

Community nurses' child protection role: views of public health nurses in Ireland

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Abstract

Public health nurses in Ireland are generalist practitioners with a wide range of roles that address the needs of clients in the community across their lifespan. Child protection is one of many of the roles of Irish public health nurses. However, with increasing caseloads, birth rates and aging populations, their child protection role is becoming more difficult to define and practise safely.

This paper presents a key finding of a qualitative study that explored the views of a group of public health nurses (n=10) regarding their role with pre-school children.

A significant theme following analysis of the interviews were the nurses' expressed concerns on their role in child protection. There is a need to define the role practised by public health nurses in child protection and to achieve a standard for this nationally.

Key words

Child protection, pre-school children, public health nursing

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Introduction and background

In Ireland, the role of the public health nurse (PHN) is guided by the Department of Health and Children (DoHC, 2000) *Circular 41*, which states that the PHN provides antenatal and postnatal care to mothers, pre-school child health, child protection, family support, home and community clinical nursing, care of the older person, care of vulnerable groups, and nursing care of intellectually and physically disabled persons. Recommended populations are approximately 2500 persons per PHN. However, in practice this number can vary from 650 to 6500, ie rural and island areas versus urban areas (Begley et al, 2004). This is further compounded by the recent increasing trends in births and the elderly population (Central Statistics Office, 2006). A migrating population of asylum-seekers to Ireland since 2000 and the aging population have dramatically increased PHNs' caseload and influenced the workload. Issues of concern for PHNs are a caseload that is too large (more than 2500 persons) to identify families at risk. Other issues are that the geographical area of practice is too large or that the role of the PHN is too broad and may need to be specialised (Begley et al, 2004; HSE, 2006).

The PHN has been identified as a key worker with children at risk in the community (DoHC, 2001a; Begley et al, 2004). It is widely documented that physical and sexual abuse receives a 'quicker response' than neglect or emotional abuse (DoHC, 2006). This is pertinent because the specific areas of neglect and emotional abuse, more than physical and sexual abuse, are the areas of child protection that can be identified and addressed immediately by the PHN. The DoHC (2001a) guidelines outline the PHN role in primary and secondary prevention through the provision of education and support to parents and as a contact point for persons with a concern about child abuse. However, PHNs are not educated sufficiently to perform the role of tertiary child protection (Hanafin, 1998). Few Irish studies have highlighted issues of child protection and the

role of the PHN in caring for 'vulnerable' families (Hanafin, 1998; Mulcahy, 2004). Appleton (1996) found that the health visitor's role in relation to working with vulnerable families was one of diversity and conflict, and unrecognised by managers and other health professionals. Moreover, a lack of consensus among health visitors on the role that they should play, in particular in detecting child abuse cases, is reported by Crisp and Lister (2004).

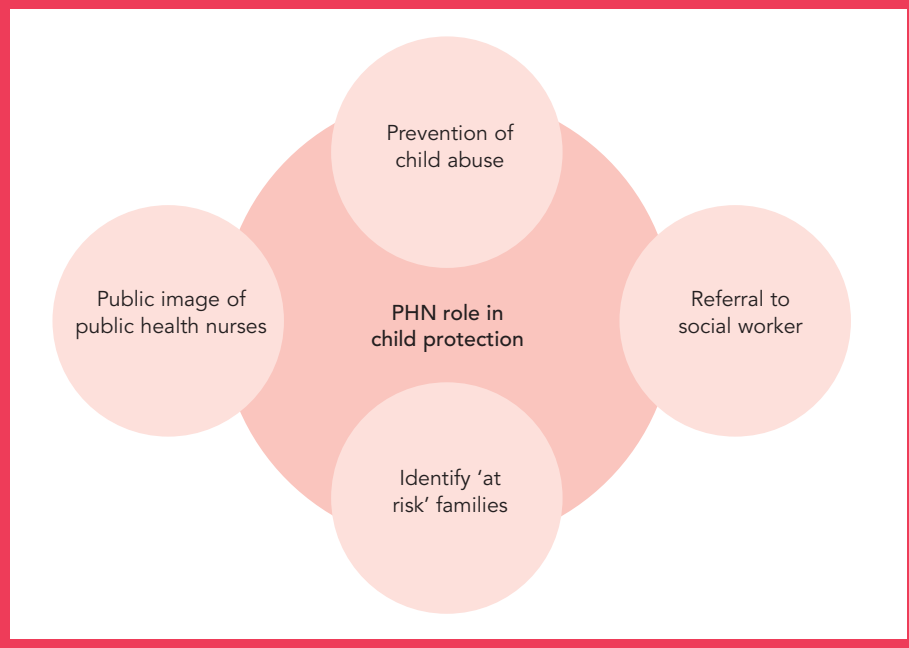
This paper presents some of the findings from a qualitative study that ascertained the views of a group of Irish PHNs (n=10) on their role with pre-school children. The findings identified six roles of Irish PHNs with pre-school children – child protection, health promotion, professional development, child health screening, community as client and parenting skills. The finding 'child protection' is presented within this paper.

Methodology

The study was qualitative in approach. Following ethical approval, information on the study was forwarded to all PHNs in one rural region (n=42) by a gatekeeper nominated by the director of public health nursing. Interested PHNs who wished to take part in the study were invited to contact the first author. The criterion for inclusion was all PHNs working within the healthcare area at the time of study who were directly involved in providing child health care to pre-school children. The exclusion criterion was if they were not involved in providing child health care to pre-school children (for instance, director of PHNs, assistant director of PHNs, PHN for schools, PHNs in liaison roles). Six participants made contact. A subsequent information session on the study and repeat invitation to participate yielded four additional participants.

The 10 participants were all female. Two participants had worked in the community for between 21 and 30 years, seven for between five and 10 years and one had less than five years' community experience. All 10 participants had dual qualifications in

Figure 1. Sub-themes: public health nurse role in child protection



general nursing and midwifery. Eight participants had a higher diploma in public health nursing, and two had a certificate in health visiting. One participant had a bachelor's degree and one a master's degree. Three participants had other qualifications in intensive care nursing, neonatal intensive nursing and lactation consultant. They were all interviewed by the first author in their own work setting. Semi-structured interviewing was employed, and the interviews lasted between 45 and 75 minutes. All of the interviews were tape-recorded and transcribed verbatim.

The first author undertook the data analysis and was guided by King's thematic template analysis (1998). Template analysis involves an initial examination of a small section of the interview data and the identification of themes. These emerging themes are then organised to form a template that is used to analyse all of the transcribed interview text. King's template analysis is popular among qualitative researchers in health care (eg King et al, 2002, 2003; Möller and Adamsen, 2010; Dykes et al, 2011).

Findings

The theme of child protection comprised four sub-themes (see Figure 1). The participants talked about their difficulties with assuming a 'monitoring' role and their professional relationships with social workers. They also expressed views on the importance of maintaining their good relationships with families and the role of primary prevention through identifying families who were 'at risk'.

Prevention of child abuse

Some confusion was evident among participants regarding their interpretation of what 'monitoring' actually meant. One participant suggested that child protection is part and parcel of the job, and that '*you would always have your antenna up*' (P3).

However, most participants relayed unease with the term 'monitoring', which they appeared to suggest was like policing or checking up. Unease was also expressed by many with being asked to monitor a child as a result of a case conference at which the PHN may not have been present:

'I see [monitoring] as an absolute minimum... I'm just there to pick it up... to refer it on... I don't see our role in child protection as hugely big' (P1).

Participants preferred to describe their role as one in which they identify suspected cases of child abuse and refer these on to the social worker. The secondary level of child protection was not discussed, but rather disguised as a routine or opportunistic health screening, as in one participant's comment:

'I would have had a reason to call' (P10).

Nevertheless, participants expressed the desire to practise at a primary prevention level where they could intervene and help families, as indicated in the following:

'At risk families should get plenty of supports' (P7).

Moreover, participants felt that primary prevention practice would avoid issues of child protection:

'The PHN refers on or links into the social worker, attends the kid's conferences and would be on-going support to the family for that' (P1).

Referral to social workers

In the context of child protection, relationships between PHNs and social workers were considered difficult by the participants. This was partly because the PHN often did not know who the social worker was. Some participants did refer to team building initiatives for PHNs and social workers. However, there were frequent changes of social workers '*and then you are back to square one*' (P6).

Participants also mentioned a lack of response or an inadequate response following referrals to social workers:

'You may hear back or you may not' (P5).

'When you try to explain your concerns to them... they don't seem to see it as a priority' (P6).

This latter comment also relates to participants' views on the confusion that can arise about what PHNs and social workers consider as a priority. Participants felt that social workers react quicker to reports of sexual and physical abuse than they appear to react to neglect or emotional abuse.

Role boundaries between PHNs and social workers were also raised by participants. This was not helped by a lack of standardised practice across geographical regions. Participants' views are expressed in the following comment:

'I do think our role is fluffy... We're not that clear' (P1).

Participants also mentioned the effort PHNs make in preparation for conferences and felt that these efforts are often unrecognised by the social workers:

'We refer to and get referrals from GPs and social workers, getting involved in case conferences, vulnerable families etc which take up a huge amount of time on your work' (P5).

Identifying 'at risk' families

Defining what exactly 'at risk' means is difficult. One participant described 'at risk' families as '*those with poor parenting skills and financially poor*' (P10).

Another participant emphasised the importance of parenting skills and the role played by PHNs in this provision:

'We play a very big role in parenting skills and education. From the first meeting, we are educating the mum about child care' (P6).

Education of mothers was considered an important PHN role. When asked what child health meant to her, one participant discussed a mother's health:

'If the mother is well she can then look after the child... I see the mother like a gatekeeper' (P4).

Other participants expressed the view that a mother is the main component in the healthy

welfare of the child and the family. However, child screening clinics are busy:

'Trying to give the time to the mothers can be difficult. That would be the biggest barrier' (P9).

Participants also talked about the lack of access to families when the mother is working. PHNs do not make home visits in the evening.

Many of the participants expressed enthusiasm for the need to address the provision of services in the community that could help families identified as being at risk. This view is illustrated in the following comment:

'I think if we have huge child protection issues it's because we haven't got in there prior to the problem' (P1).

However, practising this primary prevention role was not possible in reality due to the broad caseload carried by PHNs, and the potential for many of the groups in this caseload to be considered as being 'at risk'. This primary prevention role was recognised by all PHNs, but unpractised due to the broad caseload.

Public image of the PHN

The participants emphasised the importance of their public image, which helped them to gain access to families:

'I am the friend. I am on the good side with this family' (P10).

Participants expressed concern that getting involved in monitoring and policing families who were identified as 'at risk' could result in a threat to this friendly image and would concern the PHN:

'Well I certainly don't see my role as a monitoring role because I am not comfortable with that' (P3).

This latter comment was reflective of participants' views generally on their reluctance to visit families at secondary and tertiary management of child abuse. 'Monitoring' of children is a role assigned at case conference and not within the specific academic or professional experience of the PHN.

Discussion

This study has presented the views of a group of Irish PHNs on their role regarding child protection within the context of their overriding role with pre-school children. Of significance is the lack of clarity among participants on the PHN role in child protection and the need for clearer communication systems between social workers and PHNs.

These participants all agreed that the PHN has a mandate to visit families. This visiting role is coupled with the PHN's knowledge of the community and knowledge of how to

KEY POINTS

- The role of public health nurse in Ireland is broad and they have been identified as a key worker with children at risk in the community
- Increased workloads, increased birth rates and an aging population have led to concerns about public health nurses' ability to fulfil their child protection role
- A small qualitative study involving interviews with public health nurses in one healthcare area identified concerns about monitoring at risk children, working with social workers, identifying 'at risk' families and the public image of public health nurses
- There is a need for national standards of practice for public health nurses in secondary and tertiary child protection, and an opportunity to develop specialist and advanced roles

access services to support families. PHNs are therefore ideally placed to act as key workers (DoHC, 2001a; ICHN, 2007). However, there is evidence to suggest a considerable lack of clarity about the child protection service delivered by the PHNs (O'Sullivan, 1995; Hanafin, 1998). Moreover, further inquiry is needed to establish if PHNs want to have the role of key worker.

Participants expressed unease with a monitoring role. However, PHN practice of providing home visits to mothers and children places them in the ambiguous role of simultaneously supporting and policing (Marcellus, 2005). Participants also discussed their public image, and the importance of this image in being able to access families. They also expressed their view of the importance of their relationships with families and feared this could be marred if policing children becomes their role. However, PHNs have been described as being preoccupied with their image in the community and it is suggested that they are failing in their responsibilities to protect children (Butler, 1996).

Referral communication between PHNs and social workers was highlighted by participants as inadequate. Moreover, the participants expressed frustration with not knowing if they were to receive feedback from the social worker. Other studies concur with this belief (Skehill et al, 1999; Hanafin and Cowley, 2003). It is important to highlight here that this inadequate communication between PHNs and social workers comes at a time of upheaval in the provision of primary care in Ireland. The primary healthcare strategy (DoHC, 2001b) proposed the provision of primary care services within the community setting in Ireland. This involved the removal of services from the acute hospital setting to the community. Many health professionals including social workers are involved in these plans, however the transformation has not occurred to one national standard – services are available in one area but not in another. Over time, it is hoped that the different professionals will

share knowledge of each others' roles and provide optimum primary care.

It is reported elsewhere that 'exaggeration of hierarchy' can occur, resulting in the recommendations from the PHN being overridden by other professionals, not always in the interest of the child but rather the health service (Reder et al, 1993; Buckley, 2005). Also reported in the UK are concerns that health visitors may be filling the gap caused by a shortfall in social worker staff (Appleton, 1994). Participants also reported that their prioritisation regarding child protection was not recognised. It is reported elsewhere that referrals made are not prioritised as child abuse even when the referrer states that it is so, and that the screening process is such that many cases of child neglect never get through the system (Dingwall et al, 1983; Skehill et al, 1999). Moreover, Skehill et al (1999) report that the majority of 'new referrals' for child neglect and abuse were already known to the service. This 'revolving door' situation is common practice (Thoburn et al, 2000).

The participants expressed a view on the invisibility of their role. Similar views have been reported within health visiting in the UK, and it is advised that nurses market their role to make visible and credible the work that is done, preventing these families from reaching crisis point (Newland and Cowley, 2003; Plews et al, 2005).

There needs to be more public awareness of the role played by the PHN in the community. One of the greatest deficits in meeting the needs of children at risk is the absence of parenting skills (Reutter and Ford, 1995; Ferguson and O'Reilly, 2001; Peckover, 2002). An important aspect within child protection is observation of the parent and child together, which is not achieved by visiting when in the care of others, eg child minders (Horwath, 2005). However, visiting the mother at home after hours may not be viewed favourably by management, due to risk management issues.

Within Ireland there exists the Child Protection Notification System (CPNS)

(DoHC, 2001b). However, unlike the child protection plans for children in the UK (Munro, 2011), no structure is in place for the PHN to alter their practice in any way because a child is on the system. As highlighted by Hanafin (1998), the PHN has no formal academic or professional education in the care of children placed on the child protection register. Although at child case conferences it may be recommended for the PHN to 'monitor' the child, participants in the study offered that 'monitoring' does not protect the child. Of note also is that participants did not raise their understanding or knowledge of the CPNS in the interviews. This is of concern if this was due to a lack of awareness, though it may have been because the study question did not specially ask about child protection. It may also have been the case that the participants assumed knowledge of CPNS was 'common knowledge' and therefore did not require highlighting in the interviews. Finally, looking to the future, the opportunity to develop specialist and advanced practice roles for PHNs in child protection is evident. A specialist PHN role would focus on the provision of support and care to families identified as being 'at risk'. This role would be at early primary intervention to prevent the onset of child maltreatment through educating parents in parenting skills. At advanced practice level, the role would be within the primary healthcare network at expert level, offering education, support and guidance for practice for PHNs in their role in child protection.

Limitations

This study has a number of limitations. The first author is a PHN and the study participants were aware that her role was similar to theirs. This may have influenced their responses. However, the first author works in a different rural region and was not personally known to any of the study participants.

Furthermore, the participants were self-selecting. They may therefore have had a particular interest in their role with pre-school children, which may have influenced the study findings.

Recommendations

PHNs consider referral communication on child protection issues with social workers to be inadequate. The PHN is also restricted from following up individual cases by the large, broad workload that they possess.

PHNs dislike the recommended role of 'monitoring' in child protection. They feel it does not protect the child and that it damages their roles in working with families.

There is a need for national standards of practice in order to guide PHNs in the care of children at secondary and tertiary level following a case conference.

There is an opportunity to develop a specialist PHN role in the provision of support and care to families identified as being 'at risk', and for role development at advanced practitioner level.

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