistent with the Irish and international literature, a majority of IAs had been reported by professionals (82.5%, n=394) compared to family and other non-professional or anonymous sources (Whelan, 2018). In this study, the proportion of IAs reported by professionals is similar to (OrangaTamariki, 2017) and slightly higher than rates reported in Canada (Fallon *et al.*, 2021; Trocmé *et al.*, 2010). Findings might suggest that professionals have knowledge that influences their communications with, and receptivity by, CPW services. But the evidence in this study that parents and children in IAs presented with complex and co-occurring problems that are risk factors for abuse or welfare impairment and that in 75.6% IAs (n=363) other services were involved with the child or family, suggests there was the opportunity for professional surveillance in addition to a need for collaborative responses by those professionals and CPW.

6.11. Conclusion

This study, based on seven SWDs in quarter 1 2016, presents the only source of regionally disaggregated data on CPW assessments in Ireland. On this basis it fills a considerable gap in the knowledge base and provides evidence to support policy developments relating to data collection in addition to intervention and prevention efforts. While a number of Irish studies have explored aspects of CPW social work practice and decision-making in Ireland (Buckley, 2003; Burns and MacCarthy, 2012; Ferguson and O'Reilly, 2001; Kemp, 2008; McCormack *et al.*, 2020; O'Connell, 2014; Whelan, 2018) to date there has been no cross-sectional exploration of CPW IAs and their initial outcomes. Thus, to date there are no other sources on the profile of reported CPW that receive assessments in Ireland. This study represents an original contribution to the knowledge base.

The evidence indicates that relative to the general population, children screened in for IA have considerable needs that likely warrant service intervention and supports. The records provide clear evidence of SW's judgment that parenting capacity is impeded by the multiple stress-related problems and material challenges that these families experience. The study design and analytic approach (discussed in more detail in Chapter 8) meant it was neither possible to ascertain temporality nor to determine how these risk factors mediated or intensified other risk factors. It was however, possible to identify correlations between them and examine potential causal mechanisms.

SWs are good at identifying complex service needs and this evidence is important in profiling the needs of children and families involved in IAs. They incorporated overlapping and co-occurring 'abuse' and welfare concerns what were exacerbated in the context of parental problems and the context within which families lived. Consistent with Manion and Renwick (2008) analysis of the characteristics of children in this study including those that closed/NFA suggests they did not represent questionable cause for investigation in accordance with policy (c.f. Tusla, 2015). While several important demographic variables were not systematically documented and this is a gap in the data set, the case

files produced rich evidence. This remains uncollated at regional or national level in a way that is available for resource management, research, policy development or advocacy.

The findings demonstrate the potential value of systematically collating evidence on the demographic characteristics and circumstances of children and families involved in in IAs in order to create awareness of the scope and nature of child welfare concerns and child abuse and related service needs. This will be discussed further in Chapter 8.

Chapter 7 Explaining the decision to provide ongoing service following Initial Assessment

7.1. Abstract

This third and final findings chapter presents the results of the multivariable model to identify factors associated with the decision to provide ongoing service following IA. The chapter begins with an examination of differences between IAs that closed and those that remained open for ongoing service. The analysis assists in understanding which predictors of the decision to progress a case were significant and offers insights into what type of services are needed and where they should be focussed. The study also explored the use of a structured decision-making tool to support decision-making. Poisson regression analysis was used to predict the outcome variable ongoing service provision.

The results of univariable analysis are presented and discussed followed by the discussion of the results of the multivariable models. Almost 2 in every 5 children (38.5%, n=185) received ongoing service following IA. In a multivariable model, several clinical and organizational factors are associated with ongoing service. Factors relating to parenting capacity, family resources, prior involvement with CPW and female perpetrated partner violence determined ongoing service; children who were reported by a professional in statutory role were less likely to receive ongoing services and children whose cases were assessed by male SWs compared to female social workers were more likely to receive ongoing service. Challenging the prevailing orthodoxy that too many referrals progress to IA, the profile of children whose cases were closed/NFA indicated there was sufficient concern to warrant an IA. Many who were closed/NFA were previously involved with CPW (61.3%, n=181) and many were involved with a range of other services (62.4%, n=184) due to the range of exposures but it was also unclear if their service needs would be met without supportive case coordination.

Compared to the Irish model produced using the California Structured Decision Making© Family Risk Assessment (CA SDM© FRA) tool would have allocated more children to ongoing service. The relative merits of the models in creating prediction rules and the effect of the results in indicating intervention decisions are discussed. The discussion updates the literature on factors associated with ongoing service provision to children who are subject of IA following referral to CPW.

7.2. Aims

A number of clinical, organisational, decision maker and external factors are hypothesised to influence the assessment of need, the likelihood of abuse and the decision to provide ongoing service (Baumann *et al.*, 2011; Filippelli *et al.*, 2017b; Jud *et al.*, 2012; Lwin *et al.*, 2018b). This ecological approach informed the hypothesis for this study namely, that variables relating to child, family and the organisation in this sample would be associated with the assessment of need and risk of future abuse

and the decision to provide ongoing service following IA. It was also hypothesised that there would be different patterns of intervention across SWDs (Baumann *et al.*, 2011) as evidenced in previous Irish studies (e.g. O'Leary, 2007a; O'Leary *et al.*, 2013; O'Leary *et al.*, 2015b).

The consensus method by which Initial Assessments are conducted relates to the policy and therefore, it is a variable at the organisation level. As the literature review at Chapter 3 demonstrated, it is hypothesised that consensus based assessment frameworks and structured decision making (SDM) tools operate differently in ascertaining the level of risk and supporting decision-making (e.g. Barlow *et al.*, 2012). To explore whether or not this difference exists for this sample, data in the empirical Initial Assessment Records were coded using the modified California SDM© Family Risk Assessment Tool (NCCD, 2017) to yield a risk score and associated recommendation whether or not to progress the assessment to ongoing service (see Appendix 5 and Appendix 6). The results of that scoring tool are compared to those identified in the multivariable regression model.

Given the limited evidence on the assessment of need and risk for ongoing service provision the study addressed four questions.

1. Compared to children whose assessments are closed/NFA, what are the characteristics of those that remained open for service?
2. What are the determinants of ongoing service following Initial Assessment?
3. Compared to the current assessment model, what are rates and determinants of service provision based on a structured decision tool and what if any insights can be gained?
4. What do the findings suggest about interventions and where they should be focussed?

The findings are presented and discussed below. In Chapter 8 the methodology is appraised in relation to the goals and findings of the study. Theoretical, policy and research implications of the findings are discussed in Chapter 8 alongside the implications of findings from Chapter 5 and Chapter 6.

7.3. Results

Table 18 presents the characteristics of children who received ongoing service compared to those that closed and results of univariable evaluation of these candidate variables for the multivariable model.

Table 18 Description and evaluation of independent variables.

Characteristics	**Open for ongoing service (n=185, 38.5%)**			**IRR 95% CI**	**χ2 p**
	Number	%	χ^2, *p*		
Family Characteristics (n)					
Child male (n=260)	96	36.1	1.3655 *p* = 0.243	0.87 (0.70, 1.10)	0.242
Child age 0-4 (n=144)	64	44.4	3.0260 *p* = 0.082	1.23 (0.98, 1.56)	0.075
One parent family (230)	92	40.0	0.3965 *p* = 0.529	1.08 (0.86, 1.35)	0.530
4 or more children (111)	57	51.3	10.0024 *p* = 0.002	1.48 (1.18, 1.86)	0.008
Youngest child aged 0-4 (235)	94	40.0	0.4134 *p* = 0.520	1.08 (0.86, 1.35)	0.521
Primary earner unemployed (227)	102	44.9	7.4292 *p* = 0.006	1.37 (1.09, 1.72)	0.007
Child developmental concerns (n)					
Health (124)	66	53.2	15.2194 *p* = 0.000	1.60.(1.28, 1.99)	0.000
Education (27)	14	51.9	2.1398 *p* = 0.144	1.37 (0.94, 2.01)	0.104
Emotional and behavioural development (236)	119	50.4	27.6717 *p* = 0.000	1.86 (1.46, 2.37)	0.000
Identity (111)	61	55.0	16.4217 *p* = 0.000	1.64 (1.31, 2.04)	0.000
Family & social relationships (230)	119	51.7	32.4712 *p* = 0.000	1.96 (1.54, 2.50)	0.000
Presentation (95)	55	57.9	18.7281 *p* = 0.000	1.71 (1.37, 2.14)	0.000
Self-care (68)	37	54.4	8.4237 *p* = 0.004	1.51 (1.18, 1.95)	0.001
Witness DV (77)	39	50.7	5.675 *p* = 0.017	1.40 (1.08, 1.81)	0.010
Mental health concern (43)	22	51.2	3.1762 *p* = 0.075	1.37 (0.99, 1.88)	0.050
Findings of secondary abuse (163)	93	57.1	35.7139 *p* = 0.000	1.96 (1.58, 2.44)	0.000
At risk of significant harm (82)	80	97.6	145.4283 *p* = 0.000	3.70 (3.13, 4.37)	0.000
Category of concern					
Welfare (220)	67	30.5	11.2142 *p*= 0.001	0.67 (0.53, 0.85)	0.001
Emotional abuse (66)	28	45.4	0.4870 *p* = 0.485	1.12 (0.82, 1.52)	0.474
Physical abuse (56)	17	30.4	1.7928 *p* = 0.181	0.77 (0.51, 1.16)	0.208
Sexual abuse (38)	15	39.5	0.0151 *p* = 0.902	1.03 (0.68, 1.55)	0.901
Neglect (84)	58	69.1	40.0021 *p* = 0.000	2.15 (1.76, 2.64)	0.000
Parenting capacity, functioning & household concerns					
Basic care (122)	86	70.5	70.4940 *p* = 0.000	2.54 (2.08, 3.12)	0.000
Safety (268)	140	52.2	48.0605, *p* = 0.000	2.46 (1.85, 3.26)	0.000
Emotional warmth (153)	101	66.0	71.5542 *p* = 0.000	2.57 (2.07, 3.19)	0.000
Stimulation (66)	46	69.7	31.3572 *p* = 0.000	2.07 (1.68, 2.56)	0.022
Guidance and boundaries (242)	131	54.1	50.0832 *p* = 0.000	2.38 (1.84, 3.10)	0.000
Stability (235)	128	54.5	49.3024 *p* = 0.000	2.34 (1.81, 3.02)	0.000
Family history and functioning (341)	157	46.0	27.9590 *p* = 0.000	2.29 (1.61, 3.25)	0.000
Social resources (148)	82	55.3	25.6898 *p* = 0.000	1.79 (1.44, 2.22)	0.000
Housing (153)	95	62.1	52.5835 *p* = 0.000	2.26 (1.82, 2.80)	0.000
Parental mental health concern (166)	88	53.0	22.4320 *p*= 0.000	1.72 (1.38, 2.14)	0.000
Parental drug misuse (107)	53	49.5	7.0224 *p* = 0.008	1.40 (1.11, 1.77)	0.005
Parental alcohol misuse (135)	54	40.0	0.1686 *p* = 0.681	1.05 (0.82, 1.35)	0.680
Acrimony (74)	38	51.4	6.0606 *p* = 0.014	1.42 (1.10, 1.83)	0.008
C1 violent to c2 (26)	20	76.9	17.0958 *p* = 0.000	2.12 (1.66, 2.70)	0.000
C2 violent to c1 (106)	54	50.9	8.8334 *p* = 0.003	1.45 (1.15, 1.84)	0.002
Parent violent to child (100)	49	26.5	5.8327 *p* = 0.016	1.37 (1.08, 1.74)	0.011
Family level DV (118)	61	51.7	11.4280 *p* = 0.001	1.51 (1.20, 1.89)	0.000
Carer involved in crime (68)	34	50.0	4.3912 *p* = 0.036	1.36 (1.04, 1.79)	0.024
Parent cooperates with SW	102	30.2	34.5482 *p* =0.000	0.51(0.41, 0.63)	0.000
Prior involvement with CPW					
Parental childhood CPW (51)	36	70.6	24.7404 *p* = 0.000	2.03 (1.63, 2.53)	0.000
Child previously involved with CPW (331)	150	45.3	20.6662 *p* = 0.000	1.93 (1.41, 2.64)	0.000

Table 18 (continued)

Characteristic	Open for ongoing service (n=185, 38.5%)			IRR 95% CI	χ2 p
	Number	%	X^2, *p*		
Organisation & policy characteristics					
Reporter member public (86)	32	37.2	0.0785 *p* = 0.779	0.96 (0.71, 1.30)	0.781
Reporter statutory duty (147)	44	29.9	6.6310 *p* = 0.010	0.71 (0.54, 0.93)	0.014
Reporter professional (other) (247)	109	44.1	6.7076 *p* = 0.010	1.35 (1.07, 1.71)	0.011
SW male (130)	61	46.9	5.2874 *p* = 0.021	1.32 (1.05, 1.67)	0.017
SWD 1 (94)	39	41.5	0.4288 *p* = 0.513	1.10 (0.84, 1.44)	0.506
SWD 2 (36)	7	19.4	5.9922 *p* = 0.014	0.49 (0.25, 0.95)	0.036
SWD 3 (186)	56	30.1	9.1196 *p* = 0.003	0.69 (0.53, 0.89)	0.004
SWD 4 (32)	11	34.4	0.2513 *p* = 0.616	0.89 (0.54, 1.44)	0.628
SWD 5 (46)	33	71.7	23.6705 *p* = 0.000	2.05 (1.64, 2.56)	0.000
SWD 6 (32)	14	43.8	0.3926 *p* = 0.531	1.15 (0.76, 1.73)	0.515
SWD 7 (54)	25	46.3	1.5447 *p* = 0.214	1.23 (0.90, 1.68)	0.190

Note

* p<0.10; **p<0.05; *** p≤<0.001

7.3.1. Characteristics of children who received ongoing service

Almost two fifths of children received ongoing service following IA (38.5%, n=185). In univariable analysis, compared to children who were closed/NFA, those who received services were more likely to be aged 0-4 years than older, to have three or more siblings compared to one or two siblings, to be in a family where the primary carer was unemployed compared to those in employment and a in a family with housing concerns compared to being in a family without housing concerns. Whether a child lived in a family with one or two parents did not determine ongoing service. Except for child education, all child developmental and functioning concerns significantly increased the likelihood of ongoing service. Witnessing DV compared to not witnessing it directly, also increased the likelihood of services (IRR1.40, χ2p 0.010). One in three children experienced abuse unrelated to the primary report type (n=163, 33.9%) and the exposure was significantly associated with ongoing service (IRR 1.96, χ2p 0.000). Welfare concerns comprised the largest proportion of both closed and open IAs, but children assessed for welfare concerns, compared to those in other categories, were less likely to receive services (IRR 0.67, χ2p 0.001). Children assessed for neglect were twice as likely compared to those assessed for any other reason, to receive services (n=58, 69.1%, IRR 2.15, χ2p 0.000).

With the exception of parental alcohol misuse, all factors relating to parenting capacity and functioning increased the likelihood for ongoing services. Prior involvement with CPW (IRR1.93, χ2p 0.000) and a parent's own childhood involvement with CPW were both associated with ongoing service (IRR 2.03, χ2p 0.000).

Compared to children reported by professionals and members of the public, children reported by professionals with a statutory duty were less likely to receive ongoing service (IRR 0.71, χ2p 0.001). Those referred by other professionals were more likely to be open (IRR 1.35, χ2p 0.001). Children reported by family or members of the public were not associated with ongoing service. Children whose assessments were conducted by male compared to female social workers were more likely to receive ongoing service (n= 61, 33.0%, IRR 1.32, χ2p 0.0173). Lastly, practice varied across SWDs: the

proportion of children receiving ongoing service varied from as few as 6.1% to as many as 44.1%. Children from SWD2 (IRR 0.49, χ2p 0.036) and SWD3 (IRR 0.69, χ2p 0.004) were less likely than those from any other SWD to remain open and those from SWD5 were twice as likely to receive ongoing services (IRR 2.04, χ2p 0.000).

As univariable analyses do not account for potential multiplicative or suppressor effects by other variables, the results of univariable analysis were evaluated on the basis of methods outlined in Section 4.9.3 in the Methodology chapter above. The next section presents the results of the evaluation of the candidate variables for model development.

7.3.2. Evaluation of candidate variables

The theory-data relationship for candidate variables is strong. Variables were available for selection in analysis because they were recorded by SWs. Evidence from the current study (Chapter 6) corroborates previous findings that categories of abuse lack construct validity. Categorization reflects an accumulation of need or risk factors possibly already identified as independent variables and is eliminated from analysis. The determination that a child is 'at ongoing risk of significant harm' regarding the primary report type is subject to categorizing concerns as abuse and automatically warrants ongoing service provision. This variable was excluded from modelling. However, secondary abuse is likely to be associated with different variables and may indicate service needs that differ from the primary report type (Dawid 2013 in Best *et al.*, 2013; Dawes *et al.*, 1989; Keddell, 2016b; van der Put *et al.*, 2016). It may have been recorded by SWs in an effort to describe the cumulative adversity to which children are exposed (Bromfield *et al.*, 2007; Sidebotham *et al.*, 2016). This variable was included in the model.

The literature identified that closer collaboration with parents during IA may lead to better outcomes for children (Platt, 2006; Turnell and Murphy, 2017) especially those for who prevention and support is seen to be important. As identified in Chapters 5 and 6, the theory data relationship for 'parental cooperation' is evident in the rate at which SWs documented evidence in records. As demonstrated in the Case Study (see Chapter 5) and consistent with previous studies, parental cooperation is associated with case closure and the corollary, non-cooperation or resistance is associated with more coercive interactions with CPW (Buckley, 2003; Dingwall *et al.*, 1983/2014; Lavergne *et al.*, 2011; Lwin *et al.*, 2018b; Platt, 2005). However, as demonstrated in the case study (Chapter 5), perceived parental cooperation or compliance is a heuristic that incorporates SWs perceptions about of parenting capacity, accountability and intention and it may include disguised compliance. As evidence, it can interact with SWs perceptions about risk and the role of interventions as demonstrated in a number of studies using various designs (Benbenishty *et al.*, 2015; Davidson-Arad and Benbenishty, 2010; Kemshall, 2010; Spratt and Callan, 2004). Therefore, the variable may be collinear with other parent related independent variables or the decision and is excluded from model development. But, due to its importance as a feature of decision-making and in order to reduce the risk of wrongly rejecting variables of potential importance, its relationship to ongoing service provision is examined in a second model.

While there may be overlap between child mental health concerns and emotional development, these factors were recorded separately by SWs and may indicate different service needs. Similarly, parental substance misuse and parental mental health concerns frequently co-occur in CPW assessments (Brandon *et al.*, 2009; Cleaver *et al.*, 2011; HSE and Tusla, 2019; Sidebotham *et al.*, 2016) but, mechanisms that cause and moderate effects may differ (Bosk *et al.*, 2021; Sidebotham, 2019). Consequently, each of these variables is incorporated into the model.

Witnessing acts of DV may place children at additional risk of victimisation and perpetration in later life (e.g. Bernardi and Steyn, 2019; Dixon *et al.*, 2005; Forke *et al.*, 2018) and consequentially may indicate specific service needs but, due to its collinearity with DV exposure (Dixon and Slep, 2017) it was decided to exclude it from model development. Given the evidence for different impacts on children whether the aggressor is the mother, father or both parents (Bernardi and Steyn, 2019; Dixon and Slep, 2017; Forke *et al.*, 2018; Slep and O'Leary, 2005) the question of service provision based on DV perpetrated by a mother or a father was examined. Exposure to DV increased the risk of violence to the child (53%, n=53; χ^2 55.0169 p= 0.000). While important in terms of risk exposure and service needs, due to some collinearity with findings of secondary abuse, the measure of violence to a child excluded from model development. Categories of IA were not included in the model for ongoing service due to confounding with independent variables and the outcome.

Organisational variables included in the model were reporter in a statutory role and other professionals. The SWDs were not included in modelling but post estimation, clustering was examined.

There were no candidate variables with fewer than 5 exposures associated with the outcome. Finally, subject to the exclusion criteria, univariable results that were significant at the $\chi 2p \leq 0.10$ were included in the global multivariable model.

7.3.3. Model development

Two separate multivariable models were fitted to distinct parsimonious models of ongoing services, and to address the research question: what variables explain the decision to provide ongoing services?

As described at Table 19, when analysed in a multivariable Poisson regression, several candidate variables lost significance, indicating that relative to other variables included in the model, they no longer explained the decision to provide ongoing service. For those retained in the models the direction of association was unchanged, but the strength of association slightly reduced for most variables except in relation to child health (Model 1), a reporter in a statutory role and male social worker. The results show that the decision to provide ongoing services is multifactorial and that families with multiple and complex issues were more likely to receive ongoing services.

Table 19 Simple and multivariable regression for ongoing child protection and welfare service

	Univariable Poisson regressions		Multivariable Poisson regression	
		Null model	Full model [a,b]	Full model with parental cooperation [a,c]
	IRR (95% CI) χ2 p	IRR (95% CI)	IRR (95% CI) χ2 p	IRR (95% CI) χ2 p
Child age 0-4	1.23 (0.98, 1.56) 0.075		1.28 (1.03, 1.59) 0.028	
4 or more children	1.48 (1.18, 1.86) 0.008			
Primary earner unemployed	1.37 (1.09, 1.72) 0.007			
Child factor concerns				
Health concerns	1.60 (1.28, 1.99) 0.000		1.30 (1.07, 1.57) 0.005	1.30 (1.08, 1.57) 0.005
Emotional & behavioural development concerns	1.86 (1.46, 2.37) 0.000			
Identity concerns	1.64 (1.31, 2.04) 0.000			
Family & social relationships concerns	1.96 (1.54, 2.50) 0.000			
Presentation concerns	1.71 (1.37, 2.14) 0.000			
Self-care concerns	1.51 (1.18, 1.95) 0.001			
Mental health concerns	1.37 (0.99, 1.88) 0.050			
Findings of secondary abuse	1.96 (1.58, 2.44) 0.000		1.59 (1.30, 1.95) 0.000	1.56 (1.27, 1.92) 0.000
Parent/Family factor				
Basic care concerns	2.54 (2.08, 3.12) 0.000			
Safety concerns	2.46 (1.85, 3.26) 0.000			1.35 (1.00, 1.82) 0.047
Emotional warmth concerns	2.57 (2.07, 3.19) 0.000		1.62 (1.30, 2.02) 0.000	1.57 (1.28, 1.93) 0.000
Stimulation concerns	2.07 (1.68, 2.56) 0.022			
Guidance and boundaries concerns	2.38 (1.84, 3.10) 0.000		1.66 (1.29, 1.14) 0.000	1.42 (1.09, 1.87) 0.011
Stability concerns	2.34 (1.81, 3.02) 0.000			
Family history and functioning concerns	2.29 (1.61, 3.25) 0.000			
Social resource concerns	1.79 (1.44, 2.22) 0.000		1.37 (1.13, 1.66) 0.002	1.26 (1.03, 1.54) 0.024
Housing concerns	2.26 (1.82, 2.80) 0.000		1.28 (1.05, 1.56) 0.015	
Parental mental health concerns	1.72 (1.38, 2.14) 0.000			1.29 (1.06, 1.56) 0.012
Parental drug misuse concerns	1.40 (1.11, 1.77) 0.005			
Acrimony concerns	1.42 (1.10, 1.83) 0.008		1.41 (1.11, 1.78) 0.005	1.41 (1.12. 1.78) 0.004
Mother violent to father/ partner	2.12 (1.66, 2.70) 0.000		1.70 (1.33, 2.19) 0.000	1.57 (1.21, 2.03) 0.001
Father/partner violent to mother	1.45 (1.15, 1.84) 0.002			
Carer involved in crime	1.36 (1.04, 1.79) 0.024			
Parent cooperates with SW	0.51 (0.41, 0.63) 0.000			0.64 (0.53, 0.77) 0.000
Previous involvement				
Parent's childhood involvement CPW	2.03 (1.63, 2.53) 0.000		1.40 (1.10, 1.76) 0.005	1.77 (1.39, 2.25) 0.000
Child previously involved with CPW	1.93 (1.41, 2.64) 0.000		1.51 (1.15, 1.98) 0.002	1.33 (1.01, 1.74) 0.004
Organisation Factors				
Reporter has statutory duty	0.71 (0.54, 0.93) 0.014		0.71 (0.56, 0.90) 0.004	0.73 (0.57, 0.92) 0.007
Reporter professional (other)	1.35 (1.07, 1.71) 0.011			
SW male	1.32 (1.05, 1.67) 0.017		1.39 (1.14, 1.70) 0.001	1.34 (1.09, 1.65) 0.006
Constant		0.39 (0. 34, 0.45)	0.08 (0.05, 0.12) 0.000	0.12 (0.08, 0.17) 0.000

Notes: [a] χ2 *p* for model =0.000

[b] Post estimation deviance goodness-of-fit χ2 p=1.000, ratio deviance/degrees freedom: 248.4395/466 =0.53. Pearson goodness-of-fit χ2 p=1.000, ratio Pearson χ2/degrees freedom = 262.4503/466=0.56

[c] Post estimation deviance goodness-of-fit χ2 p=1.000, ratio deviance/degrees freedom =240.2592/465=0.52; Pearson goodness-of-fit χ2 p=1.000, ratio Pearson χ2/degrees freedom=260.6635/465 = 0.56

7.3.4. Model 1

As described at Table 19, infants, and children up to age four compared to older children were more likely to receive ongoing service. Compared to children without these findings, children with health issues, findings of secondary abuse and those previously involved with CPW were more likely to receive ongoing service. A parent's own childhood involvement with CPW was also associated with ongoing service.

In relation to parenting characteristics, compared to children for whom a social worker did not have concerns, those where there were concerns about parental emotional warmth and concerns about guidance and boundaries were more likely to receive ongoing service. At the wider family level few social resources and housing issues were associated with service provision. Acrimony between parents was associated with service provision. Interestingly, violence from a father towards a mother, more prevalent in the sample and significant in univariable analysis, was not retained in the model.

At the organisation level children referred by reporters with a statutory duty were less likely to receive ongoing service compared to children reported by any other professional or a family member or a member of the public. Assessments conducted by male SWs compared to female SWs were more likely to receive ongoing service.

Although differences in association between independent variables and service provision were not very large, the strongest relationship to the outcome was found between, DV perpetrated by a mother, concerns about parental guidance and boundaries, the absence of emotional warmth towards a child and findings of secondary abuse.

7.3.5. Model 2

As described in Table 19 when parental cooperation was added to the model, some relationships between candidate variables and the outcome changed. Conditional on included covariates parental cooperation, compared to non-cooperation or non-compliance reduced the likelihood of ongoing service. Concerns about parents' mental health and children's safety were retained in the model and increased the likelihood of ongoing service. Children in aged 0-4 years compared to other age-groups were not specifically associated with ongoing service. Housing concerns were not associated with the service provision. All other variables described in Model 1 were retained although there were slight changes in the strength of association.

7.3.6. Model 3

The CA SDM©FRA produces four risk level scores, low, moderate, high and very high. Scores that equate to high and very high risk are promoted for ongoing service (see Appendix 5 and Appendix 6).[57] Based on the data recorded in the IA, 30.6% (n=147) scored high risk and 12.3% (n=59) scored very high risk resulting in 42.5% (n=204) of IAs promoted for ongoing service, as described in Table 20 below.

The classification 'promote' significantly increased the likelihood of ongoing service (IRR=3.16, 95% CI 2.37, 3.96, χ^2 p=0.000). Univariable and multi-variable modelling was based on the outcome variable 'open' as identified in the sample, not the decision to promote based on the CA SDM©FRA risk rating.

Table 20: Child abuse and welfare related Initial Assessments open and not open for ongoing service based on the CA SDM©FRA risk designation and recommended action

Characteristics	Not open for ongoing service (n= 295, 61.5%)		Open for ongoing service (n=185, 38.5%)		IRR 95% CI
	Number	%	Number	%	
Risk level					
Low (n=98)	91	30.9	7	3.8	0.15 [0.07, 0.32] ***
Moderate (n=176)	124	42.0	52	28.1	0.68 [0.52, 0.88] **
High (n=147)	70	23.7	77	41.6	1.62 [1.30, 2.01] ***
Very High (n=59)	10	3.4	49	26.5	2.57 [2.15, 3.07] ***
Planned Action					
Promote (n=204)	79	38.7	125	61.3	2.82 [2.20, 3.62] ***
Do not promote (n=276)	216	78.3	60	21.7	

Notes: * χ2 p<0.10; **p<0.05; *** p≤<0.001 †p≥0.1

[57] Absent overrides by the case worker

Table 201 CA SDM© FRA Multivariable model of ongoing service

	Null Model	Univariable	Multivariable Poisson regression	
				Parent cooperates
Characteristics		IRR (95% CI) χ2 p	IRR (95% CI) χ2 p[a]	IRR (95% CI) χ2 p[b]
Prior welfare or neglect report		1.43 (1.28, 1.61) 0.000	1.18 (1.05, 1.32)	1.19 (1.06, 1.32)
Prior abuse report		1.47 (1.32, 1.64) 0.000	1.26 (1.14, 1.40)	1.20 (1.08, 1.33)
Prior initial assessment or ongoing service		1.65 (1.45, 1.87) 0.000	1.30 (1.13, 1.50)	1.31 (1.13, 1.51)
Prior injury or substantiated physical abuse		1.17 (0.80, 1.71) 0.429		
Four or more children in family		1.69 (1.35, 2.12) 0.000		
Parent blames child		1.89 (1.49, 2.41) 0.000	1.64 (1.06, 1.86)	1.49 (1.14, 1.96)
Youngest child in family under 2 years of age		2.23 (1.82, 2.75) 0.000	1.50 (1.19, 1.90)	1.38 (1.11, 1.72)
At least one child functioning difficulty		1.82 (1.43, 2.31) 0.001	1.46 (1.18, 1.82)	1.49 (1.20, 1.86)
Housing concern		1.80 (1.44, 2.24) 0.000	1.38 (1.09, 1.74)	1.30 (1.02, 1.64)
Two or more DV incidents in past year		1.54 (1.19, 1.99) 0.009		
Carer employs excessive / inappropriate discipline		1.77 (1.37, 2.28) 0.000		
Carer involved with CPW in childhood		2.42 (1.99, 2.94) 0.000	1.84 (1.51, 2.24)	1.93 (1.57, 2.36)
Carer mental health issues		1.76 (1.42, 2.19) 0.000	1.28 (1.03, 1.60)	1.33 (1.07, 1.65)
Carer substance misuse		1.52 (1.22, 1.90) 0.002		
Carer with criminal arrest history		1.38 (1.03, 1.84) 0.029		
Parent cooperates with SW		0.51 (0.41, 0.63) 0.000		0.66 (0.53, 0.82)
Reporter has statutory duty		0.71 (0.54, 0.93) 0.014		
Reporter professional (other)		1.35 (1.07, 1.71) 0.011		
SW male		1.32 (1.05, 1.67) 0.017	1.48 (1.18, 1.85)	1.38 (1.10, 1.73)
Cons	0.39 (0.34, 0.43)			

Notes:

a Post estimation deviance goodness-of-fit χ2 p=1.000, ratio deviance/degrees freedom =257.0742/469= 0.55. Pearson goodness-of-fit χ2 p=1.000, ratio Pearson χ2/degrees freedom = 258.638/ 469=0.55

b Post estimation deviance goodness-of-fit χ2 p=1.000, ratio deviance/degrees freedom: 250.4653/468=0.54. Pearson goodness-of-fit χ2 p=1.000, ratio Pearson χ2/degrees freedom = 252.8284/468=0.54.

Prior abuse, neglect, or welfare concerns in addition to prior involvement with CPW indicated ongoing service needs whereas prior injury did not. Current abuse assessments, compared to neglect or welfare assessments were not more likely to receive ongoing service. Large family size did not indicate service needs but having children in the family aged under two years of age indicated ongoing service needs. The parent's tendency to blame a child but not the use of excessive or inappropriate discipline, also indicated service needs. Children in families experiencing housing difficulties were more likely than those not experiencing housing difficulties, to receive ongoing service. And children with parents experiencing mental health issues were also more likely to receive ongoing service. Parents' own history with CPW was the strongest predictor of ongoing service.

Evidence of previous abuse, exposure to DV or having a parent who misuses substances and a parents' criminal arrest history were not associated with ongoing service. Current substance misuse was not associated with ongoing service provision. Compared to children whose assessments were conducted by female SWs, children whose assessments were conducted by males were more likely to receive ongoing service. Lastly, the role of a reporter was not associated with the decision.

When parental cooperation was added to the model, as shown in Table 21 there was no change to co-variables associated with the decision but the strength of association with some variables changed. Notably, parental non-cooperation interacted with the perception of parents' history of involvement with CPW and the perception of risk associated with parental mental health concerns. In both models,

the strongest associations were found between a parents' involvement with CPW during childhood and the decision to provide ongoing service.

7.3.7. Model evaluation

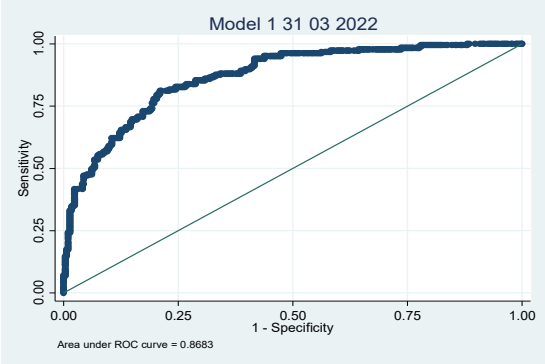
As described in Table 19 (see notes b, c) and Table 21 (see note a) models were underdispersed, signifying less variation than expected based on a binomial Poisson distribution (Coxe *et al.*, 2009; Kokonendji, 2014; Osborne, 2017). In this dataset, possible explanations for underdispersion are lack of independence between independent variables but, it is more likely to be due to the clustered structure of the population, small sample sizes or omitted unobserved variables (Kokonendji, 2014). Because IAs are conducted within SWDs, post estimation it was necessary to examine the potential fixed and random clustering effects, or grouping structure, on decisions to provide ongoing service. A mixed-effects model did not indicate differences between SWDs. Again, this may be due to variation in the number of cases across SWDs as well as the small number of groups (n=7 SWDs).

For each model, a logistic regression was run to generate a receiver operating characteristic (ROC) curve to illustrate the diagnostic ability of the model to correctly classify assessments for service delivery or no service delivery. For ease of reading, I will refer to the models as the 'Irish' models and the CA SDM©FRA models.

As displayed at Figure 17, Figure 18 and Figure 19 and Figure 20, ROC curves were plotted to evaluate the predictive accuracy of each model. Each ROC shows the curve positioned in the top left hand corner of the plot. Figure 17 shows the area under the ROC curve for Model 1 =0.8683 and Figure 18 shows the area under the ROC for Model 2 =0.8796 indicating each model has high sensitivity and high specificity and suggests their potential utility as a prediction model of ongoing service. A similar curve at Figure 19 was generated from the Model produced using CA SDM©FRA which shows the Area under the ROC curve =8569. When the variable 'parental cooperation' was included in the model of the CA SDM©FRA the logistic regression produced an area under the ROC curve =0.8671 (See Figure 20).

The results indicate that each model was good in classifying children for ongoing service, based on the variables incorporated into that model. In both the 'Irish' models (Table 19 and Figures 17 and 18) and the CA SDM©FRA models (Table 21 and Figures 19 and 20), the second models, which incorporated parents' cooperation were a better fit than the first. And both 'Irish' Model 1 and Model 2 functioned slightly better than the model based on the CA SDM©FRA.

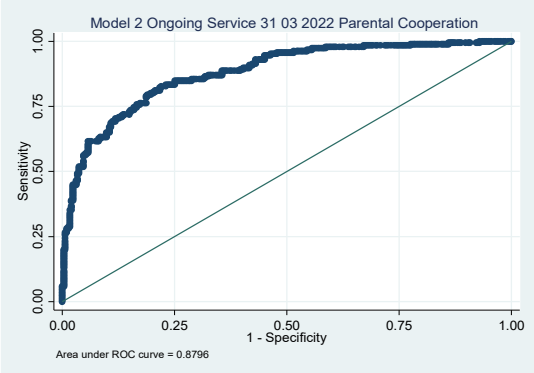
Figure 17 ROC Curve for Model 1 Ongoing Service



number of observations = 480

area under ROC curve = 0. 8683

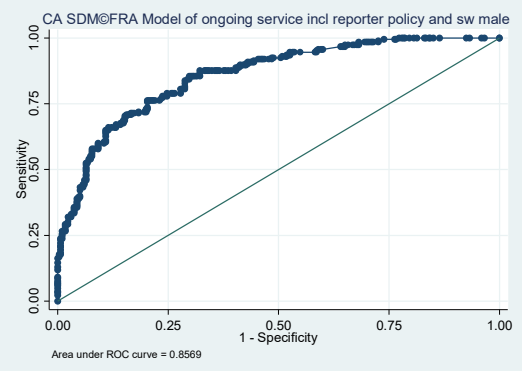
Figure 18 ROC Curve for Model 2 Ongoing Service: incorporating parental cooperation



number of observations = 480

area under ROC curve = 0.8796

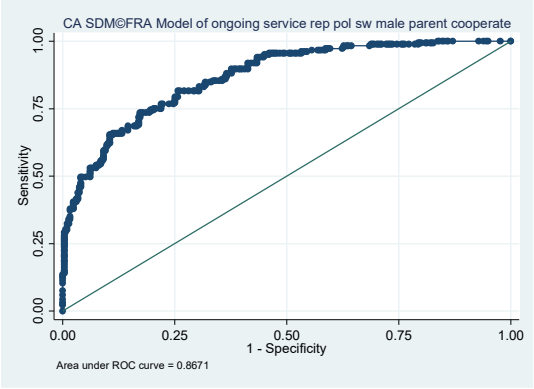
Figure 19 ROC Curve for Model 3 CA SDM© FRA



number of observations = 480

area under ROC curve = 0.8569

Figure 20 ROC Curve for Model 3 CA SDM© FRA incorporating 'parental cooperation'



number of observations = 480

area under ROC curve = 0.8671

7.4. Discussion

The discussion considers key findings. The methodology for the study and implications for the findings are appraised in Chapter 8 along with a discussion of the theoretical, policy and research implications of the findings overall.

7.4.1. Child developmental factors, substantiated abuse and service provision

The finding that children in the 0-4 age group are considered most in need of intervention compared to older children, is consistent with previous studies (Filippelli *et al.*, 2017b; Jud *et al.*, 2012; Lwin *et al.*, 2018b). This may reflect SWs perception of the necessity of timely intervention to address the distinct needs of these young children to prevent further negative impacts of exposures on developmental functioning, which may be impactful over a child's lifetime (Bentovim *et al.*, 2006; Brown and Ward, 2014; Cox and Bentovim, 2000; Featherstone *et al.*, 2014a; Filippelli *et al.*, 2017a; Filippelli *et al.*, 2017b; Filippelli *et al.*, 2021; Harris and Mildon, 2017; Jonson-Reid, 2002; NSCDC, 2012; Palusci, 2011; SCRA, 2018; Trocmé *et al.*, 2010; Trocmé *et al.*, 2001; Trocmé *et al.*, 2003). Like children in other age groups, two thirds of children in this age group were already open to CPW (66.0%, n=95) suggesting either missed opportunities for early intervention or that supports put in place were not successful. The findings suggest that Tusla should adopt a high threshold for closing cases of infants and young children given their particular vulnerabilities.

Child health concerns and findings of secondary abuse were strong indicators of service need in the Irish Models 1 and 2. It may be that indicators of health deficits are visible and impactful requiring immediate management to redress possible effects. The profile of young children in the study suggests a possible surveillance/intervention bias because in Ireland, infants, and young children, have multiple opportunities for involvement with the public health service. Consistent with the literature this finding suggest that vivid evidence (Munro, 1999a; Whelan, 2018) influences decisions to provide ongoing

services rather than the assessment of children's development needs in the context of the current difficulties being experienced.

In some jurisdictions substantiation is highly correlated with ongoing services (Font and Maguire-Jack, 2015b; Lwin *et al.*, 2018b). But a little over one in two children who experienced co-occurring abuse in addition to factors related to the current assessment received ongoing service (57.1%, n=93). This means that a significant proportion of children currently experiencing difficulties related to the reported concern in addition to co-occurring abuse did not receive service. While not currently reported, Tusla has introduced a Child Abuse Substantiation Policy that comes into effect mid-2022 (Tusla, 2022). It will be important to monitor how this impacts on decision-making and service provision.

7.4.2. Patterns of domestic violence and responses

One of the most interesting findings from the study relates to the new insights into patterns family violence and service responses. Taking account of all other indicators, DV perpetrated by a mother was one of the most significant factors associated with ongoing service and adding parental cooperation to the model slightly reduced the strength of association between DV perpetrated by a mother and the outcome. Though more prevalent and influential in univariable analysis, violence perpetrated by a father/partner did not determine service provision in the multivariable model.

It may be that in cases of male perpetrated violence, mothers were seen as having moderating effects and managing risks posed to children from their husband or partner. Other factors may have kicked in such as the mother acting protectively in some cases by going to a shelter, or a father leaving the home which mediated the likelihood of future risk and reduced the need for ongoing service. This pattern would cohere with findings in the literature and the case study (Chapter 5) indicating a tendency by SWs to rely on mothers to manage risks or reduce risks associated with violence when the perception of harm does not warrant immediate intervention (Buckley, 2003; Buckley *et al.*, 2008; Featherstone and Morris, 2021; Roy, 2021). On the other hand, the bias may reflect a view that a mother's capacity for perpetuating DV was incongruent with cultural norms about caring and protective parenting and resulted in lower thresholds for service provision. If this is the case, it also suggests that fathers/partners were not perceived to have a potential moderating effect and, that being the case it suggests gendered thinking about mothering and fathering.

The pattern of response indicate the perception of the effects on children of exposure to DV whether perpetrated by a father or mother is not homogenous, as demonstrated in relation to other aspects of SW practice (Buckley, 2002; Christie, 2001; Daniel *et al.*, 2010; Daniel and Taylor, 2006; Morris, 2009; Mulkeen, 2012; Parton, 2018; Roy, 2021; Stanley *et al.*, 2011; Stanley *et al.*, 2010). The findings provide further evidence for the socially constructed views about child abuse, DV, parenting and service needs (Buckley, 2003; Dingwall *et al.*, 1983/2014; Fallon, 2020; Keddell and Hyslop, 2018; Parton, 2018; Parton *et al.*, 1997; Platt and Turney, 2013) and a response by CPW that is likely to be ineffective in preventing further harm to children.

7.4.3. Cooperation

When parental cooperation is added to the model, compared to non-cooperation it reduced the likelihood of ongoing service. Non-cooperation was 1.57 times more likely than cooperation to be associated with ongoing service. Findings are consistent with previous studies using a range of methodologies and examining various decision points in CPW (Bartelink *et al.*, 2018; Buckley, 2003; Davidson-Arad and Kaznelson, 2010; Dingwall *et al.*, 1983/2014; Ferguson and O'Reilly, 2001; Hunt *et al.*, 2016; Lavergne *et al.*, 2011; Lwin *et al.*, 2018b; Platt, 2005; Turney *et al.*, 2012; Ward *et al.*, 2014) which suggest that during assessments the perception of parental cooperation becomes representative of parenting capacity and specifically, protective parenting and intentions to act. Parental cooperation or the inverse, non-cooperation, can act as a powerful mechanism of moral reasoning in judgments under uncertainty about children's needs and decisions about service provision (Ainsworth and Hansen, 2015; Buckley, 2003; Dingwall *et al.*, 1983/2014) and may lead SWs to overlook information that challenges these assumptions (Munro, 1996). Compared to parents who cooperated, when parents did not cooperate with CPW services, their mental health issues were influential on the decision to provide services and there were increased safety concerns for children. This interaction between the perception of parent's engagement and views about other aspects of their parenting and functional difficulties suggests the need to understand the motivation for non-cooperation or difficult behaviours when deciding on service needs (Ainsworth and Hansen, 2015; Featherstone *et al.*, 2014b).

When parenting cooperation was added to the model, compared to other children, those aged 0-4 and housing concerns were specifically not associated with ongoing services. It may be the that parents in this study who did cooperate, were effective in addressing the needs of these children and reducing risks to which they are exposed. However, given the range of needs and burdens these families faced, the finding flags a concern that SWs may have conflated cooperation with capacity.

Deficits in parenting capacity that impacted on service provision were concerns about the absence of emotional warmth by parents towards their children, insufficient guidance and boundaries and when parents were un-cooperative, concerns about child safety. The implications of these findings are discussed in Chapter 8.

7.4.4. Recurrence and intergenerational involvement

The study generated new evidence of prior involvement and assessment outcomes in addition to the prevalence of intergenerational involvement with CPW services. The proportion of IAs in which children had a history of involvement (69.0%, n=331) is not reflected in the small proportion that remained open for ongoing service (38.5%, n=185 in total). In line with the literature the rate of re-referral among children undergoing assessment was high (Fluke *et al.*, 2008; Jenkins *et al.*, 2017; Trocmé *et al.*, 2010; Trocmé *et al.*, 2014; White *et al.*, 2014; Zhang *et al.*, 2013) and it was strongly associated with service delivery (Fluke *et al.*, 1999).

Although prior involvement was associated with ongoing service, 54.7% (n=181) children previously involved were among those closed/NFA suggesting there may be IAs that should have received ongoing service that did not. Notably among children who received IA based on an index referral (n=149, 31.0%) fewer than one in four children (n=35, 23.5%) received ongoing service. In contrast with a recent Tusla Audit that concluded the low rate of ongoing service provision signified SWs were investigating too many referrals (Tusla, 2015), this finding is consistent with studies that examined closed assessments (Manion and Renwick, 2008; Simon *et al.*, 2021) and it indicates that IAs that were closed NFA did not represented a waste of effort. Rather, the findings from this study suggest many screened-out referrals represent missed opportunities to prevent future abuse and welfare deficits and that the threshold for ongoing service is too high.

Children whose parents who were intergenerationally involved with CPW were more likely than children of first generation parents to receive ongoing service. The evidence updates current international findings indicating that parental history of childhood abuse is a risk factor for involvement with CPW (Armfield *et al.*, 2021; Dixon *et al.*, 2005; Widom *et al.*, 2015). While some researchers suggest this may be due to a detection or surveillance bias (Fallon *et al.*, 2011a; Meinck *et al.*, 2016) the finding nevertheless highlights the necessity to examine factors that may confer specific service needs.

In this study, compared to first generation parents, those who were involved with CPW in their own childhood had fewer social supports (62.8% n=32, χ^2 27.2482 p= 0.00) and more housing concerns (60.8%, n=31, χ^2 =21.9621, *p*= 0.00). These findings suggest that parents intergenerationally involved with CPW have current and historic functioning concerns that impact on their parenting capacity and their children's development and wellbeing. This coheres with the understanding that early experiences of abuse and neglect are detrimental to physical, psychological and reproductive health throughout the life-course and impact on life opportunities (Metzler *et al.*, 2017; Sethi *et al.*, 2013). SWs may need to consider parent's need for therapeutic services to address complex and long-term effects of childhood abuse in addition to addressing current parenting and practical issues. The broader historic and current social context of families involved with CPW service, and the impact this has on parent's capabilities in addressing their own needs and those of their children requires to be considered when matching families with services to address a range of needs, as a means to support safe and impactful risk management strategies.

7.4.5. Characteristics of SWs

Male SWs comprised 25.2% of the workforce in the study and children assessed by male SWs were more likely than those assessed by female colleagues to receive ongoing services. It is not clear from the data why this would be the case. The literature has shown that SW characteristics influence decisions so, it is likely there are lurking variables that would influence this finding. The literature has shown that SW's attitudes towards family privacy and parental freedoms and children's interests and rights, and their view of the role of the CPW can drive perceptions about risk and decisions about service needs

(Axford and Berry, 2018; Dingwall *et al.*, 1983/2014; Doherty, 2016; Featherstone *et al.*, 2014a; Ferguson and O'Reilly, 2001; Nikolova *et al.*, 2017). Features such as case load and intensity impacts on levels of stress, perceptions of risk and SWs decision-making (Burns and MacCarthy, 2012; IASW, 2011; Munro, 1996). A better understanding of SW attitudes about risk, views of parents' engagement and the role of CPW interventions can assist in promoting practice that best serves the children and families they serve (Fluke *et al.*, 2016; Nikolova *et al.*, 2017) and in maximising the contribution that SWs can make in case management, supervision and mentoring. Understanding this requires further exploration in light of the current literature and the findings.

7.4.6. Reporting

This study provides further evidence for the screening out of children referred by families and members of the public at all decision points in referral and assessment (Whelan, 2018) which raises questions about the accessibility of helping services to families. Children reported by professionals with a statutory duty less likely to receive ongoing service. This finding raises an interesting question about the basis for mandatory reporting and warrants further investigation in light of the policy for mandatory reporting introduced Ireland in 2017 (DCYA, 2015).

7.4.7. The California Structured Decision Making© Family Risk Assessment

The application of the CA SDM© FRA was used to demonstrate an alternative analysis of the data to extend the understanding what structured decision-making might offer in the Irish context. While there were some parallels with important variables mobilized from case files for the study of ongoing service, the CA SDM© FRA used some composite variables e.g. at least one child functioning difficulty and scale variables or. two or more episodes of DV in the past year. This offers a different perspective on the case file data. Last because data which were available for coding were based on Tusla policy and the Initial Assessment Record (see Appendix 3), the data was framed by questions on that instrument. However, as stated in Chapter 6, many of the variables mobilized for analysis did not relate to individual questions in the IAR and were found in notes throughout the record.

Other variables in the CA SDM© FRA were not available in Irish case files and modifications were undertaken to achieve face validity, e.g. welfare and neglect IAs were matched to the neglect category in the CA SDM© FRA, because that instrument distinguished between neglect as an act of omission and abuse. However doing so is problematic because, as described at Table 3 in Chapter 6 there is overlap between welfare and neglect (Tusla, 2015) but, as described above, the categories receive different responses and neglect was a higher priority than all other categories (cf. Peyton, 2012).

Compared to the Irish model, using the CA SDM©FRA on the current data set would have promoted 11% more IAs for ongoing service (CA SDM©FRA n=206 compared to 38.5%, n=185). There was some overlap between IAs identified by both assessment approaches as 62.6% (n=129) of IAs promoted by the CA SDM©FRA were open for ongoing service (62.6%, n=129; $\chi^2$88.34, p=0.000). Consistent

with the second model produced by the Irish data, the strongest association was between parents' childhood involvement with CPW and ongoing service. Surprisingly the intensity of exposure to DV was not associated with the decision to provide services. Having a child under 2 years of age signalled the need for services, and this coheres with the findings from the Irish assessment framework.

Because the risk factors for service provision produced by the study or by the SDM© FRA, their validity in determining service need in an Irish setting can only be speculated. Differences in findings between the models produced by the assessment instruments were not statistically analysed. Many of these findings are consistent with the results produced by the study data. One potential benefit of such a model to practitioners' case management could be the requirement to document in a transparent way the presence of particular risk factors for recurrent abuse.

7.4.8. Differences from other studies

Though important in univariable analysis, large family size was not associated with the ongoing service based on the Irish assessment or CA SDM© FRA. This finding is counterintuitive because the literature indicates that large family size is a risk factor for child abuse (Hindley *et al.*, 2006; Sethi *et al.*, 2013; White *et al.*, 2014) and that sibling and prior involvement are risk factors for service provision in CPW (Fallon *et al.*, 2011c; Featherstone *et al.*, 2014a).

Parental substance misuse was also important in univariable analysis and is a known risk factor for recurrence, though findings concerning alcohol and other substances are mixed (White *et al.*, 2014). Relative to other co-variables, it was not associated with service provision. In a recent cross-sectional study of IAs in an English CPW department where parental substance misuse was identified, Roy (2021) noted many of the children living with parental substance misuse had significant service needs as did their parents but that, despite repeated involvement with CPW there was a very limited range of interventions available. She suggested that the reduction in universal and early help services on offer to families combined with a lack of capacity within CPW and SWs lack of confidence in their ability to work with the issue (Galvani *et al.*, 2014; Roy, 2021) may explain the high level of support needs some children and families presented with. Other researchers have identified confidence in workers ability to access community services that children and families need influences intervention decisions (Dettlaff *et al.*, 2015; Fluke *et al.*, 2016). Linked to explanations for the general low rates of intervention following IAs, it may be that for many children and families are unnecessarily referred, as CPW doesn't have the capacity to address their needs, leading to unwarranted, and sometimes harmful involvement with CPW (Buckley, 2017b; King *et al.*, 2021; Roy, 2021; Tusla, 2015). In this study many children exposed to parental substance misuse presented with multiple co-existing adversities that indicate service needs.

7.5. Concluding comments

The study provided evidence that SWs gather evidence about a large number of variables during the assessment process. Data reduction processes and model development found that few variables, primarily those relate to parenting capacity and parent functioning, predicted service provision. The evaluation of the models suggests that in this sample, they provided high discrimination for ongoing service.

The evaluation of the data set indicated that there are lurking variables relating to demographics of the population, personal factors of the Social Worker and features in the practice environment such as service availability that may impact on the models and their effectiveness in discriminating service needs. Data were under-dispersed perhaps due to the clustered structure or small sample size. Implications for assessment policy and practice for case management are discussed in Chapter 8.

Despite the limitations of the dataset, the study provides evidence to support the theoretical decision-making ecology (Baumann *et al.*, 2011).

Decisions were largely driven by factors relating to the difficulties that parents were experiencing and the impact these had on parenting capacity. In terms of designing interventions the findings highlight the necessity to take into account the specific needs that these circumstances confer on parents and on individual children.

New findings regarding rates of recurrence in assessments and the prevalence of intergenerational involvement with the services, suggest that awareness of the potential effects of childhood abuse and neglect over the life-course should inform assessment and decision-making. In terms of prevention, these findings signal the necessity of timely and effective interventions with children who suffer harm.

The findings indicate a gendered response to domestic violence. Given the weight of evidence regarding the effect of DV on children this finding suggests the necessity to re-examine patterns of domestic violence and responses in a larger sample. The findings also suggest that practice responses were biased on the basis of SW gender: this warrants further investigation to explore why and if other characteristics mediate the finding.

In Chapter 8 the implications of the findings are examined in the context on their theoretical, research and practice implications.

Chapter 8 Concluding comments and implications of study findings for practice, policy and research

8.1. Introduction

This concluding chapter provides a reappraisal of the studies and reflects on my learning throughout the PhD process. It then provides an overview of selected findings and comments on the theoretical, research and practice implications. Key recommendations for Tusla are outlined and plans for disseminating findings are detailed before concluding comments. This study set out to explore IA practice and decision-making processes, to provide evidence of the population involved in assessments and to examine and comment on drivers of service provision to children following IA. In doing so it makes novel and important contributions to the literature, some of which are highlighted below.

8.2. Overview of studies and contribution to knowledge base

The aim of the research was to explore assessment practice and decision-making for service provision in child protection and welfare in Tusla in 2015 and 2016. The research questions were,

1. How do social workers use Initial Assessments?
2. How do social workers explain their judgments and decision-making in Initial Assessments?
3. What is the demographic setting for the study?
4. What is the number and rate of IA completed and what were the decisions taken? How do rates compare to those in other Anglophone regions?
5. What is the demographic profile of children and families undergoing IA and how does it compare to the general population?
6. What is the scope and nature of assessed concerns and characteristics relating to organisational policy including the rate of recurrence, characteristics of social workers conducting assessments, and recurrence rates?
7. Do children and families undergoing IA meet the threshold for assessment in accordance with Tusla policy?
8. Compared to children whose assessments are closed/NFA, what are the characteristics of those that remained open for service?
9. What are the determinants of ongoing service following Initial Assessment?
10. Compared to the current assessment model, what are rates and determinants of service provision based on a structured decision tool and what if any insights can be gained?
11. What do the findings suggest about interventions and where they should be focussed?

The findings of each study standalone but, together they complement each other and provide a rich picture of the ecology for practice, assessment, and decision-making about service provision. The findings raise political, theoretical, ethical, and practical considerations.

The research is original in terms of design and the evidence it has generated. A number of Irish studies have explored child protection and welfare practice (Buckley, 2003; Burns and MacCarthy, 2012; Ferguson and O'Reilly, 2001; Kemp, 2008; McCormack *et al.*, 2020; O'Connell, 2014; Whelan, 2018), but to date none has explored assessment and service provision specifically. This is also the first Irish research study in the field to use a sequential exploratory design comprising a case-study and a descriptive and analytic cross-sectional study.

The case study derived from a social constructionist perspective. This enabled a rich exploration through interview and case file analysis of the situated social context for assessment practice. The study revealed and analysed the sense-making processes and discourses that were used by social workers to explain practice and the consequences of these discourses in terms of assessments and decision outcomes.

Building on that social constructivist paradigm, the cross-sectional study drew on a post positivist perspective to simultaneously explore a complex array of factors and decision outcomes in IAs. The study quantitized narrative Intake and IA records relating to all children whose assessments concluded in a three-month period in seven social work departments and used Tusla administrative data and demography. Doing so, the study generated descriptive statistics of the cohort involved in assessments and an understanding of their burdens and needs compared to the general population, the scope and nature of their specific abuse and welfare related vulnerabilities, associations between identified exposures and the decision to provide service, and evidence of the differences between the cohort of children who received ongoing service compared to those that did not.

8.2.1. Reviewing the methodology and looking forward

The case study produced rich narrative insights into the complexity of practice and highlighted some intractable problems of the system linked to under-resourcing that have been discussed elsewhere (Buckley and Burns, 2015; Burns and MacCarthy, 2012; O'Mahony, 2020). Particularly striking new evidence of the effects of under resourcing were, the nature and quality of assessments provided to children; SWs' concerns about professional expertise and oversight, particularly in relation to domestic violence (DV) and substance misuse; their anxiety about potential negative outcomes for children due to decisions to downgrade assessments, arbitrarily revise thresholds for intervention and close cases they believed should remain open, and the effect of these false negatives in generating invalid statistics. The study provides evidence in the Irish setting for the *Decision Making Ecology* (Baumann *et al.*, 2011) a theoretical framework for organizing decision-making research in child welfare.

The current practice in Tusla of restricting published evidence relating to IAs to aggregated data on outcomes limits the understanding of the characteristics of children and families, the nature and scope of their needs and factors that drive service provision. The cross-sectional study involved all individual children whose IA concluded in the first quarter of 2016 in seven Social Work Departments in Tusla.

The case files produced rich evidence, notwithstanding abstracting it was a tedious and time consuming process. The methodology and the research questions generated multiple new findings in the Irish context. Quantitizing the data and linking deprivation scores at small area levels (Haase and Pratschke, 2017b) enabled me to demographically profile children and families to describe their characteristics relative to the general population. It generated the best available estimates of the scope and nature of concerns among children and families involved in Irish CPW assessments, provided insights into the social construction of abuse, welfare concerns and service needs, and is the first study to identify analytically determinants of ongoing service provision. The study demonstrates the potential benefits of using information that is routinely collected by social workers for research to generate evidence of practice and inform policy development and advocacy.

The innovative sequential study design helped develop new insights and evidence based recommendations that a single study design would not have delivered. As identified, case factors, individual values and expertise play a role in assessments and decision outcomes, but the mechanisms that yield differences vary (Kahneman and Klein, 2009; Lwin *et al.*, 2018b). This finding provided a lens to review the patterns of response identified in the multi-variable model of decision making, particularly in the gendered responses to DV and responses based on SW gender. The findings suggest the need for training about, and further research on, individual SW values and decision strategies. Also, in light of the evidence generated by the cross-sectional study which indicates that compared to the general population, families have significant burdens and multiple service needs, many which do not warrant ongoing service in the current organisational context, the findings of the case study raise concerns about how Tusla can ensure that staff is supported and enabled to fulfil their duty of care.

As with any studies, there are a number of limitations based on the design and the data sources. The remainder of this section addresses these limitations and possible modifications. Although the generalisability of a case study is debated in the literature, the methodology is lauded for its potential to highlight causes of a given problem and generate understanding-oriented and action-oriented perspectives in ways that statistically driven studies do not (Flyvbjerg, 2006; 2011). The subjectivity of the sampling and the timing of the study could be seen as limitations but, the methodology was particularly beneficial in identifying patterns linking features of the task environment to decision outcomes and in terms of its sensitivity to unique observations from interviews and individual case files (George and Bennett, 2005). As discussed in Chapter 5, these findings once analysed in relation to the existing literature, were used to advance current theories about the specific contexts of Irish practice in addition to more general theories regarding the ecology of judgment and decision-making in CPW (Baumann *et al.*, 2011; Dalgleish, 1988). Because the study design yields such useful insights into both the micro and macro context for practice, it would be useful to have a national setting to explore whether 'local' challenges are replicated, or new ones are identified. This could help to avoid misrepresenting the findings.

The scope of the cross-sectional study was limited to the type of information available in the case files. Consistent with other studies using empirical case data, the information was not independently verified (Fallon *et al.*, 2022; Roy, 2021; Trocmé *et al.*, 2005; Trocmé *et al.*, 2010). Data on the ethnicity and nationality of children, known to be an impactful factor in decisions in CPW in Ireland and elsewhere were missing (Bilson *et al.*, 2015; Buckley and Whelan, 2018; Coulter, 2015; Fallon *et al.*, 2013a; Font *et al.*, 2012; Jenkins *et al.*, 2018; Jud *et al.*, 2013; Tilbury, 2009). It is recommended that Tusla ensures that this data be systematically gathered and collated using measures in use by the Central Statistics Office.

On reflection there was a large number of research questions particularly in relation to the descriptive cross-sectional study as outlined above. While this helped interrogate the data and generate important evidence, these will be consolidated in future publications.

It is not possible to derive causal relationships from cross-sectional study designs, but the use of the case evidence and combined population based data helped point to some mechanisms that may contribute to difficulties and which suggest where services could be targeted to prevent adverse outcomes. That said, the study was designed to describe practice in the organisational and policy context and in that regard the sampling, data source and study design were particularly beneficial.

The findings are representative of the population from which they were drawn. While the findings are valid and analysing them alongside the international literature provides comparable insights, no population is so homogeneous that we could extrapolate findings to the general population of children involved with Tusla nationally. There may be differences based on sociodemographic factors in addition to organisational factors that impact on child outcomes. A study entailing a larger and nationally representative sample would redress this limitation and commissioning such a study forms part of the recommendations from this work.

While the cross-sectional study permitted bivariate analysis of case characteristics and subcategories of abuse and welfare, it did not facilitate multivariable examination of subcategories of abuse as there were too few cases. Again, a larger sample size and nationally representative sample could facilitate this analysis. Lastly, the study reports on short-term outcomes, specifically decisions about service provision, but did not track longer-term outcomes that occurred beyond the IA. Also, cross-sectional studies may pick up more repeat referrals, and there was a high rate of recurrence in the sample. A longitudinal study design would address these limitations and the existing gap in the Irish evidence. Mindful of the limitations, this work went a long way to redress long standing gaps in the Irish statistical data.

8.2.2. Reflections on learning

From the outset, I benefited from a number of operational and structural supports. On encouragement from Professor Emeritus Christie, and with the support of local and regional managers, I was successful

in gaining funding from the Irish Research Council's Employment-Based Postgraduate Programme. The research was endorsed by the Chief Executive Officer and senior management team in Tusla. Having this research funding, and the support provided a framework for embedding the research in the organisation. It is anticipated this network will serve to ensure dissemination of findings also. The funding enabled collaboration with UCC while maintaining my employment and I gained experience in grant writing and fund management.

The transdisciplinary academic framework and supports for this PhD, within the Schools of Applied Social Studies and Public Health, enabled me to expand my network and my knowledge of quantitative and qualitative research approaches. One of the greatest outcomes for me personally and professionally was developing that expertise to generate insights into the micro level world of social work practice and the macro, population level of system responses and trends. I also developed an understanding of the potential future applications of integrating and building on these approaches, in collaboration with researchers and statisticians to address future research questions. I benefited from taking workshops on academic writing and training on literature reviews all of which helped me develop this thesis and I am sure, will serve future projects.

Undertaking this research as a PhD also provided a platform to participate in national and international conferences and a number of summer schools and working groups. As mentioned in Chapter 1, this was enormously beneficial to me. Developing conference papers served as a learning opportunity and helped crystalise and communicate the work in progress and gain valuable feedback. These conferences also provided wonderful networking opportunities which have led to a number of collaborations and recent publications.

Doing this project afforded me new insights to the world of social work practice. Reading case files and interviewing SWs increased my understanding and enhanced my commitment to this area of work, to disseminating the findings and to future collaborations with a view to improving outcomes for children and families in Ireland.

8.3. Assessment practice, judgments and decision making

8.3.1. Data

No matter what assessment model is used, SWs and policy makers need to have evidence of the scope and nature of harms and vulnerabilities of children and families involved, and to have evidence of judgments, and decision outcomes. Drawing on a social constructionist stance, Parton (1979) argued that in order to understand what is child abuse or neglect, it needs to be made 'visible' by describing certain social and personal phenomena as abusive or neglectful. In this way what comes to be considered as abuse and neglect are constructed and then operationalized by having meaning attached to certain behaviours of parents or carers that lead to negative outcomes for children. The rich evidence in case

records suggest (to echo Stevenson) it is possible for information to be gathered and 'assembled and organised in ways which will be useful to social workers' (Stevenson, 1996 p.16) and that will be useful to service managers, researchers and policy makers.

It is imperative that we have visibility and transparency at the system level, about the nature of demand, judgments about risks and decisions about service provision. The alternative, the current situation, is a problematical proposition for managing a service. Ireland lags behind other Anglophone systems in this regard; in the USA, Canada, the United Kingdom and Australia to name a few, systematic data collection based on child protection services are in use (Fluke *et al.*, 2021). It is recommended that Tusla collate and make available for use across all aspects of the service, child level administrative data from CPW services and from family support services (O'Leary and Lyons, 2023). At the individual case level, SWs identified difficulty in searching case files to inform decision making. Tusla has adopted an electronic case management system that should go some way to address the file accessibility issue.

8.3.2. Judgments of risk and making decisions

As discussed in Chapter 3, models to establish the likelihood of past abuse and models to identify the risk of future abuse, rely on different variables (Dawid 2013 in Best *et al.*, 2013; Dawes *et al.*, 1989; Keddell, 2016b; van der Put *et al.*, 2016). In practice, this necessitates different responses from CPW that incorporate therapeutic interventions to address past harm and to prevent further harm. SWs in Tusla are faced with these two different types of risk assessment as the policy for substantiation commenced in 2022 (Tusla, 2022) and applies only to certain classes of abuse allegations. The evidence from this research indicates that SWs struggle to know which variables to incorporate into risk judgments. And separately, SWs struggle incorporating risk judgments into decisions about service provision because of professional expertise and factors in the wider practice environment. These are two areas which Tusla needs to address.

This research demonstrated how models of decision making can be developed from case level data. Such modelling, based on appropriate national representative samples could be used as a basis for developing predictive risk models for both types of judgments – the likelihood of past abuse and the likelihood of future abuse. Predictive risk modelling is not without difficulties (Barlow *et al.*, 2012; Cuccaro-Alamin *et al.*, 2017; Drake *et al.*, 2020; Gillingham, 2017; Gillingham and Humphreys, 2010; Keddell, 2014b) and some of the difficulties are evidenced in this research: the model shows clear biases and there is a risk that these would become further entrenched if such a model were institutionalised.

Identifying the right signal, however, is not merely a matter of creating better techniques (Kahneman *et al.*, 2021; Silver, 2012). The second issue pertains to using the outcome of risk judgments to inform decisions. The case study showed that risk judgments are variously associated with the decision to provide service. This study found that SWs were not naïve about their decisions; case notes and interviews provided insight to a range of needs and to the ethical dilemmas of deciding who gets service, based on constraints in the organisation. This also needs attention because as this thesis has

demonstrated, the focus in policy development in Tusla on revising assessment frameworks as a means to improve outcomes may be based on a premise that rates of false negatives are higher than they really are. The *Decision Making Ecology* model of decisions produced from the case study (see Figures 12 and 13; (Baumann *et al.*, 2011)) demonstrates influences on judgments and decisions and may be instructive in this regard. Addressing these two areas can assist service managers in distinguishing case level signals of risk and service need from noise in the system that impacts on decisions and child outcomes.

Lastly, it is clear that SWs need mechanisms, time, and space for active reflection to raise consciousness about the nature of their practice and decision policies. The frustration expressed by SWs regarding the conditions for IA practice and their sense of resignation about strategies adopted to manage caseloads but also, problematically, feelings of uncertainty, reluctance and regret about difficult decisions echoes representations made previously by SWs in relation conditions for practice in Ireland (Burns and MacCarthy, 2012; IASW, 2011; O'Connell, 2014; Whelan, 2018), and elsewhere (Bostock *et al.*, 2005; Keddell and Hyslop, 2019b; Munro, 2019a). This frustration has also been identified in a Tusla staff survey conducted subsequent to this research and since the introduction of the *Signs of Safety* model of practice (Munro and Cunliffe, 2020). There is an urgent need to develop a practice framework within which SWs can systematically be supported without blame, to assert professional concerns about practice and organisational cultures even when they conflict with organisational narratives, or when decisions cannot be supported (Keddell, 2021; Munro, 2019a). Enhancing the evidence base as identified above should support SWs in this regard as it will demonstrate the nature of their work and the context for practice. It is hoped that the reports that will be produced in the first instance, will generate opportunities to support changes.

8.3.3. Assessment frameworks, tools, and patterns of response

The question of how useful the assessment process as reflected in the IA record was in helping SWs analyse risks and making the decision to provide services is not entirely clear, but it appears from the case study that it was limited. Extracting information from case file records was a cumbersome process that must mirror the sensemaking and identification of important cues by SWs when evidence is being analysed for decision-making. The studies found also that Tusla policies (HSE/Tusla, 2009/2014; Tusla, 2014c) served as reference points for judgments and decisions. As Lonne *et al.* (2020) say, assessment frameworks and tools are themselves, heuristics or rules of thumb to support decision-making.

Assessment policy has been revised by Tusla since these studies were conducted. The previous consensus model incorporating the *Framework for Assessment of Children in Need and their Families* which as evidenced here, was seen as a strength based- and solution based approach (Department of Health, 2000b; HSE/Tusla, 2009/2014) has been replaced by the *Signs of Safety* model, also a consensus model and strengths based approach (Burns and McGregor, 2019; Turnell and Murphy, 2017; Tusla, 2017) and rates of service provision have continued to decrease. The substantiation policy will likely re-focus assessments on incident-driven and risk-driven approaches to assessment and intervention

(Brown and Ward, 2014; Bywaters, 2015a; Featherstone *et al.*, 2014b; Scott, 2014; Sheehan, 2019; Spratt, 2012). Some problems identified in this study about the capacity to practice in a way that conforms with professional judgment about risk and service need persist (Munro and Cunliffe, 2020).

Using the data set I had created, the California Structured Decision Making© Family Risk Assessment Tool (NCCD, 2017) was relatively easy to complete, and despite the limitations detailed about its applicability in the Irish context, it demonstrated the viability and potential benefits of using an evidence based risk scoring instrument. As mentioned above, developing a risk prediction model based on Irish data could help SWs with judgments and decision making.

Consistent with long established patterns identified in research across Anglophone systems using a range of methodologies to examine decisions in CPW, this research demonstrates a system designed to filter more children and families out than it serves, particularly those chronically involved (Buckley, 2003; Gibbons *et al.*, 1995; Hayes and Spratt, 2009; 2014; Lwin *et al.*, 2018b; Parton *et al.*, 1997; Stevenson, 1996; Thorpe, 1997; Trocmé *et al.*, 2010; Trocmé *et al.*, 2014; Whelan, 2018). The pattern of response will likely continue to favour high risk profile assessments or urgent needs over chronic needs as discussed in this thesis (Buckley, 2015; Buckley and Burns, 2015; Furey and Canavan, 2019) and identified in Canadian research (Schumaker *et al.*, 2017; Trocmé *et al.*, 2014). This warrants further investigation as Tusla has an equal duty to prevent recurrence of harm for all children. Systematically collating case level data for analysis and research as detailed above, would assist.

8.4. Focus on parents and deference to families

Social workers explanations of their judgments and decisions incorporated aspects of what Pizzey et al., (2017) call child-centredness in parenting. Themes that emerged from the case study included SWs perception of parent's insight to the concerns, their engagement and their capacity or motivation to address concerns, in addition to factors they identified based on the domains of the assessment framework triangle (Department of Health, 2000b; HSE/Tusla, 2009/2014). As such the findings indicate that SWs incorporate what researchers say are necessary aspects of assessing parenting capacity (Houston, 2016; Jones, 2010; Pizzey *et al.*, 2017; Turney *et al.*, 2012). The model of service provision developed in the analytic cross-sectional study which showed that mostly parent related factors drove the decision to provide services, likely represents an understanding of the cumulative impact on parenting capacity of ongoing exposure to the difficulties families faced (Fluke *et al.*, 2008; Hood *et al.*, 2021). These findings highlight the need for interventions to consider a wide range of factors that enhance or impair parenting capacity (Bentovim *et al.*, 2009; Campbell *et al.*, 2010; Pizzey *et al.*, 2017; Schechter and Edleson, 1999). However, because decision-making was based on risk-driven approaches and because caseload management is frequently substituted for case management, opportunities are diminished for working therapeutically with children and families to improve long-term outcomes.

Another feature of risk management and decision-making related to the concept of subsidiarity, where responsibility for risk management was delegated to parents and/or other services, sometimes as the case study (Chapter 5) revealed, reluctantly and when SWs believed that a stable outcome was improbable or when parents had little control over the circumstances. It is a risk that the current practice model will amplify these concerns.

Efforts for preventing the occurrence and recurrence of child abuse and neglect are best understood through an ecological framework that incorporates a child and parent, the wider family and social settings and societal factors (Sethi *et al.*, 2013). This means the CPW system needs to facilitate SWs to conduct assessments based on a chronologic approach that considers heritable traits, experiences, predispositions and age in addition to interrelated non-familial influences including environment that could confer risk (Broadhurst *et al.*, 2017; Collins *et al.*, 2000; Marshall *et al.*, 2011; Widom *et al.*, 2015) and which can help give insight into intervention design (Belsky, 1993; Cicchetti and Lynch, 1993; Goulet *et al.*, 2018). Again, the systematic production of evidence about the characteristics of children and families involved in CPW will go a long way to supporting SW practice and ensuring organisational readiness and responsiveness.

8.5. Domestic violence

The management of cases involving DV is particularly problematic for SWs, and as a consequence for children and families and for the wider system. Given evidence of the high prevalence of exposure to DV among children involved with Tusla, one in seven referrals (Whelan, 2018) and one in four assessments, this concern warrants immediate action.

It was clear from the case study (Chapter 5) in the patterns of response and individual narrative accounts (Flyvbjerg, 2011) and from the model of ongoing service (Chapter 7) that the semantic question whether or not DV constitutes child abuse and the effect on children of patterns of violence within a family are clearly problematic. So too are questions of how to identify, weight and respond to the needs of children and parents who experience violence. Bivariate analysis (Chapter 6) and the univariable Poisson regression analysis (Chapter 7) indicate that SWs recognise the potential negative effects on child development and safety of disruptive and violent relationships between their parents (Erel and Burman, 1995; Finkelhor, 1990; Howe, 2001; Iwaniec, 2006). However, patterns of family violence and patterns of responses were seen through gendered discourses and practices that focused on mothers as moderators and gate keepers, whether or not they have control over men's aggression and violence, and on deficits in their parenting when they perpetrate DV.

Not all children are equally vulnerable to the effects of DV or require the support of CPW services (Finkelhor, 1994; Gilligan, 2001; Øverlien and Holt, 2019), however, the findings may indicate failure to account for its impact on a mother's parenting capacity, children's development and their service needs (Buckley, 2000b; 2003; Buckley *et al.*, 2007; Buckley *et al.*, 2011b; Gibbons *et al.*, 2010;

Horwath, 2001; Morris, 2009). They may reflect uncertainty by SWs in the assessment of the different effects of aggression and DV perpetrated by mothers and fathers on child development (Buckley *et al.*, 2011a; Saini *et al.*, 2019). Perhaps the response reflects a gendered view of the aetiology of DV; for a long time DV was associated with male aggression towards female partners that led to the development of shelters for women and children, increased public awareness education and policies. The findings may be associated with a view that mothers who are victims of DV were seen to have capacity to moderate the effects of the DV on their children by their own actions or by accessing services, whereas fathers were perceived not to have a similar moderating effect when they were victims of DV.

Featherstone and Morris (2021) recommend practice approaches that support family members who experience DV to walk professionals through their daily routines and practices to ensure they have fine-grained and very concrete understandings of the effects of harmful behaviors and experiences on all family members in a range of settings and contexts. This may be a useful approach to adopt so long as SWs are aware of and record the evidence presented.

A recent evidence synthesis on improving outcomes for children exposed to violence in the UK suggests that interventions delivered to non-abusive parents and children were most likely to be effective at improving children's behavioural outcomes (Howarth *et al.*, 2016b). In particular, it notes parenting skills training plus concurrent DV advocacy for parents was more effective than other interventions, although there was also some evidence to suggest that psychoeducation delivered in parallel to parents and children could improve behavioural outcomes (ibid). While these important findings warrant further exploration, they could be considered in the development of interventions to respond to DV and child abuse that are acceptable to all stakeholders and effective in improving outcomes for children and their parents.

These findings indicate the need for several immediate responses. SWs are currently not required to systematically record evidence of DV or the perpetrator, this needs to be changed to ensure data accurately reflects clients' experiences and service needs. SWs and managers at every level in the agency need systematically generated evidence of the characteristics of children exposed to DV in order to support them and advocate for them with other services and the judiciary. It is necessary to promote anti-discriminatory practice in all aspects of practice including record writing; SWs and managers too may benefit from training on DV to support this practice. Tusla needs to adopt evidence informed advocacy approach for all family members, women, and children especially, who are involved with the services. There is a need for oversite of risk management plans to prevent overlooking important indicators of abuse and to minimise opportunities for recurrence (Stanley *et al.*, 2010). And lastly, further research is needed on patterns of DV and responses by Tusla especially in the context of Tusla's remit in Child Protection and Welfare, Safety Planning, Family Support and Domestic Sexual and Gender Based Violence (Tusla, 2021c).

8.6. Ethics, reflexivity and the model for child protection and welfare practice

It is unclear whether 'front door' child protection and welfare services are appropriately devised to effectively respond to the situations that put children at risk of abuse and poor outcomes (King *et al.*, 2021; Lonne *et al.*, 2020). Notwithstanding, Tusla currently has a statutory duty to promote the welfare of children not receiving adequate care (Department of Health, 1991) and is uniquely designated in this role to uphold the explicit and implicit rights of children and families involved with the service (UNCRC, 2011). To echo my colleagues (Buckley, 2012; Buckley *et al.*, 2010; Fallon *et al.*, 2012; Kilkelly, 2007; O'Mahony, 2020; Whelan, 2018), in order to fulfil its duty relating to protection and family support, empirical evidence of the profile of children and families involved with the service and the responses they receive in addition to evidence of the context for practice must be central to all policy development by Tusla and Government (O'Leary and Lyons, 2023). Findings from the current studies challenge some prevailing orthodoxies about assessment and decision-making including the idea that many children and families are unnecessarily drawn into the CPW system.

The findings from this research suggest that cumulatively, the system itself with a consistently expanding remit and managerialist strategies purportedly adopted in an effort to reduce uncertainty, actually generates uncertainty and anxiety through the demands it imposes on SWs (Lees *et al.*, 2011; Lonne *et al.*, 2020; Munro, 2011b; Waterhouse and McGhee, 2009). These include role related anxieties emerging from uncertainties about the nature of abuse and the multiple needs of families, in addition to deficits in SWs' professional knowledge and expertise, in particular in relation to DV, and the necessity or otherwise of ongoing service (Barnes and Chand, 2000; Cooper, 1995; 2010; Keddell and Hyslop, 2019b; Munro, 2011b; Parton *et al.*, 1997; Saini *et al.*, 2012). These co-occur with anxieties about professional duties relating to organisation policy, work-flow and resources that impact on decisions and fears about getting them wrong (Barnes and Chand, 2000; Broadhurst *et al.*, 2010b; Buckley, 2015; Burns and MacCarthy, 2012; Cooper, 1995; 2010; IASW, 2011; Lees *et al.*, 2011; Waterhouse and McGhee, 2009). The findings reflect a system that is inequitable, not all children and families receive the services SW believe they need, posing epistemological, ethical, political, and practical problems for Tusla and Government.

The demographic profile of children and families provided clear evidence that they are significantly disadvantaged relative to the general population and by association among the least powerful in society (Lonne *et al.*, 2015). It is hoped that the role of social determinants of disadvantage and inequality among children and families involved in assessments can be brought forward into discussions about the statutory duty to intervene to support children and ensure their safety to redress potential injustices associated with intervention decisions.

Despite the intention by Tusla to develop a framework that delivers an equal chance to each child and family, the knowledge produced from these studies points to a system that prioritises a 'child protection' orientation by providing services to those presenting with the highest or immediate risks (Buckley, 2012; 2015; 2017b; Buckley and Burns, 2015; Bunting *et al.*, 2018; Gilbert *et al.*, 2011b; Hayes and

Spratt, 2009; 2014; Spratt, 2001; Whelan, 2018). Consequently, responses to others are unfairly subordinated and they are repeatedly closed without services even though their difficulties are multifaceted and may negatively impair their development and welfare. As asked elsewhere (King *et al.*, 2021; Simon *et al.*, 2021) this raises questions about the role of CPW services in Ireland.

Drawing on the work of Thompson *et al.* (2006), Lonne *et al.* (2015 p. 9) suggest that ethical practice does not just entail how SWs relate to children and families or to each other and their employers, or how they respond to the needs of their constituencies, they say

> *it is also about how policies are made and implemented, and whether or not this promotes respect and justice, and contributes to the creation of a society that cares … ethical practice is contingent on a network of services and policies working in tandem with one another; it is not just about individual organisations and practitioners. It cannot be achieved in an environment that disregards the prime values of respect for people and social justice; it is contingent on context.*

There is a need to shift from the narrow conception of the duty of care to children to one that embraces family support and protection as intertwined, not separate, paradigms (Featherstone *et al.*, 2014b; Lonne *et al.*, 2015). As this research shows, the context for practice is complex and based on ever increasing demand and policies that seek at least in their design, to ensure capacity for a consistent response to all children and families who present to Tusla's 'front door' (DCYA, 2011a; 2015; 2017; Department of Health and Children, 1999; Gloster, 2022; HSE/Tusla, 2009/2014).

The current practice model in Tusla is based on a differential response with CPW on the one hand and the *Meitheal* case co-ordination process on the other, for families with additional needs who require multi-agency intervention, but who do not meet the threshold for referral to the Social Work Department under Children First (DCYA, 2017; Tusla, 2013b). That practice model is recognised as being central to effective reforms within the agency but it has been described as challenging to achieve due to concerns about power and authority and due to the basis of the policy framework that separates protection from family support, that may see children and families fall between services (Canavan *et al.*, 2019; Featherstone *et al.*, 2014b; Lonne *et al.*, 2020; McGregor and Devaney, 2020b). It is important to acknowledge that the pathway to *Meitheal* was not well embedded when this study commenced and many children and families who were not offered service in 2016 may well be supported by the *Meitheal* programme after 2020. However, the findings of this research demonstrated that children and families with high level of service needs which may preclude involvement in *Meitheal*, were routinely closed to CPW. Together with the high prevalence rates of recurrence and intergenerational involvement among those undergoing assessment the evidence suggests the framework may allow for families to remain on the edge of service (Lonne *et al.*, 2009; McGregor and Devaney, 2020b). Problematic also is the fact that the current framework can reinforce inequality because it ignores underlying structural factors by focussing on individualist approaches to secondary prevention and the evidence base for both *Meitheal* and *Signs of Safety* is limited (Baginsky *et al.*, 2019; McGregor and Devaney, 2020b; Parton, 2019)

meaning there is uncertainty as to their effectiveness. Several commentators have suggested that public health approaches which recognise a stronger role for both universal and community-based services may achieve better outcomes for children and families and for services (Featherstone *et al.*, 2014b; Lonne *et al.*, 2020; O'Leary and Lyons, 2021; Parton, 2019). As a starting point, the systematic production of child data from both CPW and preventive services would help in making more visible the nature of demand on each side of Tulsa's service and help in tracking interaction between them (O'Leary and Lyons, 2023).

These concepts are important in relation to this research as they highlight some of the concerns discussed above, that SWs themselves raised. Particularly poignant were reports by SWs in the case study of uncertainty and regret about decisions due to their potential effect on children and families and the fear of making the wrong decision. I mentioned above the need for a culture of practice that encourages reflexivity without blame and allows for positive discussion of sources of uncertainty and error so that real-world problems can be used as opportunities to raise practice consciousness, to foster professional learning and improve decision outcomes (Kahneman and Klein, 2009; Keddell, 2014a; Lonne *et al.*, 2015; Munro, 2019a). According to Kahneman and Klein (2009) professional intuition is necessary to support good decision-making in high-pressure environments, but should be evaluated to ensure it makes sense in each context. Failure to evaluate intuition leads to over confidence, influenced by the coherence of a story but not its validity. Absent feedback on the accuracy of decisions, intuition is unlikely to be trustworthy. Several models exist that could inform the development of local and national responses to support development of evidence based expertise such as morbidity and mortality meetings in surgery (Vreugdenburg *et al.*, 2018 M&M meetings) and child protection, such as developing vignettes for use in training, or using a model of reflection in training and practice (Keddell, 2014a; Lonne *et al.*, 2015; Munro, 2019a).

8.7. Key recommendations and proposals for disseminating findings

A vast proportion of evidence that SWs are required to gather is not collated at a regional or a national level in a way that is available for research or policy development. Building on the investments in the national data infrastructure and data management systems (Tusla, 2020a), it is imperative to effective service provision and organisational management that current data collection mechanisms be extended to facilitate the production of disaggregated child-level demographic and case related data (Furey and Canavan, 2019; HSE/Tusla, 2009/2014; O'Leary and Lyons, 2021; 2023; Tusla, 2021b).

It is recommended that nationally representative samples of case level data be used to develop models of risk assessment for past abuse, for future abuse, and for service provision, to support the evidence base for practice, organisational responsiveness, and training. It is recommended a mechanism is adopted to fund systematic research studies, perhaps modelled on north American approaches (Fallon *et al.*, 2022; Sedlak *et al.*, 2010a).

It is recommended that SWs and SW managers receive training on DV and the effects on children and tensions that arise in addressing patterns of family violence. The findings from this research may be informative in this regard.

It is recommended that training be provided to service managers, policy makers and practitioners on the role of data and evidence in risk assessment and decision making and in policy development. It is important also that SWs and managers be afforded opportunities to reflect on judgment and decision making in cases that are challenging and those that work well.

The findings from these studies will be used to develop a series of reports to help stakeholders understand the data, and to highlight areas where support can be allocated, to suggest areas for social work training and to develop recommendations for future policies for data collection and analysis and research (Fallon *et al.*, 2017a). At the time of writing plans are in place to deliver presentations to local and regional teams who were involved in the research, to the Board of Tusla and the Executive Management Team. It is a particular hope that the findings will in turn, be used to advocate for resources to address the recommendations above about the organisational context and practice environment with a view to improving outcomes for children and families who are involved with the service.

The findings from this study will also generate publications aimed at a wider national and international audience.

8.8. Concluding comments

Given that there is no evident panacea to address system design issues, further research is necessary on a national scale to examine decision-making processes in addition to the initial outcomes of decisions and their effect on longer term outcomes for children. Research must also explore the relationship between tools and the decisions they generate to help address the limitations of the model, where identified. With a new National Management Team and six regional Chief Officers in place, Tusla is undertaking a significant change programme focused on three priority areas of *Practice, Culture and Structure* outlined in the *Corporate Plan 2021 to 2023* (Tusla, 2021c). That platform could be built upon to address some of the recommendations that emerge from this research.

In his forward to that corporate plan, Pat Rabbitte, Chairperson of the Board of Tusla, wrote,

> *Pursuing improvement in Practice involves not only the expertise of our professional staff but also in an increasingly regulated environment ensuring that we pursue consistency. Culture improvement will be reflected in the simple statement but complex task of realising the way in which we live out our values of Trust, Respect, Kindness and Empowerment. The behaviours to give meaning to our values are clearly stated. Structure will change quickly in our new design of the organisation to bring about the necessary corporate framework and*

> *local service delivery which will aid the consistency of practice, the growth of positive culture and address the many governance challenges of recent years (Tusla, 2021c p. 4)*

Guided by these valuable principles, the C*orporate Plan* states

> *Our national approaches to practice ensure that responses are consistent across the country and embedded with the values and behaviours of our agency. We want our referral community to know that, based on whatever reason they refer a child to Tusla, we will make an informed, collaborative, and respectful decision about what will assist the child and their family (Tusla, 2021c p. 6).*

The idea of delivering informed, consistent, collaborative and respectful services have long been central to Irish child protection and welfare policies and organisational reforms (DCYA, 2011a; 2017; Department of Health and Children, 1999; HIQA, 2012; HSE/Tusla, 2009/2014). But as this thesis shows, many efforts to deliver these objectives have focused on systemizing processes and on developing infrastructure and quality assurance of performance indicators relating to the operation of those processes.

There is an adage in business theory: 'what gets measured gets managed even if it is in conflict with the purpose of the organisation'! Although the performance and activity data that are managed and published by Tusla are extremely important, especially in the context of organizational restructuring which has been a feature of the Irish CPW system in recent decades, they are reductive as expression of quality in child-centered practice. As demonstrated here, they are also reductive as a measure of service needs and child outcomes. The prioritization of these measures seems to reflect the opportunity cost of not systematically developing empirical knowledge about the demographic characteristics and the abuse and welfare related needs of children and families at the center of these processes.

There are currently, many barriers to realizing the vision and aims outlined in Tusla's *Corporate Plan* and Government policies which encompass duties under the UN Convention on the Rights of the Child (DCYA, 2017; SI.No.470/2017, 2017; Tusla, 2021c; UNCRC, 2011). Overcoming these barriers requires commitments to upend current orthodoxies about consistency and quality to ensure that the CPW system has sufficient flexibility within it to understand and accommodate the needs of clients and safeguard individual, fair and effective responses in a transparent manner. The 'front door' needs to be thrown wide open to offer responses that respectfully embrace child protection and family support as a single immutable vision. It is my hope that the evidence from this thesis, the insights developed, and recommendations made can be used to advocate for further and vitally important changes to enhance the capacity of the Department of Children, the Board and the Management Team of Tusla and particularly, social workers to respond fairly and effectively to children and families with whom we have the privilege to be involved.

References

Adams, T. R., Handley, E. D., Manly, J. T., Cicchetti, D. & Toth, S. L. 2019. Intimate partner violence as a mechanism underlying the intergenerational transmission of maltreatment among economically disadvantaged mothers and their adolescent daughters. *Development and psychopathology,* 31**,** 83-93.

AIHW 2017. Child protection Australia 2015–16. *Child Welfare Series.* Canberra: AIHW: Australian Institute of Health and Welfare.

Ainsworth, F. & Hansen, P. 2015. Understanding Difficult Parental Behaviours During a Child Protection Investigation. *Children Australia,* 40**,** 20-22.

AlEissa, M. A., Fluke, J. D., Gerbaka, B., Goldbeck, L., Gray, J., Hunter, N., Madrid, B., Van Puyenbroeck, B., Richards, I. & Tonmyr, L. 2009. A commentary on national child maltreatment surveillance systems: Examples of progress. *Child Abuse & Neglect,* 33**,** 809-814.

Alexander, L., Lopes, B., Ricchetti-Masterson, K. & Yeatts, K. 2015. Cross-sectional Studies. Eric Notebook.

Alman, I., Lyons, O. & King, B. 2020. Characteristics of Maltreatment Related Investigations in Ontario in 2018 Involving Adolescents aged 16 to 17. CWRP Information Sheet #214E. Toronto, ON: Canadian Child Welfare Research Portal.

Altman, D. G., Deeks, J. J. & Sackett, D. L. 1998. Odds ratios should be avoided when events are common. *BMJ,* 317**,** 1318.

Arad-Davidzon, B. & Benbenishty, R. 2008. The role of workers' attitudes and parent and child wishes in child protection workers' assessments and recommendation regarding removal and reunification. *Children and Youth Services Review,* 30**,** 107-121.

Arkes, H. R. 1981. Impediments to accurate clinical judgment and possible ways to minimize their impact. *Journal of consulting and clinical psychology,* 49**,** 323.

Armfield, J. M., Gnanamanickam, E. S., Johnston, D. W., Preen, D. B., Brown, D. S., Nguyen, H. & Segal, L. 2021. Intergenerational transmission of child maltreatment in South Australia, 1986–2017: a retrospective cohort study. *The Lancet Public Health,* 6.

Austin, A. 2016. Is prior parental criminal justice involvement associated with child maltreatment? A systematic review. *Children and Youth Services Review,* 68**,** 146-153.

Axford, N. & Berry, V. 2018. Perfect bedfellows: Why early intervention can play a critical role in protecting children—A response to Featherstone et al.(2014)'A marriage made in hell: Child protection meets early intervention'. *British Journal of Social Work,* 48**,** 254-273.

Baginsky, M., Moriarty, J. & Manthorpe, J. 2019. Signs of Safety: lessons learnt from evaluations. *Journal of children's services,* 14**,** 107-123.

Baird, C., Wagner, D. & Neuenfeldt, D. 1993. Actuarial risk assessment and case management in child protective services. *Sixth national roundtable on CPS risk assessment***,** 151-168.

Bar-Hillel, M. 1980. The base-rate fallacy in probability judgments. *Acta Psychologica,* 44**,** 211-233.

Bar-Hillel, M. 1984. Representativeness and fallacies of probability judgment. *Acta Psychologica,* 55**,** 91-107.

Barber, J., Trocmé, N., Goodman, D., Shlonsky, A., Black, T. & Leslie, B. 2000. *The reliability and predictive validity of consensus-based risk assessment*, Centre of Excellence for Child Welfare.

Barber, J. G., Shlonsky, A., Black, T., Goodman, D. & Trocmé, N. 2008. Reliability and predictive validity of a consensus-based risk assessment tool. *Journal of Public Child Welfare,* 2**,** 173-195.

Barlow, J., Fisher, J. D. & Jones, D. 2012. Systematic review of models of analysing significant harm. London: Department for Education.

Barnes, V. & Chand, A. 2000. Initial assessments in child protection: The reality of practice. *Practice,* 12**,** 5-16.

Barros, A. J. & Hirakata, V. N. 2003. Alternatives for logistic regression in cross-sectional studies: an empirical comparison of models that directly estimate the prevalence ratio. *BMC medical research methodology,* 3**,** 21.

Bartelink, C., Knorth, E. J., López, M. L., Koopmans, C., Ingrid, J., Witteman, C. L. & Van Yperen, T. A. 2018. Reasons for placement decisions in a case of suspected child abuse: The role of reasoning, work experience and attitudes in decision-making. *Child Abuse & Neglect,* 83**,** 129-141.

Bartelink, C., van Yperen, T. A. & ten Berge, I. J. 2015. Deciding on child maltreatment: A literature review on methods that improve decision-making. *Child Abuse & Neglect,* 49**,** 142-153.

Bartelink, C., van Yperen, T. A. & ten Berge, I. J. 2016. Reply to the Letter to the Editor of Van der Put, Assink, & Stams about "Deciding on child maltreatment: A literature review on methods that improve decision-making". *Child Abuse & Neglect,* 59**,** 130-132.

Bartlett, J. D., Kotake, C., Fauth, R. & Easterbrooks, M. A. 2017. Intergenerational transmission of child abuse and neglect: Do maltreatment type, perpetrator, and substantiation status matter? *Child Abuse & Neglect,* 63**,** 84-94.

Baumann, D. J., Dalgleish, L., Fluke, J. D. & Kern, H. 2011. The decision-making ecology. Washington, DC: American Humane Association.

Baumann, D. J., Fluke, J. D. & Casillas, K. L. 2012. Understanding Decision-Making. *18th National Conference on Child Abuse & Neglect.* Washington, D.C.

Baumann, D. J., Law, J. R., Sheets, J., Reid, G. & Graham, J. C. 2005. Evaluating the effectiveness of actuarial risk assessment models. *Children and Youth Services Review,* 27**,** 465-490.

Baumann, D. J., Law, J. R., Sheets, J., Reid, G. & Graham, J. C. 2006. Remarks concerning the importance of evaluating actuarial risk assessment models: A rejoinder to Will Johnson. *Children and Youth Services Review,* 28**,** 715-725.

Baxter, P. & Jack, S. 2008. Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *Qualitative report,* 13**,** 544-559.

Beck, U. 1992a. From Industrial Society to the Risk Society: Questions of Survival, Social Structure and Ecological Enlightenment. *Theory, Culture & Society,* 9**,** 97-123.

Beck, U. 1992b. *Risk Society: Towards a New Modernity,* London, Sage.

Beddoe, L. 2010. Surveillance or Reflection: Professional Supervision in 'the Risk Society'. *British Journal of Social Work,* 40**,** 1279-1296.

Belsky, J. 1980. Child maltreatment: An ecological integration. *American Psychologist,* 35**,** 320-335.

Belsky, J. 1993. Etiology of child maltreatment: A developmental Ecological analysis. *Psychological Bulletin,* 114**,** 413-434.

Benbenishty, R. 1992. An overview of methods to elicit and model expert clinical judgment and decision making. *Social Service Review,* 66**,** 598-616.

Benbenishty, R., Davidson-Arad, B., López, M., Devaney, J., Spratt, T., Koopmans, C., Knorth, E. J., Witteman, C. L., Del Valle, J. F. & Hayes, D. 2015. Decision making in child protection: An international comparative study on maltreatment substantiation, risk assessment and interventions recommendations, and the role of professionals' child welfare attitudes. *Child abuse & neglect,* 49**,** 63-75.

Benbenishty, R. & Fluke, J. D. 2020. Frameworks and Models in Decision-Making and Judgment in Child Welfare and Protection. *Decision-Making and Judgment in Child Welfare and Protection: Theory, Research, and Practice***,** 3.

Benbenishty, R., Osmo, R. & Gold, N. 2003. Rationales provided for risk assessments and for recommended interventions in child protection: A comparison between Canadian and Israeli professionals. *British Journal of Social Work,* 33**,** 137-155.

Bentovim, A., Cox, A., Bingley Miller, L. & Pizzey, S. 2009. *Safeguarding children living with trauma and family violence: Evidence-based assessment, analysis and planning interventions*, Jessica Kingsley Publishers.

Bentovim, A., Turney, D., McAuley, C., Pecora, P. & Rose, W. 2006. *Enhancing the well-being of children and families through effective interventions: International evidence for practice*, Jessica Kingsley Publishers.

Berger, L. M., Slack, K. S., Waldfogel, J. & Bruch, S. K. 2010. Caseworker-perceived caregiver substance abuse and child protective services outcomes. *Child maltreatment,* 15**,** 199-210.

Berlin, L. J., Appleyard, K. & Dodge, K. A. 2011. Intergenerational Continuity in Child Maltreatment: Mediating Mechanisms and Implications for Prevention: Intergenerational Continuity. *Child development,* 82**,** 162-176.

Bernard, H. R. 2017. *Research methods in anthropology: Qualitative and quantitative approaches*, Rowman & Littlefield.

Bernardi, D. A. & Steyn, F. 2019. A Model for Female-Perpetrated Domestic Violence. *Victims & offenders,* 14**,** 441-461.

Best, N., Ashby, D., Dunstan, F., Foreman, D. & McIntosh, N. 2013. A Bayesian approach to complex clinical diagnoses: a case-study in child abuse. *Journal of the Royal Statistical Society: Series A (Statistics in Society),* 176**,** 53-96.

Biehal, N., Wade, J., Farrelly, N. & Sinclair, I. 2011. *Caring for abused and neglected children: Making the right decisions for reunification or long-term care*, Jessica Kingsley Publishers.

Biesel, K., Masson, J., Parton, N. & Pösö, T. 2020. Errors and mistakes in child protection: an introduction. *In:* Biesel, K., Masson, J., Parton, N. & Poso, T. (eds.) *Errors and mistakes in child protection: International discourses, approaches and strategies.* Bristol: Policy Press.

Bilson, A., Cant, R. L., Harries, M. & Thorpe, D. 2015. A Longitudinal Study of Children Reported to the Child Protection Department in Western Australia. *British Journal of Social Work,* 45**,** 771-791.

Blumenthal, A. 2015. Child Neglect II: Prevention and Intervention. *Canadian Child Welfare Research Portal*.

Bosk, E. A. 2018. What counts? quantification, worker judgment, and divergence in child welfare decision making. *Human Service Organizations: Management, Leadership & Governance,* 42**,** 205-224.

Bosk, E. A., Van Scoyoc, A., Mihalec-Adkins, B., Conrad, A., Hanson, K. & Chaiyachati, B. H. 2021. Integrating responses to caregiver substance misuse, intimate partner violence and child maltreatment: Initiatives and policies that support families at risk for entering the child welfare system. *Aggression and violent behavior***,** 101637.

Boslaugh, S. 2008. Encyclopedia of Epidemiology. Thousand Oaks, California: Sage Publications, Inc.

Bostock, L., Bairstow, S., Fish, S. & Macleod, F. 2005. *Managing Risk and Minimising Mistakes in Services to Children and Families: Children and Families' Services Report 6*, Policy Press.

Boxall, H., Dowling, C. & Morgan, A. 2020. Female perpetrated domestic violence: Prevalence of self-defensive and retaliatory violence. *Trends and issues in crime and criminal justice***,** 1-17.

Boyatzis, R. E. 1998. *Transforming qualitative information: Thematic analysis and code development*, sage.

Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C. & Black, J. 2009. Understanding Serious Case Reviews and their Impact: A biennial analysis of serious case reviews 2005-07.

Brandon, M., Belderson, P., Sorensen, P., Dickens, J., Sidebotham, P., Cleaver, H., Garstang, J., Harris, J. & Wate, R. 2020. Complexity and challenge: a triennial analysis of SCRs 2014-2017. Department for Education.

Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative research in psychology,* 3**,** 77-101.

Braun, V. & Clarke, V. 2012. Thematic analysis. *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological.* Washington, DC, US: American Psychological Association.

Broadhurst, K., Hall, C., Wastell, D., White, S. & Pithouse, A. 2010a. Risk, Instrumentalism and the Humane Project in Social Work: Identifying the Informal Logics of Risk Management in Children's Statutory Services. *British Journal of Social Work,* 40**,** 1046-1064.

Broadhurst, K., Mason, C., Bedston, S., Alrouh, B., Morriss, L., McQuarrie, T., Palmer, M., Shaw, M., Harwin, J. & Kershaw, S. 2017. Vulnerable birth mothers and recurrent care proceedings. *Lancaster: University of Lancaster*.

Broadhurst, K., Wastell, D., White, S., Hall, C., Peckover, S., Thompson, K., Pithouse, A. & Davey, D. 2010b. Performing 'Initial Assessment': Identifying the Latent Conditions for Error at the Front-Door of Local Authority Children's Services. *British Journal of Social Work,* 40**,** 352-370.

Bromfield, L. M., Gillingham, P. & Higgins, D. J. 2007. Cumulative harm and chronic child maltreatment. *Developing Practice: The Child, Youth and Family Work Journal***,** 34-42.

Bromfield, L. M., Lamont, A., Parker, R. & Horsfall, B. 2010. *Issues for the safety and wellbeing of children in families with multiple and complex problems Issues for the safety and wellbeing of children in families with multiple and complex problems. (NCPC Issues No. 33)* [Online]. Melbourne: National Child Protection Clearinghouse, Australian Institute of Family Studies. Available: https://aifs.gov.au/cfca/sites/default/files/publication-documents/cfca-36-children-exposure-fdv.pdf [Accessed].

Bronfenbrenner, U. 1979. *The ecology of human development: experiments by nature and design,* Cambridge, Mass;London;, Harvard University Press.

Bronfenbrenner, U. 1994. Ecological models of human development. *Readings on the development of children,* 2**,** 37-43.

Bronfenbrenner, U. 2001. Human development, bioecological theory of. *In:* Smelser, N. J. & Baltes, B. (eds.) *International Encyclopedia of the Social and Behavioral Sciences.*

Brosnan, K. 2008. Monageer Inquiry. Report presented to Ms. Mary Harney, TD, Minister for Health and Children, and Mr. Dermot Ahern, TD, Minister for Justice, Equality and Law Reform, 6 October 2008. Dublin: Department of Health and Children.

Brown, R. & Ward, H. 2014. Cumulative jeopardy: How professional responses to evidence of abuse and neglect further jeopardise children's life chances by being out of kilter with timeframes for early childhood development. *Children and Youth Services Review,* 47**,** 260-267.

Brown, S. M., Rienks, S., McCrae, J. S. & Watamura, S. E. 2019. The co-occurrence of adverse childhood experiences among children investigated for child maltreatment: A latent class analysis. *Child abuse & neglect,* 87**,** 18-27.

Brownell, M. D. & Jutte, D. P. 2013. Administrative data linkage as a tool for child maltreatment research. *Child Abuse & Neglect,* 37**,** 120-124.

Bruton, M. 1998. West of Ireland Farmer Case: Report of Review Group, presented to North Western Health Board, July 1998. Manorhamilton: North Western Health Board.

Bryman, A. 2016. *Social Research Methods,* Oxford, Oxford University Press.

Buckley, H. 1996. Child abuse guidelines in Ireland: for whose protection? *Administration,* 44**,** 37-56.

Buckley, H. 1998. *Beyond the Rhetoric: A Qualitative Study of Child Protection Practice.* NUI.

Buckley, H. 1999. Child protection practice: an ungovernable enterprise? *Economic and Social Review,* 30**,** 21-40.

Buckley, H. 2000a. Beyond the rhetoric: A 'working' version of child protection practice. *European Journal of Social Work,* 3**,** 13 - 24.

Buckley, H. 2000b. Child protection: An unreflective practice. *Social Work Education: The International Journal,* 19**,** 253 - 263.

Buckley, H. 2002. *Child Protection and Welfare: Innovation and Interventions,* Dublin, Institute of Public Administration.

Buckley, H. 2003. *Child protection work: Beyond the rhetoric*, Jessica Kingsley Publishers.

Buckley, H. 2008. Heading for collision? Managerialism, social science, and the Irish child protection system. *Child protection and welfare social work: Contemporary themes and practice perspectives. Dublin: A. & A. Farmar*.

Buckley, H. 2009. Reforming the child protection system: why we need to be careful what we wish for. *Irish Journal of Family Law,* 12**,** 27-32.

Buckley, H. 2012. Using Intelligence to Shape Reforms in Child Protection. *Irish Journal of Applied Social Studies,* 12**,** 6.

Buckley, H. 2015. The Child Protection System in 2015: Conditions For a Perfect Storm. *IASW Conference.* Dublin.

Buckley, H. 2017a. Child death reviews: an opportunity for learning? *Working with Complexity Conference, Bessborough Centre* Cork, Ireland.

Buckley, H. 2017b. Service users as receivers of risk-dominated practice. *Beyond the risk paradigm in Child Protection***,** 77-90.

Buckley, H. 2018. Special Issue on Child Protection and Domestic Violence. Routeledge Journals Taylor & Francis

Buckley, H., Basarab-Horwath, J. A. & Whelan, S. 2006a. *Framework for the Assessment of Vulnerable Children and Their Families: Assessment Tool and Practice Guidance: April 2006*, Children's Research Centre, Trinity College.

Buckley, H. & Buckley, R. 2015. The Sins of the (Irish) Fathers: Is Mandatory Reporting the Best Response? *Mandatory Reporting Laws and the Identification of Severe Child Abuse and Neglect.* Springer.

Buckley, H. & Burns, K. 2015. Child welfare and protection in Ireland: Déjà vu all over again. *Social work in Ireland: Continuities and changes.* Palgrave Macmillan.

Buckley, H., Carr, N. & Whelan, S. 2011a. 'Like walking on eggshells': Service user views and expectations of the child protection system. *Child & Family Social Work,* 16**,** 101-110.

Buckley, H., Corrigan, C. & Kerrins, L. 2010. *Report of an audit of child protection research in Ireland 1990-2009*, Children Acts Advisory Board Dublin.

Buckley, H., Holt, S. & Whelan, S. 2007. Listen to me! Children's experiences of domestic violence. *Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect,* 16**,** 296-310.

Buckley, H., Horwath, J. & Whelan, S. 2006b. *Framework for the Assessment of Vulnerable Children and Their Families: Assessment Tool and Practice Guidance,* Dublin, Children's Research Centre, Trinity College.

Buckley, H. & O'Nolan, C. 2013. An examination of recommendations from inquiries into events in families and their interactions with State services, and their impact on policy and practice. Dublin: Government Publications: DCYA.

Buckley, H. & O'Nolan, C. 2014. Child death reviews: developing CLEAR recommendations. *Child Abuse Review,* 23**,** 89-103.

Buckley, H. & O'Nolan, C. 2013. An examination of recommendations from inquiries into events in families and their interactions with state services, and their impact on policy and procedure.

Buckley, H., Skehill, C. & O'Sullivan, E. 1997. *Child Protection Practices in Ireland*, Oak Tree Press.

Buckley, H. & Whelan, S. 2018. Report on the Demographic Profile of Children at Ongoing Risk of Child Abuse. Dublin: Department of Children and Youth Affairs.

Buckley, H., Whelan, S. & Carr, N. 2011b. 'Like waking up in a Franz Kafka novel': Service users' experiences of the child protection system when domestic violence and acrimonious separations are involved. *Children and Youth Services Review,* 33**,** 126-133.

Buckley, H., Whelan, S., Carr, N. & Murphy, C. 2008. *Service users' perceptions of the Irish child protection system*, Government Stationary Office, Dublin.

Bullock, R., Little, M., S., M. & Mount, K. 1995. *Child Protection: Messages from Research,* UK, HMSO.

Bunting, L., McCartan, C., McGhee, J., Bywaters, P., Daniel, B., Featherstone, B. & Slater, T. 2018. Trends in Child Protection Across the UK: A Comparative Analysis. *The British Journal of Social Work,* 48**,** 1154-1175.

Burns, K. & Lynch, D. 2008. *Child protection and welfare social work: contemporary themes and practice perspectives,* Dublin, A. and A. Farmar.

Burns, K. & MacCarthy, J. 2012. An impossible task? Implementing the recommendations of child abuse inquiry reports in a context of high workloads in child protection and welfare. *Irish Journal of Applied Social Studies,* 12.

Burns, K. & McGregor, C. 2019. Child Protection and Welfare Systems in Ireland: Continuities and Discontinuities of the Present. *In:* Merkel-Holguin, L., Fluke, J. D. & Krugman, R. D. (eds.) *National Systems of Child Protection: Understanding the International Variability and Context for Developing Policy and Practice.* Cham: Springer International Publishing.

Burns, K., O'Mahony, C., Shore, C. & Parkes, A. 2018. What social workers talk about when they talk about child care proceedings in the District Court in Ireland. *Child & Family Social Work,* 23**,** 113-121.

Burns, K., O'Mahony, C. & Brennan, R. 2021. 'Private Family Arrangements' for Children in Ireland: The Informal Grey Space In-Between State Care and the Family Home. *The British Journal of Social Work*.

Bywaters, P. 2015a. Cumulative jeopardy? A response to Brown and Ward. *Children and Youth Services Review,* 52**,** 68-73.

Bywaters, P. 2015b. Inequalities in Child Welfare: Towards a New Policy, Research and Action Agenda. *British Journal of Social Work,* 45**,** 6-23.

Bywaters, P., Brady, G., Sparks, T. & Bos, E. 2016. Child welfare inequalities: new evidence, further questions. *Child & Family Social Work,* 21**,** 369-380.

Bywaters, P., Brady, G., Sparks, T., Bos, E., Bunting, L., Daniel, B., Featherstone, B., Morris, K. & Scourfield, J. 2015. Exploring inequities in child welfare and child protection services: Explaining the 'inverse intervention law'. *Children and Youth Services Review,* 57**,** 98-105.

Calder, M. C. 1995. Child Protection: Balancing Paternalism and Partnership. *British Journal of Social Work,* 25**,** 749-766.

Calder, M. C. 2017. Assessments in Child Care Proceedings: Observations in Practice. *The Wiley Handbook of What Works in Child Maltreatment: An Evidence-Based Approach to Assessment and Intervention in Child Protection***,** 278-294.

Calder, M. C., McKinnon, M. & Sneddon, R. 2012. National risk framework to support the assessment of children and young people.

Callaghan, J. E., Alexander, J. H., Sixsmith, J. & Fellin, L. C. 2018. Beyond "witnessing": Children's experiences of coercive control in domestic violence and abuse. *Journal of interpersonal violence,* 33**,** 1551-1581.

Camasso, M. J. & Jagannathan, R. 2013. Decision Making in Child Protective Services: A Risky Business? *Risk Analysis,* 33**,** 1636-1649.

Campbell, K. A., Cook, L. J., LaFleur, B. J. & Keenan, H. T. 2010. Household, family, and child risk factors after an investigation for suspected child maltreatment: A missed opportunity for prevention. *Archives of Pediatrics & Adolescent Medicine,* 164**,** 943-949.

Canavan, J., Devaney, C., McGregor, C. & Shaw, A. 2019. A good fit? Ireland's programme for prevention, partnership and family support as a public health approach to child protection. *In:* Lonne, B., Scott, D., Higgins, D. & Herrenkohl, T. I. (eds.) *Re-visioning public health approaches for protecting children.* Springer Cham.

Cash, S. J. 2001. Risk assessment in child welfare: the art and science. *Children and Youth Services Review,* 23**,** 811-830.

Cassidy, A., Devaney, C., McGregor, C. & Landy, F. 2016. Interfacing informal and formal help systems: Historical pathways to the Meitheal model. *Administration.*

Chaffin, M., Wherry, J. N., Newlin, C., Crutchfield, A. & Dykman, R. 1997. The Abuse Dimensions Inventory: Initial data on a research measure of abuse severity. *Journal of Interpersonal Violence,* 12**,** 569-589.

Charmaz, K. 2006. *Constructing grounded theory,* London, Sage Publications.

Christ, S. L. & Schwab-Reese, L. M. 2020. Shedding the Constraints of Formal Systems in Research on Child Maltreatment Through High-Quality Measurement and Broad Population Surveys. *International Journal on Child Maltreatment: Research, Policy and Practice,* 3**,** 105-123.

Christie, A. 2001. Gendered discourses of welfare, men and social work. *Men and social work: Theories and practices***,** 7-34.

Christie, A., Featherstone, B., Quin, S. & Walsh, T. 2015. *Social Work in Ireland: changes and continuities*, Macmillan International Higher Education.

Cicchetti, D. & Lynch, M. 1993. Toward an ecological/transactional model of community violence and child maltreatment: Consequences for children's development. *Psychiatry,* 56**,** 96-118.

Cicchetti, D. & Rizley, R. 1981. *Developmental perspectives on on the etiology, intergenerational transmission, and sequelae of child maltreatment,* San Francisco, Jossey-Bass.

Cicchetti, D. & Toth, S. L. 1995. A Developmental Psychopathology Perspective on Child Abuse and Neglect. *Journal of the American Academy of Child & Adolescent Psychiatry,* 34**,** 541-565.

CIS 1998, 2003, 2008. Canadian Incidence Study. Canadian Child Welfare Research Portal: https://cwrp.ca.

CIS 2010. *Canadian incidence study of reported child abuse and neglect, 2008 (CIS-2008): Major findings,* Ottawa, Public Health Agency of Canada.

Cleaver, H. & Horwath, J. 2001. When parents' issues influence their ability to respond to children's needs. *The child's world: Assessing children's needs***,** 273-286.

Cleaver, H., Nicholson, D., Tarr, S. & Cleaver, D. 2007. *Child protection, domestic violence and parental substance misuse: Family experiences and effective practice,* London: UK, Jessica Kingsley Publishers.

Cleaver, H., Unell, I. & Aldgate, J. 2011. *Children's needs-parenting capacity: child abuse, parental mental illness, learning disability, substance misuse, and domestic violence*, The Stationery Office.

COE 2017. Ending all forms of violence against children by 2030: The Council of Europe's contribution to the 2030 Agenda and the Sustainable Development Goals. Cedex, France: Council of Europe.

Collins, W. A., Maccoby, E. E., Steinberg, L., Hetherington, E. M. & Bornstein, M. H. 2000. Contemporary research on parenting: The case for nature and nurture. *American psychologist,* 55**,** 218.

Commission, E. 2015. 'Coordination and Cooperation in Integrated Child Protection Systems', Reflection Paper for the 9th European Forum on the Rights of the Child. *In:* Consumers, D. J. (ed.). European Commission

Connell, C. M., Bergeron, N., Katz, K. H., Saunders, L. & Tebes, J. K. 2007. Re-referral to child protective services: The influence of child, family, and case characteristics on risk status. *Child Abuse & Neglect,* 31**,** 573-588.

Connolly, M. 2009. Professional responses: Who does what in domestic violence and child protection? *Communities, Children and Families Australia,* 4**,** 36-39.

Connolly, M. 2017. Beyond the risk paradigm in child protection. London: Palgrave Google Scholar.

Constitution 2012. Constitution, article 42A.1 Thirty First Amendment of the Constitution (Children) Act 2012.

Coohey, C. 2007. What criteria do child protective services investigators use to substantiate exposure to domestic violence? *Child Welfare: Journal of Policy, Practice, and Program,* 86**,** 93-122.

Cook, L. & Gregory, M. 2020. Making Sense of Sensemaking: Conceptualising How Child and Family Social Workers Process Assessment Information. *Child care in practice : Northern Ireland journal of multi-disciplinary child care practice,* 26**,** 182-195.

Cooper, A. 1995. *Positive child protection: A view from abroad*, Russell House Pub.

Cooper, A. 2010. Legend, myth and idea: on the fate of a great paper. *British Journal of Psychotherapy,* 26**,** 219-227.

CORU 2017. Social Care Workers Registration Board Standards of Proficiency for Social Care Workers. Dublin: CORU: Social Care Workers Registration Board

Coulter, C. 2015. Final Report, Child Care Law Reporting Project.

Coulter, S., Houston, S., Mooney, S., Devaney, J. & Davidson, G. 2020. Attaining Theoretical Coherence Within Relationship-Based Practice in Child and Family Social Work: The Systemic Perspective. *The British Journal of Social Work,* 50**,** 1219-1237.

Coutinho, L., Scazufca, M. & Menezes, P. R. 2008. Methods for estimating prevalence ratios in cross-sectional studies. *Revista de saude publica,* 42**,** 992-998.

Cox, A. & Bentovim, A. 2000. *Framework for the assessment of children in need and their families: the family pack of questionnaires and scales*, Stationery Office, Department of health.

Coxe, S., West, S. G. & Aiken, L. S. 2009. The Analysis of Count Data: A Gentle Introduction to Poisson Regression and Its Alternatives. *Journal of personality assessment,* 91**,** 121-136.

Crea, T. M. 2010. Balanced Decision Making in Child Welfare: Structured Processes Informed by Multiple Perspectives. *Administration in Social Work,* 34**,** 196-212.

Creswell, J. W. 2009. *Qualitative, Quantitative, and Mixed Methods Approaches,* Thousand Oaks, CA, Sage Publications.

Creswell, J. W. 2017. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, SAGE Publications.

Creswell, J. W. & Plano Clark, V. L. 2017. *Designing and conducting mixed methods research,* Thousand Oaks, CA, Sage Publications.

Cross, T. P. & Casanueva, C. 2009. Caseworker Judgments and Substantiation. *Child Maltreatment,* 14**,** 38-52.

Crowhurst, I. & Kennedy-Macfoy, M. 2013. Troubling gatekeepers: methodological considerations for social research. *International Journal of Social Research Methodology,* 16**,** 457-462.

Crowson, M. 2019. *Poisson regression using Stata (July 2019)* [Online]. YouTube: Mike Crowson. Available: https://www.youtube.com/watch?v=Wo_QSeLV0Vk [Accessed 23 July 2020].

CSO. 2017a. *Census of Population 2016 - Profile 4 Households and Families* [Online]. https://www.cso.ie/en/releasesandpublications/ep/p-cp4hf/cp4hf/fmls/ Central Statistics Office. [Accessed 11 November 2020].

CSO. 2017b. *Press Statement Census 2016 Results Profile 4 - Households and Families* [Online]. https://www.cso.ie/en/csolatestnews/pressreleases/2017pressreleases/pressstatementcensus2016resultsprofile4-householdsandfamilies/ Central Statistics Office. [Accessed 10 October 2020].

CSO SAPS 2016. Census 2016 Small Area Population Statistics. Cork: CSO.

Cuccaro-Alamin, S., Foust, R., Vaithianathan, R. & Putnam-Hornstein, E. 2017. Risk assessment and decision making in child protective services: Predictive risk modeling in context. *Children and Youth Services Review*.

Cummings, P. & Rivara, F. P. 2003. Reporting statistical information in medical journal articles. *Archives of pediatrics & adolescent medicine,* 157**,** 321-324.

D'Andrade, A., Austin, M. J. & Benton, A. 2005. Risk and Safety Assessment in Child Welfare: Instrument Comparisons. *Journal of Evidence-Based Social Work,* 5**,** 31-56.

D'Cruz, H. 2002. Constructing the identities of 'responsible mothers, invisible men'in child protection practice. *Sociological Research Online,* 7**,** 147-171.

Dalgleish, L. I. 1988. Decision making in child abuse cases: Applications of social judgment theory and signal detection theory. *Advances in psychology,* 54**,** 317-360.

Dalgleish, L. I. 2003. Risk, needs and consequences. *In:* Calder, M. C. & Hackett, S. (eds.) *Assessments in child care: A comprehensive guide to frameworks and their use.* . Dorset, UK: Russell House Publishing.

Damant, D., Lapierre, S., Lebossé, C., Thibault, S., Lessard, G., Hamelin-Brabant, L., Lavergne, C. & Fortin, A. 2010. Women's abuse of their children in the context on domestic violence: reflection from women's accounts. *Child & Family Social Work,* 15**,** 12-21.

Daniel, B., Taylor, J., Scott, J. & Barbour, M. 2010. Noticing and helping the neglected child: A Review of the literature.

Daniel, B. M. & Taylor, J. 2006. Gender and child neglect: Theory, research and policy. *Critical Social Policy,* 26**,** 426-439.

Dankert, E. W. & Johnson, K. 2013. Risk assessment validation: A prospective study. *Los Angeles: California Department of Social Services, Children and Family Services Division*.

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**,** 1-9.

Davidson-Arad, B. & Kaznelson, H. 2010. Comparison of parents' and social workers' assessments of the quality of life of children at risk. *Children and Youth Services Review,* 32**,** 711-719.

Dawes, R. M., Faust, D. & Meehl, P. E. 1989. Clinical Versus Actuarial Judgment. *Science,* 243**,** 1668-1674.

DCYA 2011a. Children First: National Guidance for the Protection and Welfare of Children. Dublin: Government Publications.

DCYA 2011b. National Strategy for Research and Data on Children's Lives 2011 – 2016. Dublin: Government Publications.

DCYA 2012a. The Report of the Task Force on the Child and Family Support Agency. Dublin: Government Publications.

DCYA 2012b. Thirty-First Amendment of the Constitution (Children) Bill 2012: Explanatory Memorandum, 2012. Dublin: Department of Children and Youth Affairs.

DCYA 2013. Child and Family Agency Act. Dublin: Government Publications.

DCYA 2014. Better outcomes, brighter futures: The national policy framework for children and young people 2014–2020. Dublin: Government Publications.

DCYA 2015. Children First Act. *Number 36 of 2015.* Dublin: Government Publications.

DCYA 2017. Children First: National guidance for the protection and welfare of children. Dublin: Government Publications, Dublin.

DePanfilis, D. & Girvin, H. 2005. Investigating child maltreatment in out-of-home care: Barriers to effective decision-making. *Children and Youth Services Review,* 27**,** 353-374.

DePanfilis, D. & Zuravin, S. J. 1999. Predicting child maltreatment recurrences during treatment. *Child Abuse & Neglect,* 23**,** 729-743.

DePanfilis, D. & Zuravin, S. J. 2001. Assessing risk to determine the need for services. *Children and Youth Services Review,* 23**,** 3-20.

DePanfilis, D. & Zuravin, S. J. 2002. The effect of services on the recurrence of child maltreatment. *Child Abuse & Neglect,* 26**,** 187-205.

Department for Education 2016. Characteristics of children in need: 2015 to 2016. *SFR 52/2016.* London: Department for Education.

Department for Education 2017. Characteristics of children in need: 2016-17, England. London: Department for Education.

Department of Health 1970. Health Act. Dublin: Government of Ireland.

Department of Health 1976. Report of Committee on Non-accidental Injury to Children. Dublin: The Stationery Office.

Department of Health 1980. Task Force on Child Care Services: final report to the Minister for Health. Dublin: Department of Health. Dublin: Department of Health.

Department of Health 1987. Child Abuse Guidelines. Guidelines on Procedures for the Identification, Investigation and Management of Child Abuse. Dublin: Department of Health.

Department of Health 1991. Child Care Act 1991 Revised Updated to 19 August 2020. *Number 17 of 1991.* Dublin: Government Publications.

Department of Health 2000a. Framework for the assessment of children in need and their families. London: The Stationery Office.

Department of Health 2000b. Framework for the Assessment of Children in Need and Their Families. London: The Stationery Office.

Department of Health 2016. Children's Social Care Statistics for Northern Ireland 2015/16. Department of Health.

Department of Health and Children 1999. Children First: National Guidelines for the Protection and Welfare of Children. Dublin: Stationery Office.

Department of Health and Children 2009. Report of the Commission to Inquire into Child Abuse, 2009: Implementation Plan. Department of Health and Children Dublin, Office of the Minister for Children Youth Affairs.

Dettlaff, A., Rivaux, S., Baumann, D. J., Fluke, J. D., Rycraft, J. & James, J. 2011. Disentangling substantiation: The influence of race, income, and risk on the substantiation decision in child welfare. *Children and Youth Services Review,* 33**,** 1630-1637.

Dettlaff, A. J., Christopher, G. J., Holzman, J., Baumann, D. J. & Fluke, J. D. 2015. Development of an instrument to understand the child protective services decision-making process, with a focus on placement decisions. *Child Abuse & Neglect,* 49**,** 24-34.

Devaney, C. & McGregor, C. 2017. Child protection and family support practice in Ireland: a contribution to present debates from a historical perspective: Child protection, family support, child welfare, history, practice, learning. *Child & Family Social Work,* 22**,** 1255-1263.

Devaney, J. 2008. Chronic child abuse and domestic violence: children and families with long-term and complex needs. *Child & Family Social Work,* 13**,** 443-453.

Devaney, J. 2019. The trouble with thresholds: Rationing as a rational choice in child and family social work. *Child & family social work,* 24**,** 458-466.

Devaney, J. & Spratt, T. 2009. Child abuse as a complex and wicked problem: Reflecting on policy developments in the United Kingdom in working with children and families with multiple problems. *Children and Youth Services Review,* 31**,** 635-641.

Dhami, M. K. 2003. Psychological models of professional decision making. *Psychological Science,* 14**,** 175-180.

Dhami, M. K. & Ayton, P. 2001. Bailing and jailing the fast and frugal way. *Journal of Behavioral Decision Making,* 14**,** 141-168.

DHC 2000. The National Children's Strategy Our Children - Their Lives. *In:* Children, D. O. H. A. (ed.). Dublin: The Stationery Office.

DHHS 2018. Child Maltreatment 2016. Washington DC: U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

DHHS 2020. Child Maltreatment 2018. US Department of Health and Human Services. Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

Dingwall, R., Eekelaar, J. & Murray, T. 1983/2014. *The protection of children: State intervention and family life*, Quid Pro Books.

Dixon, L., Browne, K., Hamilton-Giachritsis, C. & Ostapuik, E. 2010. Differentiating patterns of aggression in the family. *Journal of aggression, conflict and peace research,* 2**,** 32-44.

Dixon, L., Browne, K. & Hamilton-Giachritsis, C. 2005. Risk factors of parents abused as children: A mediational analysis of the intergenerational continuity of child maltreatment (Part I). *Journal of child Psychology and Psychiatry,* 46**,** 47-57.

Dixon, L., Hamilton-Giachritsis, C., Browne, K. & Ostapuik, E. 2007. The co-occurrence of child and intimate partner maltreatment in the family: Characteristics of the violent perpetrators. *Journal of Family Violence,* 22**,** 675-689.

Dixon, L., Perkins, D. F., Hamilton-Giachritsis, C. & Craig, L. A. 2017. Overview and Structure of the Book. *In:* Dixon, L., Perkins, D. F., Hamilton-Giachritsis, C. & Craig, L. A. (eds.) *The Wiley handbook of what works in child maltreatment: an evidence-based approach to assessment and intervention in child protection.* NJ, USA: John Wiley & Sons.

Dixon, L. & Slep, A. M. S. 2017. Intimate partner violence and child maltreatment. *The Wiley handbook of what works in child maltreatment: An evidence-based approach to assessment and intervention in child protection.*

Doherty, P. 2016. Child protection threshold talk and ambivalent case formulations in 'borderline' care proceedings cases. *Qualitative Social Work,* 16**,** 698-716.

Dorsey, S., Mustillo, S. A., Farmer, E. M. Z. & Elbogen, E. 2008. Caseworker assessments of risk for recurrent maltreatment: Association with case-specific risk factors and re-reports. *Child Abuse & Neglect,* 32**,** 377-391.

Douglas, M. 1992. Risk and Blame: Essays In Cultural Theory. Routledge.

Douglas, M. & Wildavsky, A. 1982. Risk and culture: An essay on the selection of environmental and technological dangers. Berkeley, CA: University of California Press.

Drake, B. 1996. Unraveling "unsubstantiated". *Child Maltreatment,* 1**,** 261-271.

Drake, B. & Jonson-Reid, M. 2007. A response to Melton based on the best available data. *Child Abuse & Neglect,* 31**,** 343-360.

Drake, B., Jonson-Reid, M., Ocampo, M. G., Morrison, M. & Dvalishvili, D. 2020. A Practical Framework for Considering the Use of Predictive Risk Modeling in Child Welfare. *The ANNALS of the American Academy of Political and Social Science,* 692**,** 162-181.

Drake, B., Jonson-Reid, M. & Sapokaite, L. 2006. Rereporting of child maltreatment: Does participation in other public sector services moderate the likelihood of a second maltreatment report? *Child Abuse & Neglect,* 30**,** 1201-1226.

Drake, B., Jonson-Reid, M., Way, I. & Chung, S. 2003. Substantiation and recidivism. *Child Maltreatment,* 8**,** 248-260.

Driscoll, D. L., Appiah-Yeboah, A., Salib, P. & Rupert, D. J. 2007. Merging qualitative and quantitative data in mixed methods research: How to and why not. *Ecological and Environmental Anthropology (University of Georgia)***,** 18.

Drury-Hudson, J. 1999. Decision making in Child Protection: The Use of Theoretical, Empirical and Procedural Knowledge by Novices and Experts and Implications for Fieldwork Placement. *British Journal of Social Work,* 29**,** 147-169.

Earner-Byrne, L. 2008. Reinforcing the family: The role of gender, morality and sexuality in Irish welfare policy, 1922–1944. *The History of the Family,* 13**,** 360-369.

Eldridge, A. 2013. Gatekeeping and drinking cultures: how do we talk about drinking? *International Journal of Social Research Methodology,* 16**,** 477-489.

Elliott, I. 2020. Historical Sexual Abuse in Scouting: A Learning Review. Independent Safeguarding Consultant.

Enders, F. 2008. Encyclopedia of epidemiology. Thousand Oaks, CA: Sage Publications.

English, D. J., Marshall, D. B. & Stewart, A. J. 2003. Effects of family violence on child behavior and health during early childhood. *Journal of family violence,* 18**,** 43-57.

Enosh, G., Alfandari, R., Nouman, H., Dolev, L. & Dascal-Weichhendler, H. 2021. Assessing, consulting, reporting heuristics in professional decision-making regarding suspected child maltreatment in community healthcare services. *Child maltreatment,* 26**,** 291-301.

Enosh, G. & Bayer-Topilsky, T. 2015. Reasoning and Bias: Heuristics in Safety Assessment and Placement Decisions for Children at Risk. *British Journal of Social Work,* 45**,** 1771-1787.

EP & CEU 2016. Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). Official Journal L 119: European Parliament and Council of the European Union.

Erel, O. & Burman, B. 1995. Interrelatedness of marital relations and parent-child relations: a meta-analytic review. *Psychological bulletin,* 118**,** 108.

Esposito, T., Trocmé, N., Chabot, M., Shlonsky, A., Collin-Vézina, D. & Sinha, V. 2013. Placement of children in out-of-home care in Québec, Canada: When and for whom initial out-of-home placement is most likely to occur. *Children and Youth Services Review,* 35**,** 2031-2039.

Fallon, B. 2020. Social Construction of Maltreatment: When does poor parenting become maltreatment. Kempe Interdisciplinary Research Institute August 2020.

Fallon, B., Chabot, M., Fluke, J. D., Blackstock, C., MacLaurin, B. & Tonmyr, L. 2013a. Placement decisions and disparities among Aboriginal children: Further analysis of the Canadian incidence study of reported child abuse and neglect part A: Comparisons of the 1998 and 2003 surveys. *Child Abuse & Neglect,* 37**,** 47-60.

Fallon, B., Filippelli, J., Black, T., Trocmé, N. & Esposito, T. 2017a. How can data drive policy and practice in child welfare? Making the link in Canada. *International journal of environmental research and public health,* 14**,** 1223.

Fallon, B., Joh-Carnella, N., Trocmé, N., Esposito, T., Hélie, S. & Lefebvre, R. 2022. Major Findings from the Canadian Incidence Study of Reported Child Abuse and Neglect 2019. *International Journal on Child Maltreatment: Research, Policy and Practice***,** 1-17.

Fallon, B., Lefebvre, R., Filippelli, J., Joh-Carnella, N., Trocmé, N., Carradine, J. & Fluke, J. D. 2021. Major findings from the Ontario incidence study of reported child abuse and neglect 2018. *Child Abuse & Neglect,* 111**,** 104778.

Fallon, B., Ma, J., Allen, K., Trocmé, N. & Jud, A. 2013b. Child maltreatment-related investigations involving infants: Opportunities for resilience? *International Journal of Child and Adolescent Resilience,* 1**,** 35-47.

Fallon, B., Ma, J., Black, T. & Wekerle, C. 2011a. Characteristics of young parents investigated and opened for ongoing services in child welfare. *International Journal of Mental Health and Addiction,* 9**,** 365-381.

Fallon, B., Trocmé, N., Filippelli, J., Black, T. & Joh-Carnella, N. 2017b. Responding to safety concerns and chronic needs: trends over time. *Child and Adolescent Psychiatry and Mental Health,* 11**,** 60.

Fallon, B., Trocmé, N., Fluke, J. D., MacLaurin, B., Tonmyr, L. & Yuan, Y.-Y. 2010. Methodological challenges in measuring child maltreatment. *Child Abuse & Neglect,* 34**,** 70-79.

Fallon, B., Trocmé, N., Fluke, J. D., Van Wert, M., MacLaurin, B., Sinha, V., Helie, S. & Turcotte, D. 2012. Responding to child maltreatment in Canada: Context for international comparisons. *Advances in mental health,* 11**,** 76-86.

Fallon, B., Trocmé, N. & MacLaurin, B. 2011b. Should child protection services respond differently to maltreatment, risk of maltreatment, and risk of harm? *Child Abuse & Neglect,* 35**,** 236-239.

Fallon, B., Trocmé, N., MacLaurin, B., Sinha, V. & Black, T. 2011c. Untangling risk of maltreatment from events of maltreatment: An analysis of the 2008 Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008). *International Journal of Mental Health and Addiction,* 9**,** 460.

Fallon, B., Van Wert, M., Trocmé, N., MacLaurin, B., Sinha, V., Lefebvre, R., Allan, K., Black, T., Lee, B., Rha, W., Smith, C. & Goel, S. 2015. Ontario Incidence Study of Reported Child Abuse and Neglect-2013 (OIS-2013). Toronto, ON: Child Welfare Research Portal.

Fargion, S. 2014. Synergies and tensions in child protection and parent support: policy lines and practitioners cultures. *Child & Family Social Work,* 19**,** 24-33.

Farmer, E. & Owen, M. 1995. *Child protection practice: Private risks and public remedies,* UK, HMSO.

Fast, E., Trocmé, N., Fallon, B. & Ma, J. 2014. A troubled group? Adolescents in a Canadian child welfare sample. *Children and Youth Services Review,* 46**,** 47-54.

Featherstone, B. & Gupta, A. 2018. *Protecting children: A social model*, Policy Press.

Featherstone, B., Gupta, A., Morris, K. & Warner, J. 2016. Let's stop feeding the risk monster: towards a social model of 'child protection'. *Families, Relationships and Societies,* 7**,** 7-22.

Featherstone, B. & Morris, K. 2021. Domestic abuse and child protection: Change Project case file audit report. *Domestic abuse and child protection: Changing the conversation – making a difference for children and families.* https://www.researchinpractice.org.uk/.

Featherstone, B., Morris, K. & White, S. 2014a. A Marriage Made in Hell: Early Intervention Meets Child Protection. *British Journal of Social Work,* 44.

Featherstone, B., Morris, K. & White, S. 2014b. *Re-imagining child protection: Towards humane social work with families,* Great Britain, Policy Press.

Featherstone, B., White, S. & Wastell, D. 2012. Ireland's opportunity to learn from England's difficulties? Auditing uncertainty in child protection. *Irish Journal of Applied Social Studies,* 12**,** 5.

Ferguson, H. 1997. Protecting children in new times: child protection and the risk society. *Child & Family Social Work,* 2.

Ferguson, H. 2001. Ireland. *In:* Schwartz-Kenney, B. M., Mccauley, M., & Epstein, M. A. (ed.) *Child Abuse: A Global View.* Westport, CT: Greenwood Publishing Group.

Ferguson, H. 2011. *Child protection practice*, Palgrave Macmillan.

Ferguson, H. 2016. What social workers do in performing child protection work: Evidence from research into face-to-face practice. *Child & Family Social Work,* 21**,** 283-294.

Ferguson, H. & O'Reilly, M. i. 2001. *Keeping children safe: child abuse, child protection and the promotion of welfare,* Dublin, A. & A. Farmar.

Filippelli, J., Fallon, B., Fuller-Thomson, E. & Trocmé, N. 2017a. Infants investigated by the child welfare system: Exploring a distinct profile of risks, service needs, and referrals for support in Ontario. *Brain sciences,* 7**,** 101.

Filippelli, J., Fallon, B., Trocmé, N., Fuller-Thomson, E. & Black, T. 2017b. Infants and the decision to provide ongoing child welfare services. *Child and adolescent psychiatry and mental health,* 11**,** 24.

Filippelli, J., Lwin, K., Fallon, B. & Trocmé, N. 2021. Young children and ongoing child welfare services: a multilevel examination of clinical and worker characteristics. *Child maltreatment,* 26**,** 195-204.

Finkelhor, D. 1990. Early and long-term effects of child sexual abuse: An update. *Professional psychology: Research and practice,* 21**,** 325.

Finkelhor, D. 1994. Current information on the scope and nature of child sexual abuse. *The future of children***,** 31-53.

Finkelhor, D., Saito, K. & Jones, L. 2021. Updated Trends in Child Maltreatment, 2019. University of New Hampshire.

Finkelhor, D., Shattuck, A., Turner, H. & Hamby, S. 2015. A revised inventory of Adverse Childhood Experiences. *Child Abuse & Neglect,* 48**,** 13-21.

Fitzgerald, F. 2014. Co-ordinated child protection is agency's goal: Opinion The Child and Family Agency will put an end to haphazard child welfare efforts. *The Irish Times*, 2014 Jan 30.

Fluke, J. D. 2009. Allegory of the cave: On the theme of substantiation. *Child maltreatment,* 14**,** 69-72.

Fluke, J. D., Chabot, M., Fallon, B., MacLaurin, B. & Blackstock, C. 2010. Placement decisions and disparities among aboriginal groups: An application of the decision making ecology through multi-level analysis. *Child Abuse & Neglect,* 34**,** 57-69.

Fluke, J. D., Corwin, T. W., Hollinshead, D. M. & Maher, E. J. 2016. Family preservation or child safety? Associations between child welfare workers' experience, position, and perspectives. *Children and Youth Services Review,* 69**,** 210-218.

Fluke, J. D., Harden, B. J., Jenkins, M. & Ruehrdanz, A. 2011. Research synthesis on child welfare: Disproportionality and disparities. *Disparities and disproportionality in child welfare: Analysis of the research,* 1.

Fluke, J. D., López, M. L., Benbenishty, R., Knorth, E. J. & Baumann, D. J. 2020. *Decision-Making and Judgment in Child Welfare and Protection: Theory, Research, and Practice*, Oxford University Press.

Fluke, J. D., Shusterman, G. R., Hollinshead, D. M. & Yuan, Y.-Y. T. 2008. Longitudinal analysis of repeated child abuse reporting and victimization: Multistate analysis of associated factors. *Child maltreatment,* 13**,** 76-88.

Fluke, J. D., Tonmyr, L., Gray, J., Bettencourt Rodrigues, L., Bolter, F., Cash, S., Jud, A., Meinck, F., Casas Muñoz, A., O'Donnell, M., Pilkington, R. & Weaver, L. 2021. Child maltreatment data: A summary of progress, prospects and challenges. *Child Abuse & Neglect***,** 104650.

Fluke, J. D., Yuan, Y.-Y. T. & Edwards, M. 1999. Recurrence of maltreatment: An application of the national child abuse and neglect data system (NCANDS). *Child abuse & neglect,* 23**,** 633-650.

Flyvbjerg, B. 2006. Five misunderstandings about case-study research. *Qualitative Inquiry,* 12**,** 219-245.

Flyvbjerg, B. 2011. Case study. *The Sage handbook of qualitative research,* 4**,** 301-316.

Font, S. A., Berger, L. M. & Slack, K. S. 2012. Examining racial disproportionality in child protective services case decisions. *Children and Youth Services Review,* 34**,** 2188-2200.

Font, S. A. & Maguire-Jack, K. 2015a. Decision-making in child protective services: Influences at multiple levels of the social ecology. *Child Abuse & Neglect,* 47**,** 70-82.

Font, S. A. & Maguire-Jack, K. 2015b. Reprint of "Decision-making in child protective services: Influences at multiple levels of the social ecology". *Child Abuse & Neglect,* 49**,** 50-62.

Font, S. A., Maguire-Jack, K. & Dillard, R. 2021. The Decision to Substantiate Allegations of Child Maltreatment. *In:* Fluke, J. D., Lopez, M. L., Benbenishty, R., Knorth, E. J. & Baumann, D. J. (eds.) *Decision-Making and Judgment in Child Welfare and Protection.* Oxford University Press.

Foreman, D. M., Best, N., Dunstan, F., McIntosh, N. & Ashby, D. 2015. Improving Child Protection by Integrating Research Evidence and Clinical Experience. *International Journal of Law, Policy and the Family,* 29**,** 301-312.

Forke, C. M., Myers, R. K., Fein, J. A., Catallozzi, M., Localio, A. R., Wiebe, D. J. & Grisso, J. A. 2018. Witnessing intimate partner violence as a child: How boys and girls model their parents' behaviors in adolescence. *Child Abuse & Neglect,* 84**,** 241-252.

Forrester, D. & Harwin, J. 2006. Parental substance misuse and child care social work: findings from the first stage of a study of 100 families. *Child & Family Social Work,* 11**,** 325-335.

Forrester, D., McCambridge, J., Waissbein, C. & Rollnick, S. 2008. How do Child and Family Social Workers Talk to Parents about Child Welfare Concerns? *Child Abuse Review,* 17**,** 23-35.

Fox-Harding, L. 1997. *Perspectives in child care policy,* Harlow, England, Pearson Education.

Frankfort-Nachmias, C. & Leon-Guerrero, A. 2017. *Social statistics for a diverse society,* Thousand Oaks, Sage Publications Inc.

Freisthler, B., Merritt, D. H. & LaScala, E. A. 2006. Understanding the ecology of child maltreatment: A review of the literature and directions for future research. *Child maltreatment,* 11**,** 263-280.

Furey, E. & Canavan, J. 2019. A review on the availability and comparability of statistics on child protection and welfare, including children in care, collated by Tusla: Child and Family Agency with statistics published in other jurisdictions.

Fusch, P. I. & Ness, L. R. 2015. Are we there yet? Data saturation in qualitative research. *The qualitative report,* 20**,** 1408.

Fusco, R. A. 2015. Second generation mothers in the child welfare system: Factors that predict engagement. *Child and Adolescent Social Work Journal,* 32**,** 545-554.

Galvani, S., Hutchinson, A. & Dance, C. 2014. Identifying and Assessing Substance Use: Findings from a National Survey of Social Work and Social Care Professionals. *The British Journal of Social Work,* 44**,** 1895-1913.

Gambrill, E. 2005a. Critical thinking, evidence-based practice, and mental health. *Mental disorders in the social environment: Critical perspectives***,** 247-269.

Gambrill, E. 2005b. Decision making in child welfare: Errors and their context. *Children and Youth Services Review,* 4**,** 347-352.

Gambrill, E. 2006a. *Critical thinking in clinical practice: Improving the quality of judgments and decisions*, John Wiley & Sons.

Gambrill, E. 2006b. *Social work practice: a critical thinker's guide,* New York, Oxford University Press.

Gambrill, E. 2008. Decision making in child welfare: Constraints and potentials. *In:* Lindsey, D. & Shlonsky, A. (eds.) *Child Welfare Research: Advances for Practice and Policy.* NY: Oxford University Press.

Gambrill, E. 2010. Evidence-Informed Practice: Antidote to Propaganda in the Helping Professions? *Research on social work practice,* 20**,** 302-320.

Gambrill, E. & Shlonsky, A. 2000. Risk Assessment in Context. *Children and Youth Services Review,* 22**,** pp. 813-837.

Gambrill, E. & Shlonsky, A. 2001. The need for comprehensive risk management systems in child welfare. *Children and Youth Services Review,* 23**,** 79-107.

Garbarino, J., Sherman, D. & Crouter, A. C. 1979. Assessing the Neighborhood Context of Child Maltreatment. *Child Abuse & Neglect,* 3**,** 1059-1069.

Garfinkel, I. & Waldfogel, J. 2012. Introduction to special issue of Children and Youth Services Review on "Comparative Child and Family Policy". Elsevier.

Gautschi, J. & Benbenishty, R. 2020. Empirical Methods for Studying Decision-Making in Child Welfare and Protection. *In:* Fluke, J. D., López López, M., Benbenishty, R., Knorth, E. J. & Baumann, D. J. (eds.) *Decision-Making and Judgement in Child Welfare and Protection. Theory, Research, and Practice.* New York: Oxford University Press.

George, A. L. & Bennett, A. 2005. *Case studies and theory development in the social sciences,* MA, MIT Press.

George, C. 2017. Utilising an Attachment Perspective in Parenting Assessment. *The Wiley Handbook of What Works in Child Maltreatment: An Evidence-Based Approach to Assessment and Intervention in Child Protection***,** 222-238.

Gibbons, J., Conroy, S. & Bell, C. 1995. *Operating the child protection system: a study of child protection practices in English local authorities*, HM Stationery Office.

Gibbons, N., Lunny, L., Harrison, P. & O'Neill, G. 2010. Roscommon child care case: Report of the Inquiry Team to the Health Service Executive. *Dublin, Ireland: Health Services Executive*.

Giddens, A. 1990. The consequences of modernity. *Cambridge: Polity*.

Giddings, L. S. & Grant, B. M. 2006. Mixed methods research for the novice researcher. *Contemporary Nurse,* 23**,** 3-11.

Gifford, E. J., Eldred, L. M., Sloan, F. A. & Evans, K. E. 2016. Parental criminal justice involvement and children's involvement with child protective services: do adult drug treatment courts prevent child maltreatment? *Substance use & misuse,* 51**,** 179-192.

Gigerenzer, G. 1996. On narrow norms and vague heuristics: A reply to Kahneman and Tversky. *Psychological Review,* 103**,** 592–569.

Gilbert, N. 1997. *Combatting child abuse: International perspectives and trends*, Oxford University Press.

Gilbert, N. 2012. A comparative study of child welfare systems: Abstract orientations and concrete results. *Children and Youth Services Review,* 34**,** 532-536.

Gilbert, N., Parton, N. & Skivenes, M. 2011a. Changing patterns of response and emerging orientations. *Child protection systems: International trends and orientations***,** 243-257.

Gilbert, N., Parton, N. & Skivenes, M. 2011b. Child Protection Systems: International Trends and Orientations. New York, NY: Oxford University Press.

Gilbert, R., Fluke, J. D., O'Donnell, M., Gonzalez-Izquierdo, A., Brownell, M., Gulliver, P., Janson, S. & Sidebotham, P. 2012. Child maltreatment: variation in trends and policies in six developed countries. *Lancet,* 379**,** 758-772.

Gilbert, R., Kemp, A., Thoburn, J., Sidebotham, P., Radford, L., Glaser, D. & MacMillan, H. L. 2009a. Recognising and responding to child maltreatment. *The Lancet,* 373**,** 167-180.

Gilbert, R. & Lacey, R. 2021. Intergenerational transmission of child maltreatment. *The Lancet Public Health,* 6**,** e435-e436.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E. & Janson, S. 2009b. Burden and consequences of child maltreatment in high-income countries. *The Lancet,* 373**,** 68-81.

Gilligan, R. 2001. Promoting Positive Outcomes for Children in Need The Assessment of Protective Factors. *In:* Horwath, J. (ed.) *The Child's World Assessing Children in Need.* London and Philidelphia: Jessica Kingsley.

Gilligan, R. 2009. The" Public Child" and the Reluctant State? *Éire-Ireland,* 44**,** 265-290.

Gillingham, P. 2006. Risk Assessment in Child Protection: Problem Rather than Solution? *Australian Social Work,* 59**,** 86-98.

Gillingham, P. 2009. *The use of assessment tools in child protection: An ethnomethodological study.*

Gillingham, P. 2017. Predictive Risk Modelling to Prevent Child Maltreatment: Insights and Implications from Aotearoa/New Zealand. *Journal of Public Child Welfare,* 11**,** 150-165.

Gillingham, P. & Bromfield, L. M. 2008. Child protection, risk assessment and blame ideology. *Children Australia,* 33**,** 18-24.

Gillingham, P., Harnett, P., Healy, K., Lynch, D. & Tower, M. 2017. Decision Making in Child and Family Welfare: The Role of Tools and Practice Frameworks. *Children Australia,* 42**,** 49-56.

Gillingham, P. & Humphreys, C. 2010. Child Protection Practitioners and Decision-Making Tools: Observations and Reflections from the Front Line. *British Journal of Social Work,* 40**,** 2598-2616.

Glaser, B. & Strauss, A. 1967. *The discovery of grounded theory: strategies for qualitative research,* Chicago, Aldine.

Gloster, B. 2022. Videocast 13th April 2022

Goldstein, D. G. & Gigerenzer, G. 2011. The beauty of simple models: Themes in recognition heuristic research. *Judgment and Decision Making,* 6**,** 392-395.

Goodwin, W. L. & Goodwin, L. D. 1996. *Understanding quantitative and qualitative research in early childhood education*, Teachers College Press.

Goulet, M., Hélie, S. & Clément, M. È. 2018. Child and family needs profiles among cases substantiated by child protection services. *Child Abuse & Neglect,* 81.

Graham, J. C., Dettlaff, A. J., Baumann, D. J. & Fluke, J. D. 2015. The Decision Making Ecology of placing a child into foster care: A structural equation model. *Child Abuse & Neglect,* 49**,** 12-23.

Gray, J. 2015. Developing safeguarding services to protect children – what are the key components? *Irish Journal of Applied Social Studies,* 15.

Gray, M. & Schubert, L. 2019. Critiques of a public health model in child maltreatment. *Re-Visioning Public Health Approaches for Protecting Children.* Springer.

Green, B. L., Ayoub, C., Bartlett, J. D., Furrer, C., Von Ende, A., Chazan-Cohen, R., Klevens, J. & Nygren, P. 2015. It's not as simple as it sounds: Problems and solutions in accessing and using administrative child welfare data for evaluating the impact of early childhood interventions. *Children and Youth Services Review,* 57**,** 40-49.

Greene, J. C., Caracelli, V. J. & Graham, W. F. 1989. Toward a conceptual framework for mixed-method evaluation designs. *Educational evaluation and policy analysis,* 11**,** 255-274.

Greenland, S. 1987. Interpretation and choice of effect measures in epidemiologic analyses. *American journal of epidemiology,* 125**,** 761-768.

Greenland, S. 2004. Model-based estimation of relative risks and other epidemiologic measures in studies of common outcomes and in case-control studies. *American journal of epidemiology,* 160**,** 301-305.

Greenland, S., Pearl, J. & Robins, J. M. 1999. Causal diagrams for epidemiologic research. *Epidemiology***,** 37-48.

Greenland, S., Senn, S. J., Rothman, K. J., Carlin, J. B., Poole, C., Goodman, S. N. & Altman, D. G. 2016. Statistical tests, P values, confidence intervals, and power: a guide to misinterpretations. *European journal of epidemiology,* 31**,** 337-350.

Grove, W. M. & Meehl, P. E. 1996. Comparative Efficiency of Informal (Subjective, Impressionistic) and Formal (Mechanical, Algorithmic) Prediction Procedures: The Clinical-Statistical Controversy. *Psychology, Public Policy, and Law,* 2**,** 293-323.

Grove, W. M., Zald, D. H., Lebow, B. S., Snitz, B. E. & Nelson, C. 2000. Clinical versus mechanical prediction: a meta-analysis. *Psychological assessment,* 12**,** 19.

Guba, E. G. & Lincoln, Y. S. 1982. Epistemological and Methodological Bases of Naturalistic Inquiry. *Educational Communication and Technology,* 30**,** 233-252.

Guba, E. G. & Lincoln, Y. S. 1989. *Fourth generation evaluation*, Sage.

Guba, E. G. & Lincoln, Y. S. 1994. Competing paradigms in qualitative research. *Handbook of qualitative research,* 2**,** 105.

Haase, T. & Pratschke, J. 2017a. The 2016 Pobal HP Deprivation Index for Small Areas. trutzhaase.eu.

Haase, T. & Pratschke, J. 2017b. http://trutzhaase.eu/deprivation-index/the-2016-pobal-hp-deprivation-index-for-small-areas/ [Online]. [Accessed 10 October 2020].

Haase, T. & Pratschke, J. 2017c. Licence Agreement for the 2016 Pobal HP Deprivation Index for Small Area.

Hackett, S. & Taylor, A. 2013. Decision Making in Social Work with Children and Families: The Use of Experiential and Analytical Cognitive Processes. *British Journal of Social Work*.

Hamilton-Giachritsis, C. & Pellai, A. 2017. Child Abuse and Neglect: Ecological perspectives. *The Wiley Handbook of What Works in Child Maltreatment: An Evidence-Based Approach to Assessment and Intervention in Child Protection***,** 29-47.

Hammond, K. R. 1996. *Human judgment and social policy: Irreducible uncertainty, inevitable error, unavoidable injustice*, Oxford University Press on Demand.

Hardiker, P., Exton, K. & Barker, M. 1991. The Social Policy Contexts of Prevention in Child Care. *The British Journal of Social Work,* 21**,** 20.

Harold, G. T. & Conger, R. D. 1997. Martial conflict and adolescent distress: The role of adolescent awareness. *Child development*, 333-350.

Harris, J. & Mildon, R. 2017. Responding Differently to Neglect: An Ecological Approach to Prevention, Assessment and Treatment. *Beyond the Risk Paradigm in Child Protection: Current Debates and New Directions*, 176.

Hayes, D. & Devaney, J. 2004. Accessing Social Work Case Files for Research Purposes: Some Issues and Problems. *Qualitative Social Work,* 3, 313-333.

Hayes, D. & Spratt, T. 2009. Child Welfare Interventions: Patterns of Social Work Practice. *British Journal of Social Work,* 39, 1575-1597.

Hayes, D. & Spratt, T. 2014. Child Welfare as Child Protection Then and Now: What Social Workers Did and Continue to Do. *British Journal of Social Work,* 44, 615-635.

Heinze, G., Wallisch, C. & Dunkler, D. 2018. Variable selection–a review and recommendations for the practicing statistician. *Biometrical Journal,* 60, 431-449.

Helm, D. 2011. Judgements or assumptions? The role of analysis in assessing children and young people's needs. *British Journal of Social Work,* 41, 894-911.

Helm, D. 2013. Sense-making in a social work office: an ethnographic study of safeguarding judgements. *Child & Family Social Work*, n/a-n/a.

Helm, D. & Roesch-Marsh, A. Ecology of judgement in child welfare and protection. Seminar held, 2010. 2016-2007.

Helm, D. & Roesch-Marsh, A. 2016. The Ecology of Judgement: A Model for Understanding and Improving Social Work Judgements. *British Journal of Social Work.*

Hennessy, M. 2016. 'It's not the State's problem, it's the family's': Care system to adopt tough love approach. *The Journal.ie*, 30 October.

Henry, C. 2018. Exposure to domestic violence as abuse and neglect: Constructions of child maltreatment in daily practice. *Child abuse & neglect,* 86, 79-88.

Higgins, D., Lonne, B., Herrenkohl, T. I. & Scott, D. 2019. The successes and limitations of contemporary approaches to child protection. *Re-visioning public health approaches for protecting children.* Springer.

Higgins, D. J. 2004. Differentiating between child maltreatment experiences. *Family Matters*, 50-55.

Higgins, D. J. & McCabe, M. P. 2001. Multiple forms of child abuse and neglect: Adult retrospective reports. *Aggression and violent behavior,* 6, 547-578.

Higgins, M. 2017. Child protection social work in England: How can it be reformed? *The British Journal of Social Work,* 47, 293-307.

Hindley, N., Ramchandani, P. G. & Jones, D. P. H. 2006. Risk factors for recurrence of maltreatment: a systematic review. *Archives of Disease in Childhood,* 91, 744-752.

HIQA. https://www.hiqa.ie/areas-we-work/childrens-services [Online]. Health Information and Quality Authority. [Accessed 2 December 2020].

HIQA 2010. Guidance for the Health Service Executive for the Review of Serious Incidents including the Deaths of Children in Care. Cork: Health Information and Quality Authority.

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

HIQA 2015. Report on Inspection of the Child Protection and Welfare Services Provided to Children Living in Direct Provision Accommodation Under the National Standards for the Protection and Welfare of Children, and Section 8(1) (c) of the Health Act 2007. Dublin: Health Information and Quality Authority.

HIQA 2016. Annual overview report on the inspection and regulation of children's services — 2015. Dublin: Health Information and Quality Authority.

Holland, K. Fri, Apr 15, 2016. Media has 'absurd' views on child protection, Tusla chief claims Fred McBride says social care workers cannot 'eradicate all risks' to children. *Irish Times*.

Holland, K. Thu, Jun 21, 2018, 02:00. Tusla cannot eliminate all risk to children: it needs our support Helping vulnerable families starts with tackling disadvantage in society. *Irish Times*, Thu, Jun 21, 2018.

Holt, K. & Kelly, N. 2014. Administrative Decision Making in Child-Care Work: Exploring Issues of Judgement and Decision Making in the Context of Human Rights, and Its Relevance for Social Workers and Managers. *British Journal of Social Work,* 44**,** 1011-1026.

Holt, S. 2015. Post-separation Fathering and Domestic Abuse: Challenges and Contradictions. *Child Abuse Review,* 24**,** 210-222.

Holt, S. 2017. Domestic violence and the paradox of post-separation mothering. *British journal of social work,* 47**,** 2049-2067.

Holt, S., Buckley, H. & Whelan, S. 2008. The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect,* 32**,** 797-810.

Home, C. & Panel, E. 2016. Risk assessment instruments in child protection Risk assessment instruments in child protection. CFCA Resource Sheet. Australian Institute of Family Studies; Child Family Community Australia.

Hood, R. 2014. Complexity and Integrated Working in Children's Services. *British Journal of Social Work,* 44**,** 27-43.

Hood, R., Goldacre, A., Gorin, S. & Bywaters, P. 2020a. Screen, ration and churn: Demand management and the crisis in children's social care. *The British Journal of Social Work,* 50**,** 868-889.

Hood, R., Goldacre, A., Grant, R. & Jones, R. 2016. Exploring demand and provision in English child protection services. *British Journal of Social Work,* 46**,** 923-941.

Hood, R., Goldacre, A., Webb, C., Bywaters, P., Gorin, S. & Clements, K. 2021. Beyond the toxic trio: exploring demand typologies in children's social care. *British Journal of Social Work,* 51**,** 1942-1962.

Hood, R., Gorin, S., Goldacre, A., Muleya, W. & Bywaters, P. 2020b. Exploring drivers of demand for child protection services in an English local authority. *Child & Family Social Work,* 25**,** 657-664.

Hope, D. A. Hidden Realities: Children's exposure to risks from parental drinking in Ireland. 2011. North West Alcohol Forum Limited.

Horwath, J. 2001. Child neglect is my view your view? Working with cases of child neglect in the North Eastern Health Board. Dublin: North Eastern Health Board.

Horwath, J. 2005. Identifying and assessing cases of child neglect: learning from the Irish experience. *Child & Family Social Work,* 10**,** 99-110.

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

Horwath, J. 2007b. The Missing Assessment Domain: Personal, Professional and Organizational Factors Influencing Professional Judgements when Identifying and Referring Child Neglect. *The British Journal of Social Work,* 37**,** 1285-1303.

Houston, C., Bala, N. & Saini, M. 2017. Crossover cases of high-conflict families involving child protection services: Ontario research findings and suggestions for good practices. *Family Court Review,* 55**,** 362-374.

Houston, S. 2016. Assessing parenting capacity in child protection: towards a knowledge-based model. *Child & family social work,* 21**,** 347-357.

Howarth, E., Moore, T. H., Welton, N. J., Lewis, N., Stanley, N., MacMillan, H., Shaw, A., Hester, M., Bryden, P. & Feder, G. 2016a. IMPRoving Outcomes for children exposed to domestic ViolencE (IMPROVE): an evidence synthesis. *Public Health Research.* Southampton, UK: NIHR Journals Library.

Howarth, E., Moore, T. H., Welton, N. J., Lewis, N., Stanley, N., MacMillan, H., Shaw, A., Hester, M., Bryden, P. & Feder, G. 2016b. IMPRoving Outcomes for children exposed to domestic

ViolencE (IMPROVE): an evidence synthesis. *Public Health Research.* Southampton, UK: NIHR Journals Library.

Howe, D. 1987/2009/2017. *An Introduction to Social Work Theory*, Ashgate Publishing, Ltd.

Howe, D. 1996. Surface and depth in social work practice. *Social theory, social change and social work***,** 77-97.

Howe, D. 2001. Attachment. *In:* Horwath, J. (ed.) *The Child's World: Assessing Children in Need.* London and Philadelphia: Jessica Kingsley Publishers.

HSE 2011. Child Protection and Welfare Practice Handbook. Kildare and Dublin: Health Service Executive.

HSE 2012a. A Framework for Measuring, Managing and Reporting Social Work intake, Assessment and Allocation Activity Dublin: Health Service Executive.

HSE 2012b. Review of Adequacy for HSE Children and Family Services. Dublin: Health Services Executive.

HSE 2012c. Review of Adequacy for HSE Children and Family Services, 2010. Dublin: Health Services Executive.

HSE & Tusla 2019. Hidden Harm Practice Guide. Dublin: Tusla & HSE.

HSE/Tusla 2009/2014. HSE Child Welfare and Protection Social Work Departments Business Processes. Report of the NCCIS Business Process Standardisation Project. Limerick: HSE and Tusla.

https://cwrp.ca/canadian-incidence-study. 2021. *Canadian Incidence Study* [Online]. Canadian Child Welfare Research Portal Available: https://cwrp.ca/canadian-incidence-study [Accessed].

https://www.tusla.ie/about/. *https://www.tusla.ie/about/* [Online]. Tusla. [Accessed 8 December 2020].

Huffhines, L., Tunno, A. M., Cho, B., Hambrick, E. P., Campos, I., Lichty, B. & Jackson, Y. 2016. Case file coding of child maltreatment: Methods, challenges, and innovations in a longitudinal project of youth in foster care. *Children and youth services review,* 67**,** 254-262.

Hughes, R. C. & Rycusa, J. S. 2006. Issues in risk assessment in child protective services. *Journal of Public Child Welfare,* 1**,** 85-116.

Hulley, S. B., Cummings, S. R., Browner, W. S., Grady, D. G. & Newman, T. B. 2013. *Designing Clinical Research,* Philadelphia, Wolters Kluwer Lippincott Williams & Wilkins.

Humphreys, C. 2007. Domestic violence and child protection: exploring the role of perpetrator risk assessments. *Child & Family Social Work,* 12**,** 360-369.

Humphreys, C. & Absler, D. 2011. History repeating: child protection responses to domestic violence. *Child & Family Social Work,* 16**,** 464-473.

Humphreys, C., Regan, L., River, D. & Thiara, R. K. 2005. Domestic Violence and Substance Use: Tackling Complexity. *The British Journal of Social Work,* 35**,** 1303-1320.

Hunt, S., Goddard, C., Cooper, J., Littlechild, B. & Wild, J. 2016. 'If I feel like this, how does the child feel?'Child protection workers, supervision, management and organisational responses to parental violence. *Journal of Social Work Practice,* 30**,** 5-24.

IASW 2011. A Call for Change Discussion Document Children and Families social workers make their voices heard. Dublin: IASW.

Institute of Medicine. Preventing Violence Against Women and Children: Workshop Summary. 2011. Washington, DC: The National Academies Press.

IRC 2015. Employment Based Postgraduate Programme. Dublin: Irish Research Council.

Irish Times Editorial. 2006. History of Health Service Executive. *The Irish Times*, Tue, Jun 20, 2006.

Iwaniec, D. 2006. *The emotionally abused and neglected child: Identification, assessment and intervention: A practice handbook*, John Wiley & Sons.

Jaffe, P., Johnston, J. & Crooks, C. 2008. Custody disputes involving allegations of domestic violence: Toward a differentiated approach to parenting plans. *Family Court Review,* 46**,** 500-522.

Jedwab, M., Harrington, D. & Dubowitz, H. 2017. Predictors of substantiated re-reports in a sample of children with initial unsubstantiated reports. *Child Abuse & Neglect,* 69**,** 232-241.

Jenkins, B. Q., Tilbury, C., Hayes, H. & Mazerolle, P. 2018. Factors associated with child protection recurrence in Australia. *Child Abuse & Neglect,* 81**,** 181-191.

Jenkins, B. Q., Tilbury, C., Hayes, H. & Mazerolle, P. 2019. Do measures of child protection recurrence obscure the differences between reporting and substantiation? *Children and Youth Services Review,* 104**,** 104391.

Jenkins, B. Q., Tilbury, C., Mazerolle, P. & Hayes, H. 2017. The complexity of child protection recurrence: The case for a systems approach. *Child Abuse & Neglect,* 63**,** 162-171.

Jent, J. F., Eaton, C. K., Knickerbocker, L., Lambert, W. F., Merrick, M. T. & Dandes, S. K. 2011. Multidisciplinary child protection decision making about physical abuse: Determining substantiation thresholds and biases. *Children and Youth Services Review,* 33**,** 1673-1682.

Jeyes, G. 2014. Update on Child and Family Services: Child and Family Agency. Online: Dublin: Joint Oireachtas Committee on Health and Children.

Johnson, L. M. 2009. *Correlates of intake and disposition decisions by child protective services professionals*, University of Louisville.

Johnson, R. B. & Onwuegbuzie, A. J. 2004. Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher,* 33**,** 14-26.

Johnson, W. 2004. Effectiveness of California's child welfare structured decision making (SDM) model: a prospective study of the validity of the California Family Risk Assessment. *Madison (Wisconsin, USA): Children's Research Center*.

Johnson, W. 2006. The risk assessment wars: A commentary: Response to "Evaluating the effectiveness of actuarial risk assessment models" by Donald Baumann, J. Randolph Law, Janess Sheets, Grant Reid, and J. Christopher Graham, Children and Youth Services Review, 27, pp. 465–490. *Children and Youth Services Review,* 28**,** 704-714.

Johnson, W., Clancy, T. & Bastian, P. 2015. Child abuse/neglect risk assessment under field practice conditions: Tests of external and temporal validity and comparison with heart disease prediction. *Children and Youth Services Review,* 56**,** 76-85.

Johnson, W. L. 2011. The validity and utility of the California Family Risk Assessment under practice conditions in the field: A prospective study. *Child Abuse & Neglect,* 35**,** 18-28.

Joint Committee on the Family 1996. Kelly – A Child is Dead, Report of a Committee of Inquiry. Interim Report, April 1996. Dublin: Government Publications.

Jones, D. 2010. Assessment of parenting. *In:* Horwath, J. & Basarab-Horwath, J. A. (eds.) *The child's world: The comprehensive guide to assessing children in need.* Jessica Kingsley Publishers.

Jones, E. E. & Davis, K. E. 1965. From Acts To Dispositions The Attribution Process In Person Perception. *Advances in Experimental Social Psychology,* 2**,** 219-266.

Jonson-Reid, M. 2002. After a child abuse report: Early adolescents and the child welfare system. *The Journal of Early Adolescence,* 22**,** 24-48.

Jonson-Reid, M., Drake, B., Kohl, P., Guo, S., Brown, D., McBride, T., Kim, H. & Lewis, E. 2017. What do we really know about usual care child protective services? *Children and Youth Services Review,* 82**,** 222-229.

Jonson-Reid, M., Drake, B. & Kohl, P. L. 2009. Is the overrepresentation of the poor in child welfare caseloads due to bias or need? *Children and Youth Services Review,* 31**,** 422-427.

Jud, A. 2018. Current research on child maltreatment epidemiology. *Child and Adolescent Psychiatry and Mental Health,* 12**,** 21,-s13034-13018-10228-13031.

Jud, A., Fallon, B. & Trocmé, N. 2012. Who gets services and who does not? Multi-level approach to the decision for ongoing child welfare or referral to specialized services. *Children and Youth Services Review,* 34**,** 983-988.

Jud, A., Fegert, J. M. & Finkelhor, D. 2016. On the incidence and prevalence of child maltreatment: a research agenda. *Child and adolescent psychiatry and mental health,* 10**,** 17.

Jud, A., Fluke, J. D., Alink, L. R. A., Allan, K., Fallon, B., Kindler, H., Lee, B. J., Mansell, J. & Puyenbroek, H. v. 2013. On the nature and scope of reported child maltreatment in high-income countries: opportunities for improving the evidence base. *Paediatrics and International Child Health,* 33**,** 207-215.

Jud, A., Jones, L., Mikton, C., World Health, O., Hochschule, L., Soziale, A. & Crimes Against Children Research, C. 2015. *Toolkit on mapping legal, health and social services responses to child maltreatment*.

Kahneman, D. 1991. Judgment and Decision Making: A Personal View. *Psychological Science,* 2**,** 142-145.

Kahneman, D. 2002. Nobel Prize Lecture. *Maps of bounded rationality: A perspective on intuitive judgment and choice.* Stockholm: Nobel Prize Committee.

Kahneman, D. 2011. *Thinking, fast and slow,* London, Penguin Books.

Kahneman, D. & Frederick, S. 2002. Representativeness revisited: Attribute substitution in intuitive judgment. *Heuristics and biases: The psychology of intuitive judgment,* 49**,** 49-81.

Kahneman, D. & Klein, G. 2009. Conditions for intuitive expertise: A failure to disagree. *American Psychologist,* 64**,** 515-526.

Kahneman, D., Sibony, O. & Sunstein, C. R. 2021. *Noise: a flaw in human judgment*, Little, Brown.

Kahneman, D., Slovic, P. & Tversky, A. 1982. *Judgment under uncertainty: Heuristics and biases*, Cambridge University Press.

Kahneman, D. & Tversky, A. 1972. Subjective probability: A judgment of representativeness. *Cognitive Psychology,* 3**,** 430-454.

Kearney, J. 2013. Perceptions of non-accidental child deaths as preventable events: the impact of probability heuristics and biases on child protection work. *Health, Risk & Society,* 15**,** 51-66.

Keddell, E. 2011. Reasoning Processes in Child Protection Decision Making: Negotiating Moral Minefields and Risky Relationships. *British Journal of Social Work,* 41**,** 1251-1270.

Keddell, E. 2013. *Beyond care versus control: decision-making discourses and their functions in child protection social work.* PhD, University of Otago.

Keddell, E. 2014a. Current Debates on Variability in Child Welfare Decision-Making: A Selected Literature Review. *Social Sciences,* 3 916–940.

Keddell, E. 2014b. The ethics of predictive risk modelling in the Aotearoa/New Zealand child welfare context: Child abuse prevention or neo-liberal tool? *Critical Social Policy,* 35**,** 69-88.

Keddell, E. 2016a. Constructing Parental Problems: The Function of Mental Illness Discourses in a Child Welfare Context. *The British Journal of Social Work,* 46**,** 2088-2103.

Keddell, E. 2016b. Substantiation, decision-making and risk prediction in child protection systems. *Policy Quarterly*.

Keddell, E. 2021. Towards a critical decision-making ecology approach for child protection research. *Qualitative Social Work***,** 14733250211039064.

Keddell, E. & Hyslop, I. 2018. Role type, risk perceptions and judgements in child welfare: A mixed methods vignette study. *Children and Youth Services Review,* 87**,** 130-139.

Keddell, E. & Hyslop, I. 2019a. Ethnic inequalities in child welfare: The role of practitioner risk perceptions. *Child & Family Social Work,* 24**,** 409-420.

Keddell, E. & Hyslop, I. 2019b. "I'm in two minds about it": decision variability in child protection. New Zealand: University of Otago.

Kemp, T. 2008. Questioning quality: A critical analysis of the development and implementation of the 'quality agenda'and its impact on child protection social work practice in Ireland. *In:* Burns, K. & Lynch, D. (eds.) *Child Protection and Welfare Social Work: Contemporary Themes and Practice Perspectives.* Dublin: A. & A. Farmar.

Kempe, C. H., Silverman, F. N., Steele, B. F., Droegemueller, W. & Silver, H. K. 1962. The battered-child syndrome. *Jama,* 181**,** 17-24.

Kemshall, H. 2002. *Risk, social policy and welfare,* Buckingham, McGraw-Hill/Open University Press.

Kemshall, H. 2010. Risk Rationalities in Contemporary Social Work Policy and Practice. *British Journal of Social Work,* 40**,** 1247-1262.

Kemshall, H. 2014. Conflicting rationalities of risk: disputing risk in social policy – reflecting on 35 years of researching risk. *Health, Risk & Society,* 16**,** 398-416.

Kennedy, E. D. J. 1970. Reformatory and industrial schools system report 1970 chaired by District Justice Eileen Kennedy.

Kennedy, H. & Holt, S. 2020. Working with young people living in residential care with pre-care experience of domestic violence: Social care workers perspectives. *Journal of Social Care,* 3**,** 2.

Kesner, J. E. & Dever, B. V. 2015. An inter-reporter analysis of mandated child maltreatment reporting in the USA. *In:* Mathews, B. & Bross, D. C. (eds.) *Mandatory reporting laws and the identification of severe child abuse and neglect.* Dordrecht: Springer.

Kettle, M. 2015. The tipping point: fateful moments in child protection. *Child & Family Social Work***,** n/a-n/a.

Kettle, M. & Jackson, S. 2017. Revisiting the rule of optimism. *The British Journal of Social Work,* 47**,** 1624-1640.

Kilkelly, U. 2007. Barriers to the Realisation of Children's Rights in Ireland. Dublin: Ombudsman for Children.

King, B., Black, T., Fallon, B. & Lung, Y. 2021. The role of risk in child welfare decision-making: a prospective cohort examination of families transferred to ongoing child protection services after an investigation. *Children and youth services review,* 125**,** 105983.

Kirkman, E. & Melrose, K. 2014. Clinical Judgement and Decision-Making in Children's Social Work: An analysis of the 'front door' system. England: Department for Education.

Klein, G., Orasanu, J., Calderwood, R. & Zsambok, C. 1993. Decision Making in Action: Models and Methods (Ablex, Norwood, NJ).

Klein, G. A., Calderwood, R. & Clinton-Cirocco, A. Rapid decision making on the fire ground. Proceedings of the human factors society annual meeting, 1986. Sage Publications Sage CA: Los Angeles, CA, 576-580.

Knickerbocker, L., Heyman, R. E., Slep, A. M. S., Jouriles, E. N. & McDonald, R. 2007. Co-occurrence of child and partner maltreatment definitions, prevalence, theory, and implications for assessment. *European Psychologist,* 12**,** 36.

Knight, F. H. 1921. *Risk, uncertainty and profit,* Boston and New York, Houghton Mifflin Company The Riverside Press Cambridge.

Knoke, D. & Trocmé, N. 2005. Reviewing the evidence on assessing risk for child abuse and neglect. *Brief Treatment and Crisis Intervention,* 5**,** 310.

Kohl, P. L., Jonson-Reid, M. & Drake, B. 2009. Time to leave substantiation behind: Findings from a national probability study. *Child Maltreatment,* 14**,** 17-26.

Kokonendji, C. C. 2014. Over-and underdispersion models. *Methods and Applications of Statistics in Clinical Trials,* 2**,** 506-526.

Križ, K. & Skivenes, M. 2013. Systemic differences in views on risk: A comparative case vignette study of risk assessment in England, Norway and the United States (California). *Children & Youth Services Review,* 35**,** 1862-1870.

Krug, E. G., Mercy, J. A., Dahlberg, L. L. & Zwi, A. B. 2002. The world report on violence and health. *The Lancet,* 360**,** 1083-1088.

Laird, S. E., Morris, K., Archard, P. & Clawson, R. 2017. Working with the whole family: What case files tell us about social work practices. *Child & Family Social Work,* 22**,** 1322-1329.

Landsman, M. J. & Hartley, C. C. 2007. Attributing responsibility for child maltreatment when domestic violence is present. *Child Abuse & Neglect,* 31**,** 445-461.

Lapierre, S. 2008. Mothering in the context of domestic violence: the pervasiveness of a deficit model of mothering. *Child & Family Social Work,* 13**,** 454-463.

Lavergne, C., Damant, D., Clément, M.-È., Bourassa, C., Lessard, G. & Turcotte, P. 2011. Key decisions in child protection services in cases of domestic violence: maintaining services and out-of-home placement. *Child & Family Social Work,* 16**,** 353-363.

Lees, A., Meyer, E. & Rafferty, J. 2011. From Menzies Lyth to Munro: The Problem of Managerialism. *British Journal of Social Work*.

Lipsky, M. 1971. Street-Level Bureaucracy and the Analysis of Urban Reform. *Urban Affairs Quarterly,* 6**,** 391-409.

Lonne, B., Harries, M., Featherstone, B. & Gray, M. 2015. *Working ethically in child protection*, Routledge.

Lonne, B., Parton, N., Thomson, J. & Harries, M. 2009. *Reforming Child Protection,* Oxon, Routledge.

Lonne, B., Russ, E., Harrison, C., Morley, L., Harries, M., Robertson, S., Pearce, T. & Smith, J. 2020. The "Front Door" to Child Protection—Issues and Innovations. *International Journal on Child Maltreatment: Research, Policy and Practice***,** 1-17.

López, M., Fluke, J. D., Benbenishty, R. & Knorth, E. J. 2015. Commentary on decision-making and judgments in child maltreatment prevention and response: An overview. *Child Abuse & Neglect,* 49**,** 1-11.

Lwin, K., Fallon, B., Trocmé, N., Fluke, J. D. & Mishna, F. 2018a. A changing child welfare workforce: What worker characteristics are valued in child welfare? *Child Abuse & Neglect,* 81**,** 170-180.

Lwin, K., Fluke, J. D., Trocmé, N., Fallon, B. & Mishna, F. 2018b. Ongoing child welfare services: Understanding the relationship of worker and organizational characteristics to service provision. *Child Abuse & Neglect,* 80**,** 324-334.

Macdonald, G. & Macdonald, K. 2010. Safeguarding: A Case for Intelligent Risk Management. *British Journal of Social Work,* 40**,** 1174-1191.

MacMillan, H. L., Jamieson, E. & Walsh, C. A. 2003. Reported contact with child protection services among those reporting child physical and sexual abuse: Results from a community survey. *Child Abuse & Neglect,* 27**,** 1397-1408.

Madigan, S., Cyr, C., Eirich, R., Fearon, R. M. P., Ly, A., Rash, C., Poole, J. C. & Alink, L. R. A. 2019. Testing the cycle of maltreatment hypothesis: Meta-analytic evidence of the intergenerational transmission of child maltreatment. *Development and Psychopathology,* 31**,** 23-51.

Maguire-Jack, K. & Font, S. A. 2014. Predicting recurrent maltreatment among high-risk families: Applying the Decision-Making Ecology Framework. *Children and Youth Services Review,* 43**,** 29-39.

Malone, P. & Canavan, J. 2021. Strengthening Prevention, Early Intervention and Family Support: A Conceptual Framework for Studying System Change in Irish Child Protection and Welfare. *The British Journal of Social Work*.

Manion, K. & Renwick, J. 2008. Equivocating over the care and protection continuum: An exploration of families not meeting the threshold for statutory intervention. *Social Policy Journal of New Zealand,* 33**,** 70.

Mansell, J., Ota, R., Erasmus, R. & Marks, K. 2011. Reframing child protection: A response to a constant crisis of confidence in child protection. *Children and Youth Services Review,* 33**,** 2076-2086.

Marshall, J. M., Huang, H. & Ryan, J. P. 2011. Intergenerational families in child welfare: Assessing needs and estimating permanency. *Children and Youth Services Review,* 33**,** 1024-1030.

Maxwell, N., Scourfield, J., Featherstone, B., Holland, S. & Tolman, R. 2012. Engaging fathers in child welfare services: a narrative review of recent research evidence. *Child & Family Social Work,* 17**,** 160-169.

McCormack, C., Gibbons, M. & McGregor, C. 2020. An Ecological Framework for Understanding and Improving Decision Making in Child Protection and Welfare Intake (Duty) Practices in the Republic of Ireland. *Child Care in Practice,* 26**,** 146-162.

McGee, H., Garavan, R., deBarra, M., Bryne, J. & Conroy, R. 2002. The SAVI report: Sexual Abuse and Violence in Ireland. A national study of Irish experiences, beliefs and attitudes concerning sexual violence. Dublin: Liffey Press in association with Dublin Rape Crisis Centre.

McGregor, C. 2014. Why is history important at moments of transition? The case of 'transformation' of Irish child welfare via the new Child and Family Agency. *European Journal of Social Work,* 17**,** 771-783.

McGregor, C. 2016. Balancing regulation and support in child protection: using theories of power to develop reflective tools for practice. *The Irish Social Worker*.

McGregor, C. & Devaney, C. 2020a. A framework to inform protective support and supportive protection in child protection and welfare practice and supervision. *Social Sciences,* 9**,** 43.

McGregor, C. & Devaney, C. 2020b. Protective support and supportive protection for families "in the middle": Learning from the Irish context. *Child & Family Social Work,* 25**,** 277-285.

McGregor, C. & Quin, S. 2015. Revisiting our history post-'Celtic Tiger': so what's new. *Social work in Ireland: Changes and continuities, Basingstoke: Palgrave Macmillan***,** 1-17.

McGuinness, C. 1993. Report of the Kilkenny incest investigation. *Dublin: The Stationery Office*.

McLaughlin, M. & Jonson-Reid, M. 2017. The relationship between child welfare financing, screening, and substantiation. *Children and youth services review,* 82**,** 407-412.

Meehl, P. E. 1954. *Clinical versus statistical prediction: A theoretical analysis and a review of the evidence*, Minneapolis: University of Minnesota Press.

Meinck, F., Steinert, J., Sethi, D., Gilbert, R., Bellis, M., Alink, L. & Baban, A. 2016. Measuring and monitoring national prevalence of child maltreatment: a practical handbook.

Melton, G. B. 2005. Mandated reporting: a policy without reason. *Child Abuse & Neglect,* 29**,** 9-18.

Mendoza, N. S., Rose, R. A., Geiger, J. M. & Cash, S. J. 2016. Risk assessment with actuarial and clinical methods: Measurement and evidence-based practice. *Child Abuse & Neglect,* 61**,** 1-12.

Merriam, S. B. & Tisdell, E. J. 2015. *Qualitative research: A guide to design and implementation*, John Wiley & Sons.

Metzler, M., Merrick, M. T., Klevens, J., Ports, K. A. & Ford, D. C. 2017. Adverse childhood experiences and life opportunities: Shifting the narrative. *Children and Youth Services Review,* 72**,** 141-149.

Meyer, S., Reeves, E. & Fitz-Gibbon, K. 2021. The intergenerational transmission of family violence: Mothers' perceptions of children's experiences and use of violence in the home. *Child & Family Social Work,* 26**,** 476-484.

MHIreland. 2022. *Mental Health Ireland Research* [Online]. Available: https://www.mentalhealthireland.ie/research/ [Accessed January 31st 2022].

Miles, M. & Huberman, A. 1994. *Qualitative data analysis: an expanded sourcebook,* Thousand Oakes, CA, Sage Publications.

Mooney, J. 2018. Adult disclosures of childhood sexual abuse and section 3 of the child care act 1991: past offences, current risk. *Child Care in Practice,* 24**,** 245-257.

Mooney, J., O'Suilleabhaon, F., O'Sullivan, G. & Campbell, K. 2021. Risk versus Rights: Current challenges in Irish Social Work Practice Regarding Assessment of Adult Disclosures of Childhood Sexual Abuse. *European Conference on Social Work Research.* University of Bucharest, Romania, 5-7 May 2021 (online).

Morgan, D. G. 2009. Society and the Schools. *Report of the Commission to Inquire into Child Abuse,* 4**,** 201-244.

Morris, A. 2009. Gendered dynamics of abuse and violence in families: Considering the abusive household gender regime. *Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect,* 18**,** 414-427.

Morris, K., Mason, W., Bywaters, P., Featherstone, B., Daniel, B., Brady, G., Bunting, L., Hooper, J., Mirza, N. & Scourfield, J. 2018. Social work, poverty, and child welfare interventions. *Child & Family Social Work,* 23**,** 364-372.

Morse, J. M. 2015. "Data Were Saturated . . . ". *Qualitative Health Research,* 25**,** 587-588.

Mulder, T. M., Kuiper, K. C., van der Put, C. E., Stams, G.-J. J. & Assink, M. 2018. Risk factors for child neglect: A meta-analytic review. *Child abuse & neglect,* 77**,** 198-210.

Mulkeen, M. 2012. Gendered processes in child protection:'Mother-blaming'and the erosion of men's accountability. *Irish Journal of Applied Social Studies,* 12**,** 7.

Mumpower, J. L. 2010. Disproportionality at the" front end" of the child welfare services system: an analysis of rates of referrals," hits,"" misses," and" false alarms". *Journal of Health and Human Services Administration***,** 364-405.

Mumpower, J. L. & McClelland, G. H. 2014. A signal detection theory analysis of racial and ethnic disproportionality in the referral and substantiation process of the US child welfare services system. *Judgment and Decision Making,* 9**,** 114–128.

Munro, E. 1996. Avoidable and unavoidable mistakes in child protection work. *The British Journal of Social Work,* 26**,** 793-808.

Munro, E. 1999a. Common errors of reasoning in child protection work. *Child Abuse & Neglect,* 23**,** 745-758.

Munro, E. 1999b. Protecting children in an anxious society. *Health, Risk & Society,* 1**,** 117-127.

Munro, E. 2004a. The Impact of Audit on Social Work Practice. *British Journal of Social Work,* 34**,** 1075-1095.

Munro, E. 2004b. A simpler way to understand the results of risk assessment instruments. *Children and Youth Services Review,* 26**,** 873– 883.

Munro, E. 2005. Improving practice: Child protection as a systems problem. *Children and Youth Services Review,* 27**,** 375-391.

Munro, E. 2008. Lessons from research on decision making. *Child welfare research: Advances for practice and policy***,** 194-200.

Munro, E. 2010a. Conflating risks: Implications for accurate risk prediction in child welfare services. *Health, Risk & Society,* 12**,** 119-130.

Munro, E. 2010b. Learning to Reduce Risk in Child Protection. *British Journal of Social Work,* 40**,** 1135-1151.

Munro, E. 2011a. The Munro review of child protection. Part 1, A systems analysis.

Munro, E. 2011b. *The Munro review of child protection: Final Report. A child-centred system*, The Stationery Office.

Munro, E. 2019a. Decision-making under uncertainty in child protection: Creating a just and learning culture. *Child & Family Social Work,* 24**,** 123-130.

Munro, E. 2019b. *Effective child protection,* England, Sage.

Munro, E. & Cunliffe, J. 2020. Staff Survey PART 1: Summary Report and Critical Reflections on Implementation. Dublin: Tusla Child and Family Agency.

Munro, E., Taylor, J. S. & Bradbury-Jones, C. 2014. Understanding the Causal Pathways to Child Maltreatment: Implications for Health and Social Care Policy and Practice. *Child Abuse Review,* 23**,** 61-74.

Murphy, E. & Dingwall, R. 2007. Informed consent, anticipatory regulation and ethnographic practice. *Social science & medicine,* 65**,** 2223-2234.

Murphy, F. D., Buckley, H. & Joyce, L. 2005. The Ferns Report. Dublin: Government Publications.

Murphy, M. & Rogers, M. 2018. Working with Adult-Oriented Issues. *The Child's World: The Essential Guide to Assessing Vulnerable Children, Young People and their Families*, 250.

Murphy, R. 1998. Report of the Independent Inquiry into matters relating to child sexual abuse in Swimming. Submission to Minister for Tourism, Sport and Recreation & to the Minister for Education and Science Dublin: Joint Oireachtas Committee on Tourism, Sport and Recreation.

NCCD 2017. California SDM® Family Risk Assessment Oakland, CA: NCCD Children's Research Center.

Neuendorf, K. A. 2017. *The content analysis guidebook,* Thousand Oaks, CA, Sage.

Nikolova, K., Lwin, K. & Fluke, J. D. 2017. Attitudes on the Responsibility for Child Safety: Key Child Protection Worker Characteristics. *Journal of Public Child Welfare,* 11**,** 318-338.

Nikolova, K., Postmus, J. L., Buttner, C. & Bosk, E. A. 2020. Working together to protect women and children from domestic violence: Factors influencing willingness to collaborate between organizations. *Children and Youth Services Review,* 118**,** 105503.

Noble-Carr, D., Moore, T. & McArthur, M. 2020. Children's experiences and needs in relation to domestic and family violence: Findings from a meta-synthesis. *Child & family social work,* 25**,** 182-191.

NRP 2014. National Review Panel Annual Report 2013. Dublin: Tusla.

NRP 2016. National Review Panel Annual Report 2015. Dublin: Tusla.

NRP 2017. National Review Panel Annual Report 2016. Dublin: Tusla.

NRP 2018. National Review Panel Annual Report 2017. Dublin: Tusla.

NSCDC 2012. The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain: Working Paper No. 12. Cambridge, MA: Center on the Developing Child www.developingchild.harvard.edu.

NSCDC 2013. The Science of Neglect (InBrief). Harvard University: Center on the Developing Child www.developingchild.harvard.edu.

Nurminen, M. 1995. To use or not to use the odds ratio in epidemiologic analyses? *European journal of epidemiology,* 11**,** 365-371.

Nyathi, N. 2018. Child protection decision-making: social workers' perceptions. *Journal of Social Work Practice,* 32**,** 189-203.

Nygren, K., Walsh, J., Ellingsen, I. T. & Christie, A. 2019. What about the fathers? The presence and absence of the father in social work practice in England, Ireland, Norway, and Sweden—A comparative study. *Child & Family Social Work,* 24**,** 148-155.

O'Brien, C. 2014a. Fresh start but big challenges remain: Analysis The agency holds the promise of changing bad practices for good. *The Irish Times*, 2014 Jan 31.

O'Brien, V. 2014b. Navigating child welfare and protection in Ireland with the help of the fifth province. *Feedback*.

O'Connell, O. 2014. *Exploring the policy to practice gap: Social workers' experience of embedding child protection policy into their practice. A thesis submitted to the School of Applied Social Studies in partial fulfilment of the requirements for the degree of Masters in Social Policy.* University College Cork.

O'Connell, O. 2018. Social workers in Ireland are swamped by child protection policy. *The Guardian, International Edition*, 25th August 2018.

O'Leary, D. 2007a. AUDIT of social work practice in relation to the Child Protection and Welfare Process Practice Guidelines incorporating 'Children First, 1999' (Southern Health Board, 2003) Cork and Kerry, July 2003 to February 2006. Cork, Ireland.

O'Leary, D. 2007b. Report of Survey: views of professionals in the HSE South, Cork and Kerry involved in child protection and welfare work, about local Practice Guidelines incorporating Children First (SHB, 2003), child protection processes, cooperation and information sharing, between 2003 and 2006. Cork, Ireland.

O'Leary, D. 2017. Exploring substantiation and decision making in a prospective study of risk assessment and decisions during Initial Assessment: some findings from Wave 1. *6th National Child Protection and Welfare Social Work Conference, UCC.* University College Cork, Ireland.

O'Leary, D. 2021. Data regulation and data privacy in Europe: issues for Research on assessment and decision making in child protection. *10th European Conference for Social Work Research (ECSWR 2021) DARSIG Pre-Conference Event on Legal and organizational aspects of decision making.* Bucharest, Romania, *Online*.

O'Leary, D. 2022a. A cross-sectional profile of children and families undergoing Initial Assessment in the Irish Child Protection and Welfare service in 2016. *ISPCAN European Congress.* Estonia, Tallinn: ISPCAN.

O'Leary, D. 2022b. 'It depends what's open on the day!' Insights from empirical research into assessments and decisions for service delivery in child protection and welfare. *ISPCAN European Congress.* Tallinn, Estonia: ISPCAN.

O'Leary, D., Christie, A. & Perry, I. J. 2016a. "This is Your Pilot Speaking!" Choosing methodology for prospective research on assessment and decision making in child protection and welfare *PhD Symposium 2016 Maynooth NUI – At the forefront of Contemporary Research with Children and Young People in Ireland.* Maynooth University, Ireland.

O'Leary, D., Christie, A. & Perry, I. J. 2016b. "This is Your Pilot Speaking!" Choosing the methodology for a prospective study of risk assessment and decision making for outcomes in child protection and welfare *Decisions, Assessment, Risk and Evidence in Social Work 4th Biennial International Symposium* Coleraine.

O'Leary, D., Christie, A. & Perry, I. J. 2016c. "This is Your Pilot Speaking!" Selecting A Methodology for a Mixed Methods Study on Decision Making in Child Protection Social Work. *EUSARF XIV International Conference Shaping the Future, Connecting knowledge and evidence to child welfare practice.* Oviedo, Spain.

O'Leary, D., Fitzgerald, T. & Christie, A. 2015a. Poverty and decisions to place in care: Mapping placements in care using street-level deprivation indices. *5th European Conference for Social Work Research.* Ljublijana, Slovenia.

O'Leary, D. & Lyons, O. 2021. Examining the Prospects for Developing a National Child Maltreatment Surveillance System in Ireland. *International Journal on Child Maltreatment: Research, Policy and Practice***,** 1-23.

O'Leary, D. & Lyons, O. 2023. Exploring the potential of administrative data for understanding and advancing child protection and family support policy, practice and research in Ireland. *Irish Journal of Applied Social Studies,* 22**,** 5.

O'Leary, D., O'Sullivan, K., Christie, A. & Fitzgerald, T. 2013. Who is Taken Into Care? Knowledge Production through Dialogue with Social Workers. *European Conference for Social Work Research "Private troubles or public issues? Challenges for social work research".* Free University of Bozen-Bolzano, Italy

O'Leary, D., O'Sullivan, K., Fitzgerald, T. & Christie, A. 2015b. Poverty and decisions to place in care (residential and foster care): Mapping placements in care using street level deprivation indices. *ECSWR 5th European Conference for Social Work Research "Re-visioning social work with individuals, collectives and commuities: social work research".* Ljubljana, Slovenia.

O'Malley, P. 2008. Neoliberalism and Risk in Criminology. *In:* Anthony, T. & Cunneen, C. (eds.) *The Critical Crimnonology Companion.* Federation Press.

O'Leary, D. & Lyons, O. 2021. Examining the Prospects for Developing a National Child Maltreatment Surveillance System in Ireland. *International Journal on Child Maltreatment: Research, Policy and Practice*.

O'Mahony, C. 2020. Annual Report of the Special Rapporteur on Child Protection 2020 A Report Submitted to the Oirachtas.

O'Sullivan, D. 1979. Social definition in child care in the Irish Republic: Models of the child and child care intervention. *Economic and Social Review,* 10**,** 209-229.

OECD & EU 2016. Health at a Glance: Europe 2016 – State of Health in the EU Cycle. Paris: OECD Publishing.

Ombudsman for Children's Office 2010. A report based on an investigation into the implementation of Children First: National Guidelines for the Protection and Welfare of Children. Ombudsman for Children's Office.

Onwuegbuzie, A. J., Bustamante, R. M. & Nelson, J. A. 2010. Mixed research as a tool for developing quantitative instruments. *Journal of mixed methods research,* 4**,** 56-78.

Onwuegbuzie, A. J., Johnson, R. B. & Collins, K. M. 2009. Call for mixed analysis: A philosophical framework for combining qualitative and quantitative approaches. *International Journal of Multiple Research Approaches,* 3**,** 114-139.

Onwuegbuzie, A. J. & Teddlie, C. 2003. A framework for analyzing data in mixed methods research. *Handbook of mixed methods in social and behavioral research,* 2**,** 397-430.

OrangaTamariki 2017. Investigations and assessments. Oranga Tamariki—Ministry for Children - Key statistics and information. NZ: Oranga Tamariki—Ministry for Children.

Osborne, J. W. 2017. *Regression & Linear Modeling: Best Practices and Modern Methods,* Thousand Oaks, SAGE Publications, Inc.

Øverlien, C. & Holt, S. 2019. European research on children, adolescents and domestic violence: impact, interventions and innovations. *Journal of family violence,* 34**,** 365-369.

Överlien, C. & Hydén, M. 2009. Children's actions when experiencing domestic violence. *Childhood,* 16**,** 479-496.

PA Consulting Group 2009. Inspiring confidence in children and family services: Putting children first and meaning it – Strategic review of the delivery and management of children and family services. Dublin: PA Consulting for the Health Service Executive.

Palusci, V. J. 2011. Risk factors and services for child maltreatment among infants and young children. *Children and Youth Services Review,* 33**,** 1374-1382.

Parton, N. 1979. The natural history of child abuse: A study in social problem definition. *The British Journal of Social Work,* 9**,** 431-451.

Parton, N. 1985. *The politics of child abuse,* London, Macmillan.

Parton, N. 1991. *Governing the family: Child care, child protection and the state*, Macmillan International Higher Education.

Parton, N. 1996. Social work, risk and 'the blaming system'. *Social theory, social change and social work***,** 98-114.

Parton, N. 1998. Risk, advanced liberalism and child welfare: the need to rediscover uncertainty and ambiguity.

Parton, N. 2004. From Maria Colwell to Victoria Climbié: reflections on public inquiries into child abuse a generation apart. *Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect,* 13**,** 80-94.

Parton, N. 2006. *Safeguarding childhood: Early intervention and surveillance in a late modern society*, Palgrave Macmillan.

Parton, N. 2008. Changes in the Form of Knowledge in Social Work: From the 'Social' to the 'Informational'? *The British Journal of Social Work,* 38**,** 253-269.

Parton, N. 2009. Challenges to practice and knowledge in child welfare social work: From the 'social' to the 'informational'? *Children and Youth Services Review,* 31**,** 715-721.

Parton, N. 2014a. *The politics of child protection: Contemporary developments and future directions*, Palgrave Macmillan.

Parton, N. 2014b. Social work, child protection and politics: Some critical and constructive reflections. *British Journal of Social Work,* 44**,** 2042-2056.

Parton, N. 2017. Concerns about risk as a major driver of professional practice. *Beyond the Risk Paradigm in Child Protection: Current Debates and New Directions***,** 1.

Parton, N. 2018. The 'Social Construction of Child Maltreatment': Some Political, Research and Practice Implications. *Constructing social work practices.* Routledge.

Parton, N. 2019. Changing and competing conceptions of risk and their implications for public health approaches to child protection. *Re-visioning public health approaches for protecting children.* Springer.

Parton, N. 2020. Addressing the Relatively Autonomous Relationship Between Child Maltreatment and Child Protection Policies and Practices. *International Journal on Child Maltreatment: Research, Policy and Practice,* 3**,** 19-34.

Parton, N., Thorpe, D. & Wattam, C. 1997. Child protection: risk and the moral order. London: Macmillan.

Peckover, S., Hall, C. & White, S. 2009. From policy to practice: The implementation and negotiation of technologies in everyday child welfare. *Children & society,* 23**,** 136-148.

Peel, K. L. 2020. A beginner's guide to applied educational research using thematic analysis. *Practical Assessment, Research, and Evaluation,* 25**,** 2.

Pelton, L. H. 2015. The continuing role of material factors in child maltreatment and placement. *Child Abuse & Neglect,* 41**,** 30-39.

Perry, I. 2009. Violence: a public health perspective. *Global Crime,* 10**,** 368-395.

Peyton, L. 2012. A Review of Practice and Audit of the Management of Cases of Neglect Report on the Findings of the Pilot Phase of the National Audit of Neglect,. Dublin: HSE.

Pithouse, A., Broadhurst, K., Hall, C., Peckover, S., Wastell, D. & White, S. 2012. Trust, risk and the (mis) management of contingency and discretion through new information technologies in children's services. *Journal of Social Work,* 12**,** 158-178.

Pizzey, S., Bentovim, A., Miller, L. B. & Cox, A. 2017. Evidence-Based Assessments of Children and Families. *The Wiley Handbook of What Works in Child Maltreatment***,** 201.

Platt, D. 2005. Social workers' decision-making following initial assessments of children in need in the UK. *International Journal of Child and Family Welfare,* 8**,** 177.

Platt, D. 2006. Investigation or Initial Assessment of Child Concerns? The Impact of the Refocusing Initiative on Social Work Practice. *British Journal of Social Work,* 36**,** 267-281.

Platt, D. 2008. Care or control? The effects of investigations and initial assessments on the social worker-parent relationship. *Journal of Social Work Practice,* 22**,** 301-315.

Platt, D. & Turney, D. 2013. Making Threshold Decisions in Child Protection: A Conceptual Analysis. *British Journal of Social Work*.

Plsek, P. E. & Greenhalgh, T. 2001. Complexity Science: The Challenge Of Complexity In Health Care. *BMJ: British Medical Journal,* 323**,** 625-628.

Pluye, P. & Hong, Q. N. 2014. Combining the Power of Stories and the Power of Numbers: Mixed Methods Research and Mixed Studies Reviews. *Annual Review of Public Health,* 35**,** 29-45.

Powell, F. & Scanlon, M. 2015. *Dark secrets of childhood: Media power, child abuse and public scandals*, Policy Press.

Power, J. 2020a. Legal fears overshadow victims in new policy: Caution over legal challenges from alleged abusers is backdrop to new policy. *The Irish Times*, 2020 Feb 4.

Power, J. 2020b. Sex offenders dominated leadership' of scouting body for decades, report finds. *Irish Times*, Thu, May 14, 2020.

Price-Robertson, R., Higgins, D. & Vassallo, S. 2013a. Multi-type maltreatment and polyvictimisation: A comparison of two research frameworks. *Family Matters***,** 84-98.

Price-Robertson, R., Rush, P., Wall, L. & Higgins, D. 2013b. Rarely an isolated incident: Acknowledging the interrelatedness of child maltreatment, victimisation and trauma. *AIFS, Child Family Community Information Exchange, Melbourne*.

Public Health Agency of Canada 2010. Canadian Incidence Study of Reported Child Abuse and Neglect 2008: Major findings. Ontario, Canada: PHAC.

Putnam-Hornstein, E., Simon, J. D., Eastman, A. L. & Magruder, J. 2015. Risk of re-reporting among infants who remain at home following alleged maltreatment. *Child maltreatment,* 20**,** 92-103.

Quayle, E. & Taylor, M. 2003. Model of problematic Internet use in people with a sexual interest in children. *CyberPsychology & Behavior,* 6**,** 93-106.

Raftery, M. & O'Sullivan, E. 1999. *Suffer the little children: The inside story of Ireland's industrial schools*, New Island Books.

Regehr, C., Bogo, M., Shlonsky, A. & LeBlanc, V. 2010. Confidence and professional judgment in assessing children's risk of abuse. *Research on Social Work Practice,* 20**,** 621-628.

Ressing, M., Blettner, M. & Klug, S. J. 2010. Data analysis of epidemiological studies: part 11 of a series on evaluation of scientific publications. *Deutsches Arzteblatt International,* 107**,** 187.

Rogers, M. 2015. Parenting Positively Helping teenagers to cope with Domestic Abuse. Dublin: Tusla Child and Family Agency and Barnardos.

Rogers, M. & Parkinson, K. 2018. Exploring approaches to child welfare in contexts of domestic violence and abuse: Family group conferences. *Child & family social work,* 23**,** 105-112.

Roose, R., Roets, G. & Schiettecat, T. 2014. Implementing a strengths perspective in child welfare and protection: A challenge not to be taken lightly. *European Journal of Social Work,* 17**,** 3-17.

Rose, G. 2001. Sick individuals and sick populations. *International journal of epidemiology,* 30**,** 427-432.

Rossi, P., Schuerman, J. & Budde, S. 1996. Understanding child maltreatment decisions and those who make them. Final report of the understanding placement decisions in child welfare study. *University of Chicago, IL: Chopin Hall Center for Children*.

Rowson, R. 2006. *Working ethics: How to be fair in a culturally complex world*, Jessica Kingsley Publishers.

Roy, J. 2021. Children living with parental substance misuse: A cross-sectional profile of children and families referred to children's social care. *Child & Family Social Work,* 26**,** 122-131.

Ruch, G. 2012. Where Have All the Feelings Gone? Developing Reflective and Relationship-Based Management in Child-Care Social Work. *British Journal of Social Work,* 42**,** 1315-1332.

Rutter, H., Savona, N., Glonti, K., Bibby, J., Cummins, S., Finegood, D. T., Greaves, F., Harper, L., Hawe, P., Moore, L., Petticrew, M., Rehfuess, E., Shiell, A., Thomas, J. & White, M. 2017. The need for a complex systems model of evidence for public health. *The Lancet*.

Ryan, A. B. 2006. Researching and writing your thesis: a guide for postgraduate students. Maynooth: MACE: Maynooth Adult and Community Education.

Ryan, S. 2009. The Report of the Commission to Inquire into Child Abuse. Dublin: Government of Ireland.

Rycus, J. S. & Hughes, R. 2003. Issues in risk assessment in child protective services. *Journal of Public Child Welfare,* 1**,** 85-116.

Rzepnicki, T. L. & Johnson, P. R. 2005. Examining decision errors in child protection: A new application of root cause analysis. *Children and Youth Services Review,* 27**,** 393-407.

Saini, M., Black, T., Godbout, E. & Deljavan, S. 2019. Feeling the pressure to take sides: A survey of child protection workers' experiences about responding to allegations of child maltreatment within the context of child custody disputes. *Children and youth services review,* 96**,** 127-133.

Saini, M., Black, T., Lwin, K., Marshall, A., Fallon, B. & Goodman, D. 2012. Child protection workers' experiences of working with high-conflict separating families. *Children and Youth Services Review,* 34**,** 1309-1316.

Saltiel, D. 2013. Understanding complexity in families' lives: the usefulness of family practices' as an aid to decision-making. *Child & Family Social Work,* 18**,** 15-24.

Saltiel, D. 2015. Observing Front Line Decision Making in Child Protection. *British Journal of Social Work*.

Sandelowski, M. 2002. Reembodying qualitative inquiry. *Qualitative health research,* 12**,** 104-115.

Sandelowski, M. 2014. Unmixing Mixed-Methods Research. *Research in Nursing & Health,* 37**,** 3-8.

Sandelowski, M., Voils, C. I. & Knafl, G. 2009. On Quantitizing. *Journal of Mixed Methods Research,* 3**,** 208-222.

Sarbin, T. R. 1943. A Contributino to the Study of Actuarial and Individual Methods of Prediction. *American Journal Of Sociology,* 48**,** 593-602.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H. & Jinks, C. 2018. Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & quantity,* 52**,** 1893-1907.

Savage, L.-É., Tarabulsy, G. M., Pearson, J., Collin-Vézina, D. & Gagné, L.-M. 2019. Maternal history of childhood maltreatment and later parenting behavior: A meta-analysis. *Development and Psychopathology,* 31**,** 9-21.

Schechter, S. & Edleson, J. L. 1999. Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice: Recommendations From the National Council of Juvenile and Family Court Judges Family Violence Department.

Schumaker, K., Fallon, B., Trocmé, N., Fluke, J. D. & Black, T. 2017. Urgent Protection versus Chronic Need - The Application of an Urgent Protection or Chronic Need Taxonomy in a Child Welfare Agency Context *ISPCAN European Regional Meeting.* The Hague, Netherlands.

Schwalbe, C. 2004. Re-visioning risk assessment for human service decision making. *Children and Youth Services Review,* 26**,** 561-576.

Schwalbe, C. 2008. Strengthening the integration of actuarial risk assessment with clinical judgment in an evidence based practice framework. *Children and Youth Services Review,* 30**,** 1458-1464.

Scott, D. 2014. Understanding child neglect. *CFCA Paper No. 20.* Australia: AIFS.

Scott, D. & Faulkner, A. 2019. The role, importance and challenges of data for a public health model. *Re-Visioning Public Health Approaches for Protecting Children.* Springer.

Scott, D., Lonne, B. & Higgins, D. 2016. Public health models for preventing child maltreatment: Applications from the field of injury prevention. *Trauma, Violence, & Abuse,* 17**,** 408-419.

Scourfield, J. & Welsh, I. 2003. Risk, reflexivity and social control in child protection: New times or same old story? *Critical Social Policy,* 23**,** 398-420.

SCRA 2018. Childrens Social Work Statistics Scotland: Statistical Analysis 2016/17. Edinburgh: SCRA Official Statistics.

Sedlak, A., Mettenburg, J., Basena, J., Petta, M., McPherson, K., Greene, A. & Li, S. 2010a. *Fourth national incidence study of child abuse and neglect (NIS-4): Report to congress,* Washington DC, Administration for Children and Families. Office of Planning, Research, and Evaluation.

Sedlak, A. J., Mettenburg, J., Basena, M., Peta, I., McPherson, K. & Greene, A. 2010b. Fourth national incidence study of child abuse and neglect (NIS-4). *Washington, DC: US Department of Health and Human Services,* 9**,** 2010.

Sethi, D., Bellis, M., Hughes, K., Gilbert, R., Mitis, F. & Galea, G. (eds.) 2013. *European report on preventing child maltreatment,* Copenhagen, Denmark: WHO Regional Office for Europe.

Shanahan, C. 2015. Audit agreed as social worker hampered by 'obselete' policies. *Irish Examiner*, Saturday 24th October 2015, 01:00.

Shannon, G. 2012. Fifth Report of the Special Rapporteur on Child Protection. Dublin: Government Publications.

Shannon, G. 2017. Audit of the exercise by An Garda Síochána of the provisions of Section 12 of the Child Care Act 1991. Dublin: An Garda Síochána.

Shannon, G. & Gibbons, N. 2012. Report of the Independent Child Death Review Group 2000-2010. Dublin: Government Publications.

Sheehan, R. 2019. Cumulative harm in the child protection system: The Australian context. *Child & family social work,* 24**,** 421-429.

Shlonsky, A. 2015. Current status and prospects for improving decision making research in child protection: A commentary. *Child Abuse & Neglect,* 49**,** 154-162.

Shlonsky, A. & Friend, C. 2007. Double jeopardy: Risk assessment in the context of child maltreatment and domestic violence. *Brief Treatment and Crisis Intervention,* 7**,** 253.

Shlonsky, A. & Gibbs, L. 2004. Will the real evidence-based practice please stand up? Teaching the process of evidence-based practice to the helping professions. *Brief Treatment & Crisis Intervention,* 4.

Shlonsky, A. & Mildon, R. 2017. Assessment and decision making to improve outcomes in child protection. *Beyond the risk paradigm in child protection***,** 111-129.

Shlonsky, A. & Wagner, D. 2005. The next step: Integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management. *Children and Youth Services Review,* 27**,** 409-427.

Shmueli, G. 2010. To explain or to predict? *Statistical science,* 25**,** 289-310.

Shore, C. & Powell, F. 2020. The social construction of child abuse in Ireland: public discourse, policy challenges and practice failures. *Errors and Mistakes in Child Protection: International Discourses, Approaches and Strategies.*

SI.No.470/2017 2017. S.I. No. 470/2017 - Children First Act 2015 (Commencement) Order 2017. *In:* Ireland, G. (ed.). Dublin.

Sidebotham, P. 2019. Toxic terminology. https://www.childprotectionprofessionals.org.uk/blog/toxic-terminology Association of Child Protection Professionals.

Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Dodsworth, J., Garstang, J., Harrison, E., Retzer, A. & Sorensen, P. 2016. *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014,* London, Department for Education.

Sidebotham, P. & Heron, J. 2006. Child maltreatment in the "children of the nineties": A cohort study of risk factors. *Child Abuse & Neglect,* 30**,** 497-522.

Sidebotham, P., Heron, J. & Golding, J. 2002. Child maltreatment in the "Children of the Nineties:" deprivation, class, and social networks in a UK sample. *Child Abuse & Neglect,* 26**,** 1243-1259.

Silver, N. 2012. *The signal and the noise: the art and science of prediction*, Penguin UK.

Simon, H. A. 1945. *Administrative Behavior: A Study of Decision-Making Processes in Administrative Organizations*, Simon and Schuster Inc.

Simon, H. A. 1955. A behavioral model of rational choice. *The quarterly journal of economics,* 69**,** 99-118.

Simon, H. A. 1956. Rational choice and the structure of the environment. *Psychological review,* 63**,** 129.

Simon, H. A. 1978. Rational Decision-Making in Business Organizations. Stockholm: Nobel Prize Committee.

Simon, H. A. 1979a. Rational choice and the structure of the environment (1956). *HA Simon Models of thought***,** 20-28.

Simon, H. A. 1979b. Rational decision making in business organizations. *The American economic review,* 69**,** 493-513.

Simon, H. A. 1987. Making management decisions: The role of intuition and emotion. *Academy of Management Perspectives,* 1**,** 57-64.

Simon, H. A. 1997. *Administrative behavior: a study of decision-making processes in administrative organizations,* London and New York, The Free Press.

Simon, J. D., Gandarilla Ocampo, M., Drake, B. & Jonson-Reid, M. 2021. A review of screened-out families and child protective services involvement: a missed opportunity to prevent future maltreatment with community-based services. *Child maltreatment***,** 10775595211033597.

SIS 2005. National workload management pilot data analysis. Report 1: data analysis Dublin: Social Information Systems Ltd.

Skehill, C. 2003. Social work in the Republic of Ireland: A history of the present. *Journal of Social Work,* 3**,** 141-159.

Skehill, C., O'Sullivan, E. & Buckley, H. 1999. The nature of child protection practices: an Irish case study. *Child & Family Social Work,* 4**,** 145-152.

Skinner, G. C., Bywaters, P. W., Bilson, A., Duschinsky, R., Clements, K. & Hutchinson, D. 2021. The 'toxic trio'(domestic violence, substance misuse and mental ill-health): How good is the evidence base? *Children and Youth Services Review,* 120**,** 105678.

Slack, K. S. & Berger, L. M. 2020. Who is and is not served by child protective services systems? Implications for a prevention infrastructure to reduce child maltreatment. *The ANNALS of the American Academy of Political and Social Science,* 692**,** 182-202.

Slep, A. M. S. & O'Leary, S. G. 2005. Parent and partner violence in families with young children: rates, patterns, and connections. *Journal of consulting and clinical psychology,* 73**,** 435.

Slovic, P., Fischhoff, B. & Lichtenstein, S. 1977. Behavioral decision theory. *Annual review of psychology,* 28**,** 1-39.

Small, M. L. 2011. How to conduct a mixed methods study: Recent trends in a rapidly growing literature. *Annual review of sociology,* 37.

Smith, C., Fallon, B., Fluke, J. D., Mishna, F. & Decker Pierce, B. 2019. Organizational Structure and the Ongoing Service Decision: The Influence of Role Specialization and Service Integration. *Human Service Organizations: Management, Leadership & Governance,* 43**,** 375-391.

Snook, B., Dhami, M. K. & Kavanagh, J. M. 2011. Simply Criminal: Predicting Burglars' Occupancy Decisions with a Simple Heuristic. *Law and Human Behavior,* 35**,** 316-326.

Southern Health Board 2003. Guidelines for Implementing the Child Protection and Welfare Process and the Child Protection Notification System Incorporating *Children First National Guidelines for the Protection and Welfare of Children* and revising Local Procedures in the Southern Health Board. Cork: Southern Health Board.

Special Issue: Decision Making in Child Welfare 2005. *Children and Youth Services Review,* 27**,** 1339-1344.

Spratt, T. 2001. The Influence of Child Protection Orientation on Child Welfare Practice. *British Journal of Social Work,* 31**,** 933.

Spratt, T. 2012. Why Multiples Matter: Reconceptualising the Population Referred to Child and Family Social Workers. *British Journal of Social Work,* 42**,** 1574-1591.

Spratt, T. & Callan, J. 2004. Parents' views on social work interventions in child welfare cases. *British Journal of Social Work,* 34**,** 199-224.

Stake, R. E. 1995. *The Art of Case Study Research,* California, Sage Publications.

Stalker, K. 2003. Managing risk and uncertainty in social work: A literature review. *Journal of social work,* 3**,** 211-233.

Stanford, S. 2010. 'Speaking Back' to Fear: Responding to the Moral Dilemmas of Risk in Social Work Practice. *British Journal of Social Work,* 40**,** 1065-1080.

Stanley, N., Miller, P., Foster, H. R. & Thomson, G. 2011. Children's experiences of domestic violence: Developing an integrated response from police and child protection services. *Journal of interpersonal violence,* 26**,** 2372-2391.

Stanley, N., Miller, P., Richardson Foster, H. & Thomson, G. 2010. A Stop–Start Response: Social Services' Interventions with Children and Families Notified following Domestic Violence Incidents. *The British Journal of Social Work,* 41**,** 296-313.

StataCorp. 2015. Stata Statistical Software: Release 14.: College Station, TX: StataCorp LP.

Stein, M. & Munro, E. 2008. *Young People's Transitions from Care to Adulthood, International Research and Practice*.

Stevenson, O. 1996. Emotional abuse and neglect: a time for reappraisal. *Child & Family Social Work,* 1**,** 13-18.

Stith, S. M., Liu, T., Davies, L. C., Boykin, E. L., Alder, M. C., Harris, J. M., Som, A., McPherson, M. & Dees, J. E. M. E. G. 2009. Risk factors in child maltreatment: A meta-analytic review of the literature. *Aggression and Violent Behavior,* 14.

Stoddart, J. K. 2017. *The Risk of Risk: An Exploration of the Impact of "Risk" on Child Welfare Decision-making.* PhD, Wilfrid Laurier University.

Stoddart, J. K. 2021. The Risk of Risk: Unpacking the Influence of "Risk" on Child Welfare Decision Making. *In:* Kufeldt, K., Fallon, B., & Mckenzie, B. (ed.) *Protecting Children: Theoretical and Practical Aspects.* Ontario: Canadian Scholars' Press.

Stoddart, J. K., Fallon, B., Trocmé, N. & Fluke, J. D. 2018. Substantiated Child Maltreatment: Which factors do workers focus on when making this critical decision? *Children and Youth Services Review,* 87**,** 1-8.

Stoltenborgh, M., Bakermans-Kranenburg, M. J., Alink, L. R. & IJzendoorn, M. H. 2015. The prevalence of child maltreatment across the globe: Review of a series of meta-analyses. *Child Abuse Review,* 24**,** 37-50.

Sudland, C. & Neumann, C. B. 2021. Should we take their children? Caseworkers' negotiations of 'good enough'care for children living with high-conflict parents. *European Journal of Social Work,* 24**,** 683-695.

Swain, J. & Spire, Z. The role of informal conversations in generating data, and the ethical and methodological issues they raise. Forum: qualitative social research, 2020. FQS.

Swets, J. A., Tanner Jr, W. & Birdsall, T. 1955. The evidence for a decision-making theory of visual detection. Ann Arbour: University of Michigan Department of Electrical Engineering.

Tanner, K. & Turney, D. 2000. The role of observation in the assessment of child neglect. *Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect,* 9**,** 337-348.

Taylor, B. 2013. Case study research. *Qualitative Research in the Health Sciences.* Routledge.

Taylor, B. & Whittaker, A. 2018. Professional judgement and decision-making in social work. *Journal of Social Work Practice,* 32**,** 105 -109.

Taylor, B. J. 2012. Models for professional judgement in social work. *European Journal of Social Work,* 15**,** 546-562.

Taylor, B. J. 2016. Heuristics in Professional Judgement: A Psycho-Social Rationality Model. *British Journal of Social Work.*

Taylor, B. J. 2017a. *Decision making, assessment and risk in social work*, Learning Matters.

Taylor, B. J. 2017b. Heuristics in Professional Judgement: A Psycho-Social Rationality Model. *The British Journal of Social Work,* 47**,** 1043-1060.

Taylor, C. & White, S. 2001. Knowledge, truth and reflexivity: The problem of judgement in social work. *Journal of social work,* 1**,** 37-59.

Taylor, C. & White, S. 2006. Knowledge and Reasoning in Social Work: Educating for Humane Judgement. *British Journal of Social Work,* 36**,** 937-954.

Teater, B., Devaney, J., Forrester, D., Scourfield, J. & Carpenter, J. 2016. *Quantitative research methods for social work: Making social work count*, Macmillan International Higher Education.

Teddlie, C. & Tashakkori, A. 2010. Overview of contemporary issues in mixed methods research. *Handbook of mixed methods in social and behavioral research***,** 1-41.

Teddlie, C. & Tashakkori, A. 2012. Common "core" characteristics of mixed methods research: A review of critical issues and call for greater convergence. *American Behavioral Scientist,* 56**,** 774-788.

Thoburn, J., Lewis, A. & Shemmings, D. 1995. Paternalism or partnership: family involvement in the child protection process.

Thoburn, J. & Making Research Count Consortium 2009. Effective interventions for complex families where there are concerns about or evidence of a child suffering significant harm. London: C4EO.

Thomas, G. 2011. A Typology for the Case Study in Social Science Following a Review of Definition, Discourse, and Structure. *Qualitative Inquiry,* 17**,** 511-521.

Thompson, I., Melia, K. & Boyd, K. 2006. Nursing ethics. Edinburgh: Churchill Livingstone. Elsevier.

Thorpe, D. 1994. *Evaluating child protection,* Milton Keynes, Open University Press.

Thorpe, D. 1997. Regulating late modern childrearing in Ireland. *The Economic and Social Review,* 28**,** 63-84.

Tilbury, C. 2004. The influence of performance measurement on child welfare policy and practice. *British journal of social work,* 34**,** 225-241.

Tilbury, C. 2009. The over-representation of indigenous children in the Australian child welfare system. *International Journal of Social Welfare,* 18**,** 57-64.

Tonmyr, L. & Martin, W. K. 2014. How has child maltreatment surveillance data been used in Canada? *Health Research Policy and Systems,* 12**,** 65.

Trevithick, P. 2012. Practice perspectives. *In:* Gray, M., Midgley, J. & Webb, S. (eds.) *The SAGE handbook of social work.* London: SAGE Publications Ltd.

Trocmé, N., Akesson, B. & Jud, A. 2016. Responding to Child Maltreatment: a Framework for Mapping Child Protection Agencies. *Child Indicators Research,* 9**,** 1029-1041.

Trocmé, N., Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T., Tonmyr, L., Blackstock, C., Barter, K., Turcotte, D. & Cloutier, R. 2005. Canadian Incidence Study of Reported Child Abuse and Neglect – 2003: Major findings. Minister of Public Works and Government Services Canada.

Trocmé, N., Fallon, B., MacLaurin, B., Sinha, V., Black, T., Fast, E. & Holroyd, J. 2010. Canadian incidence study of reported child abuse and neglect: 2008 major findings. Ottawa: Public Health Agency of Canada.

Trocmé, N., Kyte, A., Sinha, V. & Fallon, B. 2014. Urgent protection versus chronic need: Clarifying the dual mandate of child welfare services across Canada. *Social Sciences,* 3**,** 483-498.

Trocmé, N., MacLaurin, B., Fallon, B., Daciuk, J., Billingsley, D., Tourigny, M., Mayer, M., Wright, J., Barter, K. & Burford, G. 2001. Canadian incidence study of reported child abuse and neglect: Final report. *Ottawa: Minister of Public Works and Government Services Canada*.

Trocmé, N., Tourigny, M., MacLaurin, B. & Fallon, B. 2003. Major findings from the Canadian incidence study of reported child abuse and neglect. *Child Abuse & Neglect,* 27.

Turnell, A. & Edwards, S. 1999. Signs of safety. *A solution oriented approach to child protection casework.* New York and London: WW Norton.

Turnell, A. & Edwards, S. 2011. The Signs of Safety Child Protection Practice Framework, 2nd Ed.

Turnell, A. & Murphy, T. 2017. Signs of Safety: Comprehensive briefing document. 4th Edition ed.

Turney, D., Platt, D., Selwyn, J. & Farmer, E. 2011. Social work assessment of children in need: what do we know? Messages from research. London: Department for Education.

Turney, D., Platt, D., Selwyn, J. & Farmer, E. 2012. *Improving child and family assessments: Turning research into practice,* London, Jessica Kingsley Publishers.

Tusla. 2012–2019. *Review of adequacy reports* [Online]. Dublin: Tusla, Child and Family Agency. Available: https://www.tusla.ie/publications/review-of-adequacy-reports/ [Accessed 9 November 2020].

Tusla 2013a. Guidance for the implementation of an Area Based Approach to Prevention, Partnership and Family Support. Dublin: Tusla Child and Family Agency.

Tusla 2013b. Meitheal – A National Practice Model for all agencies working with children, young people and their families. Dublin: Tusla Child and Family Agency.

Tusla 2014a. Assessment Guidance Framework. Dublin: Tusla Child and Family Agency.

Tusla 2014b. Policy and Procedures Responding to Allegations of Child Abuse and Neglect. Dublin: Tusla CFA.

Tusla 2014c. Threshold of Need Guidance for Practitioners in Tusla Social Work Services. Dublin: Tusla Child and Family Agency.

Tusla 2015. National Audit of the Standard Business Processes for Child Protection and Welfare Social Work Services: Intake and Initial Assessment. Dublin: Tusla Child and Family Agency.

Tusla 2016a. Guidance for Managers and Staff on the Effective Use of Performance Data and Information. Dublin: Tusla Child and Family Agency.

Tusla 2016b. Tusla Quality Improvement Framework A Tusla Approach to Improving the Quality and Safety of Services. Dublin: Quality Assurance Directorate, Tusla The Child and Family Agency.

Tusla 2017. Child Protection and Welfare Strategy 2017-2022. Dublin: Tusla Child and Family Agency.

Tusla 2020a. Tusla Data Management Strategy 2019 - 2022. Dublin: Tusla Child and Family Agency.

Tusla. 2020b. *Tusla statement on Child Abuse Substantiation Procedure (CASP)* [Online]. Dublin: Tusla Child and Family Agency. Available: https://www.tusla.ie/news/tusla-statement-on-child-abuse-substantiation-procedure-casp/ [Accessed October 2 2020].

Tusla 2021a. Child and Family Agency launches ambitious reform programme in Corporate Plan (2021 – 2023). www.tusla.ie press release: Tusla.

Tusla 2021b. Child Protection and Welfare Services Data Management Plan and Record of Processing Activities Dublin: Tusla Child and Family Agency.

Tusla 2021c. Corporate Plan 2021 – 2023. Dublin: Tusla Child and Family Agency.

Tusla 2021d. Data Protection and Privacy Policy. Dublin: Tusla Data Protection Unit, Tusla Child and Family Agency.

Tusla 2021e. Rate of re-referral derived data extracted monthly from NCCIS: Data provided to the author by the Quality and Regulation Directorate

Tusla 2022. Child Abuse Substantiation Procedure (CASP). Dublin: Tusla Child and Family Agency.

tusladata. *Annually*. *https://www.tusla.ie/data-figures/* [Online]. Dublin: Tusla. [Accessed 8th December 2020].

Tversky, A. & Kahneman, D. 1974. Judgment under Uncertainty: Heuristics and Biases. *Science,* 185**,** 1124-1131.

Tversky, A. & Kahneman, D. 1981. The Framing of Decisions and the Psychology of Choice. *Science,* 211**,** 453-458.

Tversky, A. & Kahneman, D. 2000. *Choices, values, and frames*, Cambridge University Press.

UCLA: Statistical Consulting Group. *Poisson Regression Stata Data Anslysis Examples* [Online]. UCLA: Advanced Research Computing. Available: https://stats.oarc.ucla.edu/stata/dae/poisson-regression/ [Accessed January 28 2021].

UN 1989. Convention on the Rights of the Child. New York: UN General Assembly.

UN. 2015. *Transforming our world: the 2030 Agenda for Sustainable Development* [Online]. Available: https://sdgs.un.org/ [Accessed].

UN CRC 2011. General Comment No. 13 (2011) The right of the child to freedom from all forms of violence

UNCRC 2011. UN Committee on the Rights of the Child (CRC) General Comment No. 13 (2011): The right of the child to freedom from all forms of violence CRC/C/GC/13. New York: UN.

UNICEF 2014. Hidden In Plain Sight: A statistical analysis of violence against children. New York: United Nations Children's Fund (UNICEF), Division of Data, Research and Policy.

van de Luitgaarden, G. M. J. 2009. Evidence-Based Practice in Social Work: Lessons from Judgment and Decision-Making Theory. *British Journal of Social Work,* 39**,** 243-260.

van der Put, C. E., Assink, M. & Boekhout van Solinge, N. F. 2017. Predicting child maltreatment: A meta-analysis of the predictive validity of risk assessment instruments. *Child Abuse & Neglect,* 73**,** 71-88.

van der Put, C. E., Assink, M. & Stams, G. J. J. M. 2016. The effectiveness of risk assessment methods: Commentary on "Deciding on child maltreatment: A literature review on methods that improve decision-making". *Child Abuse & Neglect,* 59**,** 128-129.

Victor, B. G., Rousson, A. N., Henry, C., Dalvi, H. B. & Mariscal, E. S. 2021. Child Protective Services Guidelines for Substantiating Exposure to Domestic Violence as Maltreatment and Assigning Caregiver Responsibility: Policy Analysis and Recommendations. *Child maltreatment,* 26**,** 452-463.

Vittinghoff, E., Glidden, D. V., Shiboski, S. C. & McCulloch, C. E. 2011. *Regression methods in biostatistics: linear, logistic, survival, and repeated measures models*, Springer Science & Business Media.

Vreugdenburg, T. D., Forel, D., Marlow, N., Maddern, G. J., Quinn, J., Lander, R. & Tobin, S. 2018. Morbidity and mortality meetings: gold, silver or bronze? *ANZ Journal of Surgery,* 88**,** 966-974.

Wagner, D. 2009. Actuarial Risk Assessment vs. Clinical Decision Making in Child Welfare/Corrections: Should we use our heads or the formula? *BOCSAR Seminar.* Sydney: New South Wales Bureau of Crime Statistics and Research.

Walsh, T. 1999. Changing expectations: The impact of 'child protection'on Irish social work. *Child & Family Social Work,* 4**,** 33-41.

Ward, H., Brown, R. & Hyde-Dryden, G. 2014. *Assessing Parental Capacity to Change when Children are on the Edge of Care: an overview of current research evidence*, Department for Education© Loughborough University.

Warner, J. 2003. An Initial Assessment of the Extent to Which Risk Factors, Frequently Identified in Research, Are Taken into Account When Assessing Risk in Child Protection Cases. *Journal of Social Work,* 3**,** 339-363.

Warner, J. & Sharland, E. 2010. Editorial. *British Journal of Social Work,* 40**,** 1035-1045.

Waterhouse, L. & McGhee, J. 2009. Anxiety and child protection–implications for practitioner–parent relations. *Child & Family Social Work,* 14**,** 481-490.

Wattam, C. 1996. The Social Construction of Child Abuse for Practical Policy Purposes-A Review of Child Protection: Messages from Research. *Child & Fam. LQ,* 8**,** 189.

Wayman, S. 2014. Child protection chief on 'walking the talk' Tusla chief executive Gordon Jeyes outlines the challenges as 'year zero' draws to a close. *Irish Times*, Tue, Dec 30, 2014, 12:15.

Weiss-Gal, I. & Savaya, R. 2012. Teaching policy practice: A hands-on seminar for social workers in Israel. *Journal of Policy Practice,* 11**,** 139-157.

Whelan, S. 2018. *At the front door. Child protection reporting in a changing policy and legislative context.* PhD Thesis, Trinity College Dublin.

White, A. & Walsh, P. 2006. *Risk assessment in child welfare: An issues paper,* NSW Department of Community Services, Centre for Parenting and Research.

White, O. G., Hindley, N. & Jones, D. P. H. 2014. Risk factors for child maltreatment recurrence: An updated systematic review. *Medicine, Science and the Law,* 55**,** 259-277.

White, S., Wastell, D., Broadhurst, K. & Hall, C. 2010. When policy o'erleaps itself: The 'tragic tale' of the Integrated Children's System. *Critical Social Policy,* 30**,** 405-429.

Whiteman, N. 2012. Ethical stances in (Internet) research. *Undoing ethics.* Springer.

Whittaker, A. 2018. How Do Child-Protection Practitioners Make Decisions in Real-Life Situations? Lessons from the Psychology of Decision Making. *The British Journal of Social Work*, bcx145-bcx145.

WHO 2014. Investing in children: the European child maltreatment prevention action plan 2015–2020. Copenhagen: WHO Regional Office for Europe.

WHO 2016. *INSPIRE: seven strategies for ending violence against children,* Geneva, World Health Organization.

Widom, C. S., Czaja, S. J. & DuMont, K. A. 2015. Intergenerational transmission of child abuse and neglect: Real or detection bias? *Science,* 347**,** 1480-1485.

Wilkins, D. 2013. Balancing Risk and Protective Factors: How Do Social Workers and Social Work Managers Analyse Referrals that May Indicate Children Are at Risk of Significant Harm. *British Journal of Social Work*.

Williams, C. & Soydan, H. 2005. When and how does ethnicity matter? A cross-national study of social work responses to ethnicity in child protection cases. *British Journal of Social Work,* 35**,** 901-920.

Winter, K. & Connolly, P. 2005. A Small-Scale Study of the Relationship Between Measures of Deprivation and Child-Care Referrals. *British Journal of Social Work,* 35**,** 937-952.

Wise, S. 1989. *Child abuse procedures and social work practice: An ethnographic approach*, The University of Manchester (United Kingdom).

Witte, S. 2020. Case file analyses in child protection research: Review of methodological challenges and development of a framework. *Children and Youth Services Review,* 108**,** 104551.

Wulczyn, F., Daro, D., Fluke, J. D., Feldman, S., Glodek, C. & Lifanda, K. 2010. Adapting a systems approach to child protection: Key concepts and considerations. *New York: UNICEF*.

Yin, R. K. 1981. The case study as a serious research strategy. *Knowledge,* 3**,** 97-114.

Yin, R. K. 2003. Designing case studies. *Qualitative research methods,* 5**,** 359-386.

Zhang, J. & Kai, F. Y. 1998. What's the relative risk?: A method of correcting the odds ratio in cohort studies of common outcomes. *Jama,* 280**,** 1690-1691.

Zhang, S., Fuller, T. & Nieto, M. 2013. Didn't we just see you? Time to recurrence among frequently encountered families in CPS. *Children and Youth Services Review,* 35**,** 883-889.

Zou, G. 2004. A modified poisson regression approach to prospective studies with binary data. *American journal of epidemiology,* 159**,** 702-706.

Appendix 1 Definitions of child abuse in Irish policy

Appendix 1 Definitions of child abuse in Irish policy (HSE, 2011; DCYA, 2011a)

Definition of "Emotional Abuse"

Emotional abuse is normally to be found in the *relationship* between a parent/carer and a child rather than in a specific event or pattern of events. It occurs when a child's developmental need for affection, approval, consistency and security are not met. Unless other forms of abuse are present, it is rarely manifested in terms of physical signs or symptoms.

Emotional abuse can be manifested in terms of the child's behavioural, cognitive, affective or physical functioning. Examples of these include insecure attachment, unhappiness, low self- esteem, educational and developmental underachievement, and oppositional behaviour. The *threshold of significant harm* is reached when abusive interactions dominate and become *typical* of the relationship between the child and the parent/carer.

Definition of "Sexual Abuse"

Sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal, or for that of others. It should be noted that the definition of child sexual abuse presented in this section is not a legal definition and is not intended to be a description of the criminal offence of sexual assault.

Definition of 'Physical Abuse'

Physical abuse of a child is that which results in actual or potential physical harm from an interaction, or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust. There may be single or repeated incidents.

Fabricated/Induced Illness

This is a form of Physical abuse and occurs where parents, usually the mother, fabricate stories of illness about their child or cause physical signs of illness, e.g. through secretly administering dangerous drugs or other substances to the child or by smothering. The symptoms that alert to the possibility of fabricated/

induced illness include:

(i) symptoms that cannot be explained by any medical tests; symptoms never observed by anyone other than the parent/carer; symptoms reported to occur only at home or when a parent/carer visits a child in hospital;

(ii) high level of demand for investigation of symptoms without any documented physical signs;

(iii) unexplained problems with medical treatment, such as drips coming out or lines being interfered with; presence of unprescribed medication or poisons in the blood or urine.

Definition of "Neglect"

Neglect can be defined in terms of an *omission*, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, and/or medical care.

Neglect generally becomes apparent in different ways *over a period of time* rather than at one specific point. For example, a child who suffers a series of minor injuries may not be having his or her needs met in terms of necessary
supervision and safety. A child whose height or weight is significantly below average may be being deprived of adequate nutrition. A child who consistently misses school may be being deprived of intellectual stimulation.

Regardless of whether a concern is about circumstantial or wilful neglect, there is a need for a response where there are concerns that a child is experiencing neglect.

While neglect may be harder to define or to detect than other forms of child abuse, there are common categories of neglect, including:

- Physical Neglect;
- Medical Neglect;
- Homelessness and Neglect;
- Inadequate Supervision;
- Emotional Neglect,
- Educational Neglect;
- Newborns Addicted or Exposed to Drugs.

The following sections give detailed information on each of these types of neglect.

Physical Neglect

Physical neglect is one of the most widely recognised forms. It includes:

- Abandonment – the desertion of a child without arranging for his reasonable care or supervision. Usually, a child is considered abandoned when not picked up within 2 days.
- Expulsion – the blatant refusal by a parent/caregiver to allow a child access to their home on a permanent basis without adequately arranging for his care by others or the refusal to accept custody of a returned runaway.
- Nutritional neglect – when a child is undernourished or is repeatedly hungry for long periods of time, which can sometimes be evidenced by poor growth.
- Clothing neglect – when a child lacks appropriate clothing, such as not having appropriately warm clothes or shoes in the winter.
- Other physical neglect – includes inadequate hygiene and forms of reckless disregard for the child's safety and welfare (e.g., driving while intoxicated with the child, leaving a young child in a car unattended).

Medical Neglect

Medical neglect encompasses a parent or guardian's denial of or delay in seeking needed health care for a child as described below:

- Denial of health care – the failure to provide or to allow needed care as recommended by a competent health care professional for a physical injury, illness, medical condition, or impairment.
- Delay in health care – the failure to seek timely and appropriate medical care for a serious health problem that any reasonable person would have recognized as needing professional medical attention. Examples of a delay in health care include not getting appropriate preventive medical or dental care for a child, not obtaining care for a sick child, or not following medical recommendations.

Homelessness and Neglect

Unstable living conditions can have a negative effect on children, and homeless children are more at risk for other types of neglect in areas such as health, education, and nutrition. Homelessness can be considered neglect when the inability by a parent or carer to provide shelter is the result of not managing their finances appropriately, and there is evidence that the money has been spent not on rent but on drugs or alcohol, or the family had been engaged in anti-social behaviour leading to eviction.

Inadequate Supervision

Inadequate supervision encompasses a number of behaviors, including:

(i) Lack of appropriate supervision

There is no defined amount of time children at different ages can be left unsupervised, and the guidelines for these ages and times vary. In addition, all children are different, so the amount of supervision needed may vary by the child's age, development, or situation. It is important to evaluate the maturity of the child, the accessibility of other adults, the duration and frequency of unsupervised time, and the neighborhood or environment when determining if it is acceptable to leave a child unsupervised.

(ii) Exposure to hazards

- Examples of exposure to in- and out-of-home hazards include:
- Safety hazards – poisons, small objects, electrical wires, stairs, and drugs.
- Smoking – second-hand smoke, especially for children with asthma or other lung problems.
- Guns and other weapons – guns that are kept in the house and are not locked up.
- Unsanitary household conditions – rotting food, human or animal faeces, insect infestation, or lack of running or clean water.
- Lack of child safety restraints.

(iii) Inappropriate caregivers

Another behavior that can fall under 'failure to protect' is leaving a child in the care of someone who either is unable or should not be trusted to provide care for a child. Examples of inappropriate caregivers include a young child, a known child abuser, or someone with a substance abuse problem.

Another common but complex example is single, working parents who are having difficulty arranging for appropriate back-up child care when their regular child care providers are unavailable. For example, a mother may leave her child home alone when the child care provider fails to show up. If the mother

does not go to work, she can lose her job and will not be able to take care of her child. However, if she leaves the child alone, she may be guilty of neglect.
It is important that parents in situations similar to this receive adequate support so that they are not forced to make these difficult decisions.

Emotional Neglect

Typically, emotional neglect is more difficult to assess than other types of neglect, but it is the general opinion that it can have a more severe and longlasting effects than physical neglect. It often occurs with other forms of neglect or abuse, which may be easier to identify, and includes:

- Inadequate nurturing or affection – the persistent, marked inattention to the child's needs for affection, emotional support, or attention.
- Exposure to chronic and/or extreme domestic violence.
- Permitted drug or alcohol abuse – the encouragement or permission by the caregiver of drug or alcohol use by the child.
- Other permitted maladaptive behavior – the encouragement or permission of this behavior (e.g. chronic delinquency, assault) under circumstances where the parent or caregiver has reason to be aware of the existence and the seriousness of the problem, but does not intervene.
- Isolation – denying a child the ability to interact or to communicate with peers or adults outside or inside the home.

Educational Neglect

The Constitution states that every child is entitled to an education and that both parents and schools are responsible for meeting certain requirements regarding the education of children. Types of educational neglect include:

- Permitted, chronic truancy – permitting habitual absenteeism from school averaging at least 5 days a month if the parent or guardian is informed of the problem and does not attempt to intervene.
- Failure to enrol or other truancy – failing to home school, to register, or to enrol a child of mandatory school age, causing the child to miss at least 1 month of school without valid reasons.
- Inattention to special education needs – refusing to allow or failing to obtain recommended remedial education services, or neglecting to obtain or follow through with treatment for a child's diagnosed learning disorder or other special education need without reasonable cause.

Newborns Addicted or Exposed to Drugs

Women who use drugs or alcohol during pregnancy can put their unborn children at risk of mental and physical disabilities. Once a referral is received from other appropriate services identifying an infant born as being affected by illegal substance abuse or withdrawal symptoms, resulting from prenatal drug exposure, a safety plan needs to be developed for the baby. An immediate risk and safety assessment must be conducted following the prompt investigation of such a referral.

Appendix 2 Intake Record

FORM: CC01.02.02
INTAKE RECORD

SECTION A

1. Report (Office use)	Date		Report No.		Case Number	

2. Details of Child

Name:		Sex M ☐ F ☐	D.o.B		Age (approx)	
Address:		Religion: Not Stated	Ethnicity:	Not Stated		
		Telephone No's:				
PPSN:		Other ID:				
Additional Information e.g. School/ Occupation/ Other:						

3. Parents

	Mother			Father		
Name:						
Address:						
Additional Information						
Telephone		DOB		Telephone	DOB	
Ethnicity	Not Stated	Religion	Not Stated	Ethnicity Not Stated	Religion	Not Stated

4. Household Composition

Name	Relationship	DOB	Additional Information e.g. School/ Occupation/Other:

5. Reporter

Name:		Reporter's relationship to child	
Address:		Telephone No:	
		Telephone No:	

Reporter wishes to remain anonymous?	Y ☐	N ☐	Discussed concern with parents/guardians	Y ☐ N ☐
Additional Information e.g. School/ Occupation/Other:				

6. Parents Aware of Report

	Mother		Father	
Are the child's parents/carers aware that this concern is being reported to the HSE?	Y ☐	N ☐	Y ☐	N ☐

7. Details of Report

8. Mode of Report	Select MODE from list	**9. Source of Report**	Select SOURCE from list
Other Specify:		Other Specify:	

RELATIONSHIPS

10. Details of significant others

Relationship *							
Name:							
Address:							
Telephone							
Religion:	Not Stated	DOB		Religion:	Not Stated	DOB	
Ethnicity:	Not Stated	Sex	Unknown	Ethnicity:	Not Stated	Sex	Unknown
Additional Information e.g. School/ Occupation/Other:							

Relationship: *							
Name:							
Address:							
Telephone							
Religion:	Not Stated	DOB		Religion:	Not Stated	DOB	
Ethnicity:	Not Stated	Sex	Unknown	Ethnicity:	Not Stated	Sex	Unknown
Additional Information e.g. School/ Occupation/Other:							

Extra pages may be added. Ref:

11. Details of Person Allegedly Causing Harm to Child

Relationship: *							
Name:							
Address:							
Telephone							
Age (Approx)		DOB		Age (Approx)	Not Stated	DOB	
		Sex	Unknown		Not Stated	Sex	Unknown
Additional Information e.g. School/ Occupation/Other:							
Details of contact with child:							
Details of any known contact with other Children:							
Location of child:							

** See list 1*

SECTION B

12. Known to Social Work Department

Based on information known at this time, is child/family known to Social Work Department?	Y ☐	N ☐

*If yes:*What is the significance of previous involvement /incidents to this referral. In particular (but not only), make reference to any, previous Notification(s) to CPNS. Child Protection Conferences and or Family Support interventions.*

13. Other Checks *(This information is recorded in case notes but it may appropriate to highlight particular details on this form.)*

SECTION C

14. Primary Report Type

Physical Abuse of Child	☐	Sexual Abuse of Child	☐	Emotional Abuse of Child		☐
Neglect of Child	☐	Child Welfare Issues	☐	Other	☐	

15. Welfare Concern Category

Child who is:

Pregnant	☐	Involved in crime	☐	Whose adoption placement has broken down	☐
A carer	☐	Abusing drugs/alcohol	☐	Educational problems / out of school	☐
Homeless (Youth)	☐	Separated, seeking asylum	☐		

Child with:

Emotional problems	☐	Complex health needs	☐	Physical disabilities	☐
Behavioural problems	☐	Specific learning disabilities	☐	Intellectual disabilities	☐
Mental health needs	☐	Severe sensory disability	☐	Communication problems	☐

Parents: (Children of parents)

with learning disability	☐	with mental health problems	☐	whose accommodation is unstable or unsuitable			☐
who lack parenting skills	☐	who misuse drugs or alcohol	☐	who've decided to place the child for adoption			☐
who are adolescents	☐	with disabilities/health problems	☐	who are homeless	☐	who are deceased	☐

Family / Household: (Children of families)

With a known abuser	☐	With someone involved in crime	☐	where domestic violence is a factor	☐
Socially isolated family	☐	With financial difficulties	☐	With significant relationship difficulties	☐
Siblings have disabilities/chronic health problems	☐	members have history of causing serious harm to others			☐
Other – please specify	☐ :				

16. Action on completion of Intake/Referral

No further action (NFA) / CW&P Referral Closed	☐	Initial Assessment required	☐

Tick as required - See guidance:

Strategy Meeting	☐	Emergency intervention required	☐
Notifiied to An Garda Siochana	☐	Provision of information and advice only	☐
Referred on to other professional agency for alternative/supporting services	☐		

Notes/Comments (Related to action)

17. Reporter Acknowledgement

Has the reporter been responded to?			
Y ☐	N ☐	Date:	

18. Agree action

SW/Professional (Sign Off)		Date:	
Team Leader (Approve)		Date:	

SECTION D

19. Allocation Status

IT Use only

20. Allocate Worker (*Designated Worker allocated to case)*

Name:		Profession			
Location:		Telephone		Date allocated	

Appendix 3 Initial Assessment Record

SECTION E

1. Initial Assessment | Date IA Commenced | | Report No. | | Case Number | |

2. Details of Child

Name:		Sex M ☐ F ☐	D.o.B		Age (approx)	
Address:		Religion: Not Stated	Ethnicity: Not Stated		
		Telephone No's:			
PPSN:		Other ID:			
Additional Information e.g. School/ Occupation/Other:					

SECTION F

3. Reason for Initial Assessment *Describe as fully as possible the nature of the problem, incident, allegations or concerns being reported*

4. Names of Persons contacted as part of the Initial Assessment

Role / Agency	Name	Information Requested	Information Received	Role / Agency	Name	Information Requested	Information Received
Child		☐	☐	Psychologist		☐	☐
Parent/Carer/Sig. Other		☐	☐	AMO		☐	☐
Parent/Carer/Sig. Other		☐	☐	Adult Services		☐	☐
Parent/Carer/Sig. Other		☐	☐	Child Psychiatry		☐	☐
PHN		☐	☐	Child Care Worker		☐	☐
GP		☐	☐	Specialist Services		☐	☐
School/Preschool		☐	☐	Probation & Welfare		☐	☐
Gardai	G	☐	☐	Youth Service		☐	☐
Hospital		☐	☐	Other HSE		☐	☐
		☐	☐	CWO		☐	☐
Other: (Please specify)							
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐

SECTION G

5. Child Developmental Needs *Please give details including strengths and current needs across the following dimensions*

(a) Health.

(b) Education.

(c) Emotional and behavioural development.

(d) Identity

(e) Family & Social Relationships

(f) Social Presentation

(g) Self care skills

6. Parents or Carers capacities to respond appropriately to the child's developmental needs *Record strengths as well as difficulties*

(a) Basic care

(b)) Ensuring safety

(c) Emotional warmth

(d) Stimulation

(e) Guidance and Boundaries

(f) Stability.

7. State issues affecting parents or carers capacities to respond appropriately to the child's needs.

8. Family and environmental factors which impact on the child and family. *Please give details of history and current situation.*

(a) Family history and functioning

(b) Social resources: wider family; community resources; social integration

(c) Housing

(d) Employment, income (please include information concerning financial difficulties)

9. Childs View Where appropriate, state the child's response to the report and child's version of events.

10. Parent View State the parents/carers response to the concern the parents/carers response to the concern(s).

11. Analysis / Summary Of Initial Assessment *(must always be completed)*

SECTION H

12. Primary Report Type Child Welfare Issues

Physical Abuse of Child	☐	Sexual Abuse of Child	☐	Emotional Abuse of Child	☐
Neglect of Child	☐	Child Welfare Issues	☐	None ☐	

13. Risk Status IF REPORT TYPE INDICATES CP CONCERN - Do not tick unless abuse/neglect is selected above)

On-going risk of significant harm	☐	No on-going risk of significant harm	☐

14. Welfare Concern Category

Child who is:

Pregnant	☐	Involved in crime	☐	Whose adoption placement has broken down	☐
A carer	☐	Abusing drugs/alcohol	☐	Educational problems / out of school	☐
Homeless (Youth)	☐	Separated, seeking asylum	☐		

Child with:

Emotional problems	☐	Complex health needs	☐	Physical disabilities	☐
Behavioural problems	☐	Specific learning disabilities	☐	Intellectual disabilities	☐
Mental health needs	☐	Severe sensory disability	☐	Communication problems	☐

Parents: (Children of parents)

with learning disability	☐	with mental health problems	☐	whose accommodation is unstable or unsuitable	☐		
who lack parenting skills	☐	who misuse drugs or alcohol	☐	who've decided to place the child for adoption	☐		
who are adolescents	☐	with disabilities/health problems	☐	who are homeless	☐	who are deceased	☐

Family / Household: (Children of families)

With a known abuser	☐	With someone involved in crime	☐	where domestic violence is a factor	☐
Socially isolated family	☐	With financial difficulties	☐	With significant relationship difficulties	☐
Siblings have disabilities/chronic health problems	☐	members have history of causing serious harm to others			☐
Other – please specify	☐ :				

15. Action on completion of Initial Assessment - *See guidance*

No further action (NFA) / Close	☐		
Child Protection	☐		
Child Welfare - Family Support Planning	☐	Family Welfare Conference	☐
Further Assessment	☐	Admission to Care	☐

Tick as required - See guidance:

Strategy Meeting	☐	Referred on to other professional agency for alternative/supporting services	☐
Notified to An Garda Siochana	☐	Provision of information and advice only	☐
Emergency intervention required	☐		

Notes/Comments (Related to action)

16. Date

Assessment ended	

17. Manager Sign-Off / Approval

SW/Professional (Sign Off)		Date:	
Team Leader (Approve)		Date:	

SECTION I

18. Allocation Status

ICT Use only

19. Allocate Worker (*Designated Worker allocated to case)*

Name:		Profession			
Location:		Telephone		Date allocated	

Note:- The allocation status is open until the Report/Referral process is complete

Appendix 4 Threshold of Needs Guidance

An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

THRESHOLD OF NEED GUIDANCE FOR PRACTITIONERS IN TUSLA SOCIAL WORK SERVICES

Document reference number	March V4	**Document drafted by**	Linda Creamer and working group
Revision number	March V4	**Document approved by**	Paul Harrison
Approval date	March 26th 2014.	**Responsibility for implementation**	Service Directors
Revision date	September 2014.	**Responsibility for evaluation and audit**	Service Directors Policy and Strategy
Commencement date	April 7th 2014.		

1 INTRODUCTION

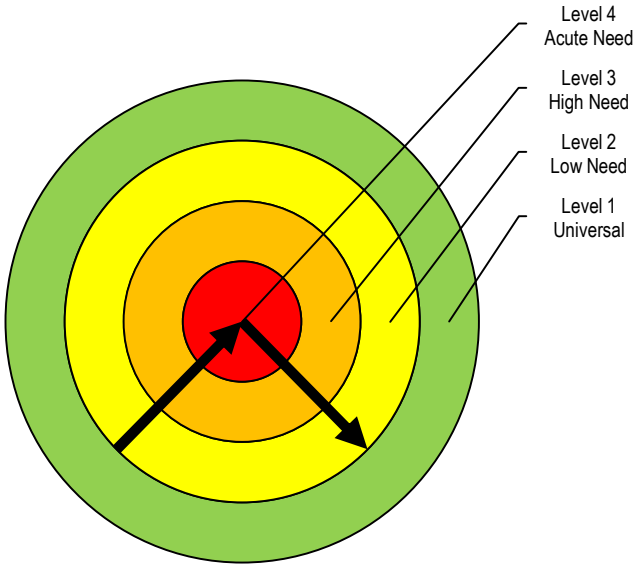
The aim of this threshold guidance is to promote clarity and consistency of response to referrals to TUSLA under *Children First* Guidance and legislation. The primary purpose is for it to support decision making at the Screening and Intake stage of the process. In addition the guidance is for practitioners and managers at all levels throughout the organisation and to assist external agencies to have a consistent understanding of the thresholds for TUSLA social work services. It also will assist practitioners and managers in assessing and identifying a child's level of need, what type of service/resource may meet those needs and what processes to follow in moving from an assessment to provision of services.

Within this part of the Guidance, four 'Levels' of intervention are described – this is a schematic way to help understand children's needs and how they might be met. A number of Matrixes of Needs and Risk are provided for each of the Levels, describing the features of that Level, illustrations of indicators of need related to the Level (structured around parent/carers capacity, family and environmental factors, and child/young person's developmental needs) and related assessment processes. It is not intended to provide a rigid or concrete set of procedures: it is important that all practitioners understand the needs of each individual child within their own context and realise that each child's situation is unique and specific to them. Nor does it provide an exhaustive list of all the possible situations for children and their families, merely illustrations to assist in decision making. The threshold guidance should also be read in conjunction with the Business Process, *Children First*, and the *Child Protection and Welfare Handbook and Assessment Framework*.

Practice Note: The threshold guidance outlines **indicators** to assist professional judgement – these indicators should not be regarded as providing reasons for referral.

2 CHILDREN'S NEEDS AND LEVELS OF INTERVENTION

Children's needs may be found on a continuum, as illustrated below. At different times in their lives, their needs may be at Level 1 (universal), Level 2 (low level, additional), Level 3 (multiple [complex] additional) or Level 4 (highly complex, acute and/or immediate risk of harm).



Level 1 - No additional needs/child achieving expected outcomes. At this Level most children have their needs met through the care of their families and the support of universally provided services (for example, schools, primary health care and leisure facilities).

Level 2 - Children with additional needs. A child or young person identified as having additional needs may require some additional support without which they would be at risk of not reaching their full potential. The additional support may relate to heath, social or educational issues.

Level 3 – Children with multiple (complex) additional needs. A child or young person whose needs are not fully met due to the range, depth, or significance of their needs and whose life chances will be jeopardised without remedial intervention/support. These children will need a more co-ordinated multi-agency response through the Meitheal Model or the Initial Assessment process.

Level 4 - Children with highly complex, acute and/or immediate risk of harm. A child or young person who may be at risk of harm will require specialist assessment from TUSLA social work teams alongside other agencies already working with him/her.

Matrixes of Needs and Risks for each of the Levels are shown from page 24 onwards. The Matrixes are an **illustrative guide only** and decisions relating to immediacy of response and

category of alleged abuse must be made subject to professional judgement of the social worker and team leader. These decisions are based on the information available to them at the point of referral and further to the outcome of preliminary enquiries. Also:

- Children can and do move from one Level to another.
- Children in levels 2-4 also need and use universal services.
- Repeated assessments should not be necessary to move children from one Level to another, and children's stories can follow them as they progress through service provision;
- There will be some children (for example, those with complex needs) who should be enabled to move quickly and effortlessly to the required service response without necessarily going up through each level. A child with complex needs will also require to access support via universal, non-stigmatising settings.
- There should be maximum consistency in the support offered to a child and family: for example, if a family with additional needs are receiving support through the Meitheal Model and are subsequently referred under *Children First* resulting in a Child Protection Plan, those involved in the existing supportive intervention(s) should continue to be involved under the leadership of the social worker.
- The level of need that a service or practitioner primarily deals with should never preclude them from contributing to positive outcomes for all children. So a universal service that primarily deals with children with no additional needs may be a key resource for the response to a child with additional, complex or acute need, making a valuable contribution to prevention and early intervention.

3 PROFESSIONAL JUDGEMENT

A primary principle is that professional judgement takes precedence over Guidance. This Guidance is designed to assist consistency of practice, not to replace or undermine the social work assessment of a child in need or at risk. The intention of the Matrixes is to support decision making about when a referral under *Children First* Guidance and legislation is required and what to expect in terms of who should receive a service and with what level of priority.

- Levels 1 and 2 indicate the circumstances in which practitioners from TUSLA, health organisations, family resource centres, education and schools, early years services etc. would be expected to intervene and provide support to a child and family in order to prevent the needs for a specialist service.
- Level 3 is most likely to have professionals from health organisations, education and schools, early year's services etc. as the Lead Practitioner but for some children at the higher end of Level 3, the Lead Practitioner will be a social worker.
- Level 4 is the point at which TUSLA social work teams will become involved. Practitioners must use their professional judgement and consider what a referral to TUSLA would bring to the intervention for the child. A referral under *Children First* by a practitioner does not discharge fully their duty of care to the child – making an appropriate referral is one important part of their duty and participating in the social work led response is also critical.

Level 1 – Universal Needs No additional support needs		
Features	**ILLUSTRATIVE EXAMPLES**	**Assessment Process**
Children with Level 1 needs **Children with no additional needs** and where there are no concerns. Typically these children live in a resilient and protective environment where their needs are met. These children will require no additional support beyond that which is universally available. **These indicators need to be kept in mind when assessing the significance of indicators from Levels 2-4.**	**L1: Parents or Carers Capacity** **Basic Care, Safety and Protection** • Parents/carers able to provide care for child's needs. • Facilitates cognitive development through interaction and play. • Enables child to experience success. **Emotional Warmth and Stability** • Parents/carers provide secure and caring parenting. • Ensure that secure attachments are not disrupted. **Guidance Boundaries and Stimulation** • Parents/carers provide guidance and boundaries to help child develop appropriate values. • Have the ability to protect from significant harm in the home and elsewhere. **L1: Family and Environmental Factors** **Family History and Wellbeing** • Supportive family relationships, including from parents who are separated. • Few significant changes in family composition. • Wider sense of larger family network and good friendships outside family unit. **Housing, Employment and Finance** • Child fully supported financially, accessing all welfare benefits. • Adequate housing. • Parents are able to manage the working or unemployment arrangements and do not perceive them as unduly stressful. • Reasonable income over time, with resources used appropriately to meet individual needs. **Social and Community Resources** • Social and friendship networks exist. • Safe and secure environment. • Access to regular and positive activities.	These children require **no additional support beyond that which is universally available.** A child welfare assessment is not needed for these children. **Examples of key universal services that provide support and this level:** • Education; • Preschool services; • Public Health Nurse Visiting Service; • Midwifery; • School Nursing; • GP; • Play Services; • Integrated Youth Support Services; • Gardaí; • Housing and Community Sector.

Features	L1: Child or Young Person's Developmental Needs	Assessment Process
	Education • Attendance at school/college/training (above 90%). • Has skills/interests. • Access to books toys and play. • Acquired a range of skills/interests, experiences of success/achievement. • No barriers to learning. • Sound home/school link. • No concerns around cognitive development. **Health** • Physically healthy, developmental checks up to date. • Adequate and nutritious diet. • Good state of mental health. • Dental and optical care as needed. • Developmental milestones appropriate. • Speech and Language development met. • Healthy lifestyle. • Sexual activity appropriate for age. **Social, Emotional, Behavioural** • Demonstrates age-appropriate responses in feelings and actions. • Good quality early attachments, child is appropriately comfortable in social situations. • Knowledgeable about the effects of crime and antisocial behaviour (age-appropriate). • Able to adapt to change. • Able to demonstrate empathy. • Positive sense of self abilities. **Family and Social Relationships** • Stable and affectionate relationships with caregivers. • Good core relationships with siblings. • Positive relationships with peers. **Identity** • Positive sense of self. • Demonstrates feelings of belonging and acceptance. • An ability to express needs. **Self-Care and Independence** • Developing age-appropriate practical and independent living skills. • Appropriate dress for different settings – allowing for age. • Good level of personal hygiene. • Able to distinguish between 'safe' and 'unsafe' contacts. • Knowledge about sex and relationships and consistent use of contraception if sexually active (age-appropriate).	

Level 2 – Low to Vulnerable Threshold for targeted support for children with additional support needs		
Features	**ILLUSTRATIVE EXAMPLES** **In assessing needs and risk that require additional services, multiple factors are likely to be present**	**Assessment Process**
Children with Level 2 needs. These children need some additional support without which they would be at risk of not meeting their full potential. Their identified needs may relate to their health, educational, or social development, and are likely to be short-term needs. If ignored these issues may develop into more worrying concerns. These children will be living in greater adversity than most other children, having a greater degree of vulnerability than most if their needs are not clear, not known or not being met and multiagency / disciplinary intervention is required. A Lead Professional should be identified to coordinate a plan around the child. *(Cont.)*	**L2: Parents or Carers Capacity** **Basic Care, Safety and Protection** • Difficulties with attachment. • Requiring support to provide consistent care e.g. safe and appropriate childcare arrangements; safe and hygienic home conditions; adequate diet. • Parental health problems that may impact on child's health or development unless appropriate support provided. • Parental mental health issues that may impact on the health or development of the child unless appropriate support provided. • Parental learning difficulties that may impact on the health or development of the child unless appropriate support provided. • Parental health/disability that may impact on the health or development of a child unless appropriate support provided. • Parental substance misuse that may impact on the health or development of the child unless appropriate support provided. • Poor engagement with universal services likely to impact on child's health or development. • Parents/carers have had additional support to care for previous child/young person. **Emotional Warmth and Stability** • Requiring support for consistent parenting regarding praise and discipline, where the child's development not yet being impaired. • Lack of response to concerns raised about child's welfare. **Guidance Boundaries and Stimulation** • Requiring support for consistent parenting in respect to routine and boundary setting. • Parent has age-inappropriate expectations that child or young person should be self-reliant. • Limited response to concerns raised about child. • Limited appropriate parental guidance and boundaries for child's stage of development and maturity.	An identification of Strengths and Needs Record Form should be completed with the child/family to identify their strengths and needs. The Meitheal plan should identify the child's strengths and additional needs, desired outcomes, and appropriate services and interventions to achieve those outcomes. If a Meitheal is refused and the needs of a child cannot be met, and may escalate, consideration should be given as to whether a Level 3 response is required. **Exit Strategy** The work with the child and family should aim to enable them to move back to universal services' support.

Features	L2: Family and Environmental Factors	Assessment Process
Timescale Timescales should be built into Service Level Agreements. These should be short term interventions (up to six months) and reviewed on a regular basis. If longer support is required you should discuss needs with specialist services and may need to move into Level 3. A child and family may need a number of these short-term supports over the child's childhood as their needs change.	**Family and Social Relationships and Family Wellbeing** • Parents/carers have relationship difficulties which may affect the child. • Parents/carers request advice to manage their child's behaviour. • Children affected by difficult family relationships. • Child is a teenage parent. • Child is a young carer. • Low level concerns about domestic abuse. • Concerns about substance misuse by parent/carer or sibling. **Housing, Employment and Finance** • Overcrowding (as per local housing guidelines) that has a potential impact on child's health or development. • Families affected by low income/living with poverty affecting access to appropriate services to meet child's additional needs. • Poor home conditions that may impact on child's welfare • Family at risk of eviction having already received support from Housing Services. **Social integration and Community Resources** • Insufficient facilities to meet needs e.g. advice/support needed to access services for disabled child where parent is coping otherwise. • Child associating with peers who are involved in antisocial or criminal behaviour. • Limited access to contraceptive and sexual health advice, information and services. • Family demonstrating low level anti-social behaviour towards others. • Child or family need immediate support and protection due to harassment discrimination and have no local support. • Significant levels of targeted hostility towards the child and their family, and conflict/volatility within neighbourhood.	**Key agencies that may provide support at this level:** **Universal and targeted** • Gardaí; • Targeted drug and alcohol information, advice and education, including advice re harm reduction; • Health e.g. PHN, GP, Midwifery, School nurse; • CAMHS; • Child Psychology; • Children's Centres, Family Centres; • Education; • Pre School Services; • Educational Psychology; • Speech and Language Therapy; • Educational Welfare; • Specialist play services; • YAP; • Voluntary and Community Services; • Early Intervention for Family Services.

Features	L2: Child or Young Person's Developmental Needs	Assessment Process
	Education • Occasional truanting, non-attendance or punctuality issues, attendance below 85%. • School action or school action plus. • Identified language and communication difficulties linked to other unmet needs. • Lack of adequate parent/carer support for child's learning. • Lack of age-appropriate stimulation and opportunities to learn. • Few or no qualifications leading to NEET (not in education, employment or training). • Child/young person under parental pressure to achieve/aspire. • No aspiration for young person. • Not educated at school (or at home by parents/carers). • The child's current rate of progress is inadequate, despite receiving appropriate early education experiences. • Education Psychology Assessment. **Health** • Concerns about reaching developmental milestones. • Not attending routine appointments e.g. immunisations and developmental checks. • Persistent minor health problems. • Missing set appointments across health including antenatal, hospital and GP appointments. • Low level mental health or emotional issues. **Social, Emotional, Behaviour** • Emergency anti-social behaviour and attitudes and/or low level offending. • Child is victim of bullying or bullies others. • Expressing wish to become pregnant at young age. • Low level substance misuse (current or historical). • Low self-esteem. • Limited peer relationships/social isolation. • Expressing thoughts of running away. • Received fixed penalty notice, reprimand, final warning or triage of diversionary intervention. • Disruptive/challenging behaviour at school or in neighbourhood. • Behaviour difficulties requiring further investigation/diagnosis. **Self-Care and Independence** • Lack of age-appropriate behaviour and independent living skills that increase vulnerability to social exclusion. • Early onset of sexual activity (13-14); sexually active young person (15+) with some risk taking behaviours e.g. inconsistent use of contraception. • Low level alcohol/substance misuse (current or historical). • Some evidence of risky use of technology leading to E-safety concerns. **Identity** • Some insecurities around identity expressed e.g. low self-esteem for learning. • May experience bullying around difference.	

Level 3 – High or Complex Threshold for Children in Need		
Features	**ILLUSTRATIVE EXAMPLES** **In assessing needs and risk that require specialist services, multiple factors are likely to be present**	**Assessment Process**
This Level applies to those children identified as **requiring specialist support**. It is likely that for these children their needs and care are at present very significantly compromised. Only a small fraction of children will fall within this band. These children will be those who are highly vulnerable or experiencing the greatest level of adversity. **Children who are not receiving adequate care and protection:** These children are potentially at risk of developing acute/complex needs if they do not receive statutory intervention. The allocated social worker will be responsible for coordinating services.	**L3: Parents or Carers Capacity** **Basic Care, Safety and Protection** • Parent/carer has mental health difficulties that have a direct impact on child's health or development. • Parent/carer substance misuse that has a direct impact on child's health or development. • Parental learning difficulties that a direct impact on child's health or development. • Parental health/disability that has a direct impact on child's health or development. • Child exposed to contact with individuals who pose a risk of physical or sexual harm to children • History of previous child protection concerns. • Child/young person left in the care of an adult known or suspected to be a risk to children, or lives in the same house as the child. **Emotional Warmth and Stability** • Parent is emotionally unavailable. • Succession of carers or child/young person has multiple carers, but no significant relationships with any of them. • Inappropriate child care arrangement. • Inconsistent parenting impairing emotional and behavioural development. • Parental instability affects capacity to nurture. • Parents/carers own emotional needs compromise those of the child/young person. **Guidance Boundaries and Stimulation** • Child/young person receives little positive stimulation despite appropriate toys being available. • Parents/carers provide inconsistent boundaries or present a negative role model which seriously impacts on child's development.	**TUSLA** will respond based on the information supplied in the referral. An Initial Assessment will be completed. Following this the case may: • be closed; • result in the formulation of a Family Support Plan being agreed with the child and its family; • be progressed to Child Protection. **Key agencies that may provide support at this level:** • Children and Family services; • Gardaí; • Specialist health or disability services; • Police; • Youth Justice Service; • Targeted drug and alcohol; • CAMHS; • Child Psychology; • Family Support Services; • Voluntary and Community services; • Services at universal level; • Health e.g. PHN, GP, Midwifery, School nurse; • NEPS; • Family Welfare Conferencing Service.

Features	L3: Family and Environmental Factors	Assessment Process
Definition: Part II, Section 3 *Child Care Act, 1991:* i It shall be a function of the HSE to promote the welfare of children who are not receiving adequate care and protection. In performing this unction the HSE shall - a) Take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children. b) Having regard to the rights and duties of parents, whether under the Constitution or otherwise – i. regard the welfare of the child as the first paramount consideration, and ii. in so far as is practicable, give due consideration, having regard to his age and understanding, to the wishes of the child; and c) have regard to the principle that it is generally in the best interests of a child to be brought up in its own family.	**Family and Social Relationships and Family Wellbeing** • Domestic Abuse where the risk to the victim is assessed as medium to high risk and the child is present within the home during the incident. • An initial domestic abuse incident is reported but the victim discloses details of historic abuse with children resident/normally resident. • Unaccompanied asylum seeking children. • Child subject to a court application where a s7 or s37 report has been ordered to be completed by social work services. • Pre-birth assessment where a history of past child protection concerns. • Risk of family relationships breakdown leading to need for child to become looked outside of family network. • Child is a young carer requiring assessment of additional needs. • Child requires assessment for respite care service due to family circumstances and has no appropriate friend/relative carer available to support. **Housing, Employment and Finance** • Homeless child in need of accommodation. • Extreme financial difficulties impacting on ability to have basic needs met. • No access to funding/community resources.	**Exit strategy** Intervention should be aimed at providing support to enable the child moving out of complex needs with an agreed action plan. This might include continuing multi-agency support coordinated by the social worker to enable the child and family's eventual move back to universal services.

Features	L3: Child or Young Person's Developmental Needs	Assessment Process
	Learning/Education • Child not in education, in conjunction with concerns for child's safety. • Chronic non-attendance/truanting/authorised absence/fixed term exclusions. **Health** • Report of child aged 10 – 13 years left regularly unsupervised. • Child born addicted to drugs including pre-births referrals. • Domestic violence is endangering the physical safety of child. • Parent/carer involved in possession, use or sale of a controlled substance in the presence of a child. • The presence of ongoing concerns relating to the use of alcohol which are affecting capacity to parent and supervise children properly. • Chronic/recurring health problems with missed appointments, routine and non-routine. • Child with a disability in need of assessment and support to access appropriate specialist services. • Serious delay in achieving physical and other developmental milestones, raising significant concerns. • Frequent accidental injuries to child requiring hospital treatment. • Significantly poor or inappropriate diet, despite interventions, with impact on child's development. • Learning and development significantly affected by parents managing child's health problems. • Significant dental decay that has not been treated. **Social, Emotional, Behavioural, Identity** • Child with serious level of unexplained and inappropriate sexualised behaviour. • Child is at risk of sexual exploitation. • Child whose behaviour is putting them at risk, including substance and alcohol misuse. • Evidence of regular/frequent substance misuse which may combine with other risk factors. • Evidence of escalation of substance use and of changing attitudes and more disregard to risk. • Frequently goes missing from home. • Failure or inability to address serious (re)offending behaviour leading to risk of serious harm to self or others. • Ongoing teenage/parent conflict which is resulting in young person repeatedly leaving family home. • Child/young person threatened physical abuse (i.e. with weapon, verbal threats or offender with existing convictions). **Self-Care and Independence** • Child suffers repeated accidental injury as a result of inadequate supervision. • Child found wandering without adequate supervision. • Child expected to be self-reliant for their own basic needs or those of their siblings beyond their capabilities, placing them at potential risk. • Severe lack of age-appropriate self-care.	

Level 4 – Complex or Acute Threshold for Child Protection		
Features	**ILLUSTRATIVE EXAMPLES** **In assessing needs and risk that require additional services, multiple factors are likely to be present**	**Assessment Process**
Children with Level 4 Needs: Children requiring specialist/ statutory integrated support. **Child Protection** Children experiencing significant harm that requires statutory intervention such as child protection or legal intervention. These children may also need to come into the care of TUSLA either on a voluntary basis or by way of Court Order. **Definition** Part II, Section 3 and 4 *Child Care Act, 1991:* 3. It shall be a function of the HSE to promote the welfare of children who are not receiving adequate care and protection. 1.Where it appears to the HSE that a child requires care or protection that he is unlikely to receive unless he is taken into care, it shall be the duty of the HSE to take him into care.	**L4: Parents or Carers Capacity** **Basic Care, Safety and Protection** • Parent/carer is unable to meet child's needs even with support and not providing adequate care. • Serious concern that an unborn child is at risk of significant harm. • Chronic or acute neglect where food, warmth and other basics often not available. • Parents/carers are unable or unwilling to continue to care for the child. • Parents/carers are unable to care for the child. • Parents/carers have or may have abused/neglected the child/young person. • Pre-birth assessment indicates unborn child is at risk of significant harm. • Lack of parental capacity means they cannot keep child/young person safe. • Parent unable to restrict access to home by adults known to be a risk to children and other adults. • Low warmth, high criticism is an enduring feature of the parenting style. • Parent's own emotional needs/experiences persistently impact on their ability to meet the child/young person's needs. • Parent/carer has mental health issue, including self-harming behaviour, that present a risk of significant harm to the child. • Parents/carers' substance misuse that presents a risk of significant harm to the child. • Parental learning difficulties that present a risk of significant harm to the child. • Parental health/disability that presents a risk of significant harm to the child. • Parents unable to care for previous children. • There is instability and violence in the home continually. **Emotional Warmth and Stability** • Deliberate cruelty or emotional ill-treatment of a child resulting in significant harm. • Child is continually the subject of negative comments and criticism, or is used as a scapegoat by a parent/carer, resulting in feelings of low worth and self-esteem and seriously impacting on the child's emotional and psychological development. • Previous child/young person(s) have been removed from parent's care. • Parents inconsistent, highly critical or apathetic towards child. **Guidance Boundaries and Stimulation** • Child is given responsibilities that are inappropriate for their age/level of maturity resulting in significant harm to the child. • Child/young person suffers harm by adult in a position of trust, staff member or volunteer behaves in a way that results in harm to a child or puts child at significant risk. • Child has no one to care for him or her.	**TUSLA** will decide on their response based on the information given by the referrer and as written in the Standard Reporting Form. In the case of suspected abuse the *HSE Child Protection and Child Welfare Practice Policy* in accord with *Children First* will be applied. On the basis of the findings and conclusions of the Initial Assessment, a decision will be made as to whether a Child Protection Conference is required. **Key agencies that may provide support at this level:** • TUSLA – Social Work, Fostering; • Family Welfare Conferencing Service; • Gardaí; • NEPS; • Child Psychology; • Specialist health or disability services; • Youth Justice Service; • Substance misuse services; • CAMHS; • Family Support Services; • Voluntary and Community Services; • Services at universal level.

Features	L4: Family and Environmental Factors	Assessment Process
	Family and Social Relationships and Family Wellbeing • Assessment identifies risk of physical, emotional, sexual abuse or neglect. • History characterised by conflict and serious, chronic relationship difficulties. • Parent/carer has unresolved mental health difficulties which affect the wellbeing of the child. • Adult victim of domestic abuse who continues to put their children at risk of significant harm as a result of their own vulnerability (including unborn). • Members of the wider family are known to be, or suspected of being, a risk to children. • Child needs to be cared for outside of their immediate family or parents/carers due to abuse/neglect. **Housing, Employment and Finance** • Hygiene conditions within the home present a serious and immediate environmental/health risk to children. • Physical accommodation places child in danger. • Extreme poverty/debt impacting on ability to care for child.	**Exit Strategy** TUSLA will work with the child and their family either to reduce the risk to a child in need and ultimately a move out of statutory intervention as described in Level 3, or will embark on court proceedings to provide foster care for the child in either a relative or non-relative fostering or residential placement.

Features	L4: Child or Young Person's Developmental Needs	Assess't Process
	Health • Unexplained injury. • Chronic/recurring health problems with missed appointments, routine and non-routine. • Serious delay in achieving physical and other developmental milestones, raising significant concerns. • Parents/carers refusal to recognise or address high level disability, serious physical and/or emotional health problems. • Carers refusing medical care endangering life/development. • Child not accessing appropriate medical care which puts them at direct risk of significant harm. • Concerns that a child is suffering or likely to suffer harm as a result of fabricated or induced illness. • Sexually Transmitted Infection in a child. • Child who is suspected to having suffered inflicted, or serious unexplained, injuries. • Significant dental decay that has not been treated. • Poor restricted diet despite intervention. • Frequent accidental injuries to child requiring hospital treatment. • Child reported as currently unsupervised 0 – 10 years. • Coerced exposure to sexual activities of others. • Failure to thrive. • Child abandoned. • Chronic lack of care resulting in immediate risk to child's safety and wellbeing. • Parent/carer is incapacitated due to drug/alcohol use. • Reports of non-accidental injury which requires medical attention. • Burns inflicted by parent/carer. • Physical punishment to a child aged 17 years or younger. • Reports where bruising has been observed and requires immediate medical assessment and opinion due to suspicions of physical abuse. • Reports of restraint and confinement by locking, caging, chaining etc. • Sibling sexual activity. **Education** • Is out of school for long period of time under 16 years of age. • Learning/development significantly affected by health problems. **Social, Emotional, Behavioural.** • Challenging behaviour resulting in serious risk to the child and others. • Child/young person beyond parental control – regularly absconds from home and places self at risk of significant harm. • Failure or inability to address complex mental health issues requiring specialist interventions. • Child under the age of 15 years engaged in sexual activity. • Subject to sexual exploitation under 18 years of age. • Is missing from home for repeated short periods of time or prolonged periods. • Young people experiencing current harm through their use of substances. **Identity** • Experiences persistent discrimination (e.g. on the basis of ethnicity, sexual orientation or disability), is socially isolated, lacks appropriate role models. • Alienates self and others. **Self-Care and Independence** • Child is left 'home alone' without adequate adult supervision or support and at risk of significant harm. • Distorted self-image and lack of independent living skills likely to result in significant harm. • Poor and inappropriate self-presentation. • Neglects to use self-care skills due to alternative priorities e.g. substance misuse. • Distorted self-image and lack of independent living skills likely to result in significant harm.	

CALIFORNIA
SDM® FAMILY RISK ASSESSMENT

r: 11/17

Referral Name: _____ **Referral #:** ____-____-____-____ **Date:** ____/____/____

County Name: _____ **Worker Name:** _____ **Worker ID#:** _____

PRIOR INVESTIGATIONS	**Neglect**	**Abuse**
1. Prior neglect investigations		
O a. No prior neglect investigations	0	0
O b. One prior neglect investigation	0	1
O c. Two prior neglect investigations	1	1
O d. Three or more prior neglect investigations	2	1
2. Prior abuse investigations		
O a. No prior abuse investigations	0	0
O b. One prior abuse investigation	1	0
O c. Two prior abuse investigations	1	1
O d. Three or more prior abuse investigations	1	2
3. Household has previous or current open ongoing CPS case (voluntary/court ordered)		
O a. No	0	0
O b. Yes, but not open at the time of this referral	1	1
O c. Yes, household has open CPS case at the time of this referral	2	2
4. Prior physical injury to a child resulting from child abuse/neglect or prior substantiated physical abuse of a child		
O a. None/not applicable	0	0
O b. One or more apply (*select all applicable*) ☐ Prior physical injury to a child resulting from child abuse/neglect ☐ Prior substantiated physical abuse of a child	0	1

CURRENT INVESTIGATION	**Neglect**	**Abuse**
5. Current report maltreatment type *(select all applicable)*		
☐ a. Neglect	1	0
☐ b. Physical and/or emotional abuse	0	1
☐ c. None of the above	0	0
6. Number of children involved in the child abuse/neglect incident		
O a. One, two, or three	0	0
O b. Four or more	1	1
7. Primary caregiver assessment of the incident		
O a. Caregiver does not blame the child	0	0
O b. Caregiver blames the child	0	1

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FAMILY CHARACTERISTICS	Neglect	Abuse
8. Age of youngest child in the home		
O a. 2 years or older	0	0
O b. Under 2	1	0
9. Characteristics of children in the household		
O a. Not applicable	0	0
O b. One or more present (*select all applicable*)		
☐ Mental health or behavioral problems	1	1
☐ Developmental disability		
☐ Learning disability		
☐ Physical disability		0
☐ Medically fragile or failure to thrive		
10. Housing		
O a. Household has physically safe housing	0	0
O b. One or more apply (*select all applicable*) ☐ Physically unsafe; AND/OR ☐ Family homeless	1	0
11. Incidents of domestic violence in the household in the past year		
O a. None or one incident of domestic violence	0	0
O b. Two or more incidents of domestic violence	0	1
12. Primary caregiver disciplinary practices		
O a. Employs appropriate discipline	0	0
O b. Employs excessive/inappropriate discipline	0	1
13. Primary or secondary caregiver history of abuse or neglect as a child		
O a. No history of abuse or neglect for either caregiver	0	0
O b. One or both caregivers have a history of abuse or neglect as a child	1	1
14. Primary or secondary caregiver mental health		
O a. No past or current mental health problem	0	0
O b. Past or current mental health problem *(select all applicable)*	1	1
☐ During the past 12 months		
☐ Prior to the last 12 months		
15. Primary or secondary caregiver alcohol and/or drug use		
O a. No past or current alcohol/drug use that interferes with family functioning	0	0
O b. Past or current alcohol/drug use that interferes with family functioning *(select all applicable*)	1	1
☐ Alcohol (☐ Last 12 months and/or ☐ Prior to the last 12 months)		
☐ Drugs (☐ Last 12 months and/or ☐ Prior to the last 12 months)		
16. Primary or secondary caregiver criminal arrest history		
O a. No caregiver has prior criminal arrests	0	0
O b. Either caregiver has one or more criminal arrests	1	0
	Neglect	**Abuse**
TOTAL SCORE		

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SCORED RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse indices, using the following chart.

Neglect Score	Abuse Score	Scored Risk Level
O 0–2	O 0–1	O Low
O 3–5	O 2–4	O Moderate
O 6–8	O 5–7	O High
O 9 +	O 8 +	O Very high

OVERRIDES

Policy Overrides. Select yes if a condition shown below is applicable in this case. If any condition is applicable, override the final risk level to very high.

O Yes O No 1. Sexual abuse case AND the perpetrator is likely to have access to the child.
O Yes O No 2. Non-accidental injury to a child under age 2.
O Yes O No 3. Severe non-accidental injury.
O Yes O No 4. Caregiver action or inaction resulted in the death of a child due to abuse or neglect (previous or current).

Discretionary Override. If a discretionary override is made, select yes, increase risk by one level, and indicate reason.

O Yes O No 5. If yes, override risk level (select one): O Moderate O High O Very High
Discretionary override reason: _____

Supervisor's Review/Approval of Discretionary Override: _____ Date: _____

FINAL RISK LEVEL *(select final level assigned)*: O Low O Moderate O High O Very high

RECOMMENDED DECISION

Final Risk Level	Recommendation
Low	Do not promote*
Moderate	Do not promote*
High	Promote
Very high	Promote

*Unless there are unresolved safety threats.

PLANNED ACTION

O Promote
O Do not promote

If recommended decision and planned action do not match, explain why:

_____

_____

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SUPPLEMENTAL RISK ITEMS

Note: These items should be recorded but are not scored.

1. Either caregiver demonstrates difficulty accepting one or more children's gender identity or sexual orientation.
   - O a. No
   - O b. Yes

2. Alleged perpetrator is an unmarried partner of the primary caregiver.
   - O a. No
   - O b. Yes

3. Another non-related adult in the household provides unsupervised child care to a child under the age of 3.
   - O a. No
   - O b. Yes
   - O c. N/A

   3a. Is the other non-related adult in the household employed?
   - O a. No
   - O b. Yes
   - O c. N/A

4. Either caregiver is isolated in the community.
   - O a. No
   - O b. Yes

5. Caregiver has provided safe and stable housing for at least the past 12 months.
   - O a. No
   - O b. Yes

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CALIFORNIA
SDM® FAMILY RISK ASSESSMENT
DEFINITIONS

PRIOR INVESTIGATIONS

1. Prior neglect investigations

Identify whether there are prior investigations where neglect was alleged, substantiated, inconclusive, or unfounded. If there are prior investigations for neglect, identify the number of priors. Neglect includes severe and general neglect, exploitation (excluding sexual exploitation), and caregiver being absent/incapacitated, regardless of whether there were also abuse allegations in the investigation.

Do not include referrals that were not assigned for investigation.

Where possible, neglect history from other county or state jurisdictions should be included. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

For differential response referrals, include Paths 2 and 3.

Consider all adults in the household and count prior investigations for which they were alleged to be perpetrators (assign the highest score that applies).

a. Choose "a" if there were no investigations for any type of neglect prior to the current investigation.

b. Choose "b" if there was one investigation, substantiated or not, for any type of neglect prior to the current investigation.

c. Choose "c" if there were two investigations, substantiated or not, for any type of neglect prior to the current investigation.

d. Choose "d" if there were three or more investigations, substantiated or not, for any type of neglect prior to the current investigation.

2. Prior abuse investigations

Identify whether there are prior investigations where abuse was alleged, substantiated, inconclusive, or unfounded. If there are prior investigations for abuse, identify the number of priors. Abuse includes physical abuse, emotional abuse, or sexual abuse/exploitation, regardless of whether there were any neglect allegations in the investigation.

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Do not include referrals that were not assigned for investigation.

Where possible, history from other county or state jurisdictions should be included. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

For differential response referrals, include Paths 2 and 3.

Consider all adults in the household and count prior investigations for which they were alleged to be perpetrators (assign the highest score that applies).

a. Choose "a" if there were no investigations for any type of abuse prior to the current investigation.

b. Choose "b" if there was one investigation, substantiated or not, for any type of abuse prior to the current investigation.

c. Choose "c" if there were two investigations, substantiated or not, for any type of abuse prior to the current investigation.

d. Choose "d" if there were three or more investigations, substantiated or not, for any type of abuse prior to the current investigation.

3. Household has previous or current open ongoing CPS case (voluntary/court ordered)

Identify whether the household has previously had or currently has an open case as a result of a prior investigation. Service history includes voluntary or court-ordered family services or Family Preservation Services but does not include delinquency services. Select the highest-scoring applicable response.

a. Choose "a" if the household has not had an open CPS case prior to this investigation.

b. Choose "b" if the household has previously had an open CPS case and that case is not open at the time of this investigation.

c. Choose "c" if the household has a currently open CPS case at the time of this investigation that began prior to this investigation.

4. Prior physical injury to a child resulting from child abuse/neglect or prior substantiated physical abuse of a child

Identify whether a child has sustained a physical injury resulting from abuse and/or neglect by a current or former adult member of the household. Also identify whether any

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adult living in the household (caregiver or not) previously injured a child in an incident of abuse or neglect.

Injury sustained as a result of abuse or neglect may range from bruises, cuts, and welts to an injury that requires medical treatment or hospitalization, such as a bone fracture or burn.

a. Choose "a" if no child has sustained a physical injury resulting from abuse and/or neglect prior to this investigation OR no current adult household member has caused such an injury OR there is no prior substantiated physical abuse to a child involving a current household member as a perpetrator, regardless of whether the child is a prior or current household member.

b. Choose "b" if a child sustained a physical injury resulting from abuse and/or neglect prior to this investigation that was not previously known to the agency, based on credible information from the child, caregivers, or others.

   OR

   Choose "b" if there was prior substantiated physical abuse of a child involving a current household member as a perpetrator, regardless of whether the child is a prior or current household member.

CURRENT INVESTIGATION

5. Current report maltreatment type (*select all applicable*)

Identify whether the current report is for neglect, physical/emotional abuse, or both. This includes referred allegations or allegations made during the course of the investigation.

a. Choose "a" if the current report is for neglect.

b. Choose "b" if the current report is for physical and/or emotional abuse.

c. Choose "c" if the report does not include the above or is for sexual abuse/exploitation only.

6. Number of children involved in the child abuse/neglect incident

Identify the number of children less than 18 years of age for whom abuse or neglect was alleged or substantiated in the current investigation. If any child is removed as a result of the current investigation, count the child as residing in the home.

a. Choose "a" if there are one, two, or three children in the household.
b. Choose "b" if there are four or more children in the household.

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7. Primary caregiver assessment of the incident

Identify whether the primary caregiver is supportive of the child in this incident or blames the child for the incident.

Blaming the child for the incident refers to the caregiver's statement that the maltreatment incident occurred because of the child's action or inaction (e.g., claiming that the child seduced him/her or the child deserved beating because he/she misbehaved).

a. Choose "a" if the primary caregiver does not blame the child for the incident.
b. Choose "b" if the primary caregiver does blame the child for the incident.

FAMILY CHARACTERISTICS

8. Age of youngest child in the home

Identify the current age of the youngest child presently in the household where the maltreatment incident reportedly occurred. If a child is removed as a result of the current investigation, count the child as residing in the home.

a. Choose "a" if all children in the household are 2 years of age or older.
b. Choose "b" if any child in the household is younger than 2 years old.

9. Characteristics of children in the household

Identify whether any child in the household has a developmental, learning, and/or physical disability; is diagnosed as medically fragile or failure to thrive; or has mental health and/or behavioral issues. Base identification on credible information from a caregiver that a child has been diagnosed, statements from a physician or mental health professional, or review of records.

a. Choose "a" if no child in the household exhibits the characteristics listed in "b."

b. Choose "b" if any child in the household exhibits characteristics listed below and select all types present. Select all types that apply for any child in the household:

- Mental health or behavioral problems. Any child in the household has mental health or behavioral problems not related to a physical or developmental disability. This could be indicated by a diagnosis made by a mental health professional in an area that impacts daily functioning, receiving mental health treatment, attendance in a special classroom because of behavioral problems, or if the child is currently taking prescribed psychoactive medications.

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- Developmental disability. A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include mental retardation, autism spectrum disorders, and cerebral palsy.

- Learning disability. Child has an individualized education plan (IEP) to address a learning problem such as dyslexia. Do not include an IEP designed solely to address mental health or behavioral problems. Also include a child with a learning disability diagnosed by a physician or mental health professional who is eligible for an IEP but does not yet have one, or who is in preschool.

- Physical disability. A severe, acute, or chronic condition diagnosed by a physician that impairs mobility, sensory, or motor functions. Examples include paralysis, amputation, and blindness.

- Medically fragile or failure to thrive.

  » "*Medically fragile*" describes a child who has any condition diagnosed by a physician that can become unstable and change abruptly, resulting in a life-threatening situation; AND that requires daily, ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members; AND that requires the routine use of a medical device or assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living; AND the child lives with an ongoing threat to his/her continued well-being. Examples include a child who requires a trach-vent for breathing or a g-tube for eating.

  » *Failure to thrive*: A diagnosis of failure to thrive by a physician.

10. Housing

Identify the family's current housing status.

a. Choose "a" if the family has housing that is physically safe.

b. Choose "b" if either of the following applies (select all applicable).

- The family has housing, but the current housing situation is physically unsafe to the extent that it does not meet the health or safety needs of the child (e.g., exposed wiring, inoperable heat or plumbing, roach/rat infestations, human/animal waste on floors, rotting food).

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AND/OR

- The family is homeless or was about to be evicted at the time the investigation began or the family becomes homeless/receives an eviction notice by the time the risk assessment is completed. Consider as "homeless" people who are living in a shelter and those living on a short-term basis with relatives or friends.

11. Incidents of domestic violence in the household in the past year

Identify whether there has been domestic violence in the household in the past year. Identification may be based on a credible report from the caregiver(s), police reports, or other records.

a. Choose "a" if, in the previous year, there has been one domestic violence incident or no domestic violence has occurred in the household.

b. Choose "b" if in the previous year, there have been two or more physical assaults or multiple periods of intimidation/threats/harassment in the household between caregivers or between a caregiver and another adult.

12. Primary caregiver disciplinary practices

Identify the disciplinary practices of the primary caregiver of the child in the household.

a. Choose "a" if the primary caregiver employs appropriate discipline.

b. Choose "b" if the primary caregiver employs excessive/inappropriate discipline. Include excessively harsh physical or emotional disciplinary practices that caused or threatened harm to the child and/or were inappropriate given the child's age or development. Do not choose "b" if the actions of the caregiver that have caused harm or injury bear no resemblance to discipline.

Examples of excessive/inappropriate discipline include but are not limited to locking the child in a closet or basement, holding the child's hand over fire, hitting the child with dangerous implements, or depriving a young child of physical and/or social activity for extended periods.

13. Primary or secondary caregiver history of abuse or neglect as a child

Identify whether either caregiver was maltreated as a child. Maltreatment includes neglect or physical, sexual, or emotional abuse.

a. Choose "a" if there are no credible statements by the primary or secondary caregiver or others, or state records of past allegations, that indicate either caregiver was maltreated as a child.

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b. Choose "b" if credible statements by the primary or secondary caregiver or others, or state records of past allegations, indicate that either caregiver was maltreated as a child.

14. Primary or secondary caregiver mental health

Identify the primary and secondary (if present) caregivers' mental health statuses.

a. Choose "a" if the primary and secondary (if present) caregivers do not have past or current mental health problems.

b. Choose "b" if credible and/or verifiable statements by the primary and/or secondary caregiver or others indicate that the primary and/or secondary caregiver:

- Has been diagnosed as having a significant mental health disorder that impacts daily functioning, as determined by a mental health professional; OR
- Has had repeated referrals for mental health/psychological evaluations; OR
- Was recommended for treatment/hospitalization or treated/hospitalized for emotional problems.

If "b," indicate whether the identified mental health problem is current (present in the last 12 months) and/or was present prior to the last 12 months before this referral.

15. Primary or secondary caregiver alcohol and/or drug use

Identify the primary and secondary (if present) caregivers' alcohol and/or drug use, both current and historical, and whether it interferes or has interfered with family functioning.

a. Choose "a" if the primary or secondary caregiver does not have and never has had a drug or alcohol problem that interferes with family functioning.

b. Choose "b" if the primary or secondary caregiver has past or current alcohol and/or drug use that interferes with his/her or the family's functioning. Such interference is evidenced by:

- Substance use that affects or affected employment, criminal involvement, or marital or family relationships; and/or that affects or affected caregiver's ability to provide protection, supervision, and care for the child;

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- An arrest in the past two years for driving under the influence (DUI) or refusing breathalyzer testing;
- Self-report of a problem;
- Treatment received currently or in the past;
- Multiple positive urine samples;
- Health/medical problems resulting from substance use and/or abuse; or
- The child's diagnosis with fetal alcohol syndrome or exposure, or the child's positive toxicology screen at birth and the primary caregiver was the birth parent.

If "b," indicate whether the identified substance use problem is current (present in the last 12 months) and/or was present prior to the last 12 months before this referral.

16. Primary or secondary caregiver criminal arrest history

Indicate whether either the primary or secondary caregiver has a criminal arrest history prior to the current complaint as either an adult or a juvenile. This includes DUIs but excludes all other traffic offenses.

Information may be located in the case narrative material, reports from other agencies, self-report, etc. Also review any police reports in the file for this information.

a. Choose "a" if neither caregiver has criminal arrests prior to this complaint.

b. Choose "b" if either caregiver has one or more criminal arrests prior to the current complaint.

OVERRIDES

Policy Overrides

Select yes if a condition listed below is applicable in this case. If <u>any</u> condition is applicable, override the final risk level to <u>very high</u>.

1. Sexual abuse case AND the perpetrator is likely to have access to the child.

One or more of the children in this household are or have been victims of sexual abuse AND the perpetrator is likely to have unmanaged access.

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2. Non-accidental injury to a child under age 2.
Any child under 2 years old in the household has any kind of physical injury resulting from the actions or inactions of a caregiver.

3. Severe non-accidental injury.
Severe non-accidental injury includes, for example, brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that requires medical treatment and seriously impairs the health or well-being of the child.

4. Caregiver action or inaction resulted in the death of a child due to abuse or neglect (previous or current).
Any child in the household has died as a result of actions or inactions by the caregiver. This child fatality may have occurred prior to the current case. Select this override if this condition has ever existed within the household.

Discretionary Override
A discretionary override is used by the ongoing worker whenever the worker believes that the risk score does not accurately portray the household's actual risk level. The worker may only increase the risk level. If the worker applies a discretionary override, the reason should be specified and the final risk level should be selected.

SUPPLEMENTAL RISK ITEMS

1. Either caregiver demonstrates difficulty accepting one or more children's gender identity or sexual orientation.
Identify whether either caregiver in the household indicates a lack of acceptance of a child's gender identity or sexual orientation. A lack of acceptance may be indicated by verbal statements (calling names, derogatory statements, etc.); actions (physical aggression, kicking the child out, etc.); or a lack of caregiver support, such as a failure to acknowledge the child's gender identity or sexual orientation.

a. Choose "No" if neither caregiver demonstrates difficulty.
b. Choose "Yes" if either caregiver demonstrates difficulty.

2. Alleged perpetrator is an unmarried partner of the primary caregiver.
Identify whether an alleged perpetrator in this incident is an unmarried partner of the primary caregiver in the household. The primary caregiver may or may not also be an alleged perpetrator.

a. Choose "No" if an alleged perpetrator is not an unmarried partner.
b. Choose "Yes" if an alleged perpetrator is an unmarried partner.

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3. Another non-related adult in the household provides unsupervised child care to a child under the age of 3.

Identify whether another unrelated adult in the household (stepparent, significant other, or roommate) provides unsupervised child care to any child in the household who is younger than 3.

a. Choose "No" if a stepparent, significant other, or roommate in the household does not provide unsupervised care for a child younger than 3.

b. Choose "Yes" if a stepparent, significant other, or roommate in the household does provide unsupervised care for a child younger than 3.

c. Choose "N/A" (not applicable) if there is only a primary caregiver in the household.

3a. Is the other non-related adult in the household employed?

Identify whether the other adult in the household (birth or adoptive parent, stepparent, significant other, or roommate) is employed or not.

a. Choose "No" if the other adult in the household (birth or adoptive parent, stepparent, significant other, or roommate) providing unsupervised care to a child in the household younger than 3 is not employed.

b. Choose "Yes" if the other adult in the household (birth or adoptive parent, stepparent, significant other, or roommate) providing unsupervised care to a child in the household younger than 3 is employed.

c. Choose "N/A" if there is only a primary caregiver in the household.

4. Either caregiver is isolated in the community.

Identify whether either caregiver in the household is isolated in the community, as evidenced by lack of communication with others, a lack of meaningful relationships, or a lack of access to community resources.

a. Choose "No" if both caregivers have relationships in the community for support.
b. Choose "Yes" if either caregiver is isolated in the community.

5. Caregiver has provided safe and stable housing for at least the past 12 months.

Identify whether the caregiver has provided safe and stable housing for the last 12 months as evidenced by housing that is physically safe for the child.

a. Choose "No" if the family has had frequent moves or if there are environmental conditions that pose a threat to the child.

b. Choose "Yes" if the family has had safe and stable housing.

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Appendix 6 Modified CA SDM© Family Risk Assessment Scoring Tool and model results

CALIFORNIA SDM FAMILY RISK ASSESSMENT MODIFIED

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Family ID	Completed by
Case reference numbers	Date

PRIOR INVESTIGATIONS	
1 Prior welfare referral and intake	
a ❍no prior welfare	0
b ❍one prior welfare	
c ❍two prior welfare	1
d ❍three or more prior welfare	2
2 Prior abuse referral and intake	
a ❍no prior abuse investigations	0
b ❍ one prior abuse investigation	1
c ❍ two prior abuse investigation	
d ❍ three or more prior abuse	2
3 Prior *unspecified* referral and intake	
a ❍no prior intakes	0
b ❍ one prior intake	1
c ❍ two prior intake	
d ❍ three or more prior intake	2
4 Prior or current IA or after (FA; FWC; CIC etc)	
a ❍ no / no mention of prior or current IA or after	0
b❍ yes, but case closed at time of this referral	1
c ❍ yes, family open to CPW at time of referral	2
5 Prior injury to a child resulting from child abuse/welfare concerns or prior substantiated physical abuse of a child	
a ❍ none / not applicable / no mention	0
b ❍ prior physical injury resulting from child abuse	1
c ❍ prior substantiated physical abuse of a child	

CURRENT INVESTIGATION	
6 Case classification at end IA	
a ❍ welfare	1
b ❍ physical abuse	
c ❍ emotional abuse	
d ❍ sexual abuse	
e ❍ neglect	
f ❍ none of the above	0
7 Number of children involved in the case	
a ❍ one, two, three	0
b ❍ four or more	1
8 Parent or carer assessment of the child	
a ❍ carer ~~(one or other)~~ does not blame child / no mention	0
b ❍ carer ~~(one or other~~) blames child	1

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FAMILY CHARACTERISTICS	
9 Age of the youngest child in the home	
a ❍ 2 years or older	0
b ❍ under 2	1
10 Characteristics of children in the household One or more with	
a ❍ no mention of difficulties in relation to any child in the household	0
b ❍ mental health or behavioural problems	1
c ❍ developmental disability	
d ❍ learning disability	
e ❍ physical disability	
f ❍ medically fragile or failure to thrive	
11 Housing	
a ❍ family has physically safe housing / no mention	0
b ❍ family has ❑ physically unsafe AND /OR is ❑homeless	1
12 Incidents of domestic violence in the household in the past year	
a ❍ none or one incident in the household / no mention	0
b ❍ two or more incidents in the household	1
13 Carer disciplinary practice	
a ❍ employs appropriate discipline / no mention	0
b ❍ employs excessive or inappropriate discipline	1
14 Carer – primary or secondary – history of abuse or welfare as a child	
a ❍ no history of abuse or involvement with CPW for either carer / no mention	0
b ❍ one or both carers have a history of abuse or involvement with CPW	1
15 Carers mental health	
a ❍ no past or current parent or carer mental health / no mention	0
b ❍ past or current mental health problem in past 12 months	1
c ❍ past or current mental health problem prior to last 12 months	
16 Parent or carer alcohol and or drug use	
a ❍ no past or current parent or carer alcohol and or drug use/ no mention	0
b ❍ past or current ❑ alcohol ❑ drug use that interferes with family functioning in past 12 months	1
c ❍ parent or carer ❑alcohol ❑ drug use that interferes with family functioning prior to last 12 months	
17 Parent or carer has criminal arrest history (arrest by Gardaí and/or crime or prison)	
a ❍ no parent or carer history of criminal arrest / no mention	0
b ❍ either parent or carer has one or more criminal arrests	1
TOTAL SCORE	

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Questions 1 to 5 relate to previous referrals, intakes, assessments and further action.
Questions 5 to 17 relate to the current IA and the intake and referral relating to that.

PRIOR INVESTIGATIONS

Questions 1 to 3 Nature of prior involvement
Tick all that apply. Where a family is not known tick (a)'no prior' for questions 1, 2 and 3 Where a family is known or was open to CPW anywhere and there is information about the type of case that was known to CPW tick all that apply for questions 1 and 2 and tick no prior intakes for question 3. Where a family is known but there is no information about the type of cases tick the appropriate classification in question 3

Question 4 Prior or current IA or subsequent SW action
Tick a or b or c. Where a family is known but there is no information that there was a previous IA or other SW action except Referral and intake tick (a) no Where a family is known and there was a previous IA or other SW action but that case closed tick (b) yes but closed …. Where there is evidence that the family – for any child – is open to CPW select (c) yes, family open to CPW at time of referral.

Question 5 Prior injury to a child resulting from child abuse/welfare concerns or prior substantiated physical abuse of a child
Tick a or b or c. Tick a none / not applicable where there is no information about prior injury or there is injury but it is not clear that it results from abuse Tick b where there is information of prior physical injury resulting from child abuse to any child Tick b where there is information that a child sustained a physical injury resulting from abuse and/or neglect prior to this investigation, based on credible information from the child, carer or others Where there is information of prior substantiated physical abuse of a child tick c

CURRENT INVESTIGATION i.e. CURRENT INITIAL ASSESSMENT

Question 6 Case classification at end IA
Tick the classification recorded at the end of the IA Record

7 Number of children involved in the case
Tick a or b. Count the number of children less than 18 years of age, in the household, for whom abuse or welfare concerns exist in the current IA. If a child is brought into care as a result of the current IA count the child as residing in the household.

8 Parent or carer assessment of the child
Tick a or b Identify whether the primary career is supportive of the child in this incident or blames the child for the incident. Blaming the child for the incident refers to the caregiver's statement that the maltreatment incident occurred because of the child's action or inaction (e.g., claiming that the child seduced him/her or the child deserved beating because he/she misbehaved). Where there is no information about this, tick a

FAMILY CHARACTERISTICS

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Question 9 Age of the youngest child in the home

Tick a or b.

Identify the current age of the youngest child presently in the household where the maltreatment incident reportedly occurred. If a child is removed as a result of the current investigation, count the child as residing in the household.

Question 10 Characteristics of children in the household
One or more with

Where there is no mention of any difficulties for any children in the household tick a. no mention

Otherwise tick all that apply.

Identify whether there is a record of any child in the household having a developmental, learning, and/or physical disability; is diagnosed as medically fragile or failure to thrive; or has mental health and/or behavioural issues. Base identification on credible information from a carer that a child has been diagnosed, statements from a physician or mental health professional, or review of records.

Tick all that apply

- Mental health or behavioural problems. Any child in the household has mental health or behavioural problems not related to a physical or developmental disability. This could be indicated by a diagnosis made by a mental health professional in an area that impacts daily functioning, receiving mental health treatment, attendance in a special classroom because of behavioural problems, or if the child is currently taking prescribed psychoactive medications

- Developmental disability. A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include mental retardation, autism spectrum disorders, and cerebral palsy.

- Learning disability. Child has learning support or is diagnosed as needing supports following assessment to address a learning problem such as dyslexia. Do not include an supports allocated solely to address mental health or behavioural problems. Also include a child with a learning disability diagnosed by a physician or mental health professional who is eligible for learning support but does not yet have one, or who is in preschool.

- Physical disability. A severe, acute, or chronic condition diagnosed by a physician that impairs mobility, sensory, or motor functions. Examples include paralysis, amputation , and blindness

- Medically fragile or failure to thrive:
- "*Medically fragile*" describes a child who has any condition diagnosed by a physician that can become unstable and change abruptly, resulting in a life-threatening situation; AND that requires daily, on-going medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members; AND that requires the routine use of a medical device or assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living; AND the child lives with an on-going threat to his/her continued well-being. Examples include a child who requires a trach-vent for breathing or a g-tube for eating.

- Failure to thrive: A diagnosis of failure to thrive by a medical professional.

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Question 11 Housing

Tick a or b.
Where there is no mention of housing tick a.
If b tick all that apply.

Physically unsafe: The housing situation is classified physically unsafe when it does not meet the health or safety needs of the child (e.g., exposed wiring, inoperable heat or plumbing, roach/rat infestations, human/animal waste on floors, rotting food)

Homeless; The family is homeless or was about to be evicted at the time the investigation began or the family becomes homeless/receives an eviction notice by the time the risk assessment is completed. Consider as "homeless" people who are living in a shelter and those living on a short-term basis with relatives or friends.

Question 12 Incidents of domestic violence in the household in the past year

Tick a or b.

Identify whether there has been domestic violence in the household in the past year. Identification may be based on a credible report from the carer(s), police reports, or other records.

Choose "a" if, in the previous year, there has been one domestic violence incident or no domestic violence has occurred in the household or if there is no mention of domestic violence.

Choose "b" if in the previous year, there have been two or more physical assaults or multiple periods of intimidation/threats/harassment in the household between caregivers or between a **carer and another adult.**

Question 13 Carer disciplinary practice

Tick a or b
Identify the disciplinary practices of the primary caregiver of the child in the household.
a. Choose "a" if the primary caregiver employs appropriate discipline or if there is no information about disciplinary practice

b. Choose "b" if the primary caregiver employs excessive/inappropriate discipline.

Include excessively harsh physical or emotional disciplinary practices that caused or threatened harm to the child and/or were inappropriate given the child's age or development.

Do not choose "b" if the actions of the caregiver that have caused harm or injury **bear no resemblance to discipline.**

Question 14 Carers' history of abuse or welfare as a child

Tick a or b.

Identify whether either carer was maltreated as a child or known to CPW. Maltreatment includes neglect or physical, sexual, or emotional abuse or welfare concerns.

a. Choose "a" if there are no credible statements by the primary or secondary carer or others, or CPW records of past allegations, that indicate either caregiver was maltreated as a child or involved with CPW as a child.
Choose a where there is no mention that a parent or carer was involved with the CPW as a child or was maltreated as a child.

b. Choose "b" if there are credible statements by the primary or secondary carer or others, or CPW records, that indicate either caregiver was maltreated as a child or involved with CPW as a child.

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Question 15 Carers mental health

Tick a OR b OR c.

a. Choose "a" if the primary and secondary (if present) caregivers do not have past or current mental health problems or if there is no mention of carer's having mental health problems.

b. Choose "b" if credible and/or verifiable statements by the primary and/or secondary caregiver or others indicate that the primary and/or secondary caregiver:

- Has been diagnosed as having a significant mental health disorder that impacts daily functioning, as determined by a mental health professional; OR
- Has had repeated referrals for mental health/psychological evaluations; OR
- Was recommended for treatment/hospitalization or treated/hospitalized for emotional problems.

c choose c if the identified mental health problem (as described above) was present prior to the last 12 months before this referral

Question 16 Parent or carer alcohol and or drug use

Tick a or b.

AND

Tick the box ❑for alcohol and/or drug use as appropriate

Identify the primary and secondary (if present) carers' alcohol and/or drug use, both current and historical, and whether it interferes or has interfered with family functioning.
a. Choose "a" if the primary or secondary caregiver does not have and never has had a drug or alcohol problem that interferes with family functioning.
Choose a. if there is no mention that a carer has an alcohol or drug problem that interferes with family functioning.

b. Choose "b" if the primary or secondary caregiver has *past* or current alcohol and/or drug use that interferes with his/her or the family's functioning. Such interference is evidenced by:

- Substance use that affects or affected employment, criminal involvement, or marital or family relationships; and/or that affects or affected caregiver's ability to provide protection, supervision, and care for the child;
- An arrest in the past two years for driving under the influence (DUI) or refusing breathalyzer testing;
- Self-report of a problem;
- Treatment received currently or in the past;
- Multiple positive urine samples;
- Health/medical problems resulting from substance use and/or abuse; or
- The child's diagnosis with foetal alcohol syndrome or exposure, or the child's positive toxicology screen at birth and the primary caregiver was the birth parent.

Choose c if the carers prior alcohol and or drug use interred with family functioning sometime prior to the 12 months preceding the referral for this IA

17 Parent or carer has criminal arrest history (arrest by Gardaí and/or crime or prison)

Indicate whether either the primary or secondary caregiver has a criminal arrest history prior to the current complaint as either an adult or a juvenile. This includes DUIs but excludes all other traffic offenses.
Information may be located in the case narrative material, reports from other agencies, self-report.

a. Choose "a" if carers have no criminal arrests prior to the referral for this IA or if there is no mention of criminal arrest history.

b. Choose "b" if either caregiver has one or more criminal arrests prior to the current complaint.

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SCORED RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse indices, using the following chart.

Neglect Score	Abuse Score	Scored Risk Level
○ 0–2	○ 0–1	○ Low
○ 3–5	○ 2–4	○ Moderate
○ 6–8	○ 5–7	○ High
○ 9 +	○ 8 +	○ Very high

OVERRIDES

Policy Overrides. Select yes if a condition shown below is applicable in this case. If any condition is applicable, override the final risk level to very high.

○ Yes ○ No 1. Sexual abuse case AND the perpetrator is likely to have access to the child.
○ Yes ○ No 2. Non-accidental injury to a child under age 2.
○ Yes ○ No 3. Severe non-accidental injury.
○ Yes ○ No 4. Caregiver action or inaction resulted in the death of a child due to abuse or neglect (previous or current).

Discretionary Override. If a discretionary override is made, select yes, increase risk by one level, and indicate reason.

○ Yes ○ No 5. If yes, override risk level (select one): ○ Moderate ○ High ○ Very High

Discretionary override reason: _____

Supervisor's Review/Approval of Discretionary Override: _____ Date: _____

FINAL RISK LEVEL *(select final level assigned)*: ○ Low ○ Moderate ○ High ○ Very high

RECOMMENDED DECISION

Final Risk Level	Recommendation
Low	Do not promote*
Moderate	Do not promote*
High	Promote
Very high	Promote

*Unless there are unresolved safety threats.

PLANNED ACTION

○ Promote
○ Do not promote

If recommended decision and planned action do not match, explain why:

_____

_____

Not for Distribution

Child abuse and welfare related Initial Assessments opened for ongoing service based on the CA SDM©FRA risk designation and recommended action

	Promoted for service n=206, 42.5%			Univariable	
Characteristics	Number	%	X^2, *p*	IRR (95% CI)	χ2 p
Prior welfare or neglect				1.43 (1.28, 1.61)	0.000
Prior abuse				1.47 (1.32, 1.64)	0.000
Prior initial assessment or ongoing service				1.65 (1.45, 1.87)	0.000
Prior injury to child				1.68 (0.79, 1.71)	0.429
Primary report type				0.73 (0.52, 1.03)	0.606
Four or more children in family				1.69 (1.35, 2.12)	0.000
Parent blames the child				1.89 (1.49, 2.41)	0.000
Youngest child in family under 2 years				2.23 (1.82, 2.75)	0.000
At least one child functioning difficulty				1.82 (1.43, 2.31)	0.001
Housing concern				1.80 (1.44, 2.24)	0.000
Two or more DV incidents in past year				1.54 (1.19, 1.99)	0.009
Carer employs excessive / inappropriate discipline				1.77 (1.37, 2.28)	0.000
Carer involved with CPW in childhood				2.42 (1.99, 2.94)	0.000
Carer mental health issues				1.76 (1.42, 2.19)	0.000
Carer substance misuse				1.52 (1.22, 1.90)	0.002
Carer criminal arrest history				1.38 (1.03, 1.84)	0.029

Appendix 7 Research output, dissemination, training, and collaborations

Appendix 7 Research output, dissemination, training and collaborations

Academic publications

2023 O'Leary D. and Lyons, O.[e] Exploring the potential of administrative data for understanding and advancing child protection and family support policy, practice and research in Ireland**,** *Irish Journal of Applied Social Studies*: Vol. 22: Iss. 1, Article 5.

2022 `O'Leary D., Who gets child protection and welfare services and why? *The Boolean: Snapshots of Doctoral Research at University College Cork*

2020 O'Leary D. and Lyons, O.[e] Examining the Prospects for Developing a National Child Maltreatment Surveillance System in Ireland. *International Journal on Child Maltreatment: Research, Policy and Practice*, 1-23.

2016 O'Leary, D. Book Review: Mary Daly and Grace Kelly Families and Poverty: Everyday Life on a Low Income. *Critical Social Policy*, *36*(1), 153–154. https://doi.org/10.1177/0261018315616208

Peer reviewed conference presentations

2022 'It depends what's open on the day!' Insights from empirical research into assessments and decisions for service delivery in child protection and welfare. *ISPCAN European Congress, Tallinn Estonia 14th June 2022*

2022 A cross-sectional profile of children and families undergoing Initial Assessment in the Irish Child Protection and Welfare service in 2016 *ISPCAN European Congress, Tallinn Estonia 14th June 2022*

2022 *'It depends what's open on the day!'* Insights from empirical research into assessments and decisions for service delivery in child protection and welfare social work. *College of Arts, Celtic Studies and Social Studies, Postgraduate Conference, University College Cork (online) 22 February 2022*

2021 O'Leary D, Lyons O.[e], Examining the prospects for developing a child maltreatment surveillance system in Ireland *8th National Child Protection and Welfare Social Work Conference UCC, Revitalising child protection and welfare social work: innovations, hope, and community, Ireland (online) 22nd October 2021*

2021 O'Leary D, Lyons O.[e], Examining the prospects for developing a child maltreatment surveillance system in Ireland *ISPCAN European Congress Module 1: An Overview of Child Maltreatment Data Collection" Milan Italy (online) 8th April 2021*.

2020 Risk assessment, decision making and case pathways in child protection: Design and methodology for a mixed methods prospective cohort study *Interdisciplinary Research on Adverse Childhood Experiences: Implications for Health and Social Care, A research day at University College Cork*, Ireland, 9th January 2020

2019 O'Leary D.,[a] Christie, A.,[b] Perry, I., [c] McCormack C.,[a] Gibbons, M., [a] McGregor, C.[d] Decision Making in Child Protection and Welfare Intake (Duty) and Initial Assessment: Two Studies Examining Influences within the Ecological Framework. *7th National Child Protection and Welfare Social Work Conference, University College Cork*, Ireland. 25th October 2019

2017 O'Leary, D.[a] Christie, A.[b] and Perry I.J.,[c] Exploring substantiation and decision making in a prospective study of risk assessment and decisions during Initial Assessment: some findings from Wave 1. *6th National child protection and welfare social work conference: Future Directions for Child Protection and Welfare: Where to and Why? 27th October 2017.*

2016 O'Leary, D., Christie, A., Perry I.J. "This is Your Pilot Speaking!" Choosing methodology for prospective research on assessment and decision making in child protection and welfare *4th International Decisions, Assessment, Risk and Evidence in Social Work Symposium, Belfast, July 2016*

2016 "This is your pilot speaking!": Choosing the methodology for a prospective study of risk assessment and decision-making. *PhD Symposium 2016 – At the forefront of Contemporary Research with Children and Young People in Ireland, National University of Ireland Mayooth, 6th September 2016*

a Tusla Child and Family Agency
b School of Applied Social Studies, University College Cork
c School of Public Health, University College Cork
d National University of Ireland Galway
e Factor Inwantesh Faculty of Social Work, University of Toronto, Canada

Workshop and seminar

2021 Data Regulation and Data Privacy in Europe: Issues for research on assessment and decision making in child protection. *10th European Conference for Social Work Research (ECSWR 2021) DARSIG Pre-Conference Event on Legal and organizational aspects of decision making. Bucharest (online) 5th May 2021*

2018 Workshop: Mixing Methods: Quantitizing Qualitative data for the Integration to a Multilevel Model of Risk Assessment and Decision Making in Child Protection Social Work, *5th International DARE Symposium, Belfast 2-3 July 2018.*

Poster presentation

2016 'This is Your Pilot Speaking!' Establishing the methodology for a prospective longitudinal study of risk assessment and decision making, for short and long-term outcomes in child protection and welfare cases. *XIV International Conference EUSARF 2016: Shaping the Future. Oviedo, Asturias, Spain, 13th -16th September 2016*

Training and workshops undertaken

2022 Odyssey Workshop, Mary Kate O'Regan, University College Cork (online) 19-20 May 2022.

2020 Kempe Interdisciplinary Research Institute, Denver, Colorado (online) July-August 2020
Course 2: Challenges in Child Maltreatment Research
Course 3: Child Abuse & Neglect Prevention Research Through a Public Health Lens

2019 Mixed-Method Synthesis Training. Evidence Synthesis Ireland and Cochrane Ireland. National University of Ireland Galway. November 2019

2016 A pre-conference for PhD-candidates at the XIV International Conference, European Scientific Association on Residential & Family Care for Children and Adolescents (EUSARF) 2016: Shaping the Future, Oviedo, Spain. 13th September 2016

2016 PG6008 Qualitative Data Analysis Software (NVivo) Training. Prof. Brendan Dooley, University College Cork.

2015 ST 6012: Survival Analysis. Dr Tony Fitzgerald, University College Cork

2015 ST6011 Advanced Biostatistics, Dr Tony Fitzgerald, University College Cork

Active working group membership

2020-2022 Decisions Assessment and Risk Special Interest Group of the European Social Work Research Association

2022 Multi-Sectoral Responses to Child Abuse and Neglect in Europe (**Euro-CAN**)
WG 1- Definition and operationalisation of child maltreatment
WG2 - Promoting secondary analyses

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Issue 1 *Sustaining parental well-being at individual, family and societal levels*

2023-01-23

Exploring the potential of administrative data for understanding and advancing child protection and family support policy, practice and research in Ireland

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Exploring the potential of administrative data for understanding and advancing child protection and family support policy, practice and research in Ireland

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Abstract

It is generally understood that administrative data at the level of the individual, family and wider population is fundamental to delivering client centred services which aim to support families and respond to and reduce child abuse. Such data is valuable to policy makers and practitioners and plays an important role in research. The focus of this paper is the potential use of administrative data from statutory family support and child protection and welfare services in Ireland for policy, practice and research. In the context of an evolving legislative and policy framework in Ireland, we provide an overview of the statutory family support and child protection services provided by Tusla, Ireland's Child and Family Agency. We suggest that this context provides an exceptional opportunity for developing administrative data sets in child protection and welfare and in family support. The benefits and challenges of developing such administrative data sets are discussed. The paper concludes with recommendations for developing and linking administrative data sets to better understand and respond to the needs of children and families presenting to the services.

Introduction

Administrative data refers to data routinely collected by public agencies in their administration of services. Specifically, in Child Protection and Welfare (CPW) and Family Support (FS), administrative data can include information such as demographic characteristics of a child and family, case characteristics, details of referral, service needs and outcomes. In CPW it is widely acknowledged that such data is fundamental to delivering client centred services which aim to reduce maltreatment recurrence and serves as a foundation to improving CPW and social care services (Brownell and Jutte, 2013; Drake and Jonson-Reid, 1999; Fallon et al., 2017; Fluke et al., 2020; Jud et al., 2013; UNICEF, 2020). Therefore, administrative data is central to public health and rights based policies and approaches and could reduce the incidence of child abuse and enhance preventive services (Sethi et al., 2013). While not collected solely for research purposes, anonymised administrative data is a concise way of obtaining data related to the scope and nature of difficulties experienced by families. In addition, gathering anonymised administration data can be used to inform State agencies on the incidence of child abuse referrals (Allnatt et al., 2022; Brownell and Jutte, 2013). Furthermore, such data is already available from a case management perspective and therefore does not create a time or resource burden as it involves extraction of data as opposed to creating a new data system. Most importantly having access to comprehensive administrative data sets means that children and

adults do not have to be questioned repeatedly for this information. In addition, staff are not burdened with completing paperwork, survey tools or interviews to capture such information.

Administrative data sets can be anonymised reducing ethical concerns regarding their re-use (Allnatt et al., 2022; Lee et al., 2022). Across the four nations of the UK, the Departments for Education collate anonymised individual-level administrative data sets relating to Children in Need and Children Looked After by local authorities. The data sets are those that local authorities are obliged to compile and submit to Government and are the basis for calculating aggregate data and statistics published annually. The anonymised data sets can be accessed by researchers following a permissions process (Scourfield et al., 2019). In addition, under a programme called Administrative Data Research UK (ADR UK) devised with the Office for National Statistics (ONS), Government established regional centres across the four nations of the UK each with a dedicated centre and team, focusing on research using administrative data from a range of sectors. Each of these centres hosts the Children in Need and Children Looked After data sets and prior to being included within datasets, individual records are assigned an Anonymous Linking Field (ALF) based on an encryption of an individual's health service number to facilitates linkage with other national datasets. Each centre is using the data sets to provide cohort profiles or by linking the data with other social, health and administrative to investigate patterns in service delivery and long-term effects of exposure to risks and adversities in childhood (Emmott et al., 2019; Lee et al, 2022; Allnatt et al., 2022).

When administrative data sets are linked, their potential benefits are enhanced. Linked administrative data sets provide opportunities to develop more complete perspectives of children and families involved with services, increase the likelihood of identifying those served by multiple services and can be used to analyse and evaluate participation across services and sectors (Allnatt et al., 2022; Broadhurst et al., 2021; Cuccaro-Alamin et al., 2021; Foust et al., 2021; Johnson et al., 2020). The data can be used to measure demand, evaluate policies and inform further developments, thus contributing to rights-based and public health-based approaches to prevention and intervention (Fallon et al., 2017; Soneson et all., 2022). When systematically and regularly collated, administrative data can be used longitudinally to generate trend analysis as well as policy analysis (Emmott et al., 2019; Hurren et al., 2017; McGhee, et al., 2015; O'Leary et al., 2015).

The development of common data sets by different countries enables comparison of national data and facilitates collaboration between Governments to enhance child and family wellbeing. At European level several initiatives have taken place to improve data collection for research purposes (Ntinapogias et al., 2015). Central to these initiatives is the understanding that nationally representative, multisectoral, disaggregated data is essential to identify trends, measure responses, identify gaps in service provision, determine the effectiveness of services and inform policy development (Euro-CAN COST Action, 2022; Meinck et al., 2016; Daly et al., 2015; Jud et al., 2015; Ntinapogias et al., 2015; Sethi et al 2013). Due to differences in policies and administrative data across countries, mechanisms promoted include population or agency surveys for child abuse and neglect using standardised methodology across European countries and across different sectors, services and professional specialties within countries (see O'Leary and Lyons, 2021; Ntinapogias et al., 2015; Jud et al., 2015) and projects in which Ireland has representation, aimed at coordinating and enabling analysis of survey data and administrative data that are routinely collected by state's agencies (Euro-CAN COST Action, 2022).

The absence of service related child and family based data severely limits informed policy and service planning (Foust et al., 2021; Herron et al., 2022; Jud et al., 2015; O'Leary, 2022). According to Foust et al. (2021) it prevents an accurate assessment of root causes of service need and outcomes, limits the identification of those who stand to benefit from the services and restricts the ability to track participants over time. These challenges complicate efforts to evaluate the efficacy and impact of CPW and FS policies and services and more equitably prioritise service improvements (Drake and Jonson-Reid, 1999; Fallon et al., 2017; Foust et al., 2021; Malone and Canavan, 2018, 2021). The resulting lack of transparency compromises aspirations for rights-based and public-health based service provision and prevention efforts.

Drawing on current legislative and policy developments in Ireland, this paper discusses the potential for developing and linking administrative data sets in CPW and in FS. The paper builds on a previous publication that examined prospects for developing a national child maltreatment surveillance system in Ireland (O'Leary and Lyons, 2021). In this paper the authors recognise the necessity for complementary survey and administrative data systems which together would enhance the evidence base for supporting children and families in ways that are effective in responding to needs and which are sustainable. This paper maintains that such developments would build on existing commitments to data collection and advances in the infrastructure and regulatory frameworks. Moreover, this represents a unique and timely opportunity to develop individual-level administrative datasets relating to children and families involved with statutory CPW and FS services in Ireland.

Irish CPW and FS services

In Ireland, Tusla, the Child and Family Agency, is the dedicated State agency responsible for improving wellbeing and outcomes for children and providing family support. The current framework for child and family services within Tusla is based on a continuum of responses that encompass Prevention, Partnership and Family Support (PPFS) services and CPW. PPFS provides a suite of targeted preventative and early intervention services for families with additional needs who require multi-agency intervention, but who do not meet the threshold for referral to the CPW services in accordance with national policies (DCYA, 2017; Tusla, 2013). Reporting of child abuse is mandatory for professionals designated in the national policy (DCYA, 2017). The statutory CPW service is a professional social work driven service that provides safety planning focused on CPW, and incorporates alternative care and permanency planning (Tusla, 2017). The framework for practice relies on the assumption of intersection between PPFS and CPW as services are designed to ensure consistent and integrated pathways that ensure intervention in a preventative and timely manner to support the child and family's needs and enhance the family's ability to meet those needs (Tusla, 2021c; 2022a).

In relation to FS and CPW specifically, wide-ranging evaluations were commissioned by Tusla to examine the implementation and streamlining of the current programme and framework for delivering the PPFS (Malone and Canavan, 2018; Shaw and Canavan, 2018). The evaluations identified positive effects of PPFS on the lives of parents and children involved and found that PPFS was culturally embedded within Tusla (Malone and Canavan, 2018). The review identified the need for better integration between early intervention and prevention services (delivered through interventions called Meitheal and through Child and Family Support Networks) and CPW services (Malone and Canavan, 2018). The researchers concluded also that effective prevention services aimed at achieving improved outcomes for families, children and young people requires integration and collaboration across state departments and professional sectors including health, mental health, disability and education (Canavan et al.,

2019; Malone and Canavan, 2021; Rodriguez et al., 2018). Shortcomings were identified in relation to data, analysis, and on outcomes and evidence frameworks (Malone and Canavan, 2018; Rodriguez et al., 2018).

In CPW, developments in service design in recent years have focused on the standardisation of policies and practices across service areas with a view to delivering consistent and integrated responses to children and families (Tusla, 2021c). In 2019, Tusla adopted Signs of Safety as the national approach to CPW practice (Burns and McGregor, 2019; Turnell and Murphy, 2017; Tusla, 2021a) replacing policies based on the Framework for the Assessment of Children in Need and their Families (Department of Health, 2000; HSE/Tusla, 2009/2014). Since 2021, all CPW services use a single integrated information system to manage child protection and welfare cases, the National Child Care Information System (NCCIS), which systematically captures critical data on children who are the subject of a CPW referral, including children in care (HSE/Tusla, 2009/2014; Tusla, 2021a). That system is being enhanced through the development of a new Tusla Case Management System which has been designed to support management of all Tusla services with a view to improving capability, quality and efficiency through improved sharing of information between relevant professionals (Tusla, 2020). Tusla has established processes for improving the quality of data it maintains by developing procedures for measuring, monitoring and reporting conformance to prescribed data quality standards and implementing continuous data improvement (Tusla, 2020).

It is widely accepted that different types of data collection are required to understand the nature and scope of child abuse and family support needs in order to inform these systems of prevention and intervention (Canavan et al., 2019; Fluke et al., 2020; Shaw et al., 2016; UNICEF, 2020). Researchers and those involved in public service provision have been advocating for the systematic development and use of individual-level administrative data-sets to inform policies for families and children in Ireland across a range of domains including FS (Rodriguez et al., 2018), intersections between FS and CPW (Malone and Canavan, 2021), CPW (Furey and Canavan, 2019; O' Leary, 2022; O'Leary and Lyons, 2021; Sethi et al., 2013), services for children and young people (Herron et al., 2022) and homelessness (Culhane, 2016).

Commentators have long expressed concerns that statistics relating to Irish CPW services provide very little scope for analysis of demand and responses within the system or for examining the efficacy of the service in delivering its intended aims (Buckley, 2003, 2012, 2017; Buckley and Burns, 2015; Buckley et al., 2010; Burns and MacCarthy, 2012; Ferguson and O'Reilly, 2001; O'Leary et al., 2013; Ombudsman for Children's Office, 2010; Thorpe, 1997). In 2019, Tusla commissioned a study which examined Irelands' data collection relative to other jurisdictions, which found many similarities across jurisdictions but identified several gaps and made recommendations to improve demographic data e.g. expansion of the classifications of abuse (Furey and Canavan, 2019). Gaps in the evidence base include a lack of evidence on the demographic characteristics of those involved with services, the scope and nature of presenting problems, the prevalence of abuse and reasons for decisions made, outcomes and service pathways (Buckley and Burns, 2015; Furey and Canavan, 2019; O'Leary, 2022b; O'Leary and Lyons, 2021; Whelan, 2018).

From a theoretical perspective, the design of the statutory FS services through PPFS has been characterised as fitting within public health approaches to prevention due to the universal acceptance that prevention and early intervention are essential for support and protection (Canavan et al., 2019). Others argue that statutory services for FS are characterised as high-risk strategies due to the focus on targeted interventions for vulnerable or at-risk communities

as well as those already in the system (Daly et al., 2015). This is true of the Irish CPW service delivery model which is similar to other Anglophone systems (see O'Leary and Lyons, 2021). There is ample evidence that such strategies respond to a minority of those who experience abuse and difficulties at the family level and that they can reinforce social inequalities in populations because they ignore underlying structural factors and focus on individual responsibility (Featherstone et al., 2014; Lonne et al., 2022; Parton, 2019). However, these strategies are essential in providing services to the populations they serve and as such, there is a moral imperative to demonstrate the scope and nature of demand and responses through the maintenance of individual-administrative data sets which is the central focus of this paper.

In CPW, a recent body of research evidence is beginning to paint a picture of the categorisation and handling of referrals (Whelan, 2018), cases open for child protection and welfare investigations within the child protection agency (Buckley and Whelan, 2018; O' Leary, 2022; O'Leary, 2022a) and longitudinal perspectives on children in state care (O'Leary et al., 2015). The studies provide evidence of the richness of data that is required to be collected by social workers to support decision-making and case-management. Most of this data remains within case records and management systems, but represents a valuable source of information that can be harnessed to conduct meaningful research and evaluation on practice, policy, and the efficacy of the CPW service in responding to the needs of children and families involved (O' Leary, 2022; O'Leary, 2022a; O'Leary and Lyons, 2021; Shaw et al., 2016; Whelan, 2018). However, as the next section describes, advances are being made both in the legislative and policy framework to enhance opportunities for research using administrative data.

The evolving data policy framework in Ireland

A review of current CPW and FS policies finds a common interest in further developing data and evidence to advance policy and improve outcomes for children and families. Under the auspices of the World Health Organisation (WHO) Regional Committee for Europe, the Irish Government has pledged a rights-based and public health approach to reducing the prevalence of child maltreatment (Sethi et al., 2013). This necessitates the development of a systematic system to monitor the prevalence of child abuse in Ireland, which could complement the current high-risk, referral and investigation-oriented approach to prevention (O'Leary and Lyons, 2021).

Recent public and government wide consultations led by the Department for Children Equality, Disability, Integration and Youth (DCEDIY) point to the need for better data collection and sharing among state agencies. The first, the Report of Public Consultation on Ireland's Combined Fifth and Sixth Report to the UN Committee on the Rights of the Child, identified the need for more data collection and data sharing in various sectors generally (DCEDIY, 2021). The second, a Report on the Public Consultation on a New Policy Framework for Children and Young People, specifically identified the need to address the dearth of data related to child abuse/maltreatment and causality data to inform robust prevention and early intervention strategies and polices (Herron et al., 2022).

The Irish Government is currently revising its national policy framework for children and young people. It is envisaged that it will incorporate the priorities set out in the EU's Strategy on the Rights of the Child 2021-2024 and the Council of Europe's Strategy for the Rights of the Child 2022-2027 (Herron et al., 2022). It is anticipated that the framework will also provide for Government departments to work collaboratively with statutory agencies and services, and the community and voluntary sectors to achieve the national outcomes established in a previous

strategy, Better Outcomes, Brighter Futures (DCYA, 2014; Herron et al., 2022). Of note, that previous strategy committed to improve data collection to ensure that the lives of children and their families are better understood (DCYA, 2014). Tusla's current Child Protection and Welfare Strategy 2017-2022 (Tusla, 2017a) highlights the necessity of measuring the work it delivers. The strategy advocates using information to build better and more effective services while being cognisant of consistency and quality in the delivery of well-managed services and effective partnerships with those working to keep children safe from harm (Tusla, 2017a).

DCEDIY has also developed a National Model of Parenting Support Services (DCEDIY, 2022b). The model is premised on the understanding that one of the most effective ways of supporting children is by supporting their parents as reflected in Government duties under the UN Convention on the Rights of the Child and the UN Convention on the Rights of People with Disabilities (DCEDIY, 2022b). The Model promotes a more coherent and strategic approach to developing and delivering parenting support services through collaborative working, cohesive planning and service delivery and establishing a cross-government network to share learning and showcase best practice across the civil and public service. The Model identified a general lack of data on demand for, availability of, outputs and outcomes of parenting support services leading to challenges in comparing the level of need with the level of funding, types of services, and quantity of parenting supports available across different areas (DCEDIY, 2022b). A steering group was established to promote a standardised, cross-sector collection of parenting support activity and outcomes data. However, the mechanisms that would deliver this data are not described in the Model (DCEDIY, 2022b). The current Government strategy on domestic and gender based violence (the Third National Domestic, Sexual and Gender-Based Violence Strategy) calls for a range of data collection strategies including the identification of current gaps in individual-level data and potential data linkage relating to children and adults impacted by policies across government departments (Doyle et al., 2021; FRA, 2014; Government of Ireland, 2022a, 2022b).

Government's Public Service Data Strategy 2019-2023 (DPER, 2019b) and Tusla's Data Management Strategy (Tusla, 2020) espouse the centrality of valid and accessible data to support informed service provision, decision making, policy development, research and accountability and the importance of improved data management, governance and architecture to deliver such quality data (DPER, 2019b; Tusla, 2020). In recent years, the Irish child protection service has invested significantly in improving the data produced and published relating to child protection referrals and the processing of cases (Tulsa, 2020). Building on these developments, the current data management strategy aims to ensure that data captured by Tusla serves the data and information needs of all stakeholders in delivering better outcomes for children, young people, families and communities (Tusla, 2020).

There have been substantial developments in the production of interactive aggregate statistics related to performance activity data for CPW and FS services in Ireland (Tusla, 2022b). In 2022, the Irish Government commissioned a research and data projects on children in care and adults who were in care as children (DCEDIY, 2022a) to respond to a gap in longitudinal research with young people leaving care (Ryan, 2009; Whelan and Smyth, 2022). One aspect of the research is the recent establishment of a joint initiative on Data Linking between Tusla, the Child and Family Agency and the Central Statistics Office (CSO) in Ireland which will facilitate the linking of children in care and school attendance data held by Tusla, with educational data held in the Administrative Data Centre in the CSO (Whelan and Smyth, 2022). The study aims to develop insights into participation in education by child in care of the state.

Currently, that anonymised administrative data that will only be available for analysis by statisticians in CSO.

Simultaneously there have been advances in the legislative and regulatory environment relating to data privacy and data sharing and improvements in relation to electronic record maintenance within Tusla (DPER, 2019a, 2019b; EP and CEU, 2016; HSE/Tusla, 2009/2014; Tusla, 2020, 2021b). National and international advances in privacy protections, data security, infrastructure, governance structures and technological innovations mean that administrative data, previously protected from release, can now be made safe for secondary analysis in ways that are consistent with data regulations and statutory guidelines for child protection and FS (Allnatt et al., 2022; Brownell and Jutte, 2013; Culhane, 2016; Culhane et al., 2017; Department of Health, 1991; EP and CEU, 2016; Lee et al., 2022; Scourfield et al., 2019). Lastly, the Health Information and Quality Authority, the independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public in Ireland, is currently revising existing standards for information management for national health and social care data collections (HIQA, 2017; HIQA 2022). These provisions and learning from the current data project between DCEDIY, Tusla and CSO (Whelan and Smyth, 2022) could pave the way to systematically make administrative data available through dedicated research hubs such as those in the UK.

Challenges and opportunities in developing administrative datasets

Scaling up systems to develop and systematically maintain administrative data sets can be challenging. Lessons learned during the development of anonymised data sets serve as resources to address such challenges. As detailed above, the legislative and regulatory frameworks for data protection and research are evolving and this can pose challenges in terms of designing anonymised data sets (Jones et al., 2019). Furthermore, such regulations can be interpreted by gatekeepers in ways that hinder research (Clarke et al., 2019; Jones et al., 2017). Those developing the SAIL databank in Wales recommend seeking legal advice to ensure that data protection policies are up to date and comprehensive (Jones et al., 2019). Similarly, ever changing policies for FS and CPW generate methodological challenges related to definitions and the interpretation and classification of presenting characteristics (Fallon et al., 2017; Fallon et al., 2010). But some of these challenges can be countered by providing time and resources to develop deep understanding and clarity about how practitioners record and code information (Green et al., 2015). While administrative data by its nature is readily available, it may be inconsistently maintained and it may be missing important variables (Allnatt et al., 2022; Drake and Jonson-Reid, 1999; Green et al., 2015; Scott and Faulkner, 2019; Soneson et al., 2022). When linking data sets, quality issues related to each individual set and variations in data structure and format can pose challenges for interoperability (Harron et al., 2017).

The administrative data generated by individual FS and CPW systems may contain biases relating to reporting, identification and response policies (Lonne et al., 2022; Shaw et al., 2016). Due to the potential of the data being fundamentally skewed, it can produce inaccurate predictions of risk and need and when linked with administrative data from other service domains such as education, welfare, disability, youth policy, health and justice, analytic models that are produced can threaten individual and group rights to non-discrimination (Keddell, 2014, 2019; Lonne et al., 2022). Others argue that when administrative data sets are accurate and large enough, they can include benefits such as breaking down silos, creating large and unbiased samples of populations involved with services, objective measures, comprehensive

long-term follow-up, continuous data collection, and relatively low expense (Brownell and Jutte, 2013; Cuccaro-Alamin et al., 2021). They can allow comparison across sub-groups and minority groups and facilitate analysis of service provision and outcomes (Soneson et al., 2022). However, concerns about biases can be offset by combining the evidence generated from analysis of linked individual level- administrative data with data and evidence from policies that incorporate rights-based, public health or social justice approaches which are not stigmatising and focus on alleviating the burden of suffering in the entire population (O'Leary and Lyons, 2021; Daly et al., 2015; Featherstone et al., 2014; Perry, 2009; Reading et al., 2009; Sethi et al., 2013). Such combined approaches are the basis of policies that address the continuum from universal to high-risk responses and which incorporate theoretical tensions based on collectivist or individualist approaches (Daly et al., 2015; Gray and Schubert, 2019; Parton, 2019; Perry, 2009). Current Irish Government FS and CPW strategies and policies could be read as an opportunity to develop just such a response.

Jones et al.. (2019) note the importance of public engagement to develop public trust in anonymised data sets because public views about data sharing are complex. This principle is central to the Irish governments current data legislation and strategy (DPER, 2019a, 2019b). As administrative data sets were not initially designed for research, they require considerable manipulation and statistical expertise to prepare them for analysis and research (Allnatt et al., 2022;. Brownell and. Jutte, 2013; Green et al., 2015). However, they are of benefit in responding to longstanding deficits in the evidence base (Hurren et al., 2017. Researchers note the necessity of funded cross-disciplinary teams to work on data preparation, technical supports, data analysis and research design and capacity building (Foust et al., 2021; Jones et al., 2019; Jud et al., 2015).

Concluding comments

The framework for the delivery of statutory FS and CWP service delivery encompasses public health and rights-based approaches through a continuum of services which recognise the inseparable links between children's circumstances and family's experiences. These approaches focus on underlying determinants of risk and need which in turn necessitate the maintenance of disaggregated administrative data for purposes of analysis. In Ireland, most of the data collected by individual statutory social workers and FS workers remains unused beyond individual case management. This paper described the opportunities and challenges for developing large-scale data sets for research and policy making in CPW and FS. An examination of the current Irish child protection and welfare and family support and data management policies outlined how individually and collectively they espouse the centrality of valid and accessible data to support informed service provision, decision making, policy development, research and accountability. It is our view that these policies, as they build on existing commitments to data collection and advances in the infrastructure and regulatory frameworks, represent a unique and timely opportunity to develop individual-level administrative data sets relating to children and families involved with statutory CPW and FS services. It is our hope and our recommendation that the commitments relating to data will be resourced to systematically develop administrative data sets for research purposes relating to children and families involved with CPW and FS in Ireland. Furthermore, it is recommended that a partnership model is realised to create dedicated multidisciplinary research hubs involving collaboration between Government and state agencies such as Tusla, Central Statistics Office and university partners. Doing so will enable an understanding of service demand and responses, facilitate research to evaluate current polices and inform future

developments, all of which aim to improve outcomes for children and families who are involved with CPW and FS services.

References

Allnatt, G., Elliott, M., Scourfield, J., Lee, A., and Griffiths, L. J. (2022). Use of Linked Administrative Children's Social Care Data for Research: A Scoping Review of Existing UK Studies. *The British Journal of Social Work*, bcac049. doi:10.1093/bjsw/bcac049

Broadhurst, K., Cusworth, L., Harwin, J., Alrouh, B., Bedston, S., Trinder, L., . . . Griffiths, L. (2021). Scaling up research on family justice using large-scale administrative data: an invitation to the socio-legal community. *Journal of Social Welfare and Family Law, 43*(3), 237-255. doi:10.1080/09649069.2021.1953856

Brownell, M. D., and Jutte, D. P. (2013). Administrative data linkage as a tool for child maltreatment research. *Child abuse and neglect, 37*(2-3), 120-124.

Brownell, M. D., and Jutte, D. P. (2013). Administrative data linkage as a tool for child maltreatment research. *Child abuse and neglect, 37*(2), 120-124. doi:https://doi.org/10.1016/j.chiabu.2012.09.013

Buckley, H. (2003). *Child protection work: Beyond the rhetoric*: Jessica Kingsley Publishers.

Buckley, H. (2012). Using Intelligence to Shape Reforms in Child Protection. *Irish Journal of Applied Social Studies, 12*(1), 6.

Buckley, H. (2017). Service users as receivers of risk-dominated practice. *Beyond the risk paradigm in Child Protection*, 77-90.

Buckley, H., and Burns, K. (2015). Child welfare and protection in Ireland: Déjà vu all over again. In *Social work in Ireland: Continuities and changes*: Palgrave Macmillan.

Buckley, H., Corrigan, C., and Kerrins, L. (2010). *Report of an audit of child protection research in Ireland 1990-2009*: Children Acts Advisory Board Dublin.

Buckley, H., and Whelan, S. (2018). Report on the Demographic Profile of Children at Ongoing Risk of Child Abuse. Dublin: Department of Children and Youth Affairs.

Burns, K., and MacCarthy, J. (2012). An impossible task? Implementing the recommendations of child abuse inquiry reports in a context of high workloads in child protection and welfare.

Burns, K., and McGregor, C. (2019). Child Protection and Welfare Systems in Ireland: Continuities and Discontinuities of the Present. In L. Merkel-Holguin, J. D. Fluke, and R. D. Krugman (Eds.), *National Systems of Child Protection: Understanding the International Variability and Context for Developing Policy and Practice* (pp. 115-138). Cham: Springer International Publishing.

Canavan, J., Devaney, C., McGregor, C., and Shaw, A. (2019). A good fit? Ireland's programme for prevention, partnership and family support as a public health approach to child protection. In B. Lonne, D. Scott, D. Higgins, and T. I. Herrenkohl (Eds.), *Re-visioning public health approaches for protecting children* (pp. 397-413): Springer Cham.

Clarke, N., Vale, G., Reeves, E. P., Kirwan, M., Smith, D., Farrell, M., . . . McElvaney, N. G. (2019). GDPR: an impediment to research? *Irish Journal of Medical Science (1971-), 188*(4), 1129-1135.

Cuccaro-Alamin, S., Eastman, A. L., Foust, R., McCroskey, J., Nghiem, H. T., and Putnam-Hornstein, E. (2021). Strategies for constructing household and family units with linked administrative records. *Children and Youth Services Review, 120*, 105706. doi:https://doi.org/10.1016/j.childyouth.2020.105706

Culhane, D. (2016). The potential of linked administrative data for advancing homelessness research and policy. *European Journal of Homelessness, 10*(3).

Culhane, D., Fantuzzo, J., Hill, M., and Burnett, T. C. (2017). Maximizing the Use of Integrated Data Systems: Understanding the Challenges and Advancing Solutions. *The ANNALS of the American Academy of Political and Social Science, 675*(1), 221-239. doi:10.1177/0002716217743441

Daly, M., Bray, R., Bruckauf, Z., Byrne, J., Margaria, A., Pecnik, N., and Samms-Vaughan, M. (2015). *Family and Parenting Support*: United Nations.

DCEDIY. (2021). Report of Public Consultation on Ireland's Combined Fifth and Sixth Report to the UN Committee on the Rights of the Child. Dublin: Department of Children, Equality, Disability, Integration and Youth.

DCEDIY. (2022a). Research and data project on children in care and adults who were in care as children. In *https://www.gov.ie/en/publication/c30a0-research-data-project-on-children-in-care-adults-who-were-in-care-as-children/*.

DCEDIY. (2022b). Supporting Parents: A National Model of Parenting Support Services. Dubiln: Department of Children, Equality, Disability, Integration and Youth.

DCYA. (2014). Better outcomes, brighter futures: The national policy framework for children and young people 2014–2020. Dublin: Government Publications

DCYA. (2017). Children First: National guidance for the protection and welfare of children. Dublin: Government Publications, Dublin

Department of Health, 1991 Child Care Act, 1991 Revised Updated to 19 August 2020, Dublin: Government of Ireland

Department of Health. (2000). Framework for the assessment of children in need and their families. London: The Stationery Office.

Doyle, J., Ashe, S., and Lawler, L. (2021 November). *Addressing domestic, sexual and gender-based violence Part One: Overview*. Dublin: Houses of the Oireachtas Library and Research Service

DPER. (2019a). Data Sharing and Governance Act 2019. Dublin: Department of Public Expenditure and Reform

DPER. (2019b). Public Service Data Strategy 2019-2023. Dublin: Department of Public Expenditure and Reform.

Drake, B., and Jonson-Reid, M. (1999). Some thoughts on the increasing use of administrative data in child maltreatment research. *Child Maltreatment, 4*(4), 308-315.

Emmott, E. H., Jay, M. A., and Woodman, J. (2019). Cohort profile: children in need census (CIN) records of children referred for social care support in England. *BMJ open, 9*(2), e023771.

EP, and CEU. (2016). Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). In (pp. 1-88). Official Journal L 119: European Parliament and Council of the European Union.

Euro-CAN COST Action (2022) https://www.cost.eu/actions/CA19106/ accessed on 10th November 2022

Fallon, B., Filippelli, J., Black, T., Trocmé, N., and Esposito, T. (2017). How can data drive policy and practice in child welfare? Making the link in Canada. *International journal of environmental research and public health, 14*(10), 1223.

Fallon, B., Trocmé, N., Fluke, J. D., MacLaurin, B., Tonmyr, L., and Yuan, Y.-Y. (2010). Methodological challenges in measuring child maltreatment. *Child abuse and neglect, 34*(1), 70-79.

Featherstone, B., Morris, K., and White, S. (2014). *Re-imagining child protection: Towards humane social work with families*. Great Britain: Policy Press.

Ferguson, H., and O'Reilly, M. i. (2001). Keeping children safe: child abuse, child protection and the promotion of welfare. Dublin: A. and A. Farmar.

Fluke, J. D., Tonmyr, L., Gray, J., Bettencourt Rodrigues, L., Bolter, F., Cash, S., Jud, A,. Meinck, F., Casas Munoz, A., O'Donnell, M., Pilkington, R and Weaver, L. (2020). Child maltreatment data: A summary of progress, prospects and challenges. *Child abuse and neglect*, 104650. doi:https://doi.org/10.1016/j.chiabu.2020.104650

Foust, R., Hoonhout, J., Andrea, L. E., Prindle, J., Rebbe, R., Nghiem, H., Suthar, H., Cuccaro-Alamin, S., Mitchell, M., Dawson, W., Palmer, L., Rak, S., Ahn, E., Hammond, I., McNellan, C., Reddy, J., Chen, W-T., Mayfield, K., Putnam-Hornstein, E., and McCroskey, J. (2021). The Children's Data Network:

Harnessing the scientific potential of linked administrative data to inform children's programs and policies. *International Journal of Population Data Science, 6*(3).

FRA. (2014). *Violence against women: An EU-wide survey: Main results*: FRA, European Union Agency for Fundamental Rights.

Furey, E., and Canavan, J. (2019). A review on the availability and comparability of statistics on child protection and welfare, including children in care, collated by Tusla: Child and Family Agency with statistics published in other jurisdictions. Galway, Ireland: UNESCO Child and Family Research Centre

Government of Ireland. (2022a). Third National Strategy on Domestic, Sexual and Gender-Based Violence Implementation Plan. Dublin: Government of Ireland.

Government of Ireland. (2022b). Zero Tolerance Third National Strategy on Domestic, Sexual and Gender-Based Violence 2022-2026. Dublin: Government of Ireland Department of Justice.

Gray, M., and Schubert, L. (2019). Critiques of a public health model in child maltreatment. In *Re-Visioning Public Health Approaches for Protecting Children* (pp. 221-234): Springer.

Green, B. L., Ayoub, C., Bartlett, J. D., Furrer, C., Von Ende, A., Chazan-Cohen, R., Klevens, J and Nygren, P. (2015). It's not as simple as it sounds: Problems and solutions in accessing and using administrative child welfare data for evaluating the impact of early childhood interventions. *Children and Youth Services Review, 57*, 40-49. doi:https://doi.org/10.1016/j.childyouth.2015.07.015

Harron, K., Hagger-Johnson, G., Gilbert, R., and Goldstein, H. (2017). Utilising identifier error variation in linkage of large administrative data sources (Vol. 17).

Herron, M., Fullerton, D., and McGrellis, S. (2022). Policy Framework for Children and Young People 2023-2028 Report on the Responses to the Public Consultation. Dublin: DCEDIY.

Health Information and Quality Authority (2017) Information management standards for national health and social care data collections. Dublin: HIQA.

Health Information and Quality Authority (2022) Catalogue: National data collections of health and social care. Dublin: HIQA

HSE/Tusla. (2009/2014). HSE Child Welfare and Protection Social Work Departments Business Processes. Report of the NCCIS Business Process Standardisation Project. Limerick: HSE and Tusla

Hurren, E., Stewart, A., and Dennison, S. (2017). New Methods to Address Old Challenges: The Use of Administrative Data for Longitudinal Replication Studies of Child Maltreatment. *International journal of environmental research and public health, 14*(9), 1066. doi:https://doi.org/10.3390/ijerph14091066

Johnson, R. D., Ford, D. V., Broadhurst, K., Cusworth, L., Jones, K., Akbari, A., Bedston, S., Alrough, B., Doebler, S., Lee, A., Smart, J., Thompson, S., Trinder, L., and Griffiths, L. J. (2020). Data Resource: population level family justice administrative data with opportunities for data linkage. *International Journal of Population Data Science, 5*(1). doi:10.23889/ijpds.v5i1.1339

Jones, K. H., Ford, D. V., Thompson, S., and Lyons, R. (2019). A profile of the Sail Databank on the UK secure research platform. *International Journal of Population Data Science, 4*(2).

Jones, K. H., Laurie, G., Stevens, L., Dobbs, C., Ford, D. V., and Lea, N. (2017). The other side of the coin: Harm due to the non-use of health-related data. *International journal of medical informatics, 97*, 43-51.

Jud, A., Fluke, J. D., Alink, L. R. A., Allan, K., Fallon, B., Kindler, H., Lee, B J., Mansell, J and Puyenbroek, H. v. (2013). On the nature and scope of reported child maltreatment in high-income countries: opportunities for improving the evidence base. *Paediatrics and International Child Health, 33*(4), 207-215. doi:10.1179/2046905513Y.0000000092

Jud, A., Jones, L., Mikton, C., World Health, O., Hochschule, L., Soziale, A., and Crimes Against Children Research, C. (2015). *Toolkit on mapping legal, health and social services responses to child maltreatment*.

Keddell, E. (2014). The ethics of predictive risk modelling in the Aotearoa/New Zealand child welfare context: Child abuse prevention or neo-liberal tool? *Critical Social Policy, 35*(1), 69-88. doi:10.1177/0261018314543224

Keddell, E. (2019). Algorithmic justice in child protection: Statistical fairness, social justice and the implications for practice. *Social Sciences, 8*(10), 281.

Lee, A., Elliott, M., Scourfield, J., Bedston, S., Broadhust, K., Ford, D. V., and Griffiths, L. J. (2022). Data resource: children receiving care and support and children in need, administrative records in Wales. *International Journal of Population Data Science, 7*(1).

Lonne, B., Herrenkohl, T. I., Higgins, D. J., and Scott, D. (2022). The Implications of Leveraging Administrative Data for Public Health Approaches to Protecting Children: Sleepwalking into Quicksand? *International Journal on Child Maltreatment: Research, Policy and Practice*, 1-17.

Malone, P., and Canavan, J. (2018). Systems Change: Final Evaluation Report on Tusla's Prevention, Partnership and Family Support Programme. NUI Galway: UNESCO Child and Family Research Centre, National University of Ireland, Galway.

Malone, P., and Canavan, J. (2021). Strengthening Prevention, Early Intervention and Family Support: A Conceptual Framework for Studying System Change in Irish Child Protection and Welfare. *The British Journal of Social Work*.

McGhee, J., Mitchell, F., Daniel, B., and Taylor, J. (2015). Taking a long view in child welfare: how can we evaluate intervention and child wellbeing over time? *Child Abuse Review, 24*(2), 95-106.

Meinck, F., Steinert, J.I., Sethi, D., Gilbert, R., Bellis, M.A., Mikton, C., Alink, L. and Baban, A., (2016). *Measuring and monitoring national prevalence of child maltreatment: A practical handbook*. World Health Organization Regional Office for Europe

Ntinapogias, A., Gray, J., Durning, P., and Nikolaidis, G. (2015). CAN-MDS surveillance system policy and procedures manual. DAPHNE III Programme"Coordinated Response to Child Abuse and Neglect (CAN) via Minimum Data Set (MDS)". Institute of Child Health, Department of Mental Health and Social Welfare - GREECE.

O' Leary, D. (2022). Who gets child protection and welfare services and why? *The Boolean*. doi: https://doi.org/10.33178/boolean.2022.1.3 in press

O'Leary, D. (2022a). A cross-sectional profile of children and families undergoing Initial Assessment in the Irish Child Protection and Welfare service in 2016. Paper presented at the ISPCAN European Congress, Estonia, Tallinn.

O'Leary, D. (2022b). *Who gets ongoing service and why? An exploration of assessment, judgments and decision making during Initial Assessments in Child Protection and Welfare Social Work in Ireland*. (PhD). National University of Ireland, University College Cork, Cork, unpublished.

O'Leary, D., Christie, A., and Fitzgerald, T. (2013). *Who is Taken Into Care? Knowledge Production through Dialogue with Social Workers*. Paper presented at the European Conference for Social Work Research "Private troubles or public issues? Challenges for social work research", Free University of Bozen-Bolzano, Italy

O'Leary, D., and Lyons, O. (2021). Examining the Prospects for Developing a National Child Maltreatment Surveillance System in Ireland. *International Journal on Child Maltreatment: Research, Policy and Practice*, 1-23.

O'Leary, D., O'Sullivan, K., Fitzgerald, T., and Christie, A. (2015). Poverty and decisions to place in care (residential and foster care): Mapping placements in care using street level deprivation indices. Paper presented at the ECSWR 5th European Conference for Social Work Research "Re-visioning social work with individuals, collectives and commuities: social work research", Ljubljana, Slovenia.

Ombudsman for Children's Office. (2010). A report based on an investigation into the implementation of Children First: National Guidelines for the Protection and Welfare of Children. Retrieved from

Parton, N. (2019). Changing and competing conceptions of risk and their implications for public health approaches to child protection. In *Re-visioning public health approaches for protecting children* (pp. 65-78): Springer.

Perry, I. (2009). Violence: a public health perspective. *Global Crime, 10*(4), 368-395.

Reading, R., Bissell, S., Goldhagen, J., Harwin, J., Masson, J., Moynihan, S., Parton, N.,Santos Pias, M., Thoburn, J. and Webb, E. (2009). Promotion of children's rights and prevention of child maltreatment. *The Lancet, 373*(9660), 332-343. doi:https://doi.org/10.1016/S0140-6736(08)61709-2

Rodriguez, L., Devaney, C., and Cassidy, A. (2018). Meitheal and child and family support networks-process and outcomes study.

Ryan, S. (2009). The report of the commission to inquire into child abuse. Dublin.

Scott, D., and Faulkner, A. (2019). The role, importance and challenges of data for a public health model. In *Re-Visioning Public Health Approaches for Protecting Children* (pp. 253-267): Springer.

Scourfield, J., Corliss, C., Wijedasa, D., Robling, M., and Clayton, V. (2019). Overview of administrative data on children's social care in England.

Sethi, D., Bellis, M., Hughes, K., Gilbert, R., Mitis, F., and Galea, G. (Eds.). (2013). *European report on preventing child maltreatment*. Copenhagen, Denmark: WHO Regional Office for Europe.

Shaw, A., and Canavan, J. (2018). Commissioning Work Package Final Report: Tusla's Programme for Prevention, Partnership and Family Support. Galway: UNESCO Child and Family Research Centre, National University of Ireland Galway.

Shaw, T. V., Lee, B., and Farrell, J. (2016). Introduction to Special Issue on Administrative/Big Data Sets and Child Welfare Research. *Journal of Public Child Welfare, 10*(4), 349-351. doi:10.1080/15548732.2016.1221707

Soneson, E., Das, S., Burn, A.-M., van Melle, M., Anderson, J. K., Fazel, M., Fonagy, P., Ford, T., Gilbert, R., Harron, K., Howarth, E., Humphrey, A., Jones, P. B., and Moore, A. (2022). Leveraging Administrative Data to Better Understand and Address Child Maltreatment: A Scoping Review of Data Linkage Studies. *Child Maltreatment*, 10775595221079308.

Thorpe, D. (1997). Regulating late modern childrearing in Ireland. *The Economic and Social Review, 28*(1), 63-84.

Turnell, A., and Murphy, T. (2017). *Signs of Safety: Comprehensive briefing document*. Retrieved from

Tusla. (2013). Guidance for the implementation of an Area Based Approach to Prevention, Partnership and Family Support. Dublin: Tusla Child and Family Agency.

Tusla. (2017). Child Protection and Welfare Strategy 2017-2022. Dublin: Tusla Child and Family Agency.

Tusla. (2020). *Tusla Data Management Strategy 2019 - 2022*. Dublin: Tusla Child and Family Agency

Tusla. (2021a). Annual Review on the Adequacy of Child Care and Family Support Services Available, 2019 Dublin: Tusla Child and Family Agency.

Tusla. (2021b). Child Protection and Welfare Services Data Management Plan and Record of Processing Activities Retrieved from Dublin:

Tusla. (2021c). *Corporate Plan 2021 – 2023*. Dublin: Tusla Child and Family Agency

Tusla. (2022a). Annual Review on the Adequacy of Child Care and Family Support Services Available, 2021. Dublin: Tusla Child and Family Agency.

Tusla. (2022b). Data hub. Retrieved from https://data.tusla.ie/

UNICEF. (2020). Selected highlights: Using administrative data for children. In *Data for Children: Matching data challenges with practical solutions* New York: UNICEF.

Whelan, S. (2018). At the front door. Child protection reporting in a changing policy and legislative context. (PhD Thesis). Trinity College Dublin, Dublin.

Whelan, S., and Smyth, D. (2022). Children in Care and Education Pathfinder Project. Dublin, National Policy Framework Roundtable 21st October 2022: Department of Children, Equality, Disability, Integration and Youth and Central Statistics Office,.

THE BOOLEAN
SNAPSHOTS OF DOCTORAL RESEARCH AT UCC

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Who Gets Child Protection and Welfare Services and Why?

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Abstract

When children are reported to Tusla Child and Family Agency, social workers may conduct Initial Assessments to determine their safety and welfare to decide if they need ongoing services. We know little about these impactful decisions. Equally, little is known about the nature of concerns investigated or about the children and families themselves. The research for my PhD addressed this evidence gap. I conducted two empirical studies in Tusla between 2015 and 2016. In the first, a case study, I used case file records and interviews to explore social workers' rationales for their judgments and decisions. In the second, a cross-sectional study, I coded written case records to profile the population undergoing assessments and identify, through multivariable analysis, factors associated with the decision to provide ongoing service.The study developed new insights into the characteristics of children and families undergoing initial assessment and into decision making processes. Social workers' judgments about service needs are informed by case factors, policies, resource constraints and their perception of their expertise and role. Almost 40% of children assessed received ongoing service. Multivariable analysis indicated decisions to provide ongoing services are multifactorial, influenced by a handful of current and historic case and organisation factors. This is the largest study of Initial Assessments conducted in Ireland to date. Implications of the findings for interventions, policy and further research are discussed.

Keywords: child protection and welfare, decision making, service provision, mixed methods, Tusla Child and Family Agency.

Background

The Child and Family Agency, Tusla, has a mandate under the Child Care Act 1991 to promote the safety and welfare of children. When reports of suspected child abuse, neglect or child welfare are received, social workers must decide whether or not a child and family needs ongoing

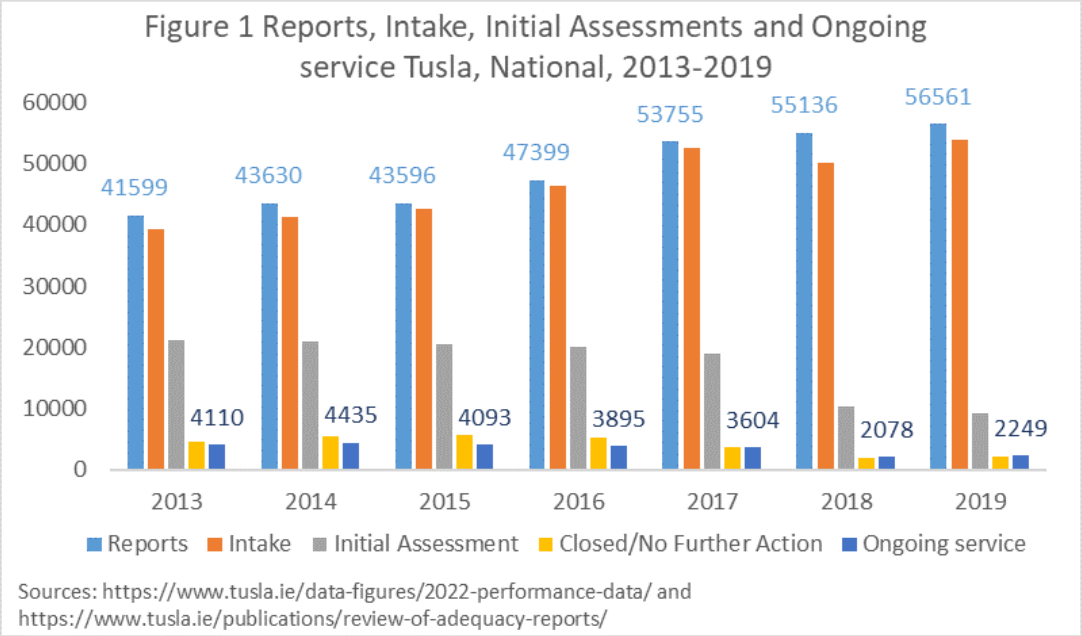
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services. These decisions are made during an Initial Assessment. In accordance with policy guidelines, the aim of Initial Assessment is to develop relationships with clients to establish, if there are unmet needs or, if a child is at risk of abuse or neglect and whether or not these needs warrant ongoing child protection or family support services. If reports involve child abuse or neglect, emergency action might be needed to make sure a child is safe. Otherwise, a child remains at home while the social worker conducts the Initial Assessment.

Researchers from a range of disciplines, including child protection and welfare, distinguish between judgments and decisions. For example, in child protection, social workers undertaking Initial Assessments make judgments about the likelihood of future risk or harm to a child and the need for intervention. Then they decide, from the options available, what actions to take. Judgments and decisions are influenced by a variety of factors including information about a child and family, child protection policies, available resources and interventions, professional knowledge and values and attitudes about the rights of children and families. Additionally, it has long been established that judgments and decisions are influenced by a range of psychological factors including past experiences and cognitive biases. These lead to variability in the outcomes of Initial Assessments. In a system which recognises the rights of children to be treated equally, it is important to understand what informs judgments and decisions.

Statistics published by Tusla show only a minority of children who are reported are receiving ongoing services, despite continuously rising rates of reports most of which warrant attention (see Figure 1). Reports by the Health Information Equality Authority, HIQA, have repeatedly indicated that - due to demand and under-resourcing - there are substantial delays in receiving Initial Assessments and this has a negative impact on providing services and on the potential efficacy of those services. The situation is similar across Anglophone child protection systems. Irish statistics and audits reveal that anywhere between 13.5% to 51.3% of children who have Initial Assessments receive ongoing service. The remainder are closed, with no further action. We know that under-resourcing of the Irish services impacts negatively on service provision, however, we know very little about how the decisions to provide ongoing services are made. Equally, little is known about the nature of concerns investigated or about the characteristics of children and families themselves. The purpose of this research is to address this gap in the Irish context.

Two empirical studies were conducted in one administrative area of Tusla between 2015 and 2016. The first, a case study, explored social workers' explanations for their judgments and decisions and examined the context for practice. The second, a cross-sectional study, profiled the population undergoing assessments and identified, through multivariable analysis, factors associated with the decision to provide ongoing service.



Focus on decision making processes

A number of writers have characterised decision making in child protection as a subjective and relationship based process. Social workers may be dealing with partial and sometimes contested information. Therefore, decisions are based on navigating uncertainty rather than absolute risk assessments. I wanted to know how social workers themselves explained how they reached decisions and what influenced them. I examined case files from 45 Initial Assessments and interviewed 10 social workers and 2 social work teams in nine departments in a single administrative area of Tusla. Based on a thematic analyses of the evidence gathered, I established that social workers used three interrelated processes to explain their judgments about needs and risks and the decision whether or not to provide ongoing service. These are

1. evidence of harm or risk used in conjunction with
2. evidence of parents' engagement and responses to the identified needs and risks, in conjunction with Social Worker's interpretation of
3. their professional expertise and role and the roles of parents and other professionals and
4. demand for services and available resources.

Children received services when there was evidence of harm due to poor parenting capacity or failure to engage constructively with the services or, where there was evidence of abuse and ongoing exposure to domestic violence, substance misuse or mental health concerns. Otherwise cases were closed. Where resources were scarce, social workers ranked risks and provided services to the highest risk cases. This meant, in some situations, cases were closed even though social workers believed they might have benefited from intervention. In such situations, if there

was uncertainty about parents' ability to manage needs and risks, social workers connected families to other services or left the door open to report back to Tusla.

Characteristics of children and families in initial assessments and factors associated with ongoing service

The cross-sectional study was based on a consecutive sample of all Initial Assessments completed during the first quarter of 2016 in seven social work departments in a single administrative region of Tusla (n=480). Information was collected from textual case file records. Children and families undergoing Initial Assessment were clustered in areas of greater deprivation compared to a national mean. Families had more children, had younger children, and had more boys than families in the general population. The primary carer in most families was the mother. One parent families were over-represented. Both one-parent families and families with cohabiting parents were disproportionally unemployed compared to their counterparts nationally. A majority children were previously involved with child protection services (69%, n=331) and one in ten (10.6%, n=51) had a parent who was involved with the services in their own childhood.

Most of the children had at least one developmental need and there were findings of abuse regarding one in three children (34%, n=163). Social workers had concerns about at least one aspect of parents' capacity to respond to children's needs and reported at least one parental behaviour identified as a risk factor for abuse in most assessments. One in four Initial Assessments involved domestic violence (24.6%, n=118) most frequently perpetrated by a father or mother's partner. Most parents were perceived to cooperate and engage with the service during the Initial Assessment (71.0%, n=341).

Almost two in every five children (38.5%, n=185) remained open for ongoing service following Initial Assessment. Factors most influential on the decision to provide ongoing service were domestic violence perpetuated by a mother to a father, concerns about parenting capacity, findings of abuse, inter-generational and historical involvement with social work and having few social supports. Being under four years old, having health care issues and having a male social worker, and a parent who did not cooperate were also influential on the decision to provide ongoing services.

Conclusions and implications for policy, practice and research

Decisions to provide ongoing service are multi-factorial, influenced by current and historic case factors, organisation factors, policies, resource constraints and social workers' perception of their own expertise and role. Almost 40% of children who received Initial Assessment received ongoing service.

The studies illustrate the benefits of analysing information about children and families undergoing assessments to support intervention decisions. Having information about the characteristics of children and families and the difficulties they are experiencing can help Tusla

develop a robust understanding of their service needs, develop training to enhance social workers' expertise and overall, enhance Tusla's capacity to advocate on behalf of its clients. The findings point to the need for further research to explore for example, why male social workers compared to their female colleagues are likely to provide services and to examine what influences social workers' confidence in their expertise. Further research is needed to explore why female perpetrated domestic violence compared to the more prevalent male perpetrated domestic violence, is more likely to warrant service intervention.

The findings suggest that there is an opportunity for Tusla to operate a lower threshold for service provision to certain categories of children. Those indicated include children under age four, children exposed to domestic violence and where there is repeated and inter-generational involvement with the services. The aim would be to expedite service provision in order to mitigate the long term effects of abuse. This could relieve the burden on waiting lists for Initial Assessments, response times and enhance the efficacy of service provision.

This study is the most comprehensive study of Initial Assessments conducted in Ireland to date. It is also the first Irish study to simultaneously explore the characteristics of Initial Assessments and investigate associations between case factors and ongoing service. However, in order to establish if the results can be extrapolated nationally, further research is needed.

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Declaration of Interests

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RESEARCH ARTICLE

Examining the Prospects for Developing a National Child Maltreatment Surveillance System in Ireland

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Abstract

The Irish Government pledged to reducing the prevalence of child maltreatment under the WHO Regional Committee for Europe plan on reducing child maltreatment. As a first step towards a rights-based and public health approach to maltreatment prevention, the WHO plan recommends making child maltreatment more visible across the region, with better surveillance through the use of national surveys that use standardized, validated instruments. We review the policy context, present current Irish data holdings, and outline some of the complexities reported in the literature concerning various surveillance methods in the context of the proposal to establish and maintain a surveillance system for child maltreatment in Ireland. Conclusions highlight the need for Ireland to adopting an approach to surveillance as soon as it is feasible. The paper outlines how such a programme is necessary to address the current absence of evidence on which prevention policies can be developed and to compliment the current child protection system. Drawing on a review of current methods in use internationally, we outline options for an Irish child maltreatment surveillance programme.

Keywords Surveillance · Child abuse · Child maltreatment · Children's rights · Data · Methodologies · Ireland

Introduction

Child maltreatment constitutes all forms of physical abuse, emotional ill-treatment, sexual abuse, deprivation, neglect, or exploitation of children resulting in actual or potential harm to a child's health, survival, development, or dignity in the context of a relationship of responsibility, trust, or power (CRC, 2011; WHO,

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1999). Child maltreatment (CM) is a widespread phenomenon, constituting both a human rights concern and a major public health problem, with at least 55 million of the European Regions' 190 million children suffering some form of physical, sexual, emotional, or psychological maltreatment (Gilbert et al., 2009; Sethi et al., 2018). In developed countries where data is available, it is estimated that somewhere between half and 90% of all child abuse victims do not come to the attention of national child protection agencies (Fallon et al., 2010; Gilbert et al., 2009). In Ireland, the single national study of adults who experienced sexual abuse during childhood identified that only 8% had reported their experiences to authorities (McGee et al., 2002). CM is a public health concern, and statistics published by state agencies underrepresent the scale of the problem.

Surveillance systems using epidemiological methods are the cornerstone of effective services to prevent child maltreatment because they provide evidence on the distribution and determinants of CM, which can be applied to inform the development and evaluation of preventive interventions (Fluke et al., 2020; Jud et al., 2016; Krug et al., 2002; Sethi et al., 2013). Different approaches yield different estimates and knowledge bases for potential interventions in CM, as is discussed below. In 2014, Ireland was one of the fifty-three member states of the WHO European Region which gave unanimous support to a resolution to reduce CM across the region and committed to better surveillance as a mechanism to achieve this (Sethi et al., 2013; WHO 2014, 2016, 2018). Ireland, through the office of the Chief Medical Officer in the Department of Health, is due to report on progress to the WHO in 2021 (WHO, 2014).

Risk factors for CM are best described through a framework based on the ecological model, which places maltreatment in the context of parent, child, family, neighborhood, and societal factors (Sethi et al., 2013). Accordingly, governments can use surveillance data to establish whether intervention is warranted at an individual, family, micro-level, or a broader macro-level (Sethi et al., 2013; Sidebotham, 2001; WHO, 1999). Jurisdictions with well-functioning surveillance systems can report trends in the prevalence of child maltreatment, provided the system is administered on a cyclical basis (Fluke et al., 2020; Meinck et al., 2016). This is beneficial for policymakers and administrators as it can support decisions for resource allocation and enable the planning, implementation, and evaluation of preventative policy and practice measures (Fallon et al., 2017; Jud et al., 2015, 2016; Trocmé et al., 2016a).

Ireland currently operates what is described as a passive surveillance system of child maltreatment and violence against children. Official statistics (discussed below) are limited to incidents referred to, and published by Tusla—Child and Family Agency, the national child protection and welfare service (Tusla), and crime statistics compiled by An Garda Síochána, the national police force (AGS), and published by the Central Statistics Office (CSO). This paper considers the prospects for a systematic surveillance programme for Ireland. The paper builds on the principle that all actions associated with reducing CM are underscored by the universal recognition of and respect for children's rights and human dignity. We review the policy context, present current Irish data holdings, and outline some of the complexities reported in the literature concerning various surveillance methods in the context of the proposal to establish and maintain a surveillance system for CM in Ireland.

The Policy Context

Maltreatment Prevention in a Public Health Framework

It is long understood by the World Health Organisation (WHO) that public health (PH) strategies aimed at preventing CM require multisectoral responses founded on robust data on the scale and scope of the problem (1999, 2002, 2013, 2014, 2018). As stated by Perry in his work on a PH perspective on violence (2009), PH provides a conceptual framework for understanding the causes of CM and developing strategies that will reduce the burden of suffering due to CM in the population. There is no agreement on a single approach to either the surveillance of or strategies aimed at the prevention of CM (see Gray & Schubert, 2019; Parton, 2019; Reading et al., 2009). Some frameworks proposed include the rights-based approaches (e.g., Reading et al., 2009), the socio-ecological framework (e.g., Krug et al., 2002), and more recently the structural perspective that aims to redress the underlying inequities contributing to children being harmed (see Axford & Berry, 2018; Bywaters, et al., 2015; Wilkinson & Pickett, 2009). These frameworks entail different conceptualizations of the problem and models of surveillance (the subject of this paper) and intervention to reduce and prevent CM.

PH approaches help to address the limitations of current child protection and welfare (CPW) systems. Current Anglo-Saxon models of CPW, including the Irish model, are characterized as high-risk strategies as they focus on the identification and management of risks in reported cases, and secondary prevention through strategies aimed at reducing recurrence (Buckley & Burns, 2015; Burns & McGregor, 2019; Gilbert et al., 2012; Scott et al., 2016). These approaches are characterized by high and increasing demands for services, overrepresentation of disadvantaged groups and communities, and at times by poor outcomes associated with service fragmentation and high recurrence rates among those referred (Buckley & O'Nolan, 2013; Scott et al., 2016). While CPW systems are extremely important, they do not address the causes and prevention of CM and can reinforce social inequalities because they ignore underlying structural factors, due to their focus on individual responsibility (Parton, 2019). Perry (2009) notes that there is a "prevention paradox" here, as high-risk approaches potentially offer benefits to specific individuals to whom they are offered but have limited impact on the population burden of suffering, whereas population-level approaches offer limited or non-benefit to the majority of individuals to whom they are offered but can exert significant impact on the burden of suffering in the population. Both are required to reduce the occurrence and consequences of CM, but they entail theoretical tensions of collectivist versus individualist approaches (see Gray & Schubert, 2019). Population-level prevention of CM requires attitudinal changes regarding the nature of risk to which policies respond and the question of who is responsible for addressing them, and require a commitment to prevention in the longer term (Klevens & Alexander, 2019; Parton, 2019).

The Irish Framework

Better Outcomes Brighter Futures (BOBF), the national policy framework for children and young people, is targeted at making Ireland "the best small country in the world for children to grow, where their rights are respected, protected and fulfilled" (DCYA, 2014). BOBF acknowledges advancements made in Ireland in developing evidence on children's lives through dedicated surveillance and survey programs that include data on children. Government has prioritized health surveillance in children, for example, the State of the Nation's Children Report (SONC), a biennial survey based on the National Set of Child Well-Being Indicators published in 2005 (see DCYA, 2016), and funded national longitudinal study of children and young people, Growing Up in Ireland, that commenced with an infant cohort in 2008 (see Nixon, 2019). Recent strategies have committed to improving data collection to ensure that children's lives are better understood (DCYA, 2014 p. 41; 2015); however, surveillance of childhood abuse is not specifically mentioned.

In Ireland, the Child Care Act (1991) provides the legislative basis for providing services to children not receiving adequate care and protection. Since 2011, the Irish CPW system has undergone comprehensive reforms to consolidate, reorient, and improve the delivery, management, and regulation of services. In 2014, Tusla was established as an independent state agency for *Child Protection and Welfare* and *Domestic, Sexual and Gender-based Violence*; heretofore, the Health Service Executive (HSE) provided these services (Burns & McGregor, 2019). Tusla has the primary statutory duty to promote children's welfare, respond to child protection concerns, and protect children in situations where they do not receive adequate care and protection (Tusla, 2020a, b). A program for Prevention, Partnership, and Family Support (PPFS) established as part of the continuum of services developed by Tusla provides a range of programs on early intervention and preventative work (for a detailed overview of developments, see Burns & McGregor, 2019). *Children First, the National guidelines for Child Protection and Welfare*, is the overarching mandate for statutory, professional, and community organizations working with children. Initially introduced in 1999 and updated in 2011, it was put on a statutory footing in 2017 resulting in the introduction of mandatory reporting of CPW concerns for professionals (DCYA, 1999, 2011, 2017; SI.No.470/2017 2017). AGS also has statutory responsibilities for the safety and welfare of children in emergency situations.

Since the 1990s, several reports have been published into the historical and current systematic abuse of children that occurred in family situations, in religious and state-run institutional settings, and in sporting organizations (e.g., Elliott, 2020; Gibbons et al., 2010; McGuinness, 1993; Ryan, 2009). These reports reveal the complex and challenging nature of the abuse concealed from authorities and services (Buckley & O'Nolan, 2013) and situations where people with a sexual interest in children rose to power and prevented known child abusers from being removed from the organizations (Power, 2020). They were instrumental in radically reforming and developing the current child protection and welfare system (Buckley & O'Nolan, 2013; Shore & Powell, 2020).

The Irish system is characterized as evolving in two related, and competing, directions: child protection and child welfare (Buckley et al., 2011). As occurred in

England in the early 1990s, Ireland broadened the parameters of concern for CPW policy, which represented a shift from a residual reactive system focused principally on non-accidental injury to one concerned with the "likely" risk of abuse or harm and the impairment to child welfare (McGregor, 2014; Parton, 2019). The recognition of typologies of abuse in addition to deficits in child welfare in "*Children First*" was reflected in the need for early intervention and preventive services and the investment in several specialist family support services, albeit they were targeted in specific geographic areas of particular disadvantage and need (Buckley & Burns, 2015; DCYA, 1999).

Several commentators have acknowledged that the central ethos of Tusla's framework and the significant developments in the regulatory side of the state offer an opportunity to embrace a children's rights ethos and focus on strengths oriented and preventive services, but have questioned the capacity to achieve its goals because of economic constraints and structural factors including the focus on the confinement for responsibility for child protection to Tusla (Buckley & Burns, 2015; Burns & McGregor, 2019). As outlined above, the conception of prevention in the Irish system currently remains in the realm of secondary approaches that prioritize early intervention in populations already identified as being at risk and tertiary interventions through CPW, where the focus is on preventing recurrence of harm and abuse. While these high-risk approaches are necessary in identifying, assessing and intervening to prevent further harm and they are attractive to policymakers, they do little to stem the tide of new cases (Perry, 2009) for which a complimentary population approach is necessary (Reading et al., 2009). Furthermore, as is detailed below in relation to the Irish system, estimates of the prevalence of abuse and of victimization produced by the CPW systems are unreliable because they incorporate aspects of system-based definitions and assessment processes (Christ & Schwab-Reese, 2020; Fallon et al., 2010).

Statistics on Child Maltreatment in Ireland

As mentioned, published statistics on the extent of child abuse in Ireland include those relating to children referred to Tusla, and statistics on recorded child victims of crime published by the CSO. Tusla publishes aggregated CPW performance and activity data relating to the number of referrals, and the categorization and responses to referrals per agency standards. Metrics include numbers of referrals processed within 24 hours, the number of Initial Assessments (investigations) completed within 40 days (21 days up to 2017), and the actions taken on completion of these Initial Assessments (see tusladata, 2020). Child-related metrics include the number of children listed on the Child Protection Notification System (CPNS), a register of children assessed by social workers to be at risk of significant harm, and the number of children in care. Up to 2009, CPW policy allowed referrals to include information on multiple children; since 2009, the policy requires that each referral relates to a unique child (HSE, 2009).

Figure 1 presents national statistics for referrals and assessment for the years 2009 to 2019. The data shows a continuous rise in referrals to CPW from 35 per 1,000

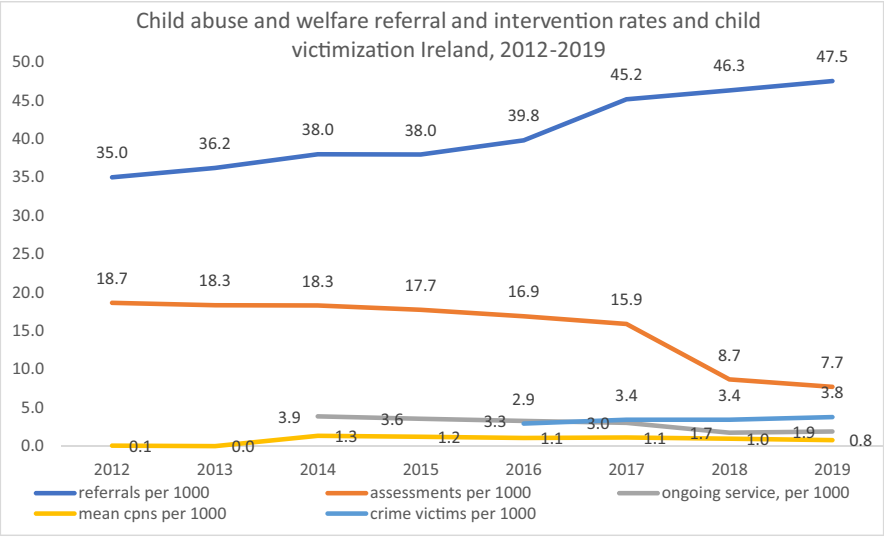


Fig. 1 Child abuse and welfare referral and intervention rates and child victimization, Ireland 2012–2019

children in 2012 to 47.5 per 1,000 in 2019. A sharp increase in referrals occurred from 39.8 per 1,000 in 2016 to 45.2 per 1,000 in 2018, which is likely associated with the advent of mandatory reporting. Approximately half of all referrals proceed to Initial Assessment (IA), the Irish equivalent of an investigation, but the IA rate per 1,000 children has dropped in recent years. Most cases fall under the threshold for ongoing service provision and are closed under the heading — No Further Action (Tusla, 2015, 2014b; tusladata, 2020).

CSO data on child victimization form part of recorded crime statistics produced by AGS (the Irish police force). These are published under reservation by the CSO due to concerns about the completeness and accuracy of the underlying data in the system from which they are extracted. Statistics show an overall increase in the number of crime victims in the Irish population between 2016 and 2019. Rates for the entire population (not shown here) rose from 3.7 victims per 1,000 people in 2016 to 4.9 per thousand in 2019. Children under 18 years of age comprise just over 19% of these recorded crime victims. The data reveal a similar pattern, showing an increase from 2.9 victims per 1,000 children in 2016 to 3.8 in 2019. Together, these data suggest that the perception of child victimization may indeed be increasing. However, trends in increased rates in referrals both to CPW and AGS reflect changes in policies that made reporting to AGS easier and, in the case of CPW in 2018, mandatory for many professionals.

Other features of CPW data raise questions about its limitations in reflecting population-level concerns about child abuse and victimization. As in other jurisdictions, there is clear evidence at the population level of a social gradient in referrals to child protection services (O'Leary et al., 2015), indicating that children from disadvantaged areas are disproportionately represented (Bywaters et al., 2015; Scott et al., 2016). Corresponding data for rates of assessment and intervention have been reducing from 2012

to 2019 (see Fig. 1) and relatively few cases receive intervention beyond assessment (Buckley & Burns, 2015; see also, Thorpe, 1997; see Fig. 1), a pattern familiar across many contemporary CPW services and may incorporate features of assessment processes and competition for scarce resources (DHSS, 2020; see Lonne et al., 2020). The aggregated statistics relate only to referrals and assessments completed within timeframes set for performance monitoring within the system and thus do not include all referrals processed. The system does not produce evidence of characteristics of children and family's referred. As in the UK, the current risk assessment focuses on the likelihood of *future* significant harm (Tusla 2014a), although a policy on substantiation of abuse having occurred is due for implementation in the coming year (Tusla, 2020a, b) (see below). Currently, coverage of children specifically victimized by domestic violence is not captured in the Tusla data but policy changes to revise this are under consideration (Furey & Canavan, 2019).

As this brief review shows, Irish statistics on child abuse and child victimization cannot serve as a proxy for evidence of the incidence or prevalence of child abuse at the population level nor that which comes to the attention of the state's agencies. Nor can it be used to provide evidence of how to develop primary preventive services. Focusing on data reported to CPW and AGS could result in zero to limited coverage on specific subgroups who have never interacted or have had limited interaction with specific administrative systems. Surveillance programs aim to cast a net wider than CPW agencies to improve the opportunity to represent experiences of subgroups otherwise not captured. In the next section, we review the alternatives available for such surveillance programs.

Current Approaches and Methodologies for Child Maltreatment Surveillance

Surveillance involves the ongoing systematic collection, analysis, and interpretation of data on child abuse incidence and prevalence. Methodologies differ across potential data sources and approaches involving continuous data collection (e.g., CANMDS, 2021) and those using cyclical, cross-sectional methods (e.g., Sedlak et al., 2010; Trocme et al., 2001, 2010; van Berkel et al., 2020). A brief overview of the three main approaches currently applied in CM surveillance: population-based surveys, sentinel-report surveys, and agency surveys is outlined. First, we examine the potential for using administrative data as a source of prevalence data on CM.

Administrative Data

Administrative data refer to information collected by public sector agencies for "registration, transaction and record keeping" when delivering a service (Woollard, 2014, p. 49). While the original intention may be unrelated to surveillance, administrative datasets from CPW agencies can prove to be a valuable source of knowledge of reported cases of CM (Fallon et al., 2017). These datasets can offer up-to-date information relating to the nature of referrals, source of reports, evidence

of substantiated abuse, demographic characteristics of children and families, out of home placements, and service responses received (Fallon et al., 2017; Trocmé et al., 2016a, 2016b).

The National Child Abuse and Neglect Data System (NCANDS) in the USA is an example of an administrative dataset. It is unique across all countries as it utilizes country-wide administrative child welfare data annually from all 50 states, the District of Columbia, and Puerto Rico (AlEissa et al., 2009; USDHHS, 2021). Originally based on aggregated data on key indicators of child protective services, NCANDS now contains case-level data on all children subjected to a child protection service (CPS) response in addition to agency file and a summary data component (Fallon et al., 2010; USDHHS, 2021). The case-level data provide yearly information relating to screened-in referrals, including the characteristics and risk factors of the child and family, the nature of the maltreatment, the determination of CPS response, and any follow-up actions (Jud et al., 2015; Sedlak et al., 2010). However, caution is warranted when comparing findings as definitional variance exists between states (USDHHS, 2021).

Several jurisdictions have considerably enhanced the value of statistics routinely published by states' agencies in recent years by including child-level metrics. For example, Aotearoa/New Zealand and Australia publish child-level information on the characteristics of and responses to children involved with child protection and youth justice (AIHW, 2021; Oranga Tamariki, 2021). The four countries in the UK independently collect and report child maltreatment data relating to children who become subject to a "child in need" categorization after referral to child protection services; the data are completed on an annual basis through an administrative dataset (AlEissa et al., 2009; Dept of Education, 2020). In England and Wales, child-level child abuse and crime victimization data from the government and the voluntary sector has been published for many years (NSPCC, 2013–2019). Yet, despite having this enhanced data, governments in England and Wales are currently undertaking a feasibility study to ascertain if conducting a new survey to effectively measure the current scale and nature of CM is needed (ONS, 2021).

Strengths

A significant strength of CM administrative data is that governments can use it to ascertain the burden of abuse and need reported to state agencies. In turn, these datasets can provide information that is mutually beneficial to clients, researchers, and agency staff, and have the potential to influence policymakers as they can assess the functioning of a child protection system (Drake & Jonson-Reid, 1999; Hurren et al., 2017; Jud et al., 2016, Jud, 2018). In CPW agencies, the extraction of information from administrative data places no additional labor on child welfare workers and can be a cost-effective means of retrieving incidence data (Jud et al, 2015). In some jurisdictions, administrative data can be linked to other related data such as justice or welfare data, creating large samples that allow for child maltreatment to be examined at a population level (Brownell & Jutte, 2013; Drake & Jonson-Reid, 1999; Trocmé et al., 2019; Vaithianathan et al., 2017). In addition, these datasets

allow for longitudinal data analysis of contact with multiple systems over time and enable researchers to study distinct subgroups throughout the life course (Hurren et al., 2017).

Weaknesses

Administrative data pose limitations when estimating prevalence, as only children referred to CPW services in a jurisdiction are included (Brownell & Jutte, 2013; Fallon et al., 2010). Administrative systems vary in the data and quality of data they collect considering that they were not initially designed for research purposes, and the variables of interest are not always present (Brownell & Jutte, 2013; Drake & Jonson-Reid, 1999; Scott & Faulkner, 2019). Consequently, comparisons between regions using administrative data are limited due to definitional variability, legal constructs and service provision (Buckley & Whelan, 2018; Furey & Canavan, 2019). While initially viewed as a cost-effective method of retrieving incidence data, there are greater costs incurred when linking and analyzing the data: this requires specialized analytic support, personnel, and financial resources to transform administrative datasets to use for research purposes (Fallon et al., 2017; Hurren et al., 2017; Trocmé et al., 2019).

Sentinel Surveys

Sentinel methods refer to survey data gathered from professionals in the community who routinely work with children or families and are likely to be aware of child maltreatment concerns. These "sentinels" can include personnel in CPW agencies, hospitals, social services, childcare, education, police departments, and the judiciary who have contact with children and are likely to be aware of CM concerns (Fluke et al., 2020; Jud et al., 2016). The aim is to establish prevalence estimates of abuse that are recognized within communities (Fluke et al., 2020).

There are three established nationally representative surveys that produce estimates on the nature and extent of reported CM using this method: these are the National Incidence Study (NIS) in the USA, the Canadian Incidence Study (CIS), and the Netherlands Prevalence Study of Child Maltreatment (NPM) (Euser et al., 2013; Sedlak et al., 2010; Trocmé et al., 2010). The CIS focuses solely on professionals working in child protection agencies. Within the European Region, the Coordinated Response to Child Abuse and Neglect (CAN) via a Minimum Data Set (MDS) is an incident-based surveillance system currently being piloted in seven countries (CAN-MDS, 2021). CAN-MDS adopts an intersectoral approach for data collection, which uses a standard methodology across countries intending to be available for implementation in all 27 member states (Ntinapogias et al., 2015).

Strengths

CPW agency professional surveys are useful as an approximation of reported cases of CM and provide trend data if administered on a cyclical basis; importantly, for governments, this trend information is provided at a lower cost than longitudinal data collection (Fallon et al., 2010; Meinck et al., 2016). Agency surveys in some jurisdictions have raised awareness of CM at a broader level. For example, CIS has facilitated knowledge development and transfer from agencies to government, assisted in developing differential response models, and assisted CPW agencies in using this data to establish service responses (Fallon et al., 2017; Tonmyr & Martin, 2014). When reported in conjunction with other methods, such as administrative data and CPW agency surveys, sentinels provide a closer approximation of actual child maltreatment in the population (Meinck et al., 2016). Sentinel records are used more broadly as a tool for policymakers to ensure equitable resource allocation and service response to referrals and as a means of evaluating the efficacy of policies for child maltreatment prevention (Jud et al., 2016; Meinck et al., 2016; Trocmé et al., 2016a, 2016b).

Weaknesses

Agency surveys can potentially create an additional work burden for staff in terms of training and form completion, resulting in a barrier to participation as workers are already heavily taxed in terms of time and cognitive load (Christ & Schwab-Reese, 2020; Jud et al., 2015; Trocmé et al., 2016a). In addition, each cycle of data collection involves new children (for example, every 5 years), thus "limiting the conclusions that can be drawn longitudinally (causality)" (Scott & Faulkner, 2019, p. 262). The time between cycles and the costs incurred in data collection for surveys make it difficult to ascertain the actual impact this methodology has on changes in policy and practice (Leeb & Fluke, 2015). Sentinel methods are prone to similar limitations as CPW surveys, in that only children who are in contact with agencies in the community will be included.

Population-Based Surveys

Population-based surveys, also known as self-report or informant surveys, are administered to representative sample of population of interest (Meinck et al., 2016). In studies relating to CM, data can be collected face-to-face or through telephone or online interviews from the sample of interest, such as adolescents or adults victimized in childhood (Fluke et al., 2020; Jud et al., 2016). Representative surveys with young people can be carried out through the school system (Meinck et al., 2016).

A number of validated survey methods exist for gathering information from children and adults. ISPCAN, in collaboration with UNICEF, the UN Secretary General's Study on Violence against Children, the Office of the High Commissioner of Human Rights, and the WHO, developed a suite of International Child Abuse

Screening (ICAST) tools and guidelines for their use. A primary aim of these tools is to enable the systematic collection of comparable data on the extent and depth of child abuse (Runyan et al., 2015; ICAST). The tools, which include a version for parents (ICAST-P), young adults (ICAST-P), and children over 11 (ICAST-P), have been internationally reviewed and tested and translated into more than 20 languages for use worldwide (e.g., Nikolaidis et al., 2018). Additionally, the Adverse Childhood Experiences (ACEs) tool gathers self-report information (Anda et al., 2006). The WHO noted that current child health surveillance approaches such as the Health Behaviour in School-aged Children (HBSC) offer potential mechanisms to support CM and child mental health well-being data collection programmes at the population level (Meinck et al., 2016).

The SAVI Report: Sexual Abuse and Violence in Ireland, published in 2002, is an example of a self-report study of the prevalence of various forms of sexual violence among Irish women and men across the lifespan from childhood through to adulthood (McGee et al., 2002). Based on a representative population-based survey involving over 3,000 Irish participants, SAVI revealed that one in five women and one in six men experienced contact abuse, and one in ten women and one in fourteen men experienced non-contact sexual abuse, during childhood (McGee et al., 2002).

Strengths

Population surveillance is beneficial as it yields prevalence rates for CM for entire populations from the representative sample (Meinck et al., 2016; Sethi et al., 2013). Indeed, these surveys are most useful when measuring and comparing exposures across countries (Meinck et al., 2016; Runyan et al., 2015). Representative population-based surveys are a cost-efficient means of gathering surveillance data in low-middle income countries (Jud et al., 2015; Leeb & Fluke, 2015). When trying to achieve "proper surveillance" of child maltreatment in a society, Christ and Schwab-Reese (2020) argue that this is best realized through random population-based surveys as this methodology illustrates what is unknown or unreported to child protection systems.

Weakness

Certain limitations exist when collecting data through adult self-report, as memories may be biased or flawed and offer rates of prevalence that are historic (Jud et al., 2016). While adolescent self-report is possibly more reliable as the information is from the recent past, there are ethical implications to consider when interviewing those under eighteen (see below) which may limit contact with certain subgroups of children (Jud et al., 2016). Finally, on a policy level, population-based surveys alone do not afford policymakers insights into child maltreatment which transfer to concrete policy changes (Jud et al., 2016).

Summary

As outlined here, there are strengths and weaknesses associated with each approach arising from the different ontologies and methodologies and the type of knowledge they produce. Gray and Schubert (2019) illustrate that two ideologies exist, one which advocates for a public health approach that recognizes CM as a risk for entire populations and one which endorses the view that efforts should focus on high-risk populations, in this case poor and economically deprived communities and individuals, leading to divergent solutions. Surveillance systems that collect data from multiple sources are considered most helpful in developing comprehensive responses to prevent child abuse (Gilbert et al., 2012; Leeb & Fluke, 2015). Two systems in particular that serve as models are the National Incidence Study of Child Abuse and Neglect (NIS) in the USA and the Netherlands Prevalence study of Maltreatment of children and youth (Euser et al., 2013; Sedlak et al., 2010).

Key Considerations

Oversight and Financing

In Ireland, as in many other countriesthe responsibility for child maltreatment prevention lies with the CPW system, the police, and the judiciary (Butchart & Mikton, 2014). The WHO recommends that government-led, national child maltreatment surveillance systems incorporate all sectors, have a lead agency with a national coordinating role, and be developed in parallel, not in competition with the existing child protection system (2014, 2015; Meinck et al., 2016). In Ireland, the commitment to undertake surveillance was given through the office of the Chief Medical Officer under the Department of Health providing the potential for a broader scope than the current CPW framework .

WHO advises that surveillance systems' development, implementation, and sustainability rely on continuous funding and partnership with those involved in data collection (WHO, 2014; Jud et al., 2015). Partnerships between universities and government serve as beneficial collaborations, as universities have the necessary technical expertise to develop good-quality monitoring, analysis, documentation, interpretation, reporting, and dissemination (Fallon et al., 2010; Jud et al., 2015; Meinck et al., 2016). Within the EU, as mentioned above, funding is available to support national efforts through several programmes including the Rights, Equality and Citizenship Programme (EC, 2018). In addition, there are opportunities for Ireland under the current EU-sponsored surveillance programme CAN–MDS.

Definitions and Measures

For the most part, there is theoretical consensus in the academic fields on definitions of specific child abuse categories (Christ & Schwab-Reese, 2020). However, a lack of agreement on how these constructs are operationalized within legal and CPW

contexts makes related data susceptible to variation, with CM definitions and subcategories differing and overlapping depending on the professional context (Christ & Schwab-Reese, 2020; Scott & Faulkner, 2019). When applying epidemiologic surveillance for child maltreatment, the lack of universal definitions for key terms presents challenges, with variation across jurisdictions, cultures, systems, and agencies (Christ & Schwab-Reese, 2020; Scott & Faulkner, 2019). Furthermore, details of how each abusive event will be measured, either at a child or family level, and whether this will be a cross-sectional or ongoing measurement need to be considered (Scott & Faulkner, 2019). Parton (2006) stressed that the subjective meaning that children give to events is often at variance with what adults might expect. In developing valid definitions, consideration needs to be given to the meaning imputed to experiences by young people concerned.

In Ireland, definitional inadequacy has affected data collection within the current child protection system, with variation evident between geographical areas a cause for concern (Buckley & Burns, 2015; Burns & McCarthy, 2012). As far back as 1987, efforts were made to institute standard definitions for use in child welfare (Buckley & Burns, 2015). A decade later, attempts were initiated through the national policy, *Children First*, to imbue a more holistic approach to child protection and welfare; this offered uniform definitions of child abuse and neglect for all sectors working with children (DCH, 1999). Thus, in theory, a common definitional framework exists in Ireland however, evidence suggests that insufficient definitional clarity exists at the CPW level (Burns & McCarthy, 2012; Horwath, 2005). A recent study of the police service involvement with child protection services in Ireland found inconsistencies surrounding the notion of risk to children that negatively impacted their statutory duty to collaborate to protect children (Shannon, 2017).

One of the noted limiting issues with definitions of CM within CPW systems is that maltreatment can be confounded with its causes or consequences for evidentiary purposes in practice (Christ & Schwab-Reese, 2020). Christ and Schwab-Reese (2020) recommend that research on CM necessitates a recognition of child maltreatment that is broad and unconstrained by cultural norms of individualized responsibility and by institutional practices. This certainly is a current concern in Ireland, where mandatory reporting came into effect in 2017, and a policy for substantiating child abuse is forthcoming. That policy, based on the interpretation of the duty on Tusla by the Irish courts, requires Tusla to investigate complaints of abuse and mitigate any risks that are identified in respect of a reported child and any child who has contact with an alleged abuser, and to disclose the allegation to third parties. As a result, discussions about abuse are increasingly framed in legalistic terms in public discourse (O'Mahony, 2020). Any surveillance system would need to address the possibility that CM would be formulated in such evidentiary terms and would need to be devised in a way to take account of any possibility of revictimization that survey methodology might induce. Whichever surveillance method is employed, the system's design and the protocols and training tools for those involved must clarify the distinction between definitions for purposes of surveillance and for reporting to Tusla for CPW investigations.

Technical Issues: Tools and Training

Common technical issues that exist at a universal level regardless of the surveillance program include time, implementation of the system, recruitment, and collaboration between government and agencies (Jud et al., 2015).

Idiosyncratic features of each potential measurement tool need an appraisal before adoption. For instance, agency surveys, which are judged to be of a higher methodological standard than population-based surveys, might pose a challenge by potentially creating an additional work burden for staff required to collect the data (Christ & Schwab-Reese, 2020; Jud et al., 2015; Trocmé et al., 2016b). However, based on the implementation of surveillance systems in other countries, recommendations and resources are available to circumvent potential technical challenges. For example, several experts recommend that research and technical supports should be offered to workers who participate in surveillance studies (ChildONEurope Secretariat, 2009; Jud et al., 2015). Based on the implementation of a Swiss surveillance system that incorporated population and agency surveys, Jud and colleagues (2018) advise sending clear, non-academic letters to agencies to invite their participation, and to suggest engaging frontline staff and administrators by seeking their input into the creation of relevant study variables through a Delphi-type approach. Lastly, they echo the need to provide research support and a helpline for frontline staff throughout the study (Jud et al., 2018).

WHO has published a toolkit on mapping legal, health, and social services' responses to child maltreatment that serves as a resource for researchers and decision-makers who use sentinel surveys and provides further guidance to what is outlined briefly here (Jud et al., 2015). The European CAN-MDS toolkit (Ntinapogias et al., 2015) also includes an operator's manual, data-collection protocol, training modules for professionals, and methodology to define relevant sectors' eligibility criteria. The toolkit is currently adapted for seven countries.

Ethical Considerations

In the appraisal of a potential surveillance system for Ireland, attention needs to be given to a number of ethical issues that arise. The key ethical considerations for a surveillance system, whichever mechanism is adopted, are the common good, equity, justice, respect for individuals, and good governance (WHO, 2017). Some ethical considerations will differ depending on the mechanism used for data collection (UNICEF, 2018). Researchers in the field have suggested that the predominance of research on CM epidemiology has focused on population surveys with adult respondents with less attention paid to analyzing reported incidents of alleged child maltreatment and corresponding agency responses (Jud et al., 2016, p.10). The latter can be of greater benefit to policymakers because they provide information about the functioning of a child protection system (Jud et al., 2016; Jud 2018; Meinck et al., 2016).

Researchers are advised to include constructs that embrace cultural contexts through use of language and "belief systems" (Fluke et al., 2020) when considering definitions of child maltreatment (Ntinapogias et al., 2015). This is especially relevant to enable researchers to be sensitive to cultural issues outside of their own expertise (Graham et al., 2013). Parton suggests that a major problem with some current attempts to collate and share a wide range of information about concerns that professional have about children is that they grossly underestimate the background and contexts for those concerns and, crucially, the meanings imputed to them by the key actors, particularly the children and young people themselves (2006, p180). As a consequence, he suggests that while children are placed at the center of services, there is a great danger that services will not be child-centered (2016, p185). In order to be useful and reflective of children's rights, Parton (2006) suggests that in the first place, children and young people need to be involved in identifying and giving meaning to the nature of their concerns and secondly, that they need to be central in deciding what they want done about them.

All surveillance methods must adhere to stringent ethical protocols regarding privacy and confidentiality throughout the research process, from the physical spaces for data collection to maintenance and storage and dissemination of data (Meinck et al., 2016; Ntinapogias et al., 2015; UNICEF, 2018). Methods adopted will need to comply with Irish legislation and European regulations for data privacy (Data Protection Commission, 2019; EP and CEU, 2016). A protocol requiring mandatory reporting is necessary in the event of a child disclosing abuse or the researcher having reasonable grounds to suspect same; it is recommended that a child protection reporting policy be agreed in advance and embedded into the ethical framework of a project (Graham et al., 2013; UNICEF, 2020). Whatever surveillance system is adopted, protocols must be in place to ensure those involved have valid professional licenses and are subject to a professional code of ethics (Ntinapogias et al., 2015).

In population-based surveys, the main ethical issues include informed consent and informed assent of child and parent/guardian, the avoidance of harm, beneficence, privacy and confidentiality, and compensation for research participants (CP MERG, 2012; Fluke et al., 2020). Including children in data collection requires additional precautions. Children as autonomous individuals are in a position to provide consent; but it is essential for the integrity of data collection that informed voluntary consent is obtained from both child and caregiver with a full understanding for the risks and benefits (Mathews et al., 2020; UNICEF, 2018, 2020). In situations where children are not legally able to consent, it is essential to obtain their assent in an age-appropriate manner to ensure they agree with participation (UNICEF, 2018, 2020). Issues surrounding consent are particularly salient in the context of child maltreatment as the child might be suffering abuse from the parent/caregiver and thus consent from this person might not be appropriate; a passive consent from caregivers might be a way to circumvent this dilemma (CP MERG, 2012). Crucially, researchers must endeavor to protect children and minimize harm and possible retraumatization at all stages of the process, from the beginning and through gathering, analyzing, and ultimately disseminating all data (Graham et al., 2013; UNICEF, 2018).

Ethical considerations such as consent and assent are necessary but may impede and skew surveillance data collection as only children whose parents consent are surveyed (Scott & Faulkner, 2019). Self-report methodologies need to consider the potential impacts of disclosing abuse on adult and child victims and need to put in place support systems to ensure participants' safety and security (CP MERG, 2012).

Concluding Comments

Protection from child maltreatment is a human rights issue. Our purpose here is not to suggest how interventions might be developed, rather it is to highlight the necessity of surveillance in pursuing this endeavor. A commitment to develop evidence on the prevalence of CM needs to be matched with a commitment to enhance or develop interventions that will specifically respond to identified needs. Developing a surveillance programme recognizes that data itself is a mechanism for change (UNICEF, 2018). This value is recognised in the reporting requirements under the UN Sustainable Development Goals (UN 2015). It is only through understanding the problem of child maltreatment that effective policies can be developed, and sustainable actions can be taken to systematically reduce and prevent it (UN 2015). As such, there is a moral imperative to implement a sustainable surveillance programme (see Table 1). This requires political foresight and long-term commitment to investing in twin approaches to reducing and responding to CM as outlined above. The Irish Government's undertaking to commence a child abuse surveillance system (WHO, 2014) offers the exciting potential to extend and enhance recent infrastructural investments within the Irish child protection and abuse prevention systems.

As described, each surveillance method comes with its own merits and drawbacks. Overall, the best surveillance is one which incorporates triangulation of multiple data

Table 1 What makes a good surveillance system?

Simplicity	The system should produce the data needed in the most simple and straightforward way possible
Flexibility	The system should be able to adapt at minimal cost to changes in the operating conditions and the data required
Acceptability	Those people who are expected to provide information, through interviews and in other ways, should be willing to participate and should be involved in the system design where possible
Reliability	A reliable system is one that detects an overwhelming proportion of the actual cases in the target population and excludes most non-cases — that is, the system should have a high sensitivity, high specificity, and high positive predictive value. This allows end users to have confidence in the accuracy of the data
Utility	The system should be practical, affordable, and increase knowledge about the problem
Sustainability	The system should be easy to maintain and update, with adequate human and financial resources allocated to assuring its ongoing operation
Timeliness	The system should generate up-to-date information with minimal delays
Responsiveness	The system should be supported by infrastructure and resources to take action based on the data

Butchart et al., (2006 p.29) adapted from Woodruff et al. (2009)

sources to offer a more reliable picture of the extent of child maltreatment (Gilbert et al., 2012; Leeb & Fluke, 2015; Merrick & Latzman, 2014). Ireland could contemplate any of the aforementioned surveillance strategies as a blueprint for a national system. In a world without budgetary constraints, Ireland might look to models used in the USA (NIS) or the Netherlands (NPM); both have compelling datasets due to the inclusion of children known to services within and beyond child protection and the NPM incorporates adolescent self-report surveys (Euser et al., 2013). Where sentinel or self-report studies are not immediately viable, Jud and colleagues (Jud et al, 2015) suggest that beginning with a "first wave of a professional survey" is most constructive. Alternatively, Ireland could consider using administrative data from Tusla to analyze how the service responds to reported child maltreatment. This would involve lateral thinking to widen the scope of data that is currently collected (ChildONEurope Secretariat, 2009; Jud et al., 2015).

It is our hope that the development of a surveillance programme will progress, as doing so will address the significant gaps in the evidence base that continue to impact the ability of service providers and policymakers in many sectors to deliver lasting and impactful services. It will facilitate the benchmarking of prevalence of abuse and examination of the effectiveness of interventions against those in other countries. Of greatest significance, making good on this commitment will assist government in fulfilling its obligation to facilitate the enjoyment of the universal and constitutional rights of Irelands' children and families.

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Declarations

Conflict of Interest The authors declare no competing interests.

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References

AIHW. (2021). Child protection data. https://www.aihw.gov.au/reports-data/health-welfare-services/child-protection/data.

AlEissa, M. A., Fluke, J. D., Gerbaka, B., Goldbeck, L., Gray, J., Hunter, N., et al. (2009). A commentary on national child maltreatment surveillance systems: Examples of progress. *Child Abuse & Neglect, 33*(11), 809–814. https://doi.org/10.1016/j.chiabu.2009.08.004

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174–186.

Axford, N., & Berry, V. (2018). Perfect bedfellows: Why early intervention can play a critical role in protecting children—A response to Featherstone et al.(2014) 'A marriage made in hell: Child protection meets early intervention.' *British Journal of Social Work, 48*(1), 254–273.

Brownell, M. D., & Jutte, D. P. (2013). Administrative data linkage as a tool for child maltreatment research. *Child Abuse & Neglect, 37*(2–3), 120–124. https://doi.org/10.1016/j.chiabu.2012.09.013

Buckley, H., & Burns, K. (2015). Child welfare and protection in Ireland: Déjà vu all over again. In *Social work in Ireland: Continuities and changes*. Palgrave Macmillan.

Buckley, H., & O'Nolan, C. (2013). An examination of recommendations from inquiries into events in families and their interactions with State services, and their impact on policy and practice. DCYA. Dublin: Government Publications.

Buckley, H., & Whelan, S. (2018). *Report on the demographic profile of children at ongoing risk of child abuse*. Department of Children and Youth Affairs.

Buckley, H., Carr, N., & Whelan, S. (2011). 'Like walking on eggshells': Service user views and expectations of the child protection system: Views and expectations of the child protection system. *Child & Family Social Work, 16*(1), 101–110. https://doi.org/10.1111/j.1365-2206.2010.00718.x

Burns, K., & MacCarthy, J. (2012). An impossible task? Implementing the recommendations of child abuse inquiry reports in a context of high workloads in child protection and welfare. *Irish Journal of Applied Social Studies, 12*. https://doi.org/10.21427/D7172P.

Burns, K., & McGregor, C. (2019). Child protection and welfare systems in Ireland: Continuities and discontinuities of the present. In L. Merkel-Holguin, J. D. Fluke, & R. D. Krugman (Eds.), *National Systems of Child Protection* (Vol. 8, pp. 115–138). Springer International Publishing.

Butchart, A., & Mikton, C. (2014). *Global status report on violence prevention, 2014*. World Health Organization.

Bywaters, P., Brady, G., Sparks, T., Bos, E., Bunting, L., Daniel, B., … Scourfield, J. (2015). Exploring inequities in child welfare and child protection services: Explaining the 'inverse intervention law.' *Children and Youth Services Review, 57*, 98–105.

CAN-MDS (2021). *CAN Via MDS*. CAN-MDS II OUTPUTS. http://can-viamds.eu/.

Child Care Act. (1991). Irish statute book.

ChildONEurope (2009). Guidelines on data collection and monitoring systems on child abuse. *ChildOnEurope*. Florence.

Christ, S. L., & Schwab-Reese, L. M. (2020). Shedding the constraints of formal systems in research on child maltreatment through high-quality measurement and broad population surveys. *International Journal on Child Maltreatment: Research, Policy and Practice*, 1–19.

CP MERG. (2012), Ethical principles, dilemmas and risks in collecting data on violence against children: A review of available literature, Statistics and Monitoring Section/Division of Policy and Strategy, UNICEF, New York

CRC, U. (2011). General Comment No. 13 (2011) The right of the child to freedom from all forms of violence.

CSO. (2020). Recorded crime — Statistics under reservation. https://www.cso.ie/en/statistics/crimeandjustice/. Accessed 14 January 2021.

Data Protection Commission, Ireland. (2019). Guidance note: Guidance on anonymisation and pseudonymisation. DPC.

Department of Health and Children. (1999). *Children First: National guidelines for the protection and welfare of children* (1st ed.). Government Publications, Dublin.

DCYA. (2011). *Children First: National guidance for the protection and welfare of children*. Government Publications, Dublin.

DCYA. (2014). *Better outcomes, brighter futures: The national policy framework for children and young people 2014–2020*. Government Publications.

DCYA. (2015). *National strategy on children and young people's participation in decision-making, 2015–2020*. DCYA. Dublin: Government Publications.

DCYA. (2016). *State of the Nation's Children: Key findings*. Government Publications, Dublin.

DCYA. (2017). *Children First: National guidance for the protection and welfare of children*. Government Publications, Dublin.

DHHS (2020). Child Maltreatment 2018. US Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

Drake, B., & Jonson-Reid, M. (1999). Some thoughts on the increasing use of administrative data in child maltreatment. *Child Maltreatment, 4*(4), 308–315.

Department of Education. (2020). *Characteristics of children in need: 2019 to 2020*. Characteristics of Children in need statistics and data. https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2019-to-2020. Accessed February 20th, 2021.

EC. (2018). The rights, equality and citizenship programme funding & tender opportunties. https://ec.europa.eu/info/funding-tenders/opportunities/portal/screen/programmes/rec#c,calls=hasForthcomingTopics/t/true/0/1/0/default-group&hasOpenTopics/t/true/1/1/0/default-group&allClosedTopics/t/true/0/1/0/default-group&+PublicationDateLong/asc. Accessed 18th March 2021.

Elliott, I. (2020). Historical sexual abuse in scouting: A learning review. Independent Safeguarding Consultant.

EP, & CEU. (2016). Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). In E. P. a. C. o. t. E. Union (Ed.).

Euser, S., Alink, L. R., Pannebakker, F., Vogels, T., Bakermans-Kranenburg, M. J., & Van IJzendoorn, M. H. (2013). The prevalence of child maltreatment in the Netherlands across a 5-year period. *Child Abuse & Neglect, 37*(10), 841–851.

Fallon, B., Trocmé, N., Fluke, J., MacLaurin, B., Tonmyr, L., & Yuan, Y.-Y. (2010). Methodological challenges in measuring child maltreatment. *Child Abuse & Neglect, 34*(1), 70–79.

Fallon, B., Filippelli, J., Black, T., Trocmé, N., & Esposito, T. (2017). How can data drive policy and practice in child welfare? Making the link in Canada. *International Journal of Environmental Research and Public Health, 14*(10), 1223.

Fluke, J. D., Tonmyr, L., Gray, J., Bettencourt Rodrigues, L., Bolter, F., Cash, S., et al. (2020). Child maltreatment data: A summary of progress, prospects and challenges. *Child Abuse & Neglect, 104650,*. https://doi.org/10.1016/j.chiabu.2020.104650

Furey, E., & Canavan, J. (2019). A review on the availability and comparability of statistics on child protection and welfare, including children in care, collated by Tusla: Child and Family Agency with statistics published in other jurisdictions.

Gibbons, N., Lunny, L., Harrison, P., & O'Neill, G. (2010). *Roscommon child care case: Report of the inquiry team to the health service executive*. Health Services Executive.

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. https://doi.org/10.1016/S0140-6736(08)61706-7

Gilbert, R., Fluke, J., O'Donnell, M., Gonzalez-Izquierdo, A., Brownell, M., Gulliver, P., et al. (2012). Child maltreatment: Variation in trends and policies in six developed countries. *Lancet, 379*(9817), 758–772. https://doi.org/10.1016/S0140-6736(11)61087-8

Graham, A., Powell, M., Taylor, N., Anderson, D. & Fitzgerald, R. (2013). *Ethical research involving children*. UNICEF Office of Research - Innocenti.

Gray, M., & Schubert, L. (2019). Critiques of a public health model in child maltreatment. In *Re-Visioning Public Health Approaches for Protecting Children* (Vol. 9). Springer International Publishing.

Horwath, J. (2005). Identifying and assessing cases of child neglect: Learning from the Irish experience. *Child & Family Social Work, 10*(2), 99–110. https://doi.org/10.1111/j.1365-2206.2005.00356.x

Hurren, E., Stewart, A., & Dennison, S. (2017). New methods to address old challenges: The use of administrative data for longitudinal replication studies of child maltreatment. *International Journal of Environmental Research and Public Health, 14*(9), 1066. https://doi.org/10.3390/ijerph14091066

HSE. (2009). *HSE child welfare and protection social work departments business processes.* Report of the NCCIS Business Process Standardisation Project (Vol. 0.9). HSE, Child and Family Social Services.

Jud, A., Fegert, J. M., & Finkelhor, D. (2016). On the incidence and prevalence of child maltreatment: A research agenda. *Child and Adolescent Psychiatry and Mental Health, 10*(1), 17. https://doi.org/10.1186/s13034-016-0105-8

Jud, A. (2018). Current research on child maltreatment epidemiology. *Child and Adolescent Psychiatry and Mental Health, 12*(1), 21,-s13034–13018–10228–13031. https://doi.org/10.1186/s13034-018-0228-1.

Jud, A., Fluke, J., Alink, L. R. A., Allan, K., Fallon, B., Kindler, H., et al. (2013). On the nature and scope of reported child maltreatment in high-income countries: Opportunities for improving the

evidence base. *Paediatrics and International Child Health, 33*(4), 207–215. https://doi.org/10.1179/2046905513Y.0000000092

Jud, A., Jones, L., Mikton, C., Eds. (2015). *Toolkit on mapping legal, health and social services responses to child maltreatment*. WHO, Geneva.

Klevens, J., & Alexander, S. (2019). Essentials for childhood: Planting the seeds for a public health approach to preventing child maltreatment. *International Journal on Child Maltreatment: Research, Policy and Practice, 1*(2), 121–132.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (Eds.). (2002). *World report on violence and health*. World Health Organization.

Leeb, R. T., & Fluke, J. D. (2015). Child maltreatment surveillance: Enumeration, monitoring, evaluation and insight. *Health Promotion and Chronic Disease Prevention in Canada, 35*(8), 3.

Lonne, B., Russ, E., Harrison, C., Morley, L., Harries, M., Robertson, S., et al. (2020). *The "Front Door" to Child Protection—Issues and Innovations*. International Journal on Child Maltreatment: Research, Policy and Practice. https://doi.org/10.1007/s42448-020-00051-9.

Mathews, B., Pacella, R., Dunne, M. P., Simunovic, M., & Marston, C. (2020). Improving measurement of child abuse and neglect: A systematic review and analysis of national prevalence studies. *PLoS ONE, 15*(1), e0227884. https://doi.org/10.1371/journal.pone.0227884

Merrick, M., & Latzman, N. (2014). Child maltreatment a public health overview and prevention considerations. *OJIN: The Online Journal of Issues in Nursing*, *19*(1).

McGee, H., Garavan, R., de Barra, M., Byrne, J., & Conroy, R. (2002). The SAVI report: Sexual abuse and violence in Ireland.

McGregor, C. (2014). Why is history important at moments of transition? The case of 'transformation' of Irish child welfare via the new Child and Family Agency. *European Journal of Social Work, 17*(5), 771–783. https://doi.org/10.1080/13691457.2014.927833

McGuinness, C. (1993). *Report of the Kilkenny incest investigation*. The Stationery Office.

Meinck, F., Steinert, J.I., Sethi, D., Gilbert, R., Bellis, M.A., Mikton, C., Alink, L. and Baban, A., (2016). *Measuring and monitoring national prevalence of child maltreatment: A practical handbook*. World Health Organization Regional Office for Europe.

Nikolaidis, G., Petroulaki, K., Zarokosta, F., Tsirigoti, A., Hazizaj, A., Cenko, E., et al. (2018). Lifetime and past-year prevalence of children's exposure to violence in 9 Balkan countries: the BECAN study. *Child and Adolescent Psychiatry and Mental Health, 12*(1), 1–15.

Nixon, E. (2019). *Children's lives in Ireland—Insights from the growing up in Ireland study.* Paper presented at the The Challenges of Success Addressing Population Growth in Ireland.

NSPCC. (2013–2019). *How safe are our children?* 2020. https://learning.nspcc.org.uk/research-resources/how-safe-are-ourchildren2020

Ntinapogias, A., Gray, J., Durning, P., & Nikolaidis, G. (2015). CAN-MDS surveillance system policy and procedures manual. *DAPHNE III Programme"Coordinated Response to Child Abuse & Neglect (CAN) via Minimum Data Set (MDS)"*. Institute of Child Health, Department of Mental Health and Social Welfare - GREECE.

O'Leary, D., O'Sullivan, K., Fitzgerald, T., & Christie, A. (2015). *Poverty and decisions to place in care (residential and foster care): Mapping placements in care using street level deprivation indices.* Paper presented at the ECSWR 5th European Conference for Social Work Research "Re-visioning social work with individuals, collectives and commuities: social work research", Ljubljana, 22–24 April 2015.

O'Mahony, C. (2020). *Annual report of the special rapporteur on child protection*. Department of Children and Youth Affairs.

ONS. (2021). *Exploring the feasibility of a survey measuring child abuse in the UK*. Office for National Statistics.

Oranga Tamariki——Ministry for Children (2021). *Child protection and youth justice statistics 2017–2020*. Oranga Tamariki——Ministry for Children. Accessed 30th March 2021.

Parton, N. (2006). *Safeguarding childhood: Early intervention and surveillance in a late modern society*. Red Globe Press.

Parton, N. (2019). Changing and competing conceptions of risk and their implicatioins for public health approaches to child protection. In *Re-Visioning Public Health Approaches for Protecting Children* (Vol. 9). Springer International Publishing.

Perry, I. (2009). Violence: A public health perspective. *Global Crime, 10*(4), 368–395.

Power, J. (2020). *'Sex offenders dominated leadership' of scouting body for decades, report finds*. https://www.irishtimes.com/news/social-affairs/sex-offenders-dominated-leadership-of-scouting-body-for-decades-report-finds-1.4253310.

Reading, R., Bissell, S., Goldhagen, J., Harwin, J., Masson, J., Moynihan, S., et al. (2009). Promotion of children's rights and prevention of child maltreatment. *The Lancet, 373*(9660), 332–343. https://doi.org/10.1016/S0140-6736(08)61709-2

Runyan, D., Brandspigel, S., Zolotor, A., & Dunne, M. (2015). *Manual for administration: The ISPCAN child abuse screening tool (ICAST)*. International Society for the Prevention of Child Abuse and Neglect.

Ryan, S. (2009). *The report of the commission to inquire into child abuse*. Dublin.

Scott, D., & Faulkner, A. (2019). The role, importance and challenges of data for a public health model. In *Re-Visioning Public Health Approaches for Protecting Children* (pp. 253–267). Springer.

Scott, D., Lonne, B., & Higgins, D. (2016). Public health models for preventing child maltreatment: Applications from the field of injury prevention. *Trauma, Violence, & Abuse, 17*(4), 408–419.

Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Li, S. (2010). *Fourth national incidence study of child abuse and neglect (NIS–4): Report to congress, executive summary*. U.S. Department of Health and Human Services, Administration for Children and Families.

Sethi, D., Bellis, M., Hughes, K., Gilbert, R., Mitis, F., & Galea, G. (Eds.). (2013). *European report on preventing child maltreatment*. WHO Regional Office for Europe.

Sethi, D., Yon, Y., Parekh, N., Anderson, T., Huber, J., Rakovac, I., et al. (Eds.). (2018). *European status report on preventing child maltreatment*. WHO Regional Office for Europe.

Shannon, D. G. (2017). *Audit of the exercise by An Garda Siochana of the provision of Section 12 of the Child Care Act 1991*. An Garda Siochana.

Shore, C., & Powell, F. (2020). The social construction of child abuse in Ireland: Public discourse, policy challenges and practice failures. In Biesel, K., Masson, J., Parton, N., & Poso, T (Eds.). *(2020). Errors and Mistakes in Child Protection: International discourses, approaches and strategies.* (pp. 55–73). Policy Press.

Sidebotham, P. (2001). An ecological approach to child abuse: A creative use of scientific models in research and practice. *Child Abuse Review, 10*(2), 97–112. https://doi.org/10.1002/car.643

SI.No.470/2017 (2017). S.I. No. 470/2017—Children First Act 2015 (Commencement) Order 2017. In G. Ireland (Ed.). Dublin.

Thorpe, D. (1997). Review essay: Regulating late modern childrearing in Ireland. *The Economic and Social Review, 28*(1), 63–84.

Tonmyr, L., & Martin, W. K. (2014). How has child maltreatment surveillance data been used in Canada? *Health Research Policy and Systems, 12*(1), 1–9.

Trocmé, N., MacLaurin, B., Fallon, B., Daciuk, J., Billingsley, D., Tourigny, M., et al. (2001). Canadian incidence study of reported child abuse and neglect: Final report: (614172012–001) . American Psychological Association.

Trocmé, N., Fallon, B., MacLaurin, B., Sinha, V., Black, T., Fast, E., et al. (2010). *Canadian incidence study of reported child abuse and neglect: 2008 major findings*. Public Health Agency of Canada.

Trocmé, N., Roy, C., & Esposito, T. (2016a). Building research capacity in child welfare in Canada. *Child and Adolescent Psychiatry and Mental Health, 10*(1), 16. https://doi.org/10.1186/s13034-016-0103-x

Trocmé, N., Akesson, B., & Jud, A. (2016b). Responding to child maltreatment: A framework for mapping child protection agencies. *Child Indicators Research, 9*(4), 1029–1041. https://doi.org/10.1007/s12187-015-9362-y

Trocmé, N., Esposito, T., Fallon, B., Chabot, M., & Delaye, A. (2019). Building research capacity in child welfare in Canada: Advantages and challenges in working with administrative data. In *Re-Visioning Public Health Approaches for Protecting Children* (Vol. 9, pp. 433–454). Springer International Publishing.

Tusla (2014a). Assessment guidance framework. In D. o. P. Strategy (Ed.), (June 2015 ed., Vol. V5, pp. 55). Tusla CFA.

Tusla (2014b). Threshold of need guidance for practitioners in Tusla social work services. In P. a. Strategy (Ed.), (pp. 15). Tusla CFA.

Tusla. (2015). National audit of the standard business processes for child protection and welfare social work services: Intake and initial assessment. (Vol. V 1.9). Tusla: Quality Assurance Directorate.

Tusla. (2020a). *About Us Tusla—Child and Family Agency*. About Us. Welcome to the Child and Family Agency Website. https://www.tusla.ie/about/.

Tusla (2020b) Tusla statement on child abuse substantiation procedure CASP, 4th February 2020 available at https://www.tusla.ie/news/tusla-statement-on-child-abuse-substantiation-procedure-casp/.
U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2021). Child maltreatment 2019. Available from https://www.acf.hhs.gov/cb/research-data-technology/ statistics-research/child-maltreatment.
UNCRC. (2011). *General Comment No13, (2011). The right of the child to freedom from all forms of violence*. United Nations Committee on the Rights of the Child.
UN Committee on the Rights of the Child (CRC) General Comment No. 13. (2011). The right of the child to freedom from all forms of violence CRC/C/GC/13 (2011b). UN CRC. https://www.refworld.org/docid/4e6da4922.html. Accessed 6 December 2018.
UNICEF. (2018). *INSPIRE indicator guidance and results framework-ending violence against children: How to define and measure change*. UNICEF.
UNICEF. (2020). *United Nations children's fund, research on violence against children during the COVID-19 pandemic: Guidance to inform ethical data collection and evidence generation*. UNICEF.
Vaithianathan, R., Putnam-Hornstein, E., Jiang, N., Nand, P., & Maloney, T. (2017). *Developing predictive models to support child maltreatment hotline screening decisions: Allegheny county methodology and implementation* (p. 60). Centre for Social data analytics, AUT University, New Zealand.
van Berkel, S. R., Prevoo, M. J. L., Linting, M., Pannebakker, F. D., & Alink, L. R. A. (2020). Prevalence of child maltreatment in the Netherlands: An update and cross-time comparison. *Child Abuse & Neglect, 103*, 104439. https://doi.org/10.1016/j.chiabu.2020.104439.
WHO. (1999). *Report of the consultation on child abuse prevention, 29–31 March 1999, WHO, Geneva*. World Health Organization.
WHO. (2006). *Preventing child maltreatment: a guide to taking action and generating evidence*. WHO, Geneva
WHO. (2014). *Investing in children: The European child maltreatment prevention action plan 2015–2020*. WHO Regional Office for Europe.
WHO. (2016). *INSPIRE: Seven strategies for ending violence against children*. World Health Organization.
WHO (2017). *WHO guidelines on ethical issues in public health surveillance*. WHO, Geneva.
WHO. (2018). INSPIRE handbook: Action for implementing the seven strategies for ending violence against children. https://www.who.int/publications/i/item/inspire-handbook-action-for-implementing-the-seven-strategies-for-ending-violence-against-children.
Wilkinson, R. G., & Pickett, K. E. (2009). Income inequality and social dysfunction. *Annual Review of Sociology, 35*, 493–511.
Woodruff, B. W., Bornemisza, O., Checchi, F., & Sondorp, E. (2009). The use of epidemiological tools in conflict-affected populations: open-access educational resources for policy-makers. http://conflict.lshtm.ac.uk/page_02.htm.
Woollard, M. (2014). Administrative data: Problems and benefits. A perspective from the United Kingdom. In A. Dusa, D. Nelle, G. Stock, & G. G. Wagner (Eds.), *Facing the future: European research infrastructures for the humanities and social sciences, Berlin* (Vol. 1st)

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