Tackling child neglect: exploring a public health approach in Scotland

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Declaration

I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree. I declare that I have composed this thesis myself and that it embodies the results of my own research. Where appropriate, I have acknowledged the nature and extent of work carried out in collaboration with others included in the thesis.

Aikaterini Kyriakou
September 2021

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Abstract

Neglect is one of the most prevalent forms of child maltreatment in the UK. The effect of neglect is complex and long-term. Despite parenting interventions to address the risk factors that contribute to neglect, the problem is still increasing. This is at least partly linked to wider structural factors of poverty and unemployment, which continue to affect some families where neglect is an issue. Although incidence of identified cases of neglect is high, many children who experience neglect are not known to services. Framing neglect as a public health issue enables practitioners to address it at the level of population health and wellbeing, rather than at an individual level.

This study aimed to explore the components of a public health approach to neglect, which is often discussed by professionals within the child protection field and in the relevant literature, but it is not clear how to translate this approach into practice. Interviews, focus groups and a three-stage online survey were used as methods to explore participants' views regarding the prevention of child neglect and to determine how families can be better supported. Participants included professionals from the fields of child protection and public health, parents in contact with services that provide support, and young people with care experience in Scotland.

The findings suggest that a public health approach should involve a combination of universal and targeted services, and a continuum of support should be made available to all parents, based on their needs. It was also suggested that the approach must make sure that such support is accessible and must recognise the importance of relationships between professionals and families, provide stable support, and promote a sense of control over their lives. In addition to this, inequalities that affect parenting need to be addressed, as a core aspect of the approach. Areas for consideration for moving forward were identified in the thesis.

Table of Contents

List of Abbreviations

ACEs	Adverse Childhood Experiences
BOS	Bristol Online Surveys
CAMHS	Child and Adolescent Mental Health Services
CELCIS	Centre for Excellence for Looked after Children in Scotland
CfE	Curriculum for Excellence
COM-B	Capability–Opportunity–Motivation–Behaviour model
CPC	Child Protection Committees
CPIP	Child Protection Improvement Programme
CPO	Child Protection Order
CSO	Compulsory Supervision Order
ECM	Every Child Matters
GDPR	General Data Protection Regulations
GIRFEC	Getting It Right For Every Child
GUEP	General University Ethics Panel
JISK	Joint Information Systems Committee
ICSO	Interim Compulsory Supervision Order
ISPCAN	International Society for the Prevention of Child Abuse and Neglect
LONGSCAN	Longitudinal Studies of Child Abuse and Neglect
NSPCC	National Society for the Prevention of Cruelty to Children
NYSPCC	New York Society for the Prevention of Cruelty to Children
PCHR	Personal Child Health Record
PhD	Doctor of Philosophy
SCR	Significant Case Reviews
SCRA	Scottish Children’s Reporters Administration
SHANARRI	Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included
TA	Thematic analysis
UK	United Kingdom
USA	United States of America
UNCRC	United Nations Convention on the Rights of Children
WHO	World Health Organization

List of Figures

List of Tables

Chapter One: Introduction

1.1 Chapter introduction

Every child has the right to dignity, fairness and protection, to the development of their full potential, and to their participation in all matters affecting them. Family is a fundamental part of a child's life, and a child should not be separated from his/her family unless s/he is not being looked after properly. Every action taken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies should be in accordance with the best interest of the child (United Nations Convention on the Rights of Children (UNCRC) 1989).

Child maltreatment is an adverse experience that negatively affects a child's life and family cohesion. Child maltreatment is defined by the World Health Organization (WHO) as "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (WHO 1999, p. 15).

The focus of this Doctor of Philosophy (PhD) project is on child neglect and its prevention in Scotland. Within the National Guidance for Child Protection in Scotland (Scottish Government 2014),[1] child neglect is defined as:

> The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child from physical harm or danger, or to ensure access to appropriate medical care or treatment. It may also include neglect of, or failure to respond to, a child's basic emotional needs. Neglect may also result in the child being diagnosed as suffering from non-organic failure to thrive, where they have significantly failed to reach normal weight and growth or

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[1] The new National Guidance for Child Protection in was published on 2nd September 2021, as this thesis was being submitted. However, this study took place place when the 2014 guidance was in place, and it therefore underpinned practice at that time.

> development milestones and where physical and genetic reasons have been medically eliminated. In its extreme form, children can be at serious risk from the effects of malnutrition, and lack of nurturing and stimulation. This can lead to serious long-term effects such as greater susceptibility to serious childhood illnesses and reduction in potential stature. With young children in particular, the consequences may be life-threatening within a relatively short period of time. (Scottish Government 2014, p. 12)

This chapter introduces the reader to the background to this thesis. First, it provides information about me, as the researcher, and about the funders of this project. Then, it focuses on the events which shaped the child protection field, and highlights what is known about the extent of child neglect. A description of the legislation and guidance relating to child protection in Scotland is also presented, followed by an introduction to the principles of public health and what a public health approach to child neglect may include. Following this, an explanation of the reasons why this study was conducted, and the study's overall aim, are presented. The final part of this chapter then outlines the seven further chapters of this thesis.

1.2 A few words about the researcher and funders

Although I was aware of violence against children through my previous studies (BSc in Psychology, MSc in Health Psychology and MA in Developmental and Therapeutic Play), I was first involved as a researcher in a project about child maltreatment in 2013 in Greece. The focus of that project was on developing guidelines for different professional sectors (i.e., health, education, police) on the management of cases of child abuse and neglect. This provided a step-by-step guide to the identification, reporting and assessing of child maltreatment. At that point, I became interested in what might enhance a preventive approach to child abuse and neglect.

This PhD project, undertaken at the University of Stirling, provided an opportunity to explore the area of prevention and to expand my knowledge by focusing specifically on child neglect. I knew that conducting a PhD degree in a language that was different from my mother tongue (I am from Greece) and in a new context (Scotland) would be demanding – demanding in terms of becoming familiar with the child protection laws and policy of another country, managing language issues, and setting up a life in a new country. However, I wanted to make a contribution to the field of child protection, which I found to be both challenging and interesting.

The PhD project was funded by a collaborative studentship between the University of Stirling and Action for Children. Action for Children is a children's charity, active throughout the four nations of the United Kingdom (UK). Their vision is that "every child and young person in the UK has a safe and happy childhood, and the foundations they need to thrive" (Action for Children 2020, paragraph 1). Action for Children is engaged in a range of activities, which include supporting parents, children, young people and families, campaigning for change, publishing research and influencing policy, and being involved in fostering and adoption processes (Action for Children 2020).

1.3 Overview of the phenomenon of child maltreatment

Concerns around child maltreatment emerged in North America and Western Europe in the late 1800s. The first legal authorisation of child protection services to intervene in order to protect children from child maltreatment emerged in the late 19th century. In the UK, Thomas Agnew, inspired by the pioneering work of the New York Society for the Prevention of Cruelty to Children (NYSPCC[2]), founded the Liverpool Society for the Prevention of Cruelty to Children in 1883. This led to the establishment of the London Society for the Prevention of Cruelty to Children a year later, which subsequently became the National Society for the Prevention of Cruelty to Children (NSPCC) in 1889. In the same year, with the efforts of the NSPCC to promote legislation, the Prevention of Cruelty to, and Protection of, Children Act 1889 (also known as the 'Children's Charter'[3]) was passed. This was the first time that public authorities in the UK could intervene in family life to protect children (NSPCC 2000). Later, in the first half of the 20th century, free school meals, medical inspections of children in primary schools, and punishment for neglecting children and welfare services were introduced in the UK.

The landscape of child protection has been shaped over the years by inquiries following a child's death due to maltreatment, often accompanied by media coverage and public attention/pressure, and I shall outline some of these here. In 1945, Dennis O'Neill (aged

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[2] NYSPCC was founded in 1874 in the USA after the death of Mary Ellen McCormack, a 10-year-old girl who experienced ongoing physical abuse by her adoptive mother in New York. It was the first child protection agency in the world that contributed to child protection legislation in the USA.

[3] In 2004, its namesake, the Children's Charter in Scotland, set out what children could expect from the adults who were in contact with them. https://www2.gov.scot/Resource/Doc/1181/0008817.pdf

13 years) was beaten to death by his foster father after he had suffered starvation for months. The subsequent inquiry (Monckton Report) (Home Office 1945) underlined failures by the agencies involved and a lack of communication between the two local authorities involved in Dennis' foster placement. The inquiry led to the Children Act 1948, which established that local authorities are responsible for children whose parents were 'unfit or unable' to care for them. In 1973, Maria Colwell (aged seven years) died due to multiple injuries inflicted by her stepfather. The report of the inquiry (Secretary of State for Social Services 1974) underlined poor communication and liaison among all those involved (i.e., schools, social services, housing services, local community). The report's publication led to more coordination between local agencies and introduced inter-agency area review committees, known later as Area Child Protection Committees.

In 1992, nine children were removed from their families in Orkney following allegations of sexual abuse. The Sheriff dismissed the case as flawed. The report of the Orkney Inquiry (Clyde Report 1992) criticised all those involved (social workers, police and the Local Council) in relation to the way in which the decision to remove the children was reached, how it was implemented and how the interviews with the children took place. The inquiry strongly influenced aspects of the Children (Scotland) Act 1995, presented later in this chapter. In the early 2000s, Victoria Climbié (eight years old) died from hypothermia in England after suffering abuse and neglect by her aunt and her boyfriend. Following the inquiry into her death (Laming 2003), Every Child Matters (ECM)[4] was launched in England. It introduced the five principles (be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic well-being) that are at the heart of interaction with all children and intend to ensure children's safety and provide the best possible chances in their lives (Every Child Matters 2003). In 2001, Caleb Ness (11 weeks old) died in Edinburgh due to non-accidental injuries caused by his father. The report of the inquiry (O'Brien Report 2003) underlined serious failures across and between a range of agencies, including a lack of co-ordination between services (health and social work), problems in sharing information across agencies, variation in the expectations of managers in different agencies, and a lack of proactive involvement of the social worker in assessment, decision-making and supervision. Following the death of Peter Connelly in 2007 and the Laming Review (2009), in an online survey with English

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[4] ECM is no longer an accepted term, as it was replaced by Help Children Achieve More in 2010.

local authorities, directors of children’s services and case study work participants reported an increase in public and practitioner interest about child protection issues following the case of ‘Baby P’ (Macleod et al. 2010).

Outside the UK, interest in child protection in the early ‘60s was prompted by the publication of the paper by paediatrician Henry Kempe and colleagues, which coined the phrase the ‘Battered Child Syndrome’ (Kempe et al. 1962). Although this was not the first time that the phenomenon had been described or had gained attention (for example, radiologists had previously speculated about the causes of unexplained injuries (Caffey 1946)), it is considered to be a crucial moment in the field of child maltreatment. The paper provided a rich insight into the phenomenon of child maltreatment, and evoked significant media attention that raised public awareness about child protection issues. The report of Kempe and colleagues (1962) was also influential in the developing field of child neglect. As noted by Dubowitz (2013), it was one of the first times that the term ‘neglect’ appeared in the medical literature; the report also outlined the need to investigate and address the social factors associated with child maltreatment and, for the first time, child neglect was included as part of a spectrum of child maltreatment.

In the late ‘80s, child neglect, together with the other forms of child maltreatment, was recognised by the UNCRC as a violation of children’s rights (Article 19) (UNCRC 1989). A decade later, the WHO (1999) recognised the phenomenon of child abuse and neglect as a major public health issue. In 2002, the WHO included child maltreatment in its typology of violence as a form of interpersonal violence under the sub-category ‘family and intimate partner violence’ (Krug et al. 2002).

1.4 The extent of child neglect

Despite recognition of child maltreatment as a major public health issue and actions to protect children from harm, child neglect is the most frequent form of child maltreatment. In Scotland, on 31 July 2020, 2,599 children’s names were listed on the Child Protection Register. Neglect was one of the most common reasons for registration (1,112) (Scottish Government 2021a). The figure of 1,112 represents 42% of all registrations for neglect in Scotland in 2020 and 0.12% of the Scottish population aged 0–15 years. This means that, for every one thousand children, one child is listed on the child protection register due to neglect.

While figures are not directly comparable, in the United States of America (USA) in 2018, 678,000 children, who were known to child protective services agencies, had experienced maltreatment. Of these children, 60.8% experienced neglect, compared to 10.7% who had experienced physical abuse, and 7%, sexual abuse (United States Department of Health and Human Services 2020). In Australia, 21% of 170,200 children who received child protection services in 2018–19 experienced neglect, and this was the second-most common type of maltreatment substantiated through investigations (the first was emotional abuse, at 54%) (Australian Government 2020).

However, these figures represent only those cases of child maltreatment (including child neglect) known to authorities. The incidence of maltreatment is often represented as an 'iceberg' (Figure 1). The iceberg metaphor highlights that, while a number of children are known to services (i.e., social services, school or police), there are likely to be children experiencing child maltreatment but who are unknown to services due to maltreatment. The metaphor also highlights that the information about child neglect is partial – based on the population who are known to services (Bianchi and Ruggiero 2009).

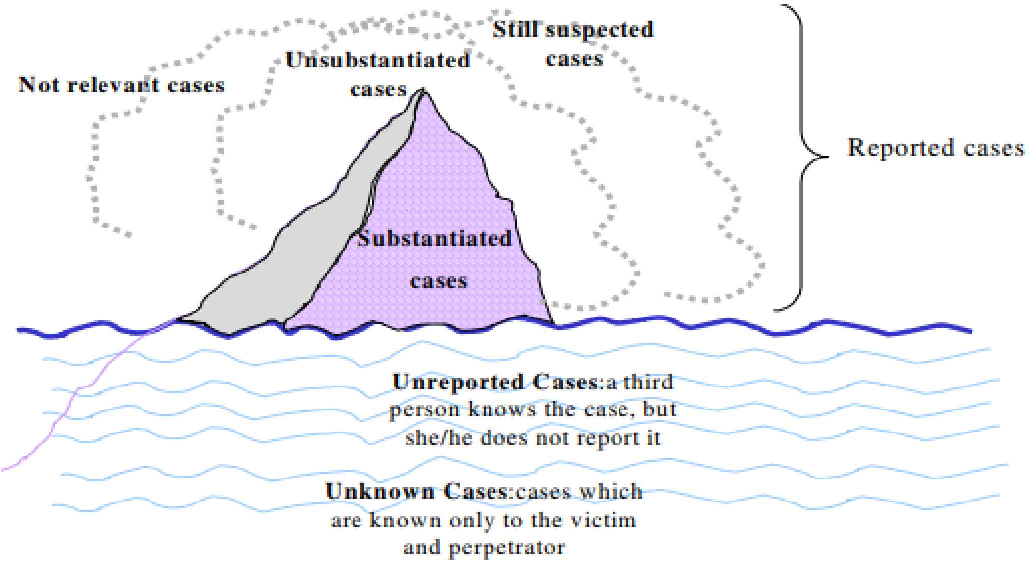

Figure 1: The child abuse and neglect iceberg (Bianchi and Ruggiero 2009)

Given the high prevalence of child maltreatment, the prevention of child maltreatment, including child neglect, is also a crucial part of the agenda in protecting children from violence. This is in accordance with UNCRC (Article 19) and is underlined by global-level organisations (i.e., the WHO), international non-for-profit organisations, such as the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), national charities, such as Action for Children in the UK (Burgess et al. 2014), and researchers in the field (Gilbert et al. 2012; Higgins 2015; Munro 2011; Scott et al. 2016). It also appears that, on a national level, many countries are committed to preventing maltreatment. In the European status report for the WHO, 37 (76%) of the 49 participating countries reported having a national action plan for preventing child maltreatment (Figure 2). However, 22% of these plans were not informed by national surveys of the prevalence of child maltreatment, which could lead to unrealistic objectives and raises concerns over their effectiveness, as these surveys offer important information about the true size of the problem (Sethi et al. 2018).

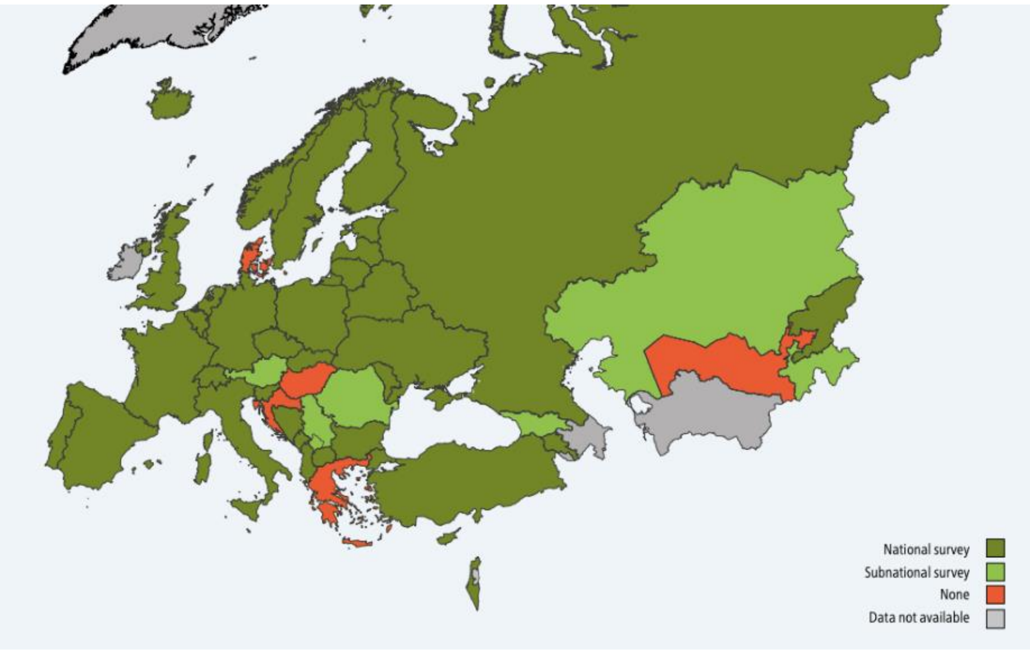

Figure 2: Countries that reported a plan on child maltreatment prevention (Sethi et al. 2018)

1.5 The Scottish context: Legislation, policy and guidance

Scotland is a country of almost 5.4 million people, and, in mid-2019 (30 June 2019), 17% of the population was under the age of 16 (National Records of Scotland 2020). The Scottish Government has a stated ambition for Scotland to be the best place in which to grow up. The stated aim was that children and young people should be at the heart of every action and their rights respected across Scotland. The Scottish Government has set out legislation, policy and statutory guidance on how the child protection systems should work in Scotland. There are three systems involved: local authorities,[5] Children's Hearings, and the Courts, and children may be involved in all three systems. The legislative framework for children that is relevant to this study includes the following Acts.

The Children (Scotland) Act 1995 outlines parental responsibilities and rights in relation to children (i.e., responsibility to safeguard and promote the child's health, development and welfare, and the right to act as the child's legal representative). Under Section 22 of the 1995 Act, the local authority has a duty to 'promote the welfare' of children in need by providing a range of services. A child is in need if he/she requires care and attention because: (a) he/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development unless the local authority provides services for him/her; (b) his/ her health or development is likely significantly to be impaired, unless such services are so provided; (c) he/she is disabled; or (d) he/she is affected adversely by the disability of any other person in his/her family (Section 93). Under Section 25, children and young people can become looked after away from home.

Under Section 27, the local authority has the duty to provide day care for children within their area who are aged five or under and who have not yet started school. Day care services offer opportunities for children to broaden their experiences and learning, and to enhance their social and educational development. In addition to day care services, a local authority may provide facilities, including training, advice, guidance and counselling for parents or other carers who accompany children whilst they are in day care.

The Children's Hearings (Scotland) Act 2011 underpins the Children's Hearings System in Scotland. Children's Hearings is a care and justice system for children and young people under the age of 18. A child or young person can be referred to Children's Hearing after a referral to the Reporter from agencies such as the police, social work or education, or referred by parents, family members, carers or any member of the public who has concerns about a child or a young person (Section 67(2) of 2011 Act), or following emergency child protection measures, such as a Child Protection Order (CPO) granted by a sheriff.

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[5] There are 32 local authorities in Scotland. The largest of these is Glasgow City Council, and the smallest is Orkney Islands Council.

A Children's Hearing consists of three volunteer Children's Panel Members (who are trained) who make decisions based on reports and discussions with families, children and young people, and professionals. The Panel can make a range of decisions, including supervision measures to protect the child/young person, or they can make an Interim Compulsory Supervision Order (ICSO) or a Compulsory Supervision Order (CSO), which can be either home-based (looked after at home) or away from the child's home (looked after away from home).

Three child-centred principles are at the core of the Children's Hearing system in Scotland:

- The welfare of the child is the paramount consideration,
- A child has the right to express her/his views is relation to decisions and these views must be taken into account,
- The no order principle (no order should be made in relation to a child unless it is better to make an order than not to).

Getting it Right For Every Child (GIRFEC) is the children's policy in Scotland, and, according to the Scottish Government, the aim is to provide the right support at the right time, from the right people (Scottish Government 2018b). Eight indicators (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included) are used to assess the wellbeing of children and to determine whether intervention is required (commonly referred to as-SHANARRI). A key aspect of GIRFEC is that it is an integrated approach in which different agencies work together under a common framework in order to have a single child's plan. This approach marks a shift from individual assessment by each agency to a more holistic consideration of the needs and concerns in the wider context of the child's life (Coles et al. 2016; Aldgate and Rose 2008). The Children and Young People (Scotland) Act 2014 embeds key elements of the GIRFEC approach into law. The 2014 Act sets out a definition of wellbeing in legislation (part 18). It requires a Child's Plan (a plan of a child's wellbeing needs, and the necessary targeted intervention/s to be provided) to be produced by the relevant authority for those children and young people who require extra support (i.e., access to mental health services), and it places duties on public bodies to work together in planning, developing and delivering services for children and young people (part 5). However, part 4 and part 5 of the Act (which required the identification of a named person for each child and young person up to their 18th birthday, who had responsibility for promoting, supporting and safeguarding the child’s wellbeing) did not come into effect.

The 2014 Act also places the UNCRC at the core of services for children and young people (part 1). Further to this, under part 3 of 2014 Act, each local authority and the relevant health board are required, in respect of each three-year period, to prepare a children’s services plan for the area of the local authority. This includes a plan for the provision of children’s and related services over the specified time and area. The aim is to ensure that services in the local authority area are provided in a way that safeguard, support and promote the wellbeing of children, provide early intervention, are integrated, are focused on preventing needs from arising, and use all the available resources. The 2014 Act also increased the duration of free early learning and childcare for pre-school children (part 6) and introduced better planning for looked after children/young people. Young people who cease to be looked after on or after their 16th birthday and whose final placement was ‘away from home’ are eligible for continuing care, up to and including the age of 21 (part 11); the aim is to provide a graduate transition out of care, maintain supportive relationships, and avoid co-occurrence of multiple disruptions in young people’s lives at the same time, with after-care extended until 26 years of age.

Another approach in children services is the Universal Health Visiting Pathway in Scotland (Scottish Government 2015). This is intended to provide a consistent approach to health visiting services across Scotland. The Universal Pathway consists of 11 home visits to all children (8 within the first year of a child’s life, and 3 Child Health Reviews between the age of 13 months and 4–5 years). When there are concerns, or when children are on the Child Protection Register, additional support is offered to children and/or carers (i.e., additional health visiting support, parenting support, and specialist medical input). The approach aims to be person-centred, focusing on safeguarding the wellbeing of children and offering advice and support to parents. It emphasises building on existing family strengths, while assessing and responding to their needs.

The National Guidance for Child Protection (Scottish Government 2014) in Scotland informs practice for anyone working in Scotland with/for children in relation to child protection. According to the Guidance (paragraph 129), all agencies, professional and public bodies, and services that deliver adult and/or child services and that work with children and their families have a responsibility to recognise and actively consider potential risks to a child, irrespective of whether the child is the main focus of their involvement. In each local authority, Child Protection Committees (CPCs) (locally based, inter-agency strategic partnerships) are responsible for the design, development, publication, distribution, dissemination, implementation and evaluation of child protection policy and practice across the public, private and wider third sectors in their locality and in partnership across Scotland (paragraph 140). The local authority is also responsible for maintaining a Child Protection Register (paragraph 57). According to the 2014 Guidance, when a child is placed on the Register, all areas of concerns are identified and recorded instead of the primary type of child maltreatment (as used to be the case).

1.6 Public health and child protection

This thesis is interested in exploring the potential of a public health approach for tackling child neglect. Public health was defined by Acheson in 1988 as “the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society” (Rechel and McKee 2014, p. 3). Fundamental to public health is the prevention of problems before they occur, through the implementation of policies and interventions that target known risk factors, quickly identifying and responding to problems if they occur, and minimising the long-term effects of the problems (WHO 2006). The focus is ‘upstream’, closer to the causes of the risk factors that contribute to the phenomenon of interest (in this case, child neglect) and on preventive actions that are aiming to reduce these factors.

Universalism and primary prevention, which targets the whole population, underpins a public health approach, but it also takes into account the population at risk and those already affected, through secondary prevention interventions, and also tertiary prevention, with interventions that focus on avoiding recurrence and enhancing healing (Tones and Green 2004). However, Marmot (2010) introduced proportionate universalism (in reducing health inequalities), which refers to the resourcing and delivering of universal health services on a scale and intensity proportionate to the degree of need.

In relation to child protection, Herrenkohl et al. (2015) and Higgins et al. (2019a) have also noted that achieving major reductions in rates of child maltreatment requires protecting all children in the population from risk, not only those at high risk. A public health approach to child maltreatment will involve strategies along a continuum: a range of strategies that are directed to a broad audience but that are also linked with specific services for individuals that need additional support (Herrenkohl et al. 2016). Strategies on a whole-of-population scale are important, given that the true prevalence of child maltreatment, as identified above (the iceberg, see Figure 1), is difficult to establish. Marmot (2014) also argued that “universalist policies were preferable to those targeted at specific groups for several reasons … targeting implies labelling with all the attendant hazards of stigma … Targeting only those at highest risk misses much of the problem” (Marmot 2014, p. 295).

Public health also recognises that a wide spectrum of factors affects individuals’ lives and their health, including societal and environmental factors. The social model of health developed by Dahlgren and Whitehead (1991) describes the multiple influences on health by mapping the relationship between the individual, their environment and health (Figure 3).

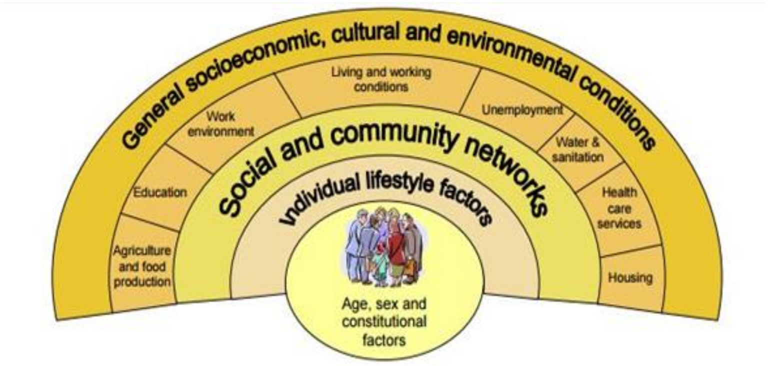

Figure 3: The social model of health (Dahlgren and Whitehead 1991, p.11)

According to this model, individuals are placed at the centre and are surrounded by layers of influences on health – moving from individual lifestyle factors and community influences (social support networks) through living and working conditions to more general social/structural conditions (economic, cultural and environmental determinants) (Dahlgren and Whitehead 1991). In relation to child maltreatment, a public health approach should consider the broader context of child health and parents’ capacity, which may be influenced by wider social factors (Browne 2007). Therefore, the social model of health is particularly appropriate and was chosen as the underpinning model of public health that informed this study, as it recognises the wide spectrum of factors that may have an impact on individuals and, in this case, family life.

1.7 Why a public health approach to child neglect is needed

The effects of neglect can be severe, affecting not only children’s lives in the short term, but also their development and their future life chances in the long term (Burgess et al. 2012; Allnock 2016). The combined short- and long-term costs of neglect for society are enormous. The estimated average lifetime cost of non-fatal child maltreatment (including costs to the health care, social care, education and criminal justice sectors, and to the wider economy in terms of lost productivity) by a primary caregiver in the UK is approximately £89,390 per child (Conti et al. 2017).

Furthermore, child protection systems face high and increasing demands that outstrip capacity to respond effectively to all children and young people in need (Community Care and UNISON 2017; Munro 2011). The recognition of neglect may be difficult for professionals as thresholds for protective interventions might not be clear and only serious incidents of neglect become known to services (Wilkinson and Bowyer 2017). There is also a need for a coordinated response to address the wider context of child neglect, such as poverty and unemployment. Based on a large quantitative study across the UK focusing on children in contact with children’s services on a single date in 2015, Bywaters et al. (2018) reported that the chances of receiving a child protection intervention increases in relation to neighbourhood deprivation. This indicates that the family’s socio-economic background is an important factor. Morris et al. (2018) reported that social workers participating in their study recognised and were more focused on the impact of poverty on family (i.e., poor housing) rather on being engaged in addressing the root of a family’s issues; namely, wider systemic inequalities. A number of pressures, such as caseloads, timescales and budget cuts, were described by social workers as being barriers in attempting to engage with the root of the issue (Morris et al. 2018).

Overall, taking the above into consideration, and the fact that, despite such efforts, child neglect still affects children’s lives, it can be argued that there is a need for a different approach to child neglect. The current PhD project was established to explore how a public health approach could contribute to tackling child neglect in Scotland, and what practitioners envisage this might look like. Although the study took place in a Scottish context, given the prevalence of neglect in and outside of the UK, it is expected that the findings of this study will make a contribution to the knowledge base in Scotland and beyond.

1.8 Structure of the Thesis

This chapter has contextualised the thesis. Chapter Two presents a narrative review of the literature regarding the phenomenon of child neglect and a public health approach in relation to this context.

In Chapter Three, the study objectives and the research questions are presented, together with a detailed description of the research methodology and methods, including the process of data collection and analysis. It reflects on ethical considerations and the processes which were followed to gain ethical approval. A description of the study participants is also presented in this chapter.

Chapters Four, Five and Six present the findings, based on the analysis of data gathered from parents (interviews and focus groups), young people with care experience (focus group and a written note provided by a young person) and professionals (online study and focus group).

Chapter Seven presents a synthesis of the results with the potential components of a public health approach to child neglect. The strengths and limitations of this study are also considered in this chapter. Finally, the thesis concludes with a discussion of the contribution of the research to the knowledge base, along with some conclusions.

1.9 Chapter summary

Child neglect is a complex phenomenon that requires multiple levels of intervention in order to be prevented. Despite the attention that a preventative approach to neglect has received, it is not clear how a public health approach to neglect could be developed in practice. This thesis aims to explore the different elements that can contribute to tackling child neglect in Scotland. It therefore makes a contribution to the knowledge base to inform practice.

Chapter Two: A review of the literature

2.1 Chapter introduction

In this chapter, the search strategy and an overview of a literature review are discussed. The chapter begins by explaining what approach was chosen for the literature review. It discusses definitions of child neglect, the magnitude of the issue, the effects of neglect on children, and the role of resilience. It continues by exploring the commitment of the Scottish Government to protecting children and young people. Then, it presents a description of different models of public health and its key principles, as well as exploring how existing research conceptualises a public health approach to child neglect. The chapter concludes by presenting the rationale for this study.

2.2 Search strategy

The purpose of this review was to explore what was already available in the field of preventing child neglect and to identify potential gaps. In particular, I intended to identify what is already known about child neglect and public health and what is the current knowledge and thinking regarding a public health approach to child neglect.

Overall, the objectives for this review were:

- To provide an overview of understanding regarding child neglect.
- To explore what constitutes public health and its potential contribution to child neglect.
- To identify the current thinking (if any) regarding a public health approach to child neglect.
- To use this review as a base to develop the current study.

However, it was apparent at the beginning of the PhD that the volume of literature on these topics is extensive, and that I would not be able to manage this volume effectively and make conclusions. Therefore, the review focused on three parts: child neglect, public health, and the common ground between these. Each part will be discussed later in this section.

According to Aveyard (2014), literature reviews are crucial parts of research because they gather the available information on a topic and provide a broad perspective on current knowledge. There are different approaches to literature reviews: systematic review (a review of a focused question that uses systematic methods to find, select and critically assess all relevant research); scoping review (a review of the existing literature in a specific field aiming to map the volume, nature, and characteristics of the research available); rapid review (the systematic review process is simplified to be conducted in a timely manner); or narrative/traditional review (review articles that discuss a specific topic without a systematic method of searching being required) (Hart 2018).

It is important to note that a systematic literature review (Higgins and Green 2011) was not within the scope of this doctoral study, as the focus was on exploring what is available, not on conducting a review to answer a specific question and have specific aims, for instance, about the feasibility or effectiveness of a certain intervention. The element of exploring a broad literature, including different types of sources (peer reviewed articles and literature outside of the academic publishing), fits better with a scoping review method, in which the aim is to provide an overview of the evidence (Moher, et al. 2015). However, mapping the volume and characteristics of the available literature, which is required in this type of review, was beyond the scope of this PhD study.

For the purposes of this study, a narrative review was chosen, in order to explore the current knowledge and to identify the key literature in three areas: child neglect, public health, and a public health approach to neglect. I chose this type of review in order to review the most important and critical aspects of the current knowledge regarding the topic and to be as inclusive as possible. However, in order to overcome any subjectivity in the study selection, which is a limitation of narrative reviews (Ferrari 2015), I used a structured approach to search the literature.

The types of literature reviewed included: (a) peer-reviewed journal articles and books; and (b) grey literature, including the legislation, policy and guidance of the Scottish Government and reports from organisations active in the UK (i.e., the NSPCC, Action for Children) and internationally (i.e., the WHO). According to Greenhalgh and Peacock (2005), reviews of interventions that are considered complex in health and social work may require a broad search method in order to include the relevant sources of information and to inform a research project.

The review was conducted in two parts, the first between December 2016 and September 2017. After that, the focus of the PhD programme was on data collection and analysis.

Later, once I completed the analysis, I reviewed the literature again, in order to include more recent studies and sources; this was conducted from June to August 2020.

As mentioned above, the review focused on three areas, and the search terms that were used for each are summarised in Table 1.

Table 1: Search terms

Focus	Search terms
Child neglect	Child neglect, child abuse and neglect, child maltreatment, child abuse, abuse and neglect Definition, define, types Consequences, outcomes, effects, impact Risk contributors, risk factors, causes
Public health	Public health, public health approach, community health, prevention Principles, key aspects, focus, basis History, evolution, development
Public health approach to child neglect	Public health approach(es) to child neglect/child maltreatment/child abuse and neglect/ child abuse, prevent child neglect/child maltreatment/child abuse and neglect/ child abuse, preventive approach/strategy to child neglect/child maltreatment/child abuse and neglect/ child abuse

2.2.1 Child neglect

The following research questions were addressed for this part of the review: What is defined as child neglect and what is the extent of the issue? What factors are contributing to child neglect and what are the consequences of experiencing neglect?

The search used the following filter: peer-reviewed journal articles in the last 20 years (1997–2017), written in English language. This timeframe was adopted for searching the literature, because the 1990s is a period when improvements in protecting children and the role of professionals occurred.

Studies were included when research participants comprised professionals involved in child protection and public health, parents, children and young people. Primary and secondary studies were both included. Articles were excluded if they only focused on physical, sexual or emotional abuse. Papers exploring child maltreatment without distinctions of types were included. Furthermore, articles were excluded if the country of the study was anywhere other than the UK, Australia and New Zealand, North America and Europe. Finally, articles about specific indicators of child neglect and/or guidelines on recognition of child neglect from specific professionals (i.e., teachers, health visitors) were excluded, as indicators and recognition of child neglect was beyond the scope of this review.

2.2.2 Public health

This part of the review addressed the following question: How has public health developed over the years, and what is considered to be a public health approach?

The search was conducted using the following filters: peer-reviewed journal articles between 1991 and 2017, and published in the English language. This timeframe was adopted because 1991 was the year in which the ecological model of public health was presented by Dahlgren and Whitehead, recognising the multiple levels of influence in health, and enhancing the development of more holistic interventions.

Papers were included when they were about defining public health and/or the key elements of this approach. Articles were excluded if the country of the study was anywhere other than the UK, Australia and New Zealand, North America and Europe. Articles focusing on preventing specific diseases (i.e., Tuberculosis) were excluded, as the focus of the review was not on infection control.

2.2.3 Public health approach to child neglect

The questions for this part of the review were: What is known about preventing child neglect? What is known about a public health approach in tackling child neglect?

The search used the following filters: peer-reviewed journal articles published in the last 20 years (1997–2017), and those published in the English language. Primary and secondary studies were both included. Articles were excluded if they only focused on physical, sexual or emotional abuse. Papers exploring child maltreatment without distinctions between types were included. Furthermore, articles were excluded if the country of the study was anywhere other than the UK, Australia and New Zealand, North America and Europe. In addition, legislation, policy documents, and guidance issued by the Scottish Government were also reviewed. The criteria for inclusion were children's safeguarding in Scotland and/or the prevention of child neglect and/or child maltreatment and currency (i.e., current legislation). Sources were excluded if they explored only physical, emotional and/or sexual abuse.

It is also important to note that, in each part of the review, books and reports from a range of organisations were considered. Inclusion was based on their relevance to the topic – what does this book/report contribute in answering the questions asked for each part of this review? Key texts were also suggested by my doctoral supervisors. The same timeframe was used in this part as in the review of journal articles.

2.2.4 Search process for articles, books and grey literature

The databases of SocIndex with Full text and Health Source: Nursing/Academic Edition were searched for related articles. Google Scholar was also used.

In the initial part of literature review, articles for all three parts, identified by search, were screened by checking the title. A total of 4,735 articles were identified from the databases and Google Scholar for all the three parts. A number of articles (1,912) were duplicates and were excluded. Following this, the remaining articles (2,823) were filtered by reading the title and abstract according to the above-mentioned criteria to determine their relevance in answering the question for each part. A total of 2,550 articles were excluded as they did not meet the criteria. The remaining (273) articles were read in full. Of these, 58 articles were identified as being relevant. Reference tracking (Greenhalgh and Peacock 2005) was employed to scan the reference lists of all 58 papers to identify any additional relevant papers. Another 107 articles were identified and read in full, and, of these, 27 articles were considered to be relevant. Finding relevant papers when searching for other sources (serendipitous discovery) (Greenhalgh and Peacock 2005) also occurred. A total of six articles were included as relevant. Overall, 91 journal articles were included in the review in the initial phase.

Books were identified through the search engine of the University of Stirling Library. Books were initially identified after screening their titles (and, when the title was too generic, their appendices) for relevance. A total of 41 books met the criteria of relevance.

After reading in more detail, 14 books were included in the review. In addition to this, six books were suggested by my supervisors. Overall, 20 books were included in the initial phase of the review.

Reports from organisations active in the UK (i.e., the NSPCC, Action for Children) and internationally (i.e., the WHO) were searched through their websites and the Google search engine to identify relevant documents. Reports from the Scottish Government were also searched where relevant. After checking the titles of the reports, 38 reports were identified and read in full. A total of ten reports were included. Fifteen more reports were included for this review, of which six were identified by reference tracking of the ten reports, eight documents were serendipitous discoveries, and one was proposed by my supervisors. A total of 25 reports were included.

The same process was repeated for the second phase of the review. The timeframe in this phase was 2017–2020. After screening, 28 new articles (21 from databases and Google Scholar, six from reference tracking, and one from spontaneous search) were included. In this second phase of the review, one book was included as being relevant and came from a suggestion by an academic at a conference. In this phase, a total of 29 reports were included: 16 were documents from the Scottish Government, six were suggested by supervisors, and seven were identified serendipitously while searching for and reading other sources.

Although the above description resembles the outputs of results for a systematic review, I chose to present it here in order to indicate the scope and range of the literature considered. Figure 4 outlines the process of including articles.

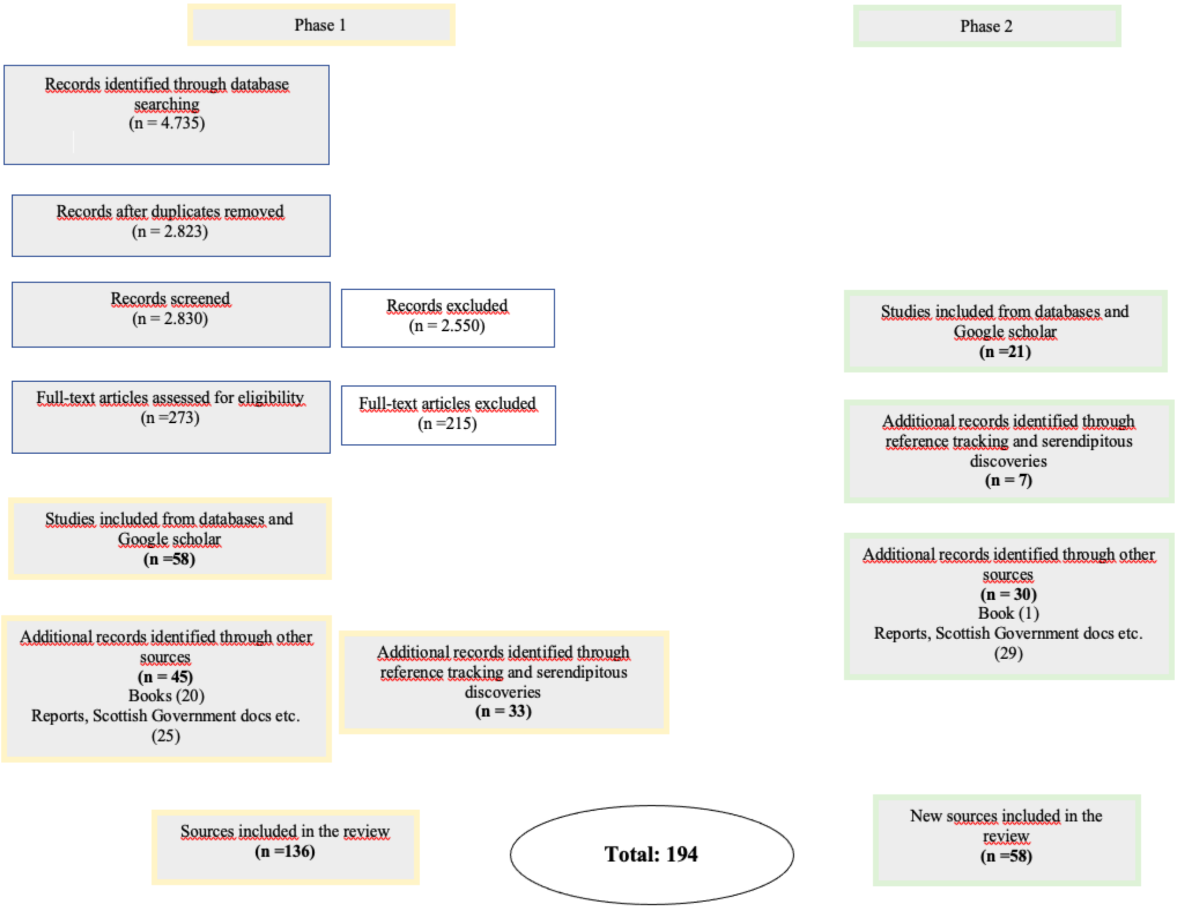

Figure 4: Phases of the literature review

2.2.5 Limitations of the review

Before proceeding to discuss what was identified in the review, it is important to underline the following limitations to bear in mind. The first limitation relates to the term ‘child maltreatment’ as it is used in the studies. In many studies, the focus is on maltreatment more broadly, and the authors do not distinguish between different types of maltreatment; therefore, the findings cannot be linked specifically to child neglect. When the term ‘child maltreatment’ is used later in this review, it refers to findings from studies in which this is used as an umbrella term, and where different types of abuse and neglect are conflated.

Another point which needs to be considered when considering this review refers to the samples of studies. Studies often focused on ‘parents’, but this does not necessarily mean mothers and fathers, as research conducted with fathers is very limited. When the term ‘parents’ is used, it usually refers to mothers. Finally, it is important to bear in mind that the studies included in this review were all from developed countries. Studies from developing countries may (or may not) identify different themes, but this was beyond the scope of this review.

In the next sections of this chapter, the themes from the literature review are presented. This is followed by an overview of the rationale for this study.

2.3 Challenges with defining the phenomenon of child neglect

It is difficult to define child neglect, as it exists across different contexts and takes a wide range of forms (McSherry 2007). Definitions may focus on parental responsibility (Dubowitz 2013). According to this perspective, parents are primarily responsible for meeting the needs of their children. However, this perspective does not fully consider the wider structural factors associated with neglect and can lead to the stigmatisation of parents. An alternative definition may focus on the 'inadequately met needs' of children, which is less blaming and has children's development at its centre (Dubowitz 2013). Another barrier to developing a generally accepted definition of child neglect is the issue of thresholds, namely, agreement on what may be the minimum levels of sufficient care for a child. Although there is some degree of agreement regarding what constitutes physical neglect (i.e., lack of food, clothing), it appears to be more challenging to determine emotional neglect (McSherry 2007). Meeting a child's needs exists on a continuum, from optimal through to inadequate, and there are no clear-cut points that distinguish 'neglect' from 'no neglect' (Dubowitz 2013).

Another issue relates to whether the focus is on the lack of parental care and the environment in which the child is living, or their effects on the child. If a definition of neglect focuses on the harm to children, prevention of harm is more difficult, and a focus on visible signs could lead to crisis-led intervention instead of a preventive approach (Glaser and Prior 2002; Daniel 2005).

The literature uses different classifications of neglect. In their classification, Barnett et al. (1993) included physical neglect as a sub-type of child maltreatment and viewed it as a failure to provide (i.e., food, clothing, shelter, medical care) and a lack of supervision. The Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) research team modified Barnett et al.'s (1993) categories and included five subtypes of child neglect (care neglect, environmental neglect, medical neglect, educational neglect, and supervisory neglect) (English and LONGSCAN 1997). Erickson and Egeland in 2002 used five subtypes (physical, emotional, medical, mental health, and educational neglect), whereas Slack et al. (2003) introduced three subtypes of neglect: physical, mental health, and cognitive. In 2004, Dubowitz and colleagues proposed three subtypes of neglect: physical; psychological; and environmental (Dubowitz et al. 2004). Later, Horwath (2007) identified six types of neglect (medical, nutritional, emotional, educational, physical, and lack of supervision and guidance) a development from Kaufman Kantor et al. (2004), who saw emotional, cognitive, supervision, and physical neglect as sub-types of neglect. Others have suggested that mental health neglect, psychological neglect and emotional neglect can be categorised under psychological or emotional abuse (Brassard and Donovan 2006, Trickett et al. 2009). The NSPCC, in their definition of child neglect, includes four types: physical, educational, emotional, and medical (NSPCC 2020).

Moreover, how neglect looks and is experienced varies depending on the child's chronological age and developmental stage. For younger children, signs of neglect may be more clear-cut. For instance, children may have speech delays and may not reach developmental milestones. For older children,[6] who have been chronically neglected, signs may not be recognised as the impact of neglect; for example, older children may have mental health issues and/or behaviour-related issues (i.e., drug use, criminal activity) linked to their childhood experiences and home circumstances (Ofsted 2018). Adolescent neglect may include lack of parental support for young people regarding their further education and employment, lack of parental acceptance of a young person's sexual orientation, lack of information on the risks to health of unprotected sex, and a lack of recognition of young people's need for independence (Hicks and Stein 2010). A study in England on the neglect of adolescents asked 24 young people (aged 11 to 18), who had been in contact with children's social care services due to safeguarding concerns, to discuss how neglect can be defined. It found that, apart from not meeting basic needs, parental neglect involved carers not equipping children with social skills, morals and manners, or self-care skills (including those needed for independent living), and not preventing children from becoming obese. It could also involve a parent prioritising a new partner over their children (in single parent families) and/or making them care for younger siblings (Rees et al. 2011).

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[6] The children's ages ranged from seven to 15 years in this report.

Last but not least, part of the challenges in identifying neglect can be linked to the ‘neglect of neglect’. In the early 1980s, the term ‘neglect of neglect’ was used to refer to the inattention to child neglect in both research and practice (Wolock and Horowitz 1984). Sullivan (2000) explored some of the factors which contributed to this. These included: the belief that neglect does not have serious consequences; that it is unfair to assign responsibility to parents where neglect is associated with poverty; it is an insurmountable problem; other forms of child maltreatment are more compelling; ambiguity and vagueness concerning definition of neglect cause confusion; and neglect provokes negative feelings and is therefore marginalized (Sullivan 2000). However, the extent and the consequences of child neglect (discussed later in this chapter) indicate that child neglect is as serious as the effects of other types of child maltreatment, and that neglect as a type is commonly recorded by child protection services (Gilbert et al. 2009). Later research by Scott and Daniel (2018a) reported that professionals are able to identify signs of neglect – so neglect is not neglected in practice – but how professionals can best respond to neglect is unclear.

As is evident from this brief summary, there is a remarkable variation in the definitions used for child neglect. The manifestation of neglect may look different across different age groups, resulting in a variety of signs that may indicate that a child or a young person is experiencing neglect. All of these can create confusion for policy makers, practitioners and academics and may influence their ability to identify and intervene effectively. However, neglect does occur, and it is often met in the area of child protection.

2.4 Magnitude of the problem of child neglect

In Scotland, information about children and young people experiencing child neglect is available from Children’s Social Work Statistics. These statistics are drawn from information collected each year by local authorities. As of 31 July 2020, 2,654 children’s names were listed on the Child Protection Register in Scotland and there were 7,315 concerns raised and recorded at child protection conferences.[7] Neglect was one of the most common concerns identified (1,112); other concerns raised referred to domestic abuse (1,132), emotional abuse (1,028), and parental substance misuse (1,135) (Scottish Government 2021a). Neglect was a recorded concern in 42% of cases where a child’s

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[7] Because multiple concerns are recorded at child protection conferences (instead of the main category of concern), the total number of concerns (7,332) is higher than the number of children registered (2,599).

name was placed on the register. This represents the 0.12% of the Scottish population aged 0–15 years. This means that, for every one thousand children in Scotland, one child is on the child protection register due to neglect.

Regarding the magnitude of child neglect, it is important to consider another source of information: data held by the Scottish Children's Reporters Administration (SCRA). According to the grounds for referral to the Reporter, and especially section 67(2)(a), referral is made when "the child is likely to suffer unnecessarily, or the health or development of the child is likely to be seriously impaired, due to a lack of parental care" (Children's Hearings Act 2011, p. 32). This appears to be directly linked to child neglect. These statistics, published by the Scottish Children's Reporter Administration (SCRA), are not cross-checked with the national child protection statistics. In 2019/20, 12,849 children were referred to the Children's Reporter,[8] of which 3,967 referrals were due to lack of parental care[9] (Scottish Children's Reporter Administration (SCRA) 2020). This equates to 1.4% of all children and young people in Scotland, which means that, for every 100 children, there are concerns that one child is experiencing some degree of neglect. Although not all the cases referred to the Reporter are referred to the Children's Hearing Panel, there were sufficient concerns regarding the adequacy of parental care in the first place to warrant a referral to the Reporter.

The statistics represented above include reported incidences and those children known to the authorities and thus it can be argued that the true population affected by child neglect is unknown (as was also mentioned in the introduction in relation to the iceberg metaphor (Bianchi and Ruggiero 2009)). Studies in the UK and USA have found that neglect ranges from 1.4% to 10.1% at population level, based on self-reported and parent-reported studies (Gilbert et al. 2009).

A study conducted by the WHO in Romania with a sample of 714 females and 581 males (aged 13–14 years) reported that 46% had experienced physical neglect, 44% emotional neglect, and 34% educational neglect. Neglect was found to be far more prevalent than physical abuse (24%) or contact sexual abuse (9%) (Browne 2002). An NSPCC study of prevalence of maltreatment across the UK, with 4,036 respondents (1,761 young adults

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[8] The role of the Reporter is to receive referrals for children and young people who are believed to require compulsory measures of supervision. The role also involves drafting a statement of grounds and deciding whether the child or young person needs to be referred to a Hearing.

[9] There are a number of Grounds of Referral. This is commonly used where there are indicators of neglect.

aged 18–24 years and 2275 children aged 11–17 years), found that 9% of young adults and 9.8% of children had been severely neglected by parents/carers during their childhood. This translates to one in ten young people/children in the community (Radford et al. 2011). Regarding types of child neglect, Stoltenborgh et al. (2013), in a meta-analysis of 29 studies, found that incidences of self-reported physical neglect were higher than self-reports of emotional neglect. Stoltenborgh et al. estimated that the global prevalence of self-reported child physical neglect was 16.3%, or 163 per 1,000 children, and the global prevalence of self-reported emotional neglect was 18.4 %, or 184 per 1,000 children, with no apparent gender differences.

More recently, Witt et al. (2017) surveyed a sample of 2,510 participants aged 14–94 years in Germany. In this quantitative study the sample was representative of the German population (age and gender). They reported that almost 10% of participants reported moderate emotional neglect, and more than 20% moderate physical neglect. Nikolaidis et al. (2018) collected quantitative data on child maltreatment in nine countries in the Balkan region (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Macedonia, Greece, Romania, Serbia, and Turkey). A total of 42,194 children aged 11, 13 and 16 years participated, and reported on past-year and life-time exposure to violence. Percentages of children’s reports for neglect experiences range from 16.7% to 37.5% for the last year, and 22.6 to 42.6% across the lifespan.

Overall, it appears that child neglect is extensive. Studies based on self-reported data appear to report higher percentages of child neglect among children and young people than official statistics show. For, instance, the NSPCC self-report study conducted in the UK (Radford et al. 2011) reported that the 9.8% of children had been severely neglected by parents/carers during their childhood, which is significantly lower than the estimated 0.11% of all children aged 0–15 who have experienced neglect and appear on National Statistics.

2.5 Risk factors for child neglect

Although child neglect occurs across race, socioeconomic background, and family structures, existing research shows that a number of factors (i.e., single parent homes, education and employment status of parents, domestic violence, mental illness, substance misuse, childhood experiences of child abuse and neglect, familial isolation, and lack of supportive resources) increase the likelihood of a child being neglected. Having knowledge of these factors is important for enhancing an understanding of both the aetiology of neglect and for its prevention. Brown et al. (1998) and Nair et al. (2003) in longitudinal studies (both in the USA) reported that the presence of four or more stress factors in parents’ lives (i.e., drug use, low income, domestic violence and mental health problems) is associated with an increased likelihood of child maltreatment. However, caution needs to be applied, as the presence of risk factors does not mean that there will be neglect, and the absence of risk factors does not exclude the possibility that neglect will occur.

According to Dubowitz (2013), risk factors are associated with four different levels: individual (child-parents); familial; community; and societal. Dubowitz’s framework, based on the ecological approach of Bronfenbrenner (1979), considers the development of the child in the context of their family, their wider social system (including communities, neighbourhoods, and society), as well as their interactions. Connell-Carrick (2003) reviewed the research on child neglect from 1990 to 2002 and reported that the majority of studies use an ecological approach to explore risk factors.

2.5.1 Factors associated with children/young people

Children with a physical or mental disability are at higher risk of experiencing neglect than their non-disabled peers (Kelly et al. 2012). Stalker and McArthur (2012), in a scoping review of 15 studies (between 1996 and 2006) about child abuse, child protection and disabled children, noted that children with communication impairments, behavioural disorders, learning disabilities and sensory impairments are at greater risk of experiencing both violence and neglect. This may be because the stress levels and financial pressure for parents with disabled children are much greater due to the complex needs of their children (Revill et al. 2013). Despite being at greater risk, researchers have also noted that disabled children are less visible in child protection systems (Taylor et al. 2016). This may be due to signs of neglect (i.e., physical signs and/or changes behaviour) of disabled children being attributed to their disability. In addition to this, thresholds for intervention may be higher for disabled children than for non-disabled children (Stalker et al. 2015).

Taylor et al. (2015), in a qualitative study in the UK with 10 deaf and disabled people who had experienced abuse in childhood, reported that deaf and disabled children and adults face barriers in disclosing abuse. Taylor et al. (2016), in a later qualitative study in Scotland, went on to report that complex care environments, specific impairment, and a lack of experience were mentioned as reasons why professionals lacked the confidence to identify significant risk for disabled children. Participants expressed concerns that action taken by them may place the child at even greater risk.

Neglect is a phenomenon that affects children and young people throughout childhood and into adolescence. Children under three years of age are more likely to experience child neglect than older children, based on reported figures (Makhlouf and Rambaud 2014), and are considered more vulnerable to neglect (especially physical and medical) as they are dependent on caregivers (Zeanah and Humphreys 2018). Being born prematurely or having low birth weight is associated with neglect; parents with premature infants and/or low birth weight may feel confused, anxious or helpless in the face of the high demands of care. As a result, it may be more difficult for them to relate to the child and to form a positive bond (Windham et al. 2004).

There is some evidence that the focus of research/practice has been on the impact of neglect on young children, whereas less attention has been paid to adolescents (Hicks and Stein 2013). Potential reasons for overlooking adolescent neglect may be the perceptions that young people are seen as being more able to escape from maltreatment and seek help. Adolescents may also be perceived by professionals as being more resilient than younger children (Rees et al. 2011). In addition to this, the focus of practice in this age group may be more on adolescents' externalised behaviour (i.e., offending) and not on its aetiology, namely on parental neglect, or other forms of maltreatment (Raws 2018).

Brandon et al. (2020), in a review of a total 368 serious cases reviews[10] over a period of three years (2014–2017), found that suicides and self-harm in adolescents with mental health problems were linked with early or continuing physical and emotional neglect. Neglect has consequences for adolescents, as it continues to have an impact on brain development (De Bellis 2005). Neglect also appears to increase the risk of poor wellbeing and risk-taking behaviour in adolescents, and Raws (2016) reported that dedicated care is needed for adolescents in order that their educational, physical and emotional needs, and safety can be ensured, considering how the negative impact of neglect (i.e., increased risk

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[10] Serious case review: takes place after a child dies or is seriously injured and abuse and/or neglect is thought to be involved. It explores what can be learned to help prevent similar incidents from happening in the future. In Scotland, these are referred to as significant case reviews.

of being involved in risk-taking behaviours) underlines that young people are vulnerable (Raws 2018).

2.5.2 Factors relating to parents and family

It is often the case that in research the term ‘parents’ means mother, as both research and practice focus more on mothers, and exploration of the role of fathers in neglect is limited. Parkinson et al.’s (2017) review of 14 literature reviews of risk factors for child neglect highlighted the focus on mothers as primary caregivers and the lack of evidence on the role of fathers. Fathers often miss out on the support available, as they may not be part of their children’s lives, or it may be more difficult for practitioners to include them in the support offered (Moran and Ghate 2005). However, there are some studies that have explored the role of fathers. A systematic review of the literature (24 studies) indicates that the presence of a father or another male figure in the house can reduce the possibilities of neglect (Connell-Carrick 2003). In a Canadian study (Stewart and Scott 2014), 121 maltreating fathers were interviewed to explore maltreatment-related problems in parenting. It was revealed that fathers were differentiated by the degree of dysfunction in relationships with their children (i.e., low, moderate or severe). Fathers with severely dysfunctional relationships had difficulties in being emotionally available to their children and responsive to their emotional needs. These results may indicate a need for interventions to enhance opportunities to fathers in building strong emotional connections with their children (Stewart and Scott 2014).

Mulder et al. (2018), in a meta-analysis of risk factors for neglect (36 studies from USA, Canada, Europe, Australia and other countries, between 1990 and 2016), reported a strong effect size between parental characteristics (i.e., history of mental health problems, low educational level, history of antisocial behaviour and/or criminal offending) and child neglect. They concluded that the effects of parent-related risk factors are stronger than the characteristics of a child, and that these factors are important in preventing child neglect. Stith et al. (2009), in their meta-analysis (155 studies, published between 1969 and 2003), also found large effect sizes between parent-related risk factors (i.e., parent perceives child as problem, parent level of stress, parent anger/hyper-reactivity, and parent self-esteem) and child neglect.

Poor emotional wellbeing of parents may influence their knowledge, skills and behaviour (i.e., unrealistic expectations of child, insensitivity regarding children’s physical and emotional needs and preoccupation with their own needs), and this is associated with higher risks of neglect (Akehurst 2015; Daniel et al. 2011). For instance, a four-year-old child may be left alone during the evening based on unrealistic expectations regarding the child’s abilities and the need for supervision.

In relation to parental depression, Stith et al. (2009) identified that it had a moderate effect on the risk of child neglect. Brandon et al. (2012), in a review of a total 184 serious cases reviews over a period of two years (2009–2011), found that mental ill-health of parents, domestic abuse and substance misuse co-existed in 86% of serious neglect cases. According to Bromfield et al. (2010) and Akehurst (2015), the presence of domestic abuse may increase the occurrence of child neglect. In their systematic review of 23 studies, Staton-Tindall et al. (2013) found that substance use by parents was associated with higher rates of referrals and re-referrals for child neglect. In Cusworth et al.’s (2019) sample of 433 children looked after away from home, maternal substance misuse was reported for 63% of children, and paternal substance misuse for 50%.

Mulder et al. (2018), in a metanalysis of 36 studies, found some evidence for the “intergenerational transmission of child neglect” (p. 208). Children with parents who experienced child abuse and/or neglect in their own childhood are at higher risk of experiencing child neglect. However, the effect size was statistically small. No conclusions were made regarding the type of child abuse and/or neglect that parent experienced and the transmission processes, as there was lack of information on the type of parental abuse (Mulder et al. 2018).

In their meta-analysis of 84 studies, Assink et al. (2018) found a significant effect of a parental history of abuse on the risk of child maltreatment. This effect was moderated by the type of maltreatment experienced by children. The largest effect was found for unspecified maltreatment type (i.e., any form of child maltreatment), and lower effect was found for children who experienced neglect and physical abuse. No significant effect on the risk of child maltreatment was found by the type of maltreatment experienced by parents in their childhood (Assink et al. 2018). Cusworth and colleagues’ (2019) Scottish study included a cohort of 433 children looked after away from home, 98% of whom had directly experienced abuse or neglect. They found that 45% of the children’s mothers and 24% of fathers were reported as having experienced neglect as children.

Regarding family composition and the risk of neglect, there are mixed findings in the literature. Children in single parent families may be at higher risk of experiencing neglect; this association is related to the impact of one person being responsible for household income, household tasks, and supervising and spending time with children (Connell-Carrick 2003). Freisthler et al. (2006) stated that no clear conclusions can be made regarding the role of single parenthood as a risk factor, due to insufficient evidence. Stith et al. (2009) found an association between single parenthood and risk of neglect, but the effect was small, and neglect also occurs in two-parent families (Connell-Carrick 2003; Corcoran and Nichols-Casebolt 2004). A quantitative study (which drew data from a longitudinal birth cohort study made up of nearly 5,000 families in 20 large cities in the USA between 1998 and 2001) found evidence that getting married to the child's biological father is linked with decreased risk for both physical and supervisory/exposure neglect by mothers, compared to be a single mother, which may reflect the challenges of parenting alone (i.e., working, and in some cases, managing on lower incomes or living in poverty) (Schneider 2016).

2.5.3 Community factors

The presence or absence of formal (i.e., organised community networks, statutory and professional services) and informal (i.e., personal social networks, family and friends) support networks appears to be important. Support networks can provide assistance to both parents and children and may include being alternative caregivers. A supportive system might include relatives, neighbours, friends, schools, after-school programmes, health and mental health agencies, other community groups, religion groups, and recreational groups.

Families where neglect is a feature often have smaller social networks and less contacts within these groups than non-neglecting parents; parents also report more isolation and less support through formal services and informal networks (Goldman and Salus 2003). Parents may mistrust the formal support offered by services as they may have experienced professionals as being unhelpful in their own childhoods. Parents frequently report fears that their children can be taken away, and these fears can prevent a trusting relationship from being developed with practitioners (Leese 2017). They may also be suspicious of the services and support offered within the community because they may perceive the support offered as an interference into their family and/or the help offered as insufficient or inappropriate to meet their needs (Ghate and Hazel 2002). Parents may also not be aware of the available support services in their areas (Burgess et al. 2012). Finally, the Care Crisis Review (2018) for England and Wales noted that parents with experience of children's social care and the family justice system appear to feel 'done to' rather than feeling that professionals work alongside them.

An approach that can be promising in enhancing children's and young people's help-seeking was described by practitioners and managers in six areas of Scotland in the Scottish review about child neglect undertaken by Action for Children in partnership with University of Stirling (Daniel et al. 2012). The approach involved a web-based child-focused service information resource, which focuses on encouraging children to seek help and providing them with information on how to do this. However, information about the available services can soon become out-of-date, and this is a limitation of this approach (Daniel et al. 2012).

Thompson (2015) argued that access to informal supports can decrease the levels of stress for parents and may reduce the risk of child maltreatment. However, studies have found that, when informal support comes from individuals or families who are also struggling, the likelihood of child maltreatment, including neglect, remains high (Freisthler, Holmes and Wolf 2014; Thompson, 2015). Families may also distrust the available informal forms of social support. This can be seen as interfering; they may perceive that their neighbourhoods are less friendly and their neighbours less helpful, or that other families are also struggling with the same issues and are thus not able to provide support (Thompson 2015).

Maguire-Jack (2014) noted that "The context in which families live does seem to have an impact on their maltreatment behaviours, above and beyond the impact of these variables at the individual level" (p. 245). Maguire-Jack and Showalter (2016), in a quantitative study with 1,326 parents from Franklin County in the USA, found that neighbourhoods perceived by residents to be more cohesive have lower levels of neglect. However, this was not the case when neglect resulted from a caregiver's mental health or substance use problems. They suggested that parents are willing to rely on their neighbours for assistance with simple issues, such as babysitting or food, but are less likely ask neighbours for support with more complex issues that involve emotional needs or behavioural change (Maguire-Jack and Showalter 2016).

A later quantitative study, with 946 parents from the same area, found that families with low incomes living in a high-poverty neighbourhood may face difficulty in accessing employment opportunities, affordable groceries and/or other amenities, which contributes to stress (Maguire-Jack and Font 2017). Maguire-Jack and Font (2017) also found both that individual poverty status and neighbourhood poverty may contribute to child maltreatment. Specifically, for child neglect, they reported that individual poverty status was linked with higher rates of emotional neglect and supervisory neglect, regardless of whether the parent lived in a low- or high-poverty neighbourhood. Physical neglect was more likely to occur where parents experienced individual poverty and lived in a high-poverty neighbourhood than where parents experienced only one type of poverty (individual or neighbourhood) (Maguire-Jack and Font 2017).

2.5.4 Societal factors

Living in poverty does not predetermine the presence of neglect (Farmer and Lutman 2012), as many families function well and have healthy relationships despite low income and lack of resources. However, the social and economic context influences the capacity of parents to care for their children. At a societal level, the literature identifies poverty (which includes unemployment, low income, poor community resources and social support, inadequate or overcrowded housing and health inequalities) as a factor that increase the occurrence of child neglect (Akehurst, 2015; Berger et al. 2017; Daniel et al. 2011; Stith et al. 2009).

In research commissioned by Action for Children, NSPCC and The Children’s Society, it was found that changes to welfare reform have a negative impact on vulnerable households (Reed 2012). Cutting benefits results in adding extra pressure to these families. Moreover, these families may depend on public services for support, but provision of this services may be affected by the withdrawal of resources (Scott and Daniel 2018a).

Nevertheless, it is important to note that the link between poverty and child neglect is complex. Poverty and child maltreatment are both related to a range of factors which contribute to neglect, such as social isolation, financial uncertainty or substance misuse. Hence, the co-occurrence of these factors increases the risk of neglect. Akehurst (2015) also underlined that neighbourhood variables that are associated with poverty, such as poor community resources, and inadequate or overcrowded housing, are potential risk factors for neglect occurrence.

Bywaters et al. (2018), in a UK-wide quantitative study, found a strong positive association between the level of deprivation and the proportion of children who are looked after and listed on the child protection register. A child in Scotland living in one of the most deprived neighbourhoods is ten times more likely to be looked after away from home than a child in a more affluent area. In this study, the construction of a UK-wide deprivation index was used (based on neighbourhood deprivation scores as a proxy measure for family socio-economic circumstances). The index relied heavily on income and employment. Other factors, such as informal social support and/or health of the population, were not considered, and they may be of significance. Although deprivation appears to be a driver of service demand, it cannot explain the differences between the UK nations in their overall rates of demand. For instance, England, with the lowest deprivation rate, should have the lowest overall rate of service demand, and Northern Ireland, with the highest deprivation, should have the highest rate of service demand. However, this is not the case, according to the study. Therefore, the authors suggested that other adjacent factors also interact with deprivation and result in differences in demand for services (Bywaters et al. 2018).

Structural and individual factors and their interactions may contribute to variations in service demand. Poverty increases pressures on families, and these pressures include a range of factors, such as low family income, parental unemployment, parental educational level, housing quality and insecurity, food and energy choice and insecurity, and parental and child health and disability (Pelton, 2015). These factors can have an impact on parents' capacity to offer adequate care or indirectly increase the stress level of parents and affect their ability to function effectively. Higher levels of stress can lead to excessive alcohol consumption, substance misuse, domestic violence and/or poor mental health, creating an intricate network of risk factors (Bywaters 2015; Phelan et al. 2010). Feelings of shame or anger as result of material hardship and inequality are also part of this mixture (McDonnell et al. 2015). Finally, it is important to note that the consequences of living in poverty are frequently treated as the result of individual choice, rather than the impact of structural disadvantage and inequality (Valentine 2014).

It is clear that families from lower socio-economic backgrounds are more likely to come to the attention of authorities than affluent families, and this may be due to the extent of scrutiny (Radford et al. 2011). Families from lower socioeconomic backgrounds are also involved in the majority of research about child neglect (Burgess et al. 2014; Bywaters et al. 2014; Daniel et al. 2011). However, this does not mean that neglect occurs only in these families; it occurs in affluent families, too. In a qualitative study with 30 professionals from different children services in England (Bernard 2017), it was noted that emotional neglect was the most common form in affluent families (i.e., teenagers in boarding schools were emotionally and physically isolated from their parents). Parents who have financial resources are able to receive private support (i.e., psychological support) and this means that, although children and young people receive support, they are not always seen by statutory child protection systems (Bernard 2017).

In conclusion, it appears that child neglect is the result of a complex interplay of risk factors. A coordinated strategy to tackle neglect and meet children's and parents' needs requires consideration of factors across multiple levels of the ecological model. Merely focusing on one or even two levels (i.e., individual factors of children and parents) will result in missing the whole picture and increase the risk that a child/young person may experience neglect.

2.6 The neglected child

Our understanding of the consequences of neglect has increased significantly over the past twenty years. Child neglect is associated with poor outcomes (in childhood and in later adult life) in a range of dimensions (i.e., health, education, identity, emotional and behavioural development, family and social relationships, social presentation and self-care skills) (Allnock 2016). However, the impacts of neglect will vary across different developmental stages.

2.6.1 Consequences of child neglect

Child neglect can be life threatening. In Scotland, a review of 20 significant case reviews from April 2012 to March 2015 (involving 23 children and young people, of whom 11 died), reported that neglect was an underlying feature in the majority of cases (12 cases) (Care Inspectorate 2016). Sidebotham et al. (2016) analysed 293 serious cases reviews in England (2011–2014) and found that, in the 62% of children who suffered non-fatal harm and 50% of the children who died, neglect was an underlying feature.

In addition to being life-threatening, neglect can also have life-changing implications for children. In a longitudinal study of 136 children who were assessed when they were 3 and 5 years old, Dubowitz et al. (2002) found an association between psychological neglect and higher levels of internalising behaviours in children aged three. By the time they were five, psychological neglect was associated with higher reports by teachers of problems in peer relationships and externalising behaviours. Hildyard and Wolfe (2002) noted that, relative to physically abused children, neglected children have more internalising problems, are socially withdrawn, have limited peer acceptance and more severe cognitive and academic deficits.

O'Hara et al. (2015) highlight the poor cognitive outcomes that neglected children face, which is often underestimated. Maguire et al. (2015), in a systematic review of 30 studies regarding the emotional, behavioural and cognitive features exhibited by school-aged children, reported that neglected children scored lower on IQ tests and had less literacy, numeracy and language skills than their non-maltreated peers. They also found that neglected children needed to repeat years and/or required extra support during their school journey. Their review underlined the importance of early identification and intervention in order to maximise children's potential (Maguire et al. 2015). Academic failure during childhood can contribute to higher rates of unemployment, teen pregnancy, and higher rates of crime as well as greater use of social services (Currie and Spatz Widom 2010; Nikulina et al. 2011).

Child neglect has been associated with childhood aggression (Demeusy et al. 2018; Kim and Cicchetti 2010; Kotch et al. 2008; Vachon et al. 2015). For instance, in a US study of 89 infants aged 26, and 38 months old and their biological mothers, it was found that neglected children exhibit higher rates of aggression in toddlerhood. However, this relationship was mediated by spatial working memory (maintaining information for a short period of time and it is related to learning and doing everyday tasks), which may indicate a target for intervention (Demeusy et al. 2018). Bland et al. (2018), in a review of 10 studies regarding the possible links between child neglect and violent behaviour in adulthood, concluded that more research is required to understand the role of other factors (i.e., gender, race, exposure to violence).

Naughton et al. (2017), in a rapid systematic review of 13 studies (containing self-reported features by the child experiencing neglect and/or emotional maltreated and with children aged 13–17 years old), found that neglected adolescents experienced more intensive internalising behaviours (depression, post-traumatic symptomatology, anxiety, sexual concerns, anger, dissociation, and sleep disturbance) compared to non-neglected young people. Neglected adolescents also had alcohol-related problems in both early (14–16 years) and late (16–18 years) adolescence compared with non-maltreated children. There was also a significant association between risk-taking behaviours (i.e., gang involvement, smoking, alcohol use, drug use, unprotected sex) and child neglect. Adolescents who had experienced neglect reported low expectations for future achievements (such as having a job, getting married). Interestingly, it was found that neglected adolescents did not have higher rates in dropping out of school than their non-neglected peers (Naughton et al. 2017).

There is evidence that child neglect can have long-term consequences for the mental and physical health of individuals. Norman et al. (2012), in a systematic review and meta-analysis (124 studies from Western Europe, North America, Australia, and New Zealand), reported that child neglect was associated with a significantly increased risk of anxiety disorders, suicidal behaviour, depression and eating disorders. There was weak/inconsistent evidence in this study about the association between child neglect and cardiovascular diseases and type 2 diabetes. Finally, limited evidence was available in order to evaluate the association between childhood neglect and problem drinking and smoking (Norman at al. 2012). Dubowitz et al. (2019), in a longitudinal study with 475 young adults in the USA (maltreated or at risk of maltreatment in their childhood), found that neglect that starts in mid-adolescence was strongly associated with later substance use in early adulthood.

The effect of child neglect has also been explored through Adverse Childhood Experiences (ACEs). ACEs[11] are stressful events or conditions occurring in children's lives that affect children directly or affect their environment (Kelly-Irving et al. 2013). The impact of ACEs on adult life was first explored by Dr Vincent Felitti in the late 1980s (Felitti et al. 1998). Since then, other studies have associated ACEs with harmful

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[11] Child maltreatment (physical, sexual and emotional abuse, neglect) domestic violence, household substance misuse, household mental ill health, criminality, separation, living in care (Couper and Mackie 2016).

behaviours (smoking, drug use or violence), and negative health outcomes (diabetes, cancer or cardiovascular disease) (Anda et al. 2008; Bellis et al. 2014; Brown et al. 2010; Cannon et al. 2010; Danese et al. 2009; Dube et al. 2009; Horwtiz et al. 2001; Hughes et al. 2017; McNutt et al. 2002; Rich-Edwards et al. 2012; Roy et al. 2010; Waite et al. 2013). For instance, Hughes et al. (2017), in a systematic review and meta-analysis of 37 studies, found strong associations between ACEs and sexual risk-taking, mental ill health, and alcohol substance use.

In Scotland, the Scottish Government has announced its commitment to preventing and reducing the negative impact of ACEs by enhancing public awareness and community actions and supporting parents and children (Scottish Government 2018a). An ‘ACEs approach’ can contribute to enhancing the understanding of the impact of adversities for professionals and the public. However, the ACEs approach can be critiqued, as there are children with no identified ACEs who need support. Moreover, an ACEs approach may contribute to interventions which focus on the individual and ignore the social condition that affect people’s lives (i.e., poverty, poor housing) (Holland 2018).

2.6.2 Resilience to adversities

Not all children with histories of neglect will experience negative outcomes related to their experience (Cicchetti 2013). The ability to achieve positive wellbeing despite the existence of adversities can be seen as one definition of resilience. Although there are a number of definitions of resilience, it is a dynamic and complex interplay of different factors (individual, family and /or community) that enables children and young people to achieve positive outcomes despite the presence of stressors, such as child maltreatment (Masten 2014). A number of characteristics appear to act as protective factors to child maltreatment: good health; a history of adequate development; above-average intelligence; hobbies and interests; humour; a positive self-concept; good peer relationships; an easy temperament; a positive disposition; an active coping style; good social skills; an internal locus of control (namely, believing one’s behaviour and life experiences are the result of personal decisions and efforts); a lack of self-blame; and a balance between seeking help and autonomy (Trickett et al. 2004).

Individual characteristics of children have been found to support resilience. Children with an easy temperament are more likely to cope with difficulties and to have an extended support network (Carr 2006). High self-esteem in children has been found to decrease levels of stress and enhance social interaction (Barnes and Josefowitz 2014). Ungar (2013) argues that targeted interventions, focused on the needs of children and young people who have experienced abuse and/or neglect, are more likely to be effective in building resilience than interventions focusing on population level. The resilience of young people is more likely to be strengthened when opportunities for communication with peers and adults are provided by and within the community and when young people have access to community facilities and events. A study of a longitudinal sample of 790 adolescents known to child protection services in the USA due to maltreatment found that adolescents who participated in organised activities (i.e., sport clubs, academic clubs) had higher levels of school engagement and fewer depressive symptoms (Kwak et al. 2018). A Canadian study with 79 children aged 6–12 years in contact with child protection services reported that, while neglected children may face difficulties with classroom routines, as a consequence of gaps in routines in their daily life, they showed greater problem-solving skills than the control group (Nolin and Ethier 2007).

Structures around the individual are also likely to help individuals to overcome the adversity they face and thus enhance resilience and chances of positive outcomes (Ungar 2017). According to Ungar (2008), resilience is influenced by the capacity of schools, communities, services and government legislators to provide adequate resources to those who are impacted by maltreatment and to change the child’s environment (i.e., the provision of a safe foster home, access to individualised curriculum at school, peer support). The capacity of individuals to navigate their way to these resources is also important (Ungar 2008). Interventions regarding the promotion of resilience need to consider the environment and the available resources, and not merely focus on changing the individual-level characteristics of children.

Regarding resilience in adulthood, one cross-sectional study with a sample of university students in the USA found that resilience moderated the association between childhood emotional neglect and psychiatric symptoms (i.e., depression, anxiety, somatization, obsession). High resilience was associated with fewer psychiatric symptoms in adulthood for individuals with experience of emotional neglect (Campbell-Sills et al. 2006). DuMont et al. (2007) found that a supportive spousal or partner relationship was associated with resilience in young adulthood of individuals with documented histories of abuse or neglect in childhood. A quantitative study undertaken in Germany with 2,486 adults who had sustained childhood adversities reported that adults’ high score of resilience was associated with less distress, symptoms of depression and anxiety and somatic symptoms over the lifespan (Beutel et al. 2017). Supportive relationships, adaptive coping skills, optimism, and intellectual ability can promote resilience and protect against the effects of child maltreatment; this is evidenced by lower levels of psychopathology, substance misuse, and interpersonal problems, and higher self-esteem during adulthood of individuals with history of child maltreatment (Afifi and MacMillan, 2011; Domhardt et al. 2015). Ben-David and Jonson-Reid (2017) reviewed the literature regarding resilience (86 studies) among adults with a history of neglect in their childhood. They noted that only a few studies focusing on adult resilience included only adults who had experienced neglect, and often studies did not discuss possible differences by maltreatment type history.

Resilience can also be examined as a factor that enhances a family's ability to cope with difficulties. Family characteristics, such as warmth, affection, cohesion, commitment and emotional support between family members, may have an inverse relationship with the likelihood of neglect, as these enable families to face adversities. Resilient families also have reasonable and specific expectations of their children, follow routines, participate in the family's celebrations, and value leisure time (Seccombe 2002). Parents' self-esteem and internal locus of control is linked with less likelihood of child maltreatment (Rooijen et al. 2013). Positive relationships between parent and child are linked with parents supporting children, providing more structure, and having stable rules (Rooijen et al. 2013). Furthermore, a literature review of 70 studies conducted in the USA noted that social support was found to positively influence the maternal-child relationship and maternal mental health (i.e., depression) (Davidson et al. 2019).

Overall, living with neglect can be damaging for children and young people. Child neglect may disturb children's lives at the time and is also linked with effects in later life. However, the ability of children and young people to overcome neglectful experiences and adversities and to not face negative outcomes needs to be recognised. Individual characteristics and the resources available in the lives of children and young people can enhance their resilience. All of the factors that increase the likelihood of a child being neglected must be considered when managing the phenomenon.

2.7 Giving children in Scotland the best start in life

The Scottish Government has expressed a commitment to improve the wellbeing of children and young people, and there is an ambition to make Scotland the best place in the world for children and young people to grow up. Getting it right for every child (GIRFEC) is one part of this policy, whereby the expressed aim is that children are placed at the centre of actions taken to protect them, and that children are safe, healthy, achieving, nurtured, active, respected, responsible and included (Scottish Government 2018b).

In relation to child maltreatment, it is stated that "All children in Scotland have the right to be protected from abuse or neglect" (Scottish Government 2020a, n. p.). Particularly for child neglect, prevention also appears to be at the centre of the Scottish Government's priorities: "We are prioritising tackling child neglect to prevent more children from suffering its damaging, long-term effects" (Scottish Government 2020b, n. p.). As mentioned in the introduction, different legislation, policies and approaches are in place in Scotland to protect a child/young person where there is a risk of significant harm. The Child Protection Improvement Programme (CPIP) was established in 2016 to make improvements in all areas of child protection, including child neglect, with the aim of ensuring that children's wellbeing is at the heart of child protection system. The CPIP report, published in 2017 (Scottish Government 2017), sets out 35 actions covering different aspects of child protection (i.e., inspections of children's services, child sexual exploitation) and, particularly for child neglect, the following actions were set out:

- Neglect Improvement Programme led by the Centre for Excellence for Looked after Children in Scotland (CELCIS) (University of Strathclyde). The programme Assessing Neglect and Enhancing Wellbeing Programme is a pilot in which CELCIS worked with three local authorities to develop and implement improvements and innovations in relation to neglect (CELCIS 2018).
- Reviews of existing policy, legislation and literature, and updated national survey by the Centre for Child Wellbeing and Protection (University of Stirling). Three reports were published in 2018, including a follow-up survey (Scott and Daniel 2018a), a rapid review of intervention literature (Scott and Daniel 2018b), and one rapid review of legislation and policy (Scott and Daniel 2018c). Among the conclusions, it was underlined that interventions for child neglect are addressing specific and targeted

issues faced by families, but these alone will not address neglect in first place. Addressing neglect requires approaching children’s lives in a holistic way, including the wider structural issues (i.e., poverty, unemployment), not just improving parenting. It was also concluded that the Scottish Government is committed to its children and young people. However, it is essential that this commitment is translated into concrete changes by the Scottish Government.

- Changing legislation relating to neglect and abuse. A review of Section 12 of the Children and Young Persons (Scotland) Act 1937 (the child cruelty provision) started in 2018, as it was considered that the way in which abuse and harm is presented in the legislation was more focused on physical harm, and the extent to which emotional harm is covered was not clear (Scottish Government 2018c). This review is still in progress and the responses to the consultation will be considered to inform the next steps (Scottish Government 2019).

As part of CPIP, the Child Protection Systems Review was also commissioned in order to review the policy, practice, services and structure of the current child protection system in Scotland. The review reported that, although child protection system in Scotland is capable of protecting children and young people at risk of, or subject to, significant harm, protecting children is challenging work. The review resulted in 12 recommendations to improve and strengthen this system in order to provide the best chances to all children and young people (Dyers 2017).

In 2018, Protecting Scotland’s Children National Policy and Child Abuse Prevention Activity (Scottish Government 2018d) was published. This set out the vision of Scottish Government for how children and young people can be protected in Scotland. In both documents, the value of prevention is recognised in protecting children and their wellbeing. In the National Policy document, the universal provision of services appears to be central. Extra support and targeted support for children and young people, as well as statutory intervention, appear to be part of a continuum of support according to their needs. Another point mentioned in the National Policy document refers to the different support that families may need at different times in their lives, which requires long-term support and contact with services, as well as the rejection of a one-size-fits-all model. Despite these aspirations, neither document contains details as to how this vision will be implemented into practice.

Protecting children and young people from child maltreatment, and specifically from child neglect, appears to be recognised by the Scottish Government as important. There also are references to the prevention of child neglect. The need for additional support for families is apparent in Scottish Government documents. I would argue that an aspiration by the Scottish Government to protect all children and young people cannot be questioned. However, more needs to be done to translate these aspirations into actions to prevent neglect in Scotland.

2.8 Public health approach

Health has been defined in many different ways. One definition, presented by the WHO in 1946, defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO 1948, p. 1). This definition, which has not since been updated, considers health in a positive way and not just the absence of disease. It also recognises multiple perspectives in an individual's life, such as their social life, the environment, and the psychological status. However, it has been criticised, as achieving a 'complete state' is not realistic. From that perspective, people with chronic diseases and disabilities would be deemed to be ill, and their capacity to cope with their challenges and to fulfil a feeling of wellbeing is ignored (Huber et al. 2011; Smith 2008). Furthermore, this definition of health may not be as useful in the development of intervention programmes because, for example, increasing the coping capacity of a patient and enhancing his/her participation in social activities may be more important than complete recovery (Huber et al. 2011).

Public health is defined by the UK's Faculty of Public Health as "the science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society" (Faculty of Public Health, 2020 p. 1). According to Public Health Scotland (2020), public health is concerned with improving the health of people in the community by: addressing the wider determents of health; protecting health by controlling contagious or infectious diseases and environmental hazards; and enhancing the quality of health and social care services for the population.

2.8.1 Different models of public health

There are various different models of public health. Lang and Rayner (2012) distinguished five models of public health. These are: (1) Sanitary-environmental, (2) Biomedical, (3) Social-behavioural, (4) Techno-economic, and (5) Ecological Public

Health. These models, each with its own core ideas, with different models having dominance at different times, have contributed to improving population health since the 19th century (i.e., control disease, increase longevity). The first four models can be represented as waves to indicate the development of public health (Figure 5) (Davies et al. 2014).

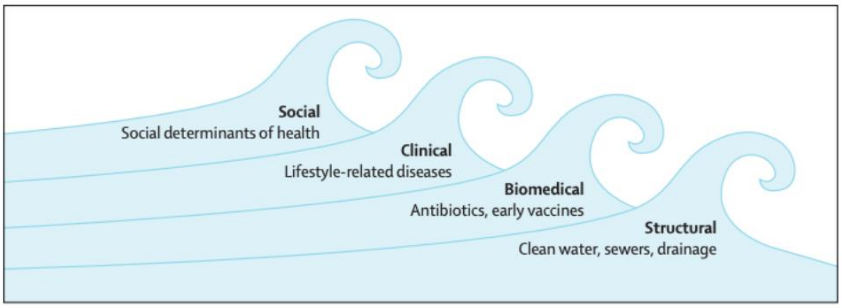
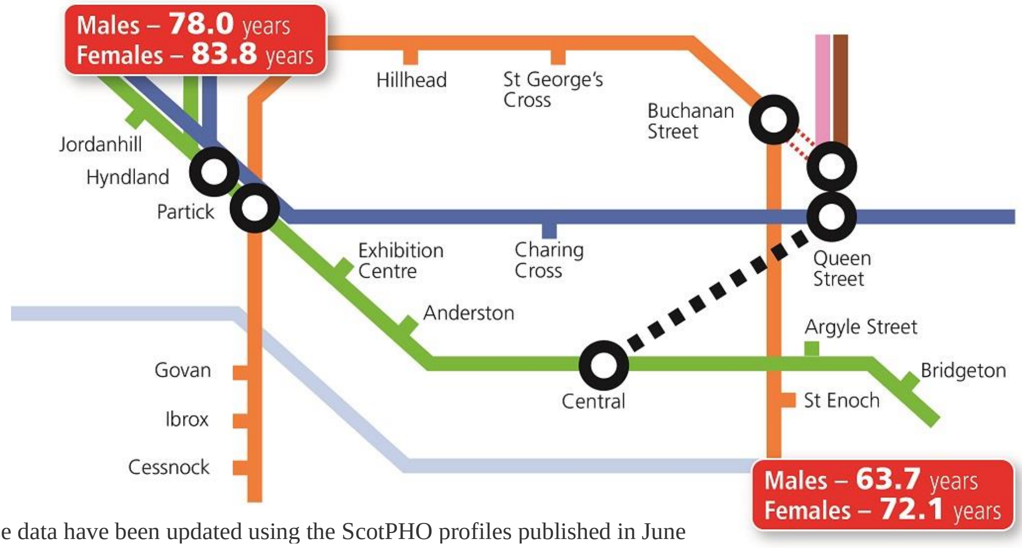


Figure 5: Four waves of public health

The first wave (from approximately 1830–1900) emerged from the recognition of the effect of the wider environment (i.e., dirt, poor hygiene, unhealthy products) on individuals as a threat to health (sanitary-environmental model). Gains in health were achieved by enhancing environmental conditions, for instance, through clean water and sewer systems. At that time and age, advances in scientific discovery (i.e., an understanding of the transmission of infectious disease) led to the second wave (from approximately 1890–1950), which recognises that health improvements require an understanding of biological causation (biomedical model). The use of antibiotics and immunisation are examples of advances of this wave. Gaining an understanding of biological processes led to the third wave (from approximately 1940–1980), which focused on addressing the behavioural circumstances of health (i.e., smoking, physical activity, food and nutrition) that have been linked with chronic diseases (social-behavioural model). Improvements in the development of a casual understanding of chronic diseases, such cardiovascular disease, diabetes, or cancer, informed preventative efforts, with the implementation of measures to promote the adoption of healthy behaviours.

Finally, the fourth wave (from approximately 1960–present) recognised that determinants of health are economic and social (techno-economic model). Low income and standards of living are linked with ill-health. Social determinants of health (i.e., unequal distribution of income, work status, access to health and education, housing conditions) are linked with health inequalities (Marmot et al. 2008). Health inequalities are defined by NHS Health Scotland (2015) as “the unfair and avoidable differences in people’s health across social groups and between different population groups” (p. 2). The Marmot Review team found that “the higher one’s social position, the better one’s health is likely to be” (Marmot 2010, p. 37). Addressing health inequalities needs to consider different actions across all of the social determinants of health (Marmot 2010).

In Scotland, people living in more deprived areas have shorter life expectancy compared to those living in less deprived areas. For males (born 2016–2018), life expectancy was 69.6 in the 10% most deprived areas compared to males in the 10% least deprived areas, which was 82.7; there is a gap of 13.1 years. For females, the gap was 9.8 years (National Records of Scotland 2019). The following image (Figure 6) illustrates differences in life expectancy in relation to areas of deprivation in Glasgow. The life expectancy of both males and females reduces by two years for every station on the underground line in Glasgow, when travelling from Jordanhill (in the more affluent west end) to Bridgeton (in the less affluent east end). A man born in Jordanhill is expected to live 14.3 years longer than his counterpart in Bridgeton, and, for a woman, 11.7 years more.



These data have been updated using the ScotPHO profiles published in June 2015 comparing the life expectancies in Broomhill (close to Jordanhill station) and Parkhead and Barrowfield (close to Bridgeton station) intermediate zones.

Figure 6: Life expectancy in Glasgow (Molony and Duncan 2016)

In addition to the four waves mentioned above, the ecological model of health can be considered as the fifth wave (Lang and Rayner 2012). It focuses on interactions of different factors that affect health. It recognises that there are complex and multi-layered connections between individuals and the environment, through which human health and behaviour emerged. According to MacDougall et al. (2007), an ecological approach considers what interventions are needed in all ecological layers in order to enhance health, wellbeing and social justice at the population level.

In the social model of health proposed by Dahlgren and Whitehead (1991), it is recognised that individuals interact with the environment within a social system, which in turn affects their health. Individuals are placed at the centre and are surrounded by layers of influences on health – moving from individual lifestyle factors and community influences (social support networks) through living and working conditions to more general social/structural conditions (economic, cultural and environmental determinants).

This model, with its ecological approach, underpins this study because it considers multiple layers of the factors that can contribute to the occurrence of neglect, which were mentioned earlier. These different layers of influence provide an holistic approach that takes into account not only children's needs in relation to child protection, and to parents' needs, but also to the impact of wider structural factors on the capacity for parenting. Managing these wider factors appears, in the literature, to be key in developing a public health approach to child neglect (Browne 2007).

2.8.2 Key principles of public health

Public health has two key principles: preventing the occurrence of a condition, by addressing determinants of which give rise to the condition, and reaching a broad segment of the population, not just individuals known as being at risk or already affected (Walley 2010).

A distinction commonly used in public health to describe the level of preventive intervention involves primary prevention (preventing a disease or the occurrence of a condition before it emerges); secondary prevention (identifying problems that already exist and intervene early to reduce spread), and tertiary prevention (treatment for population already affected by a disease or condition to ameliorate harm) (Butchart et al. 2006). Simple categorisation into interventions to prevent the occurrence or interventions that are directed to individuals at high risk may be complicated in neglect cases, as boundaries between primary, secondary and tertiary responses are not always clear. To be more specific, in some circumstances, an intervention programme may be both secondary and tertiary. For instance, therapeutic interventions can be seen as tertiary intervention, as neglect has already occurred, but also as secondary interventions, in terms of preventing an intergenerational effect (Tomison and Poole 2000).

Public health interventions can also be categorised by the reach they have into the general population. They may be universal, selected, or indicated (Runyan and Runyan 2019). Universal approaches are available to the whole population, regardless of risk or disease status. Selective approaches are targeted at high-risk individuals, whereas indicated approaches are those directed to individuals who have already been affected by a disease or a condition. Universal prevention approaches are often placed opposite to selected/indicated approaches, focused on a population at higher risk. However, simply targeting the population at risk for intervention can be problematic, as it fails to recognise that there may be part of the population not identified as targets for specific interventions but who are still at some degree of risk and need support (Graham 2007; Marmot et al. 2010). In a public health approach, interventions exist along a continuum that can reach a broad audience but are linked to providing extra support for those who need it (Higgins 2015). Marmot’s review in 2010 argued that resource allocation should benefit all of the population, but benefits should be distributed according to the need: “To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportional to the level of disadvantage” (Marmot et al. 2010, p.15). The need of policies and interventions to be proportionate to need in order to tackle health inequalities was also underlined in a later report, published in 2020 (Marmot et al. 2020).

2.8.3 Preventing the occurrence of child maltreatment

As was mentioned earlier in this chapter, research often refers to child maltreatment as a single phenomenon without differentiating between sub-types, such as child neglect or physical abuse. Therefore, it is important to reiterate that the term ‘child maltreatment’ refers to studies that were not looking specifically at child neglect.

Preventing child maltreatment is not a new feature in the area of child protection. In the early 1980s, it was identified that a preventive approach to child maltreatment needed to focus on a range of interventions to be effective. The interventions would aim to increase parental/carer understanding of child development, the parenting/carer role, and the management of home. The aim would also be to support relationships between parents and children in terms of emotional bonding and communication and enhance parents' coping skills regarding stresses associated with childcare, with special provision for the care of children with additional needs. Reducing family isolation, the promotion of peer support, easier access to social and health services, and the management of unemployment with easier access to jobs were also considered to be essential parts of the intervention. Finally, the provision of adequate housing and safe neighbourhoods, as well as the management of long-term impact of poor parenting, should also be considered (Daro and Donelly 2000).

However, across the literature and in the field of supporting families and protecting children and young people, most available studies regarding prevention of child maltreatment refer to home visiting and parenting programmes. In a systematic review of 26 reviews of child maltreatment prevention interventions, Mikton and Butchart (2009) noted that interventions may also involve sexual abuse prevention programmes, abusive head trauma prevention, media-based public awareness, support and mutual aid groups, or multi-component interventions (which included services such as family support, preschool education, parenting skills and child care).

Home visiting programmes are highly varied and may be directed at all families in a community or might target high-risk families. However, the core idea is to provide parents with information and support through pregnancy and early childhood in order to achieve better health and wellbeing for both parents and the child. Evidence of the effectiveness of these programmes is mixed, and interventions often focus on families at high risk. Duggan et al. (2004) described a home visiting programme (Healthy Start Programme, USA), which had two components, a screening stage in which families at risk were identified, and a phase of long-term home visiting of these families. The randomized trial with 643 families in Oahu (USA) found that this programme had little impact on reducing risk factors and preventing child maltreatment. In a systematic review of 21 studies, Peacock et al. (2013) found that home visiting programmes were associated with less harsh parenting, better language development in young children and a decrease in child health problems. However, they underlined that their findings were frequently not statistically significant, resulting in uncertainty regarding the effectiveness of home visiting programmes. In another systematic review, Viswanathan et al. (2018) reviewed studies that evaluated interventions that included home visiting and were focused on young mothers drawn from vulnerable populations. They reported that the evidence relating to these interventions did not consistently demonstrate benefit.

Programmes aiming to improve parenting skills are among preventative actions for child maltreatment. Sandler et al. (2011), in a review of parenting programmes (46 randomized experimental trials), found that the programmes resulted in a better parent–child relationship, improved discipline practices, school achievement and engagement, and improved social skills of children. Additionally, improved parent self-efficacy and parenting satisfaction were observed. Child behaviour problems, child abuse rates and delinquency in adolescence were reduced as a result of parenting programmes. However, significant differences were demonstrated between the intervention and control groups.

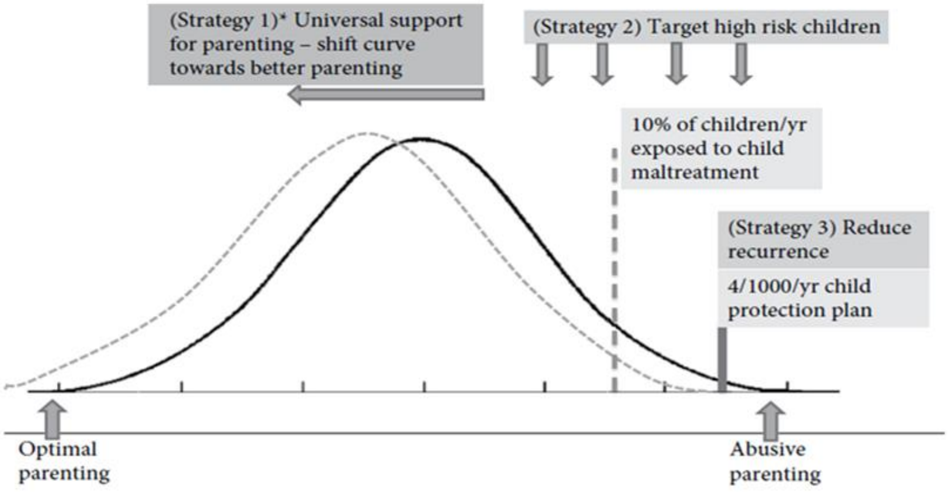
Parenting programmes have the potential to improve the mental health and wellbeing of children and improve the parent–child relationship. However, programmes often manage to reach only a specific part of population (i.e., families in deprived areas, or parents with mental health problems) rather than a broad segment of families (Sanders 2008). Potential barriers in accessing parenting programmes may involve practical issues for parents (i.e., work schedule, childcare or transportation), stigma regarding a child’s potential problem, and/or feelings of blame (Corrigan et al. 2006). According to Prinz (2016), parenting programmes need to be part of a holistic approach and be considered a normal part of life, such as childbirth classes, in order to overcome barriers.

One parenting programme that has been used and researched in different countries (including the USA, the UK, Canada, the Netherlands, Belgium, and Sweden) is the Triple-P – Positive Parenting Program (The World Triple-P 2020). This is a multilevel system of intervention that combines universal and targeted interventions for families. It aims to enhance parents’ knowledge, skills and confidence to prevent severe behavioural, emotional, and developmental problems in children and adolescents. The main programme is for parents of children aged up to 12 years, but there are also different versions of Triple-P, such as the Teen Triple-P, for parents with adolescents (12–16 years old), or the Stepping Stone, for parents of children with disabilities (Sanders 1999; Sanders et al. 2003).

A number of meta-analyses have reported consistent positive effects of Triple-P on child behaviour (Sanders et al. 2014; Wilson et al. 2012). Smedler et al. (2015), in their meta-analysis, found that Triple-P has small to medium effects for preventing the exacerbation of child behaviour problems. However, a study that aimed to assess the impact of Triple-P at population level in Glasgow (between 2010 and 2015) through the assessment of the mental health of children (aged 4–5) found no significant improvements on the social, emotional and behavioural difficulties of preschool-aged children (Marryat et al. 2017).

2.8.4 Public health approach to child maltreatment

Across the literature there are discussions about a public health approach to child maltreatment. Gilbert et al. (2012) adapted the population strategy to the prevention of disease developed by Rose, an eminent epidemiologist, and applied it to the prevention of child maltreatment. Rose argued that shifting the population distribution of a risk factor prevents more burden of disease than targeting people at high risk (Rose et al. 2008). Gilbert and colleagues argue that a public health approach to child maltreatment would direct adequate resources towards universal support for all parents (strategy 1), as well as to targeted interventions for children at high risk (strategy 2), and to interventions aiming to reduce recurrence of child maltreatment, when it does occur (strategy 3) (Figure 7). The black curve in Figure 7 can help in explaining the theoretical impact of a public health approach to child maltreatment. The X axis on the graph represents a simplified view of parenting from optimal to abusive. In theory, a population-based approach to risk factors contributing to child maltreatment occurrence will shift the black curve to the left (the dotted line) towards better parenting by a combination of universal and targeted interventions. This shift will improve the parent-child interaction, both for the whole population and for those parents in the tail of the distribution on the right (abusive parenting, which would include neglect) (Gilbert et al. 2012).



*A public health approach to child maltreatment would invest sufficient resources in universal support for parents (strategy 1) as well as targeting high risk children (strategy 2) and attempting to reducing recurrence where maltreatment has already occurred (strategy 3)

Figure 7: Distribution from optimal to abusive parenting and representation of actions of reducing child maltreatment (Gilbert et al. 2012)

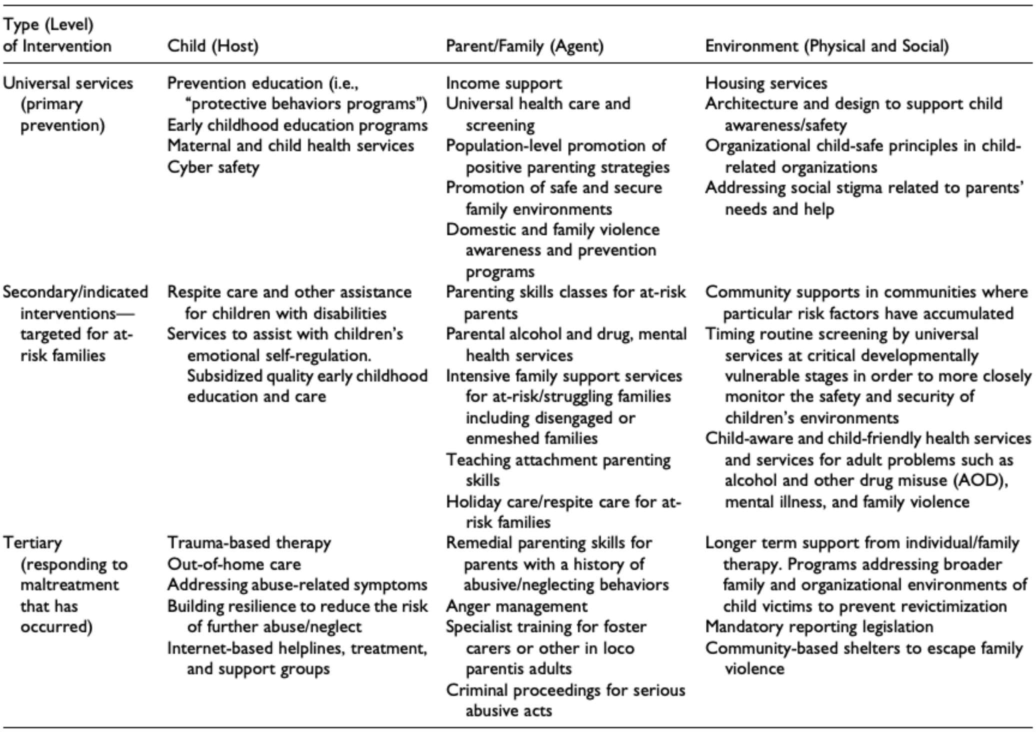
According to Butchart et al. (2006), a public health approach to child maltreatment may involve the following (essential) elements:

- Definitions (common definitions that enable identification of cases)
- Prevention (strategies that address risk and protective factors)
- Services (comprehensive responses)
- Information for effective action (sufficient methods of data gathering about the impact of services and/or interventions)
- Advocacy (awareness of the need of prevention programmes for public and policy makers; public awareness campaigns)

It is also often discussed (and mentioned in the introduction) that preventing child maltreatment requires a focus on primary prevention using universal services in order to reach a wider population of families (Bromfield et al. 2014; O’Donnell et al. 2008). However, this does not mean that families in need of further support are missed. A co-ordinated approach that combines primary prevention for the whole population, as well as secondary and tertiary prevention for families at higher risk or already in crisis, is suggested in relation to a public health approach to maltreatment (Herrenkohl et al. 2015; Higgins et al. 2019a).

A public health approach to child maltreatment, which combines services both universal and targeted, can have several advantages. First, it offers formal support to all parents in a society, which underlines that parenting is a tough job, and that all parents may face challenges. Asking for help in this context is not associated with a sign of weakness, but rather a source of support available to all who needed it. Finally, more intensive support in this approach is part of a continuum of options available to all families and not only targeted to families with risk profiles, as families may occasionally need more intensive support to address parenting challenges or other needs (Daro 2000). This approach of proportionate universalism (Marmot 2010) recognises that disadvantage is not a static concept for vulnerable families (Higgins 2015).

Scott et al. (2016) argue that a public health approach to child maltreatment is needed and recognised a lack of clarity regarding what this approach could entail. They argued that a public health approach used in the field of injury prevention (i.e., child poisonings, motor vehicle injuries) offers learning opportunities to apply a public health approach to child neglect. Specifically, they suggested that Haddon’s Matrix can be a framework for developing a public health approach in response to child protection risk factors. This provides a matrix in which interventions can be targeted to the host (individual at risk), agent (cause of disease or condition), and environment (physical and social), and involve interventions across universal, secondary, and tertiary services and at different times (pre-event, event, and post-event) (Scott et al. 2016). A proposed Haddon’s Matrix applied to a child Protection context is presented in Figure 8.



Type (Level) of Intervention	Child (Host)	Parent/Family (Agent)	Environment (Physical and Social)
Universal services (primary prevention)	Prevention education (i.e., "protective behaviors programs") Early childhood education programs Maternal and child health services Cyber safety	Income support Universal health care and screening Population-level promotion of positive parenting strategies Promotion of safe and secure family environments Domestic and family violence awareness and prevention programs	Housing services Architecture and design to support child awareness/safety Organizational child-safe principles in child-related organizations Addressing social stigma related to parents' needs and help
Secondary/indicated interventions—targeted for at-risk families	Respite care and other assistance for children with disabilities Services to assist with children's emotional self-regulation. Subsidized quality early childhood education and care	Parenting skills classes for at-risk parents Parental alcohol and drug, mental health services Intensive family support services for at-risk/struggling families including disengaged or enmeshed families Teaching attachment parenting skills Holiday care/respite care for at-risk families	Community supports in communities where particular risk factors have accumulated Timing routine screening by universal services at critical developmentally vulnerable stages in order to more closely monitor the safety and security of children's environments Child-aware and child-friendly health services and services for adult problems such as alcohol and other drug misuse (AOD), mental illness, and family violence
Tertiary (responding to maltreatment that has occurred)	Trauma-based therapy Out-of-home care Addressing abuse-related symptoms Building resilience to reduce the risk of further abuse/neglect Internet-based helplines, treatment, and support groups	Remedial parenting skills for parents with a history of abusive/neglecting behaviors Anger management Specialist training for foster carers or other in loco parentis adults Criminal proceedings for serious abusive acts	Longer term support from individual/family therapy. Programs addressing broader family and organizational environments of child victims to prevent revictimization Mandatory reporting legislation Community-based shelters to escape family violence

Figure 8: Haddon's Matrix applied to a child protection context (Scott et al. 2016, p. 413)

2.8.5 Challenges related to the public health approach to child neglect

A public health approach to child maltreatment comes with challenges. Shifting the focus to prevention of child maltreatment would mean significant change for a system that primarily relies on investigative approaches and focuses on families at high risk. This requires implementations of reform, which is demanding and linked to political will. Furthermore, public health relies on the continuous systematic collection, analysis, and interpretation of health data in order to identify risk factors, to evaluate preventive interventions, identify potential gaps and plan further actions (Aziz 2017). Prinz (2017) argues that child welfare administrative records are fundamental in order to plan, implement and evaluate preventive interventions. However, there is lack of reliable information on the prevalence data for children affected by child abuse and neglect and children at risk (Leeb et al. 2008; Scott 2013).

Another challenge is about the need for adequate resources for both universal and targeted services. Currently, the focus is on secondary and tertiary services for families at risk, or those with already escalated problems. In a public health approach, it is necessary to focus resources on actions that are universal, by providing universal services to support all families, with a scale and intensity that is "proportional to the level of disadvantage" (i.e., targeted services for vulnerable families, and early intervention for families at low-moderate risk, who may also require long-term support) (Marmot et al. 2010, p. 15). However, resources are still needed for the statutory responses for high-risk families (which are expected to be less). Funding this system of services, even the prediction that it will reduce the tertiary costs, requires additional investment (Harries and O’Donnell 2019).

Changing the focus to a preventive approach would also require co-ordination of all the sectors involved in protecting children, in both public and private sectors. It is also important to consider the role of other services (i.e., housing, mental health) which are providing services to adults but are not funded/equipped to support families to reduce the risk of maltreatment; other adult services need to play key role in intervening early to assist children in a public health approach (Scott 2009). Another challenge regarding a public health approach to child maltreatment is how it can be implemented; to date, the literature and discussions have been preoccupied with underlining the relevance and the main principles of this approach rather than exploring the complexities of its application (Harries and O’Donnell 2019).

Public health had its origins in the desire to control infection and has transitioned through a series of stages to what is now regarded as an ecological model of public health, which recognises the different layers of factors that contribute to health and intervention at all levels will be required. Therefore, given the multi-factorial causes of neglect, its prevention will require a range of preventative interventions which consider all the risk factors (not focusing only on parenting skills, i.e., home visiting programmes), all families, and their changing needs over time. A public health approach can meet these requirements for preventing child neglect, as it combines multiple levels of prevention (primary, secondary, and tertiary) together with consideration of all the population (in neglect case all families). Although there are discussions on preventing child maltreatment based on a public health approach, there is lack of information of what this means in practice. Despite some efforts to move from theory into practice (i.e., Haddon’s matrix), there is still lack of clarity in how to do this, and this area requires more evidence.

2.9 Rationale for this study

The literature highlights that neglect is a complex phenomenon and its effects are long-term. It not only affects children’s lives at the time of neglect, but it can also have an impact on their longer-term development. Although the incidence of identified cases of neglect is high, child protection systems often miss a large number of neglected children. Child neglect has been found to be the outcome of a complex interplay of factors related to individual characteristics, as well as to parents/family, community and societal elements, Thus, addressing child neglect needs to consider the multiple factors at the different levels that affect children’s lives (i.e., individual, community and societal), not just the risk factors that are linked to parents.

The literature highlights that a preventative approach should range from prevention through to active intervention and should include a combination of universal services and targeted interventions for meeting the extra needs of families. The Scottish Government has stated its commitment to protect all children in Scotland as well as preventing child neglect. However, this requires more efforts to move from rhetoric to practice.

The literature reviewed here suggests that a public health approach to child neglect has potential. Framing neglect as a public health issue enables the system to address it at the level of population health and wellbeing, rather than simply as an individual problem, and this also addresses the wider structural issues that affect families and increase the likelihood of a child being neglected. However, it is unclear what a public health approach to child neglect means in practice. Therefore, this thesis aims to explore the potential different elements that can be part of a public health approach to tackle child neglect in Scotland in order to contribute to the discussion about how this approach may be enacted in practice.

Chapter Three: Research methodology and methods

3.1 Chapter introduction

This chapter describes the research methodology and the processes followed in this study. First, the philosophical background that underpins the research design, and the methods of data collection, as shaped by this background, are considered. Then, the study design is presented, together with a description of the chosen methods. Ethical considerations are also explored, followed by the data collection process and a description of the samples. Finally, the approach taken to data analysis and reflexivity are discussed. Regarding reflexivity, it is important to note what I bring to this study and how this shaped my decisions, and this consideration is discussed throughout this chapter. The last section of this chapter (Section 3.9) links to more practical issues and the specific knowledge difficulties that influenced the steps taken.

3.2 Research Paradigm

Research is broadly framed by underlying philosophical assumptions regarding the nature of reality and how reality can be understood. Any positions taken in relation to what constitutes reality are ontological. There are two overarching ontological positions: realism, and idealism (Ormston et al. 2013). Realism refers to the idea that there is a reality which exists independently of people's experience. Idealism refers to the idea that reality is constructed by each individual's meanings and experiences. There are also variants within these broad positions. For instance, variants within realism include shallow realism (reality can be observed accurately and directly), and cautious realism (reality can be known approximately) (Blaikie 2007). Examples of variants of idealism include subtle, contextual or collective idealism (representations are constructed by individuals) and relativism or radical idealism (reality is a series of different individual constructions) (Ormston et al. 2013).

Positions in relation to ways of knowing and learning about the world, or as Cooksey and McDonald (2011) suggest, what counts as knowledge within the world, reflect what is epistemological. An inductive approach refers to a bottom-up process, in which characteristics and patterns are observed and then theories are developed. Another way that knowledge is developed is through a deductive process; in other words, a top-down process, in which theory is used to develop a hypothesis and then this is tested to be confirmed or rejected (Ormston et al. 2013). Blaikie (2007) describes two further ways of acquiring knowledge: retroduction (devising possible explanation for patterns found in the data), and abduction (the world is described by the participants' language and meanings).

The research paradigm reflects a researcher's beliefs about the world in which he/she lives (Hathcoat et al. 2019). I approached this project by holding a specific view of the world in which there is not a single truth, and that reality is constructed based on social conditions in which each person lives (idealism), and that we can learn about this world by adopting a bottom-up approach in which that reality can be observed, and theory can be developed, based on these observations (inductive research). My point of view aligns with interpretivism, which, together with positivism, are two of the main paradigms. Positivism, which assumes that reality exists independently of humans, does not align with my ontological/epistemological positioning. According to Hutchinson (1988), "Positivists view the world as being 'out there', and available for study in a more or less static form" (cited in Gall et al. 2003, p. 14). Researchers are seen as objective observers of a reality that is context-free and try to explore the cause-effect relationships of the phenomenon, in an effort to understand the world. On the other hand, interpretivism assumes that there are multiple realities, each of which are socially constructed. Regarding how knowledge can be acquired, interpretivism assumes that a social phenomenon can be understood in its context and through the experiences of individuals. In this paradigm, researchers are seen as being part of the reality that they try to understand (Kivunja and Kuyini 2017).

My project is about child neglect and its prevention, and hence related to children's lives. As I mention above, I situate my positioning within interpretivism, therefore, in order to understand the reality of children's lives and the phenomenon of child neglect, it is important to explore the lived experience of children by relating to them as individuals. Bronfenbrenner's Ecological Systems Theory of Human Development (1979) helped to inform the data sources in my study, as it provides a framework for understanding a child's development in relation to environmental factors. Various immediate and remote environments, including the child's family, children's services (health, education), the wider political, economic and cultural context, as well as the interplay between these, affect a child's development, according to this theory (Bronfenbrenner 1986). As such, my study necessitates the exploration of these different systems operating on and around children and which affect their lives. As this study was about a public health approach, I chose to adopt the social model of health developed by Dahlgren and Whitehead (1991), as it is built on Bronfenbrenner's ecological system. According to Dahlgren and Whitehead (1991), there are multiple influences on health, including individual lifestyle factors and community influences, living and working conditions, and structural conditions (socioeconomic, cultural and environmental determinants). The ecological approach that guided my study recognises the wide spectrum of factors that may affect family life, as previously mentioned in the literature review, and it helped me to consider appropriate participants for my study. For example, for the purpose of this study, data gathered with parents and young people helped me to explore individual factors and community influences, whereas data gathered with professionals contributed more at a macro level to explore how the environment influences the children's lives. Data gathered with all of the participants also helped me to gain an insight into the relationships and interactions between families and professionals.

Initially, I considered two groups based on this ecological framework: parents; and professionals involved in protecting children, such as practitioners, researchers, and policy makers. Parents are experts on their lives, and their participation can enhance research, and this can have beneficial outcomes when applying research results into practice, as they represent views of some service users. Parents in contact with services that provide support to families (including those where there is neglect) can provide valuable insight into their experiences and the difficulties they face in their daily lives. Their perspectives on the systems of support are different from those of professionals. Hence, I decided to explore with parents their experiences of and perspectives on the challenges facing families today. The following research questions were framed:

- What are the perspectives/experiences of parents on their relationships with their children and interactions with community and networks?
- What are these parents' perspectives/experiences on the impact of wider social and structural factors (i.e., poverty, unemployment) on their lives?
- What are the parents' perspectives/experiences on interventions or improvements that could better support families?

Professionals working in the field of child protection and/or health, such as practitioners, policy makers, academics or managers, have experience in working with children who have experienced neglect and with individuals experiencing adversities. Their views can offer a perspective on intervening early before neglect occurs and, thus, promote prevention. Therefore, I decided to include them and to explore their perspectives and understanding of public health approaches to, and the prevention of, child neglect. The following research questions were framed:

- What do professionals consider as the key elements/components of a public health approach to neglect?
- What are the barriers and/or facilitators to developing and implementing a public health approach to tackling child neglect?

However, I was missing the children's voices, and I was not sure how best to involve them. After reflecting on discussions during my first Annual Progress Review and when attending presentations at a conference about child maltreatment given by young people with lived experience about their contribution to research in the field of child protection, I decided to explore young people's perspectives in this study. Specifically, I considered including young people with care experience (of whom many have also experienced child neglect, based on the numbers revealed in the literature review), as their experiences of the system was crucial, and I believe that they possess important insights into how they could have been better supported. Young people aged 16+ years was an age group considered, as they had had time to reflect on their journey through the system. The objective for this group was to explore their perspectives of what can work in tackling the challenges facing children and young people with care experience. This was achieved by addressing the following research questions:

- What do young people with care experience consider to be the key elements in supporting them?
- What are the young people's perspectives on interventions or improvements that would better support them?

The perspectives of three different groups of participants were considered for this study: parents, young people, and professionals, as their views and experiences were a key source of knowledge. I considered all of these perspectives to be equally valuable during the different phases of designing and conducting this study, because, as mentioned above, I believe that there is not one single truth, and that each group, or even individual person, may have different views of what constitutes support and of overcoming issues, as they each experience reality in different contexts. These different views and experiences could contribute to generating a better understanding of the different layers of influences on health and wellbeing, as is proposed by the social model of health (Dahlgren and Whitehead 1991), and, in turn, contribute to the discussion of the potential components of adopting a public health approach to child neglect.

3.3 Research design

This study focused on exploring the everyday views of different groups of participants, as this is in accordance with my view of the world and with the ecological approach of this study, as informed by Bronfenbrenner's ecological system (Bronfenbrenner 1986) and the social model of health developed by Dahlgren and Whitehead (1991). As my ontological positioning aligns with interpretivism, which assumes that reality can be understood in its context and through the experiences of individuals, my research questions (presented in the above section) aimed to explore participants' perspectives and to gain a richly detailed understanding of their views and experiences. As it is not clear which are the potential components of a public health approach, a design to test an intervention in the field was not suitable for this study. Hence, I wanted to gain more understanding from participants' views and experiences, which would contribute to the wider discussion of how a public health approach to child neglect may look in practice.

This study aimed to explore the perspectives of various individuals in relation to a particular phenomenon. This was in line with the fundamental epistemological understanding of qualitative research that allows an in-depth examination and understanding of individuals' experiences and views (Bryman, 2012). According to Mason (2018), a qualitative approach is suitable when phenomena need to be understood by exploring "a wide array of dimensions of the social world, including the texture and weave of everyday life, the understandings, experiences and imaginings of our research participants, the ways that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate" (p. 3). Therefore, a qualitative research design was considered to be appropriate and has been employed in answering the research questions of this thesis.

3.3.1 Methods of Data Collection

Three methods of data collection were used: face-to-face semi-structured interviews, focus groups, and online surveys. These are summarised in Table 2, followed by explanations of the reason for their selection.

Table 2: Methods used for data collection

	Method	Timeframe
Parents	Face-to-face semi-structured interviews Focus group	April 2018–December 2019
Young people	Focus group	September 2018–May 2019
Professionals	3-stage online study Focus group	March 2018–May 2019

(a) Interviews

An interview is a conversation between an interviewer (who coordinates the process and asks questions) and an interviewee (who responds to questions) which aims to collect information on a topic. The advantages of this method are that it can allow the researcher to explore participants' thoughts, feelings and beliefs about a particular topic in depth, which may be about a personal and/or sensitive issue. It also allows interviewees to express their views in their own words (Patton 2015). As I aimed to explore parents' views on tackling the challenges facing families, I used face-to-face semi-structured interviews to collect data from parents. I chose the semi-structured approach, as it allowed me to ask extra questions during interviews to clarify and/or further expand certain issues that emerged during the conversation.

When choosing interviews as a method to collect data, I also considered the disadvantages. Recruiting individuals for interviews can be time-consuming (DeJonckheere and Vaughn 2019), which I considered in planning my timescale. Conducting interviews may also involve challenges, such as encountering individuals with whom it is difficult to engage in conversation, the failure of the researcher to actively listen, or using words or phrases that the interviewee may not understand (DeJonckheere and Vaughn 2019). Here, I was aware that, as English is not my first language, this could have an impact on communication. I attended training regarding interview skills (i.e., how to ask questions, listening skills) and I paid extra attention to avoiding terms that may have confused the parents involved in the project.

(b) Focus groups

Focus group discussion is a method where a group of individuals are gathered together to discuss a specific topic. The aim of a focus group is to explore and understand the perspectives of the participants of the group, based on a complex combination of individuals' beliefs and perceptions. This method may allow researchers to explore ideas formed within a social context and through interactions between participants in depth (Liamputtong 2011). I chose to use focus groups as a method, as I aimed to explore their perspectives on concepts and ideas that arose in the context of active interaction between participants and not only on their specific individual experiences.

There are advantages of using focus groups in that there is no pressure on only one person to contribute, and the group environment may enhance participants' openness (Hennessy and Heary 2005). Although I considered interpersonal interaction as an asset, this can also be a disadvantage. The desire to fit in with other group members may influence a participant's opinion and/or a dominant participant may dominate the conversation, preventing others from expressing their views (Liamputtong 2011). Hence, I paid attention so that I was alert to these possible issues, and I tried to facilitate the discussion so that all individuals could express their views if they wanted to (i.e., by asking whether others would like to add something, underlining that there are no correct or wrong answers).

Attention must also be paid to the confidentiality of the information shared with all the members of the group and not only with the researcher, as in an interview (Hennessy and Heary 2005). I considered this challenge of the potential breach of confidentiality by participants, and I asked them not to share what other individuals had mentioned in the group.

(c) Online survey

An online survey can collect a large volume of data within a relatively short time, and with populations that are situated in different geographical areas. Importantly, for the target group, I planned to use surveys with busy professionals, as an online survey can be completed at times that are convenient to respondents who can spend as much time as they want or complete the survey in multiple sessions (Regmi et al. 2016). A convenient, quick and easy-to-access online questionnaire is one way to minimise non-response (Hunter 2012). However, in an online survey, it is not always possible to explain the study to potential participants, and ensuring informed consent therefore needs extra consideration. As a potential solution, Regmi et al. (2016) suggest that detailed information about the study and the researcher's contact details should be provided on the first page. I provided detailed information relating to the study, along with my contact details, in the recruitment materials for potential participants. In addition to this, at the beginning of the questionnaire, a description of the study and details about the questionnaire were provided, and participants were asked to indicate their consent by ticking a box.

A 3-stage online survey was used with professionals to explore their perspectives and understanding of public health approach to child neglect. In summary, the online survey in Stage 1 included open-ended questions about: a public health approach to neglect; a description of a public health approach to neglect; the advantages/disadvantages of applying the approach; linking the approach with current policy and practice in Scotland; and the challenges of implementing the approach. The second stage aimed to explore professionals' understanding of child neglect and its prevention by setting broader questions, including: what constitutes child neglect; the wider social factors that affect families and contribute to child neglect; steps to prevent neglect; community-based interventions that could be included in a public health approach to neglect; funding issues; and other challenges that practitioners may face in implementing a preventative approach to neglect. The final stage of the online study adopted a different format to Stages 1 and 2. This comprised a rating exercise to determine the potential components of a public health approach to child neglect. These potential components were based on what professionals had mentioned in the previous stages (1 and 2) to allow their experiential and practical knowledge to inform the research, an inductive approach that aligns with my epistemological positioning and which was applied throughout this study. A detailed description of how data were collected through this 3-stage online study are presented later in Section 3.7.3.

In the third stage of the online study, I collected quantitative data, despite this study adopting qualitative design. I made this choice because I wanted professionals to prioritise the potential components of a public health approach in tackling child neglect as proposed by professionals in the two earlier stages. The use of numbers in the third stage was used to complement the overall qualitative approach of the study, and the aim was to enable components of the greatest importance, according to professionals' views, to emerge with greater clarity. Finally, it is important to note that I was aware of the potential dangers that including quantitative data may hold. To be more specific, I did not make any causal claims, which appears to be a common pitfall in including quantitative analysis in the study design (Maxwell 2010): making interpretations about causes was not the aim of drawing on these quantitative data, and I was aware of this.

I chose to administer the online study in 3 stages to allow me to explore professionals' perspectives in order to develop the potential components of a public health approach, step-by-step, and based on their views. While there is a broad consensus among professionals that a public health approach should be adopted, it is not clear how this might be translated into practice. Hence, professionals may face difficulties in responding to what a public health approach means in practice. Initially, I considered Delphi as a method for this study because it is a suitable approach in seeking the opinion of experts and in identifying a consensus position relating to a specific question or questions (Roth et al. 2017). As a method, it involves a panel of experts, who, based on their knowledge and expertise, are asked their opinions on a particular issue in a number of rounds. A key element of the Delphi method is that the findings for each round are shared with the panel of experts (usually between 10 and 50 participants), and they are able to reconsider previous responses, which allows the development of consensus (Barrett and Heale 2020). Despite this initial thought of using a Delphi study, this was not feasible, as there was a large number of professionals (151 professionals) who expressed an interest in taking part in the study. As a consequence, the number of experts was above the expected number, and, as the panel was not a predetermined group of people, there was no guarantee that the same people would contribute to each stage, which are both key elements in a Delphi Study. Therefore, I did not frame it as a Delphi study, but as an online study Involving 3 stages in which there was a cohort of potential participants, but where the participating professionals may not remain constant from the beginning to the end (see Table 5 in Section 3.7.3 for how the participants were tracked).

3.4 Ethical considerations

Ethical approval for the study was obtained from the University of Stirling's General University Ethics Panel (GUEP) on 22nd February 2018 (Appendix A). The following ethical issues were considered: confidentiality and anonymity; impact of participating/potential harm to participants/sensitive subjects; storage and protection of data; and dissemination of the findings. I considered these ethics throughout the project and will revisit these considerations throughout this chapter.

3.4.1 Confidentiality and anonymity

Confidentiality and anonymity both need to be considered in order to protect the privacy of participants while collecting, analysing, and reporting data (Webster et al. 2014).

I treated the information provided to me with confidence. However, there were limits to this confidentiality, and this was made clear to the participants (parents and young people) during their recruitment. According to the Postgraduate Collaborative Research Scholarship Agreement, which I signed, information would not be considered to be confidential if: "it is and can be shown to be already known to the receiving party; it was in the public domain at the date hereof other than by default of the receiving party; it enters into the public domain other than by default of the receiving party; it is required to be disclosed by law or a requirement of a regulatory body; or it is rightfully acquired from another who did not obtain it under pledge of secrecy". For example, it was made clear that, if there were concerns about the safety of the participants or their children, this information would be passed on to the supporting agency. Participants were advised about confidentiality prior to giving consent and were reminded about this again at the beginning of interviews/focus groups, and, if there were concerns, parents/young people would be informed about my actions.

Accidental breach of confidentiality was also considered, particularly for the focus groups. Group settings create the potential for accidental breaches of confidentiality, especially when participants have connections beyond the study (i.e., they live in the same area, and/or have the same social network) (Webster et al. 2014). Participants in the focus groups were informed about this issue and they agreed not to share any details about the other participants or what they had said during the discussions.

All data collected were treated in strictest confidence. I did not collect any information about potential participants regarding their reasons for referral, current situations, or personal background information. All names of the participants who were involved in interviews and focus groups were deleted during transcription and codes have been used in all the quotations that are presented later in this thesis. The locations where the interviews and focus groups took place are identified only by either ‘urban’ or ‘rural’ location. When participants mentioned a location, it was recorded in the transcript only as ‘area’. Confidentiality was also ensured by the safe storage of data, which is discussed later in Section 3.4.3.

All data were stored, analysed and reported in anonymised form. Thus, no participant could be identified if the results of this study were shared, published and/or presented. No sensitive personal data (i.e., race or ethnic origin, political opinions, religion or related beliefs) were collected, and no photos were taken. As far as the online study is concerned, the participants did not have knowledge of the other participants’ details. The names/emails of the professionals (stored in password-protected files) who participated in the online survey were known to me (researcher), as having knowledge of their email addresses was essential in order for the survey to take place.

3.4.2 Impact of participating/potential harm to participant/sensitive subjects

The current study involved research with vulnerable groups; namely, care-experienced young people aged 16+ years, and parents in touch with services that provide support for parent and families. Paying attention to the risk of harm to vulnerable families is paramount in research (Gorin et al. 2008).

Firstly, at the very beginning of the study I decided that reference to neglect was not to be included in any documents used during the interviews and focus groups with parents and young people, or by me in any discussions with them. A study title was also used: ‘Tackling the challenges facing families in Scotland today’, so there was no explicit reference to neglect. However, this was not an easy decision, and I had an ethical dilemma about using the term ‘child neglect’, as parents and young people thought they were agreeing to participate in study about challenges in their lives, whereas it was a study about preventing neglect.

I discussed this dilemma at length with my supervisors at the start of the project. My decision focused on making sure that participants felt comfortable while in a room with me, talking about their views. The term ‘neglect’ may imply blame for parents, which may make them feel uncomfortable, and I did not want to shame parents. In addition to this, given the numbers of children who are looked after due to neglect, it was likely that some of the young people had experienced neglect, but I was worried that using the word ‘neglect’ may be difficult for them to articulate it in the context of their experiences (i.e., they may not have labelled their experiences as neglect) and distressing. So, I took the view that framing it in terms of challenges did potentially overcome the difficulties of alienating or upsetting participants. This was approved by the University of Stirling’s General University Ethics Panel (GUEP). Specifically, during data collection, because the young people described feeling “horrible” when re-visiting their stories of the past every time they had to repeat what had happened to them, I chose not to refer to the term ‘child neglect’, as adopting this strategy appeared to prevent young people from feeling uncomfortable.

Another aspect that I considered in the use of different language for parents and young people (not referring to the term ‘child neglect’) was the impact that this may have on the data and my findings. My dilemma was that, without introducing the term, some of the data could not be directly linked to child neglect by the participants. I was aware of this potential limitation in the data gathered. Despite the fact that parents and young people did not directly discuss child neglect, I chose to frame the discussions around challenges in their lives. I made this choice as it was clear in the literature review that a range of difficulties are affecting their ability to parent, and this contributes to the likelihood of a child being neglected. Addressing these factors is key in a public health approach to child neglect. Therefore, I did not include the term ‘neglect’ to protect participants from potential discomfort, which may limit the ability to link these data with child neglect. However, I did place the discussion in the context of risk factors for child neglect.

Consideration was also given to the ongoing informed consent of parents and young people (Alderson and Morrow, 2004; Webster et al. 2014). The principle of autonomy was considered regarding consent, namely, parents and young people provide consent through free choice (Grieg et al. 2013). Parents and young people were informed through the study information sheet and at the beginning of the discussion that they would not be disadvantaged if they declined to participate in the study and that services would continue to be provided to them as usual. The recruitment materials set out the topic area, and consent for involvement was revisited throughout the process. In addition to the information sheet about the study, the questions which were going to be used in the interviews and focus groups were shared with participants before the interviews/focus group, so that participants could make an informed choice about whether to participate and so that they could prepare for the interview or decide to withdraw.

Furthermore, in order to protect parents and young people from potential harm and to address any distress in talking about sensitive subjects, it was made explicit to participants before the interview or focus group that they could stop or skip questions at any point. They were also informed that they could ask to take a break if they needed one, and that they could withdraw at any point. In the event that any participant recalled distressing memories and/or felt distressed/upset/uncomfortable in answering the survey questions, I checked with participants whether they wanted to continue and/or whether they wanted a break. In addition to this, a practitioner within the settings where the interviews/focus group was taking place was available during and after the interviews/focus group to offer further support to participants. Participants were able to withdraw from the study without having to provide a reason for their withdrawal, and any information provided up to that point was deleted. No parent or young person did become distressed or decided to withdraw from any conversations.

When interviewing a vulnerable population, it is necessary to signpost individuals to further support (i.e., national or local support services) (Gorin et al. 2008). Referral information for voluntary services was available in the debriefing form, in case participants need to access additional support due to issues/concerns that arose during discussion.

3.4.3 Storage and protection of data

All data were protected in accordance with the University of Stirling Research Data Management policy (University of Stirling 2018), which complies with the General Data Protection Regulations (GDPR).

A digital voice recorder was used to record interviews and focus groups, and the recordings were encrypted to keep data secure before transcription. All electronic data were kept in password-protected files, only accessible by me (researcher) and the supervisors. All paper documentation (such as consent forms) were initially kept in a locked cabinet, and papers were not left out on desks or tables. All paper documents were then scanned and saved in password-protected files and kept separate from the data and transcripts to avoid risk of matching. Paper documentation was then safely destroyed.

Part of the transcription was completed by a private company, 1st Class Secretarial Services. A data processing agreement between 1st Class Secretarial Services and the University of Stirling was requested. The agreement was developed by the Research and Innovation Services at the University of Stirling and had been signed by both parties (Appendix B). The secretarial services company also provide a privacy statement and are regulated under GDPR. In addition to this, due to the sensitive nature of the data collected, and in order to ensure complete anonymity, I requested that the transcribers selected for the work should live outside of the areas where the data were collected.

Finally, consent was also sought from participants to use their collected data in future research. These data are stored in an appropriate format for a minimum of 10 years, in compliance with the University of Stirling data storage guidelines. I intend to use DataSTORRE. To explain, this is “an online repository of multi-disciplinary research datasets produced at the University of Stirling”, and “Researchers who have research data which has potential use for other researchers are asked to upload their dataset for sharing and safekeeping” (University of Stirling 2020, n.p.).

3.4.4. Dissemination of the findings

In addition to being presented in this thesis, the findings will be disseminated at conferences and in academic journals. I have already attended and presented some preliminary results of my PhD project at conferences (Appendix C).

I will also produce leaflets (three versions) to be shared with participating young people, parents, and professionals, as I consider sharing results with participating individuals as crucial in valuing their contribution in the study. Sharing findings with parents and young people is a particular consideration, as they do not necessarily attend conferences.

Finally, it was suggested by Action for Children (although not part of the funding agreement) that practical guidelines could be developed, based on the findings of this research, in collaboration with the Policy and Campaign team of Action for Children. However, this is still in discussion, and I cannot specify any further details at this time.

In the rest of this chapter, I outline the data collection process, which includes a description of the planned sample structure, and the process of recruitment and data collection, including the study setting. For each group of participants, data collection processes will be presented separately, as the procedures differed for each group.

3.5 Parents who are in contact with services that provide support for parents and families

3.5.1 Recruitment process for parents

There were two parts to the recruitment process. First, the recruitment of the agency acting as gatekeeper and its role is discussed in the following section (3.5.1.1) and then a description of the actual recruitment of parents to work alongside for this study is presented (Section 3.5.1.2).

3.5.1.1 Recruitment of agencies to act as gatekeepers

The privacy of potential participants was paramount during the recruitment phase, and consideration should be made of the methods chosen for recruitment (Webster et al. 2014).

To allow researchers to contact potential participants directly requires that potential participants have previously provided consent to being contacted and for their contact details to be made known. I did not have any connections to parents who might be interested in taking part in my study, and I did not want to use the contact details of parents provided by an agency supporting parents, as I did not consider this to be ethical. One approach to resolving this issue was to use gatekeepers to reach parents who might be interested in participating.

The term ‘gatekeeper’ refers to individuals, groups or organisations that act as intermediaries between researchers and participants, and that support recruitment by providing a conduit for access to participants (Clark 2011). If a gatekeeper is engaged, recruitment may be more successful, as there may be a trusting relationship between individuals (potential participants) and the gatekeeper. In addition to this, when individuals are approached by a familiar person, they may feel more comfortable in saying no, if they do not want to participate (Andoh-Arthur 2019).

However, gatekeepers can also have a significantly negative impact. The role of gatekeeper requires extra time and energy on the top of their duties. Munro et al. (2005)

note that, based on their experiences of conducting research on children in need and outcomes for vulnerable children in England, social services consider engagement with research as adding an extra burden to their duties. Furthermore, a gatekeeper may grant or deny access to potential participants based on how she/he believes that knowledge is constructed, what is considered to be useful research, as well as the perceived vulnerability of participants (Andoh-Arthur 2019).

After considering all of the above, I decided to include a gatekeeper to support recruitment. This project was funded by Action for Children, and they provide a wide range of services to support children, young people and families, with more than 85 services located across Scotland. Based on their expertise and involvement in supporting families, and their investment in the research, I asked for their help in the recruitment process.

Firstly, I approached my contact person from Action for Children’s London-based office, who introduced me to the Scottish manager of Action for Children services in Scotland. Once the manager was informed about the study (I presented the project in a meeting), she suggested and contacted two specific services that provide support to families in an area in the West Scotland. The managers of both services contacted me, and I shared information about the project with them. They agreed to act as gatekeepers, and one helped me to recruit parents for the focus groups, while the other put me in contact with the manager of another service, who agreed to support me in recruiting parents for focus groups. In total, there were three services where staff acted as gatekeepers. For the purpose of this thesis, hereafter I will call these services “Service A”, “Service B” and “Service C”.

It is interesting to note that all three services supported the process and responded quickly in contacting potential participants for interviews. In addition to being part of the charity that partially funded and invested in the project, the managers’ quick responses probably reflected their interest in the topic of preventing child neglect. As Clark (2011) suggests, the engagement of gatekeepers in a research project is enhanced if the topic is perceived by the gatekeepers to be related to their role and if they see that generating findings may identify good practices that will facilitate change in the field.

3.5.1.2 Recruitment process for parents

Potential participants for interviews and focus groups were approached by a practitioner from each of the services. The practitioner was familiar to the parents and made all the initial contacts, and thus avoided passing any information about parents (i.e., names, contact details) on to me without their consent.

I wanted to ensure that parents would be fully informed before giving their consent to participate. Hence, I provided the information sheet for practitioners (Appendix D) by email to share with potential participants. Parents also had the chance to discuss the study with the practitioner and ask questions. Following the provision of information, oral consent was given to the gatekeeper by the individuals who agreed to participate. Then, the practitioner checked the availability of these parents in terms of suitable dates and times, and, based on my availability (which was flexible to best suit parents), interviews/focus groups were arranged. Consent was revisited when we met in person, and parents then signed consent forms.

Parents who participated in the study had different experiences of difficulties in their lives (i.e., mental health issues, drug issues, living in poverty, dealing with unemployment) and may also have been neglectful of their children. However, no participant was asked specifically to share his or her experience of neglect. The focus of the interviews/focus groups was on their reflection of tackling challenges faced by families.

3.5.2 Data collection

My intention was to interview parents based on their type of referral: self-referred, or referred by professionals (i.e., by health visitor). At the same time, an inclusion criterion was the age of the children. I intended to conduct eight semi-structured interviews: two individuals from each of the following groups, with the aim of exploring their perspectives and to refine a topic guide for the focus groups:

- self-referred parents of children 0–5 years old
- self-referred parents of children 10–15 years old
- referred parents of children 0–5 years old
- referred parents of children 10–15 years old

After the interviews, I planned to conduct four focus groups with parents (not the same individuals as in the interviews), to further explore what the parents had mentioned in the individual interviews.

However, in reality, this process was more complex, and I did not manage to follow the initial plan, as parents had children of different ages and the type of referral was mixed. So, I decided to conduct interviews with parents of children of any age and regardless of the type of referral. Face-to-face semi-structured interviews were conducted with six parents during June 2018. The interviews lasted between half an hour and one hour. All interviews were conducted in a private room (three in Service A, and three in Service B). The setting was familiar to the parents. Semi-structured interviews included questions about what parents are doing with their children, the area in which they live (community facilities), available support for parents, and challenges faced by parents. The schedule of the semi-structured interview can be found in Appendix E.

The initial plan was to conduct four focus groups with parents, but, after experiencing difficulties in obtaining interviews, I decided to conduct only two, one in an urban area, and one in a rural area of Scotland. The two focus groups with parents took place at the beginning of December 2018. Both took place in a private room at Services B and C. Again, the setting was familiar to parents, as services are provided there. Both focus groups lasted approximately half an hour. A topic guide was developed for the focus groups, based on the discussions with parents who participated in the individual interviews (Appendix F). This contained topics about the role of community facilities in their life, time-off from childcare, availability of support services, and a general question about the challenges of parenting.

I provided refreshments in the interviews and focus groups. All rooms had coffee/tea facilities and parents could prepare one or more for themselves. I introduced myself by saying my name and describing my role at the University of Stirling. I also provided information about my origin (Greece), as I wanted to explain my accent and to encourage participants to ask me to clarify if they could not understand what I was saying. Parents introduced themselves by saying their names, and then a short discussion to ‘break the ice’ followed (i.e., discussing children, their jobs). During all of the interviews and focus groups, an employee from Action for Children was available outside the room in case any participant felt any kind of discomfort. In all cases the employee was well known to parents, as I had requested this from Action for Children during the recruitment phase and they agreed to it. Parents were informed about the availability of the employee at the beginning of the interviews/focus groups and were assured that the employee was out of earshot but close-by to assist, if needed. However, as I noted earlier, no parents appeared to experience any discomfort during our meetings, and the employee did not need to provide support.

As noted earlier, before parents consented to participate, I spoke to them about anonymity and confidentiality, and their limits. Parents in the focus groups were informed about the issue of accidental breach of confidentiality by them, and they agreed not to share details of the other parents. I also mentioned that questions could be skipped and that they could request a break or stop at any point. Before proceeding to sign the consent form, I asked parents whether they had any questions and whether they were happy to continue. The consent of parents was confirmed by them completing the consent form. All interviews and focus group discussions were recorded using a digital voice recorder, and verbal consent to record the discussions was obtained from participants before the device was switched on. At the end of the interviews/focus groups, the participants received a debriefing form as a reminder of the purpose of the study, including my contact details and written thanks for taking part (Appendix G).

3.5.3 Sample interviews and focus groups with parents

I aimed to interview eight parents. However, a total of six parents were interviewed and these were parents whose children varied in age, with a mix of type of referral (referred/self-referred). The majority were female (four female and two male), four were aged 35–44 years, and two parents were in the age group of 25–34 years. Four parents had three children, one parent had two children, and one parent had one child. One mother mentioned that her son had been in care but had recently returned to live with her.

A total of two focus groups took place. Nine mothers participated in the group discussion in the rural area of Scotland. The focus group in the urban area was expected to have between five and six participants, but only two mothers came on the day of the focus group. In total, 11 parents participated in the focus groups, and all were female. Eight were aged 25–34 years, one was in the age group of 35–44 yeas, one was aged 45–54 years, and one was 54+ years old. The majority of them had one or two children. No participants mentioned that they had children who were not living with them. A profile of the parents who participated in interviews and focus groups is summarised in Table 3.

Table 3: Profile of parents participating in the study

Method	**Interviews**	**Focus Groups**	**Total**
No of parents	6	11	17
Age group			
16–24 years	0	0	0
25–34 years	2	8	10
35–44 years	4	1	5
45–54 years	0	1	1
54+	0	1	1
Gender			
Female	4	11	15
Male	2	0	2
Prefer not to say	0	0	0
Number of children			
One	0	4	4
Two	1	5	6
Three	4	1	5
Four or more	1	1	2

3.6 Care-experienced young people aged 16+ years

I intended to conduct four interviews and two focus groups with young people with care experience in Scotland who were aged 16+ years. To be more specific, I planned that the semi-structured interviews would be conducted with at least two care-experienced young people aged over 16 years from each of the following groups: i) care leavers, and ii) young people in the care system. Interviews were intended, apart from being an important source of data, to be used to develop the topic guides for the focus groups. I did not plan to ask any young person to share his/her specific experience of neglect.

3.6.1 Recruitment process for young people

In Section 3.6.1.1 I discussed the importance of maintaining privacy and confidentiality, and so decided to use a gatekeeper in order to recruit young people, as I had done with the parents.

I experienced a challenging and lengthy period of recruitment of young people for my project. Challenges in the recruitment of participants is a common phenomenon, especially when researching ‘hard-to-reach’ populations. These challenges may result in lengthening the timelines of the project, burnout of the researcher, or even the termination of the project (Mirick 2016). However, I considered young people's perspectives to be of paramount importance, and I continued trying to access young people.

In the original application for ethics approval, approved by GUEP in February 2018, the plan was that young people would be recruited through an organisation that is active in working alongside care-experienced young people and care leavers in Scotland (not the funder). During my initial contact by email in May 2018, the aim of the study, together with information regarding the recruitment of participants, was explained to the organisation. However, despite repeated efforts, I did not manage to succeed. I contacted the organisation by email (approximately four times) but did not receive any reply. Therefore, I decided to try to recruit young people through other organisations.

An amended ethics form was submitted to GUEP in February 2019 and was approved. Changes included the recruitment of care-experienced young people, aged 16+ years, through other similar organisations (including the funder of this project, Action for Children). Academics from the Faculty of Social Sciences at the University of Stirling involved in research with children and young people within the care system provided guidance and suggested potential key organisations. A list of potential organisations was developed, and all were contacted by email.

Some of the organisations did not answer, and two answered but workers were not able to support recruitment due to their involvement in other research projects and their limited available time. A youth worker and a social worker (working in different Council services for young people) expressed their interest in sharing the call for participation with young people in March 2019. More details about the study were discussed with both individuals, one in a teleconference, and the other in a face-to-face meeting. I also sent the information (Information sheet) via email to both individuals (Appendix H).

At the end of April 2019, after they had received all the information about the focus group, a group of young people with care experience gave their verbal consent to the social worker (mentioned above) to participate in the focus group. After being informed of their agreement, I was invited to participate in an Easter event in the local community organised for care-experienced children and young people and their families, so that the young people who had expressed their interest in taking part in the focus group could become familiar with me before the focus group took place.

Because of the difficulties in recruitment, no individual interviews were conducted. One focus group took place with five young people, and I describe the procedure and the sample below.

3.6.2 Data collection

The focus group with young people took place in May 2019 and lasted approximately one hour. There was a topic guide for this focus group, which I developed based on the research questions. It contained a number of questions about major challenges faced by young people, things that makes them feel safe and supported, and what supports they would like to see in place (Appendix I).

The participants were all members of a support group that met weekly in a community centre. The focus group took place in the (private) room where they usually met, at the suggestion of the gatekeeper, in order to be familiar and easy to reach for young people. I provided biscuits and chocolates. The room had a kitchen, so coffee/tea was also available for the young people to prepare. During the focus group, the social worker and another employee were available (not in the same room) in case any of the young people experienced discomfort and wanted to talk to someone familiar to them.

Although I had attended the event at Easter, I introduced myself by saying my name and described my role at Stirling University. I also provided information about my origin (Greece), as I wanted to encourage the young people to ask me to clarify what I was saying if they could not understand my accent. The young people introduced themselves by saying their names, and then we had a short discussion about young people’s interests/things that they like to do in order to ‘break the ice’ before starting the main part of the discussion.

As with the parent interviews and focus groups, before the young people provided their consent, I spoke about anonymity and confidentiality and their limits, and accidental breach of confidentiality by participants. I also mentioned that questions could be skipped and that they could have a break or stop at any point. Before proceeding to the consent form, I asked the young people whether they had any questions and then whether they were happy to continue. The consent of the participants was then confirmed (they signed consent form) before starting the group discussion. With their consent, the discussion was recorded with a digital voice recorder. At the end, all participants received a debriefing form with information about how I would share the findings, and the contact information of the researcher and supervisory team (Appendix J).

3.6.3 Young people's focus group sample

Five young people participated in the group discussion, and all had experience of the care system in Scotland. During the discussion, one person left early, before the group was completed, as she had planned to attend another event that was on at the same time. As a result, she did not complete the demographic form, giving details of her age group, gender, and number of siblings, which was completed by the other young people at the end of the discussion. Three of the young people were aged 16–24 years. Three of the young people had two or more siblings, and one had no siblings. One young person was just under 16 years of age, and I had an ethical dilemma about her participation, as my ethical approval provided by the University stated that I would have discussions with young people aged 16+ years.

I checked with and informed the social worker, who knew all of the young people who had expressed an interest in taking part, about the age limit. I had been informed by the social worker that all young people were 16 years old or above. However, on the day of the focus group, I received an email from the social worker about a young person who was just under 16 years old who wanted to participate. I had very limited time to decide, given that it was just a few hours before the focus group started, and I needed consent from her carers (if she was to participate). I decided that excluding her would be more harmful than including her as she was part of the group, she wanted to contribute to the discussion, and her age was so close to the age limit. A consent form was thus provided by her carers, and she participated in the focus group.

The demographic characteristics of the young people who participated are summarised in Table 4.

Table 4: Profile of the young people participating in the study

Total Participants	5[12]				
Age group		**Gender**		**Number of siblings**	
Under 16 years	1	Female	4	No siblings	1
16–24 years	3	Male	0	two siblings	1
25–34 yeas	0	Prefer not to say	0	more than three siblings	2

3.7 Professionals working in the field of child protection and/or in the area of public health

My aim was to explore with professionals their perspectives and understanding of a public health approach to child neglect. This part of the study had two components: a 3-stage online survey, and a focus group, each of which is discussed in detail in this section.

I planned to recruit 40–50 professionals from the area of child protection and/or public health. This included equal numbers of approximately 10–15 professionals representing academia, practice, management and policy-making fields. These professionals would be invited to participate in the online survey and then, after its completion, to express their interest in participating in the focus group. The involvement of professionals required at least a year of professional experience in the field of child protection and/or public health.

3.7.1 Recruitment process for professionals

At the beginning of my PhD, I had meetings with people who were active within the field of child protection and/or public health, and this included members of the Scottish Government, NHS Scotland, and Scottish universities. During those meetings they were informed about the project. Later, in the recruitment phase, potential participants for the online study were identified through these contacts. To be more specific, these contacts were asked to pass on the call for participation in the online survey throughout their networks and to invite them to participate in the study. In addition to this, email invitations were sent to relevant professional bodies, universities and charities/organisations. These included Child Protection Committees Scotland, Public Health Scotland, the Association of Child Protection Professionals, and Action for Children. The email contained information about the nature and procedures of the study,

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[12] One participant provided no demographic information.

and a link to a form that potential participants could complete to express their interest in participating within a set timeframe (Appendix K).

The online form was generated in Smart Survey (Smart Survey 2020) and requested information about the potential participants' years of experience, current job title, how long they had been in their position, their area of expertise, the category of their current job, and an email address for contact purposes (Appendix L). Recruitment began in mid-March 2018 and potential participants were given four weeks to express their interest in participating in the study. A reminder email was sent to all individuals and agencies 10 days after the initial contact, at the end of March 2018.

A total of 151 professionals expressed an interest in participating in the study. From these professionals, I recruited a sample of participants to participate in the online survey. Their selection was based on the following criteria: they had a current job role in the area of child protection and/or public health; and they had at least six months of experience in their field. A group of 145 individuals met the inclusion criteria and were eligible to participate in the online survey. They included academics, practitioners, managers and policy makers, both from the field of child protection and/or public health. Six respondents did not provide a valid email address and were thus excluded. The same group of 145 professionals were later invited to participate in the focus group.

3.7.2 Pilot study for Stage 1 of the online study

A pilot study of an online survey can be conducted to ensure the adequacy of the questions, and to ensure that the ordering of the questions and instructions are clear and adequate (Regmi et al. 2016). I used a pilot study to test the process for completing the online questionnaire (i.e., instructions for using the software) and the language used and the duration. The questionnaire used for the pilot study contained six questions regarding the need for a public health approach to neglect, how this might look in practice, advantages/disadvantages of this approach, links with current policy and practice in Scotland, and the challenges of implementation. There was also additional space to provide any other comments (Appendix M). It was estimated that it would take approximately 30 minutes to complete and that it could be completed in more than one sitting.

A sample of 25 respondents from the cohort of 145 individuals was randomly selected to be involved in this pilot phase. A group email from my university account, using the Bcc function to maintain confidentiality, was sent to the pilot sample, which explained that they had been chosen to participate in the pilot phase and had one week to complete the questionnaire. Participation in the pilot study did not exclude them from taking part in the main study, and I clarified this in the email. A link to the pilot questionnaire was also included. I sent a reminder email two days before the deadline. Seven professionals completed this questionnaire. No changes were found to be necessary for the questionnaire or to the procedure planned for after the pilot phase.

The software for the Joint Information Systems Committee (JISC) (formerly Bristol Online Surveys-BOS) platform (Online Surveys UK 2020) was used for the pilot phase and for all 3 stages of the online study described below. No URL addresses for the participants were saved in any part of the online survey. Links to the online questionnaires were sent to the cohort of professionals using my university email account, and the Bcc function was used in order to ensure the anonymity of participants.

3.7.3 Collecting data through a 3-stage online survey

At the beginning of the main phase of the online survey a welcome email was sent to the cohort of 145 participants, indicating that they had been chosen to participate in the online survey. Information about the next steps of the survey were also included in that email.

This was a 3-stage online survey including three questionnaires, described in detail below. The questionnaire in each stage contained a page with information regarding the study, a consent page, and a unique identifier area in which participants were asked to create a code unique to them by providing the first letter of their primary school, the first letter of the street they lived in age 10, the date in the month they were born, and the last letter of their first name. The same identifier questions were used in all 3 stages of the online study (and in the focus groups) in order to track their participation across each stage of the survey.

Questionnaires for each stage could be completed independently and were not completely dependent on the answers of those of the first to move to the second and third. Table 5 summarises the information related to tracking the participation of professionals across the online surveys and focus groups, which was possible by using the unique ID code generated by the respondents at each stage.

Table 5: Tracking of participants

	Professionals
All stages of online study	3
Stages 1 and 3	5
Stages 1 and 2	1
Stages 2 and 3	3
Only Stage 1	31
Only Stage 2	15
Only Stage 3	15
Only focus group	3
Stage 2 and focus group	1

At the end of each questionnaire, demographic information was requested. The participants received an email as a reminder one week before each deadline of the 3 stages of online survey.

- Stage 1 of the online survey

The first stage of the online survey started at the beginning of May 2018 and lasted until the middle of May 2018. An introduction to public health (including a definition) was provided at the start of the questionnaire in order to provide participants with an understanding of the context of the survey. In addition to this, there was a description of the social model of health as described by Dahlgren and Whitehead (1991), which underpins this study. As noted in the literature review, there are different models of public health (i.e., the biomedical, social-behavioural, and techno-economic models), and I wanted to avoid the risk of professionals adhering to a model which could not consider all the different layers of factors that may increase the likelihood of a child being neglected. The social model of health (Dahlgren and Whitehead 1991) recognises that there are multiple influences on health and wellbeing, each placed within different ecological layers (i.e., individual-community-structural factors). Therefore, I included a description of the social model of health because I wanted to provide direction to participants in relation to the model of public health on which they should focus.

Further to this, the questionnaire included open-ended questions based on the literature review (Appendix M). These related to a public health approach to neglect, a description of a public health approach to neglect, the advantages/disadvantages of applying the approach, linking the approach with the current policy and practice in Scotland, and the challenges of implementing the approach. Participants were asked to provide free-text responses. There was also additional space for the participants to provide any other comments. The questionnaire was completed by 33 professionals.

- Stage 2 of the online survey

In the first half of June 2018, the second questionnaire was sent to the full cohort of 145 professionals. In this second stage, the main text of the email included a sentence which emphasised to participants that they could participate in this stage even if they did not take part in the first round. The second questionnaire (Appendix N) contained 8 items which required free-text responses. It was estimated that the questionnaire would take 30 minutes to complete and could be completed in more than one sitting. In this stage, the questions were broader, and designed to explore the professionals' understanding of child neglect. The questions were about what constitutes child neglect, the wider social factors that affect families and contribute to child neglect, steps to prevent neglect, community-based interventions that could be included in a public health approach to neglect, funding issues, and any other challenges that the practitioners may face in implementing a preventive approach to neglect. Two further questions were asked about the role of public awareness interventions and the role of individuals with lived experience of neglect in efforts to tackle child neglect. Finally, at the end of this questionnaire there were a number of statements with which respondents were asked to state whether they agreed or disagreed. The questionnaire was completed by 22 professionals.

- Stage 3 of the online survey

The link to the third questionnaire of the online survey (Appendix O) was sent to the full cohort of 145 professionals in mid-November 2018 with a deadline to complete it by mid-December 2018. For this stage of the online survey, I wanted to ask participants to prioritise potential components of a public health approach to child neglect. As I did not want to develop a questionnaire based only on what theory states, I used what professionals had mentioned in the first two stages of the online survey in relation to their views on the implementation of a public health approach to tackle child neglect.

This questionnaire differed in the format adopted in Stages 1 and 2, and it included a rating exercise, which aimed to differentiate between interventions and to explore which were considered by professionals to be a priority for implementing strategies to tackle child neglect. The list of interventions included in the rating exercise was based on the analysis of data gathered from participants in Stages 1 and 2 of the online study.

In Stages 1 and 2 of the online study, participants mentioned different interventions that could be part of a public health approach to child neglect. These interventions were not provided in much detail (i.e., they did not include descriptions of how they might be implemented or who might deliver them) but could be categorised either as interventions at population level or at individual level. Based on the analysis of the data from these two stages, and on the level of intervention, I created a list of interventions which could be grouped into the following five types: tackling structural inequalities; communication and information; parenting programmes (pre- and post-natal); long-term support by family support services and related services; and in-school support for children and parents.

Participants were asked to rate the interventions based on four dimensions. These were:

- Important to include – the priority they would give to each intervention (5-point interval scale, in which 1 = not important at all, and 5 = very important)
- Effective in preventing child neglect – how effective the interventions would be in the prevention of neglect (5-point interval scale, in which 1 = very ineffective, and 5 = very effective)
- Feasible to implement – how feasible the interventions would be to implement or achieve (5-point interval scale, in which 1 = not at all feasible, and 5 = very feasible)
- Already available/in place – the extent to which the interventions are already available in the local authority/health board (3-point ordinal scale, in which 1 = not available/in place, and 3 = widely available)

Participants were also asked to rate the unintended consequences of implementing a public health approach to child neglect: increased workload for services which provide support to families; and families’ fear of stigmatisation. These consequences were rated based on four dimensions:

- Importance to prevent – the priority you would give to preventing each of the following elements (5-point interval scale, in which 1 = not important at all, and 5 = very important)
- Likelihood of happening – the extent to which the following points are likely to be consequences of a public health approach to neglect (5-point interval scale, in which 5 = very likely and 1 = not at all likely)
- Impact on the prevention of child neglect – the extent to which the following points will impact the efficacy of a preventative approach to neglect (5-point interval scale, in which 1 = very low impact and 5 = very high impact)
- Already occurring – the extent to which the following points are already happening in your local authority/health board (3-points ordinal scale, in which 1 = not at all, 2 = occurring to some extent, and 3 = very common)

As in the previous stages, a reminder was sent to the participants a week before the deadline. However, at the beginning of January, due to the low participation rate (*n*= 9 respondents), a notification was then sent to participants to inform them about an extension and requesting that those who had not completed the third questionnaire should submit their answer by mid-February 2019. The third stage was completed by 26 professionals.

On the deadline for completion of the third stage, the cohort group received a closing email thanking them for their participation, indicating that they would receive a summary of policy recommendations based on the results of the online survey once the study was completed.

3.7.4 Collecting data through a focus group

In the final reminder email for Stage 3 of the online survey, professionals were invited to express their interest in participating in a focus group. The aim of the focus group was to discuss in more depth the results of the online study and the potential components of a public health approach to tackle neglect. A group of ten professionals expressed an interest in taking part in the group discussion.

The focus group (4 participants) took place in the middle of May 2019 in a meeting room at the University of Stirling and lasted approximately 4 hours, including a short coffee break and a 30-minute lunch break (with coffee and lunch provided). Discussions were recorded using a voice recorder after participants had consented to its use. The discussion was focused on the seven dimensions of a potential public health approach to child neglect from the questionnaire of Stage 3 (namely, interventions to tackle structural issues associated with neglect, public awareness campaign, universal parenting programmes, sustained support by family support services and related services, in-school support for both children and parents, maximising the benefits of technology, and unintended consequences) (Appendix P). At the end of the focus groups, the participants received a debriefing form (Appendix Q).

3.7.5 Online study sample and a focus group with professionals

In the first stage, 33 professionals completed the questionnaire. In that number, I included seven extra responses from the pilot phase, as the questionnaire did not change during that phase (n = 40). I knew that the seven responses from pilot phase were not part of the 33 responses, as I used the unique identifier number to check this. There was also a sentence at the beginning of the online questionnaire in this stage, mentioning that, for those who had participated in the pilot phase, their responses had already been collected and there was no need to proceed.

The majority were female (33 female, three male, two preferred not to answer, and two missing answers). Twenty-six were working as practitioners (e.g., front-line, operational management or strategic management), four were working as practitioners and also had a second role in their job in the area of policy. Almost three-quarters of the professionals involved in the study had more than 20 years of working experience. In terms of the area of their expertise, 14 participants had experience in the area of child protection, four in the area of public health, and six in both areas.

In Stage 2 of the online study, 22 professionals completed the questionnaire, with the majority of them being female (22 female and two male). Almost half of them had more than 20 years of working experience. Three professionals had experience in the area of public health, and seven in the area of child protection. Five had experience of both areas. More than half of them were practitioners.

In the third stage of the online study, 26 professionals completed the questionnaire, of which 21 were female, and four, male. One individual, although they answered all questions, did not provide any demographic information. The majority of professionals who participated had 20+ years of working experience. Fifteen individuals had experience in either the area of child protection or public health, or both. Sixteen participants were practitioners, and five professionals represented the policy sector (e.g., Local Government, NHS Health Board, National Government).

In the final stage of data collection, four individuals participated in the focus group. All were female with 20+ years of working experience. Three were practitioners, and one represented policy (e.g., Local Government, NHS Health Board, National Government). In terms of their area of expertise, three professionals had experience in the child protection area, and one had experience of the third sector working in children's and young people's services.

The characteristics of respondents participating in each stage of the study with professionals are summarised in Table 6.

Table 6: Overview of the participants

Online study:	**Stage 1**	**Stage 2**	**Stage 3**	**Focus group**
Participants	40	22	26[13]	4
Age group				
16-24 years	0	0	0	0
25-54 years	31 (77.5%)	16 (73%)	12 (46%)	1 (25%)
55-64 years	9 (22.5%)	6 (27%)	13 (40%)	3 (75%)
64+	0	0	0	0
Gender[14]				
Female	33 (82.5%)	20 (91%)	21 (81%)	4 (100%)
Male	3 (7.5%)	2 (9%)	4 (15%)	0
Prefer not to say	2 (5%)	0	0	0
Years of experience				
0-5 years	1 (2.5%)	1 (4.5%)	0	0
6-10 years	1 (2.5%)	1 (4.5%)	0	0
11-15 years	6 (15%)	6 (27.3%)	1 (4%)	0
16-20 years	5 (12.5%)	3 (13.7%)	3 (12%)	0
20+	27 (67.5%)	11 (50%)	21 (81%)	4 (100%)
Area of expertise				
Public health	4 (10%)	3 (13.7%)	3 (12%)	0
Child protection	14 (35%)	7 (32%)	9 (35%)	1 (25%)
Other	6 (15%)	4 (18.3%)	6 (23%)	1 (25%)
Public health and Child protection	6 (15%)	5 (23%)	3 (12%)	0

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[13] One participant provided no demographic information.

[14] Two participants were missing answers for gender in Stage 1.

Public health and other	2 (5%)	0	0	0
Child neglect and other	3 (7.5%)	2 (9%)	2 (8%)	0
All categories	5 (12.5%)	1 (4.5%)	2 (8%)	2 (50%)
Job category			[15]	
Academic	2 (5%)	0	1 (4%)	0
Practice	26 (65%)	13 (59.1%)	16 (62%)	3 (75%)
Policy	6 (15%)	3 (13.7%)	5 (19%)	1 (25%)
Other	1 (2.5%)	2 (9%)	1 (4%)	0
Practice and policy	4 (10%)	3 (13.7)	1 (4%)	0
Academic, practice and policy	1 (2.5%)	0	0	0
Academic and practice	0	1 (4.5%)	0	0

3.8 Analysis of the data

3.8.1 Thematic analysis

In the analysis of qualitative data there are different approaches, such as discourse analysis or thematic analysis. Deciding on an approach to the analysis is a key decision made by the researcher, based on the aim of the study and the status of the data (Ritchie et al. 2013). Discourse analysis focuses on language and on the structure of talk within a particular discourse (Rapley 2012). Narrative analysis focuses on the interpretation of stories told by individuals (Denscombe 2014). Thematic analysis (TA) is concerned with interpreting patterns of meaning in the data (Braun and Clarke 2019).

I decided to analyse all data from the online study, interviews and focus groups using TA, as proposed by Braun and Clarke (2006), and more recently referred to as reflexive thematic analysis (Braun and Clarke 2020). The purpose of TA is “to identify patterns of meaning across a dataset that provide an answer to the research question being addressed” (Braun and Clarke 2020, n.p.). As I intended to explore topics within the data, as discussed by the participants, that can contribute to the prevention of child neglect, this type of analysis fitted with the purpose of my study.

There are different ways in which TA can be approached, such as inductively (themes are developed based on the content of the data), or deductively (theme development is directed by pre-existing theory or concepts). I did not intend to test any theory or hypothesis. Rather, I aimed to explore participants’ perspectives without this being theory-driven. As I mentioned earlier, I do not believe that there is one single truth, and

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[15] One missing response for job category in Stage 3.

that reality is constructed based on the social conditions in which each person lives. In order to understand this reality, it is important to explore the lived experience of individuals. Therefore, I chose an inductive way of conducting TA, and the themes were data-driven, and no pre-existing themes originating from theories dominated the procedure.

The interviews and focus groups were recorded using an audio recorder. All participants gave their permission to be recorded. I transcribed all the interviews with parents (six) and employed professional transcriber for transcribing the focus groups.

I used the computer software, NVivo, produced by QSR International (QSR International 1999) to organise the qualitative data because of its ability to accommodate and manage a large amount of data in one place (Bazeley and Jackson 2013). In addition to this, the function of nodes provides a structured way of coding as well as exploring and sorting themes during analysis (Wiredu 2016). I attended training regarding NVivo, as I believed that knowledge and familiarity with the environment and the features of the software was necessary to facilitate the data analysis.

However, despite the advantages of the software providing an environment in which to manage data effectively, I wanted to ensure that I fully immersed myself in the data. After discussions with my supervisors, I re-ran the analysis manually. In this second analysis of data, I used Word documents.

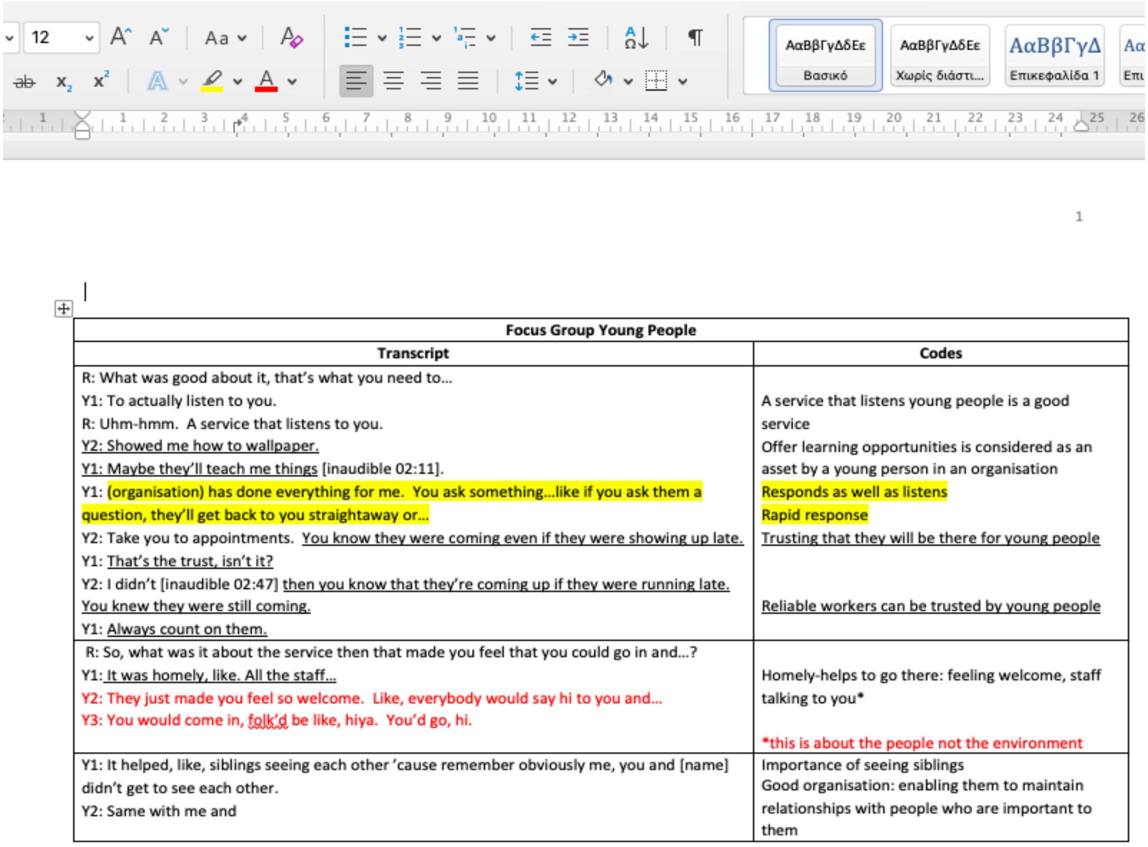
TA involves a six-phase process of analysis; namely, familiarizing oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun and Clarke 2006; Clarke and Braun 2016). I used this six-phase process to analyse the transcripts of the face-to-face interviews and two focus groups with parents, a focus group with young people, and free-text answers to the open-ended questions from Stages 1 and 2 of the online study. For every transcript per group of participants (namely, parents, young people and professionals), I followed the following steps:

1. Familiarising myself with the data

   I read all transcripts (on average about four–five times) and I took notes. I did this to familiarise myself with all aspects (i.e., content, unknown words or inaudible parts) of the data, as I saw this as an important part of analysis. I used translation software for unknown words, and I did searches on the web to fully understand the terms/concepts that were not known to me.

2. Coding

Following my familiarisation with the data, initial codes were developed. I placed extracts of each transcript on the left-hand side of a two-column table. I paid attention to each data item, and I coded it using different colours, and with underlining and bold text (Figure 9). The names of the codes were reviewed at least twice for each transcript in line with the data. This was to make sure that they made sense and were in accordance with what the participants had mentioned.



Focus Group Young People

Transcript	Codes
R: What was good about it, that's what you need to… Y1: To actually listen to you. R: Uhm-hmm. A service that listens to you. Y2: Showed me how to wallpaper. Y1: Maybe they'll teach me things [inaudible 02:11]. Y1: (organisation) has done everything for me. You ask something…like if you ask them a question, they'll get back to you straightaway or… Y2: Take you to appointments. You know they were coming even if they were showing up late. Y1: That's the trust, isn't it? Y2: I didn't [inaudible 02:47] then you know that they're coming up if they were running late. You knew they were still coming. Y1: Always count on them.	A service that listens young people is a good service Offer learning opportunities is considered as an asset by a young person in an organisation Responds as well as listens Rapid response Trusting that they will be there for young people Reliable workers can be trusted by young people
R: So, what was it about the service then that made you feel that you could go in and…? Y1: It was homely, like. All the staff… Y2: They just made you feel so welcome. Like, everybody would say hi to you and… Y3: You would come in, folk'd be like, hiya. You'd go, hi.	Homely-helps to go there: feeling welcome, staff talking to you* *this is about the people not the environment
Y1: It helped, like, siblings seeing each other 'cause remember obviously me, you and [name] didn't get to see each other. Y2: Same with me and	Importance of seeing siblings Good organisation: enabling them to maintain relationships with people who are important to them

Figure 9: Coding in Word

3. Generating initial themes

The focus in this stage was placed on the broader level of coded data. I sorted different codes into potential themes. I placed all codes in a different table, and I started to explore patterns. I also explored sub-themes. I did not have in mind any pre-existing theme(s) at this stage, and I tried to focus on the data rather than on known theory. At the end of this stage, a collection of initial themes and sub-themes was developed.

4. Reviewing themes

   I reviewed the coded extracts to check whether they sat with codes and sub-themes. At the same time, I checked all of the themes to make sure that these presented the pattern meanings of the data. A lot of moving ‘back and forward’ between themes/subthemes and coded data occurred at this phase. This helped me to review themes and combine and/or separate them in order to form a group of themes that represent data collected. I also used supervision meetings to challenge me to think critically about the analysis of my data.

5. Defining and naming themes

   For each of the themes a description was given to represent the meaning. The names of themes were finalised in this stage.

6. Reporting

   In the final stage, the writing of the report occurred. As I started writing about the results, the analysis began to shift from presenting what individuals mentioned to interpreting what story the data told in relation to research questions. Themes for each group of participants and extracts from the data are included in the final report – this thesis (Chapters Four, Five and Six).

3.8.2 Analysing the questionnaire for Stage 3 of the online study

Data from the rating exercise were analysed using Microsoft Excel software, given the small number of data (26 responses). The mean score (M) was calculated for dimensions having an interval scale, and the percentage of participants for dimensions having an ordinal scale.

3.9 Researcher reflexivity

Reflexivity refers to the “analytic attention to the researcher’s role in qualitative research” (Gouldner 1971, p. 16, as cited in Dowling 2006). According to Dowling (2006), it can be both a concept and a process. As a concept, reflexivity refers to a certain level of self-awareness (Lambert et al. 2010). It is about the recognition that researchers are part of the social world that they study (Ackerly and True 2010). As a process, reflexivity refers to the researcher’s continuous reflection on his/her values (Parahoo, 2006) and how these affect his/her research practices (Palaganas et al. 2017). In the following section, key areas that I considered, and which occurred during the research, are considered. These were about the language, access to participants, and the context of the study, as well as about the management of the data.

3.9.1 Language and context concerns

All the data collection was undertaken in English, with the majority of participants (at least those in interviews/focus groups) being native speakers. As I mentioned in the introduction, my first language is Greek, and language challenges were considered from the development of the research. Given that my accent may be unfamiliar to participants, at the beginning of each meeting I encouraged participants to feel free to ask for clarification or to notify me if I spoke too quickly or was not clear. Despite concerns regarding language, I did not feel uncomfortable or perceive any pressure during data collection. Participants were also willing in some cases to explain further what they meant if I was not sure about it. When I was dealing with the transcripts, in the phase of familiarising myself with the data, any unknown words/phrases were underlined and searched online for translations so that I was able to fully understand.

The focus of the research was the prevention of child neglect in the Scottish context. I originated from another country and, when I started this doctoral project at the University of Stirling, I had lived for only one year in the United Kingdom, but in another nation (Wales). Given that, I was not familiar with child protection systems, legislation, regulations, and policy in Scotland. However, the project required a full understanding of the context. Therefore, during the preparation phase of the research, additional time was needed to understand the Scottish policy context. The same need was apparent during data collection in order to understand the circumstances that parents and young people were facing. During data analysis, if participants had mentioned a concept that I could not fully understand, further exploration of the meaning was undertaken; in many cases, supervisors assisted me in this.

3.9.2 Approaching participants

As noted, I am not originally from Scotland and had not worked there before the start of the doctoral project, so I had no existing professional networks, apart from my immediate supervisors and the external co-funder. However, I made contacts very early in the project who enabled me to meet key people working in the area of child protection and public health, so that they were aware of the project. I was in close contact with the external co-funder of the project and had a specific contact person with whom I could explore ways in which they could support the research process. The networks that I had developed facilitated the recruitment of participants to all groups.

Despite this, there were difficulties, particularly in accessing parents and young people. Potential participants were not contacted directly by me, but by a practitioner who was familiar to parents or young people. I was faced with the challenge of repeated changes in practitioners with whom I was in contact and who could disseminate the invitations to participate in the research. Delays occurred in the recruitment phase for all parts of the study, and adjustments to the timescales were necessary to take into account the new circumstances.

Particularly regarding involvement of young people with care experience in the research, there were considerable difficulties during the recruitment phase, which resulted in delays in recruitment and adjustments to the initial timescale. All the key contacts who I approached to help facilitate the recruitment were not available to assist the process for various reasons, such as workload or reaching the end of their contract. Therefore, I explored alternative options that had not been considered in the planning stage. The option of recruiting young people with care experience within the University was considered. However, the idea was rejected, as a person to support participants with potential discomfort during or after the discussion could not be made available. Exploring alternative options was time-consuming. Through the process of involving young people in my project, I understood/reconfirmed the importance of networking.

3.9.3 Understanding the scope and maintaining the focus of the study

It has been apparent since the beginning of the project that an understanding of different structures and systems in Scotland (i.e., the social care system, health system) was necessary to develop the research strategy for this project. In addition to the child protection system, it was necessary to be familiar with the educational system, the health system and the social care system in order to synthesise and develop data collection that combined the different perspectives of people involved in child neglect cases. The same was apparent during data analysis, as participants were mentioning specific terminology, processes, or benefits with which I was not familiar (i.e., P1 to P7 for primary school). In order to manage this situation, I compiled a list of my gaps in knowledge, and I tried to understand the different areas involved, or the terminology, processes or benefits mentioned, by searching online or asking supervisors and other members in the Faculty of Social Sciences.

The parents and young people who participated in this study often discussed and evaluated specific services provided for parents, children and young people in their area. However, the focus of this study was on exploring parents’ and young people’s perspectives on how they can be better supported, rather than on evaluating these services. Therefore, I paid extra attention during data collection on maintaining the focus of the discussion, as well as during the analysing and reporting stages, and my supervisors were also asked to provide feedback on parts of the results regarding this concern.

3.10 Chapter summary

This chapter considered the methodological approach which underpinned the study, and the different stages involved in the research process in some depth. The individual interviews, the focus groups, and the three-stage online survey generated rich data, and the next chapters explore the themes and subthemes revealed in the analysis. The following three chapters will present the findings of this study. The next chapter (Four) will begin by exploring what parents think about being parents, followed by exploring the issues that may affect their lives as parents, and will conclude with parents’ views on the support offered for families, together with recommendations by parents of areas of development for supporting parents and families.

Chapter Four: Exploring parenthood – parents' perspectives of challenges related to parenting

4.1 Chapter introduction

This chapter presents the findings of the analysis of the data from the six interviews and two focus groups with parents. As mentioned earlier, I aimed to explore with parents, who were in contact with services that provide support for parents and families, their experiences of, and perspectives on, tackling the challenges facing families.

The majority of participating parents were mothers (15 mothers and two fathers). Ten participants were in the age group of 25–34 years, whereas five participants were aged between 35 and 44 years. The majority (ten participants) had one or two children, and five participants had three children, whereas two participants had four or more children. As noted in the previous chapter, no participants mentioned that they had children who were not living with them, except one mother, who reported that her son was in care but had moved back in with her recently.

At this point, I would like to note that the parents who participated in the study all had different experiences of difficulties in their lives (i.e., mental health issues, drug issues, living in poverty, dealing with unemployment) and may also have been neglectful of their children. However, no participant was asked specifically to share his or her experience of neglect. The focus of the interviews/focus groups was on their reflection of tackling challenges faced by families. This may have an impact on the findings gathered with parents, as these data were linked with challenges faced by parents instead of neglect. However, the literature review did show that it is also widely known in the field of child protection that a number of risk factors increase the likelihood of a child being neglected. Despite existing knowledge of these factors (i.e., single parent homes, education and employment status of parents, domestic violence, mental illness, substance misuse, childhood experiences of child abuse and neglect, familial isolation, and lack of supportive resources), child neglect still affects family life. Exploring these factors further to determine which of these affect parents' ability to care for their children is fundamental in supporting parents and preventing child neglect and is in accordance with the key principles of a public health approach. Hence, the findings are centred on parents' lived experience of the challenges they faced in their lives, as such challenges appear to contribute to their ability to cope with family life.

Another point to mention here is about the analysis of the data gathered with parents. Despite the fact that the discussions during the interviews were richer than those in the focus groups, probably because it was easier to talk one-to-one, no differences between the interviews and focus groups were observed in the analysis. Further to this, in the analysis of the data, I considered that some participants may actively lie and say what they believe that other people what to hear. Talking in a group setting may further affect what participants are willing to talk about. I was aware of this throughout the data collection and analysis process, but I have chosen to present precisely what parents said during conversations, as I wanted to present their realities. I was there to hear their views and not to challenge their narratives.

In addition to this, I would also like to note that the term ‘services’ is used as a blanket term in some parts; parents did not always specify which services they were talking about (i.e., statutory services, services provided by the third sector). However, in some parts, parents discussed their views on specific services, such as social services, and these are mentioned later in this chapter. Finally, I analysed the data from the interviews and focus groups separately. However, there was much overlap in themes/subthemes of each. Therefore, I chose to make a combined presentation of the findings to allow a more effective exploration of the richness of the data.

The findings are presented in three parts (Table 7):

- Reality of parenting
- Supporting parents to thrive in their lives
- Culture of supporting parents

Table 7: Subthemes and themes based on the analysis of data from parents

Subthemes	**Themes**	**Section**
Bonding and maintaining bond with children	What it means to be a parent	Reality of parenting
Protective role of parenting		
Parental resilience		
Parenting as life-changing		
Parenting is challenging for all parents	Challenges for parents	
Family composition		
Impact of environment on parenting		
Challenges related to working and finance		
Extra pressures for parents		
Special circumstances of parents		
Support from close family	Sources of support for parents vary	Supporting parents to thrive in their lives
Support from peers		
Community belonging		
Support from charity, school or other professionals		
Recognising need(s)	Determinants of parents asking (or not) for help	
Communicating need(s) and early		
Parents' feelings		
Parents' expectations of services		
Knowledge of available support		
Combination of different levels of support	Principles of supporting parents	Culture of supporting parents
Stable provision of services		
Giving parents choices to control their lives	Qualities of operational provision of support	
Interactions between parents and professionals or other providers of support		

4.2 Reality of parenting

This first section presents the reality of parenting, as discussed by participating parents. It explores two themes: the first is about what they enjoyed in being parents, whereas the second refers to the challenges faced by parents in their lives. It was my choice to present these two themes together, as these combine two different aspects of parents' lives and make a contribution to understanding the areas in which parents need support, either because these aspects were enjoyed by parents, or they were discussed as challenging areas. A more detailed description of each theme is outlined at the beginning of each sub-section below (Sections 4.2.1 and 4.2.2).

4.2.1 What it means to be a parent

Parents discussed different aspects of parenting. This involved what they enjoy about being parent; namely, the bonds between them and their children, the parental role of protecting their children, as well as parental resilience, with this being enhanced by the involvement of parents in different activities. It also involved being a parent as a life-changing and life-saving experience. I chose to start the presentation of the findings with this theme, because I was expecting that parents would focus more on the negative aspects of their lives and experiences of parenting. However, all of the parents pointed out positive aspects, and these indicated areas of consideration for further supporting parents by enhancing these positive experiences.

4.2.1.1 Bonding and maintaining bond with children

When parents were asked in the interviews about what they might enjoy about parenting, all of them (six participants) said that the bonding between them and their children is something that they enjoy. Bonding appeared for parents to be enhanced by spending time with their children. This was not only discussed as being positive from the parents' perspectives, but, as parents mentioned, children need and enjoy this too.

A single father said that he enjoys bonding with his daughter, spending time together, and playing, as they are a "wee team":

> *I: And what do you like the most about these activities with your daughter?*
> *R: Just the time, just like the bonding, just the play, (...) we're like a wee team, so we play, we do like (...), so we do a lot of painting (...) building towers and all that, so we'll sit and do all those types of stuff.*
>
> (Interview, father, single parent, one child, 4 years old)

One mother noted that spending time with her children was worth "all the money in the world", and that children need parents' time:

> *They need your time; they need your attention. Spending, spending time with them for me is all the money in the world.*
>
> (Interview, mother, single parent, three children, 12, 9 and 4 years old)

It was also noticed by another mother that children do enjoy spending time with family:

> [what children enjoy about outdoor activities] *(...) just being out and being able to kind of spend quality time as a family unit.*
>
> (Interview, mother, two-parents, four children, aged approximately 12, 10, 6 and 3 years)

According to a mother, when a parent plays with their children they are engaging with them, and this contributes to a positive relationship between parents and children. She also said that it contributes to children receiving positive feedback from parents and supports their mental wellbeing:

> *(...) if a parent was playing with their child, was engaging, the child would obviously be ecstatic, be loving it and, you know, that's a positive relationship, positive feedback from them, and their mental wellbeing would be much better.*
>
> (Interview, mother, two-parents, three children, ages unknown)

However, another mother noticed that some children were lacking bonding with their parents, as parents may not always be able to find the time. However, bonding time was the most important thing, according to her. An important aspect of bonding mentioned by her was the age of children; she said that children's need for bonding goes beyond one year of age:

> *Time is another thing, finding time as a parent, you know, that bonding time with your children, because sometimes, to be honest, the children is not only year 1.*[16] *Some kids they lack, that's love, that safety they want, that bonding they want from their parents because they are busy. (...) You know that's bonding time, that's unconditional love they deserve, you know, it's that's one of the most important things (...).*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

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[16] This mother was not a native English speaker, so here I suspect that she was talking about need for bonding beyond one year of age.

4.2.1.2 Protective role of parenting

Another aspect of parenting noted by all parents in the interviews was their role of protecting their children. Parents said that they enjoy seeing their children happy, playing and having fun. But they mentioned they want their children to be safe. A father, when he was asked about what he enjoys the most of being a parent, focused on the future of his child. He noticed that what makes him happy was to see his daughter grow up, learn and progress. At the same time, it appeared that he wanted his daughter to be able to physically protect herself, and he referred to Taekwondo.

> *I: (...) what do you enjoy the most of being a parent?*
> *R: The most (...) I think just to see the satisfaction of watching her grow and learn and progressing at things, do you know what I mean, that just makes me happy.*
>
> (Interview, father, single parent, one child, 4 years old)

> *(...) I'm going to get her into Taekwondo, so she can look after herself when she's older, do you know what I mean?*
>
> (Interview, father, single parent, one child, 4 years old)

Specifically for safety, a mother said that safety is the first priority.

> *Well, most of the time I will rather sit down see them, you know running about, play with other kids having fun. As long as they are safe. (...) safety is paramount, safety is a first priority.*
>
> (Interview, mother, single parent, three children, 12, 9 and 4 years old)

4.2.1.3 Parental resilience

All parents in the interviews and focus groups referred to other aspects of their lives that are important, such as learning new skills, working, and having time for themselves. These aspects may contribute to their resilience, and this is the reason that I chose to present it as a sub-theme. This is an important aspect in preventing child neglect, as often risk factors affect parents' ability to cope with the stresses of everyday life, as well as an occasional crisis. Resilience contributes to parents managing stress and functioning well despite challenges in life.

In regard to what may contribute to parents' resilience, learning new skills, working, and having time for themselves were referred to by parents. A father mentioned that some time for himself is useful, despite missing his children:

> *(...) So, obviously way down to, or maybe go to the cinema or something like that. I definitely think personally that a wee time apart, it's good to unwind (...) but it's you, you definitely miss your kids.*
>
> (Interview, father, single parent, two children, 11 and 9 years old)

A mother described that she loves her children and would not change them for anything, but, at the same time, she wanted to study and to work. Another mother noticed that parents having some time for themselves is beneficial, as it recharges batteries:

> *I love my kids. I will no change them for anything. But you know that sometimes like, I'm going to school, I want to work I want to do this (...).*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

> *Although we all love our kids, (...). So definitely having that kind of hour or two break away, just to kind of do what you want, even if it's just to sit in a park, have a cry, have a cup of coffee or read a book, it doesn't matter, it's always beneficial to have because it recharges your batteries (...).*
>
> (Interview, mother, two-parents, four children, approximately 12, 10, 6 and 3 years old)

A mother also noted that enhancing skills may contribute to people's confidence in applying for a job or a college course. Specifically, she said that it may involve enhancing interview skills in order for people have confidence to make new steps and to help in the experience feeling less "daunting":

> *To then again, offering, like, interview skills, you know, even if they have the confidence to apply for a job or apply for college courses, you know, that might be quite daunting to somebody, as they're like, oh, I don't want to go in for that.*
>
> (Interview, mother, two-parents, three children, ages unknown)

4.2.1.4 Parenting as life-changing

An aspect of parenting mentioned by only one mother referred to a life-changing experience. She said having her child totally changed" her life. She also commented that having children was lifesaving, as she used to have drinking issues years ago:

> *I would have a bad, not a bad (...) I went through a lot of drinking before I get the kids, years and years ago, 13 and beyond that (…) If I ever had time, I would've been dead, that's the way I see it. Since I fell pregnant with my wee boy a light switched on. That's totally changed my life.*
>
> (Interview, mother, single parent, three children, 12, 9 and 4 years old)

She further explained that she was having a nice life, which was far better than her life before children, despite experiencing changes because of children:

> *Having them and having a nice life with all the changes and having another two is far better than the life I had before that.*
>
> (Interview, mother, single parent, three children, 12, 9 and 4 years old)

4.2.2 Challenges for parents

Despite the positive aspects referred to by all parents, they also noted challenging aspects faced in their lives. There was a general agreement across discussions with parents that parenting is challenging, and they also talked about specific challenges. These referred to different factors, namely, family composition, characteristics of the environment, challenges related to working and finance, extra pressures for parents, and other special circumstances of parents. These challenges were crucial as they can be linked with risk factors for child neglect and should be considered in developing a public health approach to child neglect.

4.2.2.1 Parenting is challenging for parents

The majority of parents (both in interviews and focus groups) recognised that parenting is challenging. Parents pointed out different reasons for those challenges. Parents in the focus groups identified the practical issues of childcare as challenges, whereas three parents in the interviews referred to constant issues that change as children grow up. Two parents also recognised that all parents will face difficulties at some point.

Specifically, a mother, who considered that having children was life-changing, mentioned the stress experienced by parents, and that being parents was not easy, but nevertheless was rewarding. And, according to her, all parents will face challenges at some point:

> *(...) yes the stress is on you, I'm not gonna say it's not, I'm not gonna say is easy, because it isn't easy, it's hard but rewarded as well.*
>
> (Interview, mother, single parent, three children, 12, 9 and 4 years old)

> *Not very many parents that don't face challenges. Every parent, all will face a challenge at one stage.*
>
> (Interview, mother, single parent, three children, 12, 9 and 4 years old)

The same mother also noted that a challenge of parenting is that it does not "come with manual", and the challenges change every day, as she has three different children:

> *R: I'm just wondering, do you think that is there any difficulty of being a parent?*
> *P2: It doesn't come with a manual. Seeing, when you're pregnant. That's definitely, doesn't come with a manual. The challenges everyday are totally different. You don't know what you're waiting with when you wake up. I've got three very different children.*
>
> (Interview, mother, single parent, three children, 12, 9 and 4 years old)

Another mother referred to the notion that parents will face challenges even when their children are in their teenage years:

> *(…) you understand children can be really, really challenge even when they are in their teenage years, they can be like a pain.*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

Although other parents said that parenting was challenging, a father, during his interview, noted that he did not find parenting difficult. The only bad experience he had had was dealing with social workers. This will also be discussed in the theme 'provision of support'.

> *Not really, no, not really, I think it's … no, I don't really. The only thing was when I had dealings with social work in here (...) But other than that, that's the only bad experience.*
>
> (Interview, father, single parent, one child, 4 years old)

4.2.2.2 Family composition

As was identified in the literature review, family composition is one characteristic that may contribute to child neglect (however, the findings were mixed). Two mothers of the young people participating in the focus groups in the urban area, and three parents in interviews, described being a single parent as a challenge, and this was important, given that family composition could increase likelihood a child to be neglected.

A father mentioned that being a single parent and working is challenging. He gave up his full-time job to care for his two sons, as he did not have any other support:

> *R: It's very very challenging thing [being a single parent and working]*
> *I: In what way?*
> *R: Myself I used to be. I'm a full-time (job),*[17]*and I had to quit my job because obviously was, I'm a single parent myself. I had no one very handy to watch my two sons, so I had to quit my job and do it myself.*
>
> (Interview, father, single parent, two children, 11 and 9 years old)

A mother also said how a single parent like her could not just do any kind of job because of the restrictions imposed by parenting responsibilities:

> *Being parent, like me a single parent, I couldn't take a job in a pub at 5:00 to 12:00 at night. I've got the kids for school and I'm up for school in the morning. I've got a child, so it does affect, you are restricted. (...).*
>
> (Interview, mother, single parent, three children, 12, 9 and 4 years old)

A mother mentioned that, as a single parent, all responsibilities were on her for caring for her children, and there was no option to share these, even when she was sick. She also assumed that life would be easier for a two-parent family:

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[17] Probably he meant: in a full-time job.

> *But in my own case, you can't, even if I'm sick I have to make sure they eat, I have to make sure they're clean. I have to measure*[18] *they are safe, do you understand, so being a parent can be really really challenging, it's better when is couple like a husband and wife or when they are two rather than being one person.*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

Two participants in the focus groups in the urban area also discussed the responsibilities of single parenthood. They noticed that, as single parents, they felt that all of the responsibility is place on them, and this was constant without a break. One noted that it made them feel isolated and lonely, too.

> *R1: (...) see when you're a single parent it is, it's like (...) you just feel as if everything is on you basically, I suppose. (...) it's all on you so you've not got anybody to share like she's sick this, or you've got a concern about them or they're not well.*
>
> *R2: If they're not well or when you take them somewhere, it's just all on you so it is. It's hard, it's tough going, 24/7 so having maybe like some (...) Sometimes it's isolating as well and you just need to get on with it, but then it's lonely as well.*
>
> (Parents' focus group, urban area, two participants)

4.2.2.3 Impact of environment on parenting

All parents in the interviews and focus group talked about the characteristics of the environment in which they lived and how these affected them. They noticed that safety in the area of living can affect (positively or negative) children's outdoor activities, such as playing in the street. A father mentioned that his area was safe (i.e., no people hanging about, no gang fighting, or smashing bottles) and, when his daughter is older, he would let her play outdoors:

> *It's a pretty safe area, I think, like as I say, you don't get people hanging about, there's no like gang fighting and all that, you don't see none of that. You don't hear people smashing bottles or things like that. (...) when she's older to go out by herself, you would be alright to let her out and play, it's a pretty safe area for that.*
>
> (Interview, father, single parent, one child, 4 years old)

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[18] Probably she meant: make sure.

There were also references made to area safety in both of the focus groups with parents. In the rural focus group, a mother said that her son had the freedom to go around the neighbourhood and walk to the swing park, as "everybody knows everybody". However, she also said that, in a big city, it was not possible to have that kind of freedom:

> *I do have to say going by that as well, my son, he'll be coming six and he gets the freedom […] he can go straight up the road to the swing park and things like that. I think with it being such a small village and everybody (...)The majority knows everybody, it gets the freedom. But if we were in a big city or that, he wouldn't have that type of freedom. So I have to say I think that's a, kind of, bonus of living in such a small village. Everybody knows everybody. You know every child that belongs in this village.*
>
> (Parents' focus group, rural area, nine participants)

Mothers in the focus group in the urban area appeared to agree and noted that, these days, it was not safe, parents were scared and constantly worried, and did not let their children out to play unsupervised:

> *R1: It's just not safe these days, you just don't let your child out your sight because there's so many abductions, kidnaps, people trying those things, so you're scared, you've got that thing as well and if you do let them out to play …*
> *P2: You look out the window.*
> *P1: You're looking out the window constantly, or you're worrying, and you can't relax if you don't do it, I mean it's no really …*
>
> (Parents' focus group, urban area, two participants)

Another aspect of the environment mentioned by parents was the availability of facilities in their area. A father said that there were parks close to where he lived, shops within walking distance, as well as good connections to the town. So, he could not think of anything that was an issue:

> *(...) two wee parks dead close together, shops and that are just down the hill, so everything's local, anything I need is all just in walking distance basically, so yeah, it's pretty good, yeah. (...) Yeah, pretty good, the buses and all that are good, takes you right into the town and I can't think of anything that puts me off, no.*
>
> (Interview, father, single parent, one child, 4 years old)

Although the availability of facilities within walking distance was perceived as a positive characteristic of an area by that father, a mother referred to an incident that may indicate why, even when services are based locally, families might not use them. She described a suspected abduction in her area and noted that this makes parents worry, as it is not clear how this will affect children’s lives in the future. She also said that, although there was a hub for activities close to her house (a five-minute walk), it is scary to walk there because of the abductions in her neighbourhood:

> *But I’ve seen a lot out there. There was a suspected abduction last night, with two kids and (...) not away where I stay. It makes you worrying, you know what I mean, it’s happening on your doorstep. (...) it’s quite scary for when the kids go older, grow up and get older what kind of life they will get in. (...) There’s a hub which is further down, they have computer courses, the (day) club and some stuff but or that it may be a five-minute walk away. Doesn’t sound far but with all these abductions went on, suspected abductions went on, it’s quite scary.*
>
> (Interview, mother, single parent, three children, 12, 9 and 4 years old)

Apart from safety, in the rural focus group, parents spoke about transport difficulties and problems with accessing facilities. An inaccessible train station, expensive bus tickets, and infrequent routes were noted by parents from rural area as challenging in their everyday lives. These aspects might contribute to difficulties in accessing facilities, and add extra stress. A mother gave an example of how these affected her – traveling by train with a pram, when there is no elevator on the train station, is hard for her. Another mother said that going to the swimming pool with her daughter to the next village takes four hours by bus. In terms of how expensive buses are, this needs to be examined within the context of having a limited budget. The bus fare might take up a significant proportion of money and things that parents would prioritise to spend money on would affect other aspects, such as their food budget, which added an extra pressure on them.

> *R1: The train station for a start.*
> *R2: I’ve had a hospital appointment at least once every week for the past three weeks, and having to get to it with a pram is hard enough.*
> *R3: Train station, there’s no elevator.*
> *R4: Buses are every two hours.*
> *R2: Aye, the buses are terrible as well. Uhm-hmm.*
> *R3: And the prices of the buses ...*

> *I: How do you think this affects parents? Can you tell me more then?*
> *R1: Well for instance, I don't drive. So I let her go to the swimming pool, I have to go on the bus. And I have to wait a couple of hours for the bus to get back in the cold [...] Even it's just three miles down the road, it's still ... take about four hours of your time.*
> *R2: Just to travel three hours. It does. It takes four hours of your time to go three miles.*
> *R1: Aye, just to go to a swimming pool. Uhm-hmm.*
> *P2: To the next village.*

(Parents' focus group, rural area, nine participants)

4.2.2.4 Challenges related to working and finance

Three parents in the interviews and all parents in both focus groups said that a challenge faced by parents these days was related to finances. Although the discussion did not continue in much depth (mainly referring to financial challenges with no further details), one mother mentioned that parents are struggling (financially) and that this has affected their mental health, and this is a further issue for parents to face. This indicated how financial issues affect family life; the mental health problems of parents are considered as a factor that contributes to the likelihood that a child may be neglected by influencing parents' knowledge, skills and behaviour.

> *(...) the challenge that parents have now is mostly the most important one is the, you know, the financial aspects. (...) obviously when parents are struggling it affects their mental health, you know, and when they have mental health problems this is another thing, because their mentality is ruined.*

(Interview, mother, single parent, two children, 9 and 4 years old)

Parents in the focus groups also referred to the cost of childcare. Parents suggested that it was not worth working because all their earnings would go on childcare, and they would also lose benefits:

> *R1: It's just not worth it.*
> *R2: If you pay your childcare, you'll be left with nothing anyway, so ...*
> *R3: You're working for nothing.*

(Parents' focus group, rural area, nine participants)

> *R1: By the time you get childcare sorted your money will be gone.*
> *R2: It's just not, it's not worth your while like going to (...) By the time, like you say, you get paid then it's all taken off you for your nursery fees or full rent then you lose benefits. So, it's not really, it's not worth it, it just costs too much to go to work.*
>
> (Parents' focus group, urban area, two participants)

4.2.2.5 Extra pressures for parents

All parents also said that they are experiencing extra pressures in their lives. One example of extra pressure was about summer holidays, when the schools are off. During that period, a mother noted that, for most activities, there was a charge, and not everybody could afford this. A father suggested that during school break parents do not have "a clue what to do with them".

> *(...) like summer holidays when your wean's off school and you've got them for six weeks and you've not got a clue what to do with them.*
>
> (Interview, father, single parent, one child, 4 years old)

> *Coming of summer holiday and most of the activities you have to pay, something that is free. It's not that everybody can afford to pay even me myself. I struggle financially at times. (...) I am pretty sure so many people are facing the same problem (...).*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

Apart from activities for children during summer, parents also mentioned that paying for children to attend activities in general (i.e., gymnastics, swimming) costs a lot of money. A mother suggested that, if there were facilities where children could go, this would be a relief for parents:

> *P1: (...) he goes to his gymnastics, then he's got [...] his swimming. And there's all different things on he could go to Wednesday/Thursday.*
> *P2: But all these things that (name) is talking about (...) you need to pay for them. So, if you've got (...) as I say, if you've got two or three children and you've to take them to things like that, it's a lot of money for parents, so it is, for to take your children to stuff like that.*
>
> (Parents' focus group, rural area, nine participants)

> *If you have the right amenities for kids, then it will be a relief for parents, somewhere kids to go that they don't have to worry about money.*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

Another mother referred to managing children's behaviour. She said that, in her family, they struggled to keep her son way from their Xbox and YouTube. There were occasions when they removed the game from the child and he had a negative reaction. She also said that this was a difficulty that many parents are facing, to keep their children away of technology:

> *My eldest son, he is a nightmare at the moment. He's more concerned about the virtual world than he is the real world (...). So, I think that's quite difficult, because there have been a few occasions that we've literally had to go in and remove the Xbox, and he's had the shakes and things like that because he's just so addicted to it. And I think that's quite a difficult thing for a lot of parents at the moment because technology is all around us and trying to keep your kids away from it is quite difficult.*
>
> (Interview, mother, two-parents, three children, ages unknown)

4.2.2.6 Special circumstances for parents

A mother mentioned that she was not feeling as accepted by people in the community, because of her being different.[19] This appeared to be an extra challenge for that mother in addition to the other challenges reported previously. Not feeling as accepted by other people in the community may contribute to the isolation of families, which, according to the literature review, is a risk factor for child neglect. This could also be linked with not knowing what available support there is in the area, which is presented later in Section 4.3.2. However, the mother said that she overcame this issue and people understood that she was part of them due to her involvement in the community:

> *(...) I'm quite involved in my community and that seems to help a lot, because most if you if, if you go there (...) so I'm always everywhere, I do lot of stuff which really helped me because people now understand*

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[19] I am not referring to what kind of difference here, in order to protect the anonymity of participant.

> *that okay this this lady either you like it or not, she's part of us. They just have to accept me.*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

4.3 Supporting parents to thrive in their lives

This section explores two themes: the various sources of support for parents, and the determinants that influence parents to ask for help (or not). The first theme refers to what has helped them, or sources of support that parents thought may help them in receiving support in their lives. The second was about barriers to asking for help, based on their own experiences and/or their opinions on what may block parents from asking for help.

4.3.1 Sources of support for parents are varied

Parents discussed what has helped them in their lives in regard to receiving support. This ranged from receiving support from close family members to support offered by different sectors. In terms of the support offered, it involved help from close family members to provide parents with childcare and to share concerns, support from other parents, peers and other community members (i.e., neighbours), and support obtained through different sectors, such as education, the third sector and healthcare.

4.3.1.1 Support from close family

It was common for all parents to mention that their close family, which included parents, sisters and brothers, and aunts, were a source of support in providing childcare. One mother said that her mother helped her in order that she could work. A father also noted that his sister helped him if he needed babysitting.

> *'Cause I wouldn't be working if I've no family. If my mum didn't do that (babysitting), I couldn't go back to work.*
>
> (Parents' focus group, rural area, nine participants)

> *Any time I need a babysitter or whatever, I've got like my sister.*
>
> (Interview, father, single parent, one child, 4 years old)

However, a father found that having chats with his family about things that concerned him or about his children was very helpful. This was not mentioned by other parents in the study, who mainly discussed that close family can be a source of support for childcare.

> *I: What do you think about the extended family?*
> *R: Yeah. No, no, no, no very useful because you can let go, you can have a chat. If something's bothering you and you are bothering the kids.*

(Interview, father, single parent, two children, 11 and 9 years old)

4.3.1.2 Support from peers

In both the interviews and focus groups, parents referred to the need to meet other adults. Apart from discussing shared issues with each other, meeting with other parents could involve checking whether anyone needs help and determining how they could help each other. As was identified in the literature review, accessing informal support from individuals or families may decrease the levels of stress for parents and may reduce the risk of child maltreatment, and appears as an aspect to consider in preventing child neglect.

To be more specific, parents in the focus group in the rural area reported that meeting other adults is needed, just to have adult conversation and for company. That discussion was based on their personal experience of meeting other adults:

> *R1: (...) You need some adult time, not just, like, you stuck in the house with your weans constantly. 'Cause that would drive me mental. You need to have some adult conversation and [voices overlap 07:25].*
> *R2: For company [voices overlap 07:42].*
> *R3: Aye, exactly. Company, that's it.*

(Parents' focus group, rural area, nine participants)

In the interviews, two parents suggested that meeting with other parents could be useful. A father in an interview noted that spending time with other parents is very useful in order to have a chat and see whether they are doing well and/or need any help:

> *(...) it's very useful. It's nice spending time with other parents and have a chat to see how they are going, if they needed any help and stuff like, would be good*

(Interview, father, single parent, two children, 11 and 9 years old)

A mother also noticed that, in meeting with other parents, it would be good to catch up and see whether they can help each other:

> *It would be good having services especially in my area we can meet someone, like catch up with other parents, discuss things among ourselves to see if we can help one and other.*
>
> (Interview, mother, single parent, three children, 12, 9 and 4 years old)

Apart from informal support from peers and other parents, people in the community could help them in their parenting lives, mainly by sharing information of what is available in the community. A mother mentioned that neighbours could share information about what was available in the area, such as funfairs:

> *(...) certain people in that community might know something that that person might be interested in, or even like if there's something that's going on, like funfairs and things like that, and you've not heard about it. Your neighbour will say to you, right, okay, you know this is on? You've got kids and things like that, so it will be ideal for your kids (...).*
>
> (Interview, mother, two-parents, four children, approximately 12, 10, 6 and 3 years old)

4.3.1.3 Support from charities, schools or other professionals

Other sources of support discussed by some parents in the interviews and focus groups included support from the system, including the education sector, the third sector and healthcare providers. This was about having access to these sectors and then having conversations about them, which are both important. However, there was no further discussion of what it was that the parents got from those sectors and for whom, and this therefore needs further exploration.

In regard to what parents mentioned, parents from the urban focus group suggested that having a conversation helps to get your problems out. This conversation could be with a health visitor, a support worker, or a doctor. In addition to this, it was said that school staff can offer advice (however, none of the participants specified what kind of advice):

> *I: Who can this person be?*
> *R1: A doctor or support worker.*
> *R2: Health visitor.*
> *R1: Health visitor, or (charity organisation) [inaudible 14:41] or something like that, you can just maybe have a conversation and*

> *your problems are kind of getting out and then you feel as if you're getting if off your chest. So, I think…*
>
> R2: *Nursery teacher, school teacher if they're at school or maybe they've got learning assistants and stuff at the school that can maybe offer just some more kind of advice or something.*
>
> (Parents' focus group, urban area, two participants)

A father also described that he got support for a local charity and a support worker. The worker met with him, and together had a chat about how he could be supported to care for his children.

> *(...) I've managed to overcome all of these and the service like this, and (name) and other staff, she gave me (...). A support worker met with me and have a chat to see (...) how I can, I can develop, look ways to help my kids grow up, (...).*
>
> (Interview, father, single parent, two children, 11 and 9 years old)

4.3.2 Determinants of parents asking (or not) for help

All parents who contributed to this study referred to elements that could determine whether parents would ask for help. These involved firstly parents recognising that there is a need. Then, they noted that parents need to communicate that need early and overcome their feelings (i.e., feeling judged, or as bad parents for needing support) as well as their expectations (i.e., services might not offer them support even if they asked) that may prevent them from asking for help. Asking for help also requires parents to know what is available, and that was also noted by parents.

4.3.2.1 Recognising need(s)

The first step to asking for help involves recognising that there is a need for help. A father was referred specifically for neglect and said that, in the past, neglect may have constituted not feeding a child properly, but now it also involves not taking the child to the dentist. So, parents need to know what constitutes neglect. He seemed to be saying that child neglect is constructed differently by different people, and that, unless professionals and parents have similar definitions of what constitutes neglect, parents may be seen as being neglectful when they do not think they are. However, in relation to this point, the probability that parents might manipulate what is being said must be considered. I did not evaluate this specific information from the father as being either true or false in his case, but I listened to his perspective, which may apply to other parents. Not recognising that taking a child to the dentist is a basic need may result in the parent not exploring options of help in order to meet this need, and this needs to be considered in encouraging parents to ask for help early on.

> *Neglect used to be like not feeding your weans and hitting your weans or whatever, now neglect is not taking your wean to the dentist, do you know what I mean, that's down as neglect now, do you know what I mean, so people need to know what they can put that word neglect into (...)*
>
> (Interview, father, single parent, one child, 4 years old)

A mother referred to learning goals set in schools each year. She mentioned that knowing the targets that the school has set each year, by being more involved, would enable her to know whether her son is struggling. This suggest that she recognises that there is a need, and then asking for help is the next step. This is the subtheme presented below.

> *I think, as a whole, parents should, probably, have more, (...) more involvement of knowing what the curriculum is, what their targets are, so to speak. What their goal is at the end of the year. (...) then, I would know if my son was struggling or not, because, then, when he's getting it home, I'd like, alright, well you've to that, or you should be meeting that target, or you know. And if he wasn't, then I could then seek him extra help or go into the school and ask (...).*
>
> (Interview, mother, two-parents, three children, ages unknown)

4.3.2.2 Communicating need(s) and early

According to the literature review, parents often tend not to ask for help, as they may mistrust formal support from services due to having bad experiences of services being involved in their own childhoods, or because they fear that their children might be taken away (as is also discussed in the next sub-theme). However, all parents in this study noted the importance of asking for help and also of seeking help early, before issues escalated. Intervening early is an important aspect of preventing child neglect. A mother mentioned that parents need to speak up, as other people cannot assume that there is a need (i.e., a mental health issue) or when a person is struggling and needs help.

> *(...) it's important they speak up, you can only help people you can only give people information they need when they actually ask for it,*

> *because you can’t just go to people and I assume they have mental health problems. You can’t just walk to anybody and just think, oh this person is struggling.*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

A father advised other parents to go to services and ask for help before it “gets too much” for them:

> *(...) I’d advise them to go to the services before it gets too much for you, like go to the social workers yourself before they come to you, (...) so if you feel like…if you’re a single dad or a single mum and you’re bringing up your wean and you’re struggling, go to them and just say, listen, this is the position I’m in, I’m coming to you for help.*
>
> (Interview, father, single parent, one child, 4 years old)

4.3.2.3 Parents’ feelings

As already mentioned above, parents often tend not to ask for help. Parents referred to elements that might contribute to making them feel bad and not asking for help, and for missing opportunities for early intervention. These included feelings of being stigmatised as not being a good parent, stereotypes of who needs support, fear of social workers, and feeling judged. Specifically, a mother noted that she was feeling as though she was not good enough compared to other parents, in her words, “a bad mum”, and this was a barrier to her asking for help:

> *(...) it made me feel...not like I was a bad mum, but I just couldn’t do it the way that you see other parents doing it, (...). You compare yourself to that and you think, what is it that they’ve got that I’ve not got? So I think that is a big barrier for a lot of parents and it does kind of make them feel as if they’re not good enough.*
>
> (Interview, mother, two-parents, four children, approximately 12, 10, 6 and 3 years old)

The same mother noticed that “bad parents” or people who are “on benefits” are the ones who will usually ask for help. Being stigmatised as being bad parents or stereotyped for needing help may discourage parents to ask for help.

> *And then stereotyping as well would probably be another one, because a lot of people associate coming to places like this for help as, like I say, being stereotyped as being bad parents, or parents that are on*

> *benefits and stuff like that. And that's really not the case, but that's something that society would kind of look at, and I think that kind of puts people off as well (...).*
>
> (Interview, mother, two-parents, four children, approximately 12, 10, 6 and 3 years old)

Parents from the focus group in the rural area also mentioned that a difficulty that they were facing was people's views. It appears that people believe that when you do not have anything, then you should access services (in this case, a charity facility in the community). However, participants pointed out that this is not the case, as everybody there is the same:

> *I: What do you mean about ... with views? You said something views, folks' views?*
> *R1: You get a lot of people that…round about here that class it…obviously what I was saying (...)*
> *R2: If you've got nothing, you come here. And that's not true. That's definitely not true because as I say, all the staff welcome anybody in here. Doesn't matter what you've got and what you've not got, you're more than welcome to come in.*
> *R3: And we're all the same.*
>
> (Parents' focus group, rural area, nine participants)

Another aspect of parents' feelings is their fear of social workers. Specifically, a father described that everybody worries that social workers will take away their children and the majority of people do not trust them:

> *Everybody worries that they're going to take your daughter away from you or take your child away from you (...) the view is, 90 per cent of people would say like they don't trust social workers.*
>
> (Interview, father, single parent, one child, 4 years old)

Feeling judged was also mentioned by parents. It was noticed that they may feel judged by services and/or by other people:

> *(...) most of the time anybody that comes this, kind of, services, will probably has their guard up; and be like, no, these people are judging me (...).*
>
> (Interview, mother, two-parents, three children, ages unknown)

> *They probably feel quite judgemental, people are quite judgemental towards them (...) you know, a family where parents, maybe, don't work as well, they then face that, kind of, people judging them that way, oh you don't work, and then the children and all that. It is, it is probably quite more, more people being judgemental.*
>
> (Interview, mother, two-parents, three children, ages unknown)

4.3.2.4 Parents' expectations of services

The expectations that parents have of services may also affect whether they will ask for help. One mother said that parents may also feel that, even if they do ask for help, they will not receive any, and this may mean that they are even more reluctant to ask for help:

> *(...) if you ask for help, they won't give you anyway, so why bother that. Because they believe that even if they speak of there won't be anything done about it.*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

Expectations can also be formed from what parents hear about services. A father talked more specifically about social workers, and he mentioned that only bad stories are told about them, for instance, when a child is killed. No stories of how they help are heard, and this needs to change by telling those stories.

> *But all you hear is like negative, do you know what I mean, negative ... like in the papers or whatever, the only time you hear about social workers is if a child's been killed or something or whatever, you don't hear like if they've helped a family, (...) just get stories off of people what they've helped and they've done – good-bye.*
>
> (Interview, father, single parent, one child, 4 years old)

The same father also referred to stories about social workers who had helped other families, suggesting that these should be available in the office of social workers, as people will be able to see those. Seeing what has helped other people gives a person "the incentive to actually ask for the help":

> *(...) like if they put stuff out like that, then people ... say I was going into the office or whatever and I'm sitting, and it's on the wall, even just in their office, then you turn round and you look at it and you read it, and you're like, oh right, well, they've helped that family, and if you're a person going there for help, then that gives you the incentive*

> *to actually ask for the help, because then you see that they helped somebody, (...).*
>
> (Interview, father, single parent, one child, 4 years old)

4.3.2.5 Knowing of available support

A prerequisite for asking for help, which was not identified in the literature review, referred to knowing what is available in terms of available sources of support. A mother recognised that she was struggling, but she did not know where to go or what was available in her area. According to her, the same applies for other parents, too. This needs to be considered together with her feeling isolated, and she was the same mother who was feeling as though she was not part of her community because she was different.

> *(...) I was isolated. I had mental health problem. I was struggling. I didn't go out at all. And it's not that I don't want to go. I don't know where to go. I don't know what is happening the area to see and I know that some other parents do.*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

Parents referred to the ways in which services can provide information regarding the available support for them. This included posters or leaflets, a school letter, a talk at the school by social workers about available services, suggestions made by nurseries, and advertisement on social media:

> *I think it should be like posters up or even a leaflet in, like, a baby pack or a school letter or, you know, something for parents to know.*
>
> (Interview, mother, two-parents, three children, ages unknown)

> *I think it would be good if even (the social worker of service) could go into schools and have, like a, kind of, parents, kind of, meeting. You know to kind of, say, look, our service is here (...)*
>
> (Interview, mother, two-parents, three children, ages unknown)

> *R1: The nursery told me about this.*
> *R2: I don't know, maybe like (...). I think it is probably just word of mouth. People get to know it by mouth, but I don't know if there could be more advertising or something. (...) like posters, maybe like social media.*
>
> (Parents' focus group, urban area, two participants)

Another mother also noted that there needs to be more advertisement of services, because people are missing out:

> *I: What would you like to see in terms of services?*
> *R: Probably more advertisement, to be quite honest, because I think a lot of people miss out on services because it's not well advertised (...).*
>
> (Interview, mother, two-parents, four children, approximately 12, 10, 6 and 3 years old)

The same mother also said that advertisement could be in libraries, a place where people with children are likely to visit. Another source of information mentioned by her was her extended network/family, as a friend's grandmother told her about available support:

> *(...) And probably in libraries and that would be quite a good one to have as well, because a lot of people with kids go to libraries anyway for the book clubs and things like that. (...) then another friend of mine, it was her gran that had seen it here, that had got her involved in it. So I think just advertising in the local communities and things like (...) that would be beneficial.*
>
> (Interview, mother, two-parents, four children, approximately 12, 10, 6 and 3 years old)

Parents from the focus group in the rural area, however, mentioned that people in that small village knew of what is available, as it is "such a small village", indicating a potential difference between urban and rural areas that needs to be considered in making known information about available support:

> *I: And how parents can know about the available services.*
> *R1: So everybody in the area is pretty much aware that this is here.*
> *R2: But being such a small village, everybody does know about it.*
>
> (Parents' focus group, rural area, nine participants)

4.4 Culture of supporting parents

This third section involves two themes: principles for supporting parents, and the qualities of the support offered. The first refers to the structure of how support is delivered, whereas the second is about the actual delivery of support, focusing more on interactions between professionals and parents.

4.4.1 Principles of supporting parents

Among parents who contributed to this study there were suggestions that could contribute to how support needs to be delivered. They talked about different levels of interventions, available to all parents, and targeted interventions to meet specific needs. They also discussed the stable provision of support, which included not withdrawing services due to funding issues, and referral to other services or organisations that could offer the help required. These referrals were not made by all parents. However, these were considered as being important in contributing to understanding what characteristics could better support parents.

4.4.1.1 Combination of different levels of support

As was revealed in the literature review, preventing child maltreatment requires a coordinated approach that combines preventive actions at the population level as well as secondary and tertiary prevention for families who are at higher risk or are already in crisis (Herrenkohl et al. 2015; Higgins et al. 2019a). Parents, as expected, did not discuss this issue using this terminology. However, they referred to services provided by the third sector and in community centres in local areas, available to all parents and children. These were perceived positively by parents, however, there was no in-depth discussion of why, except in one focus group. Parents in the rural area mentioned that the third sector organisation in their area provides any kind of help to everyone, not based on their income criteria. This seemed to be just as important, as offering support to all parents in a society through universal services may normalise asking for help as it underlines that parenting is a tough job, and accepts that all parents may face challenges:

> *R1: (…) Doesn't matter what you've got and what you've not got, you're more than welcome to come in.*
> *R1: Here you can't really ask any more. I mean, here it's opened up to anybody that need it, it's for everybody, not just us. (…) anybody* can come to it.
> *R2: Anybody can walk in and ask to speak to somebody if…they help filling out forms, if they need help…or even if (…).*
>
> (Parents' focus group, rural area, nine participants)

However, having universal services does not mean treating all parents in the same way, as parents are different. According to the literature, there may be parents with extra needs that cannot be met by universal services, therefore, targeted services are needed. One father referred to how social workers need to treat people. He noted that they need to treat people in different ways, as not all are the same. He made a parallel comparison of this with his own job, in which he treats every part in a different way, as all parts are different, to make sure people who use these parts are safe; however, I have removed the specific description of this job to protect his anonymity.

> *(…) when I work, I work in (field), (…) so when I do my job, other people have got to go on it after me and they work on it. I've got to make sure that's safe, (…) so I've got to treat every (part) as a separate (part), because they're all different, and that's what social workers have got to do, they've got to treat people all different and not as the same, (…).*
>
> (Interview, father, single parent, one child, 4 years old)

As was described earlier in the rural area focus group, parents noted transport difficulties and problems accessing facilities as challenges in their lives. When they were talking about what support they valued in their area, they referred to a third-sector organisation meeting their needs of accessing big supermarkets that are not available in their area. This seemed to be meeting a special need of those parents, supporting parents to do their shopping, saving money on transportation, which they referred to as being expensive, and worrying less about accessing facilities, which may place extra pressure on them.

> *They even do a shopping trip in here, like, maybe once a month or something. They get a minibus and they take the parents to Aldi that can't away on a bus maybe because they've got weans (…).*
>
> (Parents' focus group, rural area, nine participants)

4.4.1.2 Stable provision of services

As I discussed in the literature review chapter, a public health approach that combines both universal and targeted services recognises that disadvantage for families is not a static concept. Family needs may change; families might occasionally need more intensive support to address parenting challenges or other needs when compared with other periods when they are coping well. Given this, it was noted by two parents that the stable provision of services to parents is essential for support, which was also reported by young people and professionals who participated in this study.

The stable provision involved allowing services to keep running without issues of losing funding. A mother said that she would like to see these services (such as those offered by the third sector) continue, as she would hate to be without support. Withdrawal of support may contribute to parents not trusting services and acts as a barrier to them asking for help, which is key to early intervention before issues escalate.

> *I would like this service to stay running.*[20] *Yes. I hoping it stays open and it's good because again, I would hate to feel that I had no support at all (...).*
>
> Interview, mother, two-parents, three children, ages unknown)

Stable provision also involved referral to other services in order to receive the right help. A mother mentioned that an organisation (probably in the third sector) was always there for her, and, in cases in which they could not support her, they redirected her to other organisation that could offer the help required:

> *(...) there's been some organization there that helped me a lot (...) they always have me, they never turn their back on me even though if it's not part of what they are doing (...). Even though those people cannot give you what you need, they won't leave you like that they will definitely look for an organisation or where to go. You know, they will help you directly to the right place for you to get the help you needed.*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

4.4.2 Qualities of operational provision of support

This theme was about the one-to-one interaction between parents and professionals (mainly about social workers) or other support providers (i.e., peers from a peer support programme). Although these were about treating individuals, and not addressing risk factors contributing to neglect, these were considered as important characteristics that may contribute to approaching and supporting parents and changing feelings and expectations of parents that may act as barriers in asking for help, as was noted earlier.

4.4.2.1 Giving parents choices to control their lives

As noted in the literature review chapter, parents with experience of children's social care and the family justice system may feel 'done to' rather than professionals working

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[20] There were discussions that the service could close due to budget cuts.

alongside them. A father discussed about feeling ‘done to’ and the need to have control over his life by being asked by social workers. This was the only parent who referred to that feeling, however, because of the intensity with which he talked about it, I decided to base this subtheme on his words. He pointed out that a social worker, who tries to help, needs to approach the parent(s) and to communicate that they are there to help, not to “tell them what to do”:

> *(...) so you need to come across to somebody ... if you’re trying to help somebody, then you need to come across that you’re there to help them, you don’t come across that you’re there to tell them what to do or do wrong by them (...).*
>
> (Interview, father, single parent, one child, 4 years old)

He also explained that social workers need to have a conversation with parent(s) and hear them, instead of coming with their own plans and say to parents(s) what they need to do:

> *See what they should do (...) they should come in, sit down, have a conversation like this, and then make up their minds, instead of coming to your door with their minds already made up (...), I seen it as they came to my house with already their plans, and no consulting me on them, just thinking that I’m just going to sit there and go along with it (...).*
>
> (Interview, father, single parent, one child, 4 years old)

This father also described an example of two different experiences with two social workers, one negative and one positive, and spoke of what he liked and did not like in those experiences. On the one hand, he was feeling that the first social worker was trying to “take away” his daughter, whereas the second had a different way of working. The second social worker was asking him what he needed and enabled him to express himself. The fear that social services will take their children was also mentioned earlier as a barrier to parents asking for help, and it was also noted in the literature review as a factor that stops a trusting relationship being developed with social workers.

> *(...) The way I felt with them is they were trying to take her away, and the (area) ones were trying to help you, so it’s completely two different ways they worked. They kept hanging on to try and get something bad*

> *on me (...). (...) so they changed (...) it was completely different. It was like what do you need, do you need any help (...).*
>
> (Interview, father, single parent, one child, 4 years old)

> *(...) he asked me what problems I had and what I needed help with, instead of saying to me, this is your problem and this is what you've got to do. He asked me, so then it made me be able to talk to him, and he spoke to me like a normal person, not trying to speak down to me (...).*
>
> (Interview, father, single parent, one child, 4 years old)

4.4.2.2. Interactions between parents and professionals or other providers of support

When parents were asked about what they might find difficult and/or easy in approaching or accessing services available for parents, they all referred to the interactions between them and professionals, and they mainly referred to social workers. These involved aspects of trust, using language that is easily understood by parents, the formal aspect of approaching these professionals, and empathy.

The first characteristic referred to was trust. A father noted that it was useful to have someone who you could trust, and he referred specifically to social workers:

> *It's no use having somebody (...), you don't trust, you need to have somebody you can trust, do you know what I mean?*
>
> (Interview, father, single parent, one child, 4 years old)

It was also discussed by one mother that support could be delivered by other parents, for example, those who are volunteering as part of a peer support programme. She noticed that the first step before helping is to develop trust:

> *It's trying to get them to trust us, to then help with whatever their worries are, kind of thing.*
>
> (Interview, mother, two-parents, three children, ages unknown)

Another characteristic mentioned by the same mother referred to the language used in meetings. She described that, when speaking to parents, this needs to be done in a way that parents could understand, otherwise parents may not understand what they had been told:

> *If somebody maybe talks, kind of, more local than you, it’s like you don’t have to come across all, kind of, posh and use big words and the parents are then sitting, kind of going, I’ve no idea what they’re saying to me (...). It’s (...) I think you need to speak how they speak as well (...).*
>
> (Interview, mother, two-parents, three children, ages unknown)

How formal a person may look and behave could also be an aspect that affects parents’ reactions to support offered. Specifically, a mother noted that being too formal could put parents off. A more informal approach could help in relating to and having have as well as getting the help needed:

> *I think if you have somebody that’s too formal, I think that does put you off, whereas if you have somebody that’s informal, that you know you can relate to, that you can have a bit of fun with, as well as obviously helping you with the things that obviously you feel that you’re struggling with as well, I think that’s beneficial for anybody.*
>
> (Interview, mother, two-parents, four children, approximately 12, 10, 6 and 3 years old)

Empathy was also included in qualities of interacting with parents. A father said specifically for socials workers that they need to empathise and not categorise people:

> *(...) they need to empathise with the people that they’re working with and not just categorise them all in boxes, and then have a tick box (...).*
>
> (Interview, father, single parent, one child, 4 years old)

One mother referred to why she could offer support to other parents. She said that parents perceived that other parents with similar stories could understand them better, as “they have been there”. This provides an example of what people with lived experience, which was mentioned by professionals in this study, could contribute to a public health approach to child neglect.

> *(...) people saying that, you know, when put yourself into the shoes, they know this person I'm talking to on this time understands me better because she has been there.*
>
> (Interview, mother, single parent, two children, 9 and 4 years old)

4.5 Summary

This chapter presented the findings of the analysis of the data drawn from six interviews and two focus groups with parents. As explored in the literature review, family characteristics (i.e., emotional support between family members, warmth) may enable families to face adversities and reduce the likelihood of child neglect. Parents' self-esteem and internal locus of control can also be, according to the literature, a factor that protects them from the likelihood of child maltreatment. In addition to this, positive relationships between the parent and child seems to enhance parents to support their children and to have routines and stable rules, as mentioned in the review of the literature. The parents who contributed to this study referred to aspects of their lives that they enjoyed. In summary, and in regard to their relationships with their children, the findings from the parents showed that they do enjoy spending time with their children to enhance bonding. They also mentioned other aspects of their lives, such as learning new skills, working, and having time for themselves, and these could help them to cope by enhancing their resilience. One parent recognised that having children is a life-changing/saving experience. All of these aspects, which are already known, could be part of developing a public health approach, as they might work as protective factors against child neglect.

Despite these positive aspects of parenting, it appeared that parents also faced challenges. In relation to wider social and structural factors that may affect parenting, a parent noted that financial challenges could affect parents' mental health, and this was identified by the literature review as a factor that contributes to the likelihood of a child being neglected. Extra pressure for parents related to financial was also the cost of participating in activities (i.e., swimming, summer activities during holidays). Single parents who participated in this study also noted that being the only parent limited their job opportunities.

Parents also talked about how challenges that could not be predicted may affect all parents, and that these change as children grow. This could indicate that parenting is a difficult job and this needs to be recognised by a public health approach to child neglect. Recognising challenges as part of their role may help in altering what was mentioned by parents about feeling as though they are bad parents when asking for help, and/or feeling judged for needing help, which all act as barriers in seeking help early. As noted in the literature review, parents often tend not to ask for help. However, parents in this study did underline that need for seeking help early, which is an important aspect of preventing child neglect that needs to be considered as part of public health approach. Additionally, if services are available to all, and not only targeted at those needing help, this may also be perceived positively by parents, and they could thereby overcome the above-mentioned feelings.

Another crucial point in asking for help is parents recognising a need for help. It seems that neglect can be constructed differently by different people, and that it may be the case that professionals and parents will have different definitions of what constitutes neglect. This also needs to be considered in developing a public health approach to tackle child neglect, as parents may be seen as being neglectful when they do not think they are. In terms of learning goals, which was also noted by one participant, being more involved and knowing the targets that each school has, would enable parents to know whether there are issues with their child’s learning and to ask for help. In any case, these need to be considered together with the possibility that some parents could be lying about this recognition of needs, in an effort to manipulate the different professionals involved (i.e., social worker, health visitors, teachers).

However, as identified by parents in this study, seeking help also required parents to know what is available. It appeared that parents may not know what is available for support and not knowing where to direct themselves for support. This needs to be considered together with two aspects. First, people who feel isolated from their community should be considered – as revealed in this sample, a mother was feeling isolated because she was different. Second, extended family networks may share information about the available support, including activities or facilities for children (i.e., funfairs). Knowing what is available for support could also be advertised, including posters or leaflets, a school letter, a talk at the school by social workers or other support services, suggestions made by nurseries, and advertisements at libraries and on social media, namely, in places where all parents could have access.

A challenge mentioned by a mother, which may contribute to limited access to facilities in the local area for parents and their children, was about the suspected abduction of a child, namely, a fear for the safety of children and, as a consequence, avoiding walking to a hub with activities for children. This provided an understanding of why, even when services are based locally, families might not use them, and a public health approach may overcome this issue by developing a system of accessible services available to all families. Physical access to services and other facilities may also be affected by the transport available in the area. This was a clear message in the rural area, where parents noted difficulties in reaching services and facilities, including an inaccessible train station, expensive bus tickets, and infrequent routes. These were the challenges of parents in their everyday lives and, in alignment with the literature, these may contribute to the stress they experience.

Finally, parents contributed to understanding how support could be delivered. This involved providing interventions that are available to all parents, but, at the same time, interventions that could meet specific needs. Stable provision of support, including not withdrawing services due to funding issues, and making referrals to other services or organisations that could offer help, was also mentioned as a principle in supporting families. Further to this, the following aspects, as parents noted, need consideration in interactions with parents. One aspect was about giving parents choices in how to control their lives. This was an important aspect because parents may feel ‘done to’ rather than having professionals working alongside them. Another aspect was about interaction being based on building trust and using language that is easily understood by parents. Furthermore, professionals adopting a more formal approach and showing empathy were suggested as desirable qualities in providing support to parents.

Overall, all the above points may contribute to supporting families and preventing the escalation of problems that may lead to higher risk of child neglect, which needs to be key in a public health approach to child neglect.

Chapter Five: The focus group with young people

5.1 Chapter introduction

This chapter presents the findings of a focus group and a note (provided by a young person during the discussion) with care-experienced young people aged 16+ years. The young people (*n*=5) who participated in the group discussion all had experience of the care system in Scotland. The full profile of the young people in the focus group is summarised in Table 8. This information is also provided in the summary table (Table 6) that is presented in Chapter Three, but is also provided here as reminder of the profile of the participants.

Table 8: Overview of the participants

Total Participants	5[21]				
Age group		Gender		Number of siblings	
Under 16 years	1	Female	4	No siblings	1
16–24 years	3	Male	0	two siblings	1
25–34 years	0	Prefer not to say	0	more than three siblings	2

As I mentioned in Chapter Three, I decided not to reference neglect in my discussion with the young people. Despite my ethical dilemma, I chose not include the term as I was worried that the young people would be distressed and that it may be difficult for them to label their experiences as neglect. The discussion with the young people was about their views of what might work in tackling the challenges facing children and young people with care experience. According to the literature, a large number of looked after children and care leavers have experienced child neglect, and it has been found that neglect increases the risk of poor wellbeing and risk-taking behaviour, making young people vulnerable. Dedicated care is crucial in supporting vulnerable young people when considering the negative impact of neglect. So, I did not use the term to avoid causing any discomfort for my participants, but the context of the discussion was on the ways in which young people can be better supported about the challenges facing them in their lives.

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[21] One participant provided no demographic information.

The themes, which were the output of the analysis of the data gathered with the young people, are presented in two sections: priorities in supporting young people, and the culture of supporting young people (Table 9). I chose to present this part in two sections to ensure that these were presented in a way that clearly describes what the young people told me.

Table 9: Themes and subthemes based on the analysis of data gathered with young people

Subthemes	Themes	Sections
Recognising trauma but in a superficial way	Trauma experienced by young people	Priorities in supporting young people
Young people being re-traumatised by repeating their stories		
Procedures for keeping them safe versus discomfort of young people	Contradictions of the care system experienced by young people	
Extremes from lots of procedures to *laissez faire* attitude regarding living environment		
Caring about a young person versus professional accountability		
Assumptions based on what is written on reports	Making assumptions about young people	
Assumptions based on people's previous experience		
Clear limits of services of what they offer and confidentiality	Qualities of support offered to young people	Culture of supporting young people
Facilitating asking for help by no judgment, feeling welcome and relationships		
Services offering opportunities to children and young people to meet siblings	Engaging with young people to offer support	
Enjoying the sense of belonging		
Relationships are key in young people's lives		
Building trust and the impact of feeling ignored		
No control of what information is shared	Recognising young people's sense of lack of agency and	

Lack of choice in housing for young people	providing opportunities to define their life	
Offering different choices to young people to choose and define their life		
Helping young people to achieve their full potential and maximise future life chances		
Early intervention before issues escalate	Principles of provision of support to young people	
Tailored approach to meet individuals' needs		
Continuous support is needed because of continuum of needs of young people		
Funding services to adequately support children and young people		

Details about the group are provided for each quotation drawn from the focus group. This includes the number of participants and that they each have care experience. For the quotations drawn from the notes, I provided an indication that these refer to the notes. In addition to this, in the quotations, 'R' indicates the participating young person, and 'I' indicates the researcher. Participants have been assigned a number (R1, R2, etc.) to indicate the number of different young people involved in the conversations and to protect their anonymity. However, each number is not used as a unique identifier for participants in the focus group, as it was not possible to identify each participant from the recording.

5.2 Priorities in supporting young people

This section explores three themes. The first refers to the trauma of young people and their experiences of healing (or not). The second theme is about the contradictions mentioned by young people who had experienced of being looked after or who were care leavers. The last theme in this section concerns the experience of young people about the assumptions that other people make about them.

I am presenting these three themes under the label of 'priorities', as I had a sense, both from the discussion and the analysis, that these are important aspects of their lives and could be key points in supporting them as part of a public health approach. At the beginning of each sub-section (5.2.1, 5.2.2 and 5.2.3) a more detailed description of each theme is illustrated.

5.2.1 Trauma experienced by young people

According to the literature, a public health approach to child neglect needs to meet (in addition to universal services) the specific needs of some individuals, by providing targeted services. Large numbers of young people, who have been looked after and who are care leavers have also experienced child neglect, as identified in Chapter Two. A public health approach to child neglect needs to consider this. Trauma appears to be one area of need for young people. More specifically, the young people discussed their experiences with Child and Adolescent Mental Health Services (CAMHS) for treating their trauma, and about being-retraumatised when re-visiting their life stories.

5.2.1.1 Recognising trauma but in a superficial way

Young people talked about how their trauma was approached by mental health services. Although these services recognised that there was trauma, young people felt that their treatment of trauma was superficial. The discussion about trauma arose when one of the young persons mentioned her experience with a CAMHS worker. She said that when she talked about how she felt, the worker mentioned that this was because of trauma. However, the young person said that, despite feeling this way for a long time, she was told that “it’ll be fine”. Leaving aside the likelihood that the CAMHS worker said “it’ll be fine” in a dismissive way, that does not take away from how the young person experienced this.

> *(...) I was talking to her (CAMHS worker), I was like, I’m genuinely feeling this way all the time and there’s nothing I can do about it, she went, ‘No, but it might be just the trauma you’ve experienced.’ I was like, ‘Yeah, obviously it started with that, but it’s been going on for years and I’ve been feeling the same every single day.’* And they were *just like, ‘No, it’ll be fine.’*
>
> (Focus group with young people, five participants with care experience)

A similar thing was said to another young person by a psychologist. However, the young person predicted that in a few years they will be “worse and worse”:

> *… they referred me to a psychologist. (…) they said, 'Well, you don't need it. You'll be fine in a few years.' It's, like, that few years of my life could make me ten times worse. It's not just … I'm not just going to stay the same if I have these issues. No, you're worse and worse.*
>
> (Focus group with young people, five participants with care experience)

Another young person also noted that, although there was recognition of trauma and the causes of trauma, there was no support in place to deal with the trauma experienced by these young people:

> *Or there's, like (…) from personal experience there's, like, not support there to deal with your … the trauma. So obviously they'll say, 'Oh, it's … like, the reason why you're like that is 'cause of the trauma.' But yet they've not got support in place for young people to deal with that trauma, so it's just (…)*
>
> (Focus group with young people, five participants with care experience)

Instead, it was noted that services simply try to get young people to forget about the trauma they had experienced:

> *R1: They just try and get you over the trauma …*
> *R2: They don't … they try and make you forget about it, but that's not going to happen (…)*
>
> (Focus group with young people, five participants with care experience)

Another young person in the group said that coping mechanisms had been suggested in order to deal with their trauma, but thought that distraction was not a long-term solution. Instead, more "in-depth stuff" is needed:

> *R1: Or they say … they try and give you coping mechanisms to deal with that trauma.*
> *R2: When you get your mindfulness sheets.*
> *R3: These are not going to help in the long term. It's like (…) CAMHS worker said to me, distract yourself. I'm like, that's not going to help me.*
> *R1: Like, to a certain point obviously you have to … aye, you have to try and distract yourself, but to a certain point …*
> *R2: But they're using it is a long-term method.*

> *R1: ... it does ... it doesn't ... but sometimes it doesn't always help young people. Like, sometimes it's more in-depth stuff, isn't it?*

(Focus group with young people, five participants with care experience)[22]

5.2.1.2 Young people being re-traumatised by repeating their stories

Young people referred to chronologies, and, for instance, in a social work report, involved "every single key event" that happened in her life. They noted that this approach of repeating their stories made them feel "horrible" about themselves, as this involved bringing up all the stuff done in the past. Bringing up incidents from the past, as required by the system, should not be kept on file, as one young person mentioned. This process of remembering their experiences from the past and feeling bad about it, I believe, may contribute to young people being re-traumatised from their experiences. Feeling bad about their past was the reason for my decision to not discuss their specific experiences of child neglect when designing the study but to instead focus on their reflections on how they can be better supported, given their experiences of the system.

> *R1: (...) in a chronology in your, like, social work report, they'll go over every single key event that's happened in your life, from the beginning. It's up ... you don't want to see that stuff in your report. It makes you feel ten times worse about yourself and what you've done.*
>
> *R2: Yeah. And it makes you feel horrible (chronologies) because they're bringing up all the stuff that you've done that you've been in a bad place when you've done it.*
>
> *R1: Uhm-hmm. Or for instance if you've done something, like, in the past and it could be possibly six months/a year down the line, then you go to a meeting or a report gets thingmied[23] and that gets brought up. And you're like, why is that? But obviously it's done. It's just done and it's dusted. It shouldn't be kept being brought up.*

(Focus group with young people, five participants with care experience)

5.2.2 Contradictions of the care system experienced by young people

Another area that needs to be considered according to what young people said in the focus group was about their experiences of the system in place to protect them. These

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[22] I chose to present some longer quotations, as sometimes there were discussions among the young people and I was missing the context when quotations were split.

[23] thingmied=something/some process happens to it.

referred to procedures of safety (i.e., disclosure checks for sleepovers) and how these, although in place to protect children and young people, may isolate them and make them feel discomfort.

5.2.2.1 Procedures in place for keeping young people safe versus their discomfort

There was a discussion among young people regarding procedures for sleepovers for looked after young people. According to what was described during the focus group, staying at a friend's house requires disclosure checks. This appears to affect how young people feel, as being in foster care is supposed to be like living in a family. What young people seemed to experience, based on what they mentioned, was the professional way of treating them:

> *R1: Also as well when you're being looked after, so when you're in care, if you want to (...) if you wanted to stay a friend's house or you wanted to go somewhere that, you know, the person wasn't PVG'd or, you know, didn't have a disclosure*[24]*... they'd be like, no.*
>
> *R2: For me, it takes (...) I have to give three weeks advance…Or there would be times when...for sleepovers, like, for instance if you were out with your pals, and your pals were like, oh do you want to just stay the night, and obviously if you go and ask at your foster care or residential [voices overlap].*
>
> *R1: You (...) it's not (...) it shouldn't be like that, 'cause foster care, they say it's supposed to be like a family. But then they're all like, oh sorry, we can't do this because this, this and that. It's not (...)it's always professional, professional and there's not.*
>
> (Focus group with young people, five participants with care experience)

Another aspect of procedures in place for looked after children that created difficulties was that some young people may not want to share that they are looked after. The following quotation involved a young people asking about how a procedure made them feel:

> *R1: There are some people who don't want people to know about their care experience. And if they're…you have to say to your friends,*

---

[24] According to government guidance, "there is no legal requirement to undertake disclosure checks on adults in a private household where a looked after child may stay overnight. Disclosure checks should not be sought as a precondition of an overnight stay unless there is evidence to suggest that this may be necessary." (Scottish Government 2008, p. 4)

> *'Oh, I need someone to come and just check the house…if everything's okay.' How are they going to feel … Or you don't say to your pals and then they're getting a randomer coming up and saying, oh by the way, because such-and-such wants to stay at your house, we need to do a check.*
> *R2: Police check.*
> *R1: Aye, a police check. And, like, how does that make young people feel?*

(Focus group with young people, five participants with care experience)

Another young person talked more specifically about young people feeling uncomfortable about the procedure, as it had the effect of isolating them from their peers:

> *And it makes them feel uncomfortable because they think you've got something that isolates you from everybody else.*

(Focus group with young people, five participants with care experience)

The following quotation also reflects the discomfort of a young person in the group regarding the procedure, here called risk assessment, which is in place to ensure that the child's best interests are met whilst living in care:

> *(...) if you tell anybody, be like, oh where are you going? We need to risk assess. I'm like, just shut up. There was a risk assessment for me to walk by a river. That's how bad it was.*

(Focus group with young people, five participants with care experience)

5.2.2.2 Extremes from lots of procedures to laissez faire attitudes regarding living environment

Young people also talked about the differences between being looked after and a care leaver. In this case, the example was about the living environment. A participant mentioned that there was not much thought about putting a care leaver in an unsafe environment. However, while in care there are procedures for background checks, and, if there are any concerns, an overnight stay is not allowed. This draws attention to the sharp contrast between during and after care:

> *From the minute you leave care, even if you're 18, those … that's not in place for you anymore, so it's okay to put you in somewhere that's not safe. It's okay to … but when you were in care, you know, you have to have a background check (...) if that background check came*

> *back with something on it, you wouldn't be allowed to stay there. You wouldn't be allowed to be … have an overnight there.*
>
> (Focus group with young people, five participants with care experience)

A young person also mentioned that there were procedures for checking the safety of placements:

> *See think about it, if you go in to, like, kinship care or any type of care experience or any home, before you get put in to a home, they make sure everything's safe. So why don't they do that when you move in to a newer house?*
>
> (Focus group with young people, five participants with care experience)

However, it seems that this is not the case for offering tenancies to young people when they leave care. More specifically, another young person mentioned that there is no thought regarding "how they keep people safe" (i.e., check neighbours), which may link to neglect of care leavers by the system:

> *So, there's not much thought to when they're offering particularly young people tenancies. So, there's not, like, any thought process for them to … the neighbours or who's round about them, what are they're in. So, there's not a thought about how they keep people safe.*
>
> (Focus group with young people, five participants with care experience)

5.2.2.3 Caring about a young person versus professional accountability

There was a discussion among the young people around building relationship with social workers and working on a professional basis. Although relationships will be discussed later, in the following quotation there appeared to be a contradiction between a caring relationship and professional accountability. Relationships, though, need to be at the centre of every interaction with children and young people and taken into consideration in a public health approach, as having experienced child neglect has been found to contribute to poor peer relationships and social withdrawal (Dubowitz et al. 2002; Hildyard and Wolfe 2002).

The young people spoke about social workers doing their job on a professional basis. However, as they work with people with difficult backgrounds, they needed to build a relationship with them. It seems that one of the young people felt that social workers treated them as “a case file”:

> *R1: If social workers were going to be good, they need to build that relationship with a young person.*
> *R2: Social workers seem to be doing it on a professional basis. They don’t build personal relationships. They do what they want to tick the boxes. And then they leave you.*
> *R3: With social workers, I think obviously you were saying how they’re doing it professionally but in that, kind of, job it can’t be professional. It’s got to be quite a genuine thing,*[25] *‘cause obviously if you’re a social worker, you’re working with people that came from difficult backgrounds and upbringing. So obviously you’ve got to be genuine with people. You can’t just be like, oh right, okay.*
> *R1: They treat you as a case file.*
>
> (Focus group with young people, five participants with care experience)

Another young person referred to the tension between how she experienced caring and at the same time the professional’s accountability. She mentioned that, on the one hand, the social worker was caring about her. On the other hand, it was the social worker’s responsibility if anything happened to this young person. The young person said that there was more care about what would possibly happen than what was actually happening in her life. This could contribute to the young person feeling helpless and discouraged her from asking for help, as she was experiencing a service that was not caring for her. Access to help is crucial in a public health approach, as it tries to reach the whole of the population and meet their needs. This is also considered in section 5.3.1.2.

> *Like, my social worker was like, ‘I do care about you,’ but then two minutes later she was like, ‘Oh, but if anything happened to you, my neck’s on the line.’ It’s like she cares more about what would happen if I had done something than actually what had happened to me in the final place.*
>
> (Focus group with young people, five participants with care experience)

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[25] There was no discussion in the focus group about what a ‘genuine’ thing might look like.

5.2.3 Making assumptions about young people

Young people referred to their experiences of others making assumptions about them. It was identified in the literature review that the focus of practice in the adolescent age group may be more on their external behaviour (i.e., offending, aggressive behaviour, being more difficult than younger children) and not in the aitiology, such as parental neglect. This may contribute to workers making assumptions about them, which was noted by the young people, and could make them feel judged. A public health approach needs and should enhance non-judgemental interactions with young people.

5.2.3.1 Assumptions based on what is written in reports

One of the young people mentioned that a CAMHS worker read her report and looked at her "with disgust". She also said that the reason behind this reaction was that she thought that the worker felt as though she was "the most horrible person ever", based on that written report. This young person experienced the worker as judgemental and damaging, whereas social work as a profession needs to support people in an ethical and empowering way:

> *I went to my CAMHS worker and she read my report and looked at me with disgust. Because she looked at that report and thought I was the most horrible person ever.*
>
> (Focus group with young people, five participants with care experience)

According to the young people, what is in the report does not show who young people are. It also involves their story (what has happened to them). However, young people noted that professionals think that young people are what is written on paper:

> *R1: Like, my last appointment she was like, I didn't expect you to be this girl that I knew. And I was like, the paper (…) what's written on the paper doesn't show who you are. It just shows you things (…) that have happened. It doesn't. And professionals think that on that (…)*
> *R2: What's on paper, that's you.*
> *R1: On this paper, that's you.*
>
> (Focus group with young people, five participants with care experience)

5.2.3.2 Assumptions based on people's experiences

Another aspect of making assumptions was demonstrated by a story told by a young person in which her neighbours were terrified. This was because of their experience with a previous tenant, who seems to have caused issues. Although neighbours were "very happy" with the new tenant, the young person had experienced them "looking at her weird":

> *Y1: (...) when I entered that flat, it looked like he'd had, like, knives in the wall and hammers and all sorts. And my neighbours were somewhat terrified in case they had another neighbour like my old one. (...).*
> *Y2: So, you had to deal with the fact that everybody was looking at you weird.*
> *Y1: Yeah. Well, they were very happy 'cause I'm quiet.*
>
> (Focus group with young people, five participants with care experience)

5.3 Culture of supporting young people

Young people discussed a number of different aspects regarding what works well in the system of supporting young people and how it could be improved. Four themes emerged. These were: the qualities of support offered to young people; the role of relationships and the building of trust; the sense of lack of agency and offering opportunities to define their life; as well as the principles of providing support.

5.3.1 Qualities of support offered to young people

This theme relates to the one-to one interaction between young people and professionals. As discussed in the previous chapter (Four) about parents, these characteristics may contribute to approaching and supporting young people and their changing feelings and expectations about services. These appears to be key as, according to literature, neglect is associated with experiencing more intensive internalising behaviours (depression, post-traumatic symptomatology, anxiety, sexual concerns, anger, dissociation, and sleep disturbance) and having more risk-taking behaviours (i.e., gang involvement, smoking, alcohol use, drug use, unprotected sex) (Naughton et al. 2017). Given these associations, targeted services to meet their needs are required. Regarding the qualities of provision of support, young people referred to clarity in what services can offer, and of the limits of confidentiality. They also discussed avoiding judgemental ways of interacting with young people.

5.3.1.1 Clear limits of what services offer, and confidentiality

One of the points mentioned by the young people about the qualities of support was about clarity about what the service offered and the limits of confidentiality. A young person wrote notes during the discussion, which included that having clarity on what a service offered can make them work better. Relationships and trust were also noted by this young person, but these will be discussed later in this chapter:

> *The best thing to make services better is relationships, trust and clarity on what a service offers.*
>
> (Note given by a young person during the focus group)

Two other young people referred to confidentiality. They mentioned that, if a young person is judged to be at risk, staff (from the third sector) need to follow procedures and share with other professionals. However, this was seen to be acceptable by young people, as, to them, it is clear that this information needs to be shared:

> *(Discussion about what makes (name of organisation) good)*
> *R1: (…) there's always that thing there if it's danger … a lot of them (staff in third sector) are trained in there though to deal with stuff that [voices overlap].*
> *R2: But you have that understanding 'cause it's quite clear that it has got to be shared and (…) yeah.*
> *R1: But if it's too dangerous, they have to tell professionals. So obviously, like, confidentiality kind of thing.*
>
> (Focus group with young people, five participants with care experience)

5.3.1.2 Facilitating asking for help by no judgment, feeling welcome and relationships

Part of the qualities of support offered to young people was also about characteristics that will facilitate young people to go and talk to services about their issues. A young person mentioned that she (along with others) was comfortable speaking with staff from an organisation in the third sector because that they did not judge them:

> *They're (…) I'm comfortable to speak with them and so are a lot of people. Because they won't judge you.*
>
> (Focus group with young people, five participants with care experience)

Three other participants mentioned elements that helped them to go to a service (provided by a third-sector organisation). They mentioned that, when the environment was homely, this made them feel welcomed. However, this was not about the fabric of the building, but more about the interaction with staff there:

> *R1: It was homely, like. All the staff…*
> *R2: They just made you feel so welcome. Like, everybody would say hi to you and…*
> *R3: You would come in, folk'd be like, 'Hiya'. You'd go, 'Hi'.*
>
> (Focus group with young people, five participants with care experience)

Another aspect of supporting young people to access services was about how approachable workers may seem to young people. It was mentioned by one young person that housing staff need to be more approachable, which can be achieved by building relationships. Engagement with services and developing relationships will also be discussed in the next section (5.3.2).

> *(…) workers from housing be more approachable. That if you've got an issue to … you can go up or they could come and speak to you. Obviously, that … like, building a relationship, kind of thing as well.*
>
> (Focus group with young people, five participants with care experience)

5.3.2 Engaging with young people to offer support

This theme was about the role of interactions in young people's lives. It involved considering good services that help young people to keep contact with siblings, enjoying the sense of belonging in services that are act as community, the key role of relationships in interacting with young people, and trusting other people as a result of having built a relationship with that person. Young people who have experienced neglect often face difficulties in trusting people and it may be difficult for them in being helped (Brandon et al., 2013). Given this, the engagement of young people needs to be considered in a public health approach.

5.3.2.1 Services offering opportunities to children and young people to meet siblings

The significance of relationships with siblings has been identified in research (Jones and Henderson, 2017) and in the The Promise (2020). In this study, one key aspect referred to young people having contact with their siblings. Two young people said that a service was considered to be good because they helped them to see their siblings, which was not possible otherwise:

> *R1: It helped, like, siblings seeing each other 'cause remember obviously me, you and [name] didn't get to see each other.*
> *R2: Same with me (...)*

(Focus group with young people, five participants with care experience)

5.3.2.2 Enjoying the sense of belonging

Another aspect of relationships was about the sense of belonging that young people needed to enjoy. To be more specific, young people mentioned that they enjoy feeling part of a community as well as knowing each other and having friends when receiving services (in this instance, the services they referred to were from the third sector):

> *Being in (there) you just feel part of a community. And you do something together. It's, kind of...it's, like, homely.*

(Focus group with young people, five participants with care experience)

> *I: (...) so you obviously enjoy it, so what is it that…?*
> *R1: It's a group (...) it's a community in there.*
> *R2: It's a community.*
> *R3: Everybody knows each other. You've got friends there.*

(Focus group with young people, five participants with care experience)

5.3.2.3 Relationships are key in young people's lives

In Chapter Three it was described how a young person wrote down notes, which were analysed together with data from the focus group. She noted that relationships and trust make services better. However, which of these services, or whether she meant all services, was not noted by her:

> *The best thing to make services better is relationships, trust and clarity on what a service offers.*

(Note taken by a young person during the focus group)

Relationships were also referred as a crucial factor by other young people in the focus group:

> *That's, like, a big key factor [voices overlap 28:01] relationships.*
>
> (Focus group with young people, five participants with care experience)

> *R1: People are starting to know that relationships, that is a big thing …*
> *R2: That's a huge factor.*
> *R3: That's the main key factor in anything.*
>
> (Focus group with young people, five participants with care experience)

However, according to the young people, building relationships with workers is affected by staff changes. They talked about workers from mental health and social services. One young person said that each time she went to a particular service, different workers were there, and this was hard for young people as no relationship had been built. Another young person mentioned that, although they may have worked for months with the same social worker, when the worker moves to a new job, they need to start again with a new worker who does not know "anything about them". Problems associated with staff turnover and its impact on developing relationships were also recognised by professionals involved in the study, and this will be discussed in the next chapter.

> *R1: Like the consistency, like, with workers. Like, obviously with mental health, social work obviously you … like, if you're going to mental health … from my personal experience, when I used to go, it'd be different workers each time I would go. And obviously you're not building that relationship so it can be quite hard for young people.*
> *R2: Yeah. Like, it always seems like social workers or any kind of service, you'll get a worker and you'll be with them for months and then one day they'll go, oh I'm getting a new job, and you're like … it's, like, you're just having to start at square one again with a new worker. You don't know anything about them. Not even know their name.*
>
> (Focus group with young people, five participants with care experience)

5.3.2.4 Building trust and the impact of feeling ignored

It appeared among young people that relationships and trust could influence each other. A young person mentioned that building a relationship is required before trusting someone:

> *Like, before you trust someone, you build a relationship. (...)*
>
> (Focus group with young people, five participants with care experience)

Young people also referred to examples of what relationships and trust mean. A young person during the discussion mentioned how relationships can be developed with a worker, by not telling them what they have done wrong. Whereas other young persons mentioned that trusting services always involves “counting on them”:

> *Somebody doesn’t constantly tell you what you’ve done wrong.*
>
> (Focus group with young people, five participants with care experience)

> *R1: (...) You know they were coming even if they were showing up late.*
> *R2: That’s the trust, isn’t it? Always count on them.*
>
> (Focus group with young people, five participants with care experience)

According to the young people, a barrier to building trust referred to the lack of response to complaints. Young people mentioned that their complaints do not get any response. They referred specifically to the housing sector and social services.

> *Is that...you could put a complaint in and it won’t get dealt with. They say it’ll get dealt with, but nothing will ... change.*
>
> (Focus group with young people, five participants with care experience)

> *R1: It’s the same with social work though. Like, see if you put a complaint in ... I mean, I’ve done that, and nothing ... And I never heard back from the complaint [voices overlap 13:28]. (...) Literally they ignored it.*
> *R2: No, they don’t do anything.*
> *R1: I went in to a social work office the next day and ... a couple of days later and I saw the letter lying in a bunch ... a pile of stuff that hadn’t been opened.*
>
> (Focus group with young people, five participants with care experience)

Another aspect that may affect building trust was about the lack of response when asking for help. A young person mentioned that they are told to ask for help but no help is given by services.

> *You're … they tell you to ask for help, but you don't get the help*
>
> (Focus group with young people, five participants with care experience)

Another young person said that responding "straight away" to their question is considered a good quality of a service by her:

> *I: What was good about (name of service)?*
> *R: (…) like if you ask them a question, they'll get back to you straight away (…).*
>
> (Focus group with young people, five participants with care experience)

5.3.3 Recognising young people's sense of lack of agency and providing opportunities to define their lives

It has been identified that internal locus of control, namely believing that one's behaviour and life experiences are the result of personal decisions and efforts, can act as a protective factor for the negative effects of experiencing neglect and other types of maltreatment (Trickett et al. 2004). However, the young people involved in this study noted that they experience a lack of agency in their life, and this needs to be considered in a public health approach to child neglect, to meet these specific needs of young people with care experience and protect them from the impact of adversities.

5.3.3.1 No control of what information is shared

One aspect of lack of agency referred to a young person's experience of sharing of information, when moving to a new foster care placement. The following quotation is about a young person's experience of moving to a foster care placement. She said that carers knew everything about her, but she knew nothing about them.

> *So that happened to me. When there's, like, more services, it's more (…) moving foster care placement and I went to my late (…) well my old one, and they knew everyone about me and I knew nothing about them.*
>
> (Focus group with young people, five participants with care experience)

The young person said that she was scared for her carers to see her, because they knew everything about her from the forms they had received. Instead, she went to her "granny's" (house) for tea. Carers knowing everything about her from the forms could be linked to the point made by the young people that what is written on paper is not who they are:

> *So, it was weeks I wouldn't be in for tea. Every night I'd be like, just going to go to my granny's. And, like, I would (...) they would never see me because I was, like, that scared because I was (...) I don't know (...) they know everything about me, 'cause they've got forms and they read it all.*
>
> (Focus group with young people, five participants with care experience)

The young person went on to mention that she knew only their names, dates of birth of her new carers and that they had dogs. This was the only information given before moving into her new foster home:

> *And all I know is their names. They've got dogs. (...) they were like, right, you're moving in to foster care. Here's a booklet. And it literally just had their names, Mr and Mrs (names) or their first names and said, oh this is their date of birth. Literally had their date of birth in it. And said they're nice people. They have dogs.*
>
> (Focus group with young people, five participants with care experience)

However, it was only later that she discovered her new carers had made up a book for her with pictures, including the house, the bedrooms the dogs, but she never saw it! Why the book was not passed on to her is unclear:

> *But then we found out later that they had actually made up a book and then I had, like, the pictures of the dogs in it, about ... Pictures of the house. The house. And like, they had pictures of the bedrooms and that. So I never saw that.*
>
> (Focus group with young people, five participants with care experience)

5.3.3.2 Lack of choice in housing for young people

Another aspect of lack of agency was about their experience of housing when leaving care.[26] It seems from what they said that care leavers have no choice about where they

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[26] Looked after young people can leave care once they are 16. Since 2015, a young person who is looked after in foster, kinship or residential care is eligible to remain in their current care placement until they turn 21 (Continuing Care). When Continuing Care ends, the young person is then eligible for Aftercare support until they turn 26 (Scottish Government 2016021).

live as there not enough houses to meet the demand. This needs to be considered in a public health approach to child neglect, as poor provision of housing has been identified in the literature as a risk factor for child neglect, and some of these young people will be or may already be parents:

> *R1: It's just like, right here's a house or a flat…*
> *R2: Take it.*
> *R1: Take it or leave it, basically.*
>
> (Focus group with young people, five participants with care experience)

> *R1: There's not enough houses, is there?*
> *R2: There are not enough options for young people.*
>
> (Focus group with young people, five participants with care experience)

Young people also thought that they were offered the "less desirable houses" without any other alternatives. Furthermore, once a house was accepted there was no option for them to change:

> *R1: Basically, they try and ship you off into the less desirable houses, hoping that you'll accept them without knowing any better. And then once you get stuck with it.*
> *R2: It's harder to get out of it.*
>
> (Focus group with young people, five participants with care experience)

5.3.3.3 Offering different choices to young people to choose and define their lives

Offering choices to young people could contribute in minimise sense of lack of agency and support them in defining their lives. The young person who took notes during focus group wrote that services can be better if they inform young people about the options available and also give them the option to ask for a specific service:

> *There needs to be:*
>
> - *The option to ask for a specific service*
> - *To talk about different options available*
>
> (Note taken during focus group with young people, five participants with care experience)

Another young person went on to say that a good thing about an organisation in the third sector was that they offered choices. For example, they had the opportunity to choose between group or individual activities:

> *That's a good thing about (organisation). They gave you that choice whether you wanted to be … do the group activities that they had, or you could just do it yourself.*
>
> (Focus group with young people, five participants with care experience)

A young person mentioned what she considered as being good in a service. As she describes here, she will talk to the worker even if she is in a bad mood, and there is mention that the worker asked the young person whether she wanted to talk:

> *And if I'm in a really bad mood, I'll not say a word to her. Really bad mood. She literally … you want to talk? And I'll go talk to her.*
>
> (Focus group with young people, five participants with care experience)

Another aspect of offering choices to young people refers to choosing with whom their information can be shared. A young person considered it to be good thing in a service that workers will give the young people the choice of professionals with whom they prefer their information to be shared in serious cases. Although this choice of control seems to be desirable, it may not be possible in every case.

> *(…) but they give you a choice on which professional people they tell. So, if they think, oh it's really serious, they'll maybe tell someone you're close with. If you don't want your social worker, they'll tell somebody else. They give you the choice.*
>
> (Focus group with young people, five participants with care experience)

5.3.3.4 Helping young people to achieve their full potential and maximise future life chances

As identified in the literature, adolescents who have experienced neglect have reported having low expectations of future achievements (Naughton et al. 2017). Neglected children also have been found to face issues (i.e., less literacy, numeracy and language skills), which may contribute to academic failure (Maguire et al. 2015), which in turn can contribute to higher rates of unemployment, teen pregnancy, and higher rates of crime as well as greater use of social services (Curie and Spatz Widom 2010; Nikulina et al. 2011).

Therefore, helping young people to achieve their full potential and maximise their future life chances appears to be crucial in supporting them.

It appears from what the young people mentioned that, when services are building on their abilities, this is perceived positively by young people. If I take into consideration another comment of a young person which mentioned that a relationship can be developed where the social worker “doesn’t constantly tell you what you’ve done wrong”, this may be because they prefer an asset-focused rather than a deficit-focused approach.

A young person mentioned that a third-sector organisation gave her the opportunity to participate in a programme about developing a certain talent and they financially supported her to proceed and take exams, which otherwise she will not have been able to do:

> *R1: Just so…like, once a week, if you want to come in to (programme about a talent),*[27] *they’ll give you the opportunity. Like, I’ve been given the opportunity to go to the (place), the university in (city) to do a ... (a kind of test). And without them, it would be costing me two grand.*
> *R2: Two grand?*
> *R1: Two grand. They’re paying two grand for me to do (it). So, they give you good opportunities. And they pay for your … when you go to, after (...) they will pay for you to do your uni halfway through your … halfway through and then you pay half price the rest.*
>
> (Focus group with young people, five participants with care experience)

Two other participants mentioned that a good aspect of service was that they enhanced their skills, and this included how to hang wallpaper and training in other skills:

> *I: What was good about (...)?*
> *R1: Showed me how to wallpaper.*
> *R2: Maybe they’ll teach me things (...)*
>
> (Focus group with young people, five participants with care experience)

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[27] This information has been deleted to preserve the anonymity of the young person.

5.3.4 Principles of provision of support to young people

Among the young people who contributed to this study there were referrals which could contribute to how support needs to be delivered. They talked about early intervention, and also discussed the importance of meeting the needs of young people, and of the continuum of support as needs change. They also spoke briefly about the need for investments in mental health services.

5.3.4.1 Early intervention before issues escalate

Preventing issues from escalating by intervening early was mentioned by young people and this is in accordance with the key principles of a public health approach (Walley 2010) and the commitment of the Scottish Government of improving the wellbeing of children and young people.

Young people talked about the on-time provision of support. They said that services need to intervene early:

> *R1: ... there needs to be more ... trying to think of that word ...*
> *R2: There needs to be more ... something, like, done before it gets to ...*
> *R3: Uhm-hmm. So more responsive at the time rather than ...*
>
> (Focus group with young people, five participants with care experience)

A young person mentioned a friend's story in which the person was on a waiting list for a psychologist, and it took three years, but now she is "too far in her problems" to deal with them:

> *(...) my friend was put on a waiting list and guess how long it took her to actually get a psychologist. She's now in (class-school). She was in (class-school) when she applied for it. It's taken her three years to get that. And she's too far in her problems and she can't deal with it anymore. She's been admitted for hospital for things (...).*
>
> (Focus group with young people, five participants with care experience)

The young people also mentioned that there are waiting lists, especially for mental health issues. However, there is no provision for young people to support them in the meantime.

> *R1: So if you go to the doctor's and say, like, you're not coping very well, your anxiety's really bad, they've not got groups that they can send you to. They just ...*
> *R2: You've got to do that 12-week programme thing and then if you're wanting to get one-to-one, there's a six-months waiting list. And you're like, what are you supposed to do within that ...?*

(Focus group with young people, five participants with care experience)

5.3.4.2 Tailored approach to meeting each individual's needs

The young person mentioned in her notes that there needs to be tailored plans for each young person:

> *There needs to be: (...) Tailored plans for each individual young person.*

(Note taken by a young person during the focus group)

Two participants also said that groups do not always work for all people, as they may prefer one-to-one work. One of them also noted that this is a way to make it more inclusive for all:

> *R1: And groups don't always work for everybody, you know, and that's about ...*
> *R2: No. Some people don't like the idea of group work.*
> *R1: Yeah. And some people do prefer one-to-one or ... and that's how you need to make it more inclusive for everybody. So ...*

(Focus group with young people, five participants with care experience)

5.3.4.3 Continuous support is needed because there is a continuum of needs of young people

Young people mentioned that they had bad experiences with mental health services. It appears that they are not experiencing continuous support. They mentioned that these services can be better if, when a young person says that needs support after the of 18, services provide this and do not cut them off:

> *I: What other services have (...) that's been quite good?*
> *R1: I've had some that's bad. Mental health.*
> *R2: Mental health, aye.*
> *I: Right. So how do you think that could be different?*
> *R1: Them to listen to you. Like, if you say that you still need support after the age of 18, they still need to offer support. Not just be like, oh…*
> *R2: [Voices overlap] and just cut you off and be like, oh you'll be fine.*
>
> (Focus group with young people, five participants with care experience)

The transition from child/adolescent to adult mental health services was referred by a young person in the focus group as "shocking". To be more specific, it seems that, from what the young people mentioned, "shocking" involved: not passing on notes, long waiting lists (i.e., six months), and having to start over again in the new service.

> *R1: Obviously, like, CAMHS is for under 18 and once you become 18, you have to go to adult services and the transition is shocking. Like, they don't pass on notes.*
> *R2: And the waiting list can be ridiculous as well.*
> *R3: You can be ... like, a six-months waiting list onwards and then obviously you go along to adult services, you go there, they've got no clue why you're there, so they don't know about, like, obviously you being in CAMHS. That's like ...*
> *R1: You have to do it all over again. Start again.*
>
> (Focus group with young people, five participants with care experience)

Starting again in a new mental health service without any previous details about a young person's history means that professionals have no background information about this individual. Therefore, the worker needs to ask the same questions and the young person has to bring up experiences that they have already worked on in the past, and which they may not want to work on again:

> *(...) 'Cause obviously if they could look at your file, then they would, kind of, know a bit more about your background. So, they're not asking questions that have already been asked. And know what to work on. Instead of bringing up experiences that you've already worked on which you maybe don't want to work on again.*
>
> (Focus group with young people, five participants with care experience)

5.3.4.4 Funding services to adequate support children and young people

Young people also talked briefly about the resources of services. They mentioned that services are understaffed, and this results in long waiting lists, which can be a barrier to the early intervention mentioned earlier:

> *R1: (...) waiting lists are still far too long. But hopefully ...*
> *R2: Like, six weeks.*
> *R3: It's 'cause everything's understaffed though.*
> *R1: That's a short one though.*
> *R2: Like, everything's well understaffed.*
> *R1: Yeah. You know, there are some services that you're waiting up to two years now for ... you know, for a service.*
>
> (Focus group with young people, five participants with care experience)

They also mentioned that there is some sort of investment in mental health, which may change the above picture of services (long waiting lists and limited staff numbers). However, they did not mention any further details about what this investment in mental health may be.

> *(Continued from previous quotation)*
> *R1: So, you know, with the investment that they're now putting in to mental health, it'll not happen right away, but ...*
> *R4: It's on the process.*
>
> (Focus group with young people, five participants with care experience)

5.4 Chapter summary

The literature states that a public health approach to tackle child neglect could and should involve both universal and targeted services to meet the spectrum of needs. The following points could be areas for consideration as components of a public health approach for children and young people who have already been neglected and who may have extra needs that are not adequately met by universal services. It appeared that key points in supporting young people involve treating their trauma and preventing them from being re-traumatised. This also included considering how they experience procedures for keeping them safe, and facing assumptions made by professionals or other people in society, which may make them feel discomfort. These are aspects to be prioritised, based on the experiences of the young people involved in this study.

Supporting young people could also be improved by overcoming the sense of lack of agency experienced by young people through opportunities to define their lives, and by investing in relationships that appear to be key for young people and promote trust. In addition to these, clearly defined limits of what services offer, and about confidentiality, and minimising feelings of judged in services, appeared to be aspects that improve the positive experiences of young people in accessing such services. In accordance with what parents mentioned, the young people referred to the need to intervene early before issues escalate, as, in that case, it might be difficult to overcome these. Finally, they noted the need to provide tailored approaches to meeting their needs by providing continuous support during their lifetime, along with particular consideration of the transition from child/adolescent to adult mental health services.

Chapter Six: Professionals' perspectives/views on the prevention of child neglect

6.1 Chapter introduction

This chapter presents the findings from the 3-stage[28] online study and the focus group, both conducted with professionals. My aim was to explore with professionals their perspectives on a public health approach to child neglect. The findings are presented in two parts:

- The first, Section 6.2, presents a combination of the findings based on the first two stages of the online survey and the focus group with the professionals, as there were many overlaps in how they responded in these three elements. In addition, the focus group provided a more detailed oral discussion, providing clear examples, which resonated with the comments mentioned in a more generic way in the online study. This combined presentation has allowed for a more effective exploration of the interlinks between the data from the online study and the focus group, while enhancing the richness of the data.
- The second, Section 6.3, focuses on the findings of Stage 3 of the online study that took place with professionals. It presents an analysis of a rating exercise, in which participants were asked to rate potential components of a public health approach to child neglect and the unintended consequences of implementing that approach to tackle child neglect. I chose to present these results as a separate section, as it represents a quantitative assessment of possible interventions mentioned in the earlier stages of the online study. Details about this rating exercise are presented later in the section.

Before presenting the findings in each section, I will present details of each stage of the online study and the focus group, as a reminder of what was mentioned in the Methodology chapter (Chapter 3). This includes a short description of what was asked (questionnaires) and who responded/participated (participants).

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[28] Numbers from one to ten are presented in text and then numerals thereafter. Exceptions: tables and the title of the stages of the online study.

6.2 Findings based on the online study (Stages 1 and 2) and the focus group

Regarding the online study, the first questionnaire (Stage 1) (Appendix M) included six open-ended questions based on the literature review undertaken as part of this study. The questions were about a public health approach to neglect, descriptions of a public health approach to neglect, advantages/disadvantages of applying the approach, linking the approach with the current policy and practice in Scotland, and the challenges of implementing the approach. There was also additional space provided for any other comments.

A total of 40 participants completed that questionnaire. The majority were female (33 female, three male, two preferred not to answer, and two were missing answers). Almost three-quarters of the professionals (*n*=27) involved in the study had more than 20 years of working experience. A total of 26 participants were working as practitioners (e.g., front-line, operational managements or strategic management). Of these 26 practitioners, a total of 11 had expertise in the areas of child protection and other fields, three in the area of public health and other fields, eight in the area of public health and child protection and other fields, and four had expertise in other fields, such as learning disabilities, chronic conditions, emergency services and mental health.

The second questionnaire (Stage 2) (Appendix N) contained eight open-ended questions, which were about what constitutes child neglect, the wider social factors that affect families and contribute to child neglect, steps to prevent neglect, community-based interventions that could be included in a public health approach to neglect, funding issues, and other challenges that practitioners may face in implementing a preventative approach to neglect. Two further questions were asked about the role of public awareness interventions and the role of individuals with lived experience of neglect in efforts to tackle child neglect. Finally, at the end of this questionnaire there were several statements with which respondents were asked to say whether they agreed or disagreed.

The questionnaire was completed by 22 professionals. Most of them were female (20 female and two male). Half of them (*n*=11) had more than 20 years of working experience. A total of 13 participants were practitioners, of whom five had expertise in the child protection field, one in public health, five in both public health and child protection and/or another field, and two had other expertise (i.e., child and family social work, third sector).

The discussion in the focus group was focused on the following dimensions of a potential public health approach to child neglect: interventions to tackle structural issues associated with neglect, public awareness campaigns, universal parenting programmes, sustained support by family support services and related services, in-school support both for children and parents, maximising the benefits of technology, and unintended consequences (Appendix P). These dimensions were based on Stage 3 of the online survey, which will be mentioned later in this chapter.

Four individuals participated in the focus group. All were female with 20+ years of working experience. Three were practitioners, of whom two had expertise in child protection, public health and in other fields (paediatrics), and one had expertise in another field (namely, children and young people’s services in the third sector). One professional was working in both practice and policy area and had expertise in child protection.

From here, I shall explore the themes based on the data from the first two stages of the online survey and the focus group (Table 10). I chose to present this part in three sections, because the data were rich, and I wanted to explore this in detail while also ensuring that the reader did not ‘get lost’ in the data. The three sections are:

- Complexity of responding to child neglect (section one)
- Moving forward in tackling child neglect (section two)
- Components of tackling child neglect (section three)

Table 10: Sections with themes and subthemes

Subthemes	**Themes**	**Sections**
Stigma of living in poverty	Perceptions around child neglect	Complexity of child neglect (section one)
Parents’ responsibility in meeting child’s needs		
Child neglect can be hard to detect	Challenges in the field of child neglect	
Absence of clear criteria for assessing/defining neglect		
Parents not engaging/recognising need for support can be challenging for professionals		
Workload of education staff as a barrier in their role		
Changing the approach of support services from reactive to preventative	Actions required in tackling child neglect	Moving forward in tackling child neglect (section two)
State involvement is needed in moving towards a preventative approach for child neglect		
Resources need to be available to services for supporting families		
Time is required to make changes		
Need of universal services for parents	Different structure of delivering support	
Need to tailor support to meet parents’ needs		
Wider social factors need to be foregrounded in a public health approach		
Multiagency collaboration is needed in preventing child neglect		
Enhancing understanding of population through awareness campaign	Public awareness campaign	Components of tackling child neglect (section three)
Technology as a mean to reach a large section of general population		
Need of long-term support for families	Duration and access to support for parents	
Accessible support for all families		
Valuing lived experience of child neglect	Developing a public health approach	

Parents’ feeling of intervening in their life		
Being supportive toward parents enables better support them		
Relationships between professionals and parents are needed in supporting families	Relationships	
Barriers of developing a relationship between professionals and families		
Tackling isolation of families is needed in preventing child neglect		

Throughout this section I have presented illustrative quotations from participants. In the quotations drawn from Stages 1 and 2 of the online study, some details of each participant are given. These include their area of expertise (public health, child protection and/or other) and job category (academic, practice, policy and/or other). In the quotations from the focus group, ‘R’ stands for the participating professionals, and ‘I’ the researcher. Participants have been assigned a number (R1, R2, etc.) to indicate the number of different people involved in the conversations and to protect their anonymity. However, each number is not used as a unique identifier for participants, as it was not possible to identify individual participants from the recording.

6.2.1 Complexity of child neglect (section one)

This section explores two themes: professionals’ perceptions around child neglect and the challenges that professionals face when responding to child neglect. The first refers to perceptions about child neglect which may contribute to a more limited view of the phenomenon. The second explores the difficulties that professionals face in relation to child neglect. This is both about difficulties related to the system as well as to the nature of the phenomenon.

I chose to present these two themes together and under an overall topic “complexity” as I believe that these two points are contributing to the complexity of child neglect, making it in this way a phenomenon which is not simple and straightforward in being tackled. A more detailed description of each theme is outlined at the beginning of each sub-section (6.2.1.1 and 6.2.1.2). Table 11 summarises the themes and subthemes of this section.

Table 11: Themes/subthemes of section one

Subthemes	**Themes**
Stigma of living in poverty	Perceptions around child neglect
Parents’ responsibility in meeting child’s needs	
Child neglect can be hard to detect	Challenges in the field of child neglect
Absence of clear criteria for assessing/defining neglect	
Parents not engaging/recognising need for support can be challenging for professionals	
Workload of education staff as a barrier in their role	

6.2.1.1 Perceptions around child neglect

Although there are factors that contribute to the likelihood that a child will experience neglect, as mentioned in the literature review, there needs to be consideration of what contributes to a child being neglected, as the presence of risk factors does not mean that there will be neglect, and the absence of risk factors does not exclude the possibility that neglect will occur. Focusing only on children living in poverty, and on parents’ responsibility for meeting a child’s needs, limits the possibility for seeing the full picture of child neglect, and this is presented in this theme.

6.2.1.1.1 Stigma of living in poverty

When participants in the online study (Stage 2) were asked to identify the wider social factors that affect families today and contribute to neglect, all of them (22 professionals) referred to poverty. They did not offer explanations about the ways in which poverty could have an impact on a child being neglected. However, in a different part of the survey there was a further discussion about poverty. A professional working in practice and policy noted that, although neglect can occur across families from all socio-economic backgrounds, it is “more commonly found” in deprived areas:

> *However, it is also important to recognise that neglect can occur in all communities in varying formats but more commonly found in lower socioeconomic areas of deprivation.*
>
> (Online study, public health and child protection, practice/policy and other: training development)

A participant in the focus group further articulated the issue about deprived areas and families being referred to social services more frequently than families in more affluent areas, which has been the subject of much exploration in existing research (Hood and Goldacre 2021). The question is: are families in deprived areas easier to see by social services, or is it because child neglect or other issues really exists more frequently there? She suggested that it is easier for social services to "pick it up" in deprived areas, as it where the focus is placed, and parents may not have the resources to keep it "under wraps" compared to those living in more affluent areas:

> *It could be argued that social work is a way of policing the poor. And that's where we are looking for our referrals. And that's where the focus is. That people are not tramping around the affluent areas or picking up the abuse that goes on there. It's much easier to pick up where people don't have the means to hide the abuse, whereas richer, more affluent people are much better at keeping that abuse under wraps. But it's not to say it's not going on, we're just better at picking it up in poor areas.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

In the focus group, participants also referred to the need to change how poverty is perceived in relation to child neglect. To be more specific, a participant mentioned that the link between poverty and child neglect is not completely causal, but poverty can be seen as a "stressor" in parents' lives.

> *I think it's a real challenge to try and identify poverty as a stressor, but not as completely causal. Because to stigmatise people who are poor is unforgiveable and won't work anyway.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Another professional mentioned that there is a need to "move away" from the perspective that child neglect occurs only when families live in poverty:

> *I think we have to move away from the view of neglect as well that it's only like poor people (…) who neglect children.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Some participants referred to the emotional neglect of children in families that are more affluent. Although not lacking in clothing or food, participants spoke about parents not being responsive or prioritising the emotional needs of the child. This is a crucial point, as focusing only on deprivation may result in missing a number of children, and this needs to be considered in a public health approach to child neglect.

> *(…) one of those studies that was done in America recently where they had spoken to younger people who were very clearly naming the emotional neglect by their parents. Saying my mum and dad are just on their mobile phones all day, they never speak to us, they never do anything with us. They're just on their tablets. And that wasn't poor people, that was your average families.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

> *R1: … the more affluent areas like (area), you wouldn't be seeing the dirty houses and you wouldn't be seeing hungry children. But you would see very emotionally damaged children because of parental neglect. But it's got nothing to do with not feeding them or not clothing them properly.*[29]
>
> *R2: And they'll have every device and every designer. (…) Loads, pots of money, school trips, fancy clothes. But they have certainly been emotionally neglected.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

6.2.1.1.2 Parents' responsibility in meeting their child's needs

When participants in the online study were asked to define neglect in Stage 2, they noted parents' responsibility as part of their definition. Of a total of 22 participants who answered, four professionals (all working in practice) defined child neglect as parents not providing a range of care to children. For instance, in the following quotations, it is interesting to focus on the language being used, namely "lack", "failing", "can't adequately provide", and "not being able", which refer to parents' inactions or deficits in relation to the care of children, when defining child neglect:

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[29] Not discussed was what this properly includes.

> *Lack of parental care to provide basic physical care, emotional responsiveness to child's needs, provide guidance and support child in optimising their development and talents.*
>
> (Online study, public health and child protection, other: frontline non-managerial)

> *It is the children who are not brought to the necessary hospital, dental or other appointments or when they do come are grubby. It's parents failing to spend time simply playing with and nurturing their children. It's parents whose own significant learning difficulties or mental health problems mean that they can't adequately provide for their children's needs even if they are trying their best. It's parents who aren't able to prioritise their children's needs and continue to spend money on drugs, alcohol or cigarettes while their children don't have clean or appropriately sized clothes.*
>
> (Online study, child protection, practice and academic)

Defining child neglect primarily as parents' responsibility ignores other important contributory factors to child neglect. As explored in the literature review, there are wider social factors that affect parents' ability to parent. This point is crucial to consider in preventing child neglect, as focusing only on one aspect of factors that increase the likelihood of neglect will not effectively consider the full picture of the phenomenon and its complexity.

Two participants, in the same stage of the online study (out of a total of 22), did acknowledge the wider socioeconomic factors that are linked with the phenomenon when they were defining neglect. One mentioned that social factors can contribute to the needs (of children) not being met:

> *Needs unmet through various reasons – societal included.*
>
> (Online study, other: child & family social work team, practice and other: practice educator)

The other participant explored this in much more detail and differentiated between "wilful" or "unknowingly", with the latter being linked to the economic constraints that families experience. The participant saw the latter associated with wider structures (national and local government) and in doing so framed neglect as a "social construct":

> *For me, the failure to meet needs is neglect, if it's with intent. Unknowingly neglecting the needs of a child I feel is more to do with a socioeconomic response which has been generated through generational cycles by national and local government in an effort to create the ever growing wealth gap. Wilful neglect is with purpose to harm. Unknowingly is a social construct.*
>
> (Online study, child protection, practice and policy)

Although I was expecting that all or at least the majority of professionals would acknowledge in defining child neglect the wider socioeconomic factors that contribute to the phenomenon, this was not the case. Both professionals who referred to these factors were working in the practice area, as the majority of professionals who had defined neglect responded to Stage 2 of the online study.

6.2.1.2 Challenges in the field of child neglect

All professionals involved in Stages 1 and 2 of the online study and in the focus group referred to several challenges faced by professionals working in the area of child neglect. The challenges reported involved difficulties that professionals face in fulfilling their roles, which could also act as barriers to implementing a public health approach to child neglect.

6.2.1.2.1 Child neglect can be hard to detect

The first challenge was about detecting neglect. Two professionals mentioned that detecting child neglect is not a clear-cut decision:

> *Neglect is often not obvious.*
>
> (Online study, child protection, practice and policy)

> *Neglect can be hard to evidence …*
>
> (Online study, public health and child protection, practice)

Another participant mentioned that child neglect involves not only a one-off concern, but is often a combination of concerns that will lead to evidencing it:

> *It is often only an amalgamation of combined concerns/information that lead to neglect being considered.*
>
> (Online study, child protection, practice)

In the focus group, there was discussion about referrals in relation to concerns of emotional neglect. A participant said that “we are seeing lots of children who are traumatised”, despite emotional neglect being more complicated than evidencing physical neglect.

> *If we’ve got all the other factors that tick ... the dirty house, the not turning up, the lack of food. That’s easy. But that on its own, I think we’re seeing a lot of children who are traumatised and emotionally neglected.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

However, another professional in the focus group noted that neglect could be “seen” (made visible) through children’s behaviour. This was revealed in the extract below:

> *(...) the emotional (...) It’s on the same and it’s reflected in perhaps behaviour. And we are sent children for behaviour reasons.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

6.2.1.2.2 Absence of clear criteria for assessing/defining neglect

Professionals from the online study expressed the desire for “a pathway”, “a model” or a “screening tool” which would help to identify and guide intervention regarding child neglect. Specifically, a practitioner noted that, when adopting a model which involves signs of neglect, the impact and actions of preventing neglect may provide a “clearer indication” in managing child neglect.

> *... a model which clearly identified what neglect may look like, the impact and the actions that can/should be taken to prevent it may give a clearer indication of how to approach and evidence this subject.*
>
> (Online study, public health and child protection, practice)

Similarly, another practitioner mentioned that, although there are “existing frameworks” (i.e., the Graded Care Profile), in recognising child neglect a “succinct and clearer pathway” can contribute to intervening effectively.

> *There are existing frameworks regarding neglect and screening tools being used however a more succinct and clearer pathway may be*

> *helpful … this may increase the number and effectiveness of interventions. (...) as Graded Care Profile at times can be difficult to use (...).*
>
> (Online study, public health and child protection, practice)

Another practitioner with expertise in child protection also noted a similar point. “Formalising the screening” that indicates when to act can be useful in tackling child neglect. Although “formalising the screening” is not further discussed by this professional, it may indicate that the developing of a protocol for action or a screening tool would be beneficial.

> *I think formalising the screening with action thresholds might be useful.*
>
> (Online study, child protection, practice)

6.2.1.2.3 Parents not engaging/recognising need for support can be challenging for professionals

Another challenge, which professionals identified in the focus group, was the difficulty of engaging with parents who may not recognise their need for support, or, alternatively, where the support on offer is not one which the parent(s) wishes to access. In the extract below the practitioner noted that she “does a hard-sell”. Interestingly, parents who “will not engage” are characterised as being “hard-to-reach” by this practitioner, rather than that the service on offer (parenting programme/group) may not align with what the parent would prefer. As discussed in Chapter Four, one of the key points made by parents was the view that being forced by professionals to be involved with support services is not helpful.

> *(...) I think it’s very, very difficult when you’ve got parents who they regularly turn around and say, ‘Oh, I don’t need that. I know how to parent, I know what I’m doing. And I have to say, I just do a hard-sell. … as you say, there are the cohort who will not engage in that environment (parenting programmes/groups). And I think that’s the hard-to-reach group.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

6.2.1.2.4 Workload of education staff as a barrier to fulfilling their role

This sub-theme is focused on education and the workload of staff there, as it was discussed by professionals in the focus group. Workload (not only of education staff) was mentioned by all professionals in this study as a barrier to fulfilling their role, but this will be discussed later in the section about developing relationships between parents and professionals (6.2.3.4). I focused on education, as educational staff see children on a daily basis, and, for children who have started school, they are more likely to spot indicators that a child is experiencing neglect. However, I would like to underline that the following quotations are not based on the views of teachers, but only on what was discussed in the focus group (with limited representation of the education sector).

Two participants spoke about resources that can be used to supplement the budgets available for students to participate in school trips. However, they felt that teachers would not have the time to explore what was available:

> *R1: There's so many resources that you can tap into. ... But, as you say, a teacher running a school who's running a budget who's dealing with all ...*
> *R2: Enough to do.*
> *R1: ... everything that's going on in the school, doesn't have time to be searching for that.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Regarding the involvement of the education sector in tackling child neglect, it was mentioned by a participant in the focus group that the involvement of education in tackling child neglect will be a "huge challenge" for them due to their existing responsibilities within Curriculum for Excellence.[30] It was noted that, if it is approached as adding an extra duty on their role, education staff will not be able to "deliver" what required to tackle child neglect:

> *(...) if you're talking about delivering things to young people in schools, I think it would be a huge challenge for education given all the*

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[30] The Curriculum for Excellence (CfE) is the national curriculum used from nursery to secondary school in Scotland (Education Scotland 2019).

> *other stuff that they have got on their agenda with Curriculum for Excellence. (...) They wouldn't be able to do it as yet another add-on.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

6.2.2 Moving forward in tackling child neglect (section two)

This second section considers the actions that were mentioned by professionals, and which are required in order to implement a public health approach to child neglect. It also describes the delivery style needed in tackling child neglect; this refers to how the system will need to operate and to deliver support to families in order to be more preventative than reactive.

I chose to present these two themes together because participants highlighted that the way in which support is delivered requires change. This is an important and challenging point that needs to be considered in order to move towards a public health approach to child neglect. A description of each theme is outlined at the beginning of each sub-section (6.2.2.1 and 6.2.2.2). Table 12 summarise the themes and subthemes of this section.

Table 12: Subthemes and themes of section two

Changing the approach of support services from reactive to preventative	Actions required in tackling child neglect
State involvement is needed in moving towards a preventative approach for child neglect	
Resources need to be available to services for supporting families	
Time is required to make changes	
Need of universal services for parents	Different style of delivering support
Need to tailor support to meet parents' needs	
Wider social factors need to be foregrounded in a public health approach	
Multiagency collaboration is needed in preventing child neglect	

6.2.2.1 Actions required in tackling child neglect

This theme relates to what emerged from the online survey about what is required as part of a public health approach to preventing child neglect. It refers to having a more preventative approach in supporting families before issues escalate, to links with existing policy/practice in Scotland, to the need of resources and time for changes to move forward in preventing child neglect. These actions do not refer to delivering support, as these are presented in the following theme.

6.2.2.1.1 Changing the approach of support services from reactive to preventative

Participants in Stages 1 and 2 of the online study noted that the current system is more reactive. They also mentioned that this is a barrier to working on a preventative level, as can be seen in the following quotations. More specifically, a professional mentioned that the current system prioritises managing child neglect; therefore, focusing on prevention is difficult for each practitioner:

> *Current priorities are around managing neglect and so it is difficult for an individual practitioner to choose to focus more on prevention.*
>
> (Online study, public health, practice/policy and academic)

A professional working in the policy area expressed a view that the roles in protecting a child once child protection procedures have started are clear. However, this is a reactive response. Similarly, another professional also said that interventions are driven by crisis and not introduced earlier, whereas a professional who used to work as a Health Visitor mentioned that their role is more about dealing with problems as they arise ("firefighting"), rather than preventing issues:

> *Once it has reached that level and child protection processes have started then everyone has a clear role to protect the child further and remove the risk. However, this is reactionary, waiting till the problem exists at a one child level.*
>
> (Online study, public health and child protection, policy)

> *Intervention is often crisis driven rather than at an earlier stage.*
>
> (Online study, child protection and other: children with neurodisability, acute paediatrics, vulnerable and looked after children, practice and academic)

> *(...) as a health visitor previously, our teams were working flat out firefighting rather than preventing.*
>
> (Online study, public health and child protection, academic and practice)

Interestingly, a practitioner with expertise in the child protection field noted that, currently, early intervention is not offered to many parents. It was noted that most of parents currently will not be advised or "seen" until there is an issue:

> *The disadvantage currently that most parents don't get advice or seen until something goes seriously wrong (...).*
>
> (Online study, child protection, practice)

The same practitioner also mentioned that preventing child neglect is challenging, as their role is "more reactive then proactive":

> *It is very challenging to provide a public health model now due to the changing aspect of our role (more reactive than proactive).*
>
> (Online study, child protection, practice)

Apart from noting that the system is more reactive than preventative, a small number of professionals (four out of 62 in both Stages 1 and 2) pointed out that moving towards a preventative approach to child neglect requires reorganising the system from being reactive to being preventative. This appears to provide a direction of action in relation to what a public health approach to child neglect will require. To illustrate, a professional working in policy area and academia mentioned that focusing more on preventing neglect is needed in addition to "detecting and responding" to child neglect cases. A practitioner and practice educator noticed that the system needs to be reorganised towards a public health model:

> *There needs to be much more focus on preventing neglect, rather than simply detecting and responding to it.*
>
> (Online study, public health, policy and academic)

> *We need to reorganise the whole of the welfare state and social support. Towards a public health model.*
>
> (Online study, other: child & family social work team, practice and other: practice educator)

6.2.2.1.2 State involvement is needed in moving towards a preventative approach for child neglect

In Stage 2 of the online survey, most of professionals noted that there are already links between preventing child neglect and policy in Scotland. To present some initiatives, a practitioner with expertise both in the public health and child protection field mentioned that a public health approach links with:

> *(...) the Scottish Government's commitment to having children in mind when deciding on policies.*
>
> (Online study, public health and child protection, practice).

Another professional working in policy mentioned the link to "GIRFEC" and "Links to Children Act 2014, health and social care agenda" (Online study, public health and child protection, policy), but with no further details about which parts of these are linked with preventing child neglect.

A professional also mentioned link with Child Protection Improvement Programme (CPIP) as published by the Scottish Government, and she mentioned the following extract from the report:

> *'The Framework will set out what is understood by prevention, and identify the activities, outcomes and assumptions which underpin a prevention-focused approach and an understanding of how to evaluate prevention activities. It will focus on: people and organisations that might stop abuse happening and the situations that might increase the risk of abuse happening, people at risk of being abusers.'*
>
> (Online study, public health and child protection, practice/policy and academic)

Although, as mentioned above, professionals did refer to links between preventing neglect and current initiatives at policy level, two professionals had different perspectives regarding this link. The following quotation from a professional with expertise in the child protection area indicates that initiatives do not necessarily result in change.

> *If I am being frank – again, it is disheartening that the issue of neglect is such that there is another initiative looking at how we can tackle it (...).*
>
> (Online study, child protection and other: child/adolescent/adult mental health and substance misuse, other: a mixture of strategic work, training and teaching, policies)

The other participant, a practitioner with expertise both in public health and the child protection area noted that an approach to preventing neglect does not link with existing practice in Scotland, as it "is not legislative".

> *It does not link at all as practice in Scotland is not legislative to this extent.*
>
> (Online study, public health and child protection, practice)

Despite links with the initiatives mentioned, it appears that tackling child neglect may require extra effort to be made, and this provides an area of consideration regarding a public health approach to child neglect. I believe that it raises questions on how it will be fitted within existing framework of practice and policy, what changes will be required, and who will make these. Regarding change, two professionals, both working in policy, noted that moving forward towards a public health approach to child neglect required the involvement of the state. A professional mentioned that it required "massive government commitment" to move forward:

> *This approach requires a massive government commitment in every way to drive forward (...).*
>
> (Online study, public health and child protection, practice/policy and academic)

Another professional mentioned that the Government needs to be convinced regarding the value of public health approach in preventing child neglect:

> *Need to convince the Scottish Government of the value of the approach.*
>
> (Online study, public health, policy and academic)

6.2.2.1.3 Resources need to be available to services for supporting families

There were references made to funding issues and staff cuts of services, and the implications, by most of the professionals in the online study, both in Stage 1 and Stage 2. A professional working as practitioner and in policy mentioned that limited funding and staff is a reason that parts of services are “given up”:

> *Agencies being reluctant to give up parts of their service, due to losing funding and staff.*
>
> (Online study, criminal justice, practice and policy)

Another professional with expertise in the child protection area mentioned that, due to limited finances, services are not able to support all of the people who need them, focusing often on only those of the “highest need”:

> *We do not have the finance in services to reach all those who would benefit. Criteria is often aimed at those of the highest need.*
>
> (Online study, child protection, practice/policy and academic)

Similarly, a practitioner noted in the online survey that limited resources do have an impact on delivering services to meet demand and this has an impact on beneficiaries losing their trust to services by feeling “let down”. The loss of trust in services was also mentioned by young people, as discussed in the previous chapter.

> *Resources limiting the ability to promote and deliver a service which can meet the demands. People feeling let down by services and losing trust.*
>
> (Online study, child protection, practice)

The following quotation also described the impact of the limited resources available to services. This involved a downward spiral, which starts from services not getting funding, which leads to less staff being available, then to waiting lists, and, finally, service users becoming “disillusioned” and not asking for help:

> *Local services not getting funding, which means losing staff, which can lead to waiting lists to rise and service users becoming disillusioned so stop trying to get help.*
>
> (Online study, other: local authority, practice and policy)

Another impact of less staff being available was about putting the building of relationships with families under pressure, which was an important element also discussed by parents and young people participating in interviews and focus groups.

> *Time to build trusting relationships with families is often put under pressure due to staff capacity.*
>
> (Online study, public health, policy)

6.2.2.1.4 Time is required to make changes

When professionals were asked about challenges in implementing a public health approach to child neglect, two practitioners noted that the outcome of a public health approach to tackle child neglect would take time to be seen and this can be a challenge for implementation:

> *The strategies would have to be in place long term before the benefits could be audited.*
>
> (Online study, public health and child protection, practice)

> *(…) (it) might take a while to see the impact and would be costly if applied correctly.*
>
> (Online study, child and adolescent mental health, practice)

6.2.2.2 Different style of delivering support

This theme is about how support systems could operate to help tackle child neglect. It is about making services available to all parents (universal), but also to provide targeted services that meet parents' particular needs. It also underlines that, in public health approaches, the wider social factors need to be foregrounded and different sectors should be involved in preventing child neglect.

6.2.2.2.1 Need of universal services for parents

Universal services were noted as one aspect of supporting families. A professional mentioned that increasing universal services (i.e., midwifery and health visiting) will support parents more "meaningfully". However, no explanation of what meaningfully might mean was provided:

> *Ideally, being able to increase universal service support such as midwifery and health visiting could robustly support parents more meaningfully (…).*
>
> (Online study, public health and child protection, practice/policy and academic)

An example of universal provision for support parents was universal parenting courses at the pre-natal stage of pregnancy as well as universal health visiting services. Parenting classes in early infancy for all parents was also mentioned by a professional:

> *Universal parenting courses at pre-natal stage of pregnancy Universal Health visiting services.*
>
> (Online study, child protection, practice and policy)

> *More parenting classes in high schools and during pregnancy and early infancy that should be for everyone. (…).*
>
> (Online study, child protection, practice and academic)

A participant in the focus group discussed the need for having a structured approach, but one that is flexibly delivered. In her example, the structured approach involves the screening of children in the 27th – 30th month, which results in seeing severe developmental needs earlier, rather than waiting until children's needs become more visible when they start primary school:

> *Because if you think about it, now we've just put back in the 27th month screening (…). And actually, I think we're beginning to see (…). Well, we saw some difficulties when there wasn't any screening. And I think we're beginning to (…) And in that there were children turning up in primary one at the age of five with really severe developmental needs that had not been previously recognised. And I think we're beginning to see them coming earlier again, which is good. So, in general a structured approach is probably more powerful (…).*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

It was also noticed that parenting as well as relationship courses can be delivered to all children through education:

> *Relationship and parenting courses provided to all children through education.*
>
> (Online study, child protection, practice and policy)

The role of education in reaching all children and their parents was also mentioned by professionals in the focus group. Sessions for parents and children (i.e., reading books) was an example mentioned which can be organised by schools, and made available to all parents as well as accepted by parents:

> *R1: And sometimes P1s have the sessions and then opportunities to follow-up for reading with your child and those kinds of things.*
> *R2: Yeah.*
> *R1: Which again are universal and are very obviously acceptable to parents.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

A professional in the focus group also referred to how parenting programmes can be "truly universal". She mentioned that employers need to provide time off for their employees in order to attend these programmes or to offer similar support. It was not discussed whether this referred to both parents, but this was about the post-birth area and thus available to all parents.

> *(...) it may have to be something that you bring employers onboard. So (...) people who are parents would actually be given time off their work to go for an hour's parenting programme or input or whatever. To make it truly universal.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Professionals also referred to the notion that an advantage of making services available to all parents supports non-threatening practice. A practitioner referred to "socially acceptable monitoring", suggesting that, if monitoring weight is "generally available to all", it is seen as being less threatening:

> *(…) 'socially acceptable' monitoring. Regular weighing at a baby clinic offered a lot more than a record of weight and is non-threatening if it is generally available to all.*
>
> (Online study, child protection, practice)

Similarly, professionals in the focus group discussed that parents are more likely to be engaged, when it is available to all, as they do not feel threatened that their parenting skills are questioned:

> *R1: I think parents are more likely to engage with something that they know is everybody is part of the plan and everyone is [voices overlap] or everyone's being offered.*
>
> *R2: I think people are more willing to engage because then they don't see it as someone has questioned my parenting skills.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

6.2.2.2.2 Need to tailor support to meet parents' needs

As mentioned in the literature review, a public health approach could include a continuum of strategies that range from strategies directed to a broad audience, all the way to specific services for individuals who need additional support (Herrenkohl et al. 2016). Professionals discussed how best to meet those additional needs of parents.

A professional working in policy mentioned that: "Interventions at varying levels are important to ensure they are proportionate to need" (Online study, public health, policy). A professional from the focus group mentioned that a one-size approach cannot meet all needs, and she provided an example of "frankly, horror stories" of a parenting group, where parents with different levels of needs were participating:

> *But I am aware of the idea, similar to my colleagues, that one size fits all doesn't work. Some, frankly, horror stories of a group doing triple P in (area) where a couple of the mums, they were sent there because their children were in care. And they were told to go in order to get their children back, alongside people who had a lot less need in terms of the support.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

A practitioner mentioned a list of factors that need consideration in meeting parents' needs and tackling child neglect. The first point involved the consideration of family composition but also the connections (or not) with extended family, both noted in the literature review as factors that increase the likelihood of child neglect. The second point referred to the health of parents (both physical and mental) or learning disabilities, substance/alcohol abuse, and the last point was about parental experience of their own childhoods:

> *Fragmented families. (Single parents, distance or lack of connection with extended family)*
>
> *Parental physical or mental health issues or learning disability*
> *Substance abuse/ alcohol abuse.*
>
> *Poor parental experience of being parented themselves.*
>
> (Online study, child protection, practice)

During the discussion in the focus group, two professionals referred to mothers' childhood experiences as a way to assess risk. They referred to the evaluation of mothers' experience of being parented. However, they were not sure whether the questionnaires administered by midwives involve any related information. They pointed out that this could work as indicator of how a mother will parent and as an early intervention by identifying the risk group. This referred to early intervention before birth; however, to what extent this could be seen by expecting mothers as interfering in their lives was not discussed:

> *R1: I don't know whether any of the midwife questionnaires currently actually ask the mother about her own experience of being parented. Because actually that is … I can't quote research, but I would've thought (…)*
> *R2: It's the best indicator of how you will parent.*
> *R1: (…) that that is a huge indicator. And could allow good identification of a risk group as well.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

A practitioner mentioned that parenting classes (which usually are about enhancing parenting skills and developing an understanding of child development and needs) do not meet the needs of parents who have experience trauma. In this case, therapeutic work (one-to-one) is needed.

> *We need to stop throwing parenting classes at the parents who did not experience good enough parenting themselves – we need to assess appropriately the parent's historical trauma and if they ever addressed this through therapeutic therapy and provide a therapeutic homely relationship with 1-2 people (not a host of services!).*
>
> (Online study, public health and child protection, practice)

Another practitioner with expertise in child protection noted that the trauma of parents affected their ability to prioritise children's needs. They expressed a view that trauma experienced by parents is leading to poor mental health and substance misuse. According to this professional, tackling the roots of child neglect involves investing in counselling services to address parents' difficulties:

> *Parents neglect their children primarily because they cannot prioritise their children's needs over their own usually due to trauma in their own childhood leading to poor mental ill and or substance misuse to deal with the root cause of the neglect would mean an investment in counselling services to meet the parents' difficulties.*
>
> (Online study, child protection, practice)

For one professional from the focus group, tailoring support to meet need and enabling equality of access included overcoming language barriers by having a parenting group in the parents' mother tongue (i.e., Polish). However, she mentioned that currently this flexibility does not exist:

> *The other one that we haven't mentioned is language barriers. (...) And there doesn't seem at the moment to be the flexibility for that. I mean you would hope that you could gather a group of Polish parents together because there are enough of them, and to do it in Polish. But there doesn't actually seem to be the flexibility to achieve that.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

In practice, tailoring support in meeting the needs of families may mean offering support for a protracted period, rather than on a time-limited basis, required in families where children experience neglect. For another participant, tailoring support involves allocation of family nurses based on the needs and not the age of the child:

> *Many families do need someone going into the household regularly for a time.*
>
> (Online study, child protection, practice)

> *Family Nurses to be allocated cases on a needs basis as opposed to age.*
>
> (Online study, public health and child protection, practice)

According to two practitioners, meeting needs may also be connected to providing more resources to more deprived areas in order to have "equitable service" for all children and to meet needs on the ground:

> *If the area was particularly deprived more resources should be allocated so there is an equitable service no matter where the child was born.*
>
> (Online study, public health and child protection, practice)

> *(...) Some areas not having the resources or staffing on the ground to extend services to meet need. (...) I think it really depends on the area and the resources. Sometimes trying to access services or groups for people who want to learn more and change their ways is impossible with waiting lists, cuts in funding etc.*
>
> (Online study, child protection, practice)

6.2.2.2.3 Wider social factors need to be foregrounded in a public health approach

The majority of professionals mentioned that the wider social factors that contribute to child neglect need to be addressed in a public health approach, despite the fact that, when defining neglect, the majority of responses did not refer to these structural issues. A professional mentioned that there is need to focus on the wider determinants of neglect (i.e., income, housing security and social support) as these factors affect parents' ability to care:

> *There also needs to be a much greater focus on the wider determinants of neglect (...). The parent's ability to provide good care for their*

> *children is dependent on factors such as having an adequate income, housing security, social support.*
>
> (Online study, public health, policy and academic)

It was also noted that a public health approach to child neglect mean a move away from individual cases and responsibilities. There will be more focus on addressing structural issues and on community/services around the family:

> *It would mean that neglect could be seen less as the responsibility of the individual family to address, but of the community and services around the family, and the structural issues facing families.*
>
> (Online study, child protection, academic)

> *(…) if informed by a public health approach we would take the structural issues into greater consideration, and also look for more community-based solutions. Standing back from individual cases we need to take a more focused approach to tackling the factors that affect parenting (…).*
>
> (Online study, public health/child protection and other: neglect, inequalities, academic and other: management)

Professionals also mentioned that factors affecting parents can include poverty, poor housing, poor employment, unsafe environments, and limited opportunities to improve, which are associated with addictions, mental health issues, experiencing high levels of stress, poorer lifestyle choices and less education:

> *(…) poverty and poor housing which are in turn associated with drug and alcohol misuse and mental health issues.*
>
> (Online study, public health/child protection and other: neglect, inequalities, academic and other: management)

> *(…) poor employment, lack of support services. Family breakdown. domestic violence. Substance misuse. Poor mental health.*
>
> (Online study, other: child & family social work team, practice and other: practice educator)

> *Stress caused by poverty, living with domestic abuse, living with housing uncertainly – threat of eviction, unsafe environments e.g., gangs in street.*
>
> (Online study, public health, practice/policy and academic)

> *(...) limited opportunity to improve and contribute to society has seen near two generations turn to addictions, debt, poorer lifestyle choices and with less education.*
>
> (Online study, child protection, practice and policy)

6.2.2.2.4 Multiagency collaboration is needed in preventing child neglect

Among professionals who responded in Stage 1 (40 participants) and the focus group (four participants) there was a common theme that tackling child neglect requires the involvement of different sectors. In 2002, "It's everyone's job to make sure I'm alright" (Scottish Executive 2002) was published, which highlighted that child welfare and protection is a shared responsibility. While not explicitly referencing this document, one practitioner mentioned that preventing child neglect is the "responsibility of all" and not only a "social work issue":

> *Neglect must be (...) the responsibility of all. Neglect is too often viewed as a social work issue to 'resolve' or prevent from becoming worse.*
>
> (Online study, child protection, practice)

Another practitioner also mentioned that preventing child neglect requires agencies working together. However, this may be a barrier to implementing a public health approach, according to a practitioner with child reaction expertise, as not all agencies have the same thresholds (intervention/concern):

> *Requires inter-agency working and not all agencies have same thresholds for intervention/ level of concern.*
>
> (Online study, child protection, practice)

Professionals in the focus group discussion also mentioned reasons why collaboration across different sectors is needed. A professional noted that no single agency is able to tackle the level of child neglect.

> *(...) Social work would collapse if all these children were referred to social work. So there has to be some other kind of response, because no single agency or services would be able to tackle the level of neglect that is around.*
>
> (Focus group, four participants, 20+ years of experience, area of expertise)

Another reason why collaboration is needed referred to different professionals contributing in "building up" the concern of neglect. According to a practitioner with expertise in the field of child protection, the collaboration of different agencies is needed to ensure a careful monitoring of children and support for parents in order to manage risk. In the focus groups, the emphasis was that, in order to build a "picture" of a child's experience rather than one-off concerns, professionals needed to work together to "build up a chronology":

> *Multi agencies need to work together to ensure children are being carefully monitored and parents are being supported to prevent the child suffering any abuse.*
>
> (Online study, child protection, practice and academic)

> *With neglect it's about building that picture, isn't it? So it's much more difficult with a one off concern to build the picture. Whereas if you get several professionals feeding in and building up that chronology of concern of neglect it's a much meatier evidence to present to the reporter or to present at a case conference.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Another professional in the focus group mentioned an example where, in a child's planning meeting (the child was school-aged), the health visitor of his/her younger siblings was not invited. As a consequence, important information about these three siblings was missed. The participant said that children live in families and not in isolation:

> *So, there was a child's planning meeting that had been arranged by the school, they didn't invite the health visitor who was dealing with three younger children in the family. It didn't invite ... So, they had missed*

> *… because they were focusing on one child, the school-aged child. These children don't live in isolation. They live in families.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

6.2.3 Components of tackling child neglect (section three)

The third section presents a number of different aspects mentioned by participants and which may form a public health approach to child neglect. Five themes are presented: public awareness campaigns, duration and access to support for parents, a holistic approach to the family, a positive approach in supporting parents, and relationships. Examples of potential interventions that could be part of a public health approach to tackle neglect are also presented in this section.

Although themes are titled with the core idea of a need to rule the prevention of child neglect, the sub-themes contain examples of tackling child neglect before it has been identified. A summary of the meaning of each theme in this section is outlined at the beginning of each sub-section (6.2.3.1 to 6.2.3.4). Table 13 summarise the themes and subthemes of this section.

Table 13: Themes/subthemes of section three

Subthemes	**Themes**
Enhancing understanding of population through awareness campaign	Public awareness campaign
Technology as a mean to reach a large section of the general population	
Need of long-term support for families	Duration and access to support for parents
Accessible support for all families	
Valuing lived experience of child neglect	Developing a public health approach
Parents' feeling of intervening in their life	
Being supportive toward parents enables better support them	
Relationships between professionals and parents are needed in supporting families	Relationships
Barriers to developing a relationship between professionals and families	
Tackling the isolation of families is needed in preventing child neglect	

6.2.3.1 Public awareness campaigns

The research for this thesis was carried out before Covid-19, and before the public awareness campaigns and broadcasts associated with this. However, the participants identified the part that these can play in enhancing understanding about child neglect. The participants identified what a public awareness campaign could involve, how the complexity of child neglect may affect the efficacy of an awareness campaign, and how it could be delivered.

6.2.3.1.1 Enhancing an understanding by the population through awareness campaigns

When participants in the online study were asked in Stage 2 about public awareness campaigns, it was noted by all participants (*n*=22) that it can be part of a public health approach to child neglect. Some participants also explained what this campaign may include. For instance, the following professionals with practice experience mentioned that a campaign may be about understanding child neglect (including what neglect is, ways neglect may happen, the consequences of neglect, particularly emotional neglect, and ways to prevent it):

> *Improve public understanding of the concept and ways this may happen, its impact and ways to avoid this occurring.*
>
> (Online study, public health and child protection, other: frontline non-managerial)

> *Public awareness raising campaign about the consequences of neglect, particularly emotional neglect.*
>
> (Online study, child protection, practice and policy)

> *Many people think of neglect as solely practical needs, e.g., food, clothing, not met. Perhaps a TV advertisement explaining what constitutes neglect.*
>
> (Online study, public health and child protection, practice)

During the discussion among professionals in the focus group, one professional expressed a concern about how the “general population” will understand a phenomenon, when professionals appear to face difficulties in understanding and identifying different forms and consequences of child neglect:

> *(...) when you've got professionals who struggle to name neglect, then how can you expect that to get a public health message across to the general population when professionals don't even understand, either struggle to identify or struggle to understand the consequences of neglect?*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

However, another professional in the focus group underlined that when the general population is not aware of the issue, they are not able to acknowledge, react and/or manage it:

> *(…) if you don't have awareness in the general population there's an issue, then you won't get people acknowledging it or reacting to it or looking to manage it.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Emotional neglect was also mentioned by one professional. It was proposed that a public awareness campaign could focus on increasing understanding about emotional neglect (what it constitutes and what some of the signs may be):

> *Increase awareness of what is emotional neglect and what the signs are.*
>
> (Online study, public health, practice/policy and academic)

According to a practitioner, a public awareness campaign can involve the following three messages: the importance of one-to-one interaction with all children of all ages, the impact of ACEs, and the way in which adversities can be overcome through getting support. It was also noted that these messages need to be available in places parents use:

> *(…) wherever parents go there should be public health messages on the importance of 1:1 interaction with their children – NOT just babies, school age children and teenagers need this just as much. Along with helping parents understand the impact of adverse life experiences and how to overcome this and get support.*
>
> (Online study, child protection, practice)

In the focus groups with parents, some expressed anxiety and fear about social work services. Consequently, a public awareness campaign also needs to directly address the fears which parents may have about services becoming involved in family life and identifying that asking for help does not mean children taken into care. This was articulated in the online study:

> *It's ok to ask for help – this won't result in your child being taken into care.*
>
> (Online study, public health, practice/policy and academic)

The following quotation presents an example mentioned by another professional (working in academia and practice) regarding what a public awareness campaign could involve regarding enhancing an understating of what constitutes child neglect from a child's perspective. The impact refers to a child not attending hospital appointments, which may result in not having his/her medication, missing school, and not meeting peers. These occurred as a result of structural issues affecting the family, such as unemployment of the father, and lack of easy access to hospital (distance and not being able to afford transportation):

> *A day in my life type of idea that gets across the damage caused (...) e.g., I don't always get taken to my hospital appointments and that means I am poorly a lot because I don't get my medication I should have and miss school and being with my friends. My dad lost his job and we have no car now and mum can't always afford the bus because the hospital is an hour away.*
>
> (Online study, public health and child protection, academic and practice)

6.2.3.1.2 Technology as a means to reach the general population

In the focus group discussions, professionals discussed how public health messages can be disseminated to the general population by using technology. I would like to note that the use of technology has changed in response to Covid-19 and the associated restrictions. However, this discussion took place in the pre-Covid-19 era, and this needs to be considered in reading the following section. A professional in the focus group noted that using technology is a "huge opportunity", as so many people now use technology and such messages can be offered in the formats that people use:

> *There’s a huge opportunity with technology as well, because people use technology. So, I think you can use it to advertise, you can use it to offer that public health message in formats that people will access.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Professionals in the focus group also referred to a specific example of how technology can be used in reaching the general population and by offering parents advice. This example was about the “red book” being converted into a digital app. The red book refers to the Personal Child Health Record (PCHR), which is a national standard health and development record given to parents/carers across the UK at a child’s birth.

A professional said that the red book needs to be an app, which enables parents to interact and engage to access advice. However, for parents who are having difficulties in terms of their parenting, and who are not engaging with or are avoiding services, an interactive app is unlikely to meet their needs or those of their children, as it may be difficult to engage:

> *It should be an app and it should be an app that you interact with and you engage with that gives you advice. Now, I’m not saying that some of our (...) as you say, the tail end is maybe not engaging.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

According to the professionals an app of the red book can be “a route to support”:

> *That might be a route to support (...).*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Professionals also discussed what this route may involve. The app can provide parents with information on what they should expect regarding the development of their child, red flags about signs of concern, and about behaviour.

> *That information that this is what should be expected of your child at these ages and stages. Red flags, are you concerned about this? What*

> *about behaviour? (...) if the red book became an app that had more (...).*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

In addition to these suggestions, the app may focus on positive reinforcement, and positive messages about interacting with child, such as “speak to your child”, or “being positive as often as you are negative to your child”. However, I would like to underline here that any app which uses “subliminal messages”, is unlikely to be registered, as it is unethical.

> *R1: And as you say, could ping up these subliminal messages that say (...)*
> *R2: Speak to your child.*
> *R1: Yeah, being positive six times as often as you’re negative to your child will lead to a better outcome. And reduce the behaviour difficulties, and all these.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

6.2.3.2 Duration and access to support for parents

This theme referred to the need of long-term support for parents; however, this was not specified in actual time by professionals. It was more about support being in accordance with the needs of parents. In addition to this, when considering some of the factors which affected whether parents accessed support, the participants explored the physical access to support, and how parents’ feelings about seeking support or accepting support are significant.

6.2.3.2.1 Need for long-term support for families

Some professionals identified that, currently, services can be time-limited and that consequently support can be “short-term”. The need for flexible and responsive long-term support for families, not least as needs can change over time, was a common topic among the professionals in both Stages (1 and 3) of the online study and the focus group. To be more precise, a practitioner mentioned that parents need “medium to long-term support”, which may include learning skills, coping skills, and combating loneliness and feeling of hopelessness. However, the duration of support was not further specified.

> *Everything is very short-term – parents need medium to long-term support to learn skills, coping skills, combat loneliness and feeling of hopelessness.*
>
> (Online study, child protection, practice)

According to professionals, the support provided to a family should not be withdrawn once a situation improves, as parents and children may need ongoing support to maintain change:

> *We should also not be too quick to pull out support once an issue had been resolved.*
>
> (Online study, criminal justice, practice and policy)

> *Agencies provide intervention and support then back off and then the situation re-occurs (evidenced in chronologies).*
>
> (Online study, child protection, practice)

There was an acceptance that some families may need support on/off for a long time, and this is not a failing of the service or its workers, as was noted by a professional in the focus group, but should form the basis for not withdrawing support from a family once a situation in improved:

> *(...) I think it's sensible to accept that people might need help on and off for quite a long time. And not for that to become an issue where somebody's viewed as failing. We're a service. Or a worker's viewed as failing apart from anything else.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Another professional mentioned that supporting families cannot be based on the ages of the children. Their experience appeared to be that older children were not prioritised or were not receiving the necessary support:

> *Age of children often considered a factor in whether additional support/action is taken resulting in older children being missed or not receiving necessary supports.*
>
> (Online study, public health and child protection, practice/policy and other: training development)

It was noted in the focus group that there are some families who will need support throughout their life. A professional mentioned that there is recognition about the need to offer support without time restrictions:

> *I think there's a recognition beginning now. That there are some families who will need support throughout their lives. Maybe not continually. But they'll require support for as long as they need. And as they move away from the idea that services should be able to achieve outcomes between six and nine months, and then move on.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Although there was an agreement among all professionals regarding the need for continuous support, a professional in the focus group highlighted that there are cases in which continuous support may sustain situations abusive for children:

> *(…) in situations that are just not good enough and they actually suffer terrible abuse.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

She continued by saying that providing support "for long period of time" (duration not specified) needs to be seen together with the progress of family; where parenting is poor and not "good enough" despite support, she identified that this is not a "solution" given that children can be left in a damaging and abusive environment. This may indicate a tension between offering long-term support to maintain a child at home and potentially perpetuating/propping up neglectful environment.

> *(…) And then if you could keep somebody at the good enough standard by giving them additional support, for a long period of time, that would be okay. But if you're actually providing a lot of support and it's still not good enough, then that isn't a solution. You're just continuing the damage and the abuse of children.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

6.2.3.2.2 Accessible support for all families

Another aspect mentioned by the professionals was the access to support for families. A practitioner mentioned that it needs to be "barrier-free":

> *Barrier-free access to support at an early stage.*
>
> (Online study, Other: third sector services for young careers, vulnerable families, young people affected by homelessness, practice and other: role as representative of third sector)

One barrier to accessing support that the professionals mentioned was about physical access to services. A professional in the focus group noted that there is an understanding that delivering service at community/neighbourhood level is the "the best way to do it", as frontline practitioners are close to communities. This is based on the idea of building capacity by supporting people at the right time and near to where they live:

> *(...) there is move or an understanding that community-based services and a neighbourhood approach to delivering service is the best way to do it, because I think at the frontline they're close to the communities (…) The idea that you can support people at the right time, near to where they live, and you can build capacity. (…) I mean it's the opposite of rocket science actually.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Another professional mentioned that a barrier to accessing support can be living in rural areas given the limited transport available, and that services may be based in towns/cities:

> *Rurality of families and ability/easiness of access to support systems.*
>
> (Online study, public health and child protection, practice and policy)

The following quotation from professionals in the focus group is about parents finding "services that we say they have to go to" difficult to access. A professional used an example regarding parents taking children to follow-up appointments at hospital. It was noted that it is difficult for some parents to attend these appointments, as the cost is huge, and it takes a lot of time to travel by public transport. As another professional underlined in the same discussion, not attending a follow-up health appointment for children is considered to be a form of neglect, so the parents are being labelled for their parenting, but these barriers to accessing services are an external factor affecting their lives:

> *R1: And I think sometimes we're labelling parents as neglectful, when in fact they can't actually get to the services that we say they have*

> *to go to. And a classic example in (area) is if people have to go for follow-up appointments at the sick kids.*
>
> *R2: It's just hard.*
>
> *R1: It takes hours to get there if you're going on public transport, costs a huge amount of money. But people who don't do follow-up health appointments for their children are regarded as neglected. Yet our services are so difficult for some of them to access.*
>
> *R3: Absolutely.*
>
> *R4: And people are being labelled in a way in terms of their parenting. When in fact we're putting up those barriers to people being able to access them.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

The other barrier mentioned in accessing support was related to the way parents may feel about asking for and receiving help. One aspect which was mentioned and needs to be considered in accessing support is the stigma associated with asking for help. This aspect was also a theme which arose from parents and young people who participated in this study and needs to be considered in a public health approach. Parents mentioned that being stigmatised as bad parents or stereotyped for needing help may put parents off asking for help. From the perspective of young people, it was noted that, when they are not feeling judged by staff, they are comfortable in speaking.

More specifically, about professionals, a practitioner noticed that a public awareness campaign can promote asking for help by recognising that parenting is a "hard work" and is not taught in schools:

> *Bringing up kids is hard work and not on the school curriculum. If you need help, ask.*
>
> (Online study, child protection, practice)

One aspect, which was mentioned as barrier in asking for help and needs to change, was the fear that parents may have that asking for help will result in their children being taken into care. A professional mentioned that the message can be part of a public awareness campaign:

> *It's ok to ask for help – this won't result in your child been taken into care.*
>
> (Online study, public health, practice/policy and academic)

6.2.3.3 Developing a public health approach

This theme referred to the way parents are feeling about the support they receive. The first sub-theme here was about how people with lived experience could contribute to a public health approach to child neglect. The next two sub-themes are about the feeling of intervening in family life and services being supportive towards parents. The last two were more about how services are delivered downstream and not upstream, which is the focus of public health. However, these are important aspects in supporting parents, and that is why I decided to present them as sub-themes.

6.2.3.3.1 Valuing lived experience of child neglect

An aspect mentioned and discussed by professionals was the role that people who had had lived experience of child neglect could play in developing a public health approach. When professionals were asked about it in the Stage 2 of the online study, there was a general agreement by the majority of participants that people with lived experience can contribute to efforts to tackle the phenomenon, and they suggested ways of involving people with lived experience in facing difficulties in parenting. This may indicate a way to contribute to the development of a public health approach to tackling child neglect by providing experience-based knowledge of what/when/how/who helped them.

Two professionals, both working in policy, mentioned that a person with lived experience can provide an inside perspective of experiencing child neglect, the emotional impact, and practical solutions:

> *Case studies are good, but someone who has lived it is better as they can answer the questions because they know.*
>
> (Online study, other: local authority, practice and policy)

> *(People with lived experience can offer:) Emotional impact feedback. Practical solutions.*
>
> (Online study, public health and child protection, policy)

Another professional mentioned that people with lived experience can “co-lead developments” to tackle child neglect, as knowledge gained by lived experience is equivalent to “professional knowledge”:

> *Those with lived experience of child neglect to be co-leading developments to reduce child neglect. Value the knowledge of lived experience as much as professional knowledge.*
>
> (Online study, public health, policy and academic)

According to a practitioner, people with lived experience can provide information on what would have helped them, as they can provide an important hindsight perspective.

> *I think they could tell us what would have helped when, and how that with hindsight they view things (...).*
>
> (Online study, other: planning children's services, practice and policy)

However, one practitioner reported hesitation regarding the usefulness of individual stories, as it was questioned how useful individual stories could be in contributing to managing wider social factors associated with child neglect. It was also mentioned by the same professional that the stories of people with lived experience may "alienate" others who have a different narrative or perspective:

> *Not sure about usefulness of individual stories for what is a socioeconomic/ political issue. Also assumption that stories can inspire which not always the case as can alienate.*
>
> (Online study, other: third sector, practice)

6.2.3.3.2 Parents' feelings of intervening in their lives

One professional working in both practice and policy areas of child protection noted that neglect may not be obvious, so exploring a child's life involves "a bit of interfering" from professionals. However, professionals may feel "intimidated to intervene".

> *Neglect is often not obvious and takes a bit of 'interfering' to find out what is going on in a child's life (...). They feel intimidated to intervene.*
>
> (Online study, child protection, practice and policy)

The same professional also mentioned, but at a different point in the online study, that intervening in the early stages (before issues escalate) may be seen by the public as "state interfering". However, it was mentioned that early intervention requires a mechanism, which overcomes the feeling of state interfering and enables intervention at early stages:

> *The general public will probably feel that this is the state interfering - particularly where neglect is considered low level. However, if we are speaking about early intervention then there needs to be a mechanism that kicks in at these early stages.*
>
> (Online study, child protection, practice and policy)

It appears from what the professional mentioned that getting the public to agree that professionals should have “additional powers” to intervene early in family life may be a barrier to implementing a public health approach. However, there was no further exploration of what such additional powers may look like in practice, given that local authorities already have, according to the Children (Scotland) Act 1995 (section 22), the duty to safeguard and promote the welfare of children in need by providing a range of services.

> *(barriers) Getting public agreement for additional powers.*
>
> (Online study, child protection, practice and policy)

This participant went on to indicate that the “public” may feel that any additional powers are “interfering in private family life”:

> *(...) the public feel that this would be professionals interfering in private family life.*
>
> (Online study, child protection, practice and policy)

6.2.3.3.3 Being supportive toward parents enables better support

It was noted by a professional in the online study that any approach to tackling child neglect “needs to be supportive of parents and not demonise them” (Online study, public health, policy). Another professional mentioned that an approach to supporting parents may involve offerings of “replacement behaviours”, as parents may be advised what “not to do” but may be less clear about what behaviour would enable them to meet parental responsibilities and provide what others referred to as “good enough care”:

> *What replacement behaviours look like. Parents are often told what they should not do in caring for their children, but the replacement behaviour is less often clear.*
>
> (Online study, child protection, practice and policy)

Supporting parents may also involve other parents acting as mentors for other families. This was mentioned by one parent who participated in interviews and had experience of being a mentor.

> *I think there needs to be much greater rollout of services like (title of programme) whereby families who are tried and tested positive parenting role models act as mentors and supports for families who are struggling.*
>
> (Online study, child protection, practice and academic)

Another aspect of supporting parents, which was mentioned by a practitioner, was about seeing neglect from parents' perspective. This involves focusing on what "keeps people going", such as relationships, family, career, holidays, hobbies, and socialising, because the lack of these affects people's and parents' ability to function every day:

> *Need to see neglect from the parents' perspective (...) what keeps people going is focus on positives and progressing in life (relationships, family, career, holidays, hobbies, socialising) and when this is not present for people how this impacts on your ability to get up every day and complete your tasks to a high standard.*
>
> (Online study, child protection, practice)

6.2.3.4 Relationships

An important theme across the data was about the importance of relationships in supporting parents. It involved the benefits of relationships between professionals and parents, the factors that may affect that relationship, and the relationships that parents have with their community. Relationships were referred to as being more about how services are delivered downstream. However, they were referred to by parents and young people as being a crucial part of the support. Therefore, I decided to present this here as a theme.

6.2.3.4.1 Relationships between professionals and parents are needed in supporting families

Key to supporting parents is the relationship between parents and professionals (i.e., health visitors, education staff and social workers), and, as a practitioner noted, relationships are (and should be) at the core of practice:

> *What works well in H/V, Education and SW – relationships!*
>
> (Online study, child protection, practice)

According to another professional, preventing child neglect needs “close relationships with families” with regular contact between practitioners and families. They identified that this will also enable practitioners to see when a family starts to face difficulties (i.e., a child seems less cared for and/or a parent is more stressed due to financial circumstances) and be preventive by intervening early:

> *Prevention of neglect needs close relationships and frequent contacts to work with families and to spot when things are becoming hard – either the child seems less cared for or parent more stressed by money etc. – and offering support at this point, rather than not doing anything and waiting until neglect is evident.*
>
> (Online study, other: planning children’s services, practice and policy)

Another practitioner also noted that “a safe and trusting environment” helps change. This environment is built by having relationships, as was also mentioned by young people in the previous chapter.

> *Real change occurs through learning in a safe and trusting environment.*
>
> (Online study, child protection, practice)

6.2.3.4.2 Barriers to developing a relationship between professionals and families

Developing relationship between professionals and families takes time and effort. According to the professionals, having limited time due to limited staff capacity and increased caseloads negatively affects their ability to build relationships with each family:

> *Not being able to spend the time to really get to know a family or person, due to having increased caseloads.*
>
> (Online study, other: local authority, practice and policy)

> *Not enough time to focus on relationship-based practice.*
>
> (Online study, child protection, practice)

> *Time to build trusting relationships with families is often put under pressure due to staff capacity.*
>
> (Online study, public health, policy)

A professional in the focus group echoed Munro (2011) and referred to the time spent recording what has to be done with a family compared to engaging face-to-face with families. She mentioned that professionals spend more time on recording than being with the family, and this needs to change:

> *It's about recording performance, record keeping, marking your journey (...). Huge reporting frameworks where I'm sure now the balance of face-to-face and direct support as compared with how much time you spend inputting what you've done is probably going too far the other way. I think there's a balance to be struck.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

Another aspect, which was mentioned by professionals in the focus group and affects relationships, was about the turnover of staff. For instance, it was mentioned that the short-term nature of funding contributes to the high turnover of staff, as staff change positions when they get a permanent contract:

> *(...) the funding stream is short-term. Which means you've got a huge turnover of staff, because as soon as staff can get a permanent contract somewhere, off they go, and who can blame them?*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

From the data, a theme was revealed that the way in which contracts/services are established does not meet the needs of parents. More specifically, a professional mentioned (and there was agreement from two other professionals in the focus group) that parents dislike the high turnover of staff, as, when they work with a professional with whom they "get on great" and afterwards, when the professional leaves, there is a void. This also mirrors the young people's experiences, as was described by them in the focus group.

> *R1: And parents really dislike it, because they say (...) I started working with somebody, we got on great, they were really helping*

> *us and they've gone. And nothing else (...) has filled the void. And it's the relationships that enable.*
> *R2: That's right (...) Yes.*
> *R3: Exactly.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

A professional also noted that there is no guarantee that a family will have the same worker "forever". However, the short-term funding "exacerbates" the turnover of staff and, as a consequence, this affects established relationships with parents:

> *R1: And you can never guarantee that you're going to have the same worker forever.*
> *R3: No.*
> *R2: But the short-term funding really exacerbates people moving on.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

6.2.3.4.3 Tackling the isolation of families is needed in preventing child neglect

One aspect mentioned by professionals which is related to relationships, is social isolation. The isolation of families in their community was one of the factors which was presented as contributing to neglect.

> *Loss of a community – i.e., it takes a village to raise a child. Families more isolated.*
>
> (Online study, child protection and other: children with neurodisability, acute paediatrics, vulnerable and looked after children, practice and academic)

Similarly, another professional in the focus group mentioned social isolation as a "driver" for child neglect or a "removal" of a protective factor. She also mentioned that group for parents with babies may be a way to tackle isolation, as it is a way for mothers to meet, do something for their babies and then "hang stuff on it".

> *(...) in terms of the driver for neglect, that social isolation is either a driver or a removal of a normally protected factor. (...) To be honest, in (area) groups (for parents and babies) has been well sold, and I think that's a brilliant way of tackling it, isn't it? Because you're*

> *getting mums together for something that gives them something … it's really obvious to them, but then you can hang stuff on it.*
>
> (Focus group, four participants, child protection/public health and other: third sector services to children and young people, practice and policy)

6.3 Findings from Stage 3 of the online study

This part of Chapter Six presents the findings from Stage 3 of the online study with professionals. As was already mentioned in the methodology chapter and at the beginning of this chapter, participants in Stage 3 were asked to complete a rating exercise, which had two parts.

The first part aimed to differentiate between interventions based on four dimensions (importance, effectiveness, feasibility, and already available/in place, mentioned in more detail later in this chapter). It explored what interventions were considered by professionals to be a priority in implementing a public health approach. The list of interventions included in the rating exercise was based on data provided by the participants in Stages 1 and 2 of the online study and in the analysis of these data.

In the second part of Stage 3, participants were asked to rate the unintended consequences of developing and implementing a public health approach to child neglect, as these were mentioned in the online study in Stages 1 and 2. The rating of unintended consequences was separate from the rating of interventions exercise previously mentioned. The dimensions used were also different (the importance of preventing unintended consequences, the likelihood that the consequence would happen, the extent of the impact of this consequence on the prevention of child neglect, and the extent to which this consequence already occurs).

This part of the chapter has three sections, which include the following:

- An overview of the findings regarding the ratings of each intervention based on the four dimensions.
- A comparison of the mean scores given for the four dimensions for each intervention.
- An overview regarding the unintended consequences of implementing interventions to tackle child neglect.

6.3.1 Rating interventions to tackle child neglect based on four dimensions

In the online study, in Stages 1 and 2, participants were asked to suggest interventions that could be part of a public health approach to child neglect. So, Stage 3 was informed by data gathered in Stages 1 and 2. The interventions mentioned in the first two stages were extracted from the text and then grouped according to the type of intervention. The interventions fell into five types: tackling structural inequalities, communication and information, parenting programmes (pre- and post-natal), long-term support by family support services and related services, and in-school support for children and parents. These interventions were not described in much detail by the professionals participating in the study (i.e., they did not include descriptions of how these should be implemented or who can deliver these), but could still be categorised into types and whether the interventions operated at a population or an individual level. Table 14 summarises the interventions by type.

Table 14: Interventions included in Stage 3 of the online study

Intervention Type		**Interventions**
Tackle structural inequalities	Population level	Reduce inequalities in income
		Reduce inequalities in access to employment
		Ensure a good housing experience
Communication and Information	Population level	National TV mass media campaign with links to internet resources
		Local campaign (radio, printed media)
		Websites that provide useful information for parents
		Apps that provide useful information for parents
Parenting programmes (pre- and post-natal)	Population level	Universal programme for all parents
	Individual level	Programme targeted at families most at risk with focus on early intervention
Long-term support by family support services and related services	Individual level	Long-term support for families
		Long-term support for children who have experienced neglect
In school support both for children and parents	Population level	Schools provide opportunities for sport and extra-curricular activities
		Schools promote among children the understanding of healthy relationships, children's needs and expectations of parents.
	Individual level	Schools help children develop alternative attachments to family
		Schools help to identify emerging difficulties
		Schools support parents where difficulties have been identified

The dimensions within which the participants were asked to rate each of the interventions were as follows:

- Important to include (5-point interval scale, in which 1 = not important at all and 5 = very important)
- Effective in preventing child neglect (5-point interval scale, in which 1 = very ineffective and 5 = very effective)
- Feasible to implement (5-point interval scale, in which 1 = not at all feasible and 5 = very feasible)
- Already available/in place (3-point ordinal scale, in which 1 = not available/in place; 2= partially available and 3= widely available)

I will first present the results (mean scores) of the first three dimensions, as these had the same 5-point scale, and the mean score was calculated for each intervention. Then, I will present the percentages of participants who answered that these interventions are already in place.

6.3.1.1 Importance, effectiveness and feasibility of interventions

Participants were asked to rate the extent to which they considered that each intervention was: a) important to include in a public health approach, b) effective in preventing child neglect, and c) feasible to implement. The table below (Table 15) summarises the mean scores of these three dimensions for each intervention. This is the average score derived from the sum of scores divided by the number of raters.

I have colour-coded the mean ratings of the table (Table 15) using the following interpretation in order to help patterns emerge:

Mean ratings	**Colour**	**INTERPRETED AS**
4+	green	most important, most effective, most feasible
3+	orange	moderately important, moderately effective, moderately feasible
<3	red	less important, less effective, less feasible

Table 15: Mean scores of ratings for three dimensions

Intervention Type		**Intervention**	**Important**	**Effective**	**Feasible**
			Mean Scores		
Tackle structural inequalities	Population level	Reduce inequalities in income	4.4	3.8	2.8
		Reduce inequalities in access to employment	4.3	3.6	2.7
		Ensure a good housing experience	4.4	3.8	2.8
Communication and Information	Population level	National TV mass media campaign with links to internet resources	3.9	3	4.4
		Local campaign (radio, printed media)	4	3	4.4
		Websites that provide useful information for parents	4	3.2	4.4
		Apps that provide useful information for parents	4.1	3.2	4.3
Parenting programmes (pre and postnatal)	Population level	Universal programme for all parents	4.4	3.9 (3.87)	3.9 (3.92)
	Individual level	Programme targeted at families most at risk with focus on early intervention	4.9	4.4	3.9 (3.87)
Long-term support by family support services and related services	Individual level	Long-term support for families	4.7	4.2	2.8
		Long-term support for children who have experienced neglect	4.7	4.1	3
In school support both for children and parents	Population level	Schools provide opportunities for sport and extra-curricular activities	4.4	3.8	4.2

		Schools promote among children the understanding of healthy relationships, children’s needs and expectations of parents.	4.7	4.4	4.3
	Individual level	Schools help children develop alternative attachments to family	4.2	3.7	4
		Schools help to identify emerging difficulties	4.8	4.1	4.3
		Schools support parents where difficulties have been identified	4.5	4	3.4

It is striking that the mean scores given for each of the interventions, irrespective of their type or level of intervention (population vs individual), were almost all 4 or above on a 5-point scale. This indicates that participants rated all interventions as being important as part of a public health approach to tackle child neglect. The only exception was the intervention *National TV mass media campaign with links to internet resources*, which had a 3.9 mean score on the 5-point scale. Ratings regarding the effectiveness and feasibility of interventions were more mixed.

The mean scores of the dimension, how effective practitioners considered each intervention to be, can be grouped into two categories: most effective, and moderately effective interventions. With the exception of the intervention *Schools promote among children the understanding of healthy relationships*, the interventions, which were rated as most effective, were interventions that targeted individuals. These included: *schools help identifying emerging difficulties/children’s needs and expectations of parents; schools supporting parents, where difficulties have been identified; long-term support for families and for children who have experienced child neglect; and targeted support for families most at risk with a focus on early intervention.* It needs to be highlighted that most of the population-level interventions were rated as being only moderately effective compared with individual interventions, and this contrasts with a public health approach in which implementing interventions at population level is key.

The extent to which practitioners considered that it would be feasible for an intervention to be implemented or achieved was rated by feasibility dimension. The most feasible interventions, according to the participants' ratings, were about communicating information regarding child neglect (national TV mass media campaign with links to internet resources), local campaigns (radio, printed media), websites that provide useful information for parents, and apps that provide useful information for parents, with mean scores of around 4.4 (on a 5-point scale). Interventions about supporting parents and children in school were also rated as 'most feasible' in preventing child neglect with mean score of 4 or above. These interventions had the following mean scores: schools provide opportunities for sport and extra-curricular activities (4.2); schools promote among children the understanding of having healthy relationships, children's needs and expectations of parents (4.3); schools help children develop alternative attachments to family (4.0); and schools help to identify emerging difficulties (4.3).

Schools providing support to parents, where difficulties have been identified, was rated at 3.4, whereas the programmes that aim to enhance parents' knowledge, skills and confidence pre- and post-natal, together with targeted programmes for vulnerable parents, were rated with a 3.9 score. Long-term support for children who have experienced neglect was also moderately feasible, according to participants' ratings (3.0). Tackling structural issues associated with neglect and providing long-term support by family support services and related services were rated with scores of less than 3 (on a 5-point scale), which means that these interventions were considered to be the least feasible by participants. These interventions were about reducing inequalities in income (2.8), reducing inequalities in access to employment (2.7), ensuring a good housing experience (2.8), and providing long-term support to families (2.8). Wider structural issues were identified in the literature as a risk factor for child neglect, and, considering how tackling these issues was rated as being the least feasible, these may create challenges in implementing a public health approach, as managing risk factors that give rise to a phenomenon is key to this approach.

6.3.1.2 Already available/in place

Interventions were also rated by the extent to which they are already available/in place in professionals' local authority/health board. For this dimension, a 3-point scale was used, as I wanted to offer polar points (not available versus widely available) along with a neutral option. I treated this as an ordinal scale and, therefore, did not calculate mean scores. Instead, the percentages of participants in each point of this dimension were calculated (Table 16).

Table 16: Percentages of participants

Intervention Type		**Interventions**	**Already available/in place**		
			1 (Not available/ not in place)	**2** (Available/ in place in some parts of the LA/HB)	**3** (Widely available)
Tackle structural inequalities	Population level	Reduce inequalities in income	54.5%	45.5%	-
		Reduce inequalities in access to employment	41.7%	54.2%	4.2%
		Ensure a good housing experience	39.1%	60.9%	-
Communi-cation and Information	Population level	National TV mass media campaign with links to internet resources	45.5%	54.5%	-
		Local campaign (radio, printed media)	52.2%	47.8%	-
		Websites that provide useful information for parents	-	58.3%	41.7%
		Apps that provide useful information for parents	30.4%	56.5%	13%
Parenting programmes (pre- and post-natal)	Population level	Universal programme for all parents	29.2%	50%	20.8%
	Individual level	Programme targeted at families most at risk with focus on early intervention	4.3%	82.6%	13%
Long-term support by family support services and related services	Individual level	Long term support for families	45%	50%	5%
		Long term support for children who have experienced neglect	40%	55%	5%
In-school support both for		Schools provide opportunities for sport and extra-curricular activities	4.2%	70.8%	25%

children and parents	Population level	Schools promote among children the understanding of healthy relationships, children’s needs and expectations of parents.	12.5%	66.7%	20.8%
	Individual level	Schools help children develop alternative attachments to family	12.5%	66.7%	20.8%
		Schools help to identify emerging difficulties	-	68.2%	31.8%
		Schools support parents where difficulties have been identified	4.8%	71.4%	23.8%

Although all percentages of participants for each point of this dimension are illustrated in the table, I have colour-coded in green the interventions which have a combined percentage (of point 1 and 2) of more than 70% of participants. Websites that provide useful information for parents (population level intervention), parenting programmes, both universal and targeted (population and individual level interventions), and all interventions related to in-school support for children and parents, were rated as being the most available according to participants.

The remainder of the interventions (colour-coded in red), including long-term support by family support services and related services (individual levels of interventions), tackling structural inequalities (population level interventions), and interventions regarding communication and providing information on a population level (national TV mass media campaign, local campaign, and apps that provide useful information for parents), were rated by more than 30% of participants as being not available. This is significant, as it may indicate areas for consideration in a public health approach to tackling child neglect.

No intervention was rated by more than 50% of participants as being widely available.

6.3.2 Comparing the results of all four dimensions

6.3.2.1 The top-most important interventions

The rating exercise was an effort to differentiate interventions in terms of what participants believed should be prioritised relating to a public health approach. However, as all interventions had a mean rating of 4 and above (apart from one intervention) in terms of importance, I could not prioritise interventions. Instead, I decided to explore the patterns across all dimensions of the top-most important interventions. To do this, I selected all interventions with mean score of 4.4 and above on the Importance dimension. Then, I set the following criteria: interventions with mean scores of effectiveness and feasibility at 3.8 and above. Lastly, I set to include the most important interventions, which also had the lowest feasibility scores.

Three groups of interventions were created: interventions that score highly on all dimensions (group 1), those that nearly meet the three highest criterion (group 2) and those that are important but judged to have low feasibility (group 3). These groups are presented in Table 17, in which I have also ticked the interventions that had a combined percentage of more than 70% of participants in the dimension of availability (as presented in sub-section 6.3.1.2).

Table 17: Mean scores for the top-most important (> 4.4) interventions compared to effectiveness and feasibility mean scores, and availability

	Interventions	**Mean scores**			**Available/ In place**
		Importance	Effective	Feasible	**(> 70% threshold)**
1	Schools help to identify emerging difficulties	4.8	4.1	4.3	✓
	Schools promote among children the understanding of healthy relationships, children's needs and expectations of parents	4.7	4.4	4.3	✓
2	Programme targeted at families most at risk with focus on early intervention	4.9	4.4	3.9	✓
	Universal programme for all parents	4.4	3.9	3.9	✓
	Schools provide opportunities for sport and extra-curricular activities	4.4	3.8	4.2	✓
3	Long-term support for families	4.7	4.2	2.8	-
	Reduce inequalities in access to employment	4.4	3.8	2.7	-
	Ensure a good housing experience	4.4	3.8	2.8	-

Schools help to identify emerging difficulties and promote among children the understanding of healthy relationships, and children's needs and the expectations of parents were two interventions rated as the most important, effective, and feasible in preventing child neglect. This indicated a direction towards answering the question of what a public health approach to child neglect may look like in practice. These interventions both had a combined score of more 70% in the dimension of being already available, meaning that they are already in place.

The other intervention that involved schools, namely, the school providing opportunities for sport and extra-curricular activities, was also rated as available and was considered to be among the most important and feasible intervention for tackling child neglect; however, it had a lower score for effectiveness (3.8). Therefore, although it was considered to be an important and feasible intervention, its effectiveness in preventing child neglect may be questioned.

There were two other interventions that nearly met the three highest criteria. These interventions were about parenting programmes. Providing universal programmes for all parents (at a population level) was rated as being most important and was very close (M=3.9) to being among the most effective and feasible. Targeting programmes at families who are most at risk (individual level) was rated as being the most important and effective in preventing, and almost feasible in preventing, child neglect. Both of these interventions had a combined score or more 70% in the dimension of being already available, meaning that they are already in place. This intervention could indicate a direction towards what a public health approach to child neglect may include. However, the effectiveness and feasibility of these may need further exploration.

The last group, after applying the criteria, included interventions related to tackling structural inequalities and also providing long-term support for families. Although all these interventions on a population level were rated as being most important and nearly rated as most effective, these were considered to be the least feasible in preventing child neglect, and many professionals mentioned that they are not currently available. Some of the key points made by parents and young people who contributed to this study, was the view that they need continuous support and that housing and access to employment are factors that affect their lives. As addressing structural issues is in accordance with public health principles, the low feasibility of these interventions may indicate an area of consideration in relation to preventing child neglect.

6.3.2.2 The top-most feasible interventions compared to effectiveness

Another interesting pattern emerged when looking at interventions that were rated as being most feasible to implement (Table 18). Interventions rated as most feasible interventions were about communication and information. Although these were judged to be both very feasible and important, they were judged to be only moderately effective, and this will be further discussed in the next Chapter (Seven).

Table 18: Mean score of the most effective interventions compared to their effectiveness

Intervention Type	**Interventions**	**Importance**	**Effective**	**Feasible**
		Mean scores		
Communication and Information	National TV mass media campaigns with links to internet resources	3.9	3	4.4
	Local campaigns (radio, printed media)	4	3	4.4
	Websites that provide useful information for parents	4	3.2	4.4
	Apps that provide useful information for parents	4.1	3.2	4.3

6.3.3 Unintended consequences of implementing a public health approach to tackle child neglect

As noted in the literature review, changing the approach and the implementation of new interventions always carries with it the possibility of negative unintended consequences. In Stages 1 and 2, two unintended consequences of implementing a public health approach to child neglect were identified. These were: an increased workload for services which provide support to families; and families' fear of stigmatisation. Participants in Stage 3 were asked to rate these consequences based on four dimensions:

- Importance to prevent (5-point interval scale, in which 1 = not important at all and 5 = very importance)
- Likelihood to happen (5-point interval scale, in which 5 = very likely and 1 = not at all likely)
- Impact on the prevention of child neglect (5-point interval scale, in which 1 = very low impact and 5 = very high impact)

- Already occurring (3-point ordinal scale, in which 1 = not at all, 2 = occurring to some extent and 3 = very common)

Table 19 presents the mean scores for the first three dimensions for the unintended consequences of implementing a public health approach to child neglect. It also summarises the percentages of participants who considered that unintended consequences are already happening in their local authority/health board, for each intervention.

Table 19: Mean scores of unintended consequences and percentages of participants considering the extent these already occur or not

Unintended consequences	**Importance to prevent**	**Likelihood to happen**	**Impact on the prevention of child neglect**	**Already occurring**[31]		
	Mean scores[32]			**1** (Not at all)	**2** (To some extent in my LA/HB[33])	**3** (Very common)
The increase of workload of services which provide support to families	4.4	3.6	4.3	4.2%	41.7%	54.2%
Families' fear of stigmatisation	4.6	3	4.1	4.3%	56.5%	39.1%

Participants in the study anticipated that one consequence of developing and implementing a public health approach to child neglect would be an increase in the workload of service providers. Preventing the increase of workload was rated as a high priority (M=4.4). However, the likelihood of this happening, when a public health approach is implemented, was moderate (M=3.6). According to the ratings provided by the participants, the workload of services will have an impact on the ability of services to prevent child neglect, and this had a 4.4 mean score. At the same time, the majority of participants (54.2%) answered that there is already increased workload in their local

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[31] Percentages of participants
[32] 1-5 interval scale
[33] Local authority/Health Board

authority/health board, whereas the remaining 41.7% answered that increased workload already exists to some extent their area (Table 19).

Another concern about developing services which focused on preventing child neglect was that this could stigmatise children and their families. Preventing stigmatisation was rated as being highly important (M=4.6). The impact on the efficacy of preventing neglect is above average (M=4), but only moderately likely to happen (M=3) through implementing a public health approach to child neglect. Of some concern, however, was that more than half of participants (56.5%) believed that families who required support were already being stigmatised to some extent in their local authority/health board, and a further 39.1% participants believed that this phenomenon was already very common (Table19).

6.4 Chapter summary

This chapter presented the findings of the analysis of data drawn from an online study and a focus group with professionals. As explored in the literature review, child neglect is a complex phenomenon, and a preventive approach should include a combination of universal services and targeted interventions for families and economic and government support. The findings from the analysis of the data gathered with professionals were in accordance with this. In summary, and in regard to what professionals consider to be potential components of a public health approach to child neglect, it was reported that a public health approach needs universal services, such as parenting courses at the pre-natal stage of pregnancy as well as in high school and early infancy. Sessions, available to all parents, can be delivered through education. Education can also provide population-level opportunities for sport and extra-curricular activities and promote the understanding of healthy relationships, children’s needs, and expectations of parents. This warrants further consideration, as participants mentioned that this may result in an increased workload for education staff. However, it appears from the ratings that support through school is already in place, which contradicts with the adding of these extra responsibilities to education staff.

Universal services are available to all parents and were noted by professionals as being less threatening for parents, and therefore parents are more likely to engage. An example of interventions to reach the wider population referred to by professionals was having an app of the red book, which enables parents to interact and engage and access advice. A potential intervention at population level was also the public awareness campaign reported by professionals. This may involve promoting messages in enhancing an understanding of child neglect (i.e., including what neglect is, ways in which neglect may happen, the consequences of neglect, particularly emotional neglect, and ways to prevent it), but also making it clear that asking for help does not mean that children are taken into care.

Reaching all parents is not the only pathway needed in a public health approach. It was reported that there is need to offer support in accordance with the individual needs of parents. These needs could involve consideration towards family composition but also the connections (or not) with extended family, towards the health of parents (both physical and mental), or learning disabilities, substance/alcohol abuse, and about parental experience of their childhood. Attention also needs to be paid towards the trauma of parents and treating this, as trauma can lead to poor mental health and substance misuse and can affect parents' ability to parent. Tailoring support could also involve overcoming language barriers by delivering sessions in different languages. Addressing the additional needs of parents could be a way to assess risk, intervene early and prevent child neglect, and was rated as being one of the most important interventions in preventing child neglect.

In addition to tailoring support to meet parents' needs, a public health approach needs to address the wider structural inequalities (i.e., income, employment, housing) that affect parents and contribute to the likelihood that a child may be neglected. These inequalities were considered by professionals and parents as being important in preventing child neglect. However, tackling these was rated as least feasible by professionals. As addressing structural issues is a principle of public health and important for both parents and professionals, further exploration is needed relating to why it is not feasible and how this might be changed.

Apart from the potential components of a public health approach, areas that need attention as part of the approach to tackling child neglect were reported. Professionals identified that the system needs to be re-organised to be preventative and not only reactive, as it is now. This re-organisation of the system will require time before benefits can be seen, and this was considered to be a barrier to implementing a public health approach. Further to this, despite reporting existing links with the policy in Scotland, preventing neglect requires state involvement to proceed with the required changes in policy. These changes need to be further explored, as professionals referred to links but did not specify which changes, nor did they identify in any depth how existing policy could be developed towards a public health approach to child neglect.

Supporting families also requires adequate funding. It was noted that limited resources (i.e., less staff, insecure funding) results in long waiting lists and people who use services becoming “disillusioned” and not asking for help. In addition to this, limited resources put pressure on professionals to create relationships with people who use services, and relationships work well in helping parents. Another area to consider was about improving long-term support to families. This was also underlined by the parents and young people who contributed to this study. However, it appeared from these ratings that long-term support was considered by professionals as being least feasible in implementing it. Ways of overcoming this need to be further explored, as the need for long-term support was a consistent message from all participants in this study.

Finally, when talking about preventing child neglect, the way in which parents are approached needs consideration. One key aspect regarding this was the stigma of asking for help, which was also mentioned by parents and young people. The fear that parents may be labelled as ‘bad’ parents, and judged when asking for help, discourages people from asking for help, and this could have implications for receiving help early. Professionals, when rating the unintended consequences of a public health approach, noted that families’ fear of stigmatisation already affects parents. Therefore, a public heath approach to child neglect needs to overcome this issue. Raising awareness that parenting is difficult could be a route to moving in that direction, according to the professionals who participated in this study.

Chapter Seven: Discussion

7.1 Chapter introduction

This study aimed to explore the potential different elements that could be part of a public health approach to tackling child neglect in Scotland, in order to consider how this approach might look in practice. This was accomplished through an exploration of the perspectives of three different groups: parents (in contact with support services), young people with care experience, and professionals working in the areas of child protection and/or public health. This chapter synthesises the findings presented in Chapters Four, Five and Six in order to address the aim of this study, and situates the findings in the context of the broader literature.

Below, I present the themes emerging from all participants with a focus on the different elements that could be part of a public health approach to tackle child neglect, as this allowed me to better explore the different perspectives, each of which I consider to be equally valuable. The contribution of this study and its limitations are also considered at the end of this chapter.

7.2 Key elements of a public health approach to tackling child neglect

The five key elements of a public health approach to child neglect based on the data in this study will be discussed. The first explores the understanding of child neglect, followed by a discussion about developing a public health approach within the Scottish context. The next element is about the potential components of a public health approach. The following elements presented here are about what has helped parents in receiving support as well as the qualities of individual focused provision of support. At this point, I would like to mention that both parents and professionals referred to elements that could contribute to interventions on both a population and individual level, whereas young people referred more to individual focused provision of support.

7.2.1 Understanding child neglect

A core finding is that language matters, in terms of how child neglect is defined and conceptualised. In order to have a (new) approach to preventing child neglect, it would be ideal if all those involved, across disciplines and sectors, and also families, had a shared understanding of what constitutes neglect. Without some level of shared understanding, parents may be neglectful without recognising this. In this case, as discussed later in this chapter, they may not be able to recognise their need for support. This then acts as barrier to asking for help and prevents services from intervening early before a crisis emerges. As noted earlier, it is crucial, when considering what constitutes neglect and the understanding of parents, to underline that some parents may try to manipulate professionals and draw the professionals' attention away from unsafe parenting in an effort to keep professionals outside of their family life. This makes it difficult for professionals to assess a situation and can prevent or even delay an understanding of the severity of neglect and to perform a proper assessment of risk for a child in a house (Brandon et al. 2008). This can be challenging when talking about a shared understanding of child neglect as part of a public health approach.

A common ground of what constitutes neglect can also be challenging because, as was clear from the data, professionals themselves face difficulties in defining and understanding child neglect. As noted in the literature review, defining child neglect is complicated, as it exists across different contexts and takes a wide range of forms (McSherry 2007) and includes, for instance, physical, medical, education and emotional neglect. Definitions may focus on parental responsibility, and often ignore wider structural factors affecting family life. In addition, there is no consensus on what the minimum levels of sufficient care for a child may be (Dubowitz 2013; McSherry 2007). Therefore, in developing a public health approach there is a need to overcome the complexity of defining child neglect, by contributing to developing a pathway, a model or a 'screening tool' which would help to identify and guide interventions regarding child neglect.

Further to this, the findings suggest that moving towards a public health approach to tackle child neglect requires changing the support system from being reactive to a adopting a preventative approach. Professionals pointed out that the system needs to be re-organised, focusing on the prevention of child neglect. Similarly, parents and young people also underlined the need for early intervention, but without mentioning the need for the re-organisation of systems. According to professionals, any re-organisation of systems will require time and funding, and this could be a barrier to implementing a public health approach. Harries and O'Donnell (2019) have identified that changing to a preventative approach will require funding, both for universal and statutory services.

Although in the long-term the demand for statutory service is expected to reduce, at the beginning there will be a need for extra investment. This is a point that needs consideration when developing a public health approach to child neglect, as it will require a commitment to funding the implementation of this change.

7.2.2 Developing a public health approach within the Scottish context

The findings from the data gathered with the professionals suggested that the existing context in Scotland in terms of legislation, policy and statutory guidance could be linked to a public health approach to child neglect. According to the literature review, the Scottish Government has already committed to improving the wellbeing of children and young people. GIRFEC (the children's policy in Scotland) aims to provide the right support, at the right time, from the right people (Scottish Government 2018b). In the Protecting Scotland's Children National Policy and Child Abuse Prevention Activity (Scottish Government 2018d), the Scottish Government recognises the value of prevention in protecting children and their wellbeing, and providing universal services appears to be key in supporting families, together with targeted support for children and young people in need, alongside statutory intervention for families when needed.

A universal-level approach, which has already been in place since August 2017, is the Scotland Baby Box scheme. It provides all families in Scotland with a range of essential items for the first six months after a child is born (Scottish Government 2021b). This scheme aims to contribute to tackling inequalities and is the first step in giving "the best possible start in life" to all new babies (Scottish Government 2021b, p. i). It is a practice which recognises and tries to reinforce the idea that society values and supports all children, which is an approach on a universal level. The universal provision of services needs to be central in protecting children in Scotland, as stated in the Protecting Scotland's Children National Policy and Child Abuse Prevention Activity (Scottish Government 2018d) and provided in accordance with The Promise (2020), based on the findings of the Independent Care Review. The Baby Box is a step forward in implementing the aspiration of providing the universal provision of support in Scotland, and must be considered when developing a public health approach to child neglect.

More recently, in September 2021, the new National Guidance for Child Protection in Scotland (Scottish Government 2021c) placed a stronger emphasis on structural issues (i.e., poverty, poor housing) that have an impact on family life, increase the risk of child neglect, and affect the wellbeing and safety of children and young people. In this study, financial difficulties were noted by parents as a challenge in their lives. Professionals did underline that the wider social factors that contribute to child neglect (such as poverty, poor housing, poor employment) need to be addressed in a public health approach. The emphasis of the National Guidance on the broader factors that contribute to child neglect can strengthen the focus on a public health approach to child neglect, because, as an approach, it must consider the multiple layers that increase the risk of a child being neglected and this is in accordance with the social model of health (Dahlgren and Whitehead 1991) that underpins this study. The findings of this study (discussed in Section 7.2.3) suggest that a component of such a public health approach is managing the wider social issues, and this will offer greater support to families and contribute to reducing incidences of harm to children.

The Scottish Government is committed to its children and young people (Scott and Daniel 2018a; 2018b; 2018c). However, as noted by one professional in this study, this does not necessarily result in change, and the high numbers of child neglect cases every year in Scotland do confirm that there are still families who are facing challenges, and this affects their ability to care (Scottish Government 2021a). The findings from the data gathered with the professionals illustrate that the current system is more reactive than preventive. Specifically, a practitioner with expertise in both public health and child protection noted that an approach to preventing neglect does not necessarily fit with existing practice in Scotland. Changing to a preventive approach would require massive Government commitment, which includes the provision of adequate funding to support the change. As revealed in the literature review, it is unrealistic to believe this change can go forward without the necessary funding being made available (Harries and O’Donnell 2019).

The findings from the parents’ focus group underlined that one key aspect in supporting families is to not withdraw services due to funding issues. According to the literature, how the system operates on a preventive level differs from the existing reactive system; for instance, the key is to intervene before a problem emerges or escalates, and the focus should be placed on promoting safe environments for all children and not only working with high-risk families in crisis (Lonne et al. 2020). However, services often lack the funding to focus on prevention, and parents and children with less severe issues are left without help, as resources only permit the capacity to work with high-risk families (Higgins et al., 2019b). Without adequate funding for intervening early, the system becomes overwhelmed in responding to harm (tertiary prevention). Having a clear understanding of the challenges (in this case, the funding) is crucial in developing a feasible public health approach to child neglect (Bross and Krugman 2020). Therefore, this study underlines the necessity of Government involvement in investing for this change, as part of a public health approach to child neglect.

7.2.3 Potential components of a public health approach to child neglect

Moving to what should be in a public health approach, it was found that this will need the involvement of universal services at population level (i.e., light touch pre- and post-natal parenting classes, health visiting, screening of children). This is consistent with what Sanders et al. (2017) described as a population approach to the prevention of child maltreatment, namely, an intervention designed for the whole population through universal services that can approach most families early, before issues escalate. This means that universal services, which are available to all parents and reach a wide number of families, need to be the focus of preventing not only neglect, but also all forms of child maltreatment (Bromfield et al. 2014; O'Donnell et al. 2008). Professionals noted that services that were available to all parents were less threatening for parents, increasing the likelihood that parents would engage with them. Parents also positively perceived the services provided by third sector and community centres in local areas. These are available to all parents and children, without any targeting (for instance, based on income criteria). Parents identified that all parents face challenges, and that these change as children grow. These cannot always be predicted, given (as one parent commented) that "children do not come with a manual". According to the literature, offering support to all parents through universal services promotes the message that parenting can be a tough job and that all parents may face challenges at some point (Daro 2000). Furthermore, The Promise (2020) highlights that there should be an "upscale" of universal family support services, which is a principle of a public health approach and aligns with the findings of this study.

One finding of this study was that a way to reach a broader segment of population is by using technology. For instance, professionals referred to the development of an app of the red book, which enables parents to interact and engage and access advice. Since 2020, an e-version of the red book has been available across the UK (eredbook 2021). The digitalised version of the hard copy of the red book stores information about immunisations, health reviews and screening tests and it can also provide age-appropriate guidance to help parents keep themselves and their babies healthy. According to the guidelines, in some areas, it can provide information about local services that could offer support to parents (eredbook 2021). Covid-19 has changed the way in which services are provided and has meant that numbers of face-to-face interactions have been reduced; this has implications for the health assessments of babies and children in particular. It is also challenging to keep hard-copy records of red books, preventing in this way the sharing of information with other professionals, such as via notes or review pages. This digitalised version could overcome the issue of sharing information between services and in relation to remote working. However, the red book relates only to babies and children aged up to five years. Any public health approach to neglect needs also must address the needs of older children and their parents because, as was highlighted by parents, there is need to provide support for the parents and children across all ages.

The use of technology, however, must take into account digital poverty. Many aspects of everyday life across the world have been digitalised and this has increased since the advent of the Covid-19 pandemic. However, even before the pandemic, in the UK, 11.9 million people (22%) did not have the basic digital skills needed for day-to-day life (Lloyds Bank 2019). Lacking digital skill, and/or having no access to IT due to finances, may create extra pressure for parents, who are not able to manage digital demands. In addition to this, the lack of Wi-Fi or access to suitable devices needs to be considered. These issues cause problems for children and parents, particularly those living in poverty. Even in households where there is access to the internet or devices, some parents do not have the necessary skills to help their children with learning platforms (Holmes and Burgess 2020). Therefore, although use of technology has proven advantages, digital poverty needs to be addressed to prevent excluding families and children from receiving support/services available online.

Another population-level intervention identified by professionals was public awareness campaigns. This may involve messages in enhancing understanding of child neglect (including what neglect is, ways that neglect may happen, the consequences of neglect, in particular, emotional neglect, and ways to prevent it), but also, importantly, highlighting that asking for help does not mean that children will become looked after away from home. Parents identified this as one of their fears when interacting with social services and this was a barrier to asking for help. However, what messages that an awareness campaign will communicate needs to be carefully selected and explained, and especially in the case of child neglect, where definitions are complex. As it was highlighted by the data provided by professionals, professionals appear to face difficulties in understanding and identifying different forms and consequences of child neglect. An understanding of child neglect by the “general population” could be challenging, and this raises questions about the efficacy of public awareness campaign in communicating messages that could contribute to preventing child neglect.

Interventions which focused on communication and information, although important in preventing child neglect, were rated as being only moderately effective in preventing child neglect when compared to individual interventions. This finding is interesting, as it contradicts one of the principles of a public health approach. Public health seeks to control the factors that contribute to a phenomenon at a population level. Doing this will decrease the prevalence of a phenomenon on population level. Focusing only on individual level interventions may block professionals from identifying the causes of incidents (Rose 2001). For instance, in preventing child neglect, only focusing on providing parenting programmes to parents, enhancing their skills and improving relationships with their children will fail to address challenges related to working and finance that add to the stress experienced by parents and may, as the literature review identified, affect parenting. However, this finding is consistent with other findings about public health behaviours, which highlight that providing information itself is not enough in changing the targeted behaviour. Other elements seem to interact (capability, opportunity, and motivation) and generate the behaviour; the capability–opportunity–motivation–behaviour (COM-B) model, as proposed by Michie et al. (2011), could provide a framework for developing behaviour change interventions focused on communication and information (i.e., national TV mass media campaigns with links to internet resources, local campaigns in printed media, websites, and applications with useful information for parents) that recognise the importance of all the relevant factors that influence behaviour, not just the provision of information.

When speaking about wider structural issues, the parents in this study identified working and financial difficulties as challenges in their lives. They referred, for example, to difficulties in covering the cost of children participating in activities, limited job opportunities for single parents, and poor mental health due to financial difficulties.

Professionals also noted that the wider social factors that contribute to child neglect need to be addressed in a public health approach, including poverty, poor housing, poor employment, unsafe environments, and limited opportunities to improve. However, when professionals were asked to rate the feasibility of tackling these issues, these were seen as being the least feasible of all intervention categories. Given that these wider societal factors increase the risk of child neglect (Akehurst 2015; Berger et al. 2017; Daniel et al. 2011; Stith et al. 2009) and managing factors that give rise to neglect is key principle of a public health approach (Walley 2010), implementation is challenging, particularly if tackling wider social inequalities is not perceived by professionals as being feasible. However, these wider social inequalities, which represent the general socioeconomic conditions in the social model of health (Dahlgren and Whitehead 1991) need to be addressed. The effects of structural issues that contribute to inequalities are well known and have been well researched (Marmot et al. 2020; Morris et al. 2019), and the Scottish Government has committed to "open up opportunity by delivering a strong, sustainable economy and supporting a fairer society" (Scottish Government 2020c, p. 127). The link, however, between poverty, which includes unemployment, low income, poor community resources and social support, inadequate or overcrowded housing and health inequalities, is complex. This may explain why the professionals who participated in this study perceived tackling inequalities as being the least feasible to put into practice as part of a public health approach to child neglect. In addition to this, Morris et al. (2018) reported that social workers participating in their study recognised and were more focused on the impact of poverty on families (i.e., poor housing) than on being engaged in addressing the root of the families' issues, namely wider systemic inequalities. A number of pressures, such as caseloads, timescales and budget cuts, were described by social workers as being barriers in attempting to engage with the roots of the issue (Morris et al. 2018).

In addition to a public health approach that engages with the factors that contribute to neglect, the findings also highlight the need to build on strengths and bolster resilience. While identifying that parenting was challenging, parents who contributed to this current study also referred to aspects of their lives that they enjoyed, including their relationships with their children. Parents identified that they enjoyed spending time with their children and that this enhances bonding. They also mentioned other aspects of their lives, such as learning new skills, working, having time for themselves, and these could help them to cope by enhancing their resilience. One parent recognised having children as a life-changing/live-saving experience. All those aspects, which are already known about, could be enhanced by universal services as part of a public health approach, and are likely to work as protective factors against child neglect. As explored in the literature review, family characteristics, such as emotional support between family members and warmth, enables families to face adversities and reduces the likelihood of neglect. Parents' self-esteem and internal locus of control can also be a factor that protects from the likelihood of child maltreatment, including neglect. In addition to this, positive relationships between parent and child seem to enhance parents' capacity to support their children and to have routines and stable rules (Seccombe 2002).

It emerged from the data that the education sector could contribute to implementing a public health approach to child neglect. Another component of the public health approach involved a contribution from the education sector. Support through schools was rated by professionals as being one of the most important interventions in preventing child neglect. Parents also mentioned that schools could be a source of support for them (i.e., informing parents about learning goals, offer advice); however, the comments by parents about the role of education were general and did not specify what kind of support was needed and by whom. However, it was noted by professionals that any involvement in public health by education was likely to result in an increase in workload, as teachers have already highlighted the high workload they experience. For example, a study involving teachers from Scotland and Wales reported that lack of time, together with other factors (i.e., poor collaboration, hierarchy, poor leadership), already tend to affect curriculum-making practices (Hizli Aklan and Priestley 2019).

The findings from the online survey and focus groups with professionals about the role of education were complex. In the online study, professionals rated support provided through schools (including interventions on both a population and an individual level) as being already in place. However, the professionals in the focus group confirmed that including members of the education sector in a public health approach to child neglect would add to the workload of staff, suggesting that it was not already fully in place. This may indicate that existing interventions provided within education may need to be delivered differently. For instance, schools already run sessions for parents, for example, open afternoons/evenings, parents' night, displays of work, or showing parents what children are being taught. These may contribute to enhancing parents' understanding of learning goals or contributing to their interaction with children, rated by professionals as already being in place. What was found to be adding to the workload of teachers could be including parenting and relationships as part of the mainstream curriculum.

My research focused on what parents and professionals from other sectors said, and the voices of education staff in the survey was limited. The existing literature identifies the important role that education staff (including class teachers, administrators, and support staff) play in recognising possible indicators of neglect. However, in this study, professionals focused on the step before this, namely, interacting with parents and children and providing opportunities to thrive in their lives and for intervening early before crises arise with interventions at population and individual level. Studies about school-based prevention programs have shown that they can enhance a child's knowledge, self-protection skills, and the likelihood of abuse disclosure (Topping and Barron, 2009; Walsh et al. 2018). However, these are often focused on sexual abuse, and little is known about the effects on other forms, including neglect (Gubbels et al. 2021; Stoltenborgh et al. 2015). Given all of the above, education has to play a role in a public health approach, not least because of the time that children spend in the education setting on a daily basis. However, their involvement and, in particular, their perspective of how they could contribute, while taking into account existing responsibilities, needs further exploration.

Universal services, however, cannot address the needs of all parents. It was found, based on the data, that there is need to offer support tailored to the needs of parents. Tackling child neglect will involve a blended approach of universal and targeted services which are part of a continuum of options available to families, based on their needs. This is consistent with the concept of proportionate universalism (Marmot 2010) and recognises that disadvantage is not a static state for vulnerable families (Higgins, 2015). The needs of more vulnerable families may be affected by family composition, connections (or not) with extended family, the health of parents (both physical and mental), learning disabilities, substance/alcohol abuse, and parental experiences during childhood.

Attention needs to be paid towards the trauma that parents may have experienced/are experiencing and treating this, as trauma can lead to poor mental health and substance misuse, thus affecting parenting capacity. Treating trauma was also suggested by the young people as being an important and challenging part of their lives. One young person stated that, although CAMHS services recognised her trauma, which she had experienced for a long period of time, the worker told her that that “it’ll be fine”. The likelihood of trauma is higher among care-experienced children and the link between trauma and mental health is well established (Barnardo’s Scotland 2020). In the Secure Care in Scotland: Young People’s Voices (CYCPS) report (2017), it was stated that more effort is needed to raise awareness and understanding of the links between early experiences and later mental health and wellbeing, and the support offered needs to cover the needs of children in relation to any mental health problems. The Promise (2020) underlined the need of providing accessible CAMHS support at the point it is needed, recognising the importance of mental health in children and young people. Young people also referred to the geographical area and commented that care leavers are often offered “the less desirable houses”. According to the literature, living in poor quality housing for extended periods of time has negative consequences for mental health (Pevalin et al. 2017) and according to the social model of health housing is one factor from socioeconomic conditions which affect health and wellbeing (Dahlgren and Whitehead 1991).

Addressing the additional needs of parents at risk could be a way to assess risk, intervene early and prevent child neglect, and was rated as one of the most important and effective interventions in preventing child neglect. According to the literature, the focus is to engage with families earlier than it is now and prevent crisis from emerging, which may require the involvement of statutory services. The provision of extra support to families at risk with targeted services also needs to be available, but in the long term, the demand for responding in extreme and high-risk situations, where children can be harmed, will be less likely due to early intervention (Herrenkohl et al. 2021).

Any public health approach needs to ensure that it reaches out to all children and parents, including those for whom English is not their first language. Tailoring support could also involve overcoming language barriers by delivering sessions in different languages.

7.2.4 Helping parents to receive support

Apart from the components of a public health approach, the findings propose strategies that have helped parents in their lives in regard to receiving support. The analysis of the data drawn from the parents highlights that, in order for parents to seek help, they need to recognise that there is a need. When there is no common understanding of what constitutes neglect, parents may be neglectful without recognising this. It has been found in the literature that the poor emotional wellbeing of parents may contribute to insensitivity regarding children’s physical and emotional needs, which increases the likelihood of child neglect (Akehurst 2015; Daniel et al. 2011).

Even when parents recognise that help is required, they need to know where to ask for help, and services need to be accessible. Burgess et al. (2012) highlight that parents may be unaware of the available support in their area and this could have an impact on help-seeking behaviour. As a result, they may not receive the support they need. The next stage in supporting parents, according to my study, was ensuring the accessibility of support. Access to support involves, on the one hand, physical access to the place where support is available, and, on the other hand, .

Existing research identified that potential barriers to accessing parenting programmes including practical issues (Corrigan et al. 2006). For instance, physical access to services and other facilities may be affected by the transport available in the area. Parents in this study, who lived in rural areas, identified that access to services (and also to other facilities) was difficult, not only because of limited buses and lack of accessible train stations, but also because of the cost of travel. This is significant as it limits the opportunities for parents to seek support and access services. Moreover, as one professional mentioned in the focus group, parents may be labelled as being neglectful for not attending a medical appointment, when their capacity to do so is hampered by the external factors affecting them. Parents with low incomes living in high-poverty neighbourhoods may face difficulties in accessing employment opportunities, affordable groceries and/or other amenities, which contributes to stress (Maguire-Jack and Font, 2017). In addition to this, according to a Significant Case Reviews (SCR) publication (Baker 2021), families living in rural areas and facing financial issues often face increased costs for food and transport, travel costs for appointments, and essentials such as clothes for growing children. For instance, it was noted that a child in a rural area was not attending nursery school, as parents could not afford the cost of nursery. As a result, the child missed important learning opportunities, as well as regular contact with adults and children outside the family. In this instance, the rural location and poverty of the family contributed to the child’s poor physical health being unobserved until starting school and thus limited the chances for early intervention.

Another challenge mentioned by a mother in my study, which limited access to facilities in her local community, was fear for the safety of children walking through particular areas. As a consequence, she avoided walking to a hub where there were activities for children. Thus, even when services are based locally, families might not feel able to use them. Therefore, a public health approach that aims to prevent child neglect needs to consider the range of barriers which may prevent access, in order to maximise the reach of services. Apart from practical issues, accessing parenting programmes may be difficult due to stigma and/or feelings of blame (Corrigan et al. 2006). This is consistent with the experiences of parents in my study, who reported that they felt judged by other people in society or that those providing the services judged them, and this was a barrier to approaching services and asking for help. It was also found that it is challenging for parents to ask for help, as they feel they have failed and are somehow "bad parents".

Professionals rated the stigma associated with needing support and/or using services as an unintended consequence of implementing a public health approach to neglect, and that, in their experience, it was already occurring. To overcome this barrier, parenting programmes, which provide support for parents and contribute to the prevention of neglect, should be considered as a normal part of parents' lives, as with ante-natal classes (Prinz 2016). Despite barriers to seeking help found both in this study and in the literature, the parents in my sample indicated that they advised other parents to seek help early before issues escalate.

Feeling judged appeared in the findings to also play a key role in young people's lives. Young people considered a non-judgemental approach to be an important quality of the support offered. One young person described an encounter during which she felt that a social worker had looked at her "with disgust" and experienced the social worker's demeanour as judgemental and damaging. Social work as a profession is supposed to engage with people in a way which is ethical, empowering, and which places the individual at the centre (British Association of Social Workers 2021), whereas the experience of this young person was nowhere close to that. A public heath approach to child neglect needs to promote stigma-free and non-judgemental ways of interacting with people and valuing the lived experience of child neglect could provide experience-based knowledge of what/when/how/who have helped them.

7.2.5 Qualities of individual focused provision of support

In addition to what might help parents to access support, the analysis of the data highlighted that all groups of participants referred to the need for individually focused provision of support and identified a number of important qualities, including: the stable provision of support; relationships do matter; and sense of control over life.

Parents and young people highlighted the needs for stable provision of support. The data from parents identified the need for additional funding for services to avoid their withdrawal due to a limited or non-existent budget, and the need for timely referral to services that could support families' specific needs. The young people referred to the need for continuous support in terms of mental health problems, and they described the transition from child/adolescent to adult mental health services as "shocking". They experienced long waiting lists, case notes not being passed on, and having to repeat their often-traumatic stories every time they were referred to a new service. From the professionals' perspective, it also appeared that families may need support at different stages of their lives, as circumstances and needs change. Although long-term support was rated by professionals as being most important and effective in preventing child neglect, it was considered to be the least feasible to implement. The data drawn from the professionals highlighted that limited funding for services (both currently and in the past) have an impact on the intensity and quality of the supported offered. This was described as a downward spiral in which services do not receive sufficient funding, which leads to less staff being available and increased waiting lists. According to the literature, services may lack the funding to intervene early to help families and children, with the result that parents and children, who could have been helped earlier through less intensive and less costly intervention, are left with limited help or even no help at all (Higgins et al. 2019b). Waiting lists can result in service users becoming "disillusioned" and not asking for help, which, as discussed earlier, is a barrier to early intervention. A public health approach focuses on early intervention and overcoming funding issues is a pre-requisite for successful implementation. How this funding gap might be addressed needs to be further explored.

The limited resources that are available may make it difficult for professionals, who are already under pressure, to find the time and space to develop relationships with people who use services, which are core to effective practice. The data drawn from parents also suggested that interactions between parents and professionals need to be based on trust, effective communication in ways that can be understood by parents, and empathy. Burgess et al. (2014) found that parents are more likely to change if they perceive that practitioners interact with them with empathy, intention to support and with clarity about what needs to change. It was also highlighted by professionals that having a “close relationship” with a family through regular contact enables practitioners to identify any difficulties as they occur and, therefore, intervene early.

Another theme that emerged was that short-term funding contributes to a high turnover in service staff, as those on short-term contracts seek posts that are more permanent. According to the professionals who contributed to this study, this further limits their ability to form long-term helping relationships. The same point was also noted by young people, who referred to the changes in staff in both mental health and social services. One young person said that she may have worked for months with the same social worker, but when the worker obtains a new job, they need to start again with a new worker who does not know “anything about them”. Starting with a new professional can be challenging in terms of developing a relationship and building trust, and thought needs to be given to the issue of high turnover of staff.

Another quality relating to the provision of support suggested by this study is the sense of control over life. One parent, referring specifically to social workers, suggested that they need to approach parents and communicate that they are there to help them, not to “tell them what to do”. According to the literature review, parents with experience of children’s social care and the family justice system may feel “done to” rather than supported, with professionals working alongside them (Care Crisis Review 2018). In addition to this, according to the findings of my study, when interacting with parents there is a need to use language which is understandable, otherwise there will be no communication, as parents will be unable to comprehend the context. At this point I would like to underline that the relationship between families and social work has a fundamental difference to the one between families and the third sector; families can choose to work with the third sector, but sometime families cannot choose to work with social work. This can completely change the dynamic and may have contributed to the negative comments made about social workers by the parents and young people.

Regarding relationships, it was highlighted by the findings from the young people that they considered that a service (provided by the third sector) was good when it helped them to keep in contact with their siblings. Jones and Henderson (2017) found that groups of siblings of looked after children from one family can be large, include different ages, and can also be spread across different locations (siblings may not be placed together);

this makes keeping contacts and supporting siblings challenging. The significance of relationships between brothers and sisters has also been identified in The Promise (2020) and in amendments to legislation in the Children (Scotland) Act 2020.

7.3 Limitations of the study

This study was informed by a literature review, and the data were drawn from different groups to consider multiple perspectives by using different methods of data collection, all of which could be referred to as strengths. However, the findings from this study also need to be considered within the context of its limitations.

Although I planned to conduct interviews and focus groups with more young people with care experience, only one focus group with five participants took place. This may be a potential limitation, as participants were only drawn from one area in Scotland. Experiences of the system in other areas may differ. Further to this, the focus groups with parents were shorter and less detailed than were the individual interviews with parents. Although I took great care to ensure that parents were comfortable to talk, it is possible the group setting may have restricted some topics of discussion or allowed more focus to be placed on others.

Another limitation refers to bias in the selection of the samples. This study had a convenience sample from each group (parents, young people and professionals) and was not representative of the population; they were a group of people who were interested in participating. Further to this, the parents were all in contact with Action for Children, and this is a potential limitation. Parents in contact with other services of third sector or statutory services may have different perspectives, which are not reflected. Regarding young people, the reliance on gatekeepers in communicating the study and in selecting participants may also be a potential limitation. However, this reliance was inevitable, given the difficulty of recruiting participants directly.

Furthermore, I wanted to gain multiple perspectives in meeting the aim of this study. Only two fathers took part in the parents' group, and their contribution is much appreciated. However, this meant that the majority of participants in interviews and focus groups were mothers. In addition to this, as far as I am aware, no parents or young people with special needs participated, and, given the research which links neglect and disability, this would have been valuable.

As noted in Chapter Three, I decided not to use the term ‘neglect’ in interviews and focus groups with parents and young people, as this may imply blame for parents, which may make them feel uncomfortable, and I did not want to shame parents or distress young people. This could be a limitation in relation to the data gathered with parents and young people, as some of the data were not directly linked to child neglect by the participants. However, the data were related instead to challenges in their lives, which appears, from the literature, to contribute to the likelihood of child neglect. Tackling these factors is a key aspect of promoting a public health approach, which was the focus of this study.

Finally, although it was not an aspect that could have been predicted, the data were collected before the pandemic. The special circumstances that have arisen since early 2020 will have affected parents and young people and their perspectives may now be different to the ones presented here. However, this does not mean that the findings are not valid, or that they do not make a valuable contribution. Instead, it is expected that the financial pressures and stress experienced by parents due to the pandemic, as well as the limited physical access to services and support as consequence of the policies designed to control virus spread, will result in children being at risk, not only of neglect, but also of other forms of child abuse, more so than in the pre-pandemic area. Therefore, the findings of this study remain relevant to the area of child protection.

7.4 Conclusion and contributions to the knowledge base

This study suggests that tackling child neglect requires the changing of practice in supporting parents. It is not only about commitment to preventing child neglect, but also about re-organising the systems which support families and children, as mentioned earlier, from reacting to being preventative. It was found that this approach will require clarity on three levels: the definition of child neglect; the role of each involved part in protecting children and young people; and in relation to the messages to be communicated as part of the approach.

A public health approach to tackling child neglect needs to be characterised by engaging and supporting families to thrive in their lives in a non-stigmatising way. It is suggested that this approach would involve a combination of universal and targeted services, and that a continuum of support is made available to all parent based on their needs. The needs of families are dynamic, and they change as children grow and as life circumstances change. As a result, the needs of the parents and the support required from services over time will change. The offers of support must be stable and in accordance with the need. Further to this, the approach needs to recognise that asking and receiving help is part of normal life, not something to be judged on.

This approach could lead to early interventions and prevention by promoting services at population level and this is based on the principle of public health of reaching all the population. At the same time, some families will have extra needs that cannot be covered by universal services. In those cases, the approach needs to make sure that additional targeted support is accessible: that the population is aware of the support available, and that people know when to ask for help without being afraid and/or feeling guilty. This study suggests that the approach needs to consider the way in which individual support is delivered to children and parents, including recognising the importance of relationships between professionals and families, the stable provision of support, and the sense of control over their lives. In addition to this, a public health approach to child neglect calls for inequalities that affect parenting to be addressed. This is not an addition, but a core aspect of the approach. The focus of a public health approach is moving upstream and closer to the source of a problem, and tackling the risk factors and inequalities is a crucial factor that affects family life in Scotland.

As was mentioned earlier in this thesis, my aim was to explore the different elements that can contribute to tackling child neglect in Scotland as part of a public health approach and to make a contribution to the knowledge base for practice. It is suggested that the following areas need to be considered:

- Developing a consensus about what constitutes child neglect and how that is communicated to parents/professionals/population.
- The role of education professionals and their perspectives on how they could contribute to a public health approach to child neglect.
- The re-organisation of the system to focus on the prevention of child neglect, instead of being reactive.
- Overcoming stigma experienced by families and stereotypes in society in relation to needing support.

- Linking existing efforts to tackle inequalities with the public health approach to child neglect.
- Achieving the above requires significant funding, and the Scottish Government has a crucial role to play in that direction.

Overall, the study has confirmed, as in other studies, that a public health approach may be promising in tackling child neglect. The key characteristics of a public health approach seem to be early intervention, including upstream and structural intervention, and one that involves both population-based interventions for the whole population and individual/targeted services (proportionate universalism) for those with additional needs. Changes are required at different levels – societal, policy, organisational and individual professional, and it is suggested that further research is needed in developing the approach.

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Appendices

Appendix A - Ethical approval

UNIVERSITY of
STIRLING

22 February 2018

General University Ethics Panel (GUEP)
University of Stirling
Stirling
FK9 4LA
Scotland UK

E: GUEP@stir.ac.uk

Aikaterini Kyriakou
Faculty of Social Sciences
University of Stirling

Aikaterini.kyriakou1@stir.ac.uk

Date Aikaterini

Re: Tackling child neglect: developing public health solutions in Scotland – GUEP 315

Thank you for making the requested revisions to your submission of the above to the General University Ethics Panel. I am pleased to confirm that your application now has ethical approval.

However, please address the following points raised by the GUEP panel and submit amended documents so that your file can be updated:

1. the applicant's signature should not already be embedded in the Participant Consent Form
2. The version date on information and consent sheets are wrong and require updating.

Please note that should any of your proposal change, a further submission (amendment) to GUEP will be necessary.

Please ensure that your research complies with the University of Stirling policy on storage of research data http://www.stir.ac.uk/is/researchers/data/afteryourresearch/

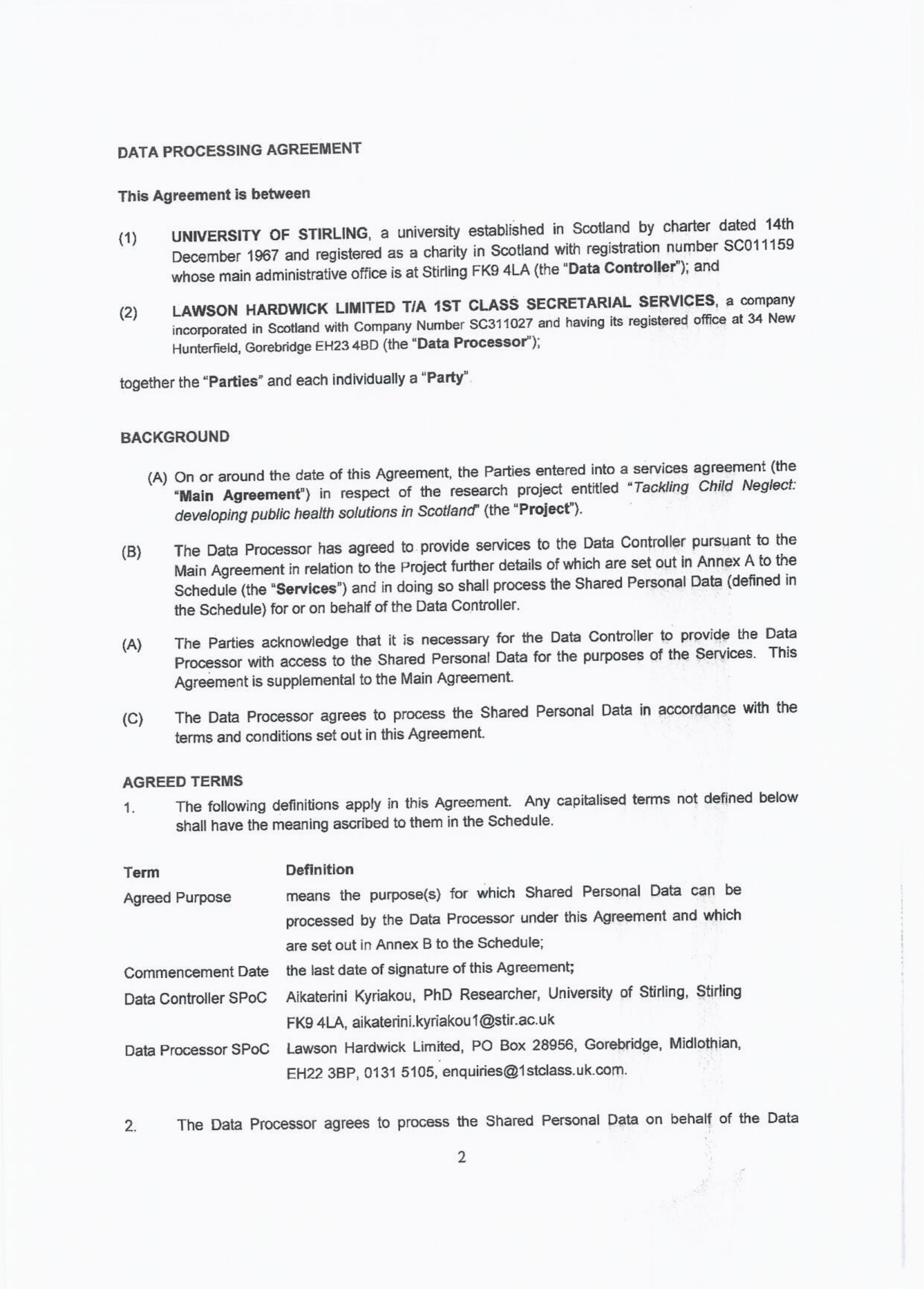
If you have any further queries, please do not hesitate to contact the Committee by email to guep@stir.ac.uk.

Good luck with your research.

Yours sincerely,

p.p. On behalf of GUEP
Professor Helen Cheyne
Deputy Chair of GUEP

Appendix B - Data processing agreement between 1st Class Secretarial Services and the University of Stirling



DATA PROCESSING AGREEMENT

This Agreement is between

(1) **UNIVERSITY OF STIRLING**, a university established in Scotland by charter dated 14th December 1967 and registered as a charity in Scotland with registration number SC011159 whose main administrative office is at Stirling FK9 4LA (the "**Data Controller**"); and

(2) **LAWSON HARDWICK LIMITED T/A 1ST CLASS SECRETARIAL SERVICES**, a company incorporated in Scotland with Company Number SC311027 and having its registered office at 34 New Hunterfield, Gorebridge EH23 4BD (the "**Data Processor**");

together the "**Parties**" and each individually a "**Party**".

BACKGROUND

(A) On or around the date of this Agreement, the Parties entered into a services agreement (the "**Main Agreement**") in respect of the research project entitled "*Tackling Child Neglect: developing public health solutions in Scotland*" (the "**Project**").

(B) The Data Processor has agreed to provide services to the Data Controller pursuant to the Main Agreement in relation to the Project further details of which are set out in Annex A to the Schedule (the "**Services**") and in doing so shall process the Shared Personal Data (defined in the Schedule) for or on behalf of the Data Controller.

(A) The Parties acknowledge that it is necessary for the Data Controller to provide the Data Processor with access to the Shared Personal Data for the purposes of the Services. This Agreement is supplemental to the Main Agreement.

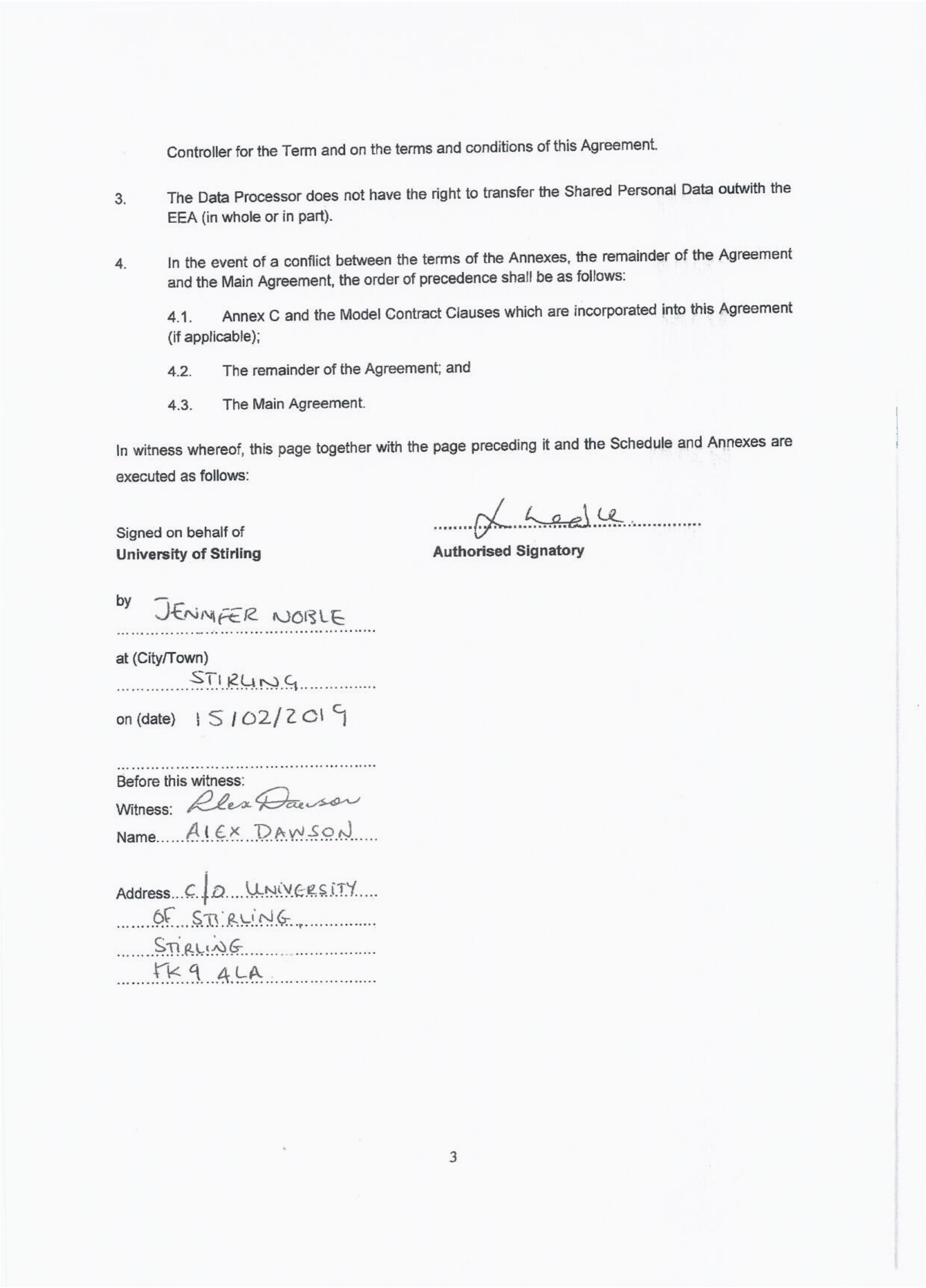
(C) The Data Processor agrees to process the Shared Personal Data in accordance with the terms and conditions set out in this Agreement.

AGREED TERMS

1. The following definitions apply in this Agreement. Any capitalised terms not defined below shall have the meaning ascribed to them in the Schedule.

Term	**Definition**
Agreed Purpose	means the purpose(s) for which Shared Personal Data can be processed by the Data Processor under this Agreement and which are set out in Annex B to the Schedule;
Commencement Date	the last date of signature of this Agreement;
Data Controller SPoC	Aikaterini Kyriakou, PhD Researcher, University of Stirling, Stirling FK9 4LA, aikaterini.kyriakou1@stir.ac.uk
Data Processor SPoC	Lawson Hardwick Limited, PO Box 28956, Gorebridge, Midlothian, EH22 3BP, 0131 5105, enquiries@1stclass.uk.com.

2. The Data Processor agrees to process the Shared Personal Data on behalf of the Data



Controller for the Term and on the terms and conditions of this Agreement.

3. The Data Processor does not have the right to transfer the Shared Personal Data outwith the EEA (in whole or in part).

4. In the event of a conflict between the terms of the Annexes, the remainder of the Agreement and the Main Agreement, the order of precedence shall be as follows:

    4.1. Annex C and the Model Contract Clauses which are incorporated into this Agreement (if applicable);

    4.2. The remainder of the Agreement; and

    4.3. The Main Agreement.

In witness whereof, this page together with the page preceding it and the Schedule and Annexes are executed as follows:

Signed on behalf of
University of Stirling

Authorised Signatory

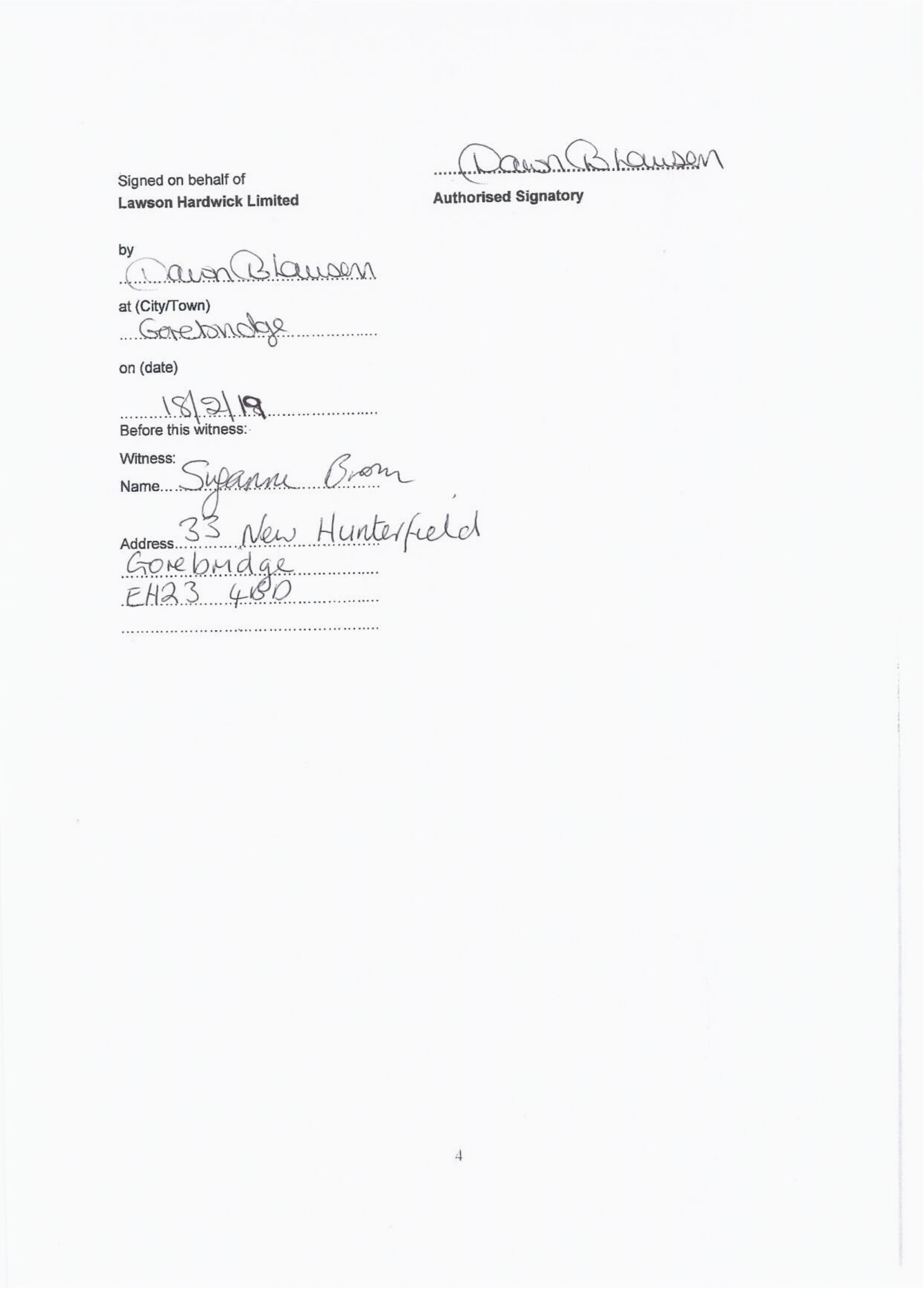
by JENNIFER NOBLE

at (City/Town) STIRLING

on (date) 15/02/2019

Before this witness:
Witness: Alex Dawson
Name ALEX DAWSON

Address C/O UNIVERSITY
OF STIRLING
STIRLING
FK9 4LA



Signed on behalf of
Lawson Hardwick Limited

Dawn B Lawson
Authorised Signatory

by
Dawn B Lawson

at (City/Town)
Gorebridge

on (date)
18/2/19

Before this witness:

Witness:
Name Suzanne Brown

Address 33 New Hunterfield
Gorebridge
EH23 4BD

4

Appendix C - Dissemination of findings in conferences

Title	Date
Second academic year	
ISPCAN 15th European Regional Conference (poster presentation)	1-4 October, 2017
Scottish Leadership Team Meeting (Action for Children Scotland) (oral presentation)	28 November 2017
Meeting with Eleanor Briggs (Action for Children England) and Department of Education (England) (oral presentation)	4 December 2017
Faculty of Social Sciences Doctoral Conference (oral presentation)	4 May 2018
7th International Congress on Interpersonal Acceptance and Rejection ISIPAR (oral presentation)	15-18 May 2018
3rd academic year	
ISPCAN International Congress on Child Abuse and Neglect, Prague (poster presentation)	1-5 September 2018
Faculty of Public Health Annual Conference (oral presentation)	November 2018
Australian Centre for Chid Protection (ACCP), University of South Australia, Adelaide (6 weeks placement): 2 presentation as part of the placement: “Tackling child neglect: developing public health solutions in Scotland” “A research project on the prevention of child neglect in Scotland or a PhD on the move”	February-March 2019
Children and Young People's Mental Health and Wellbeing: A three day conference (poster presentation)	September 2019

Appendix D - Information sheet (parents)

Centre for Child Wellbeing and Protection

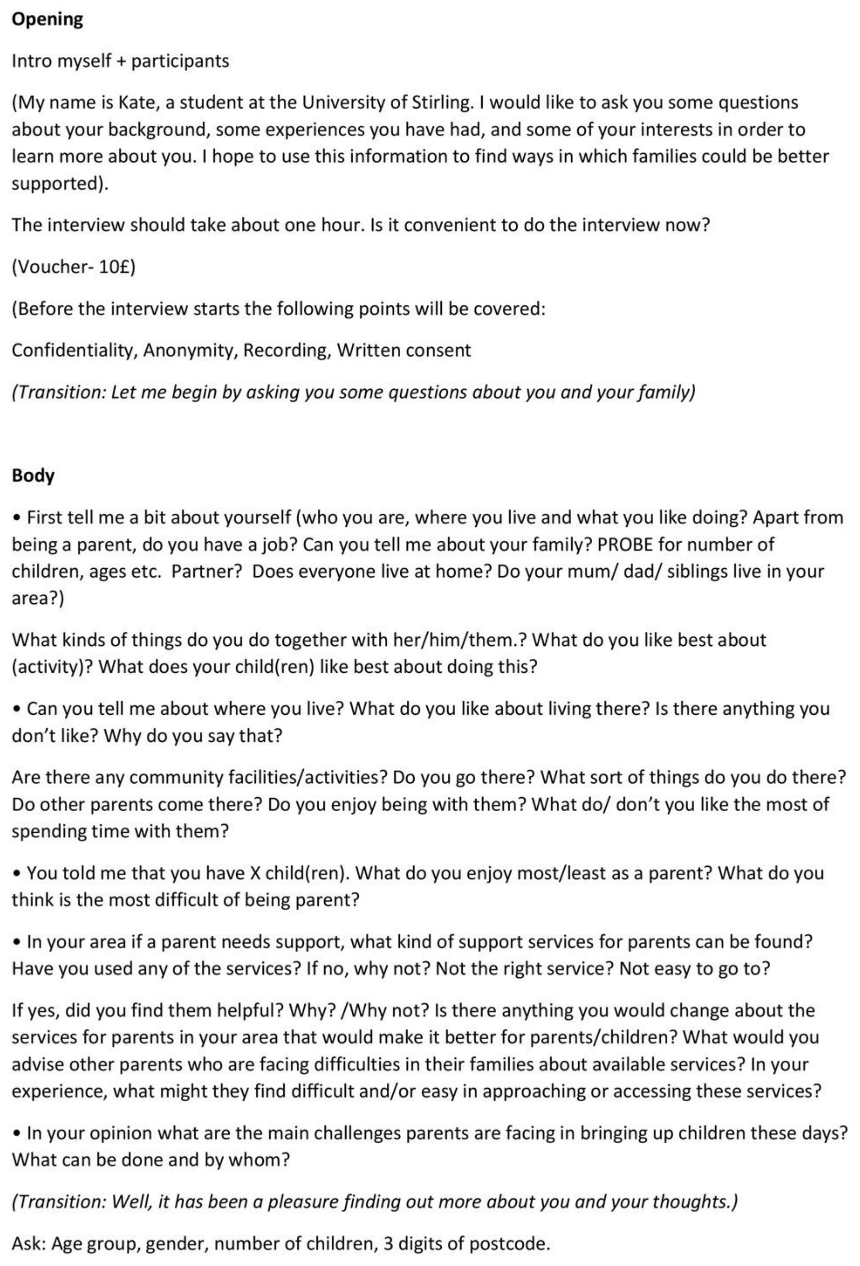
"Tackling the challenges facing families in Scotland today"

Some information about the project

What is this study?	▪ This study is taking place as part of a PhD project at the University of Stirling looking at the challenges facing parents today. ▪ As part of this study, I want to talk to parents about what can be done to better support parents in their role in the family, particularly when times are tough, and what children's and families' needs are. ▪ You have been invited to take part because your voice and your role as parent will contribute significantly to this study.
Who can take part?	Parents with children aged 0-5 or 10-15 years old who are using the services of Action for Children.
What will happen if I agree to participate?	You will be given this information sheet to keep and be asked to sign a consent form. The researcher (Kate) will ask you your views about supporting families today. The discussion will take approximately 1 hour and tea/coffee and biscuits will be provided. There will not be any follow up visits.
Do I have to take part?	No, you do not have to take part if you don't want to. If you do decide to take part, you can withdraw from the study at any time without needing to explain why. If you decide not to take part or withdraw from the study Action for Children will continue to provide you with the best possible care and services.
When and where will the study take place?	Interviews will take place between May and June 2018 in a private room in Action for Children at a time that suits you.
Are there any potential risks in taking part?	We have designed our questions to avoid parents becoming embarrassed or uncomfortable. However, if do feel upset you can ask for a break at any time or we can stop the interview. You can also say if you don't want to answer some of the questions. A practitioner from Action for Children will be also available to offer further support if you need it. But they won't be in the room during our discussion. You can withdraw from the study without having to provide a reason for this and, if you wish, any discussion we have had before that point will be deleted.

	You can also ask for your interview to be withdrawn from the study a week after the interview.
Are there any benefits in taking part?	It is hoped that by sharing your views with the research team, you will help us understand more fully the needs of children and families, and what can be done to support parents in their role in the family. However, participation in the research itself will not directly benefit you personally. However, we will offer a £10 voucher at the beginning of interview as a thank you for your participation in the study.
Need more information?	If you would like to discuss the research with someone, if you have any questions about the research or any queries you wish to raise, please feel free to contact: - *Kate Kyriakou*, (Researcher, Faculty of Health Sciences and Sports) at aikaterini.kyriakou1@stir.ac.uk / 01786467735 - *Sally Haw* (Supervisor, Faculty of Health Sciences and Sports) at s.j.haw@stir.ac.uk / 01786 466381 - *Alison Bowes* (Dean, Faculty of Social Sciences) at a.m.bowes@stir.ac.uk / 01786 467731
What happens to the answers I provide?	We value your privacy. Your answers to our questions will be kept anonymous, and anything you say will not be linked to your name in any way. The interview data will be stored in a password-protected file and only the researcher will have access. All information will be treated in confidence, unless a situation arises where concerns the safety of participants or of others. If information arises in interviews that indicates that participants or others are at risk, that information will be passed on to appropriate safeguarding officers.
Recorded media	The researcher will audio record the discussion by using a digital voice recorder. The recorded discussion will then be written into words so the data can be explored by the researcher. Audio recordings will then be destroyed.
Will the research be published?	The data may be used in official reports, scholarly publication, and other scholarly dissemination and presented at conferences, but identifying information (like names and places) will not be included in any report/publication. The anonymised interview data may also be used for training for students and professionals. You will also be able to see the results of this project (if you wish) in a booklet, which will be available to you by Action for Children.
Some extra information?	Funding: The University of Stirling and the charity Action for Children are funding this research. Review: This project has been approved through the University of Stirling General University Ethics Panel. Ethics Approval Reference GUEP315

Appendix E - Schedule of semi-structure interviews (parents)



Opening

Intro myself + participants

(My name is Kate, a student at the University of Stirling. I would like to ask you some questions about your background, some experiences you have had, and some of your interests in order to learn more about you. I hope to use this information to find ways in which families could be better supported).

The interview should take about one hour. Is it convenient to do the interview now?

(Voucher- 10£)

(Before the interview starts the following points will be covered:

Confidentiality, Anonymity, Recording, Written consent

(Transition: Let me begin by asking you some questions about you and your family)

Body

• First tell me a bit about yourself (who you are, where you live and what you like doing? Apart from being a parent, do you have a job? Can you tell me about your family? PROBE for number of children, ages etc. Partner? Does everyone live at home? Do your mum/ dad/ siblings live in your area?)

What kinds of things do you do together with her/him/them.? What do you like best about (activity)? What does your child(ren) like best about doing this?

• Can you tell me about where you live? What do you like about living there? Is there anything you don't like? Why do you say that?

Are there any community facilities/activities? Do you go there? What sort of things do you do there? Do other parents come there? Do you enjoy being with them? What do/ don't you like the most of spending time with them?

• You told me that you have X child(ren). What do you enjoy most/least as a parent? What do you think is the most difficult of being parent?

• In your area if a parent needs support, what kind of support services for parents can be found? Have you used any of the services? If no, why not? Not the right service? Not easy to go to?

If yes, did you find them helpful? Why? /Why not? Is there anything you would change about the services for parents in your area that would make it better for parents/children? What would you advise other parents who are facing difficulties in their families about available services? In your experience, what might they find difficult and/or easy in approaching or accessing these services?

• In your opinion what are the main challenges parents are facing in bringing up children these days? What can be done and by whom?

(Transition: Well, it has been a pleasure finding out more about you and your thoughts.)

Ask: Age group, gender, number of children, 3 digits of postcode.

Closing

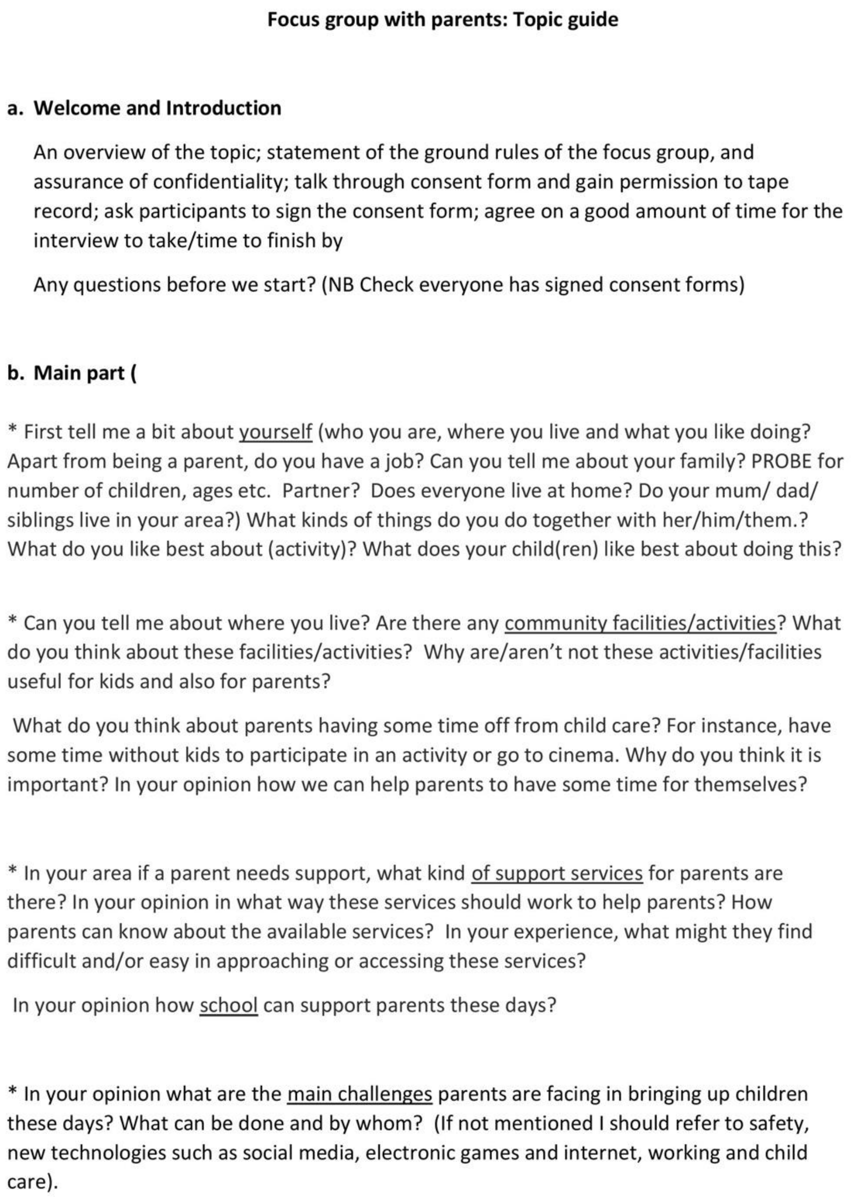
(Summarize) …

I appreciate the time you took for this interview. Is there anything else you think would be helpful for me to know so that I can have a better understanding on how parents can be supported?

I should have all the information I need. Thanks again.

Debriefing: Outline how they can keep in touch with the outcomes of the research. Provide them with debriefing form (contact names/numbers).

Appendix F - Topic guide of focus groups (parents)



Focus group with parents: Topic guide

a. Welcome and Introduction

An overview of the topic; statement of the ground rules of the focus group, and assurance of confidentiality; talk through consent form and gain permission to tape record; ask participants to sign the consent form; agree on a good amount of time for the interview to take/time to finish by

Any questions before we start? (NB Check everyone has signed consent forms)

b. Main part (

* First tell me a bit about yourself (who you are, where you live and what you like doing? Apart from being a parent, do you have a job? Can you tell me about your family? PROBE for number of children, ages etc. Partner? Does everyone live at home? Do your mum/ dad/ siblings live in your area?) What kinds of things do you do together with her/him/them.? What do you like best about (activity)? What does your child(ren) like best about doing this?

* Can you tell me about where you live? Are there any community facilities/activities? What do you think about these facilities/activities? Why are/aren't not these activities/facilities useful for kids and also for parents?

What do you think about parents having some time off from child care? For instance, have some time without kids to participate in an activity or go to cinema. Why do you think it is important? In your opinion how we can help parents to have some time for themselves?

* In your area if a parent needs support, what kind of support services for parents are there? In your opinion in what way these services should work to help parents? How parents can know about the available services? In your experience, what might they find difficult and/or easy in approaching or accessing these services?

In your opinion how school can support parents these days?

* In your opinion what are the main challenges parents are facing in bringing up children these days? What can be done and by whom? (If not mentioned I should refer to safety, new technologies such as social media, electronic games and internet, working and child care).

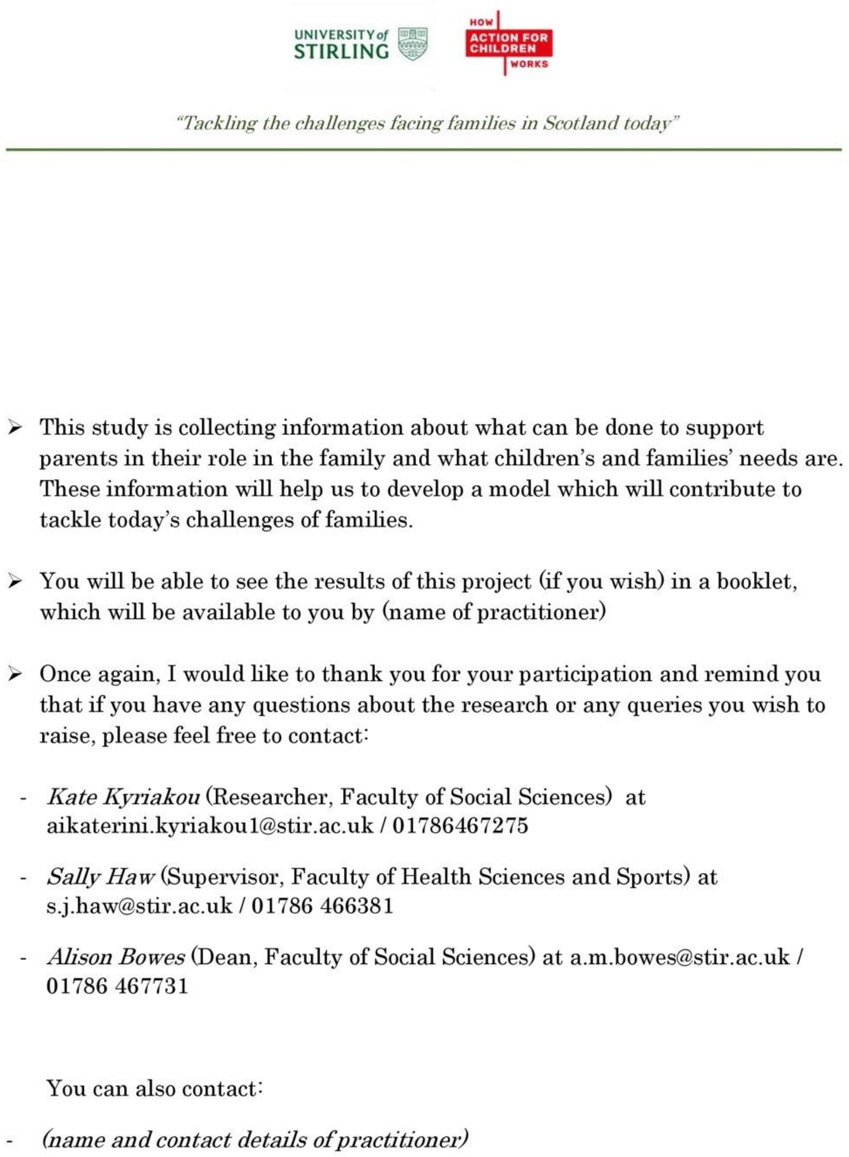
c. Conclusion – about 10 minutes
Is there anything important to you we haven't mentioned?

Obtain background information (gender, age etc.).

Thank participants for their time

Debriefing: Outline how they can keep in touch with the outcomes of the research.
Provide them with debriefing form (contact names/numbers).

Appendix G - Debriefing form (parents)



UNIVERSITY of STIRLING

HOW ACTION FOR CHILDREN WORKS

"Tackling the challenges facing families in Scotland today"

- This study is collecting information about what can be done to support parents in their role in the family and what children's and families' needs are. These information will help us to develop a model which will contribute to tackle today's challenges of families.

- You will be able to see the results of this project (if you wish) in a booklet, which will be available to you by (name of practitioner)

- Once again, I would like to thank you for your participation and remind you that if you have any questions about the research or any queries you wish to raise, please feel free to contact:

  - *Kate Kyriakou* (Researcher, Faculty of Social Sciences) at aikaterini.kyriakou1@stir.ac.uk / 01786467275
  - *Sally Haw* (Supervisor, Faculty of Health Sciences and Sports) at s.j.haw@stir.ac.uk / 01786 466381
  - *Alison Bowes* (Dean, Faculty of Social Sciences) at a.m.bowes@stir.ac.uk / 01786 467731

You can also contact:

- *(name and contact details of practitioner)*

Appendix H - Information sheet (young people)

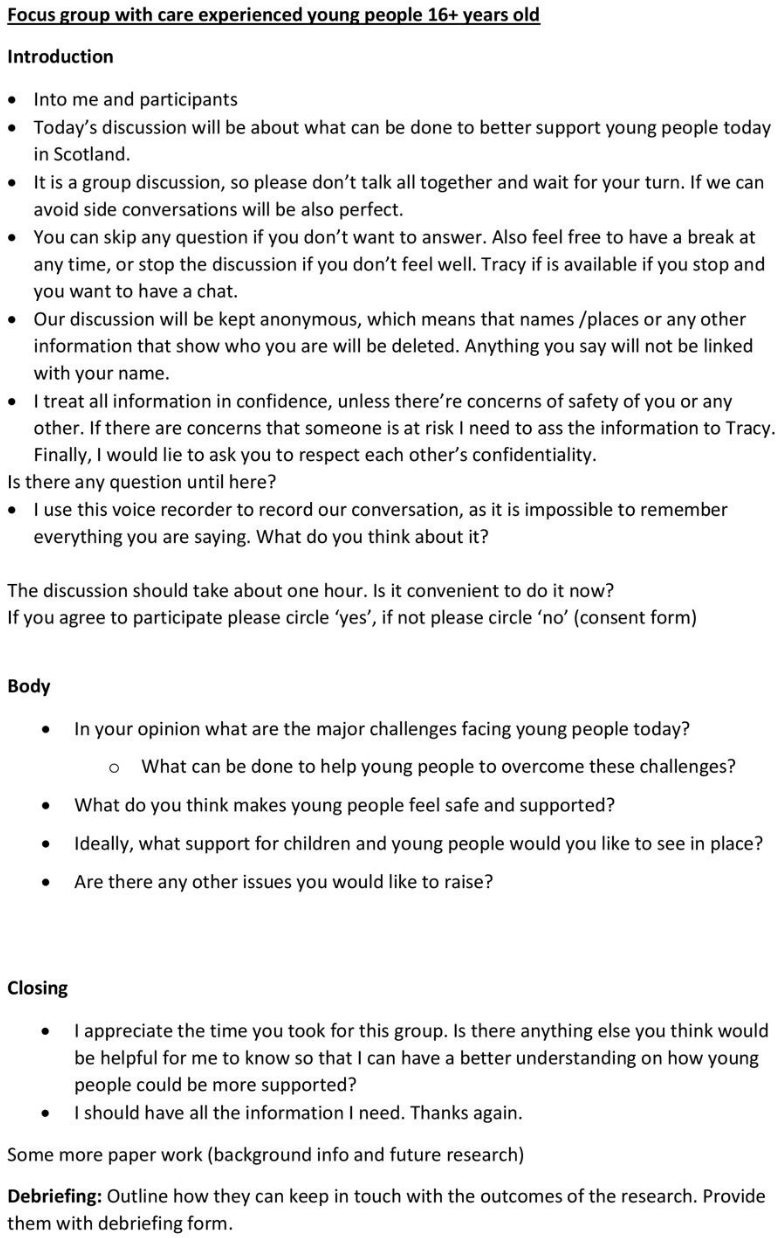
"Tackling the challenges facing families in Scotland today"

Some information about the project

What is this study?	▪ This study is taking place as part of a PhD project at the University of Stirling looking at what can work to tackling the challenges facing children, young people and families today in Scotland. ▪ As part of this study, I want to talk to young people about what works and why, in term of supporting young people in their everyday life, particularly when times are tough. ▪ You have been invited to take part because your voice and your experience will contribute significantly to this study.
Who can take part?	Young people 16+ years old in contact with the care system in Scotland.
What will happen if I agree to participate?	You will be given this information sheet to keep and be asked to sign a consent form. The researcher (Kate) will ask you your views about what works and why, in term of supporting young people in their everyday life. The discussion will take approximately 1 hour and approximately 7 people will take part. Tea/coffee and biscuits will be provided. There will not be any follow up visits.
Do I have to take part?	No, you don't have to take part, if you don't want to. If you do decide to take part, you can withdraw from the study at any time without needing to explain why. If you decide not to take part or withdraw from the study, the organisation will continue to provide you with the best possible care and services.
When and where will the study take place?	Group discussion will take place between April and May 2019 in a private room of the community centre at a time that suits you.
Are there any potential risks in taking part?	We have designed our questions to avoid people becoming embarrassed or uncomfortable. However, if do feel upset you can ask for a break at any time or we can stop the discussion. You can also say if you don't want to answer some of the questions. A practitioner from the Community Centre will be also available to offer further support if you need it. But she/he won't be in the room during our discussion. You can withdraw from the study without having to provide a reason for this and, if you wish, any discussion we have had before that point will be deleted.
Are there any	It is hoped that by sharing your views with Kate, you will help her

benefits in taking part?	understand more fully what works and how to tackling the challenges facing young people in their everyday life. Participation in the research itself will not directly benefit you personally. However, we will offer a £10 voucher at the beginning of the discussion as a thank you for your participation in the study.
Need more information?	If you would like to discuss the research with someone, if you have any questions about the research or any queries you wish to raise, please feel free to contact: - *Kate Kyriakou*, (Researcher, Faculty of Health Sciences and Sports) at aikaterini.kyriakou1@stir.ac.uk / 01786467275 - *Sally Haw* (Supervisor, Faculty of Health Sciences and Sports) at s.j.haw@stir.ac.uk / 01786 466381 - *Alison Bowes* (Dean, Faculty of Social Sciences) at a.m.bowes@stir.ac.uk / 01786 467731
What happens to the answers I provide?	We value your privacy. Your answers to the questions will be kept anonymous, and anything you say will not be linked to your name in any way. Our discussion will be stored in a password-protected file and only the researcher (Kate) will have access. All information will be treated in confidence, unless a situation arises where concerns the safety of participants or of others. If information arises in discussion that indicates that participants or others are at risk, that information will be passed on to appropriate safeguarding officers.
Recorded media	The researcher will audio record the discussion by using a digital voice recorder. The recorded discussion will then be written into words so the data can be explored by the researcher. Audio recordings will then be destroyed.
Will the research be published?	The data may be used in official reports, scholarly publication, and other scholarly dissemination and presented at conferences, but identifying information (like names and places) will not be included in any report/publication. The anonymised data from our discussion may also be used for training for students and professionals. You will also be able to see the results of this project (if you wish) in a booklet, which will be available to you.
Some extra information?	Funding: The University of Stirling and the charity Action for Children are funding this research. Review: This project has been approved through the University of Stirling General University Ethics Panel. Ethics Approval Reference GUEP315

Appendix I - Topic guide of focus group (young people)



Focus group with care experienced young people 16+ years old

Introduction

- Into me and participants
- Today's discussion will be about what can be done to better support young people today in Scotland.
- It is a group discussion, so please don't talk all together and wait for your turn. If we can avoid side conversations will be also perfect.
- You can skip any question if you don't want to answer. Also feel free to have a break at any time, or stop the discussion if you don't feel well. Tracy if is available if you stop and you want to have a chat.
- Our discussion will be kept anonymous, which means that names /places or any other information that show who you are will be deleted. Anything you say will not be linked with your name.
- I treat all information in confidence, unless there're concerns of safety of you or any other. If there are concerns that someone is at risk I need to ass the information to Tracy. Finally, I would lie to ask you to respect each other's confidentiality.

Is there any question until here?

- I use this voice recorder to record our conversation, as it is impossible to remember everything you are saying. What do you think about it?

The discussion should take about one hour. Is it convenient to do it now?
If you agree to participate please circle 'yes', if not please circle 'no' (consent form)

Body

- In your opinion what are the major challenges facing young people today?
    - What can be done to help young people to overcome these challenges?
- What do you think makes young people feel safe and supported?
- Ideally, what support for children and young people would you like to see in place?
- Are there any other issues you would like to raise?

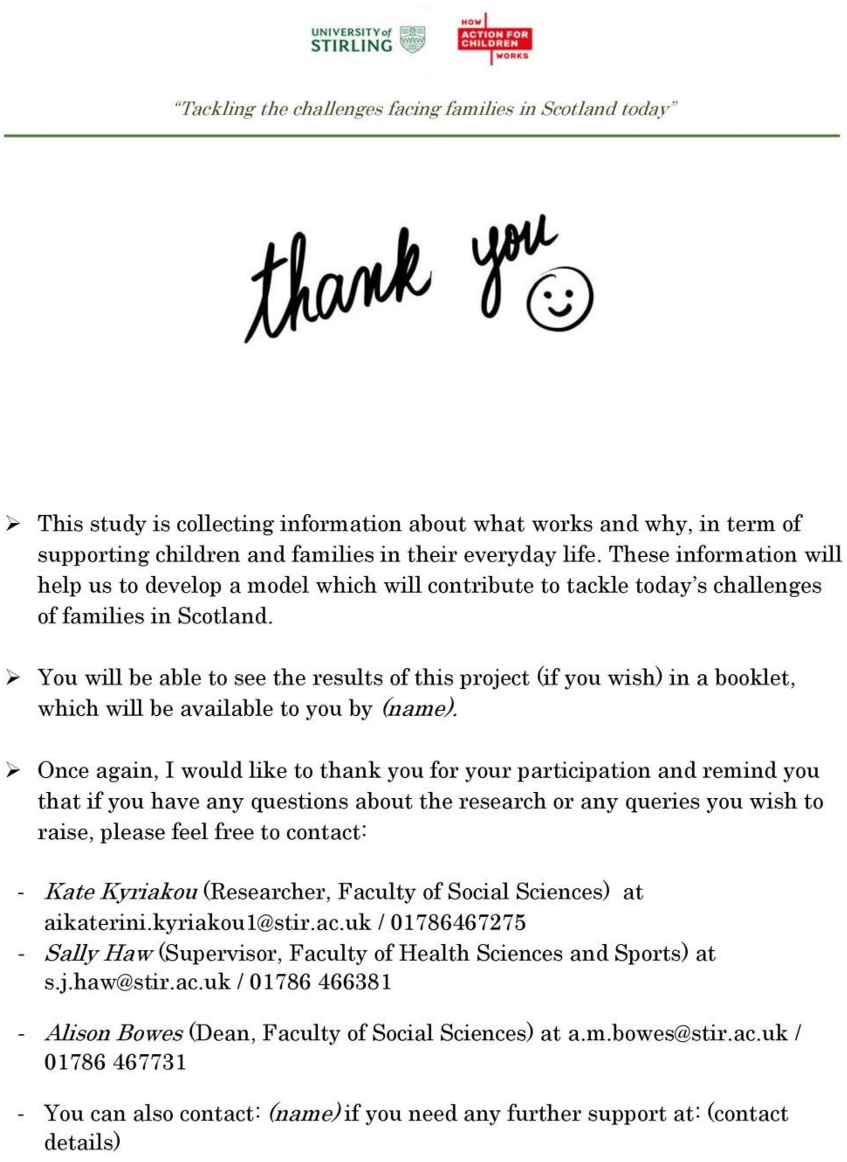
Closing

- I appreciate the time you took for this group. Is there anything else you think would be helpful for me to know so that I can have a better understanding on how young people could be more supported?
- I should have all the information I need. Thanks again.

Some more paper work (background info and future research)

Debriefing: Outline how they can keep in touch with the outcomes of the research. Provide them with debriefing form.

Appendix J - Debriefing form (young people)



UNIVERSITY of STIRLING

HOW ACTION FOR CHILDREN WORKS

"Tackling the challenges facing families in Scotland today"

thank you ☺

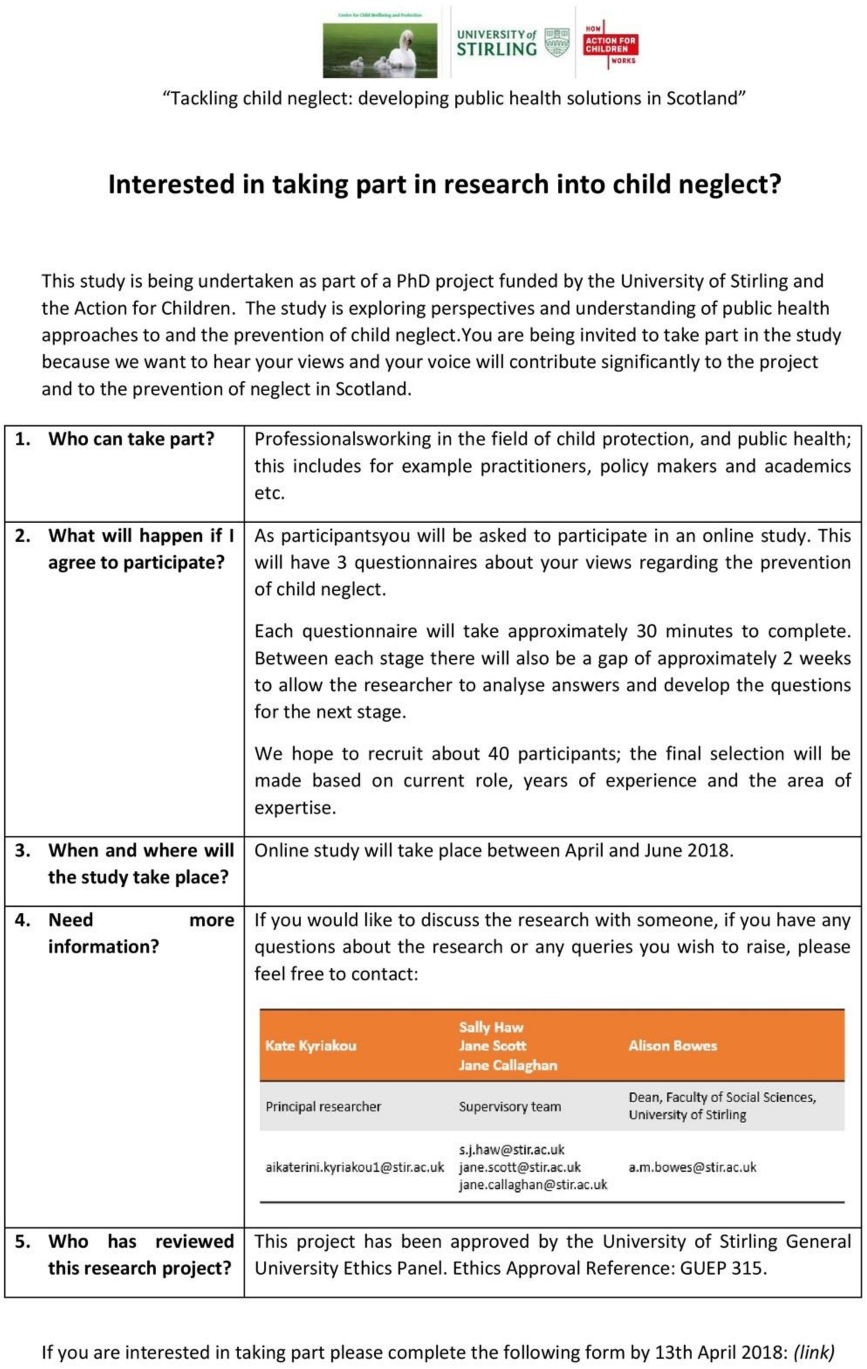
- ➢ This study is collecting information about what works and why, in term of supporting children and families in their everyday life. These information will help us to develop a model which will contribute to tackle today's challenges of families in Scotland.
- ➢ You will be able to see the results of this project (if you wish) in a booklet, which will be available to you by *(name).*
- ➢ Once again, I would like to thank you for your participation and remind you that if you have any questions about the research or any queries you wish to raise, please feel free to contact:

- *Kate Kyriakou* (Researcher, Faculty of Social Sciences) at aikaterini.kyriakou1@stir.ac.uk / 01786467275
- *Sally Haw* (Supervisor, Faculty of Health Sciences and Sports) at s.j.haw@stir.ac.uk / 01786 466381

- *Alison Bowes* (Dean, Faculty of Social Sciences) at a.m.bowes@stir.ac.uk / 01786 467731

- You can also contact: *(name)* if you need any further support at: (contact details)

Appendix K - Invitation for online study (professionals)



"Tackling child neglect: developing public health solutions in Scotland"

Interested in taking part in research into child neglect?

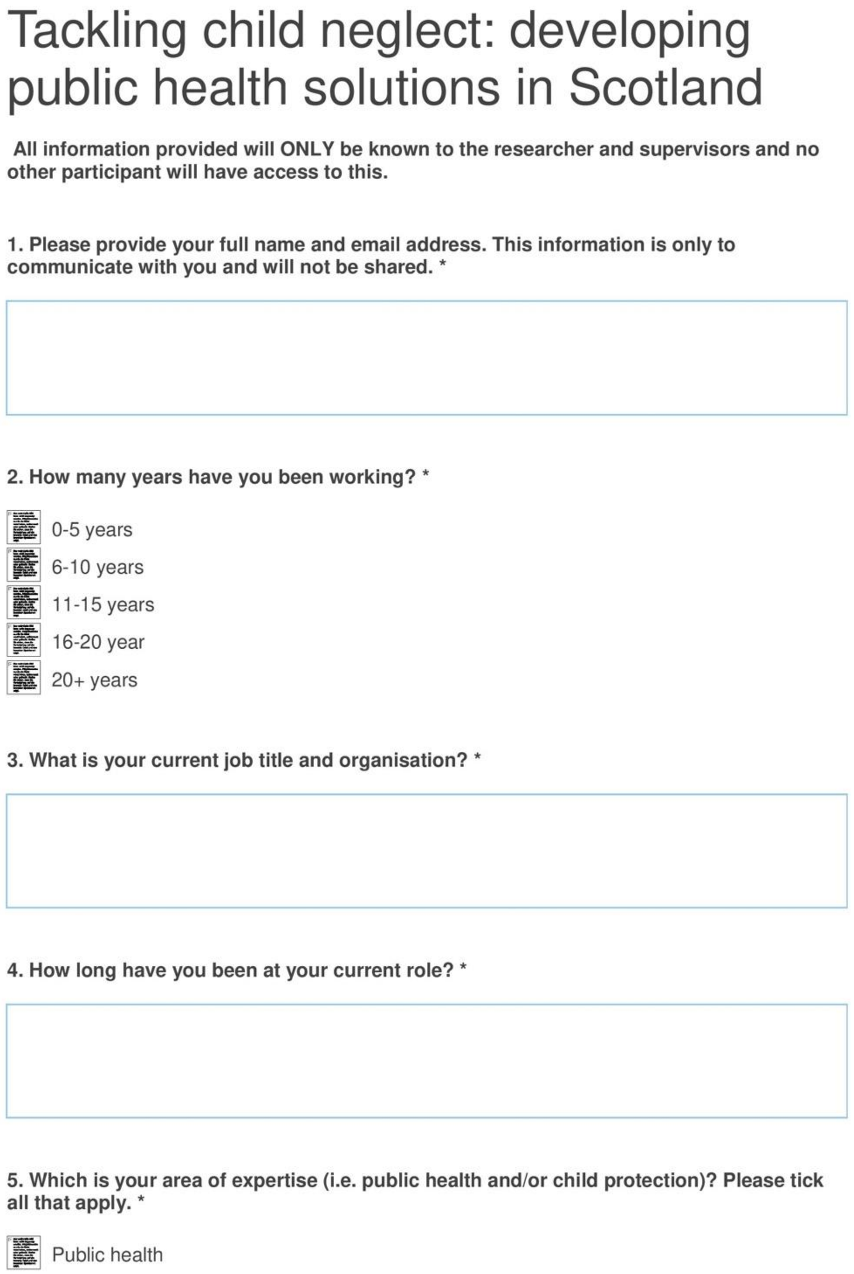
This study is being undertaken as part of a PhD project funded by the University of Stirling and the Action for Children. The study is exploring perspectives and understanding of public health approaches to and the prevention of child neglect.You are being invited to take part in the study because we want to hear your views and your voice will contribute significantly to the project and to the prevention of neglect in Scotland.

1. Who can take part?	Professionalsworking in the field of child protection, and public health; this includes for example practitioners, policy makers and academics etc.
2. What will happen if I agree to participate?	As participantsyou will be asked to participate in an online study. This will have 3 questionnaires about your views regarding the prevention of child neglect. Each questionnaire will take approximately 30 minutes to complete. Between each stage there will also be a gap of approximately 2 weeks to allow the researcher to analyse answers and develop the questions for the next stage. We hope to recruit about 40 participants; the final selection will be made based on current role, years of experience and the area of expertise.
3. When and where will the study take place?	Online study will take place between April and June 2018.
4. Need more information?	If you would like to discuss the research with someone, if you have any questions about the research or any queries you wish to raise, please feel free to contact:
5. Who has reviewed this research project?	This project has been approved by the University of Stirling General University Ethics Panel. Ethics Approval Reference: GUEP 315.

Kate Kyriakou	Sally Haw Jane Scott Jane Callaghan	Alison Bowes
Principal researcher	Supervisory team	Dean, Faculty of Social Sciences, University of Stirling
aikaterini.kyriakou1@stir.ac.uk	s.j.haw@stir.ac.uk jane.scott@stir.ac.uk jane.callaghan@stir.ac.uk	a.m.bowes@stir.ac.uk

If you are interested in taking part please complete the following form by 13th April 2018: *(link)*

Appendix L - Online form for expression of interest in participating (professionals)



Tackling child neglect: developing public health solutions in Scotland

All information provided will ONLY be known to the researcher and supervisors and no other participant will have access to this.

1. Please provide your full name and email address. This information is only to communicate with you and will not be shared. *

2. How many years have you been working? *

☐ 0-5 years
☐ 6-10 years
☐ 11-15 years
☐ 16-20 year
☐ 20+ years

3. What is your current job title and organisation? *

4. How long have you been at your current role? *

5. Which is your area of expertise (i.e. public health and/or child protection)? Please tick all that apply. *

☐ Public health

☐ Child protection
☐ Other (please specify):

6. In which of the following categories does your current job fit?Please tick all that apply. *

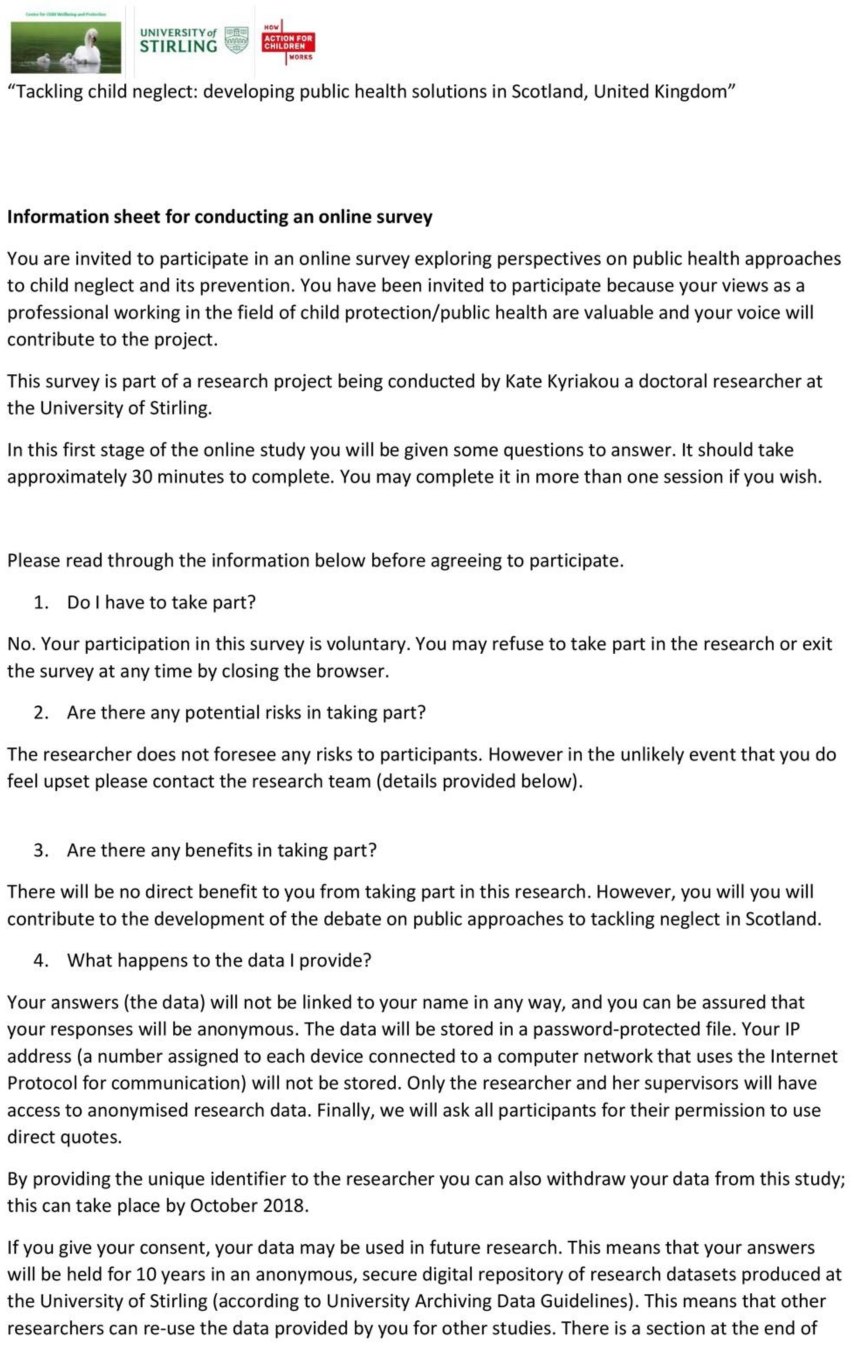
☐ Academics
☐ Practitioners
☐ Policy makers
☐ Other (please specify):

Thank you for taking the time to provide the above information.

Please press <u>Finish Survey button</u> to complete this form.

Kate Kyriakou

Appendix M - Online questionnaire (Stage 1)



"Tackling child neglect: developing public health solutions in Scotland, United Kingdom"

Information sheet for conducting an online survey

You are invited to participate in an online survey exploring perspectives on public health approaches to child neglect and its prevention. You have been invited to participate because your views as a professional working in the field of child protection/public health are valuable and your voice will contribute to the project.

This survey is part of a research project being conducted by Kate Kyriakou a doctoral researcher at the University of Stirling.

In this first stage of the online study you will be given some questions to answer. It should take approximately 30 minutes to complete. You may complete it in more than one session if you wish.

Please read through the information below before agreeing to participate.

1. Do I have to take part?

No. Your participation in this survey is voluntary. You may refuse to take part in the research or exit the survey at any time by closing the browser.

2. Are there any potential risks in taking part?

The researcher does not foresee any risks to participants. However in the unlikely event that you do feel upset please contact the research team (details provided below).

3. Are there any benefits in taking part?

There will be no direct benefit to you from taking part in this research. However, you will you will contribute to the development of the debate on public approaches to tackling neglect in Scotland.

4. What happens to the data I provide?

Your answers (the data) will not be linked to your name in any way, and you can be assured that your responses will be anonymous. The data will be stored in a password-protected file. Your IP address (a number assigned to each device connected to a computer network that uses the Internet Protocol for communication) will not be stored. Only the researcher and her supervisors will have access to anonymised research data. Finally, we will ask all participants for their permission to use direct quotes.

By providing the unique identifier to the researcher you can also withdraw your data from this study; this can take place by October 2018.

If you give your consent, your data may be used in future research. This means that your answers will be held for 10 years in an anonymous, secure digital repository of research datasets produced at the University of Stirling (according to University Archiving Data Guidelines). This means that other researchers can re-use the data provided by you for other studies. There is a section at the end of this questionnaire (after the demographic information) to ask you if you wish your data to be used in future research.

5. Will the research be published?

The data may be used in official reports, scholarly publication, and other scholarly dissemination and presented at conferences, but you will not be identifiable in any report/publication. The anonymised data may be also used for training for students and professionals, .

You will be able to access the results of the study in the form of a ‘practical guidelines for policy’ booklet that will be produced in collaboration with Action for Children. A briefing report and information sheet will also be produced by the University of Stirling, and will be available if requested.

6. Who is organising and funding the research?

The study is funded through a collaborative studentship by the University of Stirling and the charity Action for Children.

7. Who has reviewed this research project?

This project has been ethically approved via The University of Stirling General University Ethics Panel (GUEP). Ethics Approval Reference: GUEP315

8. Whom do I contact if I have concerns about this study or I wish to discuss further?

If you would like to discuss the research with someone please feel free to contact:

Kate Kyriakou	**Sally Haw** **Jane Scott** **Jane Callaghan**	**Alison Bowes**
Principal researcher	Supervisory team	Dean, Faculty of Social Sciences, University of Stirling
aikaterini.kyriakou1@stir.ac.uk	s.j.haw@stir.ac.uk jane.scott@stir.ac.uk jane.callaghan@stir.ac.uk	a.m.bowes@stir.ac.uk

Thank you in advance for your collaboration!

Electronic consent for conducting an online survey

Please select your choice below. Clicking on the “Agree” button indicates that:

- You have read and understood the above information.
- You voluntarily agree to participate.
- You agree that direct quotes from your answers be used by the researcher.

Agree to participate ☐

Do not agree to participate ☐

Questionnaire for stage one

Please create a unique identifier by providing:

- The first letter of your primary school
- The first letter of the street you lived in age 10
- The date in the month you were born
- The last letter of your first name

(box)

(This is an example to help you: Wallace High School, Henderson Street, 25th June and Tom = you write as a unique identifier WH25T)

Defining key terms as an introduction….

Child neglect is defined in the National Guidance for Child Protection (Scottish Government 2014) as:

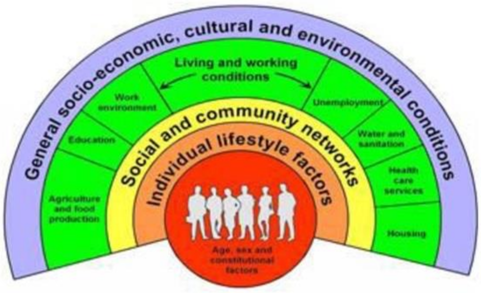
- *The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child from physical harm or danger, or to ensure access to appropriate medical care or treatment.*
- *It may also include neglect of, or failure to respond to, a child's basic emotional needs.*
- *Neglect may also result in the child being diagnosed as suffering from non-organic failure to thrive, where they have significantly failed to reach normal weight and growth or development milestones and where physical and genetic reasons have been medically eliminated.*
- *In its extreme form, children can be at serious risk from the effects of malnutrition, lack of nurturing and stimulation. This can lead to serious long-term effects such as greater susceptibility to serious childhood illnesses and reduction in potential stature. With young children in particular, the consequences may be life-threatening within a relatively short period of time.*

Public health is defined by the UK's Faculty of Public Health as

"the science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society" (Faculty of Public Health, 2017).

- According to World Health Organisation **public health interventions** aim to prevent problems occurring in the first place by implementing policies and interventions that target the known risk factors for the problem, quickly identifying and responding to problems if they do occur, and minimising the long-term effects of the problems.
- Namely, the focus is more on 'upstream' levels, near or close to the source in order to tackle any phenomenon.

- One model of public health is the social model of health, also known as the rainbow model (picture). This model consists a framework for representing the different personal and environmental factors that determine behaviours.
- At the first level individuals with a set of fixed genetic attributes such as age or sex, can be found. The next level consists of personal behaviour and ways of living that can promote or damage health (i.e. choice to smoke or not). The third level is social and community influences; family, friends and social networks. The last level includes cultural, economic and environmental factors (i.e. housing, working status, access to services and provision of essential facilities).



The following questions are trying to explore your perspectives on preventing neglect in Scotland. Feel free to be creative; there is not right or wrong answers!

1. To what extent do you agree that a public health model to tackle child neglect is needed? Please give reasons for your answer.

2. What would a public health model look like and how could it be applied in practice to tackle child neglect? Describe the elements/interventions that you think are important.

3. In your opinion what would be the advantages and/or disadvantages of applying the model you described to tackle neglect?

   Advantages: Disadvantages:

4. How does the model you described link with the current policy and practice in Scotland?

5. In your opinion what would be the challenges to implementing the model you described to tackling neglect in a Scottish context?

6. Are there other comments you would like to add?

Demographics

- How many years have you been working?

0-5 years

6-10 years

11-15 years

16-20 year

20+ years

- What is your current job title?

- How long have you been at your current role?

- Which is your area of expertise (i.e. public health and/or child protection)? Please tick all that apply.

Public health

Child protection

Other (please specify):

- In which of the following categories does your current job fit? Please tick all that apply, both for primary and secondary.

Primary role	Secondary/additional role
Academic (e.g. lecturing, research)	Academic (e.g. lecturing, research)
Practice (e.g. front-line, operational managements, strategic management)	Practice (e.g. front-line, operational managements, strategic management)
Policy (e.g. Local Government, NHS Health Board, National Government)	Policy (e.g. Local Government, NHS Health Board, National Government)
Other (please specify):	Other (please specify):

- Your age group

18 to 34, 35 to 50, 51 to 69, 70 to 87.

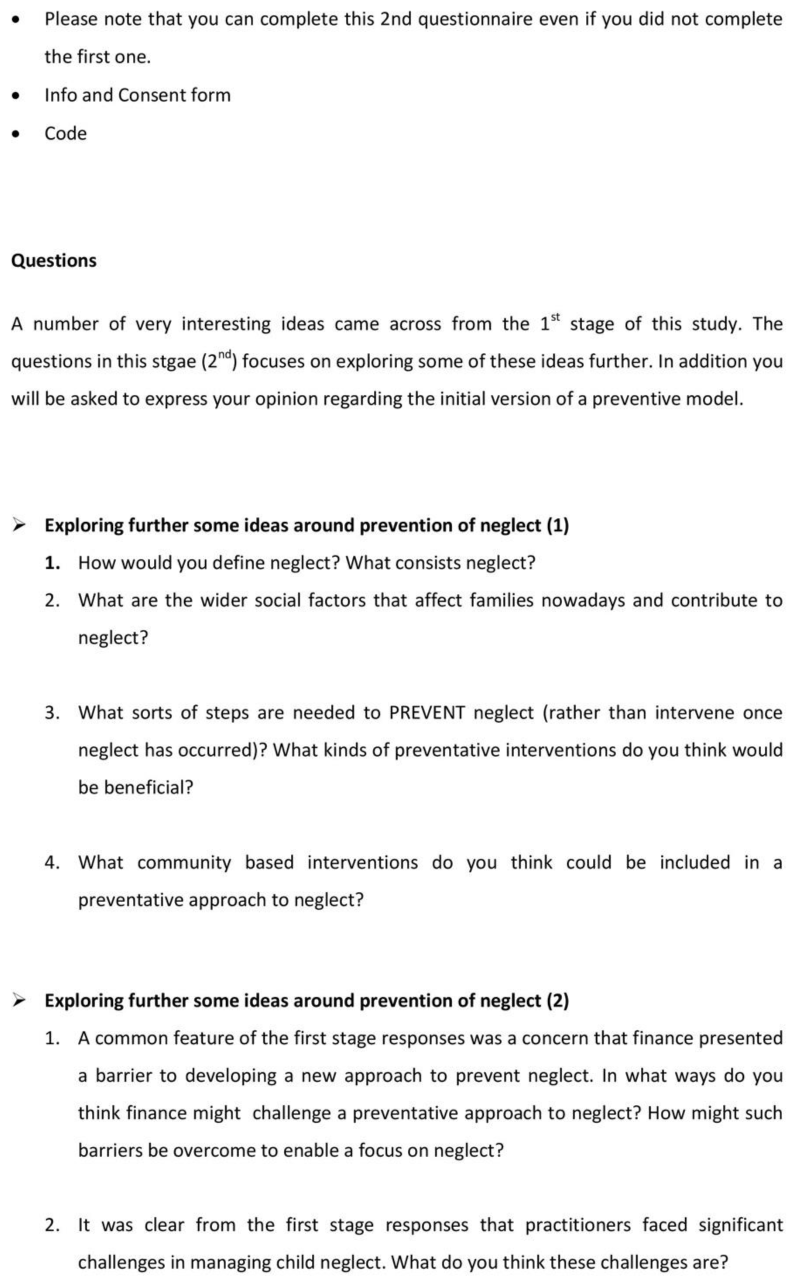
- Your gender

Male, Female, Prefer not to answer

+ Do you agree your data to be used for future research? This means that your answers will be held for 10 years at a digital repository research datasets produced at the University of Stirling (according to University Archiving Data Guidelines) and to be available to re-use for other studies.

Yes/No

Appendix N - Online questionnaire (Stage 2)



- Please note that you can complete this 2nd questionnaire even if you did not complete the first one.
- Info and Consent form
- Code

Questions

A number of very interesting ideas came across from the 1st stage of this study. The questions in this stgae (2nd) focuses on exploring some of these ideas further. In addition you will be asked to express your opinion regarding the initial version of a preventive model.

➢ **Exploring further some ideas around prevention of neglect (1)**

1. How would you define neglect? What consists neglect?
2. What are the wider social factors that affect families nowadays and contribute to neglect?

3. What sorts of steps are needed to PREVENT neglect (rather than intervene once neglect has occurred)? What kinds of preventative interventions do you think would be beneficial?

4. What community based interventions do you think could be included in a preventative approach to neglect?

➢ **Exploring further some ideas around prevention of neglect (2)**

1. A common feature of the first stage responses was a concern that finance presented a barrier to developing a new approach to prevent neglect. In what ways do you think finance might challenge a preventative approach to neglect? How might such barriers be overcome to enable a focus on neglect?

2. It was clear from the first stage responses that practitioners faced significant challenges in managing child neglect. What do you think these challenges are?

3. Another interesting point was the idea that a public awareness intervention would be useful to the prevention of neglect. What do you think of this idea? What would be the advantages and disadvantages of such a public awareness approach? What might its key messages be? What do you think such an approach might achieve?

4. How do you think people with lived experience of neglect might contribute to efforts to tackle the phenomenon?

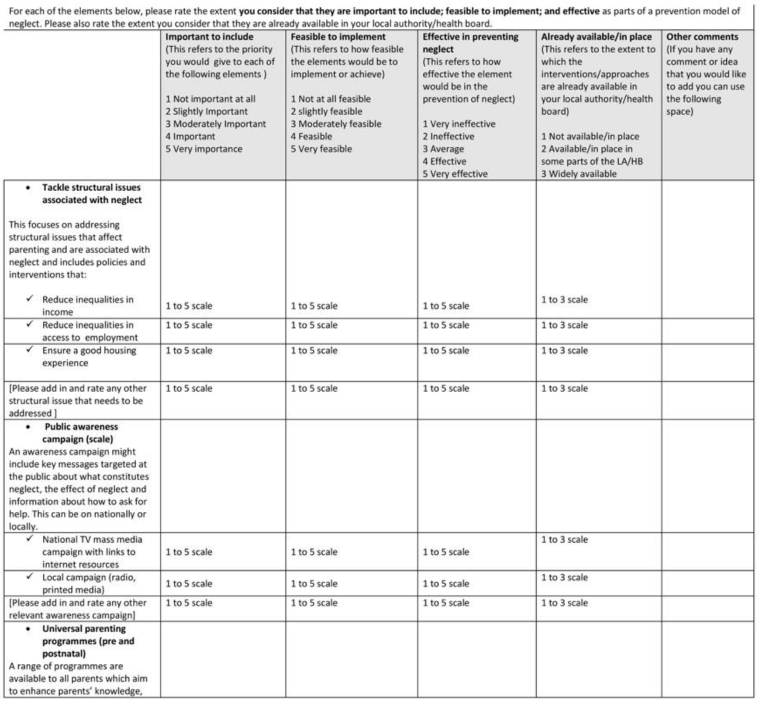
➢ **Developing a model**

In an effort to synthesize the different (and very interesting!) perspectives described during the 1st stage of this study, it appears that a public health approach to neglect could have the following elements:

Interventions for factors that affect parenting and are associated with neglect (i.e. poor housing, unemployment).
Support for parents: universal services (i.e. midwife, health visitors), community based interventions.
Targeted interventions for families in need.
Public awareness interventions.
Consider other issues: thresholds of neglect, workload of services, human resources, funding, and training for professionals.

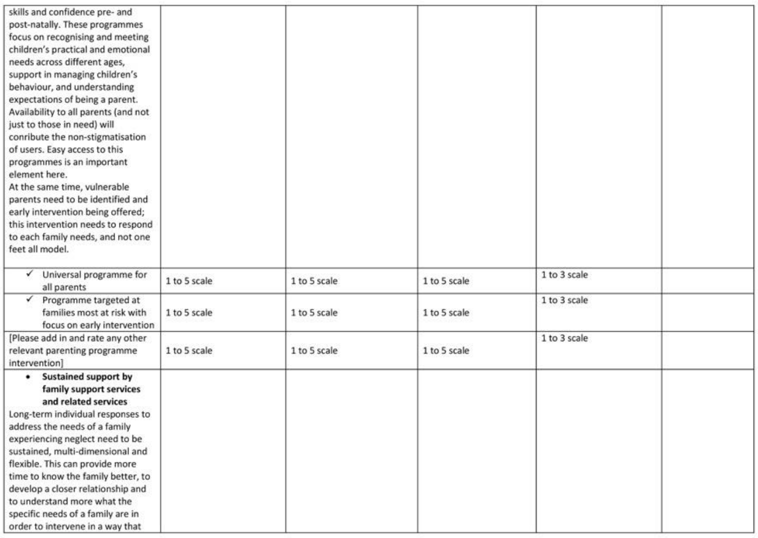
1. What do you think about these elements? Would you like to add something? Or do you think that something does not fit?

Appendix O - Online questionnaire (Stage 3)

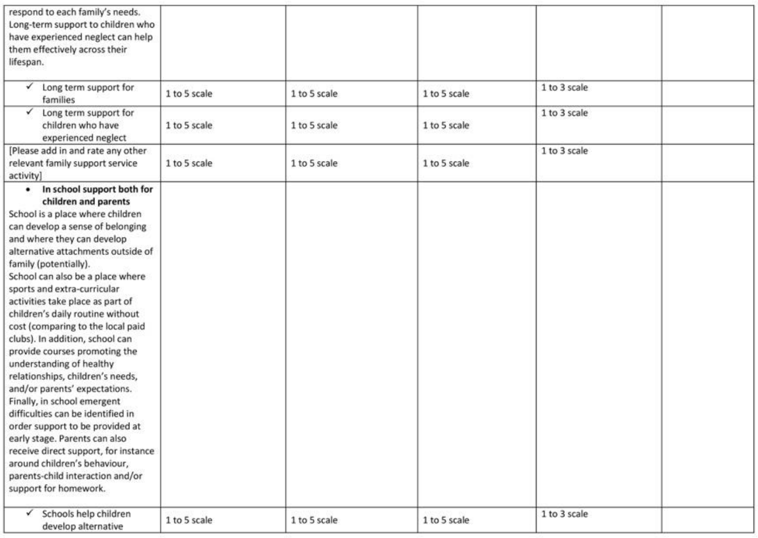


For each of the elements below, please rate the extent **you consider that they are important to include; feasible to implement; and effective** as parts of a prevention model of neglect. Please also rate the extent you consider that they are already available in your local authority/health board.

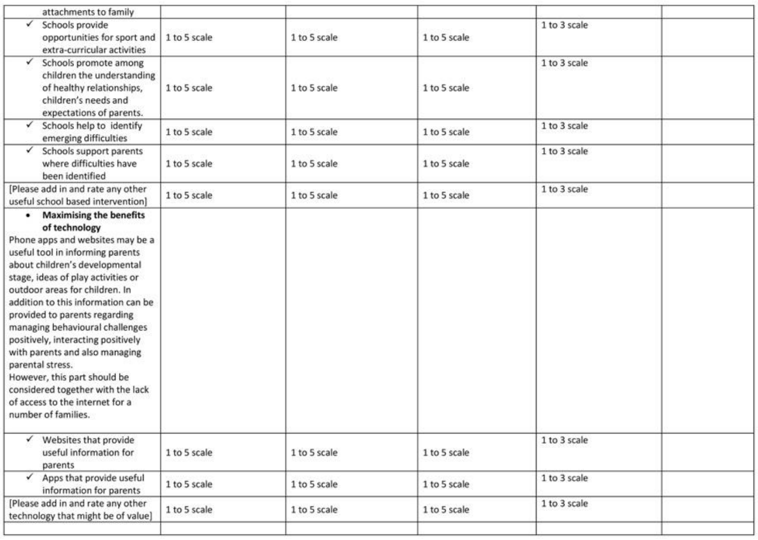
	Important to include (This refers to the priority you would give to each of the following elements) 1 Not important at all 2 Slightly Important 3 Moderately Important 4 Important 5 Very importance	**Feasible to implement** (This refers to how feasible the elements would be to implement or achieve) 1 Not at all feasible 2 slightly feasible 3 Moderately feasible 4 Feasible 5 Very feasible	**Effective in preventing neglect** (This refers to how effective the element would be in the prevention of neglect) 1 Very ineffective 2 Ineffective 3 Average 4 Effective 5 Very effective	**Already available/in place** (This refers to the extent to which the interventions/approaches are already available in your local authority/health board) 1 Not available/in place 2 Available/in place in some parts of the LA/HB 3 Widely available	**Other comments** (If you have any comment or idea that you would like to add you can use the following space)
• **Tackle structural issues associated with neglect** This focuses on addressing structural issues that affect parenting and are associated with neglect and includes policies and interventions that: ✓ Reduce inequalities in income	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
✓ Reduce inequalities in access to employment	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
✓ Ensure a good housing experience	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
[Please add in and rate any other structural issue that needs to be addressed]	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
• **Public awareness campaign (scale)** An awareness campaign might include key messages targeted at the public about what constitutes neglect, the effect of neglect and information about how to ask for help. This can be on nationally or locally.					
✓ National TV mass media campaign with links to internet resources	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
✓ Local campaign (radio, printed media)	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
[Please add in and rate any other relevant awareness campaign]	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
• **Universal parenting programmes (pre and postnatal)** A range of programmes are available to all parents which aim to enhance parents' knowledge,					



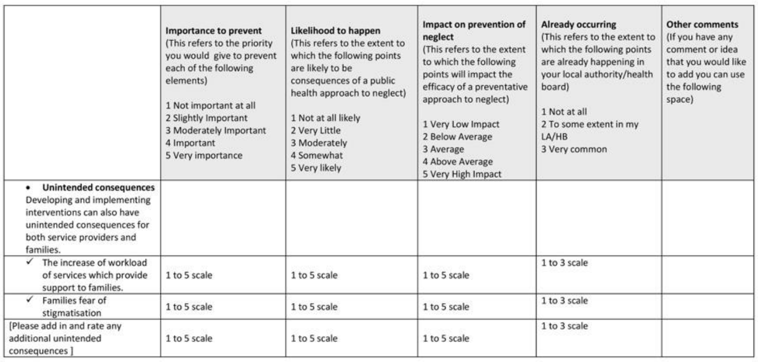
skills and confidence pre- and post-natally. These programmes focus on recognising and meeting children's practical and emotional needs across different ages, support in managing children's behaviour, and understanding expectations of being a parent. Availability to all parents (and not just to those in need) will conribute the non-stigmatisation of users. Easy access to this programmes is an important element here. At the same time, vulnerable parents need to be identified and early intervention being offered; this intervention needs to respond to each family needs, and not one feet all model.					
✓ Universal programme for all parents	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
✓ Programme targeted at families most at risk with focus on early intervention	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
[Please add in and rate any other relevant parenting programme intervention]	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
• **Sustained support by family support services and related services** Long-term individual responses to address the needs of a family experiencing neglect need to be sustained, multi-dimensional and flexible. This can provide more time to know the family better, to develop a closer relationship and to understand more what the specific needs of a family are in order to intervene in a way that					



respond to each family's needs. Long-term support to children who have experienced neglect can help them effectively across their lifespan.					
✓ Long term support for families	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
✓ Long term support for children who have experienced neglect	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
[Please add in and rate any other relevant family support service activity]	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
• **In school support both for children and parents** School is a place where children can develop a sense of belonging and where they can develop alternative attachments outside of family (potentially). School can also be a place where sports and extra-curricular activities take place as part of children's daily routine without cost (comparing to the local paid clubs). In addition, school can provide courses promoting the understanding of healthy relationships, children's needs, and/or parents' expectations. Finally, in school emergent difficulties can be identified in order support to be provided at early stage. Parents can also receive direct support, for instance around children's behaviour, parents-child interaction and/or support for homework.					
✓ Schools help children develop alternative	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	

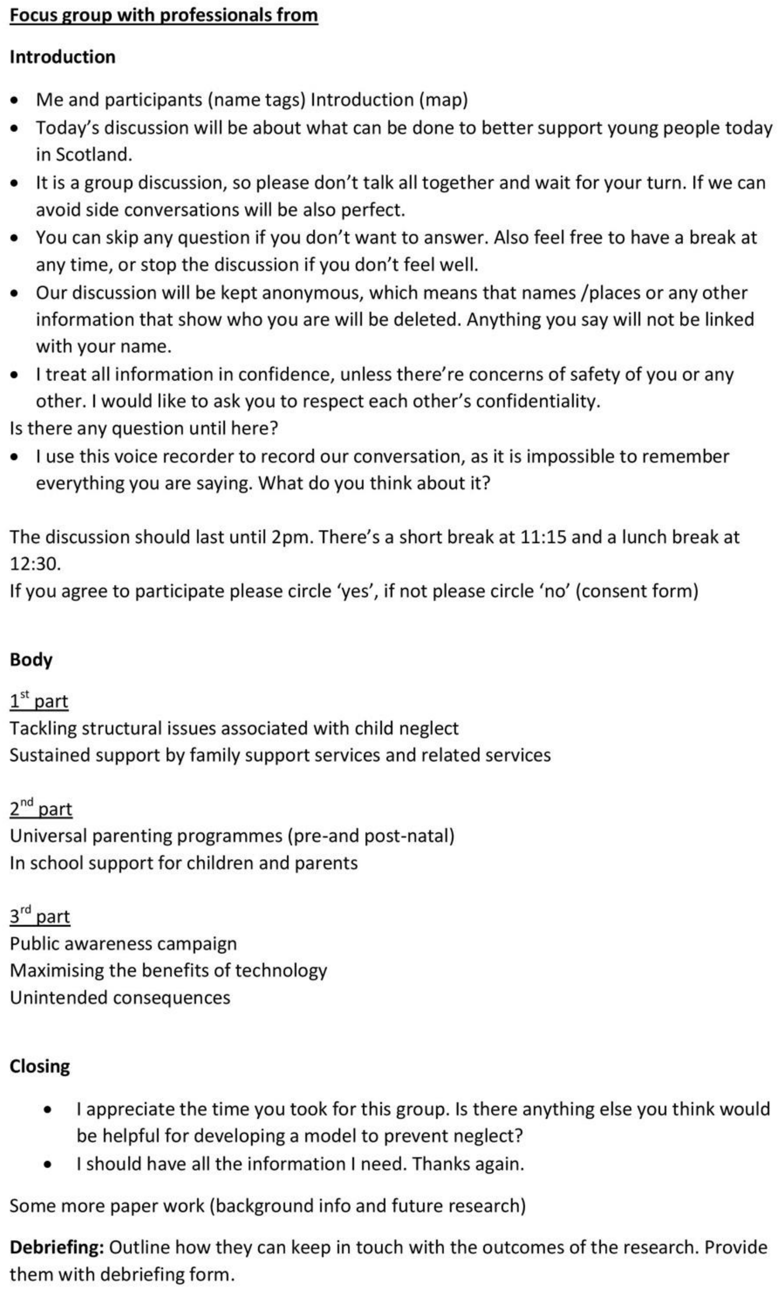


attachments to family					
✓ Schools provide opportunities for sport and extra-curricular activities	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
✓ Schools promote among children the understanding of healthy relationships, children's needs and expectations of parents.	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
✓ Schools help to identify emerging difficulties	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
✓ Schools support parents where difficulties have been identified	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
[Please add in and rate any other useful school based intervention]	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
• **Maximising the benefits of technology** Phone apps and websites may be a useful tool in informing parents about children's developmental stage, ideas of play activities or outdoor areas for children. In addition to this information can be provided to parents regarding managing behavioural challenges positively, interacting positively with parents and also managing parental stress. However, this part should be considered together with the lack of access to the internet for a number of families.					
✓ Websites that provide useful information for parents	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
✓ Apps that provide useful information for parents	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
[Please add in and rate any other technology that might be of value]	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	



	Importance to prevent (This refers to the priority you would give to prevent each of the following elements) 1 Not important at all 2 Slightly Important 3 Moderately Important 4 Important 5 Very importance	**Likelihood to happen** (This refers to the extent to which the following points are likely to be consequences of a public health approach to neglect) 1 Not at all likely 2 Very Little 3 Moderately 4 Somewhat 5 Very likely	**Impact on prevention of neglect** (This refers to the extent to which the following points will impact the efficacy of a preventative approach to neglect) 1 Very Low Impact 2 Below Average 3 Average 4 Above Average 5 Very High Impact	**Already occurring** (This refers to the extent to which the following points are already happening in your local authority/health board) 1 Not at all 2 To some extent in my LA/HB 3 Very common	**Other comments** (If you have any comment or idea that you would like to add you can use the following space)
• **Unintended consequences** Developing and implementing interventions can also have unintended consequences for both service providers and families.					
✓ The increase of workload of services which provide support to families.	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
✓ Families fear of stigmatisation	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	
[Please add in and rate any additional unintended consequences]	1 to 5 scale	1 to 5 scale	1 to 5 scale	1 to 3 scale	

Appendix P - Topic guide of focus group (professionals)



Focus group with professionals from

Introduction

- Me and participants (name tags) Introduction (map)
- Today's discussion will be about what can be done to better support young people today in Scotland.
- It is a group discussion, so please don't talk all together and wait for your turn. If we can avoid side conversations will be also perfect.
- You can skip any question if you don't want to answer. Also feel free to have a break at any time, or stop the discussion if you don't feel well.
- Our discussion will be kept anonymous, which means that names /places or any other information that show who you are will be deleted. Anything you say will not be linked with your name.
- I treat all information in confidence, unless there're concerns of safety of you or any other. I would like to ask you to respect each other's confidentiality.

Is there any question until here?

- I use this voice recorder to record our conversation, as it is impossible to remember everything you are saying. What do you think about it?

The discussion should last until 2pm. There's a short break at 11:15 and a lunch break at 12:30.
If you agree to participate please circle 'yes', if not please circle 'no' (consent form)

Body

1st part
Tackling structural issues associated with child neglect
Sustained support by family support services and related services

2nd part
Universal parenting programmes (pre-and post-natal)
In school support for children and parents

3rd part
Public awareness campaign
Maximising the benefits of technology
Unintended consequences

Closing

- I appreciate the time you took for this group. Is there anything else you think would be helpful for developing a model to prevent neglect?
- I should have all the information I need. Thanks again.

Some more paper work (background info and future research)

Debriefing: Outline how they can keep in touch with the outcomes of the research. Provide them with debriefing form.

Appendix Q - Debriefing form (professionals)

"Tackling child neglect: developing public health solutions in Scotland, United Kingdom"

Thank you for participating in this research project!

- The aim of this study is to explore with professionals active in the field of child protection the potentials of developing a public health approach to tackling neglect.
- You will be able to access the results of the study in the form of a 'practical guidelines for policy' booklet that will be produced in collaboration with Action for Children. A briefing report and information sheet will also be produced by the University of Stirling, and will be available if requested.
- Once again, I would like to thank you for your participation and remind you that if you have any questions about the research or any queries you wish to raise, please feel free to contact:

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