MORE THAN MANDATORY REPORTING: Nurses' experiences of safeguarding children in Australia

By

Lauren Elizabeth Lines

RN, BN(hons), MNg

Thesis

Submitted to Flinders University

for the Degree of

Doctor of Philosophy

College of Nursing and Health Sciences

August 2020

TABLE OF CONTENTS

THESIS SUMMARY

Child abuse and neglect is a global public health issue with significant short and long-term impacts for children, families and societies. The scale of child abuse and neglect and complexity of contributing factors means it is not easily resolved. Current approaches include a public health model, also known as safeguarding, whereby all individuals, communities and organisations have a responsibility towards the health, safety and wellbeing of children. This includes universal services for all families, through to targeted interventions for more vulnerable families and statutory services for cases of severe abuse or neglect. Nurses are the largest group of health professionals and are well-placed to respond to child abuse and neglect through this whole-of-community approach. In Australia, nurses are mandated reporters of child abuse and neglect, however, little is known about other ways that nurses respond to child abuse and neglect in the broader domain of safeguarding. It is important to understand how nurses already respond to child abuse and neglect to understand how to best support and mobilise the nursing profession to enact change for children. This qualitative study explored the perceptions and experiences of nurses working with children about how they keep children safe from abuse and neglect. A social constructionist lens underpinned the research and data was collected through semi-structured in-depth interviews with registered nurses working with children in Australia (n=21). All interviews were audio recorded and transcribed. Data was analysed inductively supported by NVivo software and identified four key themes. The first theme 'sociocultural contexts shaping nurses' perceptions of child abuse and neglect' demonstrated that nurses had difficulty concisely defining child abuse and neglect, and instead drew upon multiple sources to help them clarify instances of child abuse in their practice. The second theme 'How can we work together?': keeping children safe through therapeutic relationships' outlined nurses' recognition that meeting children's needs was often best achieved by working with the parents to make gradual changes. However, on occasions nurses needed to act immediately to protect children despite the risks of damaging therapeutic relationships. Theme three, 'Constructing a compelling case: complexities of communicating about child abuse and neglect' highlighted how nurses experienced challenges when

reporting concerns to child protection services such as feeling as though they were not taken seriously and had limited capacity to ensure children's safety. Finally, theme four 'systems and hierarchies shaping nurses' responses to child abuse and neglect' outlined how nurses perceived that systems and hierarchies that were intended to protect children, increasingly adopted a 'rule-centred' rather than child-centred approach. This thesis contributed to new knowledge through these four themes which together demonstrate that nurses enacted a range of complex skills to safeguard children extending far beyond mandatory reporting. The findings form a starting point to highlighting the complexity of nurses' practices and the need for greater recognition, education and support. However, nurses' safeguarding practices need to be underpinned by widespread policy and systems change to effectively address the challenges they face when addressing the complex problem of child abuse and neglect. More specifically, greater interprofessional collaboration is needed within organisational cultures that support professionals to maintain child-centred approaches. All of these changes must be underpinned with quality evaluation to ensure they produce positive outcomes for children who are at risk of, or are experiencing child abuse and neglect.

DECLARATION

I, Lauren Lines, certify that this thesis:

1. does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and

2. to the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text.

Lauren Lines,

29-05-2020

STATEMENT OF THE CONTRIBUTION OF OTHERS

The completion of this thesis was supported by the help of many people and organisations, including those named below:

ACKNOWLEDGEMENTS

As I wrote these acknowledgements, the first thing that came to mind was how many people have helped and supported me throughout my PhD candidature. An old African Proverb says that *It takes a village to raise a* child, and I think the same can be said for completing a PhD thesis.

Firstly, I would like to thank my supervisors: Alison Hutton and Julian Grant who have supported me throughout my candidature. Their guidance and advice were critical to my success, not only in completing this thesis, but also in helping to establish my path as an early career researcher.

I would also like to thank my husband, Hugo, whose unwavering encouragement and faith in my abilities bolstered my confidence, especially through the most challenging moments.

Thank you to my family and friends for encouraging me along the way, and for (mostly) remembering not to ask how long until I would be finished!

Importantly, I thank the twenty-one registered nurses who freely volunteered their time to share their stories with me. Without their generosity, this research would not have been possible.

Thank you to Ruth Harris, who carefully transcribed many of the interviews, meaning I could dedicate more time to data analysis and writing. I also appreciated the broader support I received at Flinders University. This includes librarian Paul Newman who helped navigate the database searching, through to all the professional development and research support services that contributed to my growth as a researcher.

Finally, I would like to thank all my colleagues and fellow Research Higher Degree (RHD) students at Flinders University who were always quick to provide encouragement, kind words and support.

LIST OF PUBLICATIONS

Lines, L. E., Hutton, AE and Grant, J. M. 2017, Integrative review: nurses' roles and experiences in keeping children safe, *Journal of Advanced Nursing*, 73 (2), 302-322, doi: 10.1111/jan13101

Lines, L. E., Grant, J. M. and Hutton, A. E. 2018, How do nurses keep children safe from abuse and neglect and does it make a difference? A scoping review, *Journal of Pediatric Nursing*, 43, e75-e84, doi: 10.1016/j.pedn.2018.07.010

Lines, L. E., Hutton, A. E. & Grant, J. M. 2019, Navigating and negotiating meanings of child abuse and neglect: Sociocultural contexts shaping Australian nurses' perceptions, *Health and Social Care in the Community*, vol. 28, no. 3, pp. 941-949, doi: 10.1111/hsc.12925

Lines, L. E., Grant, J. M. & Hutton, A. E. 2020*, Nurses' perceptions of systems and hierarchies shaping their responses to child abuse and neglect, Nursing Inquiry*, vol. 27, no. 3, doi: 10.1111/nin.12342

Lines, L. E., Grant, J. M. & Hutton, A. E. accepted manuscript*, 'How can we work together?' Nurses using relational skills to address child maltreatment in Australia: a qualitative study, Journal of Pediatric Nursing*,

Lines, L. E., Hutton, A. E. & Grant, J. M. under review*, Constructing a compelling case: nurses' experiences of communicating abuse and neglect,* submitted to *Child Abuse Review* in September 2019.

LIST OF PRESENTATIONS

CONFERENCE PRESENTATIONS

LINES, L. E. Hutton, A. E. & Grant, J. M. (accepted poster abstract), 'Making the invisible, visible: nurses' roles in responding to child abuse', Poster Presentation, Australian Institute of Family Studies (AIFS) 2020, Melbourne Convention Centre, 9-12 June 2020 (**postponed due to COVID-19**).

LINES, L. E. Hutton, A. E. & Grant, J. M. 2019, 'Working together and fighting back: complexities of addressing child abuse and neglect', Maternal, Child and Family Health Nurses Australia, Sydney, August 2019.

LINES, L. E. Hutton, A. E. & Grant J. M. 2017, 'How do nurses working with children keep them safe from abuse and neglect?', Maternal, Child and Family Health Nurses Australia, Melbourne, June 2017.

OTHER PRESENTATIONS

LINES, L. E. Hutton, A. E. & Grant, J. M. 2019, 'Working together and fighting back: complexities of addressing child abuse and neglect', Invited speaker South Australian Family Health Nurses Australia (SACFHNA) post-conference symposium, Glenside Campus, Adelaide, September 2019.

LINES, L. E. Hutton, A. E. & Grant, J. M. 2019, 'How nurses address child abuse and neglect', Three Minute Thesis (3MT), Flinders University, Heat 2 Runner-Up, August 2019.

LINES, L. E. Hutton, A. E. & Grant, J. M. 2018, 'Nurse relational skills in responding to child abuse and neglect', Poster Presentation, Research Higher Degrees Student Conference, Flinders University Tonsley Campus, Adelaide, November 2018.

LINES, L. E. Hutton, A. E. & Grant, J. M. 2017, 'How do nurses working with children keep children safe from abuse and neglect?', School of Nursing and Midwifery Research Week, Flinders University Sturt Campus, June 2017.

LINES, L. E. Hutton, A. E. & Grant, J. M. 2017, 'How do nurses working with children keep children safe from abuse and neglect?', Invited speaker South Australian Family Health Nurses Australia (SACFHNA) post-conference symposium, Glenside Campus, Adelaide, June 2017.

LINES, L. E. Hutton, A. E. & Grant, J. M. 2017, 'How do nurses keep children safe from abuse and neglect?', Invited speaker Australian College of Children and Young People's Nurses (ACCYPN), Clinical Supper Adelaide, May 2017.

LINES, L. E. Hutton, A. E. & Grant, J. M. 2015, 'Everybody's business? Nurses' role in child protection', School of Nursing and Midwifery Research Week, Flinders University Sturt Campus, June 2015.

AWARDS

Throughout my PhD candidature, I was the recipient of the following awards:

2017 College of Nursing and Health Sciences RHD Student Publication Award – Flinders University, **Lines, L. E**., Hutton, A. E. and Grant, J. M. 2017, Integrative review: nurses' roles and experiences in keeping children safe. Journal of advanced nursing, 73 (2), 302-322, doi: 10.1111/jan13101

2018 College of Nursing and Health Sciences RHD Student Publication Award – Flinders University, **Lines, L. E.**, Grant, J. M. and Hutton, A. E. 2018, How do nurses keep children safe from abuse and neglect and does it make a difference? A scoping review. Journal of pediatric nursing, 43, e75-e84, doi: 10.1016/j.pedn.2018.07.010

2019 Three Minute Thesis (3MT) Heat 2 Runner-up – Office of Graduate Research, Flinders University, *How nurses address child abuse and neglect*, July 2019.

2019 College of Nursing and Health Sciences RHD Student Publication Award – Flinders University. **Lines, L. E.**, Hutton, A. E. & Grant, J. M. 2019, Navigating and negotiating meanings of child abuse and neglect: Sociocultural contexts shaping Australian nurses' perceptions, *Health and Social Care in the Community*, vol. 28, no. 3, pp. 941-949, doi: 10.1111/hsc.12925

LIST OF TABLES

LIST OF FIGURES

TERMINOLOGY

Child   In Australia, in accordance with the United Nation Conventions on the Rights of the Child (UNCRC), a child is a person under the age of 18 years.

ACRONYMS

ACCYPN   Australian College of Children and Young People's Nurses

ACN   Australian College of Nursing

ANMF   Australian Nursing and Midwifery Federation

AWCH   Association for the Wellbeing of Children in Healthcare

CASP   Critical Skills Appraisal Programme

CFHN   Child and Family Health Nurse

CPS   Child Protection Services

ED   Emergency Department

FPM   Family Partnership Model

GP   General Practitioner

HBM   Health Beliefs Model

HCP   Health Care Professional

HV   Health Visitor

MCaFHNA   Maternal, Child and Family Health Nurses Australia

NP   Nurse Practitioner

PNP   Paediatric Nurse Practitioner

RN   Registered Nurse

SIDS   Sudden Infant Death Syndrome

SUDI   Sudden Unexpected Death in Infancy

SPCC   Society for the Prevention of Cruelty to Children

UK   United Kingdom

UNCRC   United Nations Convention on the Rights of the Child

USA   United States of America

WHO   World Health Organization

PROLOGUE

We all understand and explore the world through a particular lens which is linked to our social and cultural background. In this section, I introduce my personal and professional background as it relates to this topic and how it may have influenced the questions I asked and the interpretation of the findings. Throughout my personal and professional life, I have encountered children who experienced or were suspected of experiencing abuse or neglect. On a personal level, there were, and continue to be, news stories of the 'crisis' facing child protection, like the 'house of horrors' in Adelaide in 2008 where 21 children were found living in squalid conditions, with five siblings fed only enough scraps to keep them alive (Brice, 2011). As an older teenager, I had personal experiences with children who were abused or neglected. For example, in my rural town, some areas were considered highly suspect, such as the 'other' side of the railway line, and the 'Green House' – a rental house painted green where it was claimed that families lived transiently whilst trying to avoid any attention.

On reflection, I now realise these would have been the homes of the most marginalised families living with the greatest socioeconomic deprivation. I met one child from the 'Green House' through volunteer work at a local school. The child had immediately noticeable limitations to their language, social and motor skills, and had frequent outbursts of anger/frustration. The school tried their best to support this child, but by the time they had approval to implement supports, the family had moved on. Throughout my life whilst growing up and as an adult, I have always had family members and friends in caring roles like foster carers, teachers, nurses, social workers and carers in residential care. I often heard stories about their own encounters with child abuse and neglect, and how the 'crisis' in child protection had very real impacts on children's lives.

My background as a paediatric nurse was probably the most influential factor in my decision research a topic relating to child abuse and neglect. As a paediatric nurse in the acute care setting, I frequently encountered children who were suspected or confirmed to be experiencing abuse and neglect. For example, I encountered a child who cried constantly

when his mother visited, and two twins who had each 'fallen' off their father's lap. I saw how these children were doubly vulnerable in the hospital setting because parents, who would normally have an advocacy role, were often absent or 'difficult to engage'. At times, I was horrified by nurses' judgemental responses to parents, which placed blame on parents without considering the best interests of the child. For example, as a registered nurse employed on a casual basis, I cared for a baby who was frequently hospitalised with a chronic condition. I asked one of the regular nurses if/when the baby's family was likely to make contact. The nurse regretfully informed me that the mother no longer visits because she had been reprimanded by another nurse for neglecting her baby. The baby had reportedly arrived at the hospital in a state suggesting he had not been bathed or changed for a long time. Although the nurse who reprimanded the mother may have felt like she was advocating for the baby, this did not have a positive outcome as her actions drove away the baby's primary attachment figure leaving him alone in hospital. Although I recognised that failing to care for a baby's hygiene is not in a baby's best interests, I felt there could be a more nuanced approach that was sensitive to reasons why this baby might have poor hygiene.

These life experiences highlighted how children themselves are relatively powerless in society to make broader changes social conditions contributing to abuse and neglect. Children do not have a political voice, and adult survivors of abuse and neglect may have less capacity to make their voices heard due to ongoing disadvantage. Despite child abuse and neglect affecting children, their voices are largely absent in historical depictions produced by adults. For example, Scott and Swain (2002, p. xiv) describe children's voices as 'remain[ing] inaudible, detectable only though others' descriptions of their suffering'. This was an area in which I wanted to make a difference. I am not alone in this wish as many have gone before me with the same well-meaning attitude, but caused harm through approaches like child 'rescue' whereby poor, 'lower class' and/or Aboriginal children were removed from their families with the intention of educating them and 'improving' society (Kociumbas, 1997). In learning from past mistakes, I aim to explore assumptions about what is in children's 'best interests' and critically reflect on my own values and beliefs and how they shape my thoughts, actions and research. According to Burr (2015), all research comes

from asking particular questions from specific social contexts – there is no 'value free' research and so I recognise that my background as a paediatric nurse from a middle-class Caucasian family will influence my perceptions.

Importantly, I value the increasing push towards listening to individual children and creating space for children to speak about issues that affect them. The assumption that children are unable or too immature to have an opinion facilitates silencing of children and creates conditions where abuse can continue (Mundaly & Goddard, 2006). Fortunately, societal views about the importance of children being heard are beginning to change. For example, in South Australia, the current Children and Young People's Safety Act (2017) states that children should be able to freely express their views and have these taken seriously in accordance with their level of understanding and development. This recognises that individual children have the capacity to make decisions about issues affecting them, and that these views are unique. James (2007, p. 262) points out that children's voices are often '*held to speak with one undifferentiated voice, irrespective of class or culture…*'. Realistically, children are unique individuals with their own ideas and needs rather than a unified collective (Edgar & Edgar, 2008). Children themselves can be seen as social actors who construct their own social worlds and can be active participants in decisions that affect them in developmentally appropriate ways (Cooper & Collins, 2008; Gallacher & Kehily, 2013).

CHAPTER 1: INTRODUCTION

On a global scale, it is estimated that in 2016 over one billion, or around half of children aged 2-17 years had experienced abuse or neglect (Hillis, Mercy, Amobi, & Kress, 2016). However, exact measures of the prevalence of child abuse are difficult to create for many reasons including inconsistent definitions, underreporting and methodological issues (Australian Institute of Family Studies, 2017b; Runyan, 2015). In Australia, the most recent report by the Australian Institute of Health and Welfare (2019) indicated that around 159,000, or 2.87 per cent of children received child protection services in 2018. This number does not include children who were reported, but for whom the abuse was unsubstantiated or did not receive a response.

At present, there are no representative population studies that identify the prevalence of child abuse in Australia (Hillis et al., 2016; Mathews et al., 2016). Child abuse and neglect is typically categorised into four 'types' which are physical abuse, sexual abuse, emotional abuse and neglect; but these often co-occur and children may experience more than one form (Australian Institute of Health and Welfare, 2019; Davidson & Bifulco, 2019). Existing Australian studies from 2001 onwards involving self-report suggest prevalence may vary between 4.3 to 23 percent of children witnessing family violence, 1.4 to 23 percent experiencing sexual abuse, 5.8 to 17.1 experiencing emotional abuse, 1.6 to 4 percent experiencing neglect and 5 to 18 percent reporting physical abuse (Australian Institute of Family Studies, 2017b). Despite a global recognition and local attempts to address the problem, child abuse and neglect continues to affect vast numbers of children.

The consequences of abuse and neglect to children, families and societies are immense. At an individual level, children experience immediate harm, but adverse childhood experiences can lead to long term or even life-long effects. This includes an increased risk of mental health disorders, reduced educational achievement, poorer physical health, increased contact with the criminal justice system and higher substance use (Committee on Child Maltreatment Research Policy and Practice for the Next Decade: Phase II, 2014). Child abuse

and neglect also leads to broader economic consequences, including the high costs of medical services and loss of productivity (Thielen et al., 2016).

This chapter provides an overview of the thesis and a background and historical context to the problem of child abuse and neglect in Australia and other Western contexts. The purpose of this background information is to contextualise the research problem statement, study purpose and aims. Finally, this chapter concludes with a summary of the importance of the study and overall outline of the thesis structure.

Problem statement

Historically, responses to child abuse and neglect have been ideologically driven. The underpinning ideologies have ranged from the preservation of moral order, to the prevention and treatment of clinical conditions and more recently to a recognition of children as individuals with their own rights. There have been many mistakes along the way resulting in harm to children that should have been protected, such as ethnocentric attempts to assimilate Aboriginal Australian children (Kociumbas, 1997), overdiagnosis of sexual abuse in the Cleveland Affair[1] (Butler-Sloss, 1988) and deaths of children known to child protection services (CPS) (Fraser, 2013; Johns, 2015). There has been, and remains, a tendency to blame individual parents for actions and inactions that cause actual or potential harm to their children. This stems from a perceived disconnect between child protection practices that respond to individual children and the broader social policies that support children and families (Featherstone et al., 2017).

There is increasing recognition that children living in families with greater disadvantage and social inequities are more likely to experience adversity including child abuse and neglect (Australian Government Department of Health, 2019). Thus, attention to socio-economic factors is core to addressing child abuse and neglect in the community. In Australia, the approach of addressing child abuse and neglect by considering broader socioeconomic

---

[1] The Cleveland Affair in 1987 involved the removal of multiple children from their homes in Cleveland, UK by social service agencies for what was later found to be unsubstantiated sexual abuse.

factors is often referred to as 'keeping children safe', whereby all members of community have an individual and collective responsibility to ensure children can reach their full potential (Council of Australian Governments, 2009). Nevertheless, Australia has not yet achieved the goal of addressing social and economic factors contributing to child abuse and neglect. This is evident by increasing numbers of children reported to CPS (Australian Institute of Health and Welfare, 2019), ongoing social issues like child poverty and specific population groups facing disproportionate disadvantage. For example, child poverty is prevalent with around one-fifth of Australian children living in poverty (Davidson, Saounders, Bradvury, & Wong, 2020) and there is ongoing overrepresentation of Aboriginal children within child protection systems (Australian Institute of Health and Welfare, 2019).

Nurses are the largest group of health professionals and work with children and families across many settings. They have an important role in the whole-of-community approach to addressing child abuse and neglect. As such they are well-placed to work with children and families who may be experiencing conditions that impact upon children's safety and development with the aim of preventing, identifying and responding to child abuse and neglect. It is important to understand how nurses conceptualise and respond to child abuse and neglect to inform how the nursing profession can be most effectively be mobilised and supported to become part of the solution.

Nurses' roles in responding to child abuse and neglect in the Australian context

In Australia, all nurses are mandated reporters of child abuse and neglect, but the thresholds and requirements for reporting abuse vary across jurisdictions. There are nine separate jurisdictions in Australia; this encompasses eight states and territories, and separate legislation for employees of the federal government and state governments (Australian Institute of Family Studies, 2017a). Key differences include the 'state of mind' of the person reporting (for example, a 'belief' or a 'suspicion' of abuse), and the types of abuse that must be reported (Australian Institute of Family Studies, 2017a). For example in Queensland, a nurse must report if they have 'a reasonable suspicion' of harm to a child causing 'detrimental effects on the child's body... or psychological or emotional state...' or

that such effects are 'likely to become evident in the future' (State of Queensland, 2018). Conversely, in South Australia, legislation states that mandatory reporting must be enacted if 'the person suspects on reasonable grounds that a child or young person is, or may be, at risk' (Government of South Australia: Attorney-General's Department, 2017). Importantly, legislation also states that simply reporting does not necessarily exhaust one's duty of care to a child or young person, as there may be other ways the reporter could support the child/young person (Government of South Australia: Attorney-General's Department, 2017). The importance of supporting children beyond mandatory reporting is underpinned by broader national policy documents, such as the National Framework for Protecting Australia's Children 2009-2020 which states that child protection is 'everyone's responsibility' and 'everyone has a role to play' (Council of Australian Governments, 2009, p. 12). While nurses have roles including mandatory reporting, they also have broader responsibilities in promoting and maintaining children's health, safety and wellbeing.

Nurses' roles in detecting and reporting of child abuse and neglect to CPS are clearly defined within legislation and are generally well-supported by organisational policies and guidelines. However, not all children meet the threshold for mandatory reporting, and even those who do may not receive a statutory response. In situations where children do not receive a statutory response, nurses have a key role in engaging families on a voluntary basis in non-statutory settings where children may otherwise receive no support. This is particularly relevant to nurses who work in settings where providing care to children is a core part of their role. In Australia, this includes paediatric nurses, who typically work in acute care settings and child and family health nurses (CFHN) who work in community settings in clinics and family homes similar to health visitors in the United Kingdom. There are some school nurses in Australia, but they are a relatively small group in comparison to paediatric and CFHNs. Despite many settings in which nurses work with children, nurses' broader roles in the prevention and early intervention for child abuse and neglect are poorly researched and largely invisible (Peckover & Appleton, 2019). As such, we have a limited understanding of how nurses already prevent, detect and respond to child abuse and neglect and how the nursing profession can be most effectively mobilised to make a difference in children's lives.

Study aim

Research is needed to provide a clear understanding of nurses' roles, perceptions and experiences of responding to child abuse and neglect. Consequently, this study explored the perceptions and experiences of nurses working with children about how they respond to child abuse and neglect.

The specific objectives were:

- To explore what shapes nurses' perceptions of their role in keeping children safe.

- To identify factors that influence nurses' decision-making.

- To explore how nurses respond to children considered to be at risk of or experiencing abuse and neglect.

Significance of the research

This research will provide a greater understanding of the invisible work that nurses do in responding to child abuse and neglect. It will identify how nurses conceptualise child abuse and how this shapes their practice. The benefits of this knowledge include increasing the visibility of nurses who already manage child protection concerns a part of their role and enhancing our understanding of what influences nurses' responses to children experiencing abuse and neglect. It is important to explore influences on nurses' practices because harm to children can result if child protection practices are enacted uncritically and without an awareness of the interactions between one's values and beliefs and subsequent actions. If we understand how nurses perceive and respond to child abuse, we can identify how to mobilise and support the nursing workforce to improve outcomes for children at risk of or experiencing abuse and neglect.

What is child abuse?

Child abuse, also known as child maltreatment, has been defined by the World Health Organization (WHO, 2006, p. 9) 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'. Although the WHO has defined child abuse, understandings of child abuse vary based on historical and cultural context because child abuse is '*defined within the context of the normative and deviant child rearing behaviour of the time*' (Scott & Swain, 2002, p. xii). Thus, an absolute definition of child abuse and neglect is difficult.

Additionally, there are limitations to defining child abuse from a relativist perspective based on societal standards which may not recognise the harmful impacts of 'normal' parenting practices of the time. For example, corporal punishment was condoned historically, but this is likely to have been highly distressing for children and recent research suggests it can cause lasting harm (Ferguson, 2013; Gershoff & Grogan-Kaylor, 2016). Contemporary definitions of child abuse focus on the impacts on children by considering the harm or risk of harm to the child to assess whether circumstances or practices may be considered abuse and neglect (Mathews, 2015b). This typically involves decisions about what is in the child's 'best interests' based on adults' value judgements (Woodhead, 2015). Value judgements by their nature are inherently tied to beliefs and attitudes that are culturally and historically specific. To understand this, the next section will trace the social and historical conceptualisations of childhood and how they have influenced current understandings of child abuse and neglect.

Views of children and childhood in Western contexts

Contemporary Western views of childhood have been shaped by historical conceptualisations of children as innocent, incomplete and in need of adult protection and guidance to prevent moral and spiritual corruption. This section traces the events of western Europe that have influenced our current conceptualisations of childhood, childrearing and child abuse and neglect, and how they have subsequently shaped our societal and institutional responses. Although Australia is a multicultural society, European culture has significantly influenced the way children and childhood are understood today. In the Romantic era, children were considered 'tabula rasa' or 'blank states', at which point they were innocent, incomplete and vulnerable to corrupting influences (Benziman, 2012;

Thiele, 2012). It was the duty of adults to protect children from such influences and carefully educate and mould children until adulthood (Desai, 2010). Western views of childhood were also shaped by early Puritan views of children entering the world with inborn sin rather than innocence, thus requiring adults to teach them obedience to ensure spiritual and moral wellbeing, often through physical discipline (Brockliss & Montgomery, 2013). These views positioned children as passive recipients of adult interventions to shape them into conformant and well-behaved future citizens (Desai, 2010). It is this notion of children needing protection or rescue from corrupting influences that underpinned initial conceptualisations of child protection and 'child rescue' practices of the 1800s.

Social and historical context of child protection in Western contexts

The child rescue movement: UK, USA and Australia

The conceptualisation of children as innocent, vulnerable and needing moral and spiritual guidance underpinned the child rescue movement. For example, in the 1800's, children orphaned due to poverty or war were cared for in alms-houses[2] and later by dedicated orphanages run by religious organisations with the aim of preserving moral order (Myers, 2006; Oates, 2019). These organisations cared for resident children but did not have the authority to investigate alleged abuse or neglect in the community. The first organised and dedicated child protection agency comparable to contemporary child protection agencies was the New York Society for the Prevention of Cruelty to Children (SPCC). The New York SPCC was developed in 1875, and was soon followed by similar developments in Britain and Australia (Crane, 2018; Ferguson, 2004; Scott & Swain, 2002). Prior to the development of institutions that specifically dealt with child abuse and neglect, child abuse was managed through legislation to prosecute cruelty to animals (Scott & Swain, 2002). Children were rescued from 'bad' parents, and as 'blank slates', poor 'lower-class' children were taught to embody middle-class values (Wells, 2009). At this point, the individuals 'rescuing' children

---

[2] Alms-houses were also known as a 'poor houses' and accommodated people unable to care for themselves including the mentally ill, terminally ill and frail elderly in addition to orphaned or 'poor' children (Myers, 2006).

were not experts or professionals because there was no existing professional or scientific body of knowledge around child abuse and neglect.

In the Australian context, 'child rescue' practices aimed at preserving and maintaining 'social order' were also targeted at Aboriginal children during colonisation by European settlers. Aboriginal children orphaned due to small pox plagues brought in by the First Fleet were supposedly 'rescued' to become sources of free labour, interpreters and reconnaissance of local Aboriginal populations (Kociumbas, 1997). Although these practices were framed as rescue, they are now recognised as abduction and forced separation through which children were exploited as cheap labour and often abused by their carers (Bird, 1998; Human rights and equal opportunity commission, 1997). However, the persecution and oppression of Aboriginal people was not limited to the initial time of colonisation. Oppression of Aboriginal people continued through consecutive government polices claiming to 'protect' are now recognised as genocide given their intent of eliminating Aboriginal culture (Dudgeon, Cubillo, & Bray, 2015; Human rights and equal opportunity commission, 1997). Underpinning these government policies were settlers' Puritan Christian beliefs of the alleged need to 'save' Aboriginal children from 'immoral' parents before children could be 'corrupted' (Australian Human Rights Commission, 2014; Manne, 2004).

European settlers' ethnocentric values and beliefs around family and social structures meant they assumed Aboriginal social structures and practices to be inferior to their own (Kociumbas, 1997). Thus, there was a perceived need to educate the 'blank slate' Aboriginal child in European ways (Kociumbas, 1997). Societal views also shaped the official government policies which promoted assimilation of Aboriginal people, such as through institutions set up to educate and 'reform' Aboriginal children (Human rights and equal opportunity commission, 1997; Kociumbas, 1997). It is only in hindsight that we can see how values and beliefs of that time influenced the way so called 'child protection' was enacted, and the harms it has caused. The forced removal of Aboriginal children has led to the Stolen Generations of Aboriginal children who were taken from their families in attempts to disrupt their cultural identities and compel them to accept Western ways. Policies of assimilation that allowed forced removal of Aboriginal children have had profound and ongoing

ramifications for Aboriginal people in Australia today. Ongoing impacts include intergenerational trauma, displacement from traditional lands, disrupted kinship relations, poor health, poverty and overrepresentation in child protection and criminal justice systems (Australian Institute of Health and Welfare, 2018a, 2019; Dudgeon et al., 2015).

Professional responses through scientific knowledge

From 1880's onwards, child protection in Western countries began to be viewed in a more scientific and medicalised manner (Parton, 2006). There was a gradual change from the sole maintenance of moral values, to the application scientific advancements in public health, such as hygiene and sanitation to reduce infant mortality. The increasing recognition that child abuse and neglect could be prevented meant that from 1910 there were campaigns in Australia and the UK to promote child health though pure milk campaigns, infant welfare centres, and surveillance in kindergartens and schools (Scott & Swain, 2002; Sutherland & Commachio, 2000). One key rationale for investing in children's education, health and wellbeing was economic, believing that healthy children would promote a more productive workforce (Mayall, 2018). However, the gathering of children in kindergartens and schools made the extent of extreme poverty acutely obvious because poorer children were often inadequately clothed, malnourished and experiencing visible diseases (Mayall, 2018). Nevertheless, a moral element persisted, as demonstrated by middle-class parents complaining that lower-class children might morally and physically taint their own children (Mayall, 2018; Sutherland & Commachio, 2000). In the Australian context, this meant Aboriginal children had to attend separate schools without qualified teachers when European parents objected to the presence of Aboriginal children in state schools (Kociumbas, 1997).

As scientific knowledge grew in the fields of medicine, psychology and social sciences, child welfare practices became part of the 'expert' domain whereby expertise was seen to be held by professionals and government workers (Ferguson, 2004; Scott & Swain, 2002). The increasing scientific knowledge produced a greater understanding of influences on child wellbeing and development, including children's emotional wellbeing. For example, John Bowlby's work on attachment theory from the 1950s was especially influential in

highlighting the impacts of early attachment on child socio-emotional development (Parton, 2006). This kind of work paved the way for psychological assessment of parenting, with social work students beginning to use psychological assessment tools to assess parental capacity from the 1960s (Scott & Swain, 2002). The rapidly increasing knowledge led to greater awareness and concern over the potential for lasting impacts of abuse and neglect on children, and thus increasing interest in prevention and management (Kulkofsky, 2008).

The rediscovery of physical abuse: battered child syndrome

Although child physical abuse was recognised throughout the 1800s, it gradually slipped from public view and discussion during the world wars (Myers, 2006). In his seminal paper 'The battered-child syndrome' American paediatrician, Kemp and his colleagues rekindled public and professional awareness of childhood physical abuse through its rediscovery as 'battered-child syndrome' (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). The moral problem of child physical abuse was reconstructed as a 'clinical condition' that could be diagnosed through a clinical examination and new technologies like x-rays (Kempe et al., 1962). The name 'battered-child syndrome' was intended to grasp public emotion and prompt action, while the classification as a 'syndrome' positioned it as a 'medical problem' best managed with medical expertise (Crane, 2018). The cause of this 'clinical condition' was considered to be parental characteristics, including psychosocial diagnoses (Parton, 2006). Different medical specialties had various claims on battered-child syndrome, with radiologists asserting that only x-rays could give a definitive diagnosis of battered-child syndrome, while psychiatrists allegedly assessed abusive parents for 'brain abnormalities' (Crane, 2018). Notably, children's voices and experiences were absent in these medical accounts of battered child syndrome, but instead there were vivid descriptions and pictures of children's physical suffering (Mundaly & Goddard, 2006).

In claiming 'battered child syndrome' as the domain of medical and social work professionals, these professionals were subsequently held accountable when things went wrong (Scott & Swain, 2002). Public anger which was once directed towards parents when a child died from abuse or neglect, was also aimed at professionals and eventually politicians (Scott & Swain, 2002). Misconceptions about the capacity to accurately predict and prevent

child abuse meant public criticism and outrage followed inevitable instances of system failure (Bromfield & Holzer, 2008). The same public outrage was generated when later discredited medical techniques falsely over-diagnosed sexual abuse in Cleveland in 1987. Media responses to the Cleveland Affair, and other high-profile scandals typically result in media reports that attempt to attribute blame (Donaldson & O'Brien, 1995; Leigh, 2017a). Unfortunately, simply blaming professionals when things go wrong only oversimplifies the problem of child abuse rather than promoting critical debate and effective resolutions (Lonne & Parton, 2014).

One of the key achievements of Kemp et al's (1962) rediscovery of child abuse was the development of mandatory reporting laws for child abuse and neglect. The implementation of mandatory reporting laws commenced in the USA, and by the 1970s all Australian states and territories had followed with some form of legislation protecting children (Bromfield & Holzer, 2008).

Children as individuals with rights

During the early 1900s there were significant changes to public views about parenting, children and children's rights. For example, many middle-class women argued against paid employment for school-aged children, believing it prevented children from focussing on their education (Mayall, 2018). Prevailing public views about children emphasised nurturance to meet children's mental, moral and physical needs (Sutherland & Commachio, 2000). In line with these views was the recognition of children as individuals with their own rights, leading to the development of the Declaration of the Rights of the Child by the League of Nations in 1924, later to be developed into the more comprehensive United Nations Convention on the Rights of the Child (UNCRC) (Montgomery, 2013c)

Changing societal views lead to a gradual shift in professional attitudes towards children. In the late 1900s, children's voices and experiences became of greater interest to professionals such as psychologists and social workers, believing that children's behaviour could be used to detect abuse (Crane, 2018). This was first evidenced in the enquiry into the death of Maria Colwell at age seven whereby social workers demonstrated interest in Maria's

emotions by noting her outward behaviour (Crane, 2018). In addition, practitioner concerns about listening to children's thoughts and beliefs emerged in the 1980s whereby researchers would interview children to gain insight into their unique experiences, including experiences of violence (Crane, 2018). At this same time, doctors began to see children as independent recipients of healthcare. This led to the landmark Gillick's case[3] in 1985 where children were legally recognised as being able to make up their own mind about their medical care without the need for parental consent (Crane, 2018). Furthermore, research began to recognise that emotional abuse often accompanies physical abuse and neglect, and all forms of abuse could have severe and lasting impacts on a child's social and emotional wellbeing (Australian Institute of Family Studies, 2015).

Montgomery (2013b, p. 163) suggests a lack of attention to social factors contributing to abuse such as poverty, living conditions and racism may be due to 'selective inattention', whereby people prefer to focus on external threats of 'strangers' or 'poor mothers'. For example, selective inattention about threats to children is demonstrated through adult anxieties about child abduction manifested through 'stranger danger', despite the rarity of child abduction (Gill, 2007; Montgomery, 2013b). Prevailing attitudes from the 'child rescue' efforts of the late 1800s of 'saving' innocent children from 'bad' parents continues to blame already marginalised families for their circumstances rather than addressing the broader determinants of health. Although there will always be a need for statutory services to address serious safety concerns (Mathews, 2015a), it is important to change responses to child abuse so families' needs and underlying issues are addressed rather than simply removing children (Bromfield & Holzer, 2008). One of the problems with removing children from their parents is that it does nothing to address the root causes and underlying social problems remain. The need for change is highlighted by the fact that child protection systems are frequently implicated high-profile cases where children have died despite being known to them. Multiple inquests and inquiries have been conducted into the failure of CPS

---

[3] Gillick's case refers to precedent set in an English court named after activist Victoria Gillick. It acknowledged the legal capacity of a child to make up their own mind and consent to medical treatment without parental consent if the child had 'sufficient understanding and intelligence to give its [sic] consent' ("Gillick v West Norfolk and Wisbech AHA," 1985).

to protect children and with damning results (see for example Basheer, 2019; Johns, 2015; Nyland, 2016; Tune, 2015). In one example, state Coroner Mark Johns described the child protection system as 'broken and fundamentally flawed' when investigating the death of four-year-old Chloe Valentine in Adelaide in 2012 (Johns, 2015, p. 147).

Public health and multi-sectoral approaches

One of the unintended effects of the rollout of mandatory reporting laws following the 'rediscovery' of child abuse was that child protection systems became inundated with reports and were unable to meet demand (Bromfield & Holzer, 2008). This led to a search for other approaches to reduce the pressure on statutory services. The predominant approach has moved towards a public health model which has a broader preventative focus on societal factors that contribute to child abuse and neglect. This is a partial reversal of the positioning of child protection practices in the 'expert' domain, by recognising that everyone has a role to play. In Australia, the National Framework for Protecting Australia's Children reframes child protection as 'everyone's business' where all individuals, communities and organisations are expected to work together to promote and protect children's safety and wellbeing (Council of Australian Governments, 2009). The National Framework outlines the current approach as a 'public health model' which addresses all levels of need from universal services, early intervention, targeted intervention and statutory intervention for high-level abuse or neglect. In the United Kingdom, the equivalent approach is called 'safeguarding' which encompasses all work in promoting children's health and wellbeing, from universal services through to statutory services, with the term 'child protection' is typically reserved for cases requiring statutory intervention (Her Majesty's Government, 2018). Although the term 'safeguarding' has been widely adopted in the UK (Her Majesty's Government, 2018), it has not been consistently applied in Australia.

Child protection today – how far have we come?

From a health perspective, children today are better off than their predecessors living in times of high infant mortality and widespread post-war poverty. Reductions in infant mortality have been attributed to improved health, nutrition, immunisation and sanitation,

while causes of death such as SIDS/SUDI[4] and road traffic accidents are declining (GBD 2015 Child Mortality Collaborators, 2016; United Nations Children's Fund, 2018; World Health Organization (WHO), 2018). However, significant inequalities and disparities remain, particularly for Sub-Saharan Africans and Aboriginal Australians who still experience disproportionally high infant mortality (Australian Institute of Health and Welfare, 2018b; GBD 2015 Child Mortality Collaborators, 2016). Similarly, specific groups of children and young people experience circumstances that constitute abuse and neglect even within Australian institutions, such as child asylum seekers in detention (Australian Human Rights Commission, 2014) and young people detained in adult justice centres (Willacy, 2019). Additionally, there are ongoing local disparities that are less sensationalised, such as the higher levels of abuse and neglect in population groups such as Aboriginal communities and children living in poverty (Australian Institute of Health and Welfare, 2019; Davidson, Saunders, Bradbury, & Wong, 2018). While overarching figures suggest children may be better off overall, it is essential to consider how inequalities impact upon children's lives at local levels.

Current Australian policy frameworks outline the goal of a public health approach to prevent and intervene early for child abuse, but reports to child protection services are increasing (Australian Institute of Health and Welfare, 2019; Bromfield & Holzer, 2008). At the same time, the social factors that contribute to child abuse and neglect are increasing, placing further pressure on vulnerable families. For example in Australia, 17 per cent of children are living in poverty (Davidson et al., 2018). Similarly, many children in the most disadvantaged communities are living in environments that do not adequately support their early health and development, as indicated by a greater likelihood of being developmentally vulnerable at school age (Commonwealth of Australia, 2019). Similar patterns are reflected in other countries such as the UK with increasing social and economic pressure on families while government services are being cut, making it even more difficult for services to meet the growing needs of children and families (Peckover & Appleton, 2019).

---

[4] Refers to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Death in Infancy (SUDI).

Another challenge for professionals caring for children is how to maintain an explicit child centred approach. A child centred approach places the needs and welfare of children as the primary focus of practice (Mundaly & Goddard, 2006; Race & O'Keefe, 2017). A child centred approach recognises that children experience the world in a uniquely different way from adults and considers how practitioners' values and beliefs may impact upon their work (Mundaly & Goddard, 2006). In such a system, children and young people's wishes, feelings and experiences are placed at the centre of care (Munro, 2011). This is in contrast with historical views of children as incomplete and imperfect adults who should passively accept adult ways and teaching (Desai, 2010). While the value of a child-centred approach is well recognised, it is not necessarily translated to practice, as children and young people today still experience being silenced or ignored (Care Quality Commission, 2016; Rees, Simpson, McCormack, Moussa, & Amanatidis, 2019). Professionals cite many reasons for not listening to children, including that children may be unreliable, untruthful or misunderstood; ignoring that the same applies to adult informants (Montgomery, 2013a). Nevertheless, listening to children is complex, and Mundaly (2006) identified many practical, structural and cultural factors that affect professionals' capacity to listen to children.

Chapter summary

Child abuse and neglect is a major public health problem in Australia and internationally. The high prevalence of child abuse and neglect and complexity of contributing factors means it is best addressed through a whole-of community approach. As such, everyone is responsible for promoting children's wellbeing and responding to children experiencing adversity. The importance of understanding how cultural, social and temporal factors influence our understanding of child abuse and neglect has been outlined and demonstrated through how responses to children have not always produced positive outcomes. The potential for well-meaning interventions to cause harm to children highlights the importance of critically reflecting upon contemporary views of children and childhood, and how socially constructed conceptualisations shape our responses. This underpins the significance of exploring nurses' understandings of child abuse and neglect which are socially constructed and influence their interactions with children and families. In

recognition of the role of social practices in understanding child abuse and neglect, social constructionist theory is used explore nurses' perceptions and experiences of child abuse and neglect to better understand what shapes their understandings of child abuse and neglect. This will facilitate a greater understanding of how nurses perceive their role and how their conceptualisations subsequently influence their practices with children who may be experiencing abuse and neglect. Ultimately, this knowledge of nurses' perceptions of child abuse and neglect will help equip and support the nursing profession to promote better outcomes for vulnerable children.

CHAPTER 2: LITERATURE REVIEWS

Chapter overview

Chapter two provides a review of the international literature that relates to the nature and extent of nurses' roles in responding to child abuse and neglect. It also explores whether nursing interventions can produce measurable change for children at risk of or experiencing abuse and neglect. This chapter is comprised of two published literature reviews from 2017 and 2018. These are followed by an update of relevant research published after these two literature reviews. Literature presented in Chapter two outlines existing research evidence to demonstrate the relevance and need for this study exploring perspectives and experiences of nurses working with children about how they keep children safe from abuse and neglect.

Citation

Lines, L. E., Hutton, A. E. and Grant, J. M. 2017, Integrative review: nurses' roles and experiences in keeping children safe. Journal of Advanced Nursing*, 73 (2), 302-322, doi: 10.1111/jan13101*

Attribution of Authorship

Author contributions to this manuscript are as follows:

LL (80%), AH and JG all contributed to the conception and design of this integrative review. Data collection was done by LL (100%). The analysis and interpretation of the findings was conducted by LL (80%) in collaboration with AH and JG (20%). LL (90%) drafted the manuscript and the other authors (AH & JG) provided support in revising the work to contribute to its interpretation.

Literature review 1: Integrative review: nurses' roles and experiences in keeping children safe

Introduction

Child abuse is prevalent globally with one quarter of all adults reporting a history of childhood physical abuse and an additional 41,000 children annually recorded as victims of homicide (World Health Organisation, 2014). The definitions of child abuse vary among countries and jurisdictions, but include physical abuse, sexual abuse, psychological abuse and neglect (Williams & Weeks,

2014). The effects of child abuse are not restricted to childhood as the impacts can extend into adult life. Adults who were victims of abuse during childhood often experience increased mental health problems, greater contact with the criminal justice system, decreased educational attainment, reduced economic wellbeing and poorer personal relationships (Allwood & Widom, 2013; Covey, Menard, & Franzese, 2013; Currie & Widom, 2010; Easton, Renner, & O'Leary, 2013; Sugaya et al., 2010).

In recognition of the lasting individual and societal effects of child abuse and neglect, they have been identified as a serious public health issues in many countries (Gilbert et al., 2012; World Health Organisation, 2010). The United Nations Convention on the Rights of the Child similarly recognises that children have the right to grow and develop in an environment free from abuse and neglect (Office of the High Commissioner for Human Rights, 1990). As the largest group of health professionals, nurses have significant capacity to detect child abuse and support children and families in situations of abuse. However nurses' experiences of enacting their role in safeguarding children across both child focussed and adult services remains unknown. Given the potential impact of nurses in reducing child abuse and neglect, this area warrants investigation. Thus, a comprehensive review of the literature was undertaken to explore how nurses manage safeguarding children in their care.

Background

To combat child abuse and neglect, many countries have proposed that professionals involved with children should be involved in identifying and responding to child abuse and neglect. For example, in the UK, the focus is on safeguarding and promoting the wellbeing of all children through inter-disciplinary cooperation between all organisations and professionals who provide services to children or families (Her Majesty's Government, 2015). In Australia, the approach is similar with child protection recognised as 'everybody's business' where all sectors of society from individuals to commercial organisations are expected to participate (Council of Australian Governments, 2009). Safeguarding children occurs at several different levels and includes prevention strategies aimed at the whole population, early intervention for families at risk and targeted interventions for children considered to be experiencing abuse and neglect (Gilbert et al., 2012). The overarching philosophy that guides professionals and organisations in safeguarding children is increasingly a 'child-focussed' approach. In a child-focussed approach, the child's social,

physical and emotional wellbeing are at the core of all service delivery to the child, parents and family (Fox et al., 2015).

One of the key differences between child protection systems internationally is the role of nurses in reporting of child abuse. In countries such as the United States of America, Canada and Australia nurses are legally required to report child abuse (Mathews, 2015a). In other countries such as the United Kingdom and New Zealand there is generally no legal requirement to report abuse, although nurses may still be ethically obliged to intervene (New Zealand Government, 2012; Royal College of Nursing, 2014). In addition to reporting child abuse, nurses as a professional group are in an ideal position to identify families experiencing challenges to parenting and engage with families and services to promote children's safety and wellbeing (Her Majesty's Government, 2015; Tinker, Postma, & Butterfield, 2010). Nurses are recognised as core to supporting families and children in paediatric nursing environments and through programs such as universal home visiting where they are able to assess and promote the health and wellbeing of families (Fraser, Grant, & Mannix, 2014). Nurses working with adults may be indirectly involved with children and able to identify the needs of children at risk of abuse due to adult problems. In these roles, nurses are urged to take a child-centred approach to maintain the safety and wellbeing of children in their care (Her Majesty's Government, 2015; Munro, 2011).

Methods

Aim

The aim was to identify nurses' roles and experiences of keeping children safe.

Design

An integrative review was conducted using Whittemore and Knafl's (2005) framework for reviewing and analysing the literature. This framework uses explicit and systematic methods to reduce the risk of bias and improve reliability of the findings. An integrative review is useful for combining multiple types of evidence including both experimental and non-experimental designs to enable a more comprehensive understanding of the phenomenon of interest.

Search methods

The databases CINAHL, Medline, Scopus and Web of Science were searched in June 2015 to identify primary research studies that investigated the roles and experiences of nurses in keeping

children safe. This included studies that reported nurses' subjective experiences, perspectives, attitudes and knowledge along with more objective measures of their knowledge and attitudes. The literature search was conducted by electronic searching of databases followed by scanning the reference lists of included studies for any additional relevant studies. The first author conducted the search in September 2015 under the supervision of the co-authors using keyword combinations of the following 'nurse', 'health visit*', 'mandatory report*', 'mandatory notif*', 'child abuse', 'child maltreatment' and 'child neglect'. These keywords were applied in CINAHL, Medline, Scopus, Informit and Web of Science. Grey literature was also searched using these keywords but no relevant studies were identified. The search was restricted to English language studies published within the past ten years.

Search outcome

All results from the database searches were exported into Endnote 7 where duplicates were removed. The titles and abstracts of remaining articles were screened for relevance based on the inclusion/exclusion criteria (Table 1) and irrelevant studies were discarded.

Table 1: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
English language primary research studies.	Non-English language primary research studies.
Studies from January 2005 to September 2015.	Studies published before 2005.
Addressed the role of nurses in safeguarding children in any setting.	Study did not explicitly discuss how nurses consider children's needs, wellbeing and /or safety.
At least one participant was a frontline nurse or nurse practitioner.	No participants were frontline nurses or nurse practitioners, or the professional occupation was unclear.
	Study was evaluating or validating the use of a specific screening or assessment tool, model of care or intervention.

Studies of all research designs were included in the findings in accordance with Whittemore and Knafl's integrative review design. Next, the first author screened the remaining papers by reading the full-text to determine eligibility and discussed their eligibility with the remaining authors. Six additional studies were identified during this stage by reading the reference lists of the included studies from the database searches. Overall, 60 studies met the inclusion criteria and were included in this review (Appendix 1) The process of selection is outlined in Figure 1.

```
┌─────────────────────────────────────┐
│ Potentially relevant articles       │
│ identified after duplicates removed │
│ (n=1080)                            │
└─────────────────────────────────────┘

┌─────────────────────────────────────┐
│ Articles excluded after reading     │
│ title/abstract (n=988)              │
└─────────────────────────────────────┘

┌─────────────────────────────────────┐         ┌──────────────────────────────────────┐
│ Articles remaining (n=92)           │         │ Articles excluded (n=39):            │
│                                     │ ──────> │                                      │
│                                     │         │ Did not address nurses' role or      │
│                                     │         │ experience in safeguarding (n=33);   │
│                                     │         │ Participants' professions were       │
│ Studies for review (n=53)           │ <────── │ unclear (n=1);                       │
│                                     │         │ Evaluation of service/intervention   │
│                                     │         │ (n=5);                               │
└─────────────────────────────────────┘         └──────────────────────────────────────┘

┌─────────────────────────────────────┐
│ Studies included from hand searching │
│ (n=7)                               │
└─────────────────────────────────────┘

┌─────────────────────────────────────┐
│ Total studies included in the review │
│ (n=60)                              │
└─────────────────────────────────────┘
```

Figure 1: Flow diagram of study selection

Quality appraisal

Each study was critically appraised for methodological soundness using the Critical Skills Appraisal Programme according to their research design (Critical Skills Appraisal Programme, 2013). The qualitative CASP tool was used to evaluate the qualitative studies but as there was no specific CASP tool for mixed method studies or for the variety of quantitative designs included in this review, the existing CASP tool were adapted to suit these designs.

Methodological quality was generally high in the majority of studies (n=57), although three studies had only moderate rigour. Due to moderate to strong methodological rigour of all studies, none were excluded on the basis of inadequate rigour. The most common weakness of the qualitative studies was failure of the researcher to explicitly consider impacts of the researcher-participant relationship, while the most frequent weakness of quantitative designs was small or non-representative samples. See Appendix 2 for supporting information about the specific methodological rigour of the included studies.

Data abstraction

Next, each study was read and reread in detail and relevant information was extracted from studies. The first author was responsible for data abstraction and this process was discussed with the remaining authors. Decisions about what information was extracted were informed by the review question about nurses' roles and experiences of keeping children safe. Studies were organised into subgroups of geographical region to facilitate identification of similarities in each region (Whittemore & Knafl, 2005).

Data synthesis

Once data abstraction had been completed, descriptive coding was used to organise the data and to make analytical comparisons and contrasts as relevant to the review aim (Whittemore & Knafl, 2005). The initial codes were then organised into related areas or themes by the first author (Braun & Clarke, 2006). These themes were discussed among all three authors so emerging findings could be considered, clarified and refined. In this way, the authors developed themes that reflected the core findings while recognising and representing nuance and variability in the data. The final results and themes were agreed by all three authors as accurately representing the findings.

Results

The 60 studies were located predominantly in developed countries (n=48) and/or included exclusively nurses as the professional group under investigation (n=43). Many studies recruited nurses from a cross-section of practice settings (n=18), while other studies specifically investigated nurses working in home visiting (n=13), community health centres or schools (n=12), or hospital settings (n=14). A small number of studies (n=3) also addressed adult mental health nurses and

their contributions to keeping their clients' children safe. The three main findings relating to nurses' roles and experiences in safeguarding children were around 'insufficient knowledge', 'validation and communication' and 'balancing surveillance and support'. The finding 'insufficient knowledge' was supported by the most studies (n=44), while 'validation and communication' and 'balancing surveillance and support' were from 35 and 25 studies, respectively. Appendix 3 demonstrates which studies contributed to each of these major findings.

Insufficient knowledge

Although the majority of nurses were aware of their legal or ethical obligation to report child abuse and neglect (Davidov & Jack, 2013; Glasser & Chen, 2006; Land & Barclay, 2008; Lazenbatt & Freeman, 2006; Mathews et al., 2008; Raman, Holdgate, & Torrens, 2012; Tingberg, Bredlöv, & Ygge, 2008), the underreporting of child abuse and neglect was identified in several studies (Ben Natan, Faour, Naamhah, Grinberg, & Klein-Kremer, 2012; Herendeen, Blevins, Anson, & Smith, 2014; Lazenbatt & Freeman, 2006; Lee, Fraser, & Chou, 2007; Mathews et al., 2008; Raman et al., 2012; Schols, De Ruiter, & Öry, 2013). Nurses frequently cited insufficient knowledge of child abuse and neglect as a barrier to identifying and responding to child abuse and neglect (Borimnejad & Fomani, 2015; Francis et al., 2012; Glasser & Chen, 2006; Herendeen et al., 2014; Houlihan, Sharek, & Higgins, 2013; Lazenbatt & Freeman, 2006; Lee et al., 2007; Louwers, Korfage, Affourtit, De Koning, & Moll, 2012; Raman et al., 2012; Schols et al., 2013; Tingberg et al., 2008). Unfortunately, obtaining adequate information about reporting requirements was not always as simple as accessing the relevant policy or procedure. Some nurses did not know where to access reporting procedures (Louwers, Korfage, Affourtit, De Koning, et al., 2012), while others perceived policies were too vague or otherwise unhelpful in clinical decision-making (Land & Barclay, 2008; Lazenbatt & Freeman, 2006; Rowse, 2009b; Schols et al., 2013; Tingberg et al., 2008).

Although most nurses (49-86%) had received some training around their role as a mandated reporter of child abuse (Ben Natan et al., 2012; Fraser, Mathews, Linping, & Dunne, 2010; Hackett, 2013; Herendeen et al., 2014; Raman et al., 2012; Rolim, Moreira, Gondim, Da Silva Paz, & De Souza Vieira, 2014; Yehuda, Attar-Schwartz, Ziv, Jedwab, & Benbenishty, 2010) many nurses still desired ongoing professional development in areas of child protection (Crisp & Lister, 2006; Houlihan et al., 2013; Land & Barclay, 2008; Lazenbatt & Freeman, 2006; Lee et al., 2007; Tingberg et al., 2008; Whittaker et al., 2015; Yehuda et al., 2010). However, there were some exceptions

including surveys of Taiwanese (n=1400) and Brazilian nurses (n=104) indicating that 80 per cent and 86 per cent, respectively, had not participated in any child abuse training (Feng & Levine, 2005; Moreira, Vasconcelos, Marques, & Vieira, 2013). In general, nurses desired education that was specific to their clinical speciality. For example, health visitors wanted more information about assessing parent-infant attachment (McAtamney, 2011) while adult mental health nurses requested education around communicating with young children (Houlihan et al., 2013).

Gaps in nurses' knowledge were apparent even among studies that did not specifically investigate nurses' perceived knowledge and educational needs. For example, some nurses did not maintain a child focus, but instead considered parental intent and mitigating factors instead of impact on the child when deciding whether to report (Browne, Hartrick Doane, Reimer, MacLeod, & McLellan, 2010; Eisbach & Driessnack, 2010; Schols et al., 2013). Similarly, Land and Barclay (2008) found that some nurses became desensitised to the high prevalence of health and social problems believing these could be 'normal' and therefore acceptable in certain populations. While it is helpful to have an understanding of a child's social context when making a report, nurses may not be accurate in their assessments of the likelihood of harm from abuse or neglect. One study indicated that recent training did not influence nurses' perceptions of the seriousness of abuse or neglect (Fraser et al., 2010), while other studies have found that nurses' decisions to report were more closely linked their own subjective beliefs of child abuse and neglect than knowledge or child abuse education (Ben Natan et al., 2012; Ho & Gross, 2015). Thus, nurses may not have the necessary knowledge, skills or attitudes to make appropriate decisions about the potential seriousness and need for intervention, potentially placing children at risk of further harm. This literature highlights that nurses were aware of their responsibility to report. However due to perceived lack of information and support to guide nurses in making a mandated report, child abuse is still under-reported.

Validation and communication

Due to nurses' lack of knowledge, they were not always confident in professional judgements around keeping children safe. Sometimes, signs that a family was struggling were obvious and nurses were quick to respond (Eisbach & Driessnack, 2010; Schols et al., 2013). However, more often the suspicions around a child's wellbeing started with the nurse's intuition or a 'gut feeling' that something was not right (Rowse, 2009a; Schols et al., 2013). Health visitors in the United

Kingdom in particular emphasised that assessments need to be holistic and ongoing rather than based on individual or isolated observations (Appleton & Cowley, 2008; Lewin & Herron, 2007; McAtamney, 2011; Selbie, 2009). From there, nurses attempted to verify their concerns through monitoring the family, with some describing this process as putting together 'pieces of a jigsaw puzzle' (Wilson et al., 2008) or endeavouring to see the full 'picture' (Eisbach & Driessnack, 2010; Selbie, 2009; Whittaker et al., 2015). When the signs were vague, nurses experienced a tension between the need to ensure the child's wellbeing and the concern about 'getting it wrong' and reporting suspicions of abuse that might be unfounded (Eisbach & Driessnack, 2010; Lazenbatt & Freeman, 2006; Rowse, 2009b).

When nurses were unsure about the legitimacy of their concerns or the optimal course of action, they often discussed the situation with their colleagues (Schols et al., 2013). This was based on nurses' recognition that child protection issues were frequently the culmination of multiple complex factors and best managed through a multidisciplinary approach (Feng, Jezewski, & Hsu, 2005; Reupert & Maybery, 2014). For some nurses, the hierarchical structures of their organisations also led them to erroneously believing they must discuss each case with a senior colleague prior to reporting (Francis et al., 2012; Land & Barclay, 2008). Depending on their clinical setting, nurses discussed child safety concerns with their managers (Crisp & Lister, 2006), nursing colleagues (Wilson et al., 2008) or physicians (Feng et al., 2005; Francis et al., 2012; Pabis, Wronska, Slusarska, & Cuber, 2011). While at times this process helped affirm nurses' suspicions, it also lead to frustration when other professionals did not agree with nurses' clinical judgements (Rowse, 2009a) or subsequently excluded nurses from decision-making (Land & Barclay, 2008). For example, physicians were seen as the authority for hospital-based nurses who perceived a need to 'convince' the physician of the legitimacy of their concerns before any action could be taken (Feng, Fetzer, Chen, Yeh, & Huang, 2010; Feng & Levine, 2005; Francis et al., 2012; Rowse, 2009a).

Although child protection services may seem the most appropriate avenue to discuss child protection concerns, nurses did not always consult directly with them. Nurses reported frustrations around the process of consulting with child protection services who were seen as difficult to contact or unhelpful in addressing the child's needs (Eisbach & Driessnack, 2010; Feng et al., 2005; Lazenbatt & Freeman, 2006; Mathews et al., 2008; Rowse, 2009a; Schols et al., 2013). Many nurses were troubled by the lack of feedback following reports they made to child

protection services (Herendeen et al., 2014; Land & Barclay, 2008; Maddocks, Johnson, Wright, & Stickley, 2010; Rowse, 2009b; Schols et al., 2013; Tingberg et al., 2008). Nurses often cared deeply for the children and their families and became disheartened when they did not know what, or if anything was being done to assist the family (Kent, Dowling, & Gobnait, 2011; Kraft & Eriksson, 2015; Land & Barclay, 2008). As a result, many nurses lacked faith that the child protection services would take appropriate action on behalf of the child.

Nurses also reported poor communication between agencies involved in providing care for vulnerable children and families. In some cases this was due to concerns around confidentiality of families' information (Land & Barclay, 2008; Reupert & Maybery, 2014). Other nurses described how poor communication could place nursing staff into dangerous situations during home visiting if they were not informed of potential safety risks like domestic violence (Land & Barclay, 2008; Selbie, 2009). At other times, optimal co-ordination of services was reduced because the lack of information exchange meant that no single person was clear on exactly what services were being provided to the family (Schols et al., 2013). For example, one public health nurse recounted a situation where a family had been referred from agency to agency, only to eventually be referred back the public health nurse who had commenced the referral process (Selbie, 2009). The large number of agencies involved with some families lead to them being given conflicting information from different professionals (Reupert & Maybery, 2014). Nurses' lack of confidence in their own professional judgements led to overreliance on senior colleagues' opinions around validity of nurses' concerns. These consultations with senior colleagues often took the place of communication with child protection services, which nurses frequently did not trust to effectively safeguard the child.

Balancing support and surveillance
The qualitative studies identified that nurses valued building trust and rapport with vulnerable families to initiate and maintain positive therapeutic relationships (Browne et al., 2010; Selbie, 2009). Nurses reported that trust and rapport with families led to greater engagement with health services, especially for families who might be suspicious of services (Browne et al., 2010; McAtamney, 2011; Reupert & Maybery, 2014; Selbie, 2009). However, not all nurses believed that safeguarding children was their responsibility. For example, Crisp and Lister (2006) found that nurses tended to believe that child protection should be the responsibility of health visitors and

reported that some nurses declined requests to be interviewed citing that child protection was not part of their role. Similarly, some mental health nurses in the United Kingdom had difficulty balancing the emotional needs of their adult clients against the safety of clients' children and subsequently decided to remain impartial towards the children (Maddocks et al., 2010). This is consistent with Houlihan, Sharek and Higgins' (2013) study of 114 psychiatric nurses which found that over half (57%) the respondents asked if their client had children, but only about a third (36%) documented this finding. Conversely, Korhonen et al. (2010) found that of 331 mental health nurses, most (95%) regularly gathered information about parental status from their clients, but nurses who were parents themselves better understood the needs of children and were more likely to meet with children to assess their needs.

Unfortunately for many nurses, their focus on promoting positive therapeutic relationships led to perceived role conflicts when concerns arose about child safety. Although nurses understood the importance of reporting child abuse, they sometimes reported a tension between their primary role of supporting families while simultaneously monitoring and policing them (Davidov, Nadorff, Jack, & Coben, 2012; Kent et al., 2011; McAtamney, 2011; Tingberg et al., 2008; Whittaker et al., 2015). Some nurses were concerned that the caring and compassionate public image of nursing that gave them access to vulnerable families might be compromised by their role in surveillance for abuse and neglect (Kent et al., 2011). There is evidence to suggest that the trust nurses develop with vulnerable families can easily be damaged by reporting concerns about child abuse and neglect (Davidov, Nadorff, et al., 2012; Eisbach & Driessnack, 2010; Francis et al., 2012; Kent et al., 2011; Lazenbatt & Freeman, 2006; Mathews et al., 2008). Some nurses attempted to bypass this conflict and helped families address their problems without contacting statutory child protection services through referrals to voluntary agencies and/or continuing to monitor the family (Browne et al., 2010; Eisbach & Driessnack, 2010; Francis et al., 2012; Kraft & Eriksson, 2015; Schols et al., 2013). However, this strategy was acknowledged as potentially risky if families realised they were being watched and withdrew from services (Francis et al., 2012).

In addition to the adverse consequences of reporting of abuse on nurse-family relationships, nurses also voiced concerns over the potential for negative personal outcomes. In more extreme cases, nurses were aware of situations where family members had made threats against nurses who were believed to have made a report of abuse (Borimnejad & Fomani, 2015; Feng et al., 2005;

Kraft & Eriksson, 2015; Land & Barclay, 2008; Lee et al., 2007). While these fears may be well founded based on the clinical examples provided, nurses were also worried about having to give evidence in court (Land & Barclay, 2008; Rolim et al., 2014; Rowse, 2009b) and the potential for litigation should they report abuse that was later not substantiated (Fraser et al., 2010; Mathews et al., 2008). The potential for adverse outcomes following mandatory reporting appeared to be particularly enhanced in Taiwanese nurses due to the cultural norms around childrearing as family business that should not be interfered with (Chen, Huang, Lu, & Feng, 2015; Feng et al., 2005).

Nurses also experienced conflict between their role of supporting families through positive therapeutic relationships when parents were alleged perpetrators of severe abuse (Rowse, 2009a; Tingberg et al., 2008) or caused harm through substance abuse (Maguire, 2013; Murphy-Oikonen, Brownlee, Monetlpare, & Gerlach, 2010). Nurses reported distress over the effects of parental behaviour on children, which led to feelings of frustration, anger or disgust towards the parent/s (Maguire, 2013; Murphy-Oikonen et al., 2010; Tingberg et al., 2008). Nurses frequently placed the sole blame for the child's pain and distress on the parents, which meant the nurses experienced emotional and ethical barriers to engaging with these parents in meaningful ways (Maguire, 2013; Rowse, 2009b; Tingberg et al., 2008; Whittaker et al., 2015). Although nurses clearly understood the nature of their responsibility in caring for both the abused and abuser, their emotional response was a barrier to providing care to both parties. Nurses considered their role in reporting child abuse and neglect as punitive rather than a positive response with potential to safeguard the child. Thus nurses faced ethical dilemmas when deciding whether to intercede on behalf of the child by making a report, or whether to preserve their image of a caring, helping professional.

Discussion

This review examined the role and experiences of nurses in safeguarding children as represented in the literature. The findings indicate that nurses face several barriers to safeguarding children, which include inadequate knowledge, difficult inter-professional communication and tensions between nurses' simultaneous roles in caring and surveillance. The first finding around nurses' lack of knowledge and confidence links very closely to the difficulties nurses face around inter-professional communication and balancing support and surveillance.

Nurses were typically well aware of their legal and ethical responsibilities to report child abuse and neglect. However, due to a perceived lack of information and support, nurses did not always report their suspicions to child protection services. The level of education that nurses receive in relation to safeguarding children varies among different countries. For instance, in the United Kingdom all professionals working with children are expected to undergo training (Her Majesty's Government, 2015), whereas in comparison, in the United States of America, there is no national consistency around the type or amount of training required (Kenny, 2015). However, even nurses who had attended training showed perceived and measurable knowledge gaps.

Nurses' perceptions of their own knowledge were not necessarily related to their previous experiences with safeguarding children. For example, health visitors for whom safeguarding children was a major part of their role desired more education around assessment of mother-infant attachment (Crisp & Lister, 2006; McAtamney, 2011; Wilson et al., 2008). Measurable knowledge gaps were also identified by Ben Natan (2012) in Israel where participants (n=143) on average correctly answered only two questions out of fifteen and by Koetting et al. (2012) who found that 69 per cent of nurse practitioners (n=43) in Missouri in the United States of America did not know their organisations' policy around examining for child sexual abuse. In contrast, other authors found high levels of knowledge among nurses. For example, Chen et al. (2015) reported that on average nurses in Taiwan (n=588) scored 74 per cent in knowledge tests, while Fraser et al. (2010) found that in Queensland, Australia, between 72 to 90 per cent of nurses (n=930) correctly identified where, how and when to report.

Unfortunately, each of these four studies used different knowledge tests and so the results are not directly comparable but may suggest that nurses' knowledge varies geographically, possibly due to the differing training provided in these jurisdictions. Additionally, these studies tended to only address nurses' knowledge of abuse or neglect in severe cases requiring statutory intervention rather than nurses' knowledge of preventative and early intervention strategies.

In the wider literature, insufficient knowledge and confidence in interpreting signs of abuse and neglect is also prevalent among professionals working with children in other fields including education, psychology and medicine (Goldman, 2010; Kenny, 2004; Markenson et al., 2007; McKee & Dillenburger, 2009; Pelisoli, Herman, & Dell'Aglio, 2015). While there is evidence that

educational programs may increase professionals' knowledge, they did not always influence professionals' interpretation of signs of abuse and proposed course of action (Botash et al., 2005). Kenny (2015) contended that while it may be relatively straightforward to increase professionals' knowledge through education, in practice-based professions such as nursing, both knowledge *and* skill-based clinical competence is essential.

There is a lack of consistency of terminology around what kind of preparation and professional development nurses receive in regards to safeguarding children. Some literature refers to 'education' while other studies discuss 'training'. It becomes even more confusing when the concepts of 'training' and 'education' are used interchangeably and raises questions as to the pedagogical underpinning of professional education in safeguarding children. There is a common assumption that training professionals simply to 'follow procedures' will improve outcomes for children (Munro, 2005). However, applying procedures in the context of the dynamic and complex situations encountered when safeguarding children requires advanced cognitive skills (Dekker, 2002; Munro, 2005). In addition, the capacity to reflect on and critique the impact of personal values and beliefs on behaviour is rarely a component in training activities.

For example, a recent report from the Royal Commission into Institutional Responses to Child Sexual Abuse in Australia identified two situations of concern where simply following policies did not protect children (Munro & Fish, 2015). In one situation, multiple contradictory procedures were applicable, which confused staff and lead to no action being taken. In another situation, following procedures led to a manager suspected of sexually abusing children being able to inappropriately assess their own 'medium risk' background check (Munro & Fish, 2015). Thus it is essential that professionals are educated to understand the rationale behind safeguarding procedures rather than simply being trained to follow procedures.

Due to perceived and actual knowledge deficits, nurses experienced a lack of confidence in their professional judgements around children at risk of abuse and neglect leading to an overreliance of colleagues' opinions. Discussions with colleagues often took the place of liaison with child protection services. At times nurses received adequate support from their colleagues, but when they did not, nurses were unsure of the optimal course of action and subsequently failed to act on behalf of the child. Nurses often felt the need to seek support from colleagues due to the

ambiguity that was present in situations where a child was at risk. Ambiguity is inherent in to the field of child protection due to the complexity of families and the impossibility of predicting the future (Munro, 2011). Although inaction or lack of support from other professionals to help nurses make decisions about children at risk is clearly a problem, it is most concerning that nurses as autonomous professionals do have the confidence, knowledge, skills and commitment to take the lead when a child is at risk.

Nurses who did contact child protection services were often dissatisfied with their experience, describing poor communication practices with no or unsatisfactory intervention for the child. Nurses are not alone in their dissatisfaction with child protection services; professionals from other disciplines also described experiences with child protection services as unhelpful, unresponsive or unwilling to provide feedback about the child's case (Bryant & Baldwin, 2010; Feng, Chen, Wilk, Yang, & Fetzer, 2009; Jones et al., 2008). Scott and Fraser (2015) point out a major issue of many child protection services is a lack of systemic procedures that facilitate collaborative professional communication between child protection services and health professionals. Professionals are often not provided with feedback about the outcomes of their report and remain unsure as to the help, if any that may have been offered to the child and family. However, rather than using the flaws of child protection services as an excuse for inaction, nurses need to be aware of and take the initiative to implement additional strategies to safeguard children, such as education, harm minimisation, voluntary programs and the child's extended family support.

Implications for practice, education and research
Nurses are well positioned to safeguard children at risk of abuse and neglect. However, the literature has indicated that nurses face barriers that reduce their confidence and ability to effectively safeguard children. It is not known exactly why nurses feel underprepared for their role in safeguarding children. Many nurses receive 'training' but it appears this is not sufficient to address nurses' needs and perceived knowledge deficits. Furthermore, it has been highlighted that training is not the best way to prepare nurses for their role in safeguarding children. Future approaches could involve educational programs that recognise the complexities of the clinical judgements required to enact safeguarding practices in community and clinical settings. Additional

research would help identify whether education instead of training would enhance nurses' confidence and practices around keeping children safe.

Strengths and limitations

This review was strengthened by the use of a specific framework to guide the review. It was also enhanced by the implementation of a recognised tool to assess each study's quality and the large number and variety of international studies included in the analysis. However there are some limitations. Reviewing the international literature highlights that countries have their own local policies, procedures and services for safeguarding children. This means that the studies may not be directly comparable due to differing local conditions. Additionally, this review included all relevant studies where at least one participant was a practicing nurse, meaning that findings in some studies also included perspectives of other professions. However, this was necessary to compare and contrast nurses' experiences from a variety of practice settings across all published studies.

Conclusion

Nurses are aware of their role in safeguarding children, but do not always have the confidence to respond to children at risk of abuse or neglect. It is not clear whether further education of nurses around safeguarding children would help to address this issue. It appears that nurses want support to assist with decision-making about children at risk, regardless of nurses' individual professional responsibilities in this area. Further research is needed to better understand why nurses do not feel empowered to advocate for children and to determine if education rather than training would augment their practice.

Citation

Attribution of Authorship

Author contributions to this manuscript are as follows:

LL (80%), AH and JG each contributed to the conception and design of this scoping review. Data collection was done by LL (100%). The analysis and interpretation of the findings was conducted by LL (80%) in collaboration with AH and JG (20%). LL (90%) drafted the manuscript and the other authors (AH & JG) provided support in revising the work to contribute to its interpretation

Literature review 2: How do nurses keep children safe from abuse and neglect, and does it make a difference? A scoping review.

Introduction

Child abuse and neglect is a significant global public health issue (World Health Organization, 2006). Contemporary approaches to addressing the problem of child abuse and neglect recognise that a multi-disciplinary approach involving all sectors of society is a valuable way forward (Wulczyn, Daro, Fluke, Feldman, & Clodek, 2010). One such approach is the public health model that aims to prevent abuse, provide early intervention and on-going care to children and families when abuse does occur (World Health Organization, 2006). A public health approach is necessary because factors that leave children vulnerable to abuse and neglect are often multifactorial and dependent on the interplay of various social, economic and parental factors (Proctor & Dubowitz, 2014). For example, poverty (Maguire-Jack & Font, 2017), homelessness (Haskett et al., 2017), parental wellbeing (Proctor & Dubowitz, 2014) and childhood disability (Jones et al., 2012) can influence a child's likelihood of experiencing abuse and neglect. Children who experience one or more of these risk factors come in contact with different services, meaning that all professionals who work with children have an important role in keeping children safe from abuse and neglect.

Nurses are the largest group of health professionals and have frequent contact with children who are at increased risk of abuse and neglect. They may work directly with children in paediatric or child health settings, and indirectly through their work with parents who are experiencing adversity like homelessness or poor physical health. For example, mental health nurses consider the wellbeing of their client's children (Korhonen et al., 2010; Maddocks et al., 2010) and nurses working with women are aware of the impacts of domestic violence on women and their children (Brykczynski, Crane, Medina, & Pedraza, 2011; Drinkwater et al., 2017). This places nurses in an ideal position to contribute to prevention, identification and responses to vulnerable children and families across settings from primary health care to tertiary paediatric hospitals.

Nurses are ethically and in some jurisdictions also legally obliged to intervene when children are at risk of harm (International Council of Nurses, 2009; Mathews, 2015a; Sahib El-Radhi, 2015). Unfortunately, recent literature has shown that nurses are not always well equipped to keep children safe, perceiving a lack of knowledge and confidence in their role (Lines, Hutton, & Grant, 2017). Despite the challenges that nurses encounter, it remains unclear whether or not they are effective in keeping children safe in ways that make measurable differences to children's lives. Consequently, the purpose of this scoping review is to firstly describe what nurses do to keep children safe from abuse and neglect, and secondly to identify evidence related to the effectiveness of nursing practice in safeguarding children. This knowledge will guide decision making around which professional groups are best equipped to prevent, identify and respond to child abuse and neglect.

The effectiveness of interventions that address child abuse and neglect have been reported in existing literature. For example Fryda and Hulme (2015) and Walsh, Zwi, Woolfenden, and Shlonsky (2015) have reviewed the literature on interventions to prevent sexual abuse, while Poole, Seal, and Taylor (2014) and Mikton and Butchart (2009) have looked at interventions to prevent neglect, physical abuse and/or emotional abuse. However, these reviews look at the effectiveness of specific programs without consideration of the personnel who are involved in their implementation. This review will contribute to current knowledge by synthesising the literature to identify what nurses do to keep children safe and which interventions are supported by the strongest evidence. In addition, this review will contextualise the main findings by outlining

nurses' professional characteristics and the rationale for nurse involvement in keeping children safe.

Methods

This scoping review was guided by Arksey and O'Malley's (2005) framework in addition to more recent literature on scoping reviews (Colquhoun, 2016; Colquhoun et al., 2014; Daubt, van Mossel, & Scott, 2013; Khalil et al., 2016; Levac, Colquhoun, & O'Brien, 2010). Although there is currently no consensus on the definition of a scoping review (Daubt et al., 2013), we have used the Colquhoun et al. (Colquhoun, 2016; Colquhoun et al., 2014) definition as outlined in the 'current best practices for the conduct of scoping reviews' (Colquhoun, 2016). A scoping review is '*a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence and gaps in research related to a defined area or field by systematic searching, selecting and synthesising existing knowledge*'(Colquhoun, 2016; Colquhoun et al., 2014). This scoping review design was chosen because the authors expected that evidence in this field would be produced using a wide variety of methodologies and thus would be better synthesised by a scoping review than a systematic review (Khalil et al., 2016). In this way, it was intended that this scoping review would map existing research, identify any gaps in the literature and if necessary, make recommendations for future research (Khalil et al., 2016). This review followed the five key stages of Arksey and O'Malley's framework which were 1. Identifying the research question, 2. Identifying relevant studies, 3. Study selection, 4. Charting the data and 5. Collating, summarising and reporting the results (Arksey & O'Malley, 2005; Levac et al., 2010). The optional sixth step of consultation with stakeholders was not undertaken as it was not relevant to this review (Arksey & O'Malley, 2005; Levac et al., 2010).

1. Identifying the research question

The research question arose from the need to understand how nurses contribute to keeping children safe and whether nurses' interventions can make a difference for children. Due to known difficulties associated with directly measuring abuse, including under-reporting and observation bias (Flemington & Fraser, 2016; Howard & Brooks-Gunn, 2009), it was necessary to also include studies that measured factors that contribute to abuse and neglect without directly measuring abuse and neglect.

2. Identifying relevant studies

The second step in this review was to identify relevant studies through searching databases, grey literature and the reference lists of relevant literature. The first author initially searched the literature using keywords such as 'abuse', 'neglect', 'child' and 'nurse' but it became clear this was generating large volumes of irrelevant papers. Consequently, the authors involved their department's librarian to assist with setting up a search that included proximity operators to reduce the number of irrelevant results (see Table 2) in August 2017. Given the variety of roles that nurses perform worldwide, the search strategy included terms such as 'nurse*' and 'health visit*' to include literature relating to nurses using different titles. A search of the grey literature was also conducted including websites of the National Society for the Prevention of Cruelty to Children, Trove, major children's hospitals, Google, Google Scholar and the Australian Institute of Family Studies.

Table 2: Search strings

Database	Search String
Scopus	(TITLE-ABS-KEY ((nurse* OR "health visitor*")) AND TITLE-ABS-KEY ((child OR children OR infant* OR adolescen*) W/3 (abuse* OR neglect* OR violen* OR maltreat*))) AND (LIMIT-TO (DOCTYPE , "ar")) AND (LIMIT-TO (LANGUAGE , "English")) AND (LIMIT-TO (PUBYEAR , 2017) OR LIMIT-TO (PUBYEAR , 2016) OR LIMIT-TO (PUBYEAR , 2015) OR LIMIT-TO (PUBYEAR , 2014) OR LIMIT-TO (PUBYEAR , 2013) OR LIMIT-TO (PUBYEAR , 2012) OR LIMIT-TO (PUBYEAR , 2011) OR LIMIT-TO (PUBYEAR , 2010) OR LIMIT-TO (PUBYEAR , 2009) OR LIMIT-TO (PUBYEAR , 2008) OR LIMIT-TO (PUBYEAR , 2007)) Limited to: 2007-2017; English Language, category 'articles',
CINAHL	TI (nurse* OR "health visitor") OR AB (nurse* OR "health visitor") AND TI((child OR children OR infant* OR adolescen*)N3 (abuse* OR neglect* OR violen* OR maltreat*)) OR AB ((child OR children OR infant* OR adolescen*) N3 (abuse* OR neglect* OR violen* OR maltreat*)) OR (MM "Nurses") AND (MH "Child Abuse, Sexual") OR (MM "Child Abuse") Limiters: Published Date: 20070101-20170810, English language.
Web of Science	(TS=(nurse* OR "health visitor*")) *AND* **LANGUAGE:** (English) Refined by: **TOPIC:** ((child OR children OR infant* OR adolescen*) NEAR/3 (abuse* OR neglect* OR violen* OR maltreat*)) AND **LANGUAGES:** (ENGLISH) AND **DOCUMENT TYPES:** (ARTICLE) AND **DOCUMENT TYPES:** (ARTICLE)
Medline	(nurse* or "health visitor").mp AND ((child or children or infant* or adolescen*) adj3 (abuse* or neglect* or violen* or maltreat*)).mp Limited to: 2007-2017, English language, journal article.

3. Study selection

At the study selection stage, it became clear that were many papers that described nurses' roles in keeping children safe but did not necessarily provide data to support the effectiveness of the interventions. For example, some studies reported on nurses' experiences or perspectives rather than how the intervention affected their clients. Consequently, the inclusion and exclusion criterion were developed to include only studies that reported evaluation data relating to client outcomes (Table 3). Only studies published from 2007 until August 2017 were included to ensure they reflected current practice. The full-text of 104 papers were accessed and sixty-three were excluded because they did not meet the inclusion and exclusion criteria. The majority of these came from database searching (n=30) while some came from reference list searching (n=6), the grey literature (n=1) and the authors' previous knowledge of the topic (n=2). A full outline of the study selection can be found in Figure 2.

Table 3: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
English language	Non-English language
Published in 2007 onwards.	Published prior to 2007
Described and/or evaluated how nurses intervene to keep children safe from abuse and neglect.	Did not describe or evaluate how nurses intervene to keep children safe from abuse and neglect
Nurses are involved in implementation of program/intervention	No nurses involved in implementation or program/intervention, or unclear whether nurses are involved.
Reported on client outcomes.	Did not report on client outcomes.

```
┌─────────────────────────────┐
│ Potentially relevant articles identified │
│ after duplicates removed (n=1080) │
└─────────────────────────────┘

┌─────────────────────────────┐
│ Articles excluded after reading │
│ title/abstract (n=988) │
└─────────────────────────────┘

┌─────────────────────────────┐                    ┌──────────────────────────────────────┐
│ Articles remaining (n=92) │ ──────────────→    │ Articles excluded (n=39):              │
│                             │                    │                                        │
└─────────────────────────────┘                    │ Did not address nurses' role or experience in │
                                                    │ safeguarding (n=33);                   │
┌─────────────────────────────┐                    │ Participants' professions were unclear (n=1); │
│ Studies for review (n=53) │ ←──────────────    │ Evaluation of service/intervention (n=5); │
└─────────────────────────────┘                    └──────────────────────────────────────┘

┌─────────────────────────────┐
│ Studies included from hand searching │
│ (n=7) │
└─────────────────────────────┘

┌─────────────────────────────┐
│ Total studies included in the review │
│ (n=60) │
└─────────────────────────────┘
```

Figure 2: Flow diagram of study selection

4. Charting the data

Arksey and O'Malley's (2005) framework was used to chart the data by summarising key information from the included studies into a purpose made data charting form (Khalil et al., 2016; Levac et al., 2010) (see Appendix 4). However, complete charting of the data was not possible when studies did not provide sufficient information, for example information specifically about nurses' roles was often only given a cursory mention.

5. Collating summarising and reporting the results

As there is currently no standardised reporting guidance for scoping reviews (Colquhoun, 2016), data were reported thematically according to the aims of the study. For example, it was found that nurses' work ranges across the spectrum from prevention through to intervening after abuse had occurred, and so relevant data were reported under this heading. This is consistent with the recommendations of Daudt et al. (2013) who presented their findings thematically to facilitate linking of the findings with the research goals. After charting the data, it was clear that there were

many different measures of how nurses keep children safe and so this data was summarised in Appendix 5 to answer the second part of the review aim.

An additional step of quality appraisal of the included studies (Daubt et al., 2013) was implemented using the Critical Appraisal Skills Program tools. This was undertaken with the intention of contextualising the evidence rather than to exclude studies of poor quality. Overall, study quality was generally high (n=39), although some studies did not provide sufficient information for the quality to be adequately assessed (n=2).

Results

There were 41 studies that met the inclusion criteria. They were conducted primarily in the USA (n=20), Australia (n=7) and Japan (n=4), but there were also a small number from The Netherlands (n=3), Canada (n=3), United Kingdom (n=3), and Nigeria (n=1). Only six studies looked at official reports of abuse or neglect, while the remainder (n=35) looked at other outcomes such as parental risk factors, child outcomes and service use or quality. The results will now be outlined firstly by considering what the literature shows that nurses do to keep children safe, followed by a discussion around whether nurses' interventions make a difference to abuse and neglect.

What do nurses do to keep children safe?

Nurses' interventions to keep children safe involved activities across the spectrum of prevention, detection and intervention after abuse had occurred. In the majority of studies, nurses worked to prevent abuse and neglect (n=32). This occurred most frequently through nurse home visiting in the post-natal period (n=20), especially for families experiencing vulnerabilities such as poverty, family violence or young maternal age. Other studies reported nurses' preventative interventions that included parent education for shaken baby syndrome (n=6), group parent education and activities (n=4), assessment of risk factors in primary care (n=1), sexual abuse education for adolescent girls (n=1) and residential services for parents with mental illness (n=1). Only one study from the Netherlands exclusively reported on how nurses detected abuse and this study investigated how nurses could screen for suspicious injuries in the emergency department (Louwers, Korfage, Affourtit, Scheewe, et al., 2012).

Although nurses were most frequently involved in prevention, some studies (n=8) outlined how nurses intervene when child abuse is suspected or confirmed. For example, common responsibilities of nurses in the USA involved assessment, treatment and/or involvement in the court proceedings of children and young people following sexual assault (n=4). Nurses in Japan and the USA also used home visiting to intervene in families with known abuse and neglect issues (n=1), working with sexually abused adolescents (n=1) and supporting grandparents who were custodians of their grandchildren due to parental abuse or neglect (n=1).

What do nurses do to keep children safe: prevention and intervention

The studies showed that nurses use a range of skills to prevent and address abuse in a variety of settings. Nurses prevented abuse primarily through working with parents in both structured and individually tailored interventions. For example, structured educational interventions included those that aimed to reduce the risk of abusive head trauma through education of new parents (Altman et al., 2011; Dias et al., 2017; Fujiwara, 2015; Goulet et al., 2009; Reese, Heiden, Kim, & Yang, 2014; Zolotor et al., 2015) or prevent sexual abuse through the education of adolescent girls (Ogunfowokan & Fajemilehin, 2012). Conversely, nurses who worked with families who were experiencing multiple risk factors typically delivered more flexible interventions in recognition of unique and complex family needs. Although Kemp et al. (2011; 2012) described their home visiting programs as 'structured', nurses still had the flexibility to tailor the programs to meet families' individual goals and needs. The ways that nurses intervened to prevent abuse included comprehensive assessment of children and parents (Dubowitz, Lane, Semiatin, & Magder, 2012; Kemp et al., 2012; Kitzman et al., 2010), developmental screening (Kemp et al., 2012), education (Mejdoubi et al., 2015), motivational interviewing (Robling et al., 2016), role modelling (McDonald et al., 2009), group facilitation (Kendall, Bloomfield, Appleton, & Kitaoka, 2013; McDonald et al., 2009; Porter et al., 2015), videotaping and discussion of parent-infant interactions (Guthrie, Gaziano, & Gaziano, 2009; Hogg, Coster, & Brookes, 2015) and referrals to relevant services (Fujiwara, Natsume, Okuyama, Sato, & Kawachi, 2012; Sawyer, Frost, Bowering, & Lynch, 2013; Stubbs & Achat, 2016).

However, nurse intervention after abuse had occurred, took a less educative approach and focussed on collection of evidence and meeting victims' physical and emotional needs. In one study, nurses only had a brief role in documenting indicators for suspicious injuries to help flag

potential cases of physical abuse with emergency department doctors (Louwers, Korfage, Affourtit, Scheewe, et al., 2012). In the remaining studies (n=7) where nurses addressed suspected or confirmed abuse or neglect, they took a more comprehensive approach that attended to the complexity of issues. For example, public health nurses in a Japanese study (Kobayashi, Fukushima, Kitaoka, Shimizu, & Shimanouchi, 2015) found that nurses provided a variety of interventions including assessment of family needs and resources, building a trusting relationship and facilitating management of issues contributing to abuse. Kelley et al. (2010) in the USA found that nurses worked with social workers to enhance the health and wellbeing of grandparent custodians whose grandchildren had experienced abuse and neglect.

At other times, nurses worked directly with victims to address their physical and emotional wellbeing following sexual abuse (Bechtel, Ryan, & Gallagher, 2008; Golding, Wasarhaley, Lynch, Lippert, & Magyarics, 2015; Hornor, Thackeray, Scribano, Curran, & Benzinger, 2012). For example, paediatric sexual assault nurse examiners were involved in physical assessment, referrals and court proceedings for children or adolescents (Bechtel et al., 2008; Golding et al., 2015; Hornor et al., 2012; Patterson & Campbell, 2009). Similarly, Edinburgh and Saewyc (2009) reported that nurse practitioners were involved with the longer-term needs of adolescents after sexual abuse such as crisis intervention, connecting with schools, health education and screening. Thus nurses played a significant role in assessing children and families affected by abuse and attending to their immediate and on-going needs.

Rationale for selecting a nurse to deliver the intervention

Although it was evident that nurses are important in prevention and intervention in child abuse and neglect, it was not always explicitly stated why nurses were chosen to deliver the intervention. In home visiting, the rationale for the choice of a nurse was typically built upon on the existing body of evidence for nurse home visiting, for example (Armstrong, Fraser, Dadds, & Morris, 2000; Olds et al., 1997; Olds et al., 1999). Alternatively, nurses were chosen because of the inherent trust that families may have in nurses (Sadler et al., 2013). However, at other times the rationale for choosing an nurse seemed to be opportunistic given nurses' existing roles which put them in an ideal position to address abuse and neglect – for example screening for abuse in emergency departments (Louwers, Korfage, Affourtit, Scheewe, et al., 2012), educating new parents about shaken baby syndrome (Altman et al., 2011; Zolotor et al., 2015) or addressing

psychosocial risk factors in primary care (Dubowitz et al., 2012). There was also an example of nurses identifying a community need and developing a home-visiting intervention to improve the health and wellbeing of adolescent girls following sexual abuse (Edinburgh & Saewyc, 2009). However, in some studies, it was unclear or not stated why a nurse was chosen to be involved in the delivery of care to prevent or address abuse and neglect (McDonald et al., 2009; Ogunfowokan & Fajemilehin, 2012).

Characteristics of nurses who respond to abuse and neglect

Even though nurses worked in a variety of ways to prevent and address abuse and neglect, their roles or professional characteristics were not always clearly outlined. For example, some home visiting nurses were simply described as 'public health nurses' (Garcia, McNaughton, Radosevich, Brandt, & Monsen, 2013; Kobayashi et al., 2015) with no summary of their professional background, education and qualifications. Similarly, interventions relating to prevention of abusive head trauma stated that nurses were working in maternity or perinatal units (Altman et al., 2011; Dias et al., 2017; Fujiwara, 2015; Goulet et al., 2009; Reese et al., 2014; Zolotor et al., 2015). In some cases, nurses did receive training about the intervention (Dias et al., 2017; Dubowitz et al., 2012) or were provided with a program handbook (Kendall et al., 2013). The lack of information in some cases about nurses' background other than their attendance at short training session suggests that nurse characteristics such as education, professional experience and qualifications were not considered as influential to these programs' outcomes. A clear exception was specialist paediatric sexual assault nurse examiners who needed a specific level of education to be accredited to perform their role (Golding et al., 2015).

Can nurses make a difference for children?

The literature has shown that nurses work in a variety of way to prevent, detect and respond to abuse and neglect. This section presents the evidence around whether nurses' interventions can make a difference for children.

What measures are used to determine whether nurses are effective?

The studies in this review used a variety of measures to determine the effects of nurse interventions to prevent and intervene in cases of abuse and neglect. For example, some of the studies directly measured abuse or neglect through reports to child protection services (n=6),

severity of abuse or neglect (n=1), detection or hospitalisation for abuse (n=4), health professional documentation of abuse (n=2) and family self-reports of violence (n=2). As it is not always possible to directly measure abuse and neglect, some studies used other measures such as parent factors that might impact upon the risk of child abuse and neglect, such as parental knowledge and behaviours (Altman et al., 2011; Dias et al., 2017; Fujiwara, 2015; Goulet et al., 2009; Guthrie et al., 2009; Reese et al., 2014) or parent health and wellbeing (Flemington & Fraser, 2016; Kelley et al., 2010; Kemp et al., 2012; Porter et al., 2015; Rowe & Fisher, 2010b). Still other studies focussed on whether nurses' interventions could influence child physical and mental wellbeing (Edinburgh & Saewyc, 2009; Kemp et al., 2011; Olds et al., 2007; Sawyer et al., 2013; Sawyer et al., 2014) or educational outcomes (Kitzman et al., 2010; Olds et al., 2007) given the known negative impacts of abuse in these areas.

The final way that studies evaluated the impacts of nurse interventions was through broader service measures such as the quality of nursing care (Bechtel et al., 2008; Hornor et al., 2012), service use (Sawyer et al., 2013; Sawyer et al., 2014; Zolotor et al., 2015) and judicial outcomes (Golding et al., 2015; Hornor et al., 2012; Patterson & Campbell, 2009). The ways that nurses can make a difference for children will be discussed, firstly in regards to the outcomes that directly measured abuse and neglect, followed by those that focussed on parental risk factors and child health and wellbeing outcomes. Finally, the ways that nurses influence service use and quality will be summarised. An outline of these results can also be found in Appendix 5.

Do nurses make a difference to direct measures of abuse and neglect?
Some studies (n=13) directly measured nurses' impacts on abuse and neglect. This included the number and nature of reports to child protection services, health professionals' self-reports of abuse/neglect, detection of abuse, non-accidental injuries and parental report of in-home violence. In three out of five studies, children who received home visiting by a nurse had fewer substantiated reports of abuse (Eckenrode et al., 2017; Mejdoubi et al., 2015; Zielinski, Eckenrode, & Olds, 2009). In the remaining studies, there was no change in reports to child protection services (Barlow et al., 2007; Dubowitz et al., 2012) or the number of active cases (Sadler et al., 2013), although it was suggested this could be due to surveillance bias where home visiting nurses are more likely to see and report abuse. It was unclear whether nurses were able to effectively prevent shaken baby syndrome as two studies showed no change (Dias et al., 2017; Zolotor et al.,

2015), while the remaining study showed a significant decrease in abusive head injuries (Altman et al., 2011). Other studies used parental or health professional self-report or documentation to explore whether the nurse was able to influence the incidence or severity of abuse with varying results (Dubowitz et al., 2012; Kobayashi et al., 2015). Thus it seems that nurses might be successful in reducing rates and severity of abuse in some situations but not others; it is not clear what leads to this difference in outcomes between studies.

Do nurses make a difference to risk factors for abuse and neglect?
As abuse and neglect cannot always be directly measured, some studies looked at other parent and child outcomes or risk factors. These were mainly parent-related factors such as parental knowledge (Altman et al., 2011; Dias et al., 2017; Fujiwara, 2015; Goulet et al., 2009; Guthrie et al., 2009; Reese et al., 2014), stress (Fujiwara et al., 2012; Kendall et al., 2013; McDonald et al., 2009; Porter et al., 2015; Sawyer et al., 2013) parental behaviours such as responsivity (Flemington & Fraser, 2016; Guthrie et al., 2009; Kemp et al., 2011; Porter et al., 2015) and provision of an appropriate home environment (Flemington & Fraser, 2016; Guthrie et al., 2009; Mejdoubi et al., 2015). Although some results were mixed, the studies generally indicated that nurses had a positive impact upon parents' knowledge, attitudes, stress, mood and perceived health (Guthrie et al., 2009; Hogg et al., 2015; Kemp et al., 2012; Kendall et al., 2013; Porter et al., 2015; Stubbs & Achat, 2016). There were some studies that looked at maternal social trust (n=2) and pregnancy spacing (n=3), but these gave conflicting results making it difficult to tell whether nurses can reliably make a difference in this area (Fujiwara et al., 2012; Olds et al., 2007; Robling et al., 2016; Sadler et al., 2013; Stubbs & Achat, 2016). Importantly, although nurses may be able to influence parental risk factors for child abuse, it was not evident whether this had an impact on actual cases of abuse and neglect.

Do nurses have an effect on outcomes for children at-risk of or experience abuse or neglect?
Given the adverse effects of child abuse and neglect on children's educational and health outcomes, some studies (n=7) investigated how nurse interventions mitigated the impacts of abuse and neglect. In particular, studies in this review looked at infant physical and mental health (Edinburgh & Saewyc, 2009; Kemp et al., 2011; Olds et al., 2007; Sawyer et al., 2013; Sawyer et al., 2014), rates of breastfeeding, educational outcomes (Kitzman et al., 2010; Olds et al., 2007), child substance use (Kitzman et al., 2010) and adolescent sexual health (Edinburgh & Saewyc, 2009).

66

There was again mixed outcomes, with several studies finding no or minimal impact on infant health (Sawyer et al., 2013; Sawyer et al., 2014) while others identified improved mental development (Kemp et al., 2011) or lower infant/child mortality (Olds et al., 2007). However, (Olds et al., 2007) identified that in their study this difference in child mortality was only just statistically significant. In later childhood, studies of nurse home visiting indicated there were higher grade point averages in primary school (Kitzman et al., 2010; Olds et al., 2007) and lower rates of substance use (Kitzman et al., 2010). Similarly, in Edinburgh and Saewyc's (2009) study with sexually abused adolescent girls, they found that after their home visiting intervention, adolescents had fewer sexually transmitted infections, reduced risky behaviour and no pregnancies. However, the lack of a control group in this study makes it difficult to say whether this was due to the intervention or other factors.

Do nurses have an impact on service quality and service use?

The final area that was measured to determine whether nurses could influence child abuse and neglect was around service quality and service use. This was most frequently around the health care or judicial outcomes following child or adolescent sexual assault (Bechtel et al., 2008; Golding et al., 2015; Hornor et al., 2012; Patterson & Campbell, 2009). Two studies found that when a specialist sexual assault nurse was involved in the young person's care, he/she was more likely to receive appropriate interventions such as screening for pregnancy and sexually transmitted infections (Bechtel et al., 2008; Hornor et al., 2012). Nurses' influence also seemed to extend to the judicial system where two studies showed higher numbers of guilty verdicts (Golding et al., 2015; Patterson & Campbell, 2009), although one of these studies used a mock jury (Golding et al., 2015). Another study identified no change in judicial outcomes (Hornor et al., 2012), making it uncertain whether nurses can consistently influence judicial outcomes for child and adolescent victims of sexual assault.

There were also mixed results around whether nurses' influenced families' use of health services, with two home visiting programs showing no change (Sawyer et al., 2013; Sawyer et al., 2014). Conversely, an intervention to prevent abusive head injury was associated with fewer phone calls to a nurse telephone advice centre relating to infant crying (Zolotor et al., 2015), which the authors suggested could mean the intervention adequately equipped parents to manage infant crying.

Discussion

The findings of this review demonstrate that nurses intervened in many different ways to keep children safe from abuse and neglect. However, the evidence around whether nurses can make a difference to children was mixed. For example, studies with similar interventions such as nurse home visiting, showed instances where nurses had positive impacts, such as Eckenrode et al. (2017); Garcia et al. (2013). While other studies demonstrated no or minimal impact (Fujiwara et al., 2012; Sawyer et al., 2013; Sawyer et al., 2014). This could be due to the large number of variables between the studies such as health care delivery in different countries, presence of maternal psychosocial risk factors and the lack of clarity and consistency around nurse characteristics. However, it is important to look at the broader context of factors that may impact upon results – for example Flemington and Fraser (2016) found that mothers involved in home visiting experienced deteriorating depressive symptoms, but also showed higher levels of responsivity to their child. Thus even though nurses were not able to influence mothers' mental health, they were able to affect the quality of parenting. It is also important to note that although many of these studies (n=33) were undertaken in colonised countries (countries settled/invaded by other countries who displaced local inhabitants (Taylor & Guerin, 2014)) none of the interventions specifically addressed child abuse and neglect in First Nations (native) populations where there are typically higher rates of child abuse and neglect.

Another key finding from this review was that the included studies were all specific programs that aimed to address abuse and neglect rather than nurses' daily practices in keeping children safe. Recent literature that suggests nurses frequently experience concerns around child abuse and neglect in their usual practice settings (Lines et al., 2017) such as emergency departments (Reijnders, Giannakopoulos, & de Bruin, 2008; Tiyyagura, Gawel, Koziel, Asnes, & Bechtel, 2015), schools (Hackett, 2013; Kraft & Eriksson, 2015; Kraft, Rahm, & Eriksson, 2017) and paediatric or neonatal inpatient areas (Barrett, Denieffe, Bergin, & Gooney, 2017; Lavigne, Portwood, Warren-Findlow, & Brunner Huber, 2017; Saltmarsh & Wilson, 2017) which are practice settings that are largely absent from this review. Consequently, nurses' activities within this review may not be representative of all the ways that nurses keep children safe. For example, nurses are mandated notifiers of abuse in countries such as the USA and Australia (Mathews, 2015a), yet there was no discussion of mandatory notification by nurses whether this makes a difference for children. Thus

although the broader literature suggests that nurses keep children safe in a wider variety of settings, there is no evidence as to what impact these other nurse interventions might have on outcomes for children.

It is also difficult to know whether nurses might be preventing abuse and neglect in ways that were not measured, or even not measurable. It is known that nurses have a unique role in building and sustaining relationships with families who might be suspicious of services. For example, nurses have a valuable role in building relationships with families and may be the only contact the family has with the health system (Browne et al., 2010; Fraser, Grant, & Mannix, 2016). In this way, nurses use advanced social skills to cultivate a relationship of trust with families who may be suspicious of services; this occurs to the extent that families have reported that their nurse was 'like a friend' (Landy, Jack, Wahoush, Sheehan, & MacMillan, 2012; Zapart, Knight, & Kemp, 2016). Within this professional 'friendship', nurses facilitated parental reflection, including encouraging parents to reflect upon how their behaviours may impact upon their child's health and wellbeing (Fraser, Grant, et al., 2016). Due to the relational nature of this aspect of nurses' interventions, it is difficult to measure parental relationships and reflection, but more importantly, it is unclear whether nurses' relational interventions led to changes that prevented child abuse and neglect. Consequently, it is not known whether nurses might have other positive effects on the prevention of child abuse and neglect that were not measured through this review.

Despite the relational aspect of nurse interventions, there was a variable emphasis on nurse characteristics across the literature. In some studies, nurses had postgraduate qualifications and/or were advanced practice nurses (Bechtel et al., 2008; Edinburgh & Saewyc, 2009; Patterson & Campbell, 2009). This could be related to the level of skill required – for example, complexity of skill varied from completing a risk assessment form (Louwers, Korfage, Affourtit, Scheewe, et al., 2012) to autonomous home visiting and case management (Edinburgh & Saewyc, 2009). However, there were discrepancies in the information about nurse characteristics even across similar interventions – such as delivering autonomous care in the context of home visiting (Edinburgh & Saewyc, 2009; Kemp et al., 2011; Kemp et al., 2012). This shows a lack of clarity around the significance of nurses' educational preparation considered essential knowledge to deliver the intervention. This review did not compare the difference between the success of nurse interventions delivered by bachelor prepared nurses compared to nurses who had postgraduate

qualifications that explicitly prepared them to work with vulnerable families, so it is uncertain what affect this had on abuse related outcomes.

It is important to consider nurse education and their specialisations because this has an impact upon nurses' level of knowledge and competence. In Australia, one such example can be found in the Australian Registered Nurse Standards of Practice, which inform the scope of practice of all registered nurses in Australia, as compared to specialist standards which recognise and inform the unique characteristics of specialist nursing practice in caring for children. Perhaps most significantly, the registered nurse standards for practice do not explicitly outline the importance of advocating for vulnerable populations such as children (Nursing and Midwifery Board of Australia, 2016). However, the specialist standards for Maternal, Child and Family Health Nurses, and for Children and Young People's Nurses specifically recognise children as a vulnerable group who may need nurses to negotiate and challenge priorities when adults demonstrate attitudes or behaviours that put children at risk of harm or neglect (Australian College of Children & Young People's Nurses, 2016; Maternal Child and Family Health Nurses Australia, 2017). The diversity of ways that nurses keep children safe within this scoping review coupled with these examples of specialist standards show it is essential all specialist nurses who work with children are equipped with advanced communication skills and knowledge of core elements for children's wellbeing.

Limitations

This review has some limitations. Firstly, the included studies were not representative of the nursing profession's daily activities in preventing, detecting and responding to child abuse and neglect. This means that the results may not accurately reflect the kinds of activities nurses are involved in, but more importantly, it means that many nurse interventions remain invisible with unknown effectiveness. Although there is a body of research relating to nurses' everyday experiences in keeping children safe, no literature was found that addressed whether nurses' daily interventions are actually effective making a difference in the lives of children who may be at risk of or experiencing abuse and neglect.

Another limitation of this review lies in the established difficulties associated with measuring abuse and neglect. All measures of abuse and neglect have limitations – for example underreporting of abuse and different definitions across jurisdictions (Wald, 2014) and

surveillance bias where nurse intervention means abuse is more likely to be detected and reported (Howard & Brooks-Gunn, 2009). Other measures such as improving parental knowledge do not necessarily translate to improved outcomes for children (Walsh et al., 2015). It was also challenging to compare the different study designs and outcome measures; many of which were conducted in different countries, populations and health settings.

Conclusion

This review outlined the ways that nurses keep children safe from abuse and neglect and whether these interventions made a difference to children's lives. It is clear that nurses prevent, detect and respond to abuse and neglect across many settings through interventions with children and their families. However, it was less obvious whether nurses' interventions were able to make positive changes in children's lives given the mixed findings and indirect measures of abuse and neglect. In addition, the interventions assessed in this study did not represent nurses' daily activities in keeping children safe, making it difficult to determine the extent to which nurses keep children safe from abuse and neglect. Further research or a systematic review is needed to investigate the range of different ways that nurses keep children safe, but more importantly whether nurses can make a measurable difference in the lives of children in all areas of their practice.

Update of literature: studies published after the original two literature reviews.

Since the publication of the two original literature reviews (Lines, Grant, & Hutton, 2018; Lines et al., 2017), many new studies have been published about the work of nurses in preventing and responding to child abuse and neglect. This section will outline relevant new literature and how it builds upon the content of the two published literature reviews. This involves 1) summarising literature published after August 2015 that relates to nurses' roles and experiences in keeping children safe, and 2) summarising literature published after September 2017 that explored the nature of nurses' work in keeping children safe and which interventions hold the strongest evidence for future practice.

Methods

Studies in this update were identified through informal database searching, automated database alerts, hand searching of reference lists and author networking rather than structured searches of the literature. The updated literature will now be presented in two sections: 1) nurses' roles and experiences in keeping children safe and 2) how nurses keep children safe, and does it make a difference?

Update literature review 1: Nurses' roles and experiences in keeping children safe

Many (n=30) additional studies have been published about nurses' roles and experiences in keeping children safe from abuse and neglect since Lines et al. (2017). These predominantly came from the USA (n=8), UK (n=8), Sweden (n=5), Australia (n=2), Israel (n=2) and New Zealand (n=2). The remaining studies came from Canada, China and Pakistan (n=1 in each country). The core findings of these studies still reflect the findings of literature review one and are summarised under the three main themes identified in Lines et al. (2017) which are: 'Insufficient knowledge', 'Validation and communication' and 'Balancing support and surveillance'. Additional studies from the updated literature search are summarised in Appendix 6.

Insufficient knowledge: update

The theme 'insufficient knowledge' outlined nurses' perceptions of the limitations of their knowledge and skills relating to child abuse and neglect (Lines et al., 2017). Literature published from August 2015 onwards again showed that nurses were typically aware of their responsibility to respond to child abuse and neglect. However, Kuruppu, Forsdike, and Hegarty (2018) found that

many Australian general practitioners and practice nurses were uncertain about the details of local legislation and processes that occur after a report. Nurses' participation in training worldwide was variable, with two studies presenting proportions of participants who had received training around child abuse and neglect. Lavigne et al. (2017) identified that 75 per cent of participants had training (USA), while Li et al. (2017) found that only 3 per cent of participants had (China). Irrespective of participation in education/training, nurses still desired more opportunities for professional development (Ceccucci, 2018; Foster, Olson-Dorff, Reiland, & Budzak Garza, 2017; Kraft et al., 2017; Kuruppu et al., 2018; Maul et al., 2019; Sundler, Whilson, Darcy, & Larsson, 2019). The only study that was a partial exception to this was the audit conducted by Patrick et al (2020) in which only a 'small' but unspecified number of participants felt they needed further training after attending a safeguarding training session. However, it is difficult to determine to what extent this reflects the specific experiences of nurses because Patrick et al. (2020) did not report how many participants were nurses.

As identified by Lines et al. (2017), education/training must be role specific; this was further illustrated in a study of general practitioners and practice nurses in the UK where all participants (n=54) had received training around mandatory reporting but very few had training in documentation of domestic violence concerns (Drinkwater et al., 2017). Importantly, this update highlights the need for education/training that addresses nurses' values and beliefs, with Li et al. (2017) and Maul et al. (2019) finding that some health care professionals (HCPs) do not report physical abuse due to personal views around physical discipline. In summary, additional literature published since September 2015 shows the same key concerns are still present around nurses' perceptions of their knowledge; nurses continue to feel underprepared and perceive the need for additional education/training to support them in their role of responding to child abuse and neglect.

Validation and communication: update

This theme 'validation and communication' outlined nurses' perceptions of uncertainty in decision-making around child abuse and neglect, meaning they frequently wanted to verify their concerns before acting (Lines et al., 2017). Nurses reported experiencing uncertainty in their judgements, citing concerns that they might be wrong, or that actions might instead prompt negative outcomes for children, families or the nurse themselves. Nurses described strategies they

used to help them make decisions when they were unsure, including continued assessment and monitoring (Einboden, Rudge, & Varcoe, 2019) and consultation with colleagues (Dahlbo, Jakobsson, & Lundqvist, 2017; Saltmarsh & Wilson, 2017; Taylor, Smith, & Taylor, 2016; Tiyyagura et al., 2015). Despite these strategies, nurses still lacked confidence that Child Protection Services (CPS) would support the child in an effective and timely manner if/when they reported their concerns (Ceccucci, 2018; Einboden et al., 2019; Kraft et al., 2017; Kuruppu et al., 2018; Li et al., 2017; Maul et al., 2019; Saltmarsh & Wilson, 2017; Sigad, Beker, Lev-Wiesel, & Eisikovits, 2019; Tchernegovski, Reupert, & Maybery, 2017). For example, Ceccucci (2018) found in their study of USA nurse practitioners (n=110), only half (52%) perceived that reporting abuse was beneficial for the child. This lack of confidence in CPS was compounded by poor communication and collaboration, with many nurses describing insufficient feedback or lack of collaborative involvement (Dahlbo et al., 2017; Patrick et al., 2020). In some instances, poor communication and collaboration were due to varied understandings across different professional groups. For example, Tung, Williams, Ayele, Shimasaki, and Olds (2019) and Williams, Ayele, Shimasaki, Tung, and Olds (2019) found that nurses working within the Nurse Family Partnership program had different approaches to care and conceptualisations of risk and safety compared with CPS staff, leading to misunderstandings and misalignment of service goals (Tung et al., 2019; Williams et al., 2019). In summary, nurses continued to experience a lack of confidence in assessing and responding to potential child abuse in the context of perceived lack of support from CPS.

Balancing support and surveillance: update

The theme 'balancing support and surveillance' describes nurses' perceptions of tension between supporting and engaging parents whilst advocating for children's safety/wellbeing (Lines et al., 2017). Nurses balanced the choice of reporting abuse – which may lead to no action or even negative child outcomes – against monitoring and addressing concerns themselves through non-statutory means (Dahlbo et al., 2017; Einboden et al., 2019). One reason nurses were hesitant to report concerns was a belief that families may disengage from services completely if families felt nurses were watching or had reported abuse (Dahlbo et al., 2017). This was problematic because simply reporting families to CPS did not guarantee a CPS intervention. In the context of perceived inadequate responses from CPS, nurses saw themselves as advocates for children, which was most clearly illustrated by Sigad et al. (2019) who described HCPs as 'pioneers' acting as sole advocates

for children. Nurses worked towards positive outcomes for children by maintaining therapeutic relationships with families; this included distancing themselves from CPS and investigation processes (Barrett et al., 2017). However, nurses' relationships with families were complex due to nurses' emotional responses such as uncertainty and disappointment (Barrett et al., 2017; Dahlbo et al., 2017; Gibbs, Dickinson, & Ramussen, 2019; Kraft et al., 2017; Kuruppu et al., 2018; Saltmarsh & Wilson, 2017; Sigad et al., 2019; Tchernegovski et al., 2017) while recognising the importance of a continued focus on the child (Gibbs et al., 2019; King, 2016; Sigad et al., 2019). Despite nurses' efforts to manage their emotional responses, their responses may still have impacted therapeutic relationships. For example Saltmarsh and Wilson (2017) reported that nurses were protective of vulnerable neonates and claimed ownership by referring to them as 'my baby', potentially marginalising the family. Although many recent studies highlighted nurses' role in support and advocacy for children, two studies found that some nurses in China and Pakistan believed addressing child abuse and neglect was not their responsibility (Li et al., 2017; Maul et al., 2019). Thus overall, the updated literature shows that nurses continue to face challenges in supporting children through therapeutic relationships in the context of surveillance for child abuse and neglect. Importantly, there were no studies were found that refuted current findings or suggested alternate findings for any of the three themes.

Update literature review 2: How do nurses keep children safe from abuse and neglect, and does it make a difference?

Since the publication of Lines et al. (2018), some additional research (n=13) has been published investigating how nurses keep children safe from abuse and neglect, and whether this can make a measurable difference in children's lives. Studies were published predominantly in the USA (n=6) and Australia (n=4), with the remaining three studies from the UK (n=2) and Canada (n=1). The interventions were similar to the original literature review as they were predominantly home visiting programs based on the Nurse Family Partnership (NFP) program[5] developed by Olds et al in the USA (n=8). Some studies built upon other existing evidence such as the Runaway

---

[5] The Nurse Family Partnership program involves pre and postnatal nurse home visits for women experiencing economic or social disadvantage to promote physical health and social connections.

Intervention Program[6] (n=1), Minding the Baby[7] (n=1) and Period of PURPLE Crying[8] abusive head injury prevention program (n=1). The remaining two studies evaluated the Parenting and Life Skills Intervention for Teen Mothers[9] and Family Connects[10]. See Appendix 7 for a summary table of the 13 studies included in this update of literature review two.

What do nurses do to keep children safe?

The 13 most recent studies showed that nurses continued working across the spectrum of prevention, detection and intervention after child abuse and neglect, with the majority (n=12) focussed around prevention (Barnes et al., 2017; Barr et al., 2018; Cox et al., 2019; Dodge, Goodman, Bai, O'Donnell, & Murphy, 2019; Goldfeld, Price, & Kemp, 2018; Goldfeld et al., 2019; Kitzman et al., 2020; Matone et al., 2018; Sawyer et al., 2019; Segal, Nguyen, Gent, Hampton, & Boffa, 2018; Slade et al., 2020) and one focussing on addressing the impacts of abuse (Bounds, Edinburgh, Fogg, & Saewyc, 2019). Some studies (n=5) provided additional data or research on interventions outlined in the original literature review, including the Minding the Baby program (USA) (Slade et al., 2020), Nurse Family Partnership (USA) (Kitzman et al., 2020), South Australian Nurse Home Visiting Programme[11] (Sawyer et al., 2019), the Runaway Intervention Program (USA) (Bounds et al., 2019) and Period of Purple abusive head trauma prevention program (Canada) (Barr et al., 2018) thereby increasing the quality of evidence available relating to the impacts nurses may have through these interventions.

What do nurses do to keep children safe: prevention and intervention

Findings again demonstrated that nurses use a range of skills to prevent and respond to child abuse and neglect. This involved working primarily with mothers (n=12 studies) during pregnancy

---

[6] The Runaway Intervention Program is a trauma-informed intervention run by nurse practitioners for runaway youth who have experienced sexual assault or exploitation

[7] Minding the Baby is delivered by nurses and social workers to young first-time mothers in underserved communities with high poverty rates to improve developmental, health and relationships outcomes.

[8] The Period of PURPLE Crying program is a post-natal educational intervention delivered by nurses and midwives to prevent abusive head trauma from 'shaken baby syndrome'.

[9] The Parenting and Life Skills Intervention for Teen Mothers was an interactive educational program delivered by a nurse and social worker with the aims of improving parenting and life skills of young mothers.

[10] Family Connects is a short-term universal nurse home visiting intervention to support all families after the birth of a child.

[11] The South Australian Nurse Home Visiting program is a universal, post-natal home visiting program offered to all mothers after birth.

and infancy. The only exception was the Runaway Intervention Program through which nurse practitioners worked directly with young people following sexual assault/exploitation whilst educating and supporting the young person's parents (Bounds et al., 2019). Programs varied in the level of structure/standardisation, such as the highly structured and standardised the Period of PURPLE Crying intervention which involved only the presentation of program materials and answering parental questions (Barr et al., 2018). Other interventions were broader in scope but had a pre-planned schedule, location and broad topics to address (Cox et al., 2019; Sawyer et al., 2019). Some programs had designated schedules but specified they adapted to the needs of parents by responding to individual health, social, educational and/or emotional needs at each contact (Barnes et al., 2017; Dodge et al., 2019; Goldfeld et al., 2018; Goldfeld et al., 2019; Segal et al., 2018). Conversely, in the Runaway Intervention Program, the frequency of contacts and types of interventions followed a broad guide, but explicitly acknowledged that care should be tailored to the life circumstances and needs of each young person (Bounds et al., 2019).

Rationale for selecting a nurse to deliver the intervention

Studies again did not necessarily clearly and consistently articulate the rationale for selecting a nurse to deliver the intervention and specific characteristics of these nurses. For example, Cox et al. (2019) - Parenting and Life Skills Intervention for Teen Mothers, reported that nurses delivered educational modules with a health focus, such as contraception and injury prevention. This suggests that nurses' professional expertise was both important and relevant. Conversely, for Barr et al. (2018), the rationale for nurse involvement in the 'Period of PURPLE Crying Program' appeared to be linked to nurses' convenient access to families throughout the postnatal period. In home visiting interventions, nurse involvement was typically based on existing evidence for nurse home visiting such as Nurse Family Partnership and/or nurses' pre-existing roles in early childhood services (Dodge et al., 2019; Goldfeld et al., 2018; Goldfeld et al., 2019; Kitzman et al., 2020; Matone et al., 2018; Paine et al., 2020; Sawyer et al., 2019; Segal et al., 2018). The evidence for Nurse Family Partnership was also used to underpin the Group Family Nurse Partnership[12] which provided group educational support in an interactive, facilitated environment (Barnes et al., 2017).

---

[12] The Group Family Nurse Partnership is a program delivered by nurses and midwives providing group support for pregnant and postnatal (up to 12 months) mothers who were young or with low educational attainment.

For example, Bounds et al. (2019) did not state why nurse practitioners were best equipped to care for sexually assaulted/exploited young people, but previous studies explained that the 'Runaway Intervention Program' was inspired by an unmet community need originally identified by nurses (Edinburgh & Saewyc, 2009).

Characteristics of nurses who respond to abuse and neglect

The qualifications, education and training of nurses who prevented and responded to child abuse and neglect again varied widely. Some studies presented little detail of nurses' qualifications, education and training, once again suggesting that these may be considered unimportant or irrelevant to outcomes for children (Lines et al., 2018). For example, Matone et al. (2018) did not mention staff qualifications, education or training, while other authors provided only limited information that staff were 'trained' (Cox et al., 2019; Dodge et al., 2019) or 'experienced' with access to a program manual (Barnes et al., 2017). Similarly, in the 'Period of PURPLE Crying program', Barr et al. (2018) did not outline nursing staff overall education and qualifications, but stated that nurses received training about the program and its implementation through dedicated educators (Barr et al., 2018). Segal et al. (2018) did not directly provide specific details of nurses' education and qualifications, but the program website indicated nurses were 'experienced' and given ongoing support and professional development (ANFPP National Program Centre, N.D.).

On the other hand, some studies provided highly specific information about the education, qualifications, training and ongoing support of nurses delivering the program. For example, the Right@home[13] program explained that nurses were child and family health nurses with postgraduate qualifications and additional training in the NFP model (Goldfeld et al., 2018; Goldfeld et al., 2019). These nurses subsequently received program-specific training supplemented by monthly group supervision (Goldfeld et al., 2018; Goldfeld et al., 2019). Sawyer et al. (2019) provided a similar level of detail, explaining that nurses were registered nurses with additional qualifications in community child health nursing and had received 'extensive training' in program delivery and child protection supplemented by ongoing multidisciplinary support. Nurse qualifications, education and training also appeared important to Bounds et al. (2019) (Runaway

---

[13] The Right@home program is a nurse home visiting intervention delivered through a universal child and family health service and targeted towards pregnant women experiencing adversity.

Intervention Program) who explained that nurse practitioners were experienced advanced practice nurses with further training in trauma-informed care and the philosophy underpinning the program. The small number of studies and heterogeneity of interventions and nurse characteristics means that comparisons of the effectiveness of interventions by nurses with different levels of qualifications, education and training could not be made. However, the potential influence of nurses' education, qualifications, training and ongoing support are all important considerations when exploring nurses' capacity to successfully prevent and respond to child abuse and neglect in society.

Can nurses make a difference for children?

Nurses prevent and respond to child abuse and neglect in a variety of ways. The following section examines evidence from the updated literature (September 2017 to present) relating to whether nurses can make a measurable difference for children at risk of or experiencing child abuse and neglect.

What measures are used to determine whether nurses are effective?

The 13 most recent studies used a variety of measures to assess the effectiveness of programs through which nurses worked to prevent and respond to child abuse and neglect. These measures fit within the same broad categories as the original literature review, which were direct measures of child abuse and neglect, risk factors for child abuse and neglect, child or young person health/wellbeing and service use and quality.

Do nurses make a difference to direct measures of abuse and neglect?

Four studies (Barr et al., 2018; Dodge et al., 2019; Matone et al., 2018; Segal et al., 2018) reported on whether nurses can make a difference to direct measures of abuse and neglect. Three of these had positive findings (Barr et al., 2018; Dodge et al., 2019; Segal et al., 2018). Barr et al. (2018) reported that there was a 35 per cent reduction in admission for abusive head trauma in infants aged under 24 months in British Columbia seven years after the implementation of an ongoing abusive head trauma prevention program. Similarly, Segal's study of the Australian Nurse Family

Partnership Program for Aboriginal Infants[14] in Central Australia found there were fewer reports to CPS, investigations and days in care (Segal et al., 2018). Furthermore, Dodge (2019) reported fewer CPS investigations following the implementation of their Family Connects universal family home visiting program. Unlike the findings of Barr et al. (2018), Dodge et al. (2019) and Segal et al. (2018), Matone et al. (2018) found in their study of families enrolled in early childhood home visiting services[15] that children were more likely to experience physical abuse. Matone et al. (2018) suggested that this could be attributed to children experiencing abuse from a caregiver not receiving the intervention and also because home visiting services were not supported with services that could comprehensively meet families' needs. Thus as reported in Lines et al. (2018), programs delivered by professionals including nurses had inconsistent effects on the rates and severity of child abuse and neglect.

Do nurses make a difference to risk factors for abuse and neglect?

Seven recent studies (Barnes et al., 2017; Cox et al., 2019; Dodge et al., 2019; Goldfeld et al., 2018; Goldfeld et al., 2019; Paine et al., 2020; Slade et al., 2020) reported on risk factors for abuse and neglect, but with mixed and conflicting findings (see Table 4, p. 83). For example, maternal confidence, self-efficacy and stress were not consistently increased by nurse delivered interventions. Although the Parenting and Life Skills Intervention for Teen Mothers showed improved maternal self-esteem and preparedness (Cox et al., 2019), the Group Family Nurse Partnership demonstrated no changes in maternal sensitivity or confidence (Barnes et al., 2017). Similarly, three of the newer studies reported on parental responsivity, with Slade (2020) (Minding the Baby) finding increased maternal reflective functioning and Goldfeld (2019) (Right@home) reporting increased maternal responsivity. However, Paine (2020) (Nurse Family Partnership) found no change in maternal use of internal emotional state language when communicating with their baby. The variable impacts on maternal confidence, self-efficacy, stress and responsivity are consistent with mixed findings in the original literature review in these domains (Lines et al., 2018).

---

[14] The Australian Nurse Family Partnership Program for Aboriginal Infants is a modified nurse home visiting intervention delivered by an Aboriginal community-controlled health service to all pregnant Aboriginal women.
[15] Matone et al. 2018 evaluated the outcomes of three separate early childhood home visiting services which were the Pennsylvania Nurse-Family Partnership, Parents as Teachers and Early Head Start programs.

In the same way, newer studies demonstrated variable impacts on mothers' mental health. Both Slade et al. (2020) (Group Nurse Family Partnership) and Barnes et al. (2017) (Minding the Baby) reported no change in maternal depressive symptoms. Conversely, Dodge et al. (2019) reported decreased maternal anxiety and depressive symptoms through their Family Connects program for all new mothers. A key difference between these interventions was that Slade (2020) and Barnes (2017) were targeting mothers with specific risk factors, while Dodge (2019) reported on a universally offered intervention. Mixed findings about the potential impact nurses have on maternal mental health were also present in the original literature review (Lines et al., 2018).

Other findings from the newer literature included unchanged maternal parenting attitudes, life skills and substance use in the Group Family Nurse Partnership (Barnes et al., 2017). However, Barnes (2017) did find there were fewer repeat pregnancies at 36 months, which is a similar trend to the original literature review where two out of three studies found increased pregnancy spacing. Importantly, Goldfeld's (2018; 2019) evaluation of the Right@home program found an improvement in the suitability of the home environment. This findings is consistent with all three studies reporting on suitability of the home environment from the original review (Flemington, Waters, & Fraser, 2015; Guthrie et al., 2009; Mejdoubi et al., 2015), suggesting nurses may be well positioned to improve children's home environments.

Do nurses influence outcomes for children at-risk of or experiencing abuse or neglect?

Three studies reported on the outcomes of programs delivered by nurses on measures of child or young person health and wellbeing. The three key positive impacts were fewer criminal convictions for female youth (Kitzman et al., 2020)(Nurse Family Partnership), higher rates of infant breastfeeding at age 6 months (Barnes et al., 2017) (Group Family Nurse Partnership), and decreased emotional distress and suicidal ideation/attempts in young people in the Runaway Intervention Program (Bounds et al., 2019). Criminal convictions, emotional distress and suicidal ideation/attempts were not reported in the original literature review, but Barlow et al. (2007) (nurse home visiting) had reported no impact on breastfeeding rates.

Although the original literature review demonstrated improved infant/child behaviour (as a measure of child mental health) (Barlow et al., 2007; Kitzman et al., 2010; Mejdoubi et al., 2015; Ordway et al., 2014; Rowe & Fisher, 2010a), more recent studies did not reflect this trend. For

example, Sawyer et al. (2019) (South Australian Nurse Home Visiting program) found no difference in in child externalising/internalising behaviours at age five years and Barnes (2017) (Group Nurse Family Partnership) reported no change in infant cooperativeness. Kitzman (2020) (Nurse Family Partnership) also reported on youth behaviour as a measure of program success but found no changes in domains such as risk-taking and internalising/externalising behaviours. These mixed findings arising from different interventions makes it unclear whether nurses can consistently influence outcomes for children at risk of or experiencing abuse or neglect.

Do nurses have an impact on service quality and service use?

Two recent studies (Barnes et al., 2017; Dodge et al., 2019) explored the impacts of interventions delivered by nurses on service quality or service use. Barnes et al. (2017) (Group Nurse Family Partnership) found no change in mothers' use of health and social services, while Dodge et al. (2019) (Family Connects) reported an 83 per cent uptake of community services in response to nurse referrals. Dodge et al. (2019) also found variable impacts on the use of emergency departments, with fewer visits for infant related reasons but increased visits for maternal health concerns. The mixed findings about whether nurses can influence service use is consistent with previous research (n=3). In the original literature review, Sawyer et al. (2013) and Sawyer et al. (2014) South Australian Nurse Home Visiting) found no difference in service use, while Zolotor et al. (2015) (Period of PURPLE Crying intervention) identified fewer phone calls about infant crying to a nurse help line. All of the above outcomes for children and families are summarised in Table 4 on the following page.

Table 4: Summary of nurse effects on measures of abuse and neglect

Key: **Bold with an Asterix (*)** = updated since original review

Effect	Studies	Summary of effects (statistically significant, if relevant)
Direct measures of abuse & neglect		
Reports to child protection services	**Dodge et al. 2019*** **Segal et al. 2018*** Barlow et al. 2007 Dubowitz et al. 2012 Eckenrode et al. 2016 Mejoubi et al. 2015 Sadler et al. 2013 Zielinski et al. 2009	**Lower rates of CPS investigation.** **Fewer reports, fewer investigations and few days in care.** No change. No change. Fewer substantiated reports. Fewer reports. No change in active child protection cases. Longer time until first report; fewer overall reports.
Severity of abuse/neglect	Kobayashi et al. 2015	Reduced severity of abuse/neglect.
Detection of abuse	Louwers et al. 2012	Five times higher rate of detection of abuse.
Parental reports of violence	Dubowitz et al. 2012 Mejdoubi et al. 2013	Less psychological & physical aggression towards children (maternal report). Reduced victimisation and perpetration of intimate partner violence.
Abuse/neglect documented in medical record.	**Matone et al. 2018*** Dubowitz et al. 2012 Robling et al. 2016	**Children more likely to experience physical injury** No change in abuse/neglect documented in medical record Higher rates of documented abuse/neglect.
Non-accidental injury (child)	**Barr et al. 2018*** Altman et al. 2011 Dias et al. 2017 Zolotor et al. 2015	**35% reduction in in admissions for abusive head injury.** 75% decrease in abusive head injury incidence. No change in hospitalisation for abusive head injury. No change in incidence of abusive head injury.

Effect	Studies	Summary of effects (statistically significant, if relevant)
Risk factors for abuse & neglect		
Knowledge and attitudes	**Barnes et al. 2018***	**No change in parental attitudes**
	Altman et al. 2011	Most parents could recall intervention (head injury prevention)
	Dias et al. 2017	Most parents could recall intervention (head injury prevention)
	Fujiwara et al. 2015	Increased maternal knowledge of crying and dangers of shaking a baby.
	Goutlet et al. 2008	Most parents felt information and action plan was useful (head injury prevention).
	Guthrie et al. 2008	Increased parenting knowledge.
	Hogg et al. 2015	Increased parenting knowledge.
	Ogunfowokan & Fajemilehin 2012	Increase in girls' knowledge of sexual abuse; no change in attitudes.
	Reese et al. 2014	Most parents recalled intervention and had increased knowledge of head injury prevention.
Self-efficacy; maternal confidence; parental stress	**Cox et al. 2019***	**Improved maternal self-esteem & preparedness**
	Barnes et al. 2017*	**No change in maternal sensitivity or confidence**
	Fujiwara et al. 2012	No change in in parental stress
	Hogg et al. 2015	Increased parental confidence
	Kendall et al. 2013	Reduced parental stress; increased self-efficacy
	Kemp et al. 2012	Mothers felt more able to care for themselves and their baby
	McDonald et al. 2009	Improved self-confidence, decreased parental stress
	Porter et al. 2015	Reduced parental stress
	Rowe & Fisher 2010	Increased maternal confidence
	Sawyer et al. 2014	No change in parental stress or satisfaction with parenting role
	Sawyer et al. 2013	Reduced parental stress; greater satisfaction with parenting role
	Stubbs & Achat 2016	Most parents felt better able to cope
Home environment	**Goldfeld et al. 2019***	**Improved suitability of home environment**
	Flemington et al. 2015	Improved suitability of home environment
	Guthrie et al. 2008	Improved suitability of home environment
	Medjoubi et al 2015	Improved suitability of home environment

Effect	Studies	Summary of effects (statistically significant, if relevant)
Birth spacing	**Cox et al. 2019*** Olds et al. 2007 Sadler et al. 2013 Robling et al. 2016	**Fewer repeat pregnancies at 36 months.** Longer pregnancy spacing. Longer pregnancy spacing. No change in pregnancy spacing
Parental responsivity	**Paine et al. 2020*** **Slade et al. 2020*** **Goldfeld et al. 2019*** Flemington et al. 2015 Guthrie et al. 2008 Kemp et al. 2011 Porter et al. 2015 Ordway et al. 2014 Sadler et al. 2013	**No change in maternal use of internal emotional state language.** **Increased maternal reflective functioning.** **Increased maternal responsivity** Increased maternal responsivity Increased maternal responsivity Increased maternal responsivity No change in attachment or maternal responsivity No change in parental reflective functioning High risk mothers had improved reflective functioning
Parental social trust and community connectedness	Fujiwara et al. 2012 Stubbs & Achat 2016	No change in social trust Increased participation in community groups
Parent/carer physical and mental health.	**Dodge et al. 2020*** **Slade et al. 2020*** **Barnes et al. 2018*** Flemington et al. 2015 Hogg et al. 2015 Kelley et al. 2010 Kemp et al. 2012 Porter et al. 2015 Sadler et al. 2013 Rowe & Fisher 2010	**Lower rates of maternal anxiety and depression** **No change in maternal depressive or PTSD symptoms** **No change in maternal depressive symptoms** Increased maternal depressive symptoms Reduced anxiety and depressive symptoms Increased perceived health. Increased perceived health, no change in objective measures. Reduced maternal depressive symptoms. No difference in maternal depressive symptoms or psychological distress Improved maternal mood.

Effect	Studies	Summary of effects (statistically significant, if relevant)
Substance Use	**Barnes et al. 2018*** Olds et al. 2007 Robling et al. 2016 Sawyer et al. 2014 Sawyer et al. 2013	**No change in alcohol, tobacco or other substance use (mothers).** Lower substance use (mothers). No change in smoking (mothers). No change in alcohol or tobacco use (mothers). No change in alcohol or tobacco use (mothers).
Functioning	**Cox et al. 2019*** Kelley et al. 2010 Kobayashi et al. 2015 McDonald et al. 2009	**No change in life skills.** No change in perceived physical functioning. Improved family functioning. No change in mothers' family functioning; grandmothers perceived lower family conflict.
Reliance on welfare	Olds et al. 2007	Lower reliance on food stamps; no change in welfare use.
Child health and wellbeing outcomes		
Sexual health	Edinburgh & Saewyc 2009	Reduced STIs and no pregnancies (adolescent).
Infant/child behaviour	**Kitzman et al. 2019*** **Sawyer et al. 2018*** **Barnes et al. 2018*** Barlow et al. 2007 Kitzman et al. 2010 Mejdoubi et al. 2015 Rowe & Fisher 2010 Ordway et al. 2014	**Fewer criminal convictions for female youth, no change for male youth.** **No change in other behavioural measures.** **No difference in externalising/internalising behaviours or child-parent relationships.** **No change in infant cooperativeness.** Infant more cooperative. Reduced internalising behaviour, unchanged externalising behaviour. Reduced internalising behaviour, unchanged externalising behaviour. Reduced infant crying and fussing; improved infant sleep. Reduced externalising behaviour.

Effect	Studies	Summary of effects (statistically significant, if relevant)
Infant/child physical and mental health.	**Slade et al. 2020*** **Bounds et al. 2019*** **Sawyer et al. 2018*** Kemp et al. 2011 Sadler et al. 2013 Sawyer et al. 2014 Sawyer et al. 2013 Edinburgh & Saewyc 2009 Olds et al. 2007	**More infants securely attached, but no change in disrupted mother-baby affective communication.** **Decreased emotional distress and suicidal ideation/attempts.** **No difference in school readiness or physical health.** Improved mental development for children of psychologically distressed mothers. Improved attachment relationships at 12 months. More infants up-to-date with screening & immunisation at 12 months, but not 24 months. No change in infant health. Small change in infant sleep; otherwise no change. Decreased risky behaviour (adolescent). Lower infant mortality.
Substance use	Kitzman et al. 2010	Lower substance use (child).
Child educational success	**Kitzman et al. 2020*** Kitzman et al. 2010 Olds et al. 2007	**Graduation proportion unchanged, but more graduations with honours.** **Youth born to most vulnerable mothers had better math scores, working memory and emotional recognition.** **No change in nonverbal intelligence or sustained attention.** Higher GPAs. Higher GPAs.
Rates of breastfeeding	**Barnes et al. 2018*** Barlow et al. 2007	**Higher rates of breastfeeding at infant age 6 months.** No change
Service use and quality		
Judicial outcomes (with Sexual Assault Nurse Examiner (SANE))	Golding et al. 2015 Horner et al. 2012 Patterson & Campbell 2008	Guilty verdict more likely when SANE testified (mock juror). No change in judicial outcomes. Guilty verdict more likely when SANE involved.
Quality of care	Bechtel et al. 2008 Horner et al. 2012	More likely to receive appropriate interventions post-sexual assault. More likely to receive appropriate interventions post-sexual assault.

Effect	Studies	Summary of effects (statistically significant, if relevant)
Service use	**Dodge et al. 2019***	**Greater uptake of referrals to community services.**
		Fewer ED visits for babies, but increased ED visits for mother.
	Barnes et al. 2018*	**No change in service use.**
	Sawyer et al. 2013	No change in service use.
	Sawyer et al. 2014	No change in service use.
	Zolotor et al. 2015	Fewer phone calls to parent help line about infant crying.

Discussion

The findings of the updated literature published since August 2015 (literature review 1) and September 2017 (literature review 2) are comparable to the findings of the original literature reviews (Lines et al., 2018; Lines et al., 2017). There are two key findings that stand out from these reviews and updates. Firstly, looking at the research from 2005 through to present, nurses continue to perceive poor knowledge, collaboration and support in their role of responding to child abuse and neglect. This has implications for the capacity of nurses to effectively respond to vulnerable children. The other key finding is the continued overrepresentation of studies that assess the effectiveness of specific programs to prevent and/or address child abuse and neglect rather than necessarily reflecting the full scope of nurses' practices with children and families. For example, the effectiveness of nurses' mandatory reporting was not evaluated, nor were nurses' intuitive or spontaneous interventions they may have been implemented when encountering a family with unmet needs. Thus, it remains unknown to what extent these findings firstly represent the full extent of nurses' practices in responding to child abuse and neglect, and more importantly whether these interventions can make a difference for children at risk of abuse and neglect.

Nurses continue to perceive poor knowledge, collaboration and support

It is not known why nurses continue to perceive poor knowledge, collaboration and support in their role in responding to child abuse and neglect. It is possible that nurses' educational preparation and access to ongoing professional development is a factor, but it is not the full story. In many instances, nurses expressed a desire for additional education despite participation in educational opportunities (Lines et al., 2017). In particular, when nurses were asked about their professional development needs, they articulated educational needs that were often highly specific and unique to their context of practice. The absence of shared multi-disciplinary understandings may also be a contributing factor to nurses' perceptions of poor support and collaboration, with two studies finding that nurses had very different conceptualisations of risk and safety compared to CPS staff (Tung et al., 2019; Williams et al., 2019). Importantly, few studies (9 of 90) investigated the roles and experiences of nurses in Australia, therefore the extent to which the findings are applicable to nurses practicing in Australia is unknown. Despite child protection being 'everyone's

responsibility' (Council of Australian Governments, 2009), limited literature especially in the Australian setting means it is difficult to understand the unique experiences of nurses in Australia and how they can be best equipped and supported to make a difference for children.

The scope and efficacy of nurse roles is unclear

Literature review 2 and its update explored the evidence around whether nurses can make a measurable difference for children experiencing abuse and neglect. However, the transferability of this evidence is unclear because studies measured the outcomes of specific programs that were delivered solely or partially by nurses rather than explicitly measuring the effectiveness of nurses' interventions. Evidence for the effectiveness of nurse interventions is variable, with some studies showing positive impacts for children and their environment, but others show no or even adverse changes. The reason for the mixed results is unclear, but the diversity of study designs, interventions, settings, populations, health care systems and nurse characteristics makes comparisons very difficult. Furthermore, many studies compared intervention groups to control groups where the control group received 'usual care' which often still included care from nurses. Importantly, although literature review one showed that nurses practice in a variety of settings, including primary care, health visiting, schools, specialist paediatric inpatient units and GP clinics; the interventions identified in literature review two were more limited, comprising almost entirely of specific programs to prevent and respond to child abuse, most of which were postnatal home visiting interventions. The overrepresentation of specific interventions means the literature does not present a balanced picture of the nature and scope of nurse interventions.

This is problematic because firstly, it does not represent nurses' daily practices in settings where child protection is not a primary aim, and as such does not capture nurses' spontaneous and intuitive responses to vulnerable children and families. Secondly, without representing the full scope of nurses' responses to child abuse and neglect, the effectiveness of nurses' broader holistic roles remains unknown. Thus, although it is known that nurses work across many settings with children and families, the full scope and

potential effectiveness of their interventions to prevent and respond to child abuse and neglect remain invisible.

Without a clear representation of nurses' daily practices and their outcomes, there is limited evidence to guide other professionals' understandings of nurses' roles. The limited evidence has ramifications on the ability to build shared understandings and promote effective interdisciplinary collaboration. Similarly, organisations employing nurses have no basis on which they can build policy and practice frameworks to underpin nurses' roles and provide nurses with necessary educational and practical support. Furthermore, it is difficult to provide nurses with education that is relevant and specific to their context of practice if there is a limited understanding of what they do. This highlights the need to explore nurses' roles and experiences to begin to understand their invisible work and provide the necessary educational, professional and organisational support. Such research will provide a starting point from which the effectiveness of nurses' roles can be evaluated to assess how nursing profession might be mobilised more effectively to prevent and respond to child abuse and neglect in society.

Chapter summary

This chapter summarised literature firstly around nurses' roles and experiences in responding to child abuse and neglect and secondly, whether nurses' interventions can make a difference in children's lives. Key findings showed that nurses encountered child abuse and neglect in a variety of settings but experienced many challenges including poor knowledge, collaboration and support. Importantly, it was clear that nurses worked across the whole spectrum of prevention, detection and intervention following abuse which presented many opportunities to respond. However, it is difficult to assess the effectiveness of nurses' practice because evidence was mixed on whether nurses can make a measurable difference for children. The available evidence primarily reported effectiveness of nurses' roles in specific programs rather than accurately representing the full nature, scope and effectiveness of nurses' roles. As a result, nurses' effectiveness in preventing, detecting and responding to child abuse and neglect remains unclear. Furthermore, the limited number of Australian studies raises doubts about the transferability to nurses working in Australia.

CHAPTER 3: METHODS AND METHODOLOGY

Chapter summary

The aim of this research was to explore nurses' perceptions and experiences of keeping children safe from abuse and neglect. This chapter outlines the theoretical foundations and methodology of the research and how they link to the research question and objectives. The study used a qualitative approach underpinned by social constructionist theory. Social constructionism aims to explore and critique knowledge located within sociocultural contexts that is often unquestioningly replicated and maintained. This chapter will also demonstrate how the overarching theoretical foundation of the study link to the specific research methods that were used to recruit participants, collect data and analyse the findings.

Research approach

Approaches to research typically lie within two broad paradigms known as positivism and constructivism. Positivism is based in the assumption that there is a reality 'out there' to be studied, and aims to determine the causation of phenomenon using strictly controlled variables (Polit & Beck, 2012). A positivist approach studies phenomena through experimentation to promote replication and generalisability of results (Denzin & Lincoln, 2013a). For this reason, there is usually considerable effort placed on objectivity and preventing researcher 'contamination' of the phenomenon and research findings (Polit & Beck, 2012). In contrast, a constructivist approach recognises that there is no fixed objective reality waiting to be discovered, but instead reality is constructed by social interactions between individuals in society. This includes a recognition of the impacts of political and ethical influences on how the research is framed and interpreted (Denzin & Lincoln, 2013a). Consequently, rather than aiming to establish causation, a constructivist approach presents the complexities of human experiences (Saldana, Leavy, & Beretvas, 2011). More specifically, a constructivist approach explores individuals' behaviour, feelings and experiences of their social worlds to gain an emic or 'insider' view of participants' perceptions (Holloway & Galvin, 2016). Throughout this process, the researcher-participant relationship is recognised and addressed through reflexivity that acknowledges the relational co-construction of data (Holloway & Galvin, 2016). Given that the aim of this research was to explore nurses' perceptions and experiences of keeping children safe from abuse and neglect, this is best suited to

a qualitative approach which can investigate how nurses personally understand child abuse and neglect in the context of their professional social worlds.

Assumptions about knowledge

This section outlines the assumptions about truth, knowledge, epistemology and ontology that underpin this research. Firstly, the researcher believes that individuals experience a shared reality which is communicated and sustained through social relationships. In other words, there is an accepted 'order' of things that collectively guides how humans interact and relate (Burr, 2015; Gergen, 2015). Although we perceive an objective reality in terms of the physical world, the ways in which we interpret and interact with our physical word are inherited, constructed and maintained from our collective social interactions (Burr, 2015). For example, the metaphors of the 'war on drugs' or the 'war on terror' frame our thinking to regard some people as the enemy, thus shaping the way we manage the issue (Gergen, 2015). However, if other metaphors were used, this could lead us to construct different ways of conceptualising problems in society. In this way, our interactions create a collective subjective reality in which people live, work and understand the world.

This understanding of our shared subjective reality subsequently affects our perceptions of what can be known, or what types of knowledge exist, leading to a discussion of the epistemological assumptions of this research. This study is based upon the relativist assumption that knowledge can be obtained by engaging in dialogue with people about their social realities (Brinkmann, 2013). This view is contrary to the dominant realist paradigm that values scientific discovery over socially held knowledge and meaning. This divergence is typically framed as the debate between 'realism' and 'relativism'. Realism asserts a 'real' reality exists independent of human consciousness and has inherent characteristics that can be discovered and measured (Guba & Lincoln, 2008). In this way, it is supposed that objective truths can be learned by thorough investigation with rigorous research methods (Burr, 2003). However, all knowledge is produced as a result of asking questions that arise from a particular personal, cultural and historical standpoints (Burr, 2003). As a result, it is difficult to assert an objective truth because different answers might be found by asking questions from another perspective.

In contrast to realism, a relativist perspective argues that knowledge does not simply 'exist' but is actively created and sustained by human interactions (Guba & Lincoln, 2008). In this way, knowledge gained by a researcher is co-constructed through researcher-participant interactions that take place in a particular context, time and place (Gubrium & Holstein, 2003). This approach rejects the view that we can obtain objective and unbiased knowledge by searching for universal truths. Rather, knowledge is always socially constructed and is tied to specific contexts where it is produced. For example, some knowledge we take for granted is maintained through social consensus but can be easily challenged (Gergen, 2015). This is demonstrated historically, where mental illness has been considered 'madness' or 'demon possession', which justified persecution and social isolation of affected individuals (Roach Anleu, 2006). Conversely, current conceptualisations of mental illness acknowledge an underlying pathology which can be treated and often cured by health professionals (Roach Anleu, 2006). For this reason, Burr (2015) maintains that we need to take a 'critical stance towards taken-for-granted knowledge' because views that we hold as true may not be universal or static.

The considerable cultural and historical variations in the norms associated with parenting further highlight the importance of critiquing what we believe to be true. For example, definitions of what constitutes responsible parenting varies across time, class and culture as perceptions about children 'change with fashion' (Furedi, 2002). Contemporary Western views about children and childhood place emphasis on the perceived vulnerability of children, and the 'need' for greater adult supervision of children to mitigate any 'risks' (Clark & Gallacher, 2013; Gill, 2007). This is in contrast to children born in the 1960's and 70's who were frequently allowed, if not expected, to play outside the home unsupervised (Edgar & Edgar, 2008). This clearly demonstrates one way that changing social values have more recently swung towards the perceived need to keep children safe from all threats at the expense of children's independence (Gill, 2007).

It is difficult to find universal consensus around what is considered to be child abuse because perceptions of appropriate childrearing practices are embedded within prevailing attitudes of 'normal' versus deviant parenting at any time (Scott & Swain, 2002). As such, there is no single way to raise children. For example, many Aboriginal Australians view parenting as a community responsibility based upon kinship relationships and practices shared through oral traditions (Moore & Riley, 2010). In contrast, Western parenting tends to be more individualistic and is

principally the responsibility of the immediate family (Edgar & Edgar, 2008). In this way, our knowledge about children and the 'right' ways to raise children are not static but are socially constructed and vary with changing societal values and among different cultures. For this reason, social constructionism is a useful way to explore how nurses understand child abuse and neglect.

What is social constructionism?

Social constructionism critiques knowledge and social practices that are unquestioningly replicated and maintained over time (Burr, 2003; D'Cruz, 2004). Knowledge and social practices cannot be taken for granted because knowledge is culturally and historically specific (Burr, 2003). As such, there can be no objective 'truths' about the ways we understand the world. This is particularly evident in the field of child protection, where childrearing practices deemed acceptable in one culture can elicit strong disapproval in another culture. Similarly, societal values and practices around activities such as child labour, the appropriate age for sexual activity and physical discipline have changed dramatically over the past few hundred years (Aries, 1962; Montgomery, 2013b). Childrearing practices are closely linked to what societies have understood to be truths about children. For example, conceptualisations of childhood as a time of moral uncleanness from which children needed to be 'saved' legitimised corporal punishment of children (Brockliss & Montgomery, 2013). Similarly, sociocultural conditions of the 1800's and 1900's in Western countries meant that young people's incomes were considered essential to families' economic stability, thus giving social sanctions for children to work to supplement family incomes (O'Dell, Crafter, & Montgomery, 2013). Today, corporal punishment and child labour may be considered abuse, highlighting that child abuse is defined by the extent to which it deviates from dominant societal expectations of 'normal' (Roach Anleu, 2006).

What are the core principles of social constructionism?

There are many views on what social constructionism is, and as such there is no authoritative source to define social constructionism (Gergen, 2015). Gergen (2015) has described social constructionism as multiple and continuing dialogues to which anyone can contribute. Although there are many different perspectives about social constructionism, there are some shared central concepts about knowledge and truth (Burr, 2003; Gergen, 2015). Burr (2003) explains these shared understandings as taking 'critical stance toward taken-for-granted knowledge'; in

particular, the way that knowledge is historically and culturally specific, sustained by social processes and linked to social action. It is important to take a critical stance towards knowledge, because what we understand to be true holds implicit values that may silence, suppress or privilege certain worldviews and groups. In this way, our knowledge and assumptions influence the ways that we live together, interact and function in society.

Critiquing taken-for-granted knowledge

Given that there is no neutral and 'value-free knowledge', one of the major features of social constructionism is that it takes a critical stance toward taken for granted knowledge. This means that we need to be aware that our observations of the world are not necessarily concrete or shared by others. For example, the ways that we understand and 'know' about the world around us are based on our own views and imperfect ways of assessing the world. Similarly, because we were born and socialised into a world that already held meaning, it is not always obvious to us the assumptions we are making (Berger & Luckman, 1972). Thus it is important to be cautious of what we assume to be true about the world, including the common ways that we categorise information (Burr, 2003). A social constructionist perspective reminds us that categories do not simply and unproblematically exist in the world; but rather such categories develop as we interact with and interpret our environment (Gergen, 2015).

One such example has been demonstrated by the colonisation of countries like Australia, Canada and the USA where white childrearing practices were assumed to be superior to those of the First Peoples (Dudgeon et al., 2015). European settlers' perceptions of the First Peoples' supposed poor education and cultural inferiority meant settlers believed children would best be 'caught' and raised by white families (Dudgeon et al., 2015). In this way, the assumed superiority of the dominant white childrearing practices legitimised the oppression and removal of the First Peoples' children. However, even while doing this, settlers turned a blind eye to the harmful practices within their own culture such as the societal rejection of 'immoral' lower-class children or children of unmarried mothers and the employment of children in hazardous factories (Dudgeon et al., 2015). This belief that invading cultures' child rearing practices were superior has led to significant and on-going harm to many generations of Australian Aboriginals. Thus it is necessary to critically examine what we assume to be right and appropriate childrearing strategies as failure to do so has historically led to significant harm to children and their communities. By taking a critical stance,

the structures that privilege certain forms of knowledge can be identified to examine why they are assumed to be right and how they might silence or oppress other voices and forms of knowledge.

Knowledge is specific to historical and cultural backgrounds

The way that we see and learn about the world is linked to our personal values, beliefs and attitudes. It is impossible to explore at the world with no prior experience or background, which means that our ways of understanding the world are linked to our historical and cultural backgrounds (Burr, 2003). Consequently, it is important to understand that our ways of looking at the world may not be the best or only possible way. One key example of this can be found in the contrast between what constitutes 'good' parenting in across different cultures. In some societies with more collectivist values, all adults have socially defined roles to ensure the safety and wellbeing of all children in the community (Nyarko, 2014). In this way, children can safely 'roam the streets' as they play and visit their family, friends and neighbours. However, in more individualistic typically Western societies, children are more likely to be viewed as 'fragile', 'vulnerable' and thus 'requiring' constant parental supervision (Furedi, 2002).

Social interactions shape and sustain knowledge

Another central premise of social constructionism is that knowledge is not derived purely from the nature of the world, but from our shared ways of interacting with each other and our environment (Burr, 2003). As people interact, they develop and communicate their understandings about each other and their shared experiences (Berger & Luckman, 1972). Social environments and their institutions are in this way created and sustained by human interactions; these social constructed social norms in turn serve to constrain and guide human activity (Berger & Luckman, 1972). Consequently, knowledge can be considered as both created and sustained through human interactions. Through this process, people create a shared reality through which they experience the world. However, this process of creating and sustaining knowledge is not always visible to us when the ideas are widely accepted and familiar (Gergen, 2015).

One example of how social interactions shape and sustain knowledge is through socially constructed institutions such as our modern health care systems. Health care systems are comprised of professionals who work together in socially defined disciplines, such as nurses, doctors and physiotherapists. These disciplines were constructed historically, passed on through

future generations and are embedded in the nature and function of modern health care systems (O'Reilly & Lester, 2017). Disciplinary roles and boundaries in health care continue to develop and change in response to societal needs and expectations (Bynum, 2008). The roles and activities of the health professions may be taken for granted because they form the subjective reality of the current Western health care system (Burr, 2015; Gergen, 2015).

Within Western health care institutions, individuals have clearly defined professional roles through which they collaborate to achieve common goals. Efficient progress towards these goals is promoted by institutional regulation of individuals' activities through reward and discipline of behaviour (Foucault, 1995). Foucault refers to the idea of institutions actively influencing individuals' behaviour to promote institutional interests and goals as 'disciplinary power' (Foucault, 1995). It is necessary to consider how disciplinary power operates within healthcare systems because nurses' understanding and practices of addressing child abuse and neglect are located within these social and institutional contexts. For example, each country or jurisdiction has their own legislation around if/how nurses should address child abuse or neglect, and different health and welfare organisations have specific policies and procedures that nurses must follow.

Knowledge is linked to social action

Burr (2015) describes how different constructions of the world can lead to different actions being socially sanctioned. For example, the construction of mental illness as a medical problem located within the person legitimises the dominant treatment with medication and psychotherapy (Gergen, 2015). In previous times, mental illness or 'madness' was considered to be a punishment for sin, or later 'insanity'; a condition necessitating isolation from society to preserve social and economic conditions (Roach Anleu, 2006). Consequently, the way that mental illness is framed and understood impacts upon the way that it is managed or treated. This shows that our knowledge and ways of understanding the world are linked to the actions that we individually or collectively make.

Is everything a social construct?

One major criticism of the relativist position is that relativism dismisses the existence of the material world by arguing that absolutely *everything* is a social construct (Burr, 2003; Hacking, 1999). However, social constructionism does not claim that there is no physical reality, but instead

explains that as soon as we start describing a physical reality, we enter the world of discourse, which categorises and describes the world in ways that reflect reality (Burr, 2003). For example, it is not necessary to debate biological existence of childhood as it is a universal part of the human lifespan, but rather our collective understandings of childhood and adult interactions with children are socially constructed as they vary across culture, class and time (James & Prout, 2004).

Society shaping the person, or person shaping the society?

There are different views about the degree to which society is considered to shape the individual, or whether individuals shape their society. This question asks us to consider to what extent individuals have agency to enact change and determine their own identity, or whether they are simply products of their society. Berger and Luckmann (1972) consider that people together produce their social environment through on-going processes that negotiate and produce to social order. In this way, people together are continually constructing their social world, which is sustained and modified through social processes that continue to influence individuals within (Berger & Luckman, 1972). Thus, it is a multi-directional process through which people influence their environment through ongoing social interactions, but are also to a certain extent constrained by their social environment (Burr, 2015). For example, children acquire language, which is an existing part of their social environment (Burr, 2015), but language changes over time as new words are added, meanings of words change and some words fall out of use.

In summary, social constructionism requires a critique of how different factors influence our perspectives of what is true and who decides on what is true. This is especially important for a topic like child abuse and neglect, which is inextricably linked to prevailing community values and beliefs linked to time, place and culture. The nature of what is considered appropriate parenting is in constant flux and is by no means universally accepted. Subsequently, in order to explore how nurses understand child abuse and neglect, it was necessary to take an approach that recognised the ways that nurses constructed child abuse and neglect within the context of their social environments.

Research methods

In-depth interviews were used to gather data to meet the research aim of exploring how nurses who work with children understand child abuse and neglect and how this shapes their responses

to children at risk. Interviews are useful to capture the perspectives of nurses who work with children because they help the researcher to understand in detail how participants see their world (Liamputtong, 2013). Through conversation we learn about the world, and during research interviews the researcher and participant co-construct understanding and knowledge about this topic (Gergen, 2015). Interviews are especially useful for topics that would be otherwise inaccessible to study, such as individual's attitudes and personal experiences (Peräkylä & Ruusuvuori, 2013). In this way, interviews can facilitate an understanding of the ways that nurses keep children safe as nurses reconstruct their experiences through conversations with the researcher.

Participant selection

After obtaining ethical approval, purposive recruitment (Holloway & Galvin, 2016) was used to select registered nurses working with children in Australia. Nurses met the inclusion criteria if they had at least one experience caring for children or families where there were concerns about abuse and/or neglect to ensure they could talk directly about their experiences. Even though all nurses in Australia have a legal and ethical responsibility to keep children safe, nurses who did not work directly with children were excluded. This decision was made because nurses working with children have daily contact with children and families and thus more frequent experiences responding to abuse. Nurses working with children are also expected to have a higher level of expertise in advocating for children, supporting families and responding to situations that are potentially harmful to children's wellbeing (Australian College of Children & Young People's Nurses, 2016; Maternal Child and Family Health Nurses Australia, 2017). Although participants were mainly clinicians (n=16), some participants (n=5) worked in managerial or other non-clinical roles. They were included because nurses who work with children directly or indirectly at all levels of practice will influence the way that nurses keep children safe from abuse and neglect. School nurses were not specifically excluded from the study, but no school nurses contacted the researcher to participate in the study.

Recruitment

Purposive recruitment was achieved by contacting professional organisations that had registered nurses as part of their membership. The professional organisations which were approached and

subsequently consented to share information about this study with their members/associates were as follows:

- Australian Nursing and Midwifery Federation (ANMF);

- Australian College of Children and Young People's Nurses (ACCYPN);

- Maternal, Child and Family Health Nurses Australia (MCaFHNA);

- Australian College of Nursing (ACN);

- Association for the Wellbeing of Children in Healthcare (AWCH).

An additional organisation became aware of this project through the researcher's professional contacts and subsequently approached the researcher with their interest in becoming involved. This organisation was a small not-for-profit community service with a child and family program but has not been named due to the risk of identification.

These organisations were asked to share information with their members through a flyer adapted from Appendix 8. In addition, two of the organisations (ACCYPN and the local branch of MCaFHNA) invited the researcher to speak at their local members' events. Verbal and written information about the study was subsequently distributed to registered nurses at these events with the approval of the organisations. Individuals who were interested in participating were asked to contact the researcher via email. The researcher then emailed potential participants the full details of the study including the letter of introduction, information sheet and consent form (Appendix 9, 10 and 11) so they could come to an informed decision.

Ethical considerations

Ethical approval was sought and received from Flinders University Social and Behavioural Research Ethics Committee (no. 7296) prior to commencement of the study. Research is conducted with the intent of generating knowledge that will benefit society, but it is important that the research process itself does not cause harm. Ethical conduct in research ensures that researchers act out of respect and concern for research participants so participants' safety, wellbeing and human rights are maintained (National Health and Medical Research Council, 2018). In Australia, that all

research must be conducted in line with the National and Medical Research Council's 'National Statement on Ethical Conduct in Human Research' which includes the requirement that all research involving human participants is first reviewed by a research ethics committee. This study was initially guided by the 2015 National Statement of Ethical Research, until it was updated in 2018. The updates were minor and did not change the way the research would be conducted. The ways that the principles within this code were understood and applied to this research are now explained and discussed.

Merit and integrity

The merit of a research project refers to whether it is justifiable by its possible benefits to society and its contributions to knowledge (National Health and Medical Research Council, 2018). This project has merit as it is likely to improve our understanding of how nurses currently care for children at risk of abuse and how changes might be made in the future to enhance nurses' practice. Ideally, this would lead to improved services and outcomes for children experiencing abuse and neglect. To further ensure this project's merit, a thorough review of relevant literature has been conducted (see Chapter 2) and all stages of the research were supervised by two experienced researchers with clinical and academic expertise in children's nursing.

Integrity is another important characteristic of ethical research. Integrity refers to the way a researcher conducts themselves and the extent to which the researcher is committed to generating knowledge both ethically and honestly (National Health and Medical Research Council, 2018). It is especially important that the qualitative researcher has integrity because they collect data through relationships with participants and must make context specific, on-the-spot decisions about the appropriateness and sensitivity of their questions (Kvale, 2007; Morris, 2015). In this context, maintaining integrity included respecting participants' time by keeping the interviews to the pre-agreed duration and by responding to the participants' non-verbal communication, such as suggesting short breaks during the interview.

Justice and Beneficence

Justice in research refers to ensuring the research is fair to its participants and that research findings are disseminated in a way that is accessible to the wider community (National Health and Medical Research Council, 2018). The researcher ensured the research was just by outlining at the

beginning the expected time commitment (up to 90 minutes) and remained true to this. Participants were also provided with copies of their transcript to review and approve to ensure their experiences had been accurately represented. Several participants expressed a wish to see the findings of the study once it is available, and details of the publications will be shared with participants as these become available so participants can see the outcomes of their contributions.

Similarly, beneficence means that the researcher must consider how they will balance risks to participants against the potential benefits of the project to the wider community (National Health and Medical Research Council, 2018). While it is hoped that this research will assist nurses better care for children being abused or neglected, it cannot be guaranteed that all nurses will benefit. This was outlined to participants in the participant information (Appendix 10) along with the risks of participating. The main risk identified for participants was the potential for distress upon discussing sensitive topics of child abuse. This was addressed by outlining possible counselling services in the participant information (Appendix 10). However, no participants showed or reported distress, and there was no need to remind participants of the counselling services listed in the participant information.

Respect

Respect for participants means recognising the inherent value of human beings and being mindful of participants' wellbeing (National Health and Medical Research Council, 2018). The researcher demonstrated respect for individuals by recognising their autonomy and decisions to participate or not in this research. However, consent in qualitative research does not end with the participant simply agreeing to participate because the interview process itself is dynamic and participants may have different needs throughout the interview (Morris, 2015). Respect for participants was demonstrated by negotiating times, locations and methods of communication (i.e. Skype, phone, face-to-face) and acknowledging that participants were busy professionals, often with family responsibilities outside of work hours. Another way respect was demonstrated was by suggesting we take a break from the interview when participants received phone call or wanted to obtain food/drink. Participants were also thanked for the time they had dedicated to attending and participating in the interview.

Data collection

Data was collected through one-on-one, semi-structured interviews up to 90 minutes long from August 2016 until August 2017. Interviews (n=21) were conducted face-to-face (n=14), by phone (n=5) or via Skype (n=2) dependant on participant location and preferences. The benefit of offering phone and Skype interviews was to facilitate inclusion of geographically distant participants, but also increased flexibility for participants, such as for nurses who had work and family responsibilities which made physically attending an interview difficult (Jenner & Myers, 2018; Lo Iacono, Symonds, & Brown, 2016; Oates, 2015; Trier-Bieniek, 2012).

There was no clear difference in the quality of interview content between those conducted face-to-face compared with those on Skype or the telephone. However, the nature of phone and Skype interviews means they are dependent upon technology which is vulnerable to error or malfunction (Seitz, 2016). Two interviews were affected by failure of technology in some way. Interview 2 (Skype) was cut short because as the interview neared its closing stages, a power outage cut off the researcher's computer and Wi-Fi access. Similarly, during Interview 3 (Skype) the participant requested we use 'Skype for Business', and despite attempts at preparation, there was a need to download additional software at the time of the interview. In both cases, the interview was shorter than planned, but the overall quality of the conversation and data was not affected. Some authors have voiced concerns that audio quality might be impaired in telephone or Skype interviews (Deakin & Wakefield, 2014; King & Horrocks, 2010), however, in this study, audio quality was often higher in phone and Skype interviews. This could be partially attributed to the fact that several face-to-face interviews were held in public places (cafes, pubs) at the suggestion of participants and subsequently had greater background noise than Skype and phone interviews which were typically conducted from the researcher's home. The quality of audio could also be due to ongoing improvements in technology and internet bandwidth which reduces dropouts and buffering in Skype interviews (Jenner & Myers, 2018).

The interview guide (Appendix 12) was developed by drawing upon the researcher's professional knowledge of what nurses do to keep children safe, and relevant topics identified from a literature review (Lines et al., 2017). The benefit of semi-structured interviews was that the sequencing of questions could be adapted to each participant and changed over time to accommodate emerging

understandings of the topic (Holloway & Galvin, 2016; Merriam & Tisdell, 2016). The questions focussed on nurses' specific professional experiences relating to abuse and neglect, but also on participants' own values and beliefs as shaped by personal and professional factors. The interview guide was used to focus the interviews; however, the researcher only asked questions deemed most relevant depending upon the participants' specific roles and experiences (Merriam & Tisdell, 2016). The interview guide was reviewed by all the authors but not pilot tested as it was intended to be general guide rather than a strict list of questions (Holloway & Galvin, 2016). Instead, preliminary analysis and reflections on the interview process meant the interviewer individualised questions to suit each participants' context without changing the interview guide itself. For example, Participant 3 and 4 were working in non-clinical roles, whereas in preparing the interview guide, the researcher had assumed this study would primarily interest nurses working in frontline roles. Consequently, the approach was adapted to ask questions that were relevant to participants' current roles as well as questions that drew upon their past experiences as a clinician. It was also found over time that the researcher could ask more 'natural' questions by not referring directly to the interview guide, but instead asking questions to clarify or elaborate on topics the participant spontaneously discussed. Merriam and Tisdell (2016) explain this is a common adjustment as researchers become more experienced and familiar with the skills required for interviewing.

At the commencement of each interview, participants were offered the opportunity to ask any additional questions about the study and were asked to sign a consent form (Appendix 11). At the same time, the researcher also confirmed that participants were willing to have their interview audio recorded. This was especially important for interviews conducted via Skype or the telephone because participants could not actually see the audio-recorder, and may have otherwise been unsure if/when they were being recorded (Lo Iacono et al., 2016). Participants were also informed that they could take a break at any point during the interview and decline to answer specific questions.

Interviews started by asking the participant to share some basic descriptive information about themselves (King & Horrocks, 2010) such as their years of experience as a registered nurse, and how many of those years were working with children. They were also asked about their qualifications and current role within their organisation. This helped to contextualise their role in

keeping children safe whilst starting the interview on a relatively easy and non-threatening topic (King & Horrocks, 2010). Once their professional background was clear, the researcher followed up by asking each participant to share an experience when they had cared for a child where there had been concerns about abuse and neglect. The researcher took mental and hand-written notes during the participants' stories to facilitate asking for clarification after they had come to a natural conclusion (Taylor, Bogdan, & DeVault, 2016). The aim was to interrupt participants as little as possible during their initial story to develop rapport and show respect for their contributions (Morris, 2015). This also had the purpose of helping the researcher learn what most important for each participant and how they personally constructed their experiences, rather than enforcing the researcher's pre-conceived ideas and agenda (Taylor, Bogdan, et al., 2016).

Although participants were initially not interrupted during their stories, later in the interview the researcher questioned participants' viewpoints when there was a lack of understanding or a need to clarify their point of view. Some research texts advocate that the researcher takes a 'non-judgemental' approach (Holloway & Galvin, 2016; Merriam & Tisdell, 2016). However, Minichiello (2008) argues that it is not necessary, or helpful from a data collection perspective for the researcher to take a 'non-judgmental' position. This is because in typical conversations, people are used to others evaluating, judging, approving and/or disapproving of their ideas (Minichiello, Aroni, & Hays, 2008). However, what is important is that the researcher is not 'overly critical' but gives feedback to the participant as the participant refines and builds upon their ideas (Minichiello et al., 2008). Similarly, Taylor, Bogdan, et al. (2016) explain this concept as avoiding 'negative judgements' about participants and their views which could discourage openness and damage rapport. In this way, the researcher gave feedback about the participants' ideas to build rapport and lead to further co-construction of ideas in a conversational style (Gubrium & Holstein, 2003).

For example, when defining child abuse and neglect, Participant 18 explained that emotional abuse, sexual abuse and neglect were all difficult to clearly and succinctly define, whereas physical abuse could be easily defined:

P 18: I don't think it's very clear at all I don't think it would be easy to pick up [emotional abuse], I think physical [abuse] is the only one you could put in a neat box and say 'yep.'

Interviewer: Mmm but I guess even with physical… I guess if you play devil's advocate there's different ideas about smacking or not smacking, some people say that any form of smacking is physical abuse…

In this way, the researcher opened the possibility that physical abuse, like other forms of abuse, might also be difficult to define. However, the researcher did this in a way that indirectly disagreed with the participant rather than highlighting outright the perceived flaws in the participant's argument. Ultimately, this had the outcome of the participant revising her view to account for the different cultural values around physical discipline in society:

P 18: I dunno, it depends, like some people think a smack is abuse and that's okay for them to believe that as well.

Researcher influence and reflexivity

One criticism of qualitative research lies in the concern that data could be 'biased' because of the researcher's personal characteristics and interactions with participants (Miles, Huberman, & Saldana, 2014). Regardless of the methods used, the researcher will inevitably affect the process through their own characteristics, background, experiences and priorities (Gergen, 2015). Subsequently, it is much more useful to think in terms of reflexivity, which means the researcher critically and openly reflects upon their background and characteristics and how this might influence their participants, findings and interpretations (Gergen, 2015). For example, Kimpson (2005) described when researcher and participants have a shared background, it can help the researcher identify their own unconsciously held beliefs when participants' values and beliefs cause the researcher to reflect more deeply. Thus it can be more helpful to think about researcher positioning and how this influences the co-construction of knowledge. Some examples of researcher characteristics that could have influenced data collection and interpretation in this study include the researcher's personal characteristics, social role as a researcher and professional role as a paediatric registered nurse.

Factors such as age, gender, ethnicity and class can all influence the researcher and participant relationship (Raheim et al., 2016; Van Mol et al., 2014). This is linked to discussions around researchers interviewing 'up' or 'down', or as an 'insider' or 'outsider' where the researcher is assumed to take a certain position based on their own characteristics in comparison to the

participant (Ryen, 2003). However, this is a fairly simplistic view of the relationship between the researcher and participant, with Van Mol et al. (2014) arguing that unambiguous 'insider' and 'outside' statuses do not exist due to the complexity of social relationships, but instead there may be times where the researcher experiences 'insiderness' during the interview due to shared understandings and experiences. Similarly, even when the researcher perceives themselves to be equal to the participants, participants may not agree with this assumption (Tang, 2002). In this study, although the researcher considered themselves to be of equal background to participants, one participant exercised censorship of information. She later explained that this was because she felt the researcher was younger and needed to be protected from the potentially distressing nature of the interview content. This shows one way the researcher's characteristics influenced data collection that is collected, even without the researcher initially being aware.

The perception that participants are intentionally altering the information shared with the researcher is not unique to this study. For example, Miller (a white American) felt one participant gave an overly positive portrayal of white Americans, and questioned whether her own ethnicity might have been a factor (Miller, 2010). The participant in Miller's study may have framed their views of white Americans in a certain way avoid embarrassment or awkward confrontations with their white American interviewer (Rosenblatt, 2003). This is a good example of how knowledge is co-constructed between researcher and participant, because there are many ways that the researcher's characteristics and backgrounds can influence the way a participant shares their stories and it is likely the researcher will not always be aware of the extent and nature of ways participants subsequently frame their stories.

Another way to explain why some participants provided information in certain ways could be because the researcher was a professional peer. In some respects, interviewing a peer can be helpful, as the researcher does not need to seek explanations for basic concepts and may be able to generate in-depth conversations about complex concepts (Coar & Sim, 2006). However, when interviewing other health professionals, Coar and Sim found that some participants felt their professional knowledge was being tested and so displayed 'proper' professional attitudes towards the researcher. Thus peer participants may be more careful around what they say for fear that it may place their professional competence in question (Coar & Sim, 2006; Raheim et al., 2016). In this study, the researcher's position as a professional peer may have been further reinforced by

the participant information sheet (Appendix 10) which in accordance with ethical requirements stated that professional misconduct would be reported to the Australian Health Practitioner Regulation Agency in line with relevant legislation and procedures.

In the same way as researcher characteristics can influence data collection, the researcher's background, experiences and values can also influence the way that data is interpreted in the co-construction of knowledge. However, rather than assuming that the researcher's personal values and beliefs do not matter, or can be effectively 'set aside' (Holloway & Galvin, 2016) the research process instead explicitly acknowledges the researcher's background, values and beliefs to be open about how these have influenced the research throughout the whole process.

Reflection on interview and process

After each interview the researcher reflected upon their experiences through a reflective journal (Kvale & Brinkmann, 2009). Excerpts from the researcher's reflective journal can be found in Appendix 13. Part of the reflection involved considering the interview questions and to what extent they were understood by the participants. One key change that was made was around the definitions of abuse. Instead of asking how abuse/neglect is defined – which tended to elicit a simplistic response about the four 'types' of abuse (i.e. physical, emotional, neglect, sexual), this question was changed to focus on how participants identify and define these types of abuse in their practice. For example, the researcher would say something like 'the main types of abuse are physical, emotional, sexual abuse and neglect, when you're caring for children, how do you decide if children are experiencing/at risk of one of these forms of abuse?.' This style of question was much better understood by participants.

Transcription of the interviews

As soon as possible after each interview, the researcher either personally transcribed (n=12) or arranged for a professional transcriber (n=9) to transcribe the audio recordings. The researcher chose to access the services of a professional transcriber due to constraints on being able to complete all the transcriptions in a timely fashion. Interviews were transcribed verbatim, meaning that no attempts were made to 'correct' participants' grammar or speech patterns as this can risk altering participants' intended meaning (Kvale & Brinkmann, 2009). When sections of the interview were unclear or inaudible in the recordings allocated to the professional transcriber, she

highlighted these sections so the researcher could review them. In most cases, the sections that were unclear could be completed based on the researcher's memory of the interview and familiarity with the terminology used by nurses. There were a few examples of jargon or specific words that were inaudible in the recording – where possible, the researcher asked the participant to clarify by email. Participants were frequently able to confidently identify the word or phrase they had used. For example, some details of specific events or the names of places were audibly unclear, and so the researcher clarified these with participants to ensure they had been correctly recorded.

Following interview transcription, participants were given the opportunity to review their transcript and make changes prior to inclusion in data analysis. One participant chose to withdraw her transcript as she was concerned about how her employer might respond as she had not formally sought permission. Although this participant was reassured that her identity and that of her employer would not be disclosed, she still wished for her transcript to be withdrawn. This interview is not reported in this study or included in the total number of interview participants (n=21). Other participants (n=4) instead chose to edit their transcript; one participant redacted some of her answers, whilst others (n=3) made minor typographical changes and/or clarified acronyms and jargon. The remaining 17 participants did not make any changes to their transcript.

Privacy and confidentiality

Another part of maintaining respect for participants is by ensuring confidentiality and anonymity. This involved referring to each participant by their interview number (i.e. Participant 1, Participant 2) rather than their name, and by removing identifying information such as names and places from the interview transcripts. In addition, audio recordings were deleted once the interview transcript had been completed and participants had reviewed and/or made changes to their transcript. Resulting transcripts were only accessible to the researcher and their supervisors, and these transcripts were stored on a password protected computer to prevent unauthorised access. Similarly, the professional transcriber was required to sign a confidentiality agreement to indicate that she would not disclose information from the interviews.

Data saturation

Data saturation began to occur around interview 17, meaning the researchers realised that participants were reiterating similar concepts and building upon prior interviews. This was first noticed when participants began providing the same kinds of responses to interview questions. The researchers understood data saturation as 'theoretical saturation', which is where 'new data do not contribute new themes or patterns in the analysis' (Given, 2016, p. 135). There is an ever-present possibility of new or novel findings, but the researchers recognised that at a certain point, additional interviews would provide only 'diminishing returns' (O'Reilly & Parker, 2012; Saumure & Given, 2008). At the same time, it was also becoming clear that nurses' roles are very context specific. As such, the researcher was beginning to get more in-depth and nuanced information from participants based on the developing knowledge and improvements in interview technique such as asking tailored and context specific follow-up questions. Consequently, an additional five pre-booked interviews were conducted to provide more nuanced and context-specific data. These further interviews confirmed the researchers' sense that theoretical saturation was occurring.

Data analysis

Once the researcher received or completed each transcript, they were read and re-read to become familiar with their content. The researcher paid particular attention to the interviews transcribed by the professional transcriber as because these were less familiar than interviews the researcher transcribed personally. Transcripts were then exported into NViVo software where the data was coded inductively. Coding was commenced after six interview transcripts had been completed. Coding is the process of applying 'labels' that assign meaning to the information gathered in a qualitative study (Miles et al., 2014). The researcher began coding during the data collection phase to facilitate cycling back and forth between existing data and considering how to generate new and potentially better data in future interviews (Miles et al., 2014). At the beginning, coding was 'descriptive' which means it 'summarises the primary topic of the excerpt'; often by using a single noun (Saldana, 2016, p. 4). However, descriptive coding was soon found to be too simplistic to represent all concepts present in the data, so the researcher moved on to use other additional kinds of codes. Other key types of coding that were used were process coding and holistic coding. According to Saldana (2016), process coding is suitable for nearly all forms of qualitative research. Process coding uses gerunds, also known as "ing" words to represent actual

and conceptual actions (Saldana, 2016). For the passages of text that did not relate to action, the researcher used holistic coding to capture their meaning; holistic coding can be defined as a way to 'grasp basic themes or issues in the data by absorbing them as a whole' (Saldana, 2016, p. 166). See Appendix 14 for examples of descriptive, process and holistic codes.

As additional transcripts were completed, these were coded using the above coding methods. The researcher also went back to earlier interviews to identify any links with newer data and determine whether any codes could be subsumed into existing or broader codes as the analysis progressed (Saldana, 2016). The researcher went back and forth between interviews, coding and re-coding at this stage, in recognition that qualitative research is rarely sequential but instead iterative, reflexive and cyclical (Silver & Lewins, 2014). As coding progressed, the researcher found that process coding was the most useful because large portions of the interview content were action oriented as nurses were often described experiences of keeping children safe through actual or conceptual actions. This process of going back and forth over the interview data and coding and recoding was repeated until all interviews had been coded.

Over time, the coding process produced a very large number of codes. Due to the way that NViVo displays data and the size of a computer screen, it was it difficult to visualise all codes at once to facilitate linking of concepts. As a result, all the codes were printed onto paper, cut into strips and arranged conceptually with blu-tac on a large sheet of poster paper. Some initial examples of this process are recorded by photographs (See Appendix 15). This helped the researcher visualise the all the data simultaneously and more easily move parts of the data to explore how various pieces might relate to each other without the limitations of a computer. According to Gibbs (2014), it is not unusual for a qualitative researcher to temporarily move away from computer-assisted qualitative data analysis software while they think and rethink the data analysis. The process of moving away from NVivo for a short while helped to visualise the data, and explore the connections between various pieces of data without the need to 'drag and drop' codes together which caused lagging and misplaced codes (accidentally 'dropped' into other nodes) when attempted directly in NViVo.

In addition to sorting codes into areas of similarity, NViVo and the poster of printed codes were used to help the researcher identify codes that were identical or very similar in meaning,

especially those that were used only once or twice. When codes were similar or identical, the researcher referred to the relevant data to assess whether the codes could be subsumed into a single code. For example, the codes 'Child protection services (CPS) minimising nurse's concerns' and 'CPS discounting or discrediting signs of abuse' were subsumed into 'CPS discounting or minimising signs of abuse'. This process was repeated as required, and the codes were updated in NViVo.

During the process of sorting and arranging codes on poster paper, the researcher discussed developing ideas and connections with the other two researchers. This iterative process helped to refine ideas and connections into four initial key themes. These four initial themes and their content are presented in Appendix 16 as a mind map, and the initial theme names are summarised below:

1. Assessments of abuse/neglect stem from nurses' culture, values and beliefs;

2. To keep children safe, nurses establish/maintain positive relationships with parents;

3. Making a notification is a skill;

4. Tension between individuals and organisational structures.

Over time, as the researcher began to write up the themes, these theme names were updated as follows to more accurately represent the content and meaning:

1. Sociocultural contexts shaping nurses' perceptions of child abuse and neglect;

2. 'How can we work together?': keeping children safe through therapeutic relationships;

3. Constructing a compelling case: complexities of communicating about child abuse and neglect;

4. Systems and hierarchies shaping nurses' responses to child abuse and neglect.

Finally, when the researchers had decided upon these four final themes, it was clear they all contributed to the overarching theme of nurses' roles and experiences as 'more than mandatory

reporting'. This overarching theme also forms the title of this thesis. See Table 5 for a summary of the process of theme development.

Table 5: Summary of theme development

Process of theme development	Theme 1	Theme 2	Theme 3	Theme 4
Initial themes; As presented in Appendix 16.	Assessments of abuse/neglect stem from nurses' culture values beliefs	To keep children safe, nurses establish/maintain positive relationships with parents	Making a notification is a skill	Tension between individuals and organisational structures
Interim themes; As presented in manuscript form in Chapters 5-8	Contextualising and defining child abuse	Nurse relational skills in addressing child abuse	Nurse experiences of communicating concerns of child abuse	Nurse perceptions of how systems and hierarchies shape their responses to abuse
Final themes; As presented in remainder of thesis (Chapters 9 and 10)	Sociocultural contexts shaping nurses' perceptions of child abuse and neglect	'How can we work together?': keeping children safe through therapeutic relationships	Constructing a compelling case: complexities of communicating about child abuse and neglect	Systems and hierarchies shaping nurses' responses to child abuse and neglect
Overarching theme: *More than mandatory reporting: nurses' experiences of safeguarding children in Australia*				

Synthesis of data

After the four main themes were established, data was further synthesised by applying two key frameworks which were 1) social constructionism (Berger & Luckman, 1972; Burr, 2015; Gergen, 2015) and 2) Foucault's (1995) concept of 'disciplinary power'. The social constructionist framework underpinning this research facilitated a deeper understanding of how nurses conceptualise child abuse and neglect within their unique social contexts, including the factors they perceived as influencing their capacity to respond. Social constructionism was applied to all four of the synthesised findings, or 'discussion points' which are displayed in Figure 3 on the following page. More specifically, social constructionism provided a lens to understand how socially constructed conceptualisations of both child abuse and nursing roles were inextricably linked to nurses' enactment of their role within the social structures of the CPS and health care systems. Understanding how socially constructed views of both child abuse and nursing roles within social and health care systems can shape nursing practice is core to mobilising the nursing workforce to make a difference for vulnerable children. For example, nurses identified how families' assumptions about the roles of nurses and CPS influenced the ways nurses subsequently interacted with families when addressing concerns about child abuse or neglect.

As data analysis and synthesis progressed, it became increasingly clear that nurses' experiences of responding to child abuse and neglect were inextricably linked to the hierarchal structures of the CPS and health care systems. To better understand how broader systemic and organisational structures could affect nurses' conceptualisations of child abuse and subsequent enactment of their role, Foucault's concept of 'disciplinary power' was applied (Foucault, 1995). Disciplinary power provided a lens to explore how nurses' understandings of child abuse and their experiences of responding to child abuse were shaped by the hierarchal structures of the CPS and health care systems. In particular, the concept of disciplinary power was applied to the final synthesised finding 'Discussion point 4: Critiquing and moving beyond compliance cultures'. This was because nurses perceived that compliance cultures within CPS and health care systems had significant impacts on how and if they could address child abuse and neglect. This process of data synthesis is summarised in Figure 3 on the following page.

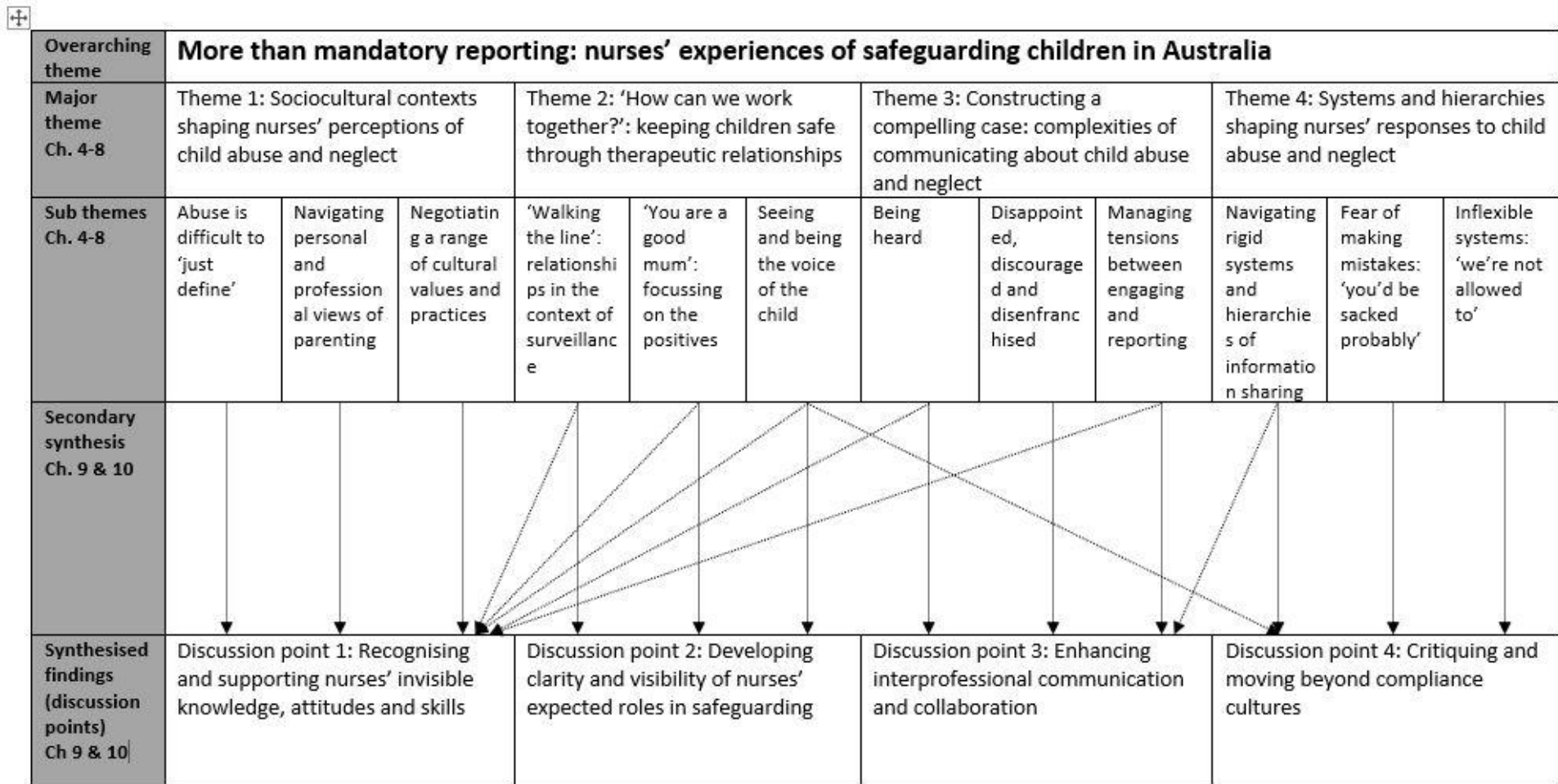| Overarching theme	More than mandatory reporting: nurses' experiences of safeguarding children in Australia											
Major theme Ch. 4-8	Theme 1: Sociocultural contexts shaping nurses' perceptions of child abuse and neglect			Theme 2: 'How can we work together?': keeping children safe through therapeutic relationships			Theme 3: Constructing a compelling case: complexities of communicating about child abuse and neglect			Theme 4: Systems and hierarchies shaping nurses' responses to child abuse and neglect		
Sub themes Ch. 4-8	Abuse is difficult to 'just define'	Navigating personal and professional views of parenting	Negotiating a range of cultural values and practices	'Walking the line': relationships in the context of surveillance	'You are a good mum': focussing on the positives	Seeing and being the voice of the child	Being heard	Disappointed, discouraged and disenfranchised	Managing tensions between engaging and reporting	Navigating rigid systems and hierarchies of information sharing	Fear of making mistakes: 'you'd be sacked probably'	Inflexible systems: 'we're not allowed to'
Secondary synthesis Ch. 9 & 10												
Synthesised findings (discussion points) Ch 9 & 10	Discussion point 1: Recognising and supporting nurses' invisible knowledge, attitudes and skills			Discussion point 2: Developing clarity and visibility of nurses' expected roles in safeguarding			Discussion point 3: Enhancing interprofessional communication and collaboration			Discussion point 4: Critiquing and moving beyond compliance cultures		

Figure 3: Visual representation of data synthesis

Quality of qualitative research

It is essential to consider the quality of research to assess its 'truth value'. There are many ways that this can be accomplished and it has been the topic of considerable debate (Denzin & Lincoln, 2013b; Holloway & Galvin, 2016). For example, strategies such as checklists have been criticised because simply ticking boxes risks a false sense of security (Buus & Agdal, 2013), and checklists may be used inappropriately by individuals with little theoretical understanding of qualitative research (Morse, 2018). Similarly, there is a risk that checklists could begin to frame how research is conducted and lead to uncritical and poor research planning and process (Barbour, 2014). The diversity of qualitative approaches and its relational nature means that there is no simplistic, unified approach to assessing the quality (Barbour, 2014; Denzin & Lincoln, 2013b). Qualitative research occurs in the context of relationships and direct engagement with the social world, which raises additional considerations such as trust, collaboration and responsivity to participants' own agendas (Denzin & Lincoln, 2018). Thus, qualitative research evaluation needs to be 'holistic, dialogical and emergent' (Denzin & Lincoln, 2013b, p. 353) as decisions influencing the quality of the research are made continually throughout the research process (Torrance, 2013).

In the absence of definitive criteria through which to judge the quality of qualitative research, Morse (2018) explains that careful and appropriate choice and implementation of strategies to establish and provide evidence of the project's rigor are essential. These strategies should be chosen in line with the goal of building trustworthiness and placing 'enough rigor in the methods so that the researcher is certain of the results, and the consumer is confident enough to implement… the results' (Morse, 2018, p. 814). Some strategies appropriate to this study included member checks, providing an audit trail and researcher reflexivity (Morse, 2018). Instead of reflexivity, Morse (2018) advocated for bracketing as another way of ensuring high quality research. However, bracketing was not consistent with the theoretical approach of social constructionism, which recognises that knowledge is co-constructed and therefore it is not possible for the researcher to bracket themselves off from the research (Gergen, 2015). Instead, the researcher forms part of the phenomenon being studied (Holloway & Galvin, 2016). To demonstrate quality of this study, the concept of reflexivity rather than bracketing was implemented throughout this chapter to report on the researcher's background and explore how the researcher's characteristics have influenced and contributed to the results and interpretation.

There is no uniformly accepted definition of reflexivity, nevertheless it has been widely accepted as an essential component of qualitative research (Li, 2018; Lumsden, 2019; Mann, 2016; Preissle & deMarrais, 2015; Spyrou, 2018). One important function of reflexivity is to facilitate exploration and critique of the complex relationships between the researcher and the social world, especially in recognising the researcher as a part of the social world they are studying (Lumsden, 2019; Spyrou, 2018). Reflexivity is an ongoing process that involves 'thinking, experiencing and acting to shape research outcomes' (Li, 2018, p. 17). For example, by recognizing the ways that researcher background and identity influences the questions they ask and the ways participants may respond, the researcher can actively negotiate the 'messy nature' of the social world, including its hierarchical structures and power relations (Lumsden, 2019, p. 1). Reflexivity can be demonstrated to others is through a research diary which documents the process of reflexivity for others to see (Li, 2018; Preissle & deMarrais, 2015). This can also form part of an audit trail of the research.

Providing an audit trail, also known as auditability, refers to 'logging and then describing… procedures clearly enough so that others can understand them, reconstruct them and subject them to scrutiny' (Miles et al., 2014, p. 317). This process of providing an audit trail also assists consumers of research determine to what extent the research can be applied to their situations. At the time of the research, the researcher does not know the extent to which their research might be drawn upon by future studies or by other fields which may go beyond what was originally intended (Barbour, 2014). Thus, by providing an audit trail of decisions, it can help others assess the extent the research might be relevant or applicable to other settings or fields of study. Throughout this chapter, methods have been described in detail to provide the reader with a clear understanding of the strategies and decisions that have been made throughout. This included the rationale for decisions, especially decisions that were made or changed during the research process based on emerging information or changing situations.

Conclusion

This chapter described and justified research theoretical and methodological approaches and outlined the research design and methods. Social constructionism facilitated an understanding of multiplicity of ways nurses may conceptualise child abuse and neglect, including the influence of nurses' personal backgrounds, professional experiences and organisational contexts. The

variability in the ways that child abuse and neglect has been constructed culturally and historically demonstrates that social constructionism is an appropriate theoretical approach to explore how nurses who work with children conceptualise child abuse.

CHAPTER 4: FINDINGS - OVERVIEW

This chapter outlines the major findings of the study that explored nurses' perceptions and experiences of keeping children safe from abuse and neglect. An analysis of the 21 in-depth interviews with registered nurses working with children in Australia led to four key themes, each with three associated subthemes (Figure 4). The volume of the data and complexity and nuance of the findings means they have been presented in four separate chapters, each addressing one of the four key themes in detail. Each chapters (chapters 5-8) contains a manuscript that is either published or has been submitted for publication in a peer-reviewed journal. This first chapter outlines the findings in their entirety, including how the four major themes are linked.

Summary of participants

Twenty-one participants agreed to have their transcript included in this study. All participants were female and were working with children at the time of participation. The summary of participant characteristics is presented in Table 6 in disaggregate form. In Australia, the nursing workforce caring for children is relatively small, and so participants might be identifiable if details were presented in aggregate form.

Table 6: Participant characteristics in disaggregate form

Participant characteristic	Number of participants (n=21)
Geographical location	
South Australia	n=19
Queensland	n=1
Victoria	n=1
Remoteness	
Metropolitan	n=18
Rural or remote	n=3
Context of practice	
Child and family health	n=10
Paediatrics	n=7
Combined paediatrics and child and family health	n=2
Other community settings	n=2
Primary role within organisation	
Clinician	n=16
Manager	n=4
Non-clinical	n=1
Years of experience in nursing	
Less than 10	n=0
10 to 19	n=7
20-29	n=6
30-39	n=7
40+	n=1

As outlined in Table 6, participants worked in three key practice settings which were child and family health, paediatrics and other community settings. In Australia, maternal child and family health nurses (known as child and family health nurses in some jurisdictions) have similar roles to health visitors in the UK and typically work in family homes or clinics. Paediatric nurses usually work in acute care settings such as hospitals. In comparison, community nurses do not have a nationally defined role in Australia, but community nurses in this study were employed by welfare-focussed non-government organisations. See Table 7 for a comparison of these nursing roles in Australia.

Table 7: Comparison of paediatric, community and child and family health nurses in Australia

Nurse	Main qualification	Further education or qualification?	Context of practice
Paediatric nurse	Registered or enrolled nurse.	No specific education or further qualifications required.	Acute care; typically in hospitals.
Community nurse	Registered or enrolled nurse.	No specific education or further qualifications required.	Variable; examples include welfare or health focussed government or not-for-profit community-based organisations.
Child and family health nurse	Registered nurse.	Requires specialist tertiary education in child and family health.	Family homes and community clinics.

Overview of key themes

The four key themes arising from this study were:

- Theme 1: Sociocultural contexts shaping nurses' perceptions of child abuse and neglect;

- Theme 2: 'How can we work together?': keeping children safe through therapeutic relationships;

- Theme 3: Constructing a compelling case: complexities of communicating about child abuse and neglect;

- Theme 4: Systems and hierarchies shaping nurses' responses to child abuse and neglect.

A visual summary of the relationship between the four themes and their respective subthemes is provided in Figure 4.
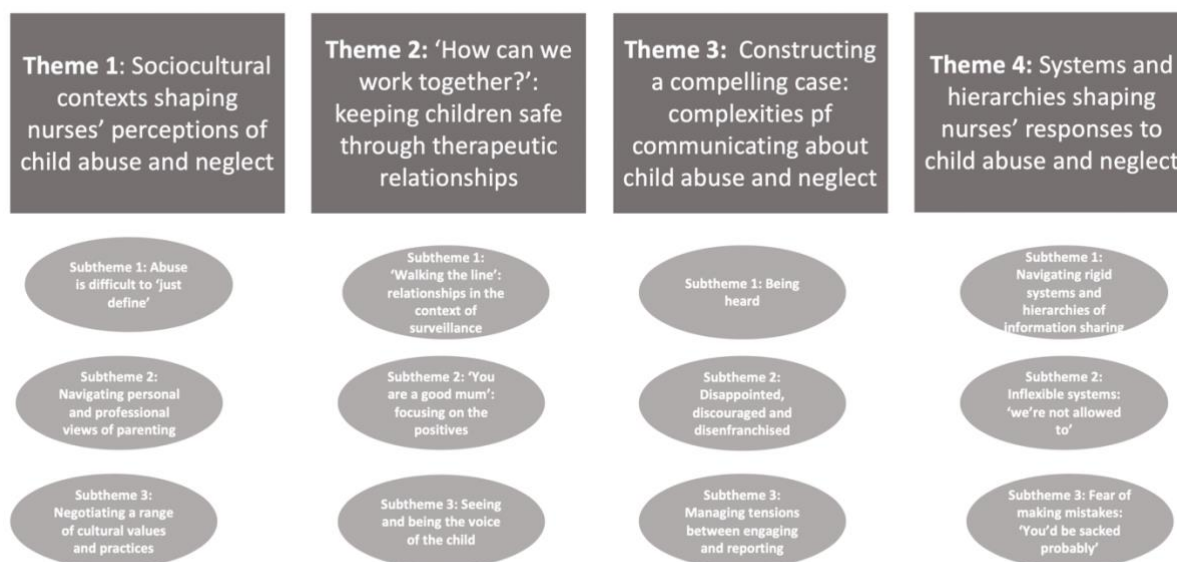
Figure 4: Summary of themes and their associated subthemes

The first theme 'sociocultural contexts shaping nurses' perceptions of child abuse and neglect' outlined how nurses had difficulty concisely defining abuse and neglect and were guided by a range of sources including their personal and professional backgrounds. ''How can we work together?': keeping children safe through therapeutic relationships' explored how nurses used relational skills to manage the tension between maintaining family engagement whilst addressing concerns around child safety and wellbeing. Throughout the process of working with families, the theme 'constructing a compelling case: complexities of communicating about child abuse and neglect' examined nurses' challenges when communicating their concerns to child protection services and deciding if/how to discuss this with families. Finally, all nurses' practices were influenced by the organisational contexts of their work, and so the theme 'systems and hierarchies shaping nurses' responses to child abuse and neglect' identifies nurses' experiences of working within socially constructed institutions created to keep children safe.

These four themes are presented in detail through copies of the manuscripts published or submitted to peer-reviewed journals in chapters five to eight. Although the manuscripts contain some repetition, such as in their respective methods sections, they are presented in full for the purpose of transparency.

These manuscripts were jointly authored by Lauren Lines, Alison Hutton and Julian Grant. All authors (LL 80%, AH 10%, JG 10%) contributed to the conceptualisation and development of the manuscripts. LL (100%) collected the data; LL conducted the data analysis (80%) in consultation and discussion with AH (10%) and JG (10%). LL (100%) wrote the original draft of each manuscript, and all authors contributed to critical revision and editing of the manuscripts (LL 80%, AH 10%, JG 10%).

Chapter summary

Chapter four outlined the overarching findings from this study and how they are linked. These four themes are now presented in greater detail in chapters five to eight. Each of the four themes is presented in manuscript form because they are all published or currently under review.

CHAPTER 5: FINDINGS - THEME 1

Theme 1: Sociocultural contexts shaping nurses' perceptions of child abuse and neglect

Introduction

Child abuse and neglect impacts large numbers of children globally, but the precise number of affected children remains unknown (World Health Organisation, 2016). Child abuse can include physical, sexual, emotional abuse and neglect, with many children experiencing multiple forms of abuse (van Scoyoc, Wilen, Daderko, & Miyamoto, 2015). Nurses, especially those working with children, have numerous roles in keeping children safe; including prevention, early intervention and addressing the physical and psychosocial needs of children who have been abused (Lines et al., 2018). In paediatric and child health settings, nurses address abuse and neglect directly through their practice with children and families, as well as indirectly through referrals to child protection services.

In paediatric and child health settings, nurses have daily contact with children and thus need knowledge and skills to identify and respond to child abuse. In some settings such as emergency departments, nurses use formalised assessment tools including screening guidelines to assess suspicious physical injuries (Escobar et al., 2016). However, in paediatric and community child health settings, nurses are reliant on clinical judgements to form a suspicion whether child abuse may be occurring and decide whether they should refer to child protection authorities (Dahlbo et al., 2017; Saltmarsh & Wilson, 2017). There is limited existing research that explicitly explores nurses' decision-making processes in relation to child abuse and neglect, but it is known that in neonatal, school and public health settings nurses believe their initial suspicion is based upon a 'gut feeling' or 'intuition' (Kraft & Eriksson, 2015; Saltmarsh & Wilson, 2017; Schols et al., 2013). These feelings could be because signs of abuse are often insidious and inconclusive, and when nurses feel unsure they are less likely to report abuse (Svard, 2016). Nurses consider multiple information sources when assessing for abuse, but not all factors are considered equally. For

example, Appleton, Harris, Oates, and Kelly (2013) found health visitors in the United Kingdom focussed more on maternal factors than the baby's behaviour and concluded that health visitors' assessments needed to place a more explicit focus on the child. It is important to understand what factors influence nurses' assessments of child abuse and neglect to recognise how this subsequently affects children experiencing abuse.

Aim

This paper reports on one of four themes from a larger qualitative study that explored the question: 'what are nurses' perceptions and experiences of keeping children safe from abuse and neglect?' It was intended the findings would provide an insight into nurses' understandings of child abuse and inform how the nursing workforce can be mobilised and supported to respond to children experiencing abuse. This study identified four themes (numbered for clarity) through an inductive analysis and are 1) contextualising and defining child abuse, 2) nurse relational skills in addressing child abuse, 3) nurse experiences of communicating concerns of child abuse and 4) nurse perceptions of how systems and hierarchies shape their responses to abuse. The aim of this paper is to report on the first theme which outlines how nurses interpreted child abuse and neglect within their sociocultural contexts. The three key subthemes within this paper are: abuse is difficult to 'just define', navigating personal and professional views of parenting and negotiating a range of cultural values and practices. A summary of the four broad themes, the theme addressed in this manuscript and its subthemes are outlined in Figure 5.
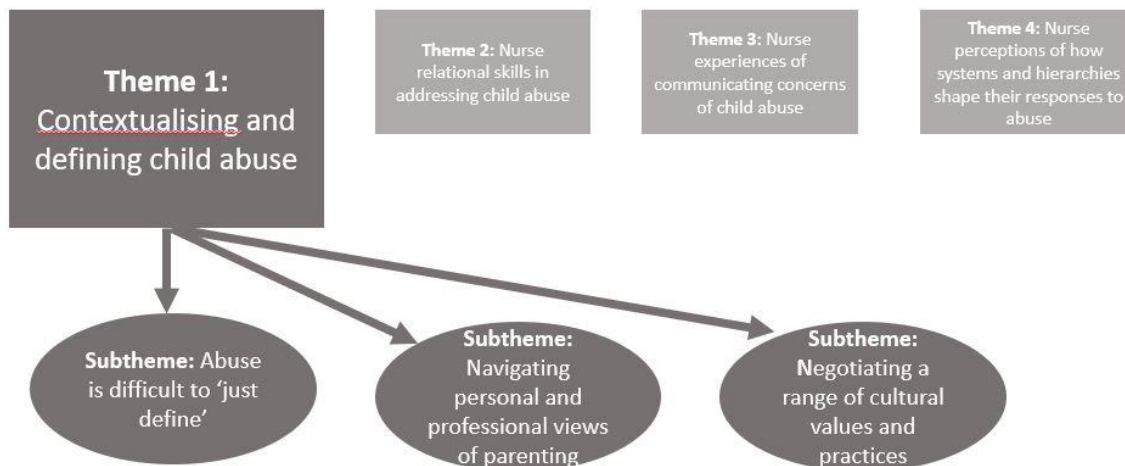
Figure 5: Summary of themes and subthemes

Methods

Framework

The research design was guided by a social constructionist approach which recognises knowledge and social practices as based within sociocultural contexts and often unquestioningly replicated and maintained (Burr, 2015). This sociocultural context is particularly evident in child abuse and neglect because acceptable childrearing practices vary dramatically across social and historical contexts. For example, contemporary western views have changed from accepting corporal punishment as an 'important disciplinary tool' to the classification of these behaviours as assault (Montgomery, 2013b). This approach means that the ways nurses keep children safe can be understood as culturally situated and reinforced through everyday practices. As researchers, we ourselves recognised the ways we 'know' about the world stem from our own backgrounds and cultural values that are produced by our social environment (Berger & Luckman, 1972). Consequently, the researchers acknowledge that their clinical backgrounds including paediatric nursing (all authors) and child health nursing (JG) will have influenced interpretation of the data.

Design

Data was collected through semi-structured, in-depth interviews with nurses who worked with children in Australia. Participants were recruited by purposive sampling through advertisements published by professional organisations relevant to nursing. Although all nurses in Australia have

an ethical and legal responsibility to respond to suspected child abuse, this study only included nurses who worked directly with children because they had frequent encounters with child abuse.

Ethics

This study was given ethical approval by Flinders University Social and Behavioural Research Ethics Committee (no. 7296). All participants were given information about their rights and provided written consent.

Data collection

The first author collected data through semi-structured, in-depth interviews (60 to 90 minutes long). Interviews were face-to-face (n=15), by telephone (n=5), or Skype (n=2) depending on participant location and preferences from August 2016 to August 2017. An interview guide (Appendix 12) was developed based on a review of the literature (redacted for peer review), but not pilot tested because it was intended as a general guide only. Preliminary analysis and reflections on the interview process meant the interviewer individualised questions to suit each participant's context but the interview guide was not changed. Data saturation started at interview 17, but an additional five booked interviews were conducted because the researchers became aware that nurses' experiences were context specific. These additional five interviews provided more nuanced data.

Interviews were audio recorded and transcribed by the primary researcher (n=13) or a professional transcriber (n=9). Participants could review and modify their de-identified transcripts; n=17 made no changes, n=4 made minor changes and n=1 chose to withdraw their transcript. The reason for withdrawal was the participant's concern they had not formally sought their employer's permission to participate.

Data analysis

Transcriptions were read and re-read by the first author before being coded inductively using NVivo software. Coding started with descriptive codes, but process and holistic codes (Saldana, 2016) were used later to better represent the data's complexity and nuances. Over time, the analysis produced a large number of codes (n=563) which were printed and displayed on poster paper to facilitate simultaneous visualisation (Gibbs, 2014). Similar codes were subsumed into single codes and arranged according to content until four clear themes were evident. The

researchers met regularly during data analysis to ensure codes and themes were confirmable and representative. Supplementary file 1 (Appendix 17) outlines some examples of initial coding and how they formed the final codes. Following a framework of social constructionism, we acknowledge that codes, themes and subsequent findings arise from our interpretations of the data which are linked to our own sociocultural contexts. This understanding of researchers' backgrounds as intrinsically linked to the findings is based on the premise that objectivity is impossible because researchers explore phenomena using particular perspectives, and it is not possible to 'step outside' of social backgrounds when conducting research (Burr, 2015).

Findings

Demographics

Twenty-one interviews were included in this study. Participants were all female and typically very experienced clinicians (from 10 and 40 years). All worked with children at the time of recruitment. Most participants practiced in metropolitan areas (n=18 metro, n=3 rural/remote), predominantly in the state of South Australia (n=19), but also in Queensland (n=1) and Victoria (n=1). Overall, 10 nurses worked in child and family health (CH), seven in paediatrics (P), two in both paediatrics and child health (P&CH) and the remaining two in community roles (C). In Australia, the role of a child and family health nurse is equivalent to that of a health visitor in the United Kingdom, whereas a paediatric nurse generally practices in acute care settings. Community nurses do not have a consistent nation-wide role, but community nurse participants worked for community-based, non-government organisations.

Key finding 1: Abuse is difficult to 'just define'

In Australia, there is no national definition of abuse and neglect as these are specific to each jurisdiction. Even nurses from the same legislative jurisdictions had different ways of defining abuse which varied from personal views, through to definitions that made links to guidelines and policies. For example, when asked to define abuse and neglect, Participant 1 (C) responded: *'that's quite a difficult question to just define…'* and explained *'[child protection service] do have some guidelines… which I don't just happen to be able to reel off the top of my head'* while also acknowledging: *'it would depend on the situation…'* Other participants (n=2) referred to Children's Rights, with Participant 3 (CH) outlining how children's human rights could be applied to abuse and neglect: *'you have a right to live in an environment that is free from violence and… supports*

your health and wellbeing.' Similarly, some participants referred to research evidence, such as Participant 5 (P&CH) who discussed harms of domestic violence on children: *'they [parents] say they only argue… or fight when the child's not there**. Well, we know from research… that there's still a huge impact on children.'* In this way, nurses drew upon a variety of sources including law, clinical guidelines, Children's Rights and research findings to try to explain abuse, but no participant clearly and succinctly defined abuse and neglect.

In other situations, participant definitions did not have a clear evidence base. For example, when asked to define child abuse, Participant 18 (P) initially explained that physical abuse was the only type of abuse that *'you could put in a neat box*.' On further exploration, Participant 18 (P) elaborated that physical abuse could be contentious: *'it does come down to your beliefs… some people think a smack is abuse and that's okay for them to believe that.'* Similarly, Participant 2 (P) acknowledged the diversity of parenting practices, but explained she had clear boundaries between acceptable and abusive parenting behaviours: *'outright screaming at your child… that's not appropriate in any parenting style'*. The examples illustrate that these nurses had difficultly concisely defining abuse and neglect, and instead attempted to do so using existing ideas, beliefs and preconceptions.

Defining abuse and neglect was reported to be a balancing act because there is no perfect environment for a child. Instead, defining abuse was explained as making a professional judgement around whether parenting was *'good enough'* (P 5, 15 & 20). For example, Participant 19 (CH) recalled a home that was *'pretty messy,'* but explained she did not consider the situation to be neglect because the children were well cared for and *'there's risks in every household.'* Similarly, Participant 22 (CH) explained that nursing assessments need to recognise that it is not possible for parents to respond to *all* of their child's needs: *'it's being responsive to that child and it doesn't have to be 100 per cent of the time because that's actually not realistic.'* In the emergency setting, Participant 21 (P) described how she encountered children following accidental injury and that was difficult to determine to what extent parents were culpable, because: *'any accident with a child is in hindsight preventable…'* but acknowledged that families' decisions may not have the same priorities as health professionals. In this way, determinations of neglect were always *'subjective'* (P 21, P) because they depended upon professionals' interpretations.

Nurses indicated they often encountered ambiguous signs and it was difficult to build upon their suspicions. When this occurred, 14 of the 21 nurses explained they brought their focus back to the child. These nurses explicitly articulated a child-centred approach to defining abuse and neglect, *'It's about having the child at the centre… when we talk about incidents [of abuse], what's that like for the child? How have they experienced that?'* (P 1, C). Similarly, Participant 20 (CH) outlined how she would contextualise different parenting practices by looking at the bigger picture of a child's experience and consider: *'Is that baby being loved and… nurtured?'* However, this practice of defining abuse by whether the child is loved could be used to discount children's experiences of abuse within loving families. Thus, nurses found that even when putting the child first, there was still the need to use professional judgement to contextualise their observations. For example, Participant 5 (CH&P) explained that in some families, a child might be loved but could still be in a situation of abuse: *'I have seen families where the parents do love the child but they are still abusive or neglectful'* (P 5, CH&P).

When contextualising ambiguous signs of abuse, nurses believed it required ongoing observation to piece together the details. Suspicions of abuse were considered to start with an intuition, with Participant 15 (CH) explaining: *'you can't actually put your finger on it, something just doesn't add up.'* Often, this came down to nurses' previous experiences which taught them: *'sometimes everything can look fine… but there's just something that you know isn't quite right'* (P 4, P). For example, in hospital settings, paediatric nurses drew upon their clinical knowledge and experience of 'normal' to detect things out of the ordinary: *'something wasn't quite right with her [the baby]. She was really, really sick for a [baby with] pertussis… she was having brachycardias and apnoeas even without coughs, so we got a bit concerned.'* (P 13, P). This example shows how Participant 13 used her clinical knowledge of pertussis to identify this baby was showing unusual signs, which were later attributed to illicit drug exposure. Even though nurses might have suspicions based on previous experiences, they equally outlined the importance of avoiding: *'jump[ing] to conclusions'* (P 5, CH&P) before conducting a full assessment. For example, nurses believed children's behaviours might be indicators of abuse, but observations on a single occasion may not reflect usual behaviour: *'a one-off day… that baby doesn't want to be held by its mother at all, is not necessarily saying something's terribly wrong, they [baby] might be sick…'* (P 11, CH).

In summary, the first key finding showed that in the absence of a single set of unifying guidelines, nurses drew upon a variety of sources to construct working definitions of child abuse and neglect. Because nurses constructed their definitions from multiple places, interpretations of child abuse and neglect differed according to individual nurses and their social contexts.

Key finding 2: Navigating personal and professional views of parenting

In addition to drawing upon local policies, legislation and research, nurses' constructions of abuse were influenced by their own experiences, values and beliefs as they compared and contrasted situations with past experiences. Just over half of participants were cognisant of how their personal characteristics influenced their practice and openly reflected on this during the interviews. For example, Participant 4 (P) was aware her views on children's body piercings were not mainstream: '*piercing a child's ears… I hate to see that because… that child's not made that decision. You've inflicted that pain on them and it's cosmetic and it's for your benefit, not the child's.*' Although Participant 4 (P) personally disagreed with children's body piercings, other nurses' personal experiences meant they had different things they were uncomfortable with, such as the presence of pets around young children (P 19 & 22), standards of household hygiene (P 20) and physical discipline (P 2 & 11). For example, Participant 19 (CH) was '*a bit cautious of dogs'* and thus saw it essential to keep children separate from one family's outdoor dog.

In attempting to manage their personal views, nurses outlined the importance of putting their values: '*to one side*' (P 22, CH) when working with families, recognising there are many different ways to parent. Participant 18 (P) expressed the tension inherent in attempting to compartmentalise one's values and beliefs: '*we're taught not to put our values… on people… but we have to use our own values in order to decipher what's happening*.' Although nurses had their own standards of ideal parenting, they saw how inequity might prevent all parents from achieving this perceived optimal standard. Participant 17 (CH&P) explained: '*it's about thinking… this is what I have to support me in my parenting quest but what does this family have to support them?'* In this way, Participant 17 recognised that expecting the same standard of parenting from all families with vastly different access to support and resources was unrealistic. Nurses conceded that although a child's situation may not be optimal, it might not be reasonable to expect more given parents' personal, social and environmental circumstances. Although all nurses wanted to improve children's situations, they frequently felt limited in what they could do due to lack of resources

and/or perceived inaction from child protection services. Instead, nurses recognised that their standards around what is best for children would shift due to continued exposure: '*it's almost like your tolerance for what you felt was okay actually had to go up…*' (P 22, CH). Through this desensitisation process, nurses reconstructed their definitions of abuse and needs of children were perceived less acutely over time.

In many instances, participants expressed awareness that their personal views influenced practice, but then did not appear aware of how these views intersected with their assessments of abuse. This was illustrated in two nurses' explanations of what constitutes neglect, in which their views reflected values and beliefs about children's needs that were specific to their time and cultural context. For example, Participant 22 (CH) discussed the importance of childhood immunisation in the context of a family's transient accommodation and inadequate health records: '*we don't know whether the baby is even immunised, so this basic… needs of a baby.*' This quote demonstrates Participant 22's professional view of immunisations as essential for maintaining a child's health. Similarly, Participant 14 (CH) had expectations about appropriate supervision for children as she described her experiences in a remote Aboriginal community: '*you'll see a two-year-old running around and think 'who's actually minding her' and then [community members] say 'well, no, no we are' or 'no, no nana's over there or someone's over there' so kind of broadly being watched but not enough.*' These examples show that an awareness of personal values and beliefs may not translate to understanding how values and beliefs shape practice.

Key finding 3: Negotiating a range of cultural values and practices
Recognising abuse and neglect was particularly challenging when nurses worked with families who were culturally different from themselves. Families who were culturally different often had parenting practices which did not necessarily conform to nurses' own beliefs about parenting. For example, some families had different views and practices relating to physical discipline and infant bed-sharing.

The challenge of defining child abuse within varying cultural contexts was apparent in nurses' attempts to explain what might be considered 'culturally acceptable' parenting practices in Australia. For example some nurses (n=5) discussed actions they deemed culturally acceptable by contrasting them with 'Australian' cultural values. When discussing their experiences working with

families from different cultural backgrounds, P3 (CH) said: '*It doesn't matter whether it's culturally acceptable to smack a child in another country, it's not culturally acceptable to do it here*.' There was significant variation in participants' views on the appropriateness of physical discipline, ranging from those who were completely against physical discipline (P 2, 3, 11), to those who felt that mild physical discipline might be warranted in certain situations (P 9, 18). Only one participant (P 22, CH) explicitly referred to research evidence when discussing their view on the acceptability of physical discipline. Subsequently, basing assessments of abuse and neglect on what each nurse deems 'culturally acceptable' is likely to be highly variable, and may not be based on research evidence around the impacts of physical discipline.

Co-sleeping was another contentious area for participants because of nurses' awareness of the role of co-sleeping in Sudden Infant Death Syndrome. Participants used the term 'co-sleeping' as synonymous with 'bed-sharing' in line with the language of local guidelines (for example South Australia Health, 2016). Several nurses (n=6) discussed their concerns around co-sleeping, often explicitly referring to their local infant safe sleep guidelines. As with physical discipline, nurses had different views on co-sleeping, and whether it was an acceptable cultural practice. For example, Participant 8 (C) disputed co-sleeping as a cultural practice: [people say] *''oh it's cultural to co-sleep' but it's not.'* Conversely, Participant 14 (CH) worked closely with Aboriginal families and empathised with their reasons for co-sleeping: '*I think they [mothers] do that [co-sleep] because they know where the kids are at night, they keep them safe.*' However, regardless of nurses' personal views around co-sleeping, Participant 1 (C) recognised that the guidelines are not law, so parents are free to disregard them: '*they're really a guideline… it's not the law that you can't co-sleep*' (P 1, C). When parents did choose to co-sleep, it came down to professional judgement around whether the nurse should notify child protection services: 'if *I've given [a] parent that advice and they still chose to co-sleep then that mixed with some other risks… may be enough to make a notification but… that's a really blurry line coz lots of parents co-sleep and they're never notified about.*' (P 1, C). In this way, cultural practices that are not consistent with local guidelines can lead to nurses' constructing certain cultural practices as child abuse and led to ambiguity around appropriate actions.

Discussion

This paper reports on how nurses navigate definitions of child abuse and neglect which are constantly being constructed and reconstructed both culturally and temporally. This is core to nurses' experiences of addressing abuse and neglect. In the absence of guidelines that could apply to all possible scenarios and sociocultural contexts, nurses drew upon multiple factors including official guidelines, legislation, research evidence through to personal and professional experiences of parenting to help them understand child abuse and neglect. Although it is rare that child abuse fits simple or straightforward definitions (Einboden, 2017), the difficulty in naming abuse presents a dilemma for nurses given that in some countries (i.e. USA, Australia) nurses are legally required to report abuse and neglect, while in other jurisdictions they have an ethical duty to prevent harm to children (International Council of Nurses, 2012). If nurses use their own values and beliefs to define child abuse and neglect, there is likely to be significant variation amongst professionals who all have different specialised knowledge along with their own values and beliefs. To some extent, this may be inevitable in a field as complex as child protection, however, it is essential to consider to what effect nurses' experiences, and sociocultural positioning could have on children who are experiencing abuse and neglect.

Values and beliefs influence the way people see the world; they originate from and are continuously shaped by an individual's sociocultural context (Gergen, 2015). Values refer to what people find personally meaningful, and inform how the world 'should' be, while beliefs refer to what individuals perceive to be true (Foresman, Fosl, & Watson, 2016). As such, beliefs nurses hold to be true about child abuse many not be universally applicable. Burr (2015) further argues that there can be no value-free or impartial knowledge because all knowledge is derived from looking at the world from a particular perspective, or by asking certain questions. In this way, it is unavoidable that nurses' values and beliefs will influence the ways they understand and interpret situations of potential child abuse and neglect. As a result, it's important that nurses actively manage their values and assumptions so they can mitigate any potential impacts on children.

Actively managing values and beliefs is important because research into other areas of healthcare shows that health professionals' personal views can influence the type and quality of care they provide to clients. For example, a systematic review by Hendry et al (2017) found that mental health nurses' conservative attitudes about clients' sexual health meant nurses avoided

136

conversations about sexuality. Similarly, another systematic review identified that primary care clinicians' personal beliefs about osteoarthritis meant they were less likely to recommended evidence-based treatments (Egerton, Diamond, Buchbinder, Bennell, & Slade, 2017).

In this study, participants' personal parenting beliefs appeared to shape their interpretation of potential child abuse and neglect. According to Gergen (2015), our beliefs, such as those about parenting, are developed through interactions with others and are not necessarily shared across other social contexts. For example, Participant 22's (CH) views of immunisation as a basic necessity, and Participant 14's (CH) beliefs around what constitutes adequate supervision reflect their socially constructed perceptions about inherent 'needs' of children. However, 'needs' of a child are subjective, and assume a uniform and uncontroversial view about what is good for children (Woodhead, 2015). Such statements about children's 'needs' typically leave the goal unsaid and un-critiqued (Woodhead, 2015). It might therefore be more accurate to say that children *need to be immunised* to prevent infectious disease and promote herd immunity. Immunisation has only been constructed as a 'need' of children in relatively recent times, thus demonstrating that perceived needs of children are closely linked to the values and beliefs of a particular culture and time. Similarly, discussions about children's 'need' for adult supervision, make value judgements about adults' parenting roles and children's vulnerability by assuming children cannot survive without constant adult attention (Furedi, 2002). Although many children do die from injuries linked to 'lack of supervision' (Damashek, Drass, & Bonner, 2013), the precise level of required supervision remains unclear and debated. This means nurses need to be critical of their own values and beliefs which are linked to their culture rather than necessarily based on children's needs.

Nurses' definitions of child abuse and neglect are not neutral, but stem from their values and beliefs of which they may not be aware. If nurses are unaware of the intersection between their values and beliefs and how they define child abuse and neglect, they could risk expecting unfairly high or rigid standards of parenting, or alternatively may accept practices known to be harmful to children. There is also a risk that populations who do not fit mainstream childrearing practices could be unfairly targeted for different rather than harmful parenting practices. Given the possible impacts of nurses' personal values and beliefs on the way they interpret potential child abuse and neglect, it is imperative that nurses working with children critically examine their own cultural,

personal or professional values to determine how their views influence their practice and to what extent their practice is consistent with research evidence. Existing literature supports the use of critically reflecting on practice to 'bring assumptions to the surface' and prevent professionals practicing on 'autopilot' (Bassot, 2016). The risk of practicing on 'autopilot' can include stagnation of practice, loss of creativity and working in discriminatory or oppressive ways (Bassot, 2016). In contrast, reflective practice can help practitioners become agents of social change, through individual practice development through to identifying oppressive organisational structures and practices (Garneau, 2016; Smith, 2016; Wood, 2017).

Reflective practice is the ability to enhance one's own practice through analysis of past events (Bassot, 2016) and is underpinned by self-awareness of how one's values, beliefs and feelings influence behaviour (Atkins & Schutz, 2013). Nurses in this study had varying levels of reflective practice and self-awareness, as indicated by some nurses appearing unaware of their own values and beliefs, to others who were active in reflection and critique. Given that defining abuse and neglect can be difficult and subjective, it's imperative that nurses critically reflect upon the factors that influence their decision-making. If nurses are unaware of influences on their decisions, there is a risk that decisions around abuse and neglect will not be targeted towards where they are most needed – which is children at greatest risk of harm. Nurses hold a position of authority in their roles of assessing child abuse and can be gatekeepers of information meaning what they say, or fail to say, can influence child protection services' decisions around children and families (Einboden, 2017; Peckover & Aston, 2018). Thus, it is essential that nurses critically reflect on what influences their decisions so they can explore and articulate the extent to which assessments are based on personal values and beliefs, professional experiences and/or evidence informed practice. This will promote nurses' capacity to manage their values and assumptions and any subsequent impact upon children and families.

Study limitations

This study was limited to a small sample (n=21) of nurses from Australia, primarily in the state of South Australia. Thus, views may not reflect perspectives of nurses in other geographical areas. Similarly, participants all had at least 10 years of experience in nursing, and so their perspectives are unlikely to represent those of individuals new to the nursing profession.

Conclusion

Nurses have many opportunities to make a difference for children experiencing abuse and neglect. This study has shown the ways nurses understand child abuse are shaped by their values and beliefs which originate from their sociocultural contexts. It is possible that certain values and beliefs could adversely affect the ways that nurses respond to situations of potential abuse, such as influencing if or how nurses respond to situations that may be harmful to children. As such, nurses need to take a critical reflective approach towards their understandings of child abuse to explore how personal views may influence their practices around promoting children's safety. There needs to be organisational and structural support to facilitate professional opportunities and capacity for nurses to incorporate critical reflection into their daily practices with children and families. If nurses are supported to explicitly reflect on how their personal values and beliefs shape their practice, they can consider the potential impacts on how they implement evidence-informed approaches and maintain a clear focus on children's wellbeing.

CHAPTER 6: FINDINGS - THEME 2

Theme 2: 'How can we work together?': keeping children safe through therapeutic relationships

Lines, L. E., Grant, J.M. & Hutton, A. E. (accepted manuscript), *'How can we work together?' Nurses using relational skills to address child maltreatment in Australia: a qualitative study, Journal of Pediatric Nursing*.

Introduction

Child protection has traditionally been a social work role (Scott & Swain, 2002), meaning strategies that nurses use to keep children safe from maltreatment have not been fully investigated. Nurses working with children frequently encounter child maltreatment, and in the Australian context, nurses' roles include but are not limited to mandatory reporting of child maltreatment (Australian Institute of Family Studies, 2018; Lines et al., 2017). Some child protection systems such as those in Australia, the United States and United Kingdom were founded on an approach of receiving reports and conducting investigations into cases of alleged maltreatment (Fuller, 2014; Nyland, 2016). However, this system was designed to respond to only the most severe cases, and children who do not meet the threshold for statutory intervention may not receive assistance from child protection services (Runyan, 2015). Unfortunately, the approach of responding to individual cases fails to consider the underlying complexity of factors that make child maltreatment more likely such as poverty, deprivation and social isolation. Instead, there needs to be a broader focus on 'keeping children safe' whereby everyone including governments, communities and individuals contribute to supporting all children to grow and develop to their full potential (Australian Government Department of Health, 2019). This approach to keeping children safe involves professionals working together to implement a child-centred approach, in which children's needs and voices are prioritised throughout decision-making and subsequent interventions (Her Majesty's Government, 2018).

Nurses contribute to this broader whole-of-community approach to keep children safe. For example, keeping children safe, or safeguarding, is a recognised part of health visitors' roles in the United Kingdom (Fraser et al., 2014; Peckover & Appleton, 2019) and it is increasingly becoming part of child and family health nursing in Australia (Fraser, Hutchinson, & Appleton, 2016).

Similarly, a recent literature review across multiple practice settings demonstrated that nurses' roles included identification, early intervention and addressing the effects of maltreatment (Lines et al., 2018). Although nurses have many roles in helping to keep children safe, nurses across multiple settings frequently experience anxiety and uncertainty when faced with the complexities of child maltreatment (Barrett et al., 2017; Dahlbo et al., 2017; Kraft et al., 2017; Lines et al., 2017). Unfortunately, it is difficult to know how to best equip and support nurses to keep children safe because the precise nature and scope of nurses work in this area is poorly researched and largely invisible (Peckover & Appleton, 2019).

The aim of this paper is to report on one of four themes identified from an inductive analysis of a broader qualitative study that explored nurses' perceptions and experiences of helping to keep children safe from maltreatment. This study aimed to provide an insight into how nurses understand child maltreatment, and to provide some beginning evidence around ways we can support and equip the nursing workforce to contribute to keeping children safe. The four themes (numbered for clarity) identified from the inductive analysis, were 1) contextualising and defining child maltreatment (Lines, Hutton, & Grant, 2019), 2) nurse relational skills in addressing child maltreatment; 3) nurse experiences of communicating concerns of child maltreatment; and 4) nurse perceptions of how systems and hierarchies shape their response to child maltreatment (Lines, Grant, & Hutton, 2020b). This paper reports only on the second theme relating to nurses' perceptions of the relational skills they used to address child maltreatment. In particular, this theme outlines how nurses experienced a tension between maintaining access to children through therapeutic relationships with parents, whilst still maintaining a child-centred focus in addressing situations potentially harmful to children's wellbeing.

Methods

Framework

This qualitative research was underpinned by a social constructionist approach. A social constructionist approach recognises knowledge and social practices as located within specific sociocultural conditions which are typically maintained over time (Burr, 2015). In child protection, social practices are especially apparent because parenting and childrearing practices vary across social and historical contexts. For example, childrearing practices 'change with fashion' (Furedi, 2002) because they are embedded within prevailing attitudes of 'normal' parenting (Scott &

Swain, 2002). In the context of this research, a social constructionist approach recognises the ways that nurses keep children safe are culturally situated and embedded within daily practices.

Design

Data collection was through semi-structured, in-depth interviews with registered nurses working with children in Australia (n=21). Purposive sampling was used to recruit participants by advertising the study through organisations relevant to nursing (such as the nursing union and professional groups) through flyers and invited presentations. Interested individuals then contacted the researcher by email and were subsequently provided with full details of the study so they could make an informed decision. Ethical approval (no. 7296) was granted by Flinders University Social and Behavioural Research Ethics Committee.

Data collection

The first author (female) collected the data, and is a clinician (registered nurse with experience in paediatric nursing) and PhD candidate with previous qualitative research experience. Interviews (60-90 minutes long) were conducted face-to-face (n=15), via telephone (n=5) or through Skype (n=2) based on participant location and preferences. Interviews occurred from August 2016 until August 2017. At the commencement of each interview, the first author summarised the study's purpose, obtained written consent and addressed participant questions. Interviews were guided by an interview guide; example questions can be found in Table 8. This interview guide was developed from a recent literature review (Lines et al., 2017) but not pilot tested because it was meant to be a broad guide only. Data saturation began to occur at interview 17. An additional five booked interviews were conducted providing more nuanced information about nurses' experiences in different contexts.

Table 8: Example interview questions

• Think about one or more times that you've cared for children when there were concerns about abuse and neglect. Please tell me about these experiences in any way you'd like.
o What actions did you take? Is there anything you'd do differently upon reflection?
• How do you see your role in keeping children safe from abuse and neglect?
• How do you personally define child abuse and neglect?

Interviews were audio recorded and transcribed by the primary researcher (n=13) or professional transcriber (n=9). Participants were able to review and amend their transcripts; most participants (n=17) did not make changes, some (n=4) made minor changes while one opted to withdraw their transcript. This participant withdrew because they had not sought formal permission from their employer, leaving a total of 21 transcripts included in this study. All transcripts were de-identified by removing names, organisations and places, and the professional transcriber signed a confidentiality agreement. Following transcription, the first author checked each transcript for accuracy against the audio recordings.

Data analysis

Interview transcripts were read and re-read by the first author and then coded inductively through a thematic analysis. Transcripts were imported into NVivo where the author commenced descriptive coding, but later changed to process and holistic codes to better represent the data's complexity and nuances (Saldana, 2016). An example of initial coding can be found in the Supplementary File. The coding process produced many codes (n=563) which were printed and displayed on poster paper to enhance visualization of the dataset (Gibbs, 2014). While displayed on paper, similar codes were reduced into single representative codes and further arranged and re-arranged into areas of similarity until four clear themes were evident. The same process was followed to generate the subthemes, whereby the content of each theme was arranged and re-arranged into areas of related meaning to develop the subthemes. The three authors met frequently during the analysis phase to discuss emerging codes and themes in detail to ensure codes and developing themes were confirmable and representative of the data. Once the thematic analysis was complete, the themes underwent a secondary analysis guided by a social constructionist framework. The thematic analysis is presented within the Findings section of this manuscript, and the findings from the secondary analysis are presented in the Discussion.

Findings

Twenty-one nurses who work with children agreed to have their transcripts included in this study. Participants (all female) had from 10 to 40 years of experience in nursing and worked with children at the time of the research. Participants typically practiced in metropolitan locations (n=18 metro, n=3 rural/remote) in three Australian states (n=19 South Australia, n=1 Queensland, n=1 Victoria). Participants' main roles were in child and family health (CH, n=10), paediatrics (P,

n=7), combined child and family health and paediatrics (CH & P, n=2) and other community settings (C, n=2). In the Australian context, child and family health nurses work in clinics and family homes in a similar role to health visitors in the United Kingdom. Paediatric nurses typically work in acute care, and all paediatric nurse participants worked in specialist paediatric wards or units. Nurses working in Australian community settings other than child and family health do not have a nationally consistent role, but community nurses in this study worked for welfare-focused organisations. Please refer to Table 9 for more information on the respective roles of these nurses in Australia.

Table 9: Comparison of paediatric, community and child health nurses in Australia

Nurse	Main qualification	Further education or qualification?	Context of practice
Paediatric nurse	Registered (AQF[16] Level 7) or enrolled nurse (AQF Level 5).	No specific education or further qualifications required.	Acute care; typically in hospitals.
Community nurse	Registered (AQF Level 7) or enrolled nurse (AQF Level 5).	No specific education or further qualifications required.	Variable; examples include welfare or health focussed government or not-for-profit community-based organisations.
Child health nurse	Registered nurse (AQF Level 7).	Requires specialist tertiary education in child and family health (AQF Level 8).	Family homes and community clinics.

This manuscript reports on just one theme from the qualitative study. Please see Figure 6 for a visual overview of the relationships between the themes identified in the broader study, and the theme and associated subthemes addressed within this manuscript. The key theme addressed by this manuscript outlines how relational practice was central to how nurses engaged and maintained positive relationships with families to address concerns about child maltreatment. The subthemes presented are 1) 'Walking the line': relationships in the context of surveillance, 2) 'You are a good mum': focusing on the positives and 3) Seeing and being the voice of the child.

---

[16] The Australian Qualifications Framework (AQF) is the national policy in Australia that regulates the education and training sector to provide quality assurance and enable alignment with international qualification frameworks (AQF Council 2013). Level 5 is a diploma (required for an enrolled nurse), Level 7 is a bachelor degree (registered nurse) and Level 8 is a graduate certificate or graduate diploma (specialist child health nurse) (Australian Qualifications Framework Council, 2013).

Throughout the findings, we refer to Appendix 19 which summarises, describes and defines key relational skills reported by nurses in this study.
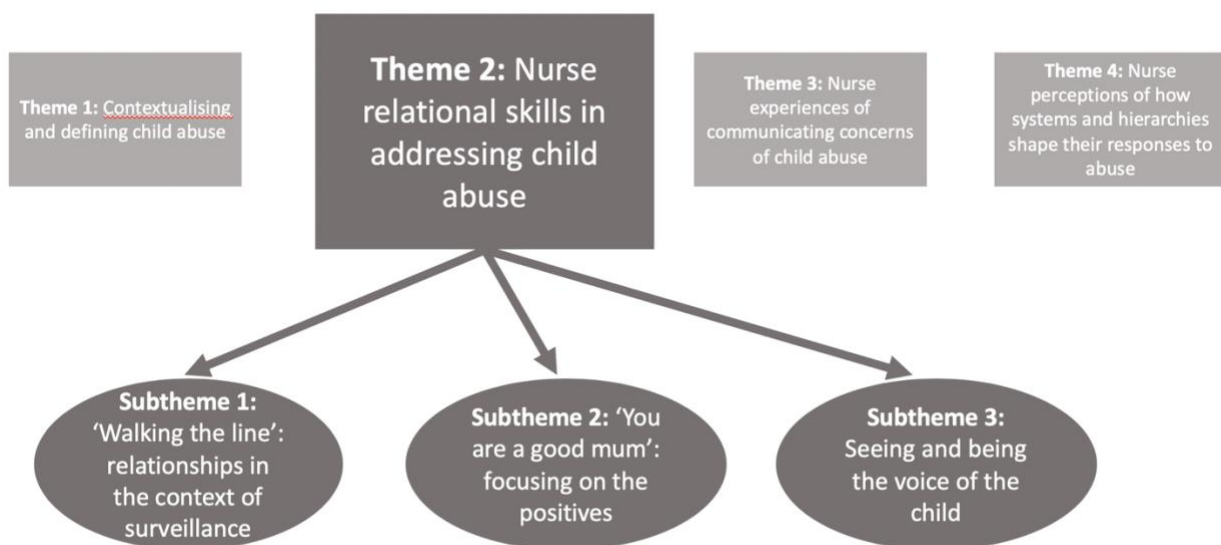
Figure 6: Summary of themes and subthemes

Subtheme 1: 'Walking the line': relationships in the context of surveillance

Nurses felt that a positive community perception of their role increased families' initial trust so that they could get a 'foot in the door' (P 14 & 22) even when other services could not. Participant 10 (CH) explained: '[the] community sense [is] social workers come when you've got problems whereas nurses… we're just there for the baby.' Despite overall positive perceptions of nurses, there were still situations where nurses felt families were wary: 'They'll go… 'Are you going to take my child away? Is that why you're here?'' (P 17, CH & P). Child and family health nurses attempted to allay families' fears by reinforcing their role in supporting families to stay together. Conversely, some paediatric nurses were not convinced that keeping families together should be the goal of child protection services. Participant 21 (P) warned 'a lot of very serious injuries and deaths… are caused by not removing children early enough from a very dangerous environment.'

Nurses' close contact with families meant they could observe for signs of maltreatment. When families noticed nurses' surveillance, child health nurses in particular drew families' attention towards the more positive, friendlier aspects of their nursing role. For example, Participant 12 (CH) explained when she noticed something potentially concerning, she started by asking ''tell me your

story' [that] doesn't come across so threatening.' Other nurses emphasised the importance of keeping the family together, as opposed to the perceived role of child protection in child removal: 'how can we work together so that your child does stay with you?' (P 15, CH). In this way, nurses actively constructed their role as friendly and approachable (see Appendix 19, point 1) rather than rather than the eyes and ears of child protection services.

Although being friendly and approachable was important, nurses had to balance being friendly against prioritising children's health and safety. Family disengagement was 'always a significant worry when raising child protection concerns' (P 6, P) but sometimes necessary to ensure children's safety. At the beginning of the therapeutic relationship, nurses often delayed bringing up mildly concerning issues (P 5, 9 & 11). 'You've got ten concerns, if you list off those concerns to the parent… you're probably not going to be developing that rapport' (P 5, CH & P). Nurses believed if they established an ongoing relationship with the family, child safety concerns could be addressed over time. Alternatively, if nurses confronted the family on the first interaction, they knew families might completely disengage so nobody could continue working with the child. However, nurses reported attending to urgent safety concerns straightaway regardless of the potential impact on the relationship (see Appendix 19, point 5). For example, Participant 12 (CH) observed a firearm in a home, and immediately discussed this with the family and reported to child protection services.

In community or child health settings, nurses tried to engage or re-engage families who were reluctant to be involved in ongoing care (see Appendix 19, point 2). Participant 1 (C) explained that one method involved making repeated contact and waiting until the family was ready: 'we just kept… sending messages… or popping round and leaving a note and really letting her [mother] know that we were still here' (P 1, C). However, this had limitations as nurses did not want families to feel harassed: 'you've gotta walk the line between … trying to get them to engage and ... stalking them.' (P 11, CH). In some situations, nurses were able to leverage support of cultural consultants to build trust in culturally diverse populations, for example: 'to have the Aboriginal cultural consultant there, it really breaks down those barriers' (P 22, CH). This shows that nurses balanced engagement with families against the risk that persistence could drive the family away.

Maintaining family engagement was seen as crucial because otherwise, children's safety would be unknown. Sometimes nurses referred families to other services, but if families did not accept referrals, nurses were left as the only point of contact. When nurses' suspicions were aroused, many participants (n=14) felt it was important to maintain contact with the family either directly or through families' use of other services. In the community setting, nurses felt it was their job to monitor situations and gather enough information to determine whether they might escalate their concerns. For example, in South Australia legislation requires individuals report if they 'suspect on reasonable grounds' that a child is at risk (Government of South Australia: Attorney-General's Department, 2017) – but it sometimes took time to gather information to establish 'reasonable grounds.' Participant 3 (CH) explained 'it's really your job as a monitoring service… to continue to monitor but gather information that… supports your concerns.' This could involve covert surveillance strategies such as making excuses to keep in contact: 'try and make reasons again for you to keep an eye on that child' (P 17, CH&P). Similarly, in paediatric hospital settings, nurses used other covert surveillance strategies to monitor children's wellbeing: 'I tend to listen through the curtains' (P 2, P) or 'I… make myself look busy in the room' (P 17, CH & P).

Sometimes nurses' surveillance practices were more open and met with hostility. This tended to occur in paediatric hospital settings where parents were in foreign environments and less able to control nurse involvement. For example, Participant 13 (P) recalled caring for a baby whose mother was suspected of neglectful feeding practices. Subsequently, nurses watched closely to assess the mother's feeding practices: 'we were physically having to watch her with every feed' (P 13, P). Participant 13 had difficulty building rapport with this mother who was resistant to nurse involvement: 'she was really frustrating. She didn't like me and that really bothered me'. Thus, nurses were not always successful in walking the line between constructing and maintaining a therapeutic relationship with families whilst involved in surveillance for child maltreatment.

Subtheme 2: 'You are a good mum': focusing on the positives

This theme outlines how nurses focused on the positive aspects of situations to maintain therapeutic relationships with parents whilst still addressing child protection concerns. One strategy nurses used to shift away from a negative outlook was showing empathy towards parents' backgrounds and/or current situations. On the surface, this strategy could seem 'parent' rather than child-centred, but nurses deliberately used this strategy to enact change for children

(see Appendix 19, point 3). For example, many nurses, especially those in child health settings, recognised that the ability to tactfully discuss concerns with parents was key to establishing ongoing engagement (see Appendix 19, point 2). Participant 3 (CH) provided an illustration of different strategies and their perceived effects: '[if you say] I think your child's unsafe so I'm going to notify,' the parent's going to go 'oh yeah, get stuffed', but if you're saying 'you're being the best parents that you can be but there's just a few issues here and here. We really want to work with you to support you.'' Similarly, Participant 10 (CH) outlined what she might say to a mother when she had concerns about a child's safety: 'You can say 'I know you want the best for your child but what I'm seeing is that there's lots of things going on for you and it's making it hard for you.' In doing so, Participant 10 recognised challenges the parent might be facing, whilst simultaneously acknowledging the situation was not acceptable for the child.

For nurses, it was important to promote respectful relationships with families to reinforce their role as supporting the family. Participant 9 (CH) explained her role as focusing on the positives: 'I see the job I do as more of a life coach saying 'you are a good mum. You're doing good… Look at what the baby's doing. Look how it [baby] looks at you.' Nurses recognised families could have low confidence and needed encouragement rather than criticism to make changes. For example: 'some of these women are down at the bottom… they get depressed and have had everyone put them down and… sometimes a little bit of hope, they hang onto that' (P 15, CH). Conversely, paediatric nurses saw more extreme cases, including children hospitalised due to severe maltreatment. In these situations, paediatric nurses had difficulty empathising with the parent: 'I am angry at them [abusive parents]… they still get the same amount of care… [but] I don't engage with them as much.' (P 18, P). This shows nurses used various strategies such as focussing on the positives, being non-judgemental and avoiding overt criticism, but this could be challenging when nurses experienced negative feelings towards their clients.

Subtheme 3: Seeing and being the voice of the child
Although nurses wanted to maintain positive relationships with families, they recognised children's safety was a separate priority through a child-centred approach (see Appendix 19, point 9). This was highlighted by Participant 4 (CH) and 20 (CH), respectively: 'the ultimate goal is to keep the child safe, and I always think to myself… are they [children]… absolutely safe right now?' However, the extent to which nurses were child-centred was not the same, nor static for any

individual nurse. Even nurses who articulated child-centred views were aware they could easily lose that focus without ongoing application of reflective practice to ensure children's needs were prioritised (see Appendix 19, point 7). These nurses were appreciative of colleagues who brought them back to see the child's perspective. For example, Participant 10 (CH) explained that case reviews were an opportunity to reflect and remind colleagues to focus on the child: 'our case conference discussion is so important, to kind of go 'hang on where's the baby at? Is the baby still thriving? Have we checked baby's development?' So sometimes… we haven't talked at all about the baby' (P 10, CH). Although most participants (n=20) explicitly stated the child was their priority, this was not always internalised and consistently applied. In one instance, Participant 18 (P) was more concerned about parental intent than impact on the child: 'people will see this behaviour and they may take it that you [parent] are intentionally hurting your child.'

Some nurses, especially child health nurses, described specific strategies to promote a child-centred approach (Appendix 19, point 9). For example, Participant 11 (CH) used perspective taking to look at situations from the child's eyes: 'I literally try and look through the eyes of that child, like as an infant in a bassinette I think of lying there and looking up, what are the faces, what do I see, what do I hear? (P 11, CH). Nurses then communicated what the child might be experiencing in a tactful and understandable way (see Appendix 19, point 4). For example, some participants interpreted what children communicated through behaviour and play and fed this back to parents. This was clear in Participant 12's approach to educating a new mother about her baby's attachment behaviours: 'I might say to the mum 'look at how he's looking at you. He's really trying to make eye contact with you and get to know you'' (P 12, CH). Although nurses preferred to use indirect techniques such as speaking for the child to communicate children's perceived needs, some situations were obviously dangerous, and nurses addressed these immediately (see Appendix 19, point 5). For example, Participant 22 (CH) explained: 'If it's really clearly going to be harmful, then I need to say it outright.' In this example, like the earlier situation of a firearm in a home, nurses reported addressing immediate risks promptly and directly.

In contrast to child health nurses, some paediatric nurses felt uncomfortable addressing their concerns with parents, for example Participant 2 (P) explained: 'I… feel uncomfortable telling people how to parent. I don't think it's my place'. Similarly, Participant 4 (P) discussed how she felt the philosophy of family-centred care could prevent paediatric nurses from intervening: 'it's so

ingrained that the parent knows their child better than anybody else, so it's sometimes hard... for a nurse to say 'well, actually, maybe you should try doing it this way.'' Some paediatric nurses feared parents could react negatively to their involvement: 'You will have tears, or you will be told where to go in a not-so-nice way' (P 18, P). This suggests some paediatric nurses may not be equipped or prepared to discuss concerns about parental behaviours with families, and it may not be within their scope of practice. For example, Participant 13 (P) outlined how nurses might promote the wellbeing of a baby whose mother was using illicit substances: 'nurses would probably… reiterate about safe feeding and… hygiene for children, all those sorts of things, but I think most of the other parts are out of our scope [of practice].'

Despite the inherent difficulties of promoting change for children at risk of harm; nurses acknowledged this as an essential part of their role, which requires a responsive attitude towards professional development needs and opportunities (see Appendix 19, point 6). For example, Participant 7 (P) highlighted that there is not necessarily a single approach to discussing maltreatment with parents: 'it is uncomfortable sometimes to talk about some of this stuff, it's not easy and there isn't a perfect way.' This was particularly evident when nurses were addressing suspicious injuries: 'it's not an easy space to work in at times, particularly if… you can see harm on the child and you want to… explore that' (P 12, CH). Instead, exploring concerns with parents was considered a progressively developed skill: 'the more we do it, the better we become at it' (P 7, P). Nurses gained confidence to discuss their concerns over time, as outlined by Participant 8 (C) who routinely checked whether infants had a safe sleeping environments: 'towards the end [of the program] we were able to feel confident to do things like go into bedrooms and check out [the safety of] cots. In the beginning I would never have done that.' These insights from participants demonstrate that although addressing situations of possible maltreatment may initially feel uncomfortable, nurses can develop these skills with appropriate support.

Overall, nurses agreed listening to children was important (see Appendix 19, point 8) but reported challenges in doing so. For example, children's communication was not necessarily verbal, but included behaviour and play, meaning 'you can listen, but then how do you know what it is that you're hearing?' (P 1, C). Sometimes it was necessary to explore children's views because developmental stages meant children interpreted events differently to adults. For example Participant 21 (P) encountered a school-aged child who misunderstood what would happen after

fracturing his arm: 'he's hysterical... everything's disposable in society and so when it's broken you put it in the rubbish bin, and he thought we were going to put his arm in the rubbish bin.' Participant 21 recognised that school-age children are usually concrete thinkers and have achieved logical reasoning but not abstract thought (Peterson, 2014). This example highlights the importance of understanding children's voices within a developmental context. Nurses also explained it was not up to them to determine the validity of children's stories: 'if the child is coming to you with these kind of stories... you do take it at face value and report what you managed to find out.' (P 11, CH).

Discussion

The findings demonstrated that nurses applied relational practices to identify and address child maltreatment through therapeutic relationships with parents. In doing so, nurses attempted to balance positive relationships with parents with the need to identify, prevent and/or mitigate harm to vulnerable children. This discussion draws upon social constructionist theory to present a secondary analysis of thematic findings.

Participants articulated the importance of taking a child-centred approach to ensure children's needs were at the forefront of decision-making. A child-centred approach recognises the power asymmetry between children and adults, and constructs children as individuals with their own rights (Coyne, Hallstrom, & Soderback, 2016 2016; Munro, 2011). A child-centred approach is especially valuable in child protection where children's needs can be overlooked in the context of adult problems. Although participants understood the importance of placing children's needs first, it was evident that child-centred practices existed on a spectrum. For example, even nurses who showed highly child-centred attitudes reflected on times they had not demonstrated a child-centred approach. Nurses' reflections on their limitations in enacting child-centredness highlights the importance of ongoing critical reflection to determine to what extent children are placed first and foremost at any given time. A child-centred approach is imperative in keeping children safe. For example, inquiries into the deaths of Chloe Valentine (Australia) and Daniel Pelka (United Kingdom) demonstrated that children's needs became overshadowed by adults' problems and priorities with dire consequences (Fraser, 2013; Johns, 2015). The tendency of professionals to overlook children's needs and accept parental explanations despite mounting evidence to the contrary is prevalent and has become known as the 'rule of optimism' (Kettle & Jackson, 2017).

Although most (n=20) participants articulated the importance of putting children's needs first, actually doing so could be difficult due to the complexities of navigating actual or potential parental reactions. Nurses practice within specific sociocultural contexts that affect their actual and perceived roles in addressing child maltreatment, which in turn influence how parents might respond. Although individuals actively construct their social positions and identities, they are to some extent products of the societies in which they live (Burr, 2015). For nurses, this means that they are constantly negotiating and renegotiating relationships with families in the context of socially constructed community perceptions and organisational norms which govern their roles.

One example of how organisational norms guided nurses' practices was demonstrated by paediatric nurses who recalled feeling uncomfortable about influencing parenting (P 2, 4 & 6). One participant (P 4) attributed this to the philosophy of family centred care which she believed inhibited nurses' ability to challenge parental behaviours. Similarly, Participant 13 believed that addressing parental behaviours such as substance use was outside of her scope of practice as a paediatric nurse. Family-centred care can be defined as 'a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child/person, and in which all the family members are recognised as care recipients' (Shields, Pratt, & Hunter, 2006). However, family-centred care can assume that parental preferences and needs are compatible with those of their children (Shields, 2017; Smith, Shields, Neill, & Darbyshire, 2017; Uniacke, Browne, & Shields, 2018). Instead, in situations of child maltreatment, parental preferences and choices may adversely impact upon their children. The philosophy of family-centred care and the way it is enacted might not facilitate paediatric nurses' capacity to holistically respond to potential child maltreatment.

Other key societal factors that affect nursing roles and practices are the settings and models of care under which nurses work. For example, in Australia, child health nurses use a primary health care approach (Grant, Mitchell, & Cuthbertson, 2017) while paediatric nurses typically work in acute care settings which emphasise a biomedical approach (Fraser, Waters, Forster, & Brown, 2017 & Brown, 2017). Primary health care is a holistic approach that addresses social and environmental conditions contributing to health and illness (Talbot & Verrinder, 2014) while a biomedical approach focuses on how physiological function or dysfunction affects the body as a whole (Baum, 2015). These separate approaches are reflected in the language of the specialist

standards for nurses working with children in Australia. For example, in the National Standards of Practice for Maternal, Child & Family Health Nurses, the language focusses not only on the child and family, but also on the broader social environment including the social determinants of health (Grant et al., 2017). Conversely, the Standards of Practice for Children and Young People's Nurses which apply to paediatric nurses acknowledge the importance of primary healthcare, but do not consistently use the language of primary healthcare (Australian College of Children & Young People's Nurses, 2016). As social practices and knowledge are located within specific sociocultural contexts (Burr, 2015), it could be that nurses' perceived levels of comfort and subsequent practices in addressing parenting stem from organisational cultures and models of care. These different practice orientations of paediatric nurses and child health nurses have implications for their respective roles and scopes of practice in identifying, addressing and following up parental behaviours and social circumstances impacting children.

In addition to the influence of organisational norms such as models of care, nurses were active agents in constructing their own identities in the eyes of families. Nurses were aware of the socially constructed negative images of healthcare professionals who survey and monitor families (Aston et al., 2015), and so used covert strategies to assess for child maltreatment. Nurses attempted to construct their role as supportive and friendly, but existing literature suggests this predisposes nursing skills to being seen as 'simple and easy' in comparison to specialised biomedical skills (Aston et al., 2015). The application of highly competent relational skills in difficult and complex situations to address child maltreatment (summarised in Appendix 19) demonstrates nurses' application of relational practice.

Relational practice has been explained as the enactment of effective, responsive and ethical nursing care in the context of nurse-client relationships (Doane & Varcoe, 2007). However, relational practice is highly complex and requires nurses to negotiate a multitude of interrelated factors including personal characteristics, client expectations, workload demands, organisational priorities and prevailing ideologies against their perceived professional role (Doane & Varcoe, 2007). The value of nurses' unique relational practices in addressing child maltreatment has also been argued by several other recent studies (see for example Einboden et al., 2019; Mawhinney, 2019; Williams et al., 2019). In the current study, the highly developed skills demonstrated by participants were likely due to their considerable expertise (most participants worked in nursing

for at least 10 years; mean=24.6 years, range=10-40 years). As such, the complexity and expertise underlying nurses' relational practices needs to be more widely recognised to facilitate nurses' capacity to enact change for children at risk of maltreatment.

In implementing relational practices, nurses displayed specific communication skills that enabled them to raise concerns with parents without triggering disengagement and terminating nurses' access to children. Many of these skills were associated with specific professional attitudes that made nurses more inclined to address their concerns. For example, nurses had to be willing to address concerns with parents (attitude) but needed to do so in a supportive way (skill). The identification of these skills in this study is important because it helps to uncover the seldom recognised but highly complex skills nurses use to address child maltreatment. This provides beginning evidence that nurses need to be supported to develop, maintain and continually improve their skills so they have maximal capacity to provide care to children who are experiencing maltreatment.

Limitations

This study has some limitations. All participants were experienced in the nursing profession (mean=24.6 years) and so their views on keeping children safe might not reflect views of nurses new to the profession. Similarly, a small sample (n=21) of nurses mainly from one Australian state means findings may not reflect perspectives of nurses more broadly. Another potential limitation was that the data was coded by a single researcher; however frequent and detailed discussions with the research team ensured that the emerging codes and themes were consistent with the data.

Conclusion

This study further demonstrates that nurses are key to keeping children safe from maltreatment. One unique strength that nurses bring is their application of relational practice to engage parents in a positive therapeutic relationship whereby child maltreatment can be identified and addressed. However, nurses needed to balance children's needs against the importance of maintaining therapeutic relationships, especially as it was not always possible to achieve both goals. Many nurses used a child-centred approach, but the extent to which nurses were child-centred varied, and it required ongoing reflection to keep children in focus. As such, we need to

recognise the complexity of these practices to ensure nurses are supported to develop, maintain and continually improve their skills to promote better outcomes for children.

CHAPTER 7: FINDINGS - THEME 3

Theme 3: Constructing a compelling case: complexities of communicating about child abuse and neglect

Lines, L. E., Hutton, A. E. & Grant, J. M. under review, *Constructing a compelling case: nurses' experiences of communicating abuse and neglect,* submitted to *Child Abuse Review* in September 2019.

Introduction

Addressing child abuse and neglect requires a multi-disciplinary approach where professionals work together to promote children's wellbeing. Nurses are one profession who have regular contact with children and are ideally positioned to identify and respond to child abuse. One way that nurses respond to child abuse is through reporting suspected abuse to child protection services (CPS) who subsequently screen cases and determine whether an intervention is warranted. In countries such as Australia, Canada and the United States of America reporting child abuse is mandated by law, while in other countries, such as in New Zealand and the United Kingdom it is based on professional judgement (Drake & Jonson-Reid, 2015; Mathews, 2015a).

In Australia, legislation that governs reporting, assessment and intervention for child abuse and neglect varies across the eight states and territories. However, in all jurisdictions, legislation is broadly underpinned by three key principles of 1) the child's best interests, 2) early intervention and 3) children and young peoples' participation in decision making (Australian Institute of Family Studies, 2018). All states and territories have mandatory reporting legislation that requires nurses to report child abuse and neglect (Australian Institute of Family Studies, 2017a). Accordingly, nurses must report when they have either a reasonable 'belief' or 'suspicion' that a child is experiencing sexual abuse (n=6 jurisdictions) and/or is at risk of harm or death (n=6 jurisdictions) (Australian Institute of Family Studies, 2017a). When a report is made to CPS, CPS will assess whether an investigation is warranted, initiate investigations and subsequently intervene when children meet the criteria for statutory protection. Actions that CPS can take include referral to voluntary organisations to support the family, through to removal of the child from parental care. In 2009, the Council of Australian Governments (2009) developed the National Framework for Protecting Australia's Children 2009-2020 which emphasises prevention and early intervention for

child abuse and neglect, with statutory CPS reserved for children at risk of significant harm. In this way, lesser concerns where children who are not in immediate or severe danger can be cared for through a whole of community approach (Appleton & Peckover, 2015; Mathews, 2015a). Despite this approach, the number of children reported to CPS continues to rise, and most children who are notified receive no intervention beyond an initial assessment (Drake & Jonson-Reid, 2015; Featherstone, Gupta, & Morris, 2016).

As such, when child abuse is reported to CPS, this does not necessarily mean the child will receive a statutory intervention. A metasynthesis by McTavish et al. (2017) concentrated on 12 countries with mandatory reporting laws including Australia and identified that health professionals frequently perceived the reporting process as negative for many reasons including lack of institutional support, dismissive attitudes from CPS, ineffective interventions and harmful outcomes for children. However, in situations where nurses are unable to enact change by working with the family or by referring to voluntary services, the only way to make a difference for these children may be through reporting to CPS. Given that a CPS response to a nurse's mandatory report may be the only way some children receive an intervention, nurses must be skilled in clearly outlining their concerns to CPS when they believe children are at high risk of harm.

Nurses are the largest group of health professionals and are often involved in reporting abuse and neglect to CPS. However, nurses may perceive a lack of knowledge and professional conflict over the decision to report, especially when parents are also the nurse's clients (Lines et al., 2017). Nurses may continue working with families after making a report, and need to decide how or if they will discuss their decision to report with parents. It is not known how nurses communicate their concerns about abuse and neglect to CPS and how or if they communicate these same concerns with parents. Consequently, this paper reports on the third of four themes identified from a qualitative study that aimed to explore nurses' perceptions and experiences of keeping children safe from abuse. The four themes from this larger study were established through inductive analysis (numbered for clarity) and are 1) contextualising and defining child abuse (Lines et al., 2019), 2) nurse relational skills in addressing child abuse, 3) nurse experiences of communicating concerns of child abuse and 4) nurse views around how systems and hierarchies shape their responses to abuse (Lines et al., 2020b). This paper specifically reports on the third

theme relating to nurses' perceptions and experiences of communicating and reporting child abuse.

Methods

Framework

This qualitative study was guided by a social constructionist approach which recognises knowledge and social practices are unique to the sociocultural conditions that produce and maintain them (Burr, 2015). Social constructionism is relevant to the exploration of nurses' perceptions and experiences of child abuse because parenting practices are embedded within social and historical contexts. For example, Jenks (2005) argues that child abuse has always existed as a 'constant feature of human social relations', but through societal change, certain practices become normalised while others are considered deviant. In short, societal thresholds of what 'counts' as abuse and neglect have changed over time and continue to evolve with ongoing social change. In this study, it is understood that the ways nurses respond to child abuse are shaped by these societal perceptions and practices of abuse which are enacted and sustained in nurses' daily practices.

Ethics

Ethical approval was granted by Flinders University Social and Behavioural Research Ethics Committee. Written consent was obtained from each participant, including permission to audio record their interview. Participants could review their transcript and make changes prior to inclusion in the study.

Participants

Nurses were recruited by purposive sampling by advertising the study through professional nursing organisations. Nurses were eligible to participate if they worked with children in Australia and were registered nurses. Potential participants contacted the researchers with enquiries and/or to indicate their interest in the study via the first author's university email address. Twenty-two nurses were initially recruited, but one later withdrew leaving a total of 21 participants.

Data Collection

Semi-structured, in-depth interviews lasting from 60 to 90 minutes were held either face-to-face (n=15), via telephone (n=5) or through Skype (n=2). The questions were based on an interview guide (Lines et al., 2017) developed from a literature review (Lines et al., 2019). Interviews were conducted by the first author from August 2016 to August 2017. They were subsequently transcribed by the first author (n=12) or a professional transcriber (n=9) after signing a confidentiality agreement. The first author checked transcripts against the audio recordings to ensure accuracy. Data saturation started at interview 17, but an additional five booked interviews were conducted to provide additional nuanced information about nurses' experiences across different contexts.

Data Analysis

The first author read and re-read transcripts before exporting into NVivo where they were coded inductively. The first author initially used descriptive coding, but changed to process and holistic codes (Saldana, 2016) to better represent the data's complexity. This process produced many codes (n=563). All codes were printed and arranged on poster paper to enable visualisation of the whole dataset (Gibbs, 2014). At this point, codes were physically arranged and rearranged by similarity until four clear themes became evident. This process was led by the first author supported with regular consultation and direct input from the remaining authors. Throughout this process, codes with equivalent meanings were merged into single representative codes. The authors met frequently throughout data analysis to ensure that codes and developing themes were reflective of the data.

Findings

Participants

Participants (n=21) practised in three main settings, paediatrics (n=7), child health (n=10) and community (n=2). The remaining participants (n=2) had backgrounds in both child health and paediatrics. In Australia, paediatric nurses typically work in acute care, while child health nurses have a role similar to health visitors in the United Kingdom. Conversely, community nurses do not have a nationally consistent role, but community nurses in this study worked for non-government organisations. See Table 10 for details of participants' primary role within their organisation.

Table 10: Summary of nurse roles and area(s) of work (n=21)

Nurse role	Participants (P), total n=21
Registered nurse in community setting	P 1 & 8 (n=2)
Paediatric registered nurse	P 2, 6, 13, 18 & 21 (n=5)
Child health nurse	P 9, 11, 14, 15, 19, 20, 22 (n=7)
Registered nurse with experience in paediatrics & child health	P 5 & 17 (n=2)
Non-clinical paediatric registered nurse	P 4 (n=1)
Nurse manager (paediatrics)	P 7 (n=1)
Nurse manager (child health)	P 3, 10 & 12 (n=3)

Themes

This paper reports on the theme relating to nurses' experiences of communicating with CPS and families when reporting abuse and neglect. Nurses reported being aware of their responsibilities as mandated reporters of child abuse but frequently had trouble 'being heard' by CPS. As such, nurses experienced disappointment with CPS responses to children and felt disenfranchised when it came to effecting change for children. Nurses also had to decide if and how to discuss potential involvement of CPS with families, especially as this could elicit negative reactions. The findings are reported in three subthemes (numbered for clarity) which are 1) 'being heard', 2) 'disappointed, discouraged and disenfranchised' and 3) 'managing tensions between reporting and engagement.'

Being Heard

Nurses believed their role was to present 'facts' or 'evidence' (P 2, 4, 5, 11, 17, 20, 22) when reporting abuse to CPS. Nurses typically considered facts or evidence to be objective, precise and verifiable events they had personally encountered rather than perceptions or subsequent conclusions (P2, 3, 5, 7, 10, 11, 15, 20, 21). Participant 15 explained: '*I've just gotta present all the situation and the features and my concerns*.' Nurses recognised it was not their role to speculate about what may have occurred: '*you can only give very factual statements, it's not up to us to say*

how they sustained those injuries' (P 21). In the state of South Australia, where the majority of participants practised (n=19), legislation states nurses must report if they *'suspect on reasonable grounds'* that a child is at risk of abuse or neglect (Government of South Australia: Attorney-General's Department, 2017, p. 26). However, participants' experiences of being dismissed by CPS meant nurses felt they needed 'evidence' (P2, 4, 5, 17, 20) from which to argue their suspicions. For example, Participant 2 explained her thought process when deciding whether to report: *'[I] hesitate and go 'well, hold on a second. Do I have the evidence to fight back to them [CPS] over this?'* Similarly, Participant 4 reflected on an experience where she had decided not to report: *'I think should I have reported it, and why didn't I? I think it was that decision 'well, I've no evidence, this is really just hearsay.''* This demonstrates that despite the legal requirement to report if one *'suspect[s] on reasonable grounds'* (Government of South Australia: Attorney-General's Department, 2017, p. 26), participants still felt 'evidence' was essential.

When nurses provided what they saw as factual reports, some nurses (P3, 5, 6, 8, 22) felt the likelihood of action hinged on how seriously CPS took their concerns. For example, Participant 5 outlined how *'they would actually verbally discount you as you're reporting, saying comments like 'is that all you're reporting?' or 'this doesn't sound so serious.'* As a result, some nurses reported firmly advocating for the child to try and communicate the seriousness of the situation. Participant 10 recalled: *'I've almost felt like I've really had to fight the case… because [CPS are] a bit dismissive of what I'm saying.'* This demonstrates nurses' experiences of being discounted as CPS reconstructed the situation to make it seem less severe. However, nurses who had witnessed the situation had a greater sense of urgency, which they felt needed to be communicated effectively.

Nurses had strategies to ensure they were heard such as planning their report in advance. For example, Participant 9 wrote down and read out her concerns without pausing to prevent interruptions and opportunities for discounting: '*I would always write it out before I rang, and I would read it point by point so they couldn't interrupt me'*. Other nurses carefully chose their words to ensure the level of urgency would be understood: '*I was very wise towards the end as to how to say things… maybe it's because they're social workers and they don't have the medical knowledge and if you present it as being alarming they often took notice of it'* (P8). In Australia, CPS staff are typically social workers with different professional backgrounds to nurses, meaning situations nurses perceived as serious were not automatically interpreted this way by CPS (Tung et

al., 2019; Williams et al., 2019). For example, Participant 10 felt she had to outline the consequences of poor infant growth, explaining that: *'saying 'I'm worried baby's not gaining enough weight', that's probably not enough. You need to actually say 'and if baby doesn't start gaining weight the vital organs are going to be compromised'.*' Thus, some nurses (P 6, 10, 22) saw their role as educating CPS around how children's health needs can influence their risk of harm.

Two participants (3 & 10) in senior positions also saw their role as educating inexperienced staff in making an effective report. For example, Participant 3 explained how staff were educated and supported in the process of reporting: *'the team leaders will… coach them through what to say to actually get their point across so that they [CPS] will take it seriously'* (P 3). This shows nurses saw reporting abuse as an important skill to convince CPS that their concerns were legitimate.

Disappointed, discouraged and disenfranchised

Nurses were frequently discouraged by inadequate responses from CPS and outlined examples of disappointing or devastating consequences. Participant 21 recalled a situation where: *'doctors and nurses recommended that those [babies] didn't go home with the parents, and [the] social worker sent them home and they came back both dead the next day'*. At other times, nurses explained that although CPS did respond, the response took so long that children had already experienced harm. For example, Participant 12 recalled a family where she felt: *'the children were unsafe to remain in the care of their parents.'* Although CPS did ultimately intervene, this took time: *'it took probably three years before there ended up being an investigation… and the children were all removed'* (P 12). Negative experiences meant that some participants reported hesitating before reporting, as articulated by Participant 2: *'I hope I never have to report… because it sounds horrible… it's almost like they [CPS] view us as nitpickers.'*

Despite negative perceptions, nurses still recognised their legal duty to report. Even when nurses felt they had insufficient evidence, they preferred to report than have a child harmed (P2, 3, 4, 5, 6, 11, 22). This was demonstrated by Participant 3 who explained: *'I would rather err on the side of caution, than not do anything and see a child come to harm.'* When doing so, nurses placed the accountability for decision-making back onto CPS: Participant 6: *'I do always go on the side of, if it doesn't sit right with me, I'll do it [make a notification] because then they [CPS] can decide if it really is an issue.'*

Ultimately, some nurses felt they had little control over potential outcomes, and could only hope that action would be taken: *'[your notification is] always a piece of the puzzle and… you have to kind of trust that they are the statutory body and they will have all the bits of the puzzle.'* (P1). Other nurses believed they could prompt CPS to act by making repeat notifications. For example, Participant 12 explained '*I think the response from [CPS], it hinges largely on the number of notifications they get,'* in the same way, Participant 6 said she would *'notify, notify, notify'* in an attempt to prompt action. However, repeat notifications were not necessarily enough to elicit a response as outlined by Participant 20: '*I made another notification, the hospital social worker made a notification and the doctor made a notification and it was still [only] a notifier concern'* (lowest level of risk). These circumstances demonstrate that once nurses have reported to CPS, they may feel disempowered to influence what happens next and can only make additional notifications in the hope this might lead to intervention.

Many nurses (P1, 6, 7, 10, 12, 22) believed that repeated notifications would increase the likelihood of a response from CPS, such as by building a *'picture'* (P10, 12, 22) or *'story'* (P7). Conversely, Participant 1 recalled a situation where repeat reports elicited no action. Participant 1 recounted how seven different professionals from multiple organisations independently enacted their duty as mandated reporters but it made no difference: *'I remember that [CPS] felt that we'd all just got together and decided that we would all notify to make it look worse.'* Participant 1 learned of this misunderstanding because she was working closely with CPS and was able to explain that there was no collusion, but rather individual professionals who each held concerns about the child's safety.

Although nurses recalled many experiences of dissatisfaction with CPS responses, some nurses pointed out that CPS enact positive change. Participant 6 explained: '*Sometimes making a notification means that good things are going to happen to that family.'* Similarly, Participant 11 reflected upon a family who received help after a notification: *'[it] turned out really good that time, she [mother] was very actually thankful that I had called [CPS].'* In the same way, Participant 17 outlined immediate action that occurred when she reported sexual abuse: '*the sexual abuse… was tiered straight away… they actually sensed the urgency for that.'* However, the language participants used when recalling positive outcomes suggests this is the exception rather than the norm.

Managing tensions between engaging and reporting

Reporting child abuse to CPS may be seen as a punitive measure and perceived negatively by families. This last finding outlines how and if nurses communicate their concerns with families to when reporting abuse.

Nurses were typically open about their role in mandatory notification of abuse and neglect, with nurses in child health and community home visiting settings explicitly discussing their report with families (n=11). In this way, these nurses promoted openness by explaining to families they would aim to discuss any concerns prior to reporting. Participant 19 gave an example of what she might say to a family: *'if I have any concerns, I do have to let child protection know, but I what I would do is if at all possible I'd talk to you about it first'*. On some occasions, nurses indicated that simply raising concerns with a parent might resolve the issue without the need to report. Participant 1 gave an example of this: '*mum had an air-conditioning unit right next to the crib so heat was blasting onto baby… she thought she was keeping baby warm but it really was a bit overheating… I wouldn't have notified about that, that's more about education… but if I came the next time and she was still doing that, then I might [make a report] … coz baby's not safe.'*

However, nurses did not always feel comfortable discussing their intention to notify due to fear of parental reactions (P 5, 6, 10, 12, 14, 17, 20, 22). For example, Participant 5 experienced anger from parents: *'we've certainly had violent parents come into [location] office after reports have been made'.* Although CPS does not disclose the identity of reporters, families knew *somebody* must have reported. Participant 22 believed *'it's quite easy for families to work out who's done the notification'.* Participant 20 explained this could be because the nurse was the only one to witness a particular incident: *[CPS say]* '*oh we heard… there were nappies on the table…' [and] she [mother] knows that it's all from me, because… nobody else would have seen that.'*

In contrast to nurses from other settings, no paediatric nurses shared their experiences of discussing their intention to report with families. Instead, Participant 6 recounted how she made a report that prompted police intervention, but even afterwards, the family did not know who had reported. Participant 6 recalled: '*they [family] still talk about when it all blew up and whoever dobbed on us, and… [I'm] keeping this straight, deadpan face.*' When paediatric nurses were explicitly asked about discussing their intention to report with families, one paediatric nurse

explained she was anxious that families might respond negatively: *'that's something I haven't had to do, but I would fear doing that… you've got to worry how the parents are going to react.'* (P 13). In contrast, child health and community nurses tended to believe discussing their intention to report depended on the quality of the relationship with the family (P 5, 10, 11, 12, 20, 22), with some recognising there are situations where it would not be appropriate due to risk of relationship damage (P 5, 14, 22) and/or perceived danger to themselves or family members (P 5, 12, 17, 20).

Some nurses (P5, 14, 22) explained that making a notification could damage trust and relationships with families. The decision to notify was especially complex in Aboriginal communities where historical interference caused significant harm and ongoing mistrust in government services. Participant 14 (CH) indicated nurses needed to be cautious when making a notification: *'there is the fine line about reporting, reporting, reporting, because then you also will lose an element of trust, and if you lose that you won't get anywhere'.* Some nurses' experiences had also shown them there might be little meaningful intervention from CPS: *'notifying doesn't mean you're going to get a response, it actually generally means you're not going to get a response'* (P 10). Conversely, Participant 5 highlighted that it should not matter how CPS respond: *'If you suspect abuse or neglect you have to report that… your report should be irrelevant to what the outcome might be.'* This observation shows different perspectives around the level of discretion nurses should use when deciding whether to make a notification, with some nurses weighing up their decision, while others reported regardless of outside factors.

In anticipation of potential negative reactions from families, nurses described mitigating strategies such as reframing reporting as a positive. For example, Participant 3 would explain to families: 'if we do this [report] we can support you to actually get to the point where this [issue] is no longer happening, or you're better resourced, or you feel like you can cope with parenting.' Similarly, Participant 20 emphasised the role of CPS in building parental capacity: 'I'm not reporting because I don't think you're capable… I'm reporting because I want you to get the services involved who can help you.' Participant 15 used a similar strategy which involved being with and supporting the family in an urgent situation. At this time, Participant 15 described how a broken door needed immediate attention to prevent a toddler running onto the street: 'we told her [mother] straight out, 'we have to report this' and we didn't leave that house, we gave her our phone [and] got her

to ring [government department] and said, 'we need to have a lock put on this door'. Through this approach, Participant 15 successfully addressed safety concerns by being with the mother and empowering her to enact change.

Another strategy nurses used when discussing their intention to report with families involved distancing themselves from the process. For example, Participant 10 outlined her role as neutral in presenting just 'facts' about the family. For example: '[I tell families] it's not up to me how child protection respond; all I do is present factual information.' (P 10). Although 'facts' were based on nurses' direct experiences and observations, 'facts' could be constructed in different ways. Participant 20 described how she outlined to a mother what she would be sharing with CPS: 'I have to… tell [CPS] that I've been there and what I saw, but at the same time trying to be positive that he's [baby] put weight on, and I'll definitely be telling them that I think there are positives from the visit.' In this example, Participant 20 was highlighting her lack of control 'I have to… tell [CPS]' and focussed on the positives of what she had observed.

Discussion

This study showed that nurses felt disappointed, discouraged and disenfranchised, believing they were not always taken seriously and had little control over outcomes following a report to CPS. This perception occurred despite all participants being very experienced (range= 10-40 years) and often with extensive experience responding to child abuse. Although participants saw reporting abuse as a potentially ineffective strategy, they still took their role as a mandated reporter seriously. The perceived likelihood of inaction following a report meant nurses felt the need to advocate for children and 'fight back' (P 2) while at other times, nurses reported a more passive response such as 'trust' (P1) that CPS would respond.

Nurses' perceptions of not being taken seriously by CPS in this study are comparable to nurses' experiences with other professionals, such as doctors. Historically, the nursing profession developed as helpers of the medical profession whereby nurses unquestioningly followed the orders of doctors (Ehrenreich & English, 2010). This is further compounded by the conceptualisation of nursing as 'women's work' undertaken primarily by women who may be socialised into 'appropriate' gender roles of subordination to men (Roberts, 2006). Even in recent times, nurses work in 'caring' for clients continues to be constructed as less important than

166

'curing' work of doctors (Treiber & Jones, 2015). Although submission to doctors is no longer necessary, nurses' oppression is maintained by the hierarchical healthcare system which sustains the status quo and socialises nurses into their identities (Roberts, 2006; Ward, 2009).

Unfortunately, ongoing oppression means nursing knowledge may be devalued with potentially fatal results. For example, nurses were the first to raise concerns which initially went unheard during the events leading to the deaths of 12 children following cardiac surgery in Canada in 1994 (Gilmour & Huntington, 2014). In the same way, nurses' concerns were also at first ignored in similar circumstances in Australia in 2005 when at least 13 individuals died due to the negligence of a surgeon (Gilmour & Huntington, 2014). The ways that nursing practice has been constructed historically and is maintained through daily interactions and social practices may contribute to nurses' perceptions of not being taken seriously.

Professionals who are involved in reporting child abuse can become disillusioned when they feel powerless to elicit change (McTavish et al., 2017; Sigad et al., 2019). In accordance with Bandura's theory of self-efficacy, if people believe they cannot enact change they may reduce their efforts, or even stop trying (Bandura, 1982). This has significant implications for nurses because they may be less motivated to address child abuse if they feel powerless to enact change for vulnerable children. To help professionals work through perceptions of powerlessness, Kenny (2015) recommended ongoing discussion-based education whereby feelings of frustration or negativity can be addressed. Other authors have reported successfully increasing health professionals' self-efficacy in responding to child abuse through educational interventions involving interactive workshops and case studies (Fraser et al., 2018; Lee & Chau, 2016). Unfortunately, many interventions aimed at improving professionals' responses to child abuse have focused primarily on factual knowledge (Walsh, 2019) or ignore factors underlying nurses' actions (Einboden, 2017). Instead, education informed by a Health Beliefs Model (HBM) which recognises that individuals' actions are not solely dictated by their knowledge (Skinner, Tiro, & Champion, 2015) could help address the broader enablers and barriers to responding to child abuse. For example, even if nurses have sufficient knowledge to identify and respond to child abuse, if they do not believe their expertise is valuable, this may form a barrier to action. Further research is needed to identify whether discussion-based education that addresses participant feelings, and/or education

underpinned by the Health Beliefs Model can produce sustained behaviour change and improve outcomes for children.

Participants reported gaining valuable support and a sense of camaraderie from colleagues within their organisations. This was significant because despite having many years of clinical experience (range=10-40 years), nurses still encountered complex decisions that they wanted to discuss. Nurses may find discussions and critical reflection with multi-disciplinary colleagues challenging at times because professionals view child abuse according to their professional orientation. For example, although Alberth and Büllinger-Niederberger (2015) did not specifically investigate nurses, they found paediatricians described child abuse through a biomedical lens, while midwives emphasised practical care of mother and baby. Similarly, Williams et al. (2019) found that nurses working within the Nurse-Family Partnership program used fundamentally different assessment procedures and understood safety and risk differently to CPS workers. These differences led to challenges in effective collaboration arising from contrasting expectations (Williams et al., 2019). Thus, some perceived difficulties with 'being heard' or feeling 'disempowered, disenfranchised and disappointed' could be due to varying professional conceptualisations of child abuse between nurses and CPS. The ways that Australian nurses conceptualise child abuse and neglect is linked to their sociocultural contexts, and this is further discussed in Lines et al. (2019).

Nurses' perceptions of powerlessness calls for greater multi-disciplinary collaboration between nurses and CPS. Existing research shows nurses often perceived lack of confidence in responding to abuse and neglect (Lines et al., 2017), which is likely to be augmented if continually experiencing dismissive reactions from CPS. Recent research has demonstrated that greater alignment in organisational 'mission and methods' was associated with higher perceived collaboration between CPS and nurses working within the Nurse-Family Partnership program (Tung et al., 2019). For example, nurses felt collaboration was strongest when CPS used a similar strengths-based approach that supported families to stay together (Tung et al., 2019). This suggests differences in disciplinary approaches between participants and CPS may have contributed to perceived communication difficulties. Unfortunately, poor communication and collaboration between different professionals and agencies is an ongoing issue and has been identified as a contributing factor in several child deaths (Fraser, 2013; House of Commons Health Committee, 2003; Johns, 2015). Some authors (Walsh, 2019; Williams et al., 2019) have suggested

multi-disciplinary education that facilitates networking across disciplines may promote shared understandings, while others have developed an inter-disciplinary framework for educating pre-service professionals with the goal of establishing a shared language and culture of collaboration (Grant, Gregoric, Jovanovic, Parry, & Walsh, 2018). Further research is needed to determine whether these approaches can effectively promote collaboration and lead to better outcomes for children.

One such framework offering improved communication for professionals working with children and families is the Family Partnership Model (FPM). The FPM draws upon qualities and skills of individual professionals to build relationships with families and support them to enact positive change (Davis & Day, 2010). The FPM is practiced broadly across the UK, but within the Australian nursing workforce, FPM has only been widely implemented into child health nurse education and practice. As such, the FPM is not core to the educational preparation of specialist paediatric nurses. Even so, the application of FPM is apparent in the different safeguarding practices of child health nurses and paediatric nurses within this study. For example, many child health nurses recognised the importance of honesty (P 3, 10, 11, 15, 19), but were concerned about potential implications of discussing their intention to report on trust and therapeutic relationships (P 5, 14, 22), both of which are core to the FPM. In contrast, no paediatric nurses discussed potential relational benefits of openly discussing their intention to report with families, but could still identify potential negatives such as disengagement and negative parental reactions (P 6, 13, 18). It is possible that the differences between child health and paediatric nurses' attitudes towards discussing their intention to report child abuse with families could be due the extent to which the FPM is embedded within and core to their practice.

Nevertheless, both child health and paediatric nurses experienced uncertainty and lack of control when discussing, or deciding whether to discuss, concerns about abuse and neglect with families. This included anxieties around how families might react and how/if CPS would respond. Although nurses were aware of relevant guidelines, their application is based upon individual judgement within unique social and organisational contexts (Munro, 2018). These findings suggest nurses need ongoing support to maintain confidence in the face of uncertainty and complexity. In child protection, all practice occurs under some level of uncertainty, and so there needs to be greater application of critical reflection to retrospectively learn from the quality of decision-making

(Munro, 2018). For nurses, this may include education around the use of critical reflection to develop practice, and the provision of time and organisational support to facilitate application of these skills. However, when current organisational culture promotes blame and 'fixing' individual professionals rather than looking holistically at the complex and unpredictable circumstances surrounding decision-making (Leigh, 2017a), education alone is unlikely to be enough.

Study Limitations

There are some limitations to this study. The sample (n=21) included only experienced nurses who mostly practised in one Australian state (n=19). Thus, findings may not reflect views of nurses more broadly.

Conclusions

Nurses have an important role in communicating cases of child abuse and neglect to CPS so children and families can receive appropriate support. This study showed nurses recognised the importance of their role, but often believed they were not taken seriously by CPS and felt powerless to enact change for the child. At the same time, nurses were weighing up how and if to share their intention to report to CPS with families to minimise negative reactions. This occurred within a context of uncertainly around how/if CPS would intervene, and how families might react. Consequently, there is a need for more effective collaboration between nurses and CPS to promote better communication and coordination of responses. Further research is needed to explore whether discussion-based and multidisciplinary education could address nurses' perceptions of powerlessness and promote shared understandings between nurses and CPS. Although education may go some way to addressing nurses' concerns, this needs to occur within the broader context of organisational culture change.

CHAPTER 8: FINDINGS - THEME 4

Theme 4: Systems and hierarchies shaping nurses' responses to child abuse and neglect

Introduction

Child abuse and neglect has long been recognised as a major public health issue. As such, many countries have developed legislation and systems to prevent and address child abuse (Mathews & Bross, 2015). This includes statutory child protection services who are alerted to cases of abuse through reports such as those made by health and welfare professionals who are legally and/or ethically bound to intervene. However, child abuse is a complex problem with no known immediate or simple solutions. Criticisms of contemporary child protection systems include the failure to consistently produce positive outcomes for children (Tonmyr, Mathews, Shields, Hovdestad, & Afifi, 2018), and systems have increasingly taken a 'risk averse' approach which can lose sight of children (Munro, 2018).

For example, a report by the Care Quality Commission into out-of-home care in the United Kingdom found that children and their voices are often invisible and overlooked by the systems responsible for caring for them (Care Quality Commission, 2016). This invisibility of children has been a contributing factor in the deaths of several children known to child protection systems in countries including Australia and the United Kingdom (Fraser, 2013; Johns, 2015; Keeley, Bullen, Bates, Katz, & Choi, 2015).

In the Australian context, there is a growing recognition of the importance of a whole-of-community approach to addressing child abuse and neglect. For example, the National Framework for Protecting Australia's Children 2009-2020 recognises the need to 'move from seeing 'protecting children' merely as a response to abuse and neglect to one of promoting the safety and wellbeing of children' (Council of Australian Governments, 2009). Thus the concept of 'keeping children safe' in this paper encompasses a holistic approach that addresses broader

factors that contribute to abuse and neglect to ensure children are supported to reach their full potential (Australian Government Department of Health, 2019; Council of Australian Governments, 2018). This means that everyone in society has an individual and collective responsibility in supporting children to 'grow up in thriving families and communities and develop into healthy, connected, nurturing and productive adults and parents' (Council of Australian Governments, 2018).

Nurses in Australia have a professional and legal responsibility to respond to child abuse through mandated reporting (Australian Institute of Family Studies, 2018; Nursing and Midwifery Board of Australia, 2018). In child specific contexts, specialist standards for practice also recognise nurses' broader roles in advocacy for children, supporting parents/carers and responding to situations that may compromise children's health, safety or development (Australian College of Children & Young People's Nurses, 2016; Maternal Child and Family Health Nurses Australia, 2017). Nurses both in Australia and internationally work with children across the spectrum of prevention, early intervention and addressing the impacts of abuse, but this role is poorly researched and often invisible (Einboden et al., 2019; Peckover & Appleton, 2019; Taylor, Smith, et al., 2016). Despite nurses' widespread roles in keeping children safe, there is a dearth of research that reports on nurses' experiences and interactions within the systems and organisations designed to keep children safe, including how these institutions shape nurses' practices in preventing and responding to child abuse.

The aim of this paper is to report on one finding from a broader qualitative study that asked, 'what are nurses' perceptions and experiences of keeping children safe from abuse and neglect?' An inductive primary analysis produced four key themes. The theme reported in this manuscript relates to how nurses perceived that systems and hierarchies influenced their capacity to respond to child abuse and neglect.

Methods

This study was informed by social constructionist theory which recognises that society and its practices are continually constructed and reconstructed by human social interactions (Burr, 2015). Society has established institutions that set up predefined ways of thinking and acting that produce both constraints and opportunities for the individuals involved (Berger & Luckman, 1972;

Parton, 2012). Social institutions promote efficient progress towards their goals by regulating individuals' activities and relationships through reward or discipline of certain behaviours (Foucault, 1995). Interactions between institutions and individuals is an ongoing process whereby people are continually building upon and changing institutions, frameworks and meanings produced by previous generations (Burr, 2015; Parton, 2012). A recognition of the interactions between socially constructed institutions and human actors is important for understanding how nurses respond to child abuse and neglect because nurses' practice occurs within specific social and institutional contexts. For example, legislation, policies and organisational cultures all present constraints, opportunities and regulation of nurses as they respond to child abuse and neglect.

Flinders University Social and Behavioural Research Ethics Committee granted ethical approval prior to the commencement of this study. Written, informed consent was provided by all participants.

Data Collection and Analysis

Semi-structured, in-depth interviews were used to collect data from nurses working with children in Australia. Recruitment occurred through purposive sampling with advertisements distributed through professional organisations of interest to nurses. In Australia, all nurses have a responsibility to respond to abuse. However, this study only included nurses who worked specifically with children. The rationale for only including nurses who worked with children is because nurses working with children have daily contact with children and families and thus more frequent experiences responding to abuse. Nurses working with children are also expected to have a higher level of expertise in advocating for children, supporting families and responding to situations that are potentially harmful to children's wellbeing (Australian College of Children & Young People's Nurses, 2016; Maternal Child and Family Health Nurses Australia, 2017).

Interviews (60-90 minutes) were conducted by the first author either in-person (n=14), by telephone (n=5) or through Skype (n=2) based on participant location and preferences from August 2016 to August 2017. The interviews were guided by an interview guide (refer to Lines et al., 2019) which was produced through a literature review (Lines et al., 2017). At interview 17, signs of data saturation were evident, meaning the researchers recognised that participants were reiterating similar concepts and building on previous interviews. The researchers understood data

saturation as 'theoretical saturation', which is where 'new data do not contribute new themes or patterns in the analysis' (Given, 2016). The researchers acknowledged the ongoing possibility of new or novel findings, recognising that at a point additional interviews would provide only 'diminishing returns' (O'Reilly & Parker, 2012; Saumure & Given, 2008). An additional five pre-booked interviews were conducted to provide more nuanced and context-specific data and confirmed the researchers' sense that theoretical saturation was occurring. All interviews were audio recorded and transcribed by a professional transcriber (n=9) or the first author (n=12). Participants were offered the chance to review and modify their de-identified transcript; most (n=17) made no changes and some (n=4) made minor changes. One interview in addition to the 21 was conducted but not discussed in this manuscript because the participant chose to withdraw.

Participants were 21 female Australian nurses, primarily from the state of South Australia (n=19). Participants came from three settings which were child health (n=10), paediatrics (n=7) and community (n=2). The remaining participants (n=2) had backgrounds in both child health and paediatrics. Paediatric nurses in Australia typically work in acute care settings, especially hospitals, while child health nurses have similar roles to health visitors in the United Kingdom and work in clinics or family homes. Community nurses do not have a nationally defined role in Australia, but community nurses in this study were employed by non-government organisations with a welfare focus.

The first step of data analysis was to read and re-read transcripts before coding inductively (first author). Although descriptive codes were used initially, process and holistic codes were used later in the process to more comprehensively represent the data's complexity and nuances (Saldana, 2016). This was an iterative process by which the researchers cycled back and forth between existing data and considered how to generate new and potentially better data in future interviews (Miles et al., 2014). Examples of initial coding and how they later composed the final codes can be found in Supplementary File 1 (Appendix 20). In accordance with social constructionist theory, the codes, themes and findings arise from the authors' interpretations of the data which are linked to our own social, cultural and institutional contexts. As discussed by Burr (2015), complete objectivity in research is unachievable because the world is investigated through particular perspectives, by asking certain questions, and by individuals living in particular cultures and times.

For example, the researchers all have a background in children's nursing which is likely to have influenced the way we interpreted the data.

Throughout the process of data analysis, the research team met regularly to check codes were confirmable and representative. The first author arranged the codes thematically, and these were rearranged collaboratively during team discussions until four themes were agreed upon by consensus. These four key themes were 'contextualising and defining child abuse', 'nurses' relational practices in responding to child abuse', 'nurses' communication with child protection services and families' and 'nurses' perceptions of the ways organisational structures influence their responses to child abuse.' The first theme 'contextualising and defining child abuse and neglect' outlined how nurses had difficulty concisely defining abuse and neglect and were guided by a range of sources including their personal and professional backgrounds. 'Nurses relational practices in responding to child abuse' explored how nurses used relational skills manage the tension between maintaining family engagement whilst still addressing concerns around child safety and wellbeing. Throughout the process of working with families, the theme 'nurses communication with child protection services and families' examined nurses' challenges when communicating their concerns to child protection services and deciding if/how to discuss with families. Finally, all of nurses' practices were influenced by the organisational contexts of nurses' work, and so the theme 'nurses' perceptions of systems and hierarchies shaping their responses to child abuse and neglect' identifies nurses' experiences of working within socially constructed institutions created to keep children safe. This current manuscript reports only on the final theme.

Findings

This manuscript reports on the theme relating to nurses' perceptions of how systems and hierarchies shaped their responses to child abuse and neglect. Nurses experienced many challenges arising from the systems and hierarchies that have been developed with the intention of keeping children safe. This theme encompasses three subthemes: 'navigating rigid systems and hierarchies of information sharing', 'fear of making mistakes: 'you'd be sacked probably'' and 'inflexible systems: 'we're not allowed to''. The first subtheme explores how nurses acknowledged the importance of information sharing to keep children safe, but encountered many barriers to doing so. 'Fear of making mistakes' describes how nurses recognised the potential impacts of mistakes on children and families, but also perceived a punitive culture in which mistakes were

punished. Finally, 'inflexible systems' outlines how nurses recognised that systems and organisational cultures intended to keep children safe could themselves form a barrier to effectively responding to children. These three themes are now discussed in full. Participants are referred to by number and their context of practice: child health (CH), paediatrics (P) and community (C).

Navigating rigid systems and hierarchies of information sharing

Nurses frequently described formal structures and procedures that were in place to facilitate their responses to child abuse. These included mandatory reporting, information sharing guidelines and pathways through which they could highlight or escalate their concerns. Unfortunately, these systems and procedures were imperfect; they could be confusing, ineffective or actively exclude nurses. This meant nurses frequently had to navigate around rigid systems to address concerns about child abuse and neglect.

One key challenge described by participants (n=15) was the experience of accessing and/or sharing information when there were concerns for the child's safety or wellbeing. Nurses were aware they legally could, and indeed ethically *should*, disclose confidential information when a child was at risk. However, there were perceived barriers to sharing information, such as overly complex legislation and/or clinical guidelines. This was exemplified by Participants 10 (CH) and 20 (CH) respectively: '*they're legal documents that go on forever*' and '*I feel more confused now that the information sharing guidelines are out.*' Participant 4 (P) further elaborated that her organisation had a policy of reporting decisions to disclose information through the clinical incident system. This meant decisions to share information were managed in the same way as a clinical error, despite being an intentional decision: *'that could still be a block to people sharing information… if they think they've then got to report it as an incident'* (P4, P). It also added a secondary organisational procedure to a clinical decision which adds time in an already time-poor environment. In this system where there are many perceived barriers to disclosure, it could be easy for nurses to take a parent rather than child-centred approach to disclosure: *'I can only really say what I think the parent is comfortable saying.'* (P8, C).

In Australia, laws and policies around what information can be shared and under what circumstances vary across jurisdictions, but only some explicitly permit sharing of information

when children may be at risk. This study showed that nurses experienced gatekeeping of information within this legislative context. Some participants (P1, 4, 6, 10, 22) outlined how it could be difficult to know what services families were accessing, especially around issues affecting their children's wellbeing. For example, Participant 10 (CH) recalled seeking information about whether a mother was receiving treatment to reduce the impacts of mental illness on her parenting, but the doctor was unwilling to share information. Participant 10 explained: *'sometimes all we need to know is are you seeing this family? …I don't need to know… what they talked about, I just need to know… 'are you concerned, and have you got a plan to follow up*?' Conversely, Participant 22 (CH) outlined her more successful attempts at seeking information: '*I actually contacted who she [mother] said was her GP (general practitioner) and… they weren't able to give me a lot of information but they were able to tell me that she'd actually only been to one of them once.*' Other nurses (n=2) such as Participant 9 perceived a hierarchy of staff who were 'allowed' to access information which varied according the individual's role:

'we're always going through five people before we get to the person that knows the most… for me, to talk to the cops is just not on… I wouldn't get the information… as a [child health] nurse that I would've got as a mental health nurse.' (P 9, CH).

When nurses knew whether parents were seeking help for issues impacting upon their parenting, they felt better able to make assessments about children's safety and the need for action.

The perceived difficulty accessing information from other professionals meant that nurses also used informal strategies to share information. For example, Participant 14 (CH) discussed how in a rural area information sharing was done more freely: *'we sort of are a little bit outside… the rigidity of being in the city, but without…breaking the rules.'* This could be because in a small community the nurse knew other professionals personally and could trust they would use information appropriately. Similarly, in the hospital setting paediatric nurses could seek informal feedback about children with suspected abuse-related injuries: *'sometimes it will be if we're taking a patient up [to be admitted]… I will say 'oh by the way, how's this person going'* (P 18, P). This process helped Participant 18 evaluate her practice by identifying whether her suspicions of abuse or neglect had later been substantiated. Thus, even though formal systems were in place to

facilitate information sharing, at times nurses felt they had to circumvent these systems to access information.

Participants frequently described situations of abuse and neglect that needed input from other professionals and/or child protection services. In hospital settings, communication about these situations involved passing information up the chain of command, to nursing team leaders, nurse managers and doctors who would then be responsible for the plan of action. For example, four paediatric nurses (P 7, 13, 18 & 21) outlined the importance of highlighting concerns to the treating doctor for further assessment and intervention. Participant 13 (P) recalled: '*I remember just flagging [concerns] to the doctor that was going to be looking after them, and they [doctor] basically dealt with that.*' At other times, nurses escalated concerns to their nursing team leader (TL) who would then be responsible for informing the doctor: '*escalate it to the TL and… the TL and medico can discuss.*' (P 7, P). These paediatric nurses typically did not have continuity of care for a child/family due to shift work and variable client allocation, and so 'handing over' their concerns was considered an important strategy in responding to abuse and neglect.

Unfortunately, the act of 'handing over' information meant information flow was one-way, with paediatric nurses frequently excluded from decision-making. For example, Participant 13 (P) explained that a lack of ongoing involvement meant decisions could seem erratic: '*we don't see what else happens behind the scenes and how a decision can go from one extreme to the next, and then we're discharging the baby into this mum's care [when she] hasn't even been able to see the baby for the week.*' Furthermore, paediatric nurses often did not know how cases were handled once they reported to a manager or child protection: '*Usually [nursing staff] leave it in the [nurse manager's] hands… but I'm not sure how she escalates that*' (P13, P), and '*I would think they have social workers and a connection with the outside entity so perhaps it does get escalated further*' (P 21, P). Sometimes, paediatric nurses felt once concerns had been reported to child protection services, there was nothing further they could contribute: '*as a nurse, what more can you do?*' (P 4, P)

Conversely, in child health settings, nurses reported a more proactive and hands-on approach to managing and escalating concerns about child abuse. Instead of being excluded after reporting their concerns, nurses often continued to be involved with the family and are included in decisions

made about the child/family. Nurses in these settings typically had awareness and access to escalation procedures if they were dissatisfied with the response to the child (P 10, 11, 12, 20, 22). The options for escalation of concerns initially involved discussing cases in formal case review meetings, or speaking with their manager. The manager could then escalate concerns to more senior staff within the organisation. One nurse explained this could go all the way to the Minister for Child Protection: '*it can go all the way up to the Minister if we feel strongly enough about lack of action*' (P 12, CH). Unlike the paediatric hospital setting, in child health settings, nurses were frequently involved with families on an ongoing basis and so managers would discuss possible options to support the family and/or provide feedback about the outcomes when concerns about inadequate responses were escalated.

Fear of making mistakes: 'You'd be sacked probably'

All participants were acutely aware of negative consequences of child abuse and neglect; this included harm to children, as well as harm to professional reputations and employment prospects. For this reason, many nurses (n=11) were worried about making a mistake or missing signs of abuse. This was demonstrated by Participant 2 (P) who upon hearing a news story of a local case of child abuse wondered: *''did I ever nurse these girls?' I want to know who they are so I can look up whether I've ever nursed them and I've missed this.'* Nurses explained that although they may have concerns about many different families, it was difficult to predict which of these children may become the next news headline: *'you think 'am I going to see this on the news that the children have been… violently harmed''* (P 15, CH). Participant 9 (CH) expressed sympathy for professionals who had been implicated in high profile cases: *'that's the thing I disliked about the press, that whole 'get her, blame her'. I'm thinking 'why? One day you'll make a bad decision too and be out there.'*

Nurses felt it was important to prevent professional consequences should children come to harm despite nurses' interventions. For example, nurses frequently alluded to the importance of following organisational policies and protocols: *'if you… never bothered to follow the specific referral pathways then, I don't know what would happen to you, you'd be sacked probably'* (P20, CH). Unfortunately, it was not always possible to follow policies. This could be due to lack of clarity: '*you question [organisation] about [the policy], it's 'oh well… we're not quite sure yet; it's still a work in progress'* (P4, P) or lack of resources: '*if we actually followed that procedure to the*

179

letter… I think that'd be a fulltime job for at least five people' (P6, P). Many participants (n=7) emphasised the importance of documentation, including as a strategy to prevent accusations of poor practice through a lasting record of the nurse's decision making. For example, Participant 11 (CH) explained '*if it is going to go anywhere… those [case]notes are going to be pulled [to] write a report at least, if not go to court'* and Participant 22 (CH) '*if it goes to something terrible like a coroner, that documentation is critical.'* Thus nurses had the dual responsibility of protecting their own professional reputation as well as children's safety and wellbeing.

In the context of unpredictable outcomes, nurses often sought or provided validation and confirmation of assessments and decisions. For example, through getting a second opinion: '*you should certainly be discussing concerns with somebody and maybe getting another opinion as to how you should address it'* (P4, P) or to confirm they had been thorough: '*sometimes you can't do anything… you've tried all your avenues and you just wanna feel and hear that there was no more that could be possibly be done'* (P15, CH). Participant 18 (P) felt it was important to validate her concerns to prevent false allegations: '*sometimes it takes a fresh set of eyes and ears to either disagree with you and tell you why they're disagreeing, or agree with you coz… you've got that suspicion and then that's all you can think about and you don't see past that'*. Some nurses (n=3) had trusted family members or colleagues with whom they would discuss concerns and were not always the organisation's officially designated person. For example, Participant 11 (CH) did not find the designated child protection nurse in her workplace useful: '*some of them have never even done family home visiting,'* but instead she valued the knowledge of another nurse in her area.

While discussions with colleagues could help identify different perspectives, they could also lead to disagreement around whether concerns about were valid. Nonetheless, when nurses felt strongly about a child's wellbeing, they would intervene without gaining validation. For example, Participant 18 (P) pointed out a child's unexplained bruising and subdued behaviour as potential signs of abuse to the treating doctor. The doctor disagreed with Participant 18's assessment: *'he [doctor] was kind of like 'oh no' [it's not abuse]''* and so Participant 18 reported her concerns to child protection services without the doctor's consensus.

Inflexible systems: 'We're not allowed to'

Nurses consistently reported that at system and organisational levels, processes were not organised to effectively keep children safe. For example, Participant 7 (P) outlined how documentation took away from nurses' time providing patient care: *'a child gets admitted… they're only there for… not even 24 hours, and have a six-page admission process.'* Similarly, Participant 19 (CH) worked with a socially-isolated mother who did not have access to transport to attend group parenting activities: *'it would be good to have… baby car seats back in [work] cars and permission to take the mums without having to go through Fort Knox'.* This shows that systems and processes intended to promote children's safety could also form barriers in meeting families' needs. In the same way, expectations around what nurses could achieve in a short time frames could be unrealistic: *'you have got [health service] KPIs (Key Performance Indicators) to make, you've got questionnaires to complete, you've got [baby's] weight so how do you manage… that one hour… well, you can't'* (P 20, CH). Although systemic issues are outside the influence of an individual nurse, changes in the way individuals act within the system could make a difference for some clients. For example, Participant 7 (P) identified that some professionals do not individualise their approach and render their interventions ineffective: *'their response… didn't take into context the fact that she [mother] couldn't afford a certain [infant] formula…. it was just a waste of everybody's time.'*

Another issue described by nurses was that services for children and families did not always link, and there could be duplication and poor coordination: *'everybody just does their own little bit rather than communicating together'* (P 4, P). Participant 7 (P) further elaborated: *'I think we all work in little silos; NGOs (Non-Government Organisations), education, children's services, obstetrics and gynae services, special care nursery to children in the same hospital… we have all sorts of pockets.'* This was perceived as problematic because clients did not necessarily receive a well-organised service as Participant 10 (CH) explained: *'there tends to be a bit of a scattergun approach… you might have, for one client, six different services involved all doing a little bit the same but a different focus. It just gets confusing for everyone involved.'* This approach of working in silos was similarly reflected when Participant 8 (C) attended a medical appointment with a family: *'It was me who said 'I think she [child] needs a referral to the child development unit' and he [doctor] said 'well, that's not my job; it's a different department.'* In other instances, there were no services available for certain clients. For example, Participant 8 (C) had difficulty identifying

relevant services for school-aged children: *'once someone starts school all of that drops off and there's nothing.'* This lack of services was often exacerbated by rural or remote location (P 1, 12, 14).

This siloed approach seemed to be reinforced by the different models of care that underpinned hospital (biomedical) versus community care (primary health care). Participant 17 who has worked in both child health and paediatrics explained that: *'[Child and family health] is very much about that, really needing to get that intimate knowledge from [families] about finances, and relationships and genetic history and family tree and it's about actually trying to create a relationship… **not a lot of that is needed in the hospital situation**.'* The perception that holistic information about a family is 'not needed' in the hospital setting reflects the model of care underlying acute care where medical issues are given priority over social determinants of health even though there is an interplay between both. Participant 13 (P) similarly reflected the view that addressing social determinants of health was not part of her role as a paediatric nurse: *'when you hear every time there's these social issues… everyone's like 'oh again?'* However, some paediatric nurses disagreed with this perspective (P 2, 7), with Participant 2 (P) explaining that: *'nurses in general don't see the psychological wellbeing of the child as part of their job, but it actually intertwines every aspect of their job'* while Participant 7 (P) lamented her observation that addressing social issues could be perceived as a burden by paediatric nurses: *'it's almost like that's not… glamorous enough… it's just [seen as] an additional burden.'*

Discussion

This study presented nurses' perceptions of how systems and hierarchies influenced their responses to child abuse and neglect. Nurses experienced difficulties accessing information about children, fear of making mistakes and inflexible systems which reduced their capacity to address child abuse. Socially constructed roles and institutions, such as nurses roles within healthcare organisations, are constructed and inherited from previous generations, and maintained through collective social interactions (Gergen, 2015). These socially constructed roles and institutions influence how nurses interpret and interact with their environments as they respond to child abuse and neglect. These influences may be taken for granted by nurses because they constitute the subjective reality in which nurses live and work (Burr, 2015). While social institutions form frameworks and structures for nurses and other social actors, the social institutions themselves

are maintained and gradually changed through the daily practices of social actors (Burr, 2015). This theoretical positioning forms a lens through which we can understand how nurses perceive their roles in responding to child abuse are shaped by the systems in which they work.

One way that socially constructed roles and institutions influenced nurses' practice is through the philosophy underpinning care in their organisation or setting. This philosophy of care plays out in nurses' daily practices and is continually being constructed and reconstructed through the interactions and practices of social actors (Gergen, 2015) such as nurses, other health professionals and clients. In the hospital setting, there is a narrow biomedical focus on physical illness, while in community settings, there may be a broader focus on how social and physical environments interact with the individual (Talbot & Verrinder, 2018). Given that child abuse and neglect has many complex contributing factors such as poverty, deprivation and inequality (Bywaters et al., 2016; Featherstone et al., 2017), a biomedical approach cannot comprehensively prevent and mitigate the impacts of child abuse. Specifically, a biomedical approach lacks a broader focus on the social and economic conditions that make child abuse and neglect more likely (Baum, 2015). It could be argued that the approach of addressing child abuse and neglect using a biomedical lens continues '*reinforcing aspects of the status quo*' (Baum, 2015) and lends legitimacy to the claims of some paediatric nurses (P13, 17, 18, 21) that addressing social determinants of health is not their responsibility.

Social roles and practices meant there could be negative professional consequences should a child experience severe harm from abuse or neglect. Nurses were aware they might come under public scrutiny and implemented strategies to mitigate the risk of public criticism, such as following policies, documentation and consultation with colleagues. However, following policies was not always possible, with some policies experienced as unrealistic or unachievable (P 4, 6, 10, 20). This represents a culture of rule-following, whereby a disproportionate focus on failures within the child protection system has led to an emphasis on proceduralism and legalism whilst devaluing clinical judgement and relationship-based practice (Lonne & Parton, 2014). Good practice subsequently becomes constructed as actions that adhere to policy, rather than necessarily helping the child (Lonne & Parton, 2014). However, the practice of following policies without a broader understanding of their context and application does not necessarily protect children (Munro, 2011).

Although participants worked within organisations that framed children's well-being as a core goal, nurses perceived that approaches to care were not always child-centred. This was demonstrated when nurses reflected on specific examples of how organisational cultures and policies were enacted in ways that did not maintain a child-centred approach. For example, Participant 7 (P) recalled a situation where health professionals recommended infant formula that a mother could not afford, while Participant 8 (C) encountered a doctor who claimed that providing referrals was not their responsibility. It is possible that the health professionals described by Participants 7 and 8 were following policies and/or locally accepted practices, but they were not taking a child-centred approach. Thus, while socially constructed systems and hierarchies invariably influence the opportunities available to health professionals responding to child abuse, it is important to consider how uncritically following rules may overshadow meeting children's actual needs (Lines et al., 2017; Munro, 2018).

The implementation of policies and guidelines alone do not result in positive changes for children. This was demonstrated in participants' experiences of the enactment of local Information Sharing Guidelines (ISG). Failure to adequately share information has been a key factor in many child deaths from abuse and neglect in Australia and worldwide (Keeley et al., 2015). Most (n=19) participants practiced in the state of South Australia where the ISG were released in 2014 (2 years before data collection) and apply to all government services and non-government organisations with government contracts (OmbudsmanSA, 2014). The ISG are intended to '*provide a mechanism for information sharing when it is believed a person is at risk of harm*' (OmbudsmanSA, 2014). Despite the positive intentions of this initiative, nurses in this study (n=12) still experienced poor information sharing within their organisation and between government organisations. Some also experienced challenges interpreting or applying the ISG (n=3). Notably, the ISG is not mandatory for private organisations – such as medical clinics – who may also hold key information about a child's safety. Instead, both public and private institutions providing services to children are governed by a complex array of national and state-based legislation, many of which differ in terms of what can be shared with whom, and under what circumstances (Adams & Lee-Jones, 2017). Similarly, while organisational structures and policies provide a mechanism for information sharing, Keeley et al. (2015) identified that interagency trust and social networks were key factors in enabling information sharing. Conversely, the presence of a risk averse culture discouraged

information sharing due to staff anxieties about potential complaints from clients or legal action (Keeley et al., 2015). According to Munro (2011), there is no truly risk-averse practice, just risk shifting - and in the situation of poor information sharing, professionals are simply shifting risk back onto vulnerable children. Thus, introduction of policies is not a fail-safe way to promote children's safety and wellbeing but needs to be supported with culture change that allows professionals to work together locally and across agencies.

Foucault argues that institutions actively monitor and discipline their members to promote efficiency and maintain social order (Foucault, 1995). Individuals who do not conform to the prescribed norm may be punished. This understanding of institutions as constantly monitoring and disciplining their staff could be one explanation for why professionals working with children may take a 'rule-centred' rather than child-centred approach. Organisations have policies and procedures around how to respond to child abuse which outline the norms of behaviour; deviation from these norms may be punished through formal and informal sanctions. For example, Taylor, Smith, et al. (2016) described a situation whereby a nurse disclosed concerns about potential child harm to her supervisor, who responded by asking whether the nurse had completed her documentation. This sends the covert message that the task of documentation is more important than responding to children's immediate needs. In this way, compliance with policies and procedures can be reinforced to staff through covert organisational messages, such as managers' responses to incidents (Munro, 2011). Consequently, institutional practices that reinforce absolute compliance with policy may encourage professionals to take a rule-centred rather than child-centred approach.

When faced with institutional practices that promote rule following at all costs, health professionals need to use critical-thinking and judgement when enacting policies to ensure they achieve the goal of promoting children's safety and well-being. This requires organisational and systemic cultural change rather than policy change alone. The implementation of new or revamped policies of itself cannot change the underlying rule-centred approach that is maintained by social practices within these institutions. To effectively change the culture of uncritically following rules, attention must be given to the extent that individuals are rewarded and/or sanctioned by institutions for following rules at the expense of taking a child-centred approach. Instead, flexible and creative thinking that maintains a child-centred approach needs to be

encouraged and rewarded whereby professionals are supported to reflect on and learn from practice rather than being punished or blamed for potentially unpredictable outcomes (Munro, 2018)

Conclusions

Nurses work within institutions and systems that are legally and/or ethically obliged to prevent and respond to child abuse and neglect. These institutions shape nurses' practices by influencing the opportunities available to nurses whilst also enforcing certain constraints. Nurses perceived that these institutions, systems and hierarchies had significant impact on their capacity to prevent and respond to child abuse. Notably, nurses reported a risk-averse culture that promoted a rigid, rule-centred approach rather than enacting an explicit child-centred approach. Systems and organisational cultures that are risk-averse and rule-centred make it difficult to listen to children and place their needs first and foremost. Now that we understand how nurses perceive the systems and hierarchies as shaping their practice, we can act to promote change. At the individual level, nurses need to be critical thinkers and reflectors to continually evaluate how their decisions and practices uphold a child-centred approach. However, given the role of institutions in governing professionals' behaviour, this needs to be underpinned with leadership which reconstructs organisational and systemic cultures to promote and support an authentic child-centred approach.

Chapter Summary

Chapters four to eight have outlined the key findings which were the four main themes from the study and their associated subthemes. Together, these four themes demonstrated the complexity of nurses' perceptions and experiences of keeping children safe from abuse and neglect as 'more than mandatory reporting'. The findings also highlighted many challenges nurses face when working in this field. In the next chapter, key findings will be discussed to show how they are interconnected what this means for the nursing profession as they participate in a whole of community approach to keeping children safe.

CHAPTER 9: DISCUSSION

Chapter nine provides an overall summary of the findings arising from research that explored nurses' perceptions and experiences of keeping children safe from abuse and neglect. The key findings outlined in chapters four to eight will be critiqued and discussed using a social constructionist framework to explore what this means for the nursing profession now and moving forward in their role of keeping children safe. Given the multi-disciplinary nature of keeping children safe, the discussion will outline what this research means for all organisations that nurses work for and interact with when preventing and responding to child abuse and neglect. Key recommendations for practice change, nurse education and organisational culture are also highlighted. Finally, the chapter closes with overall conclusions and how the findings contribute to the broader picture of child abuse and neglect.

Summary of key findings and contributions from this research

This thesis presents unique empirical research that explored perceptions and experiences of nurses who work with children about how they keep children safe from abuse and neglect. Research in Australia and internationally shows that nurses are frequently involved in prevention and intervention for child abuse and neglect (Lines et al., 2018). However, nurses may lack confidence in their role which has remained largely invisible in existing literature (Lines et al., 2017). This study provided insights into how nurses who work with children in Australia understand their role in keeping children safe. Data was collected through interviews with twenty-one registered nurses who work with children in Australia. Analysis of data was conducted through the lens of social constructionism (Burr, 2015) and the concept of 'disciplinary power' within institutions (Foucault, 1995). This facilitated an understanding of how complex and interrelated socially constructed conceptualisations of child abuse and neglect led to specific social actions. The concept of disciplinary power also provided a lens to understand how nurses perceive hierarchical structures as influencing their capacity to respond to vulnerable children. Overall, this thesis contributed to new knowledge by demonstrating that nurses see responding to child abuse and neglect as an important part of their practice but faced many challenges in doing so. Namely, keeping children safe is complex and requires the application of high-level decision-making and communication skills in contexts of uncertainty. All of this occurs within hierarchical organisations

and systems that do not place children at the centre of care and inhibit nurses' capacity to respond. These findings are now discussed to explore what opportunities they offer for leveraging and supporting the nursing profession to promote better outcomes for vulnerable children in Australia. Please refer to Figure 3: Visual representation of data synthesis in Chapter 4 (p. 117).

Discussion point 1: Recognising and supporting nurses' invisible knowledge, attitudes and skills

As part of a whole-of-community approach, nurses have an important role in prevention, early intervention and mitigating impacts of child abuse (Lines et al., 2018). This thesis demonstrated that preventing and responding to child abuse and neglect involves highly complex knowledge and skills underpinned by specific attitudes, values and beliefs (Lines, Grant, & Hutton, 2020a). These skills are enacted within complex and dynamic situations where information may be missing or ambiguous (Lines et al., 2020a). Despite the array and complexity of nurses' skills identified through this study, nurses' specific skills to date have been largely invisible within research literature and public policy (Peckover & Appleton, 2019). When nurses' skills have been recognised, they are often devalued as 'softer' skills in comparison with the technical skills privileged by biomedical healthcare systems (Aston et al., 2015). As such, working within this biomedical model of care maintains the status quo of devaluing and obscure nurses' complex roles in addressing child abuse and neglect.

Given the complexity of nurses' skills, and the dynamic and unpredictable situations in which they are enacted, this could explain why many nurses feel underprepared to keep children safe (Lines et al., 2017). Although nurses may attend education or training, many educational/training approaches emphasise factual knowledge (Walsh, 2019), whereas participants in this study identified skills and attitudes that were not purely fact or knowledge based. For example, nurses described the need for high-level communication, relationship building and decision-making skills as they worked to 'balance engagement and disengagement' (Appendix 19). Similarly, nurses enacted an 'ability and willingness to tactfully discuss concerns with parents' (Appendix 19). Thus, if nurses are to respond to child abuse and neglect in a meaningful way, the complexity of their knowledge and skills needs to be acknowledged, valued and supported. For existing nurses, this could involve supporting them to develop critical thinking skills and confidence to apply their knowledge to complex situations, along with opportunities continually reflect on and develop their practice.

Critical thinking is an essential attribute because nurses are frequently required to make quick decisions in complex and diverse health settings (Candela, 2015). In child protection, decisions generally involve uncertainty and ambiguity and so require the application of critical thinking skills (Munro, 2018). Critical thinking does not have a consistent definition (Westerdahl, Carlson, Wennick, & Borglin, 2020), but is understood to underpin clinical judgement and decision-making, all of which have implications for client safety (Manetti, 2019; Von Colln-Appling & Giuliano, 2017). When nurses have critical thinking skills, they can make decisions based on multiple sources of information including context specific factors (Rohde & Domm, 2017). However, evidence for effective ways to teach and measure critical thinking skills in nursing is limited, and existing research involves small sample sizes and short time frames (Manetti, 2019; Von Colln-Appling & Giuliano, 2017). Furthermore, direct links between nurses' critical thinking skills and client outcomes have not been established (Zuriguel Perez et al., 2015). Additional research is needed to firstly assess whether nurse critical thinking skills can influence outcomes for vulnerable children, and if so, what strategies can effectively equip nurses with these skills.

This study has begun to identify knowledge, skills and attitudes that nurses working with children use to respond to child abuse and neglect in Australia. Participants were from a small sample (n=21) of nurses from three practice settings (paediatric, child health and community). As such, it may not be representative of the full range of knowledge, skills and attitudes enacted by nurses across all settings in Australia. To provide nurses with the most relevant education, preparation and support, we need further research that comprehensively explores the range of necessary knowledge, skills and attitudes. Once the scope of nurses' safeguarding skills, knowledge and attitudes is clear, we can implement tailored educational interventions that build capacity within the nursing workforce to effectively prevent and respond to child abuse and neglect. At present, an additional challenge lies in the lack of consistency across Australia in education and training for health professionals about safeguarding children (Grant et al., 2018; Parry, Maio-Taddeo, Arnold, & Nayda, 2009). A clearer picture of nurse knowledge, skills and attitudes for responding to child abuse and neglect would provide an evidence-based from which consistent educational approaches could be developed. However, given the limited research linking professional

education or training with measurable outcomes for children (Walsh, 2019), any educational intervention must be underpinned by quality, long-term evaluation.

Discussion point 2: Developing clarity and visibility of nurses' expected roles in safeguarding

In the United Kingdom, the scope of nurses' work in keeping children safe has been referred to as 'safeguarding'. Safeguarding encompasses the promotion of the welfare of all children in society through to statutory child protection responses for children at risk of severe harm (Her Majesty's Government, 2018; Peckover & Appleton, 2019). Although health professionals have a 'critical role to play in safeguarding and promoting the welfare of children' (Her Majesty's Government, 2018), the specific role of nurses within safeguarding has not been comprehensively outlined nor critically examined (Peckover & Appleton, 2019). For example, in the UK, there is only one document that provides a detailed explanation of nurses' roles in safeguarding (Peckover & Appleton, 2019), and this document applies only to health visitors and school nurses working within the 'Healthy Child Programme' (Department of Health, 2012). As such, it does not outline nursing practice in other settings, and a definition of nursing roles in safeguarding remains unclear and ambiguous. Although there is some albeit limited explanation of nursing roles in safeguarding in the UK, there is no equivalent definition in the Australian context.

Within a public health approach, the term 'safeguarding' can be used to outline the responsibilities of specific such as health professionals, so expectations are clear and shared by everyone. The change from responding to individual cases of child abuse and neglect towards a broader safeguarding, or public health approach, was first proposed by the Australian Government in 2009. For example, the National Framework for Protecting Australia's Children 2009-2020 states that: 'Australia needs to move from seeing 'protecting children' merely as a response to abuse and neglect to one of promoting the safety and wellbeing of children' (Council of Australian Governments, 2009). Although a public health approach is defined and discussed within relevant Australian policy documents, the specific term 'safeguarding' is not used prior to 2016. From 2016 onwards, some documents intermittently use the term safeguarding (2-3 times) but do not define it (see for example Australian Human Rights Commission, 2018; Department for Child Protection, 2020; Victoria State Government, 2016). This absence of a definition for safeguarding means it is unclear how safeguarding should be applied and enacted by health and welfare professionals in Australia.

In contrast to the absence of a clear definition of safeguarding in Australia, there are specific legislative and professional standards that designate all nurses as mandated reporters of child abuse and neglect in Australia (see for example Government of South Australia: Attorney-General's Department, 2017; Nursing and Midwifery Board of Australia, 2018). Mandatory reporting is important, but an emphasis on this aspect of nurses' roles perpetuates the focus on responding to individual cases. In the absence of a safeguarding context, mandatory reporting guidelines serve to detract from the rhetoric that child protection is 'everyone's business' (Council of Australian Governments, 2009) by reinforcing the idea that child protection services (CPS) should be solely responsible for keeping children safe. One way to address this imbalance could be to implement explicit definitions and expectations of safeguarding for health professionals, including nurses. For example, in the UK, there are specific safeguarding guidelines that apply to all 'individuals who work with children and young people in any capacity' (Her Majesty's Government, 2018, p. 5), thus helping to reinforce safeguarding roles as more than simply reporting abuse. Furthermore, this explicit safeguarding guidance for health professionals in the UK facilitates collaboration and shared responsibility for children across the separate organisations that provide child protection services and health care.

In Australia, there are no comparable guidelines for health professionals that explicitly outline their safeguarding responsibilities. Nevertheless, some professional guidelines and standards for nurses already encompass activities that could be considered safeguarding – such as standards for specialist nurses working with children. For example, the Australian College of Children and Young People's Nurses (2016, p. 5) expects that nurses working with children 'support parents and caregivers in their parenting role', while the Maternal, Child and Family Health Nurses' (2017, p. 15) standards require nurses to 'support families to provide developmentally enriching experiences for their children in safe and secure environments'. Even though these examples represent safeguarding activities, they are not explicitly named as such.

The lack of explicitly defined safeguarding roles for nurses in Australian legislation and professional standards in the context of clearly defined mandatory reporting duties serves to reinforce narrow perceptions of nurses' roles. More specifically, it also gives scope for some nurses, such as participants in this (n=4 paediatric nurses) and other studies (see for example Crisp & Lister, 2006; Maddocks et al., 2010; Newman & Vasey, 2020) to claim that certain aspects of

safeguarding are not their responsibility. These attitudes risk undermining the effectiveness of contemporary approaches which require child protection to be not only 'everyone's business', but part of everyday practice (Parton & Williams, 2019). While this study demonstrated that nurses working with children in Australia undertake a variety of safeguarding activities, these actions are not clearly labelled and defined as such. Consequently, it is difficult to name, discuss and critique nurses' roles in safeguarding which are effectively invisible in Australian legislation and professional guidelines.

In the absence of explicit guidelines, it is unclear how the nursing profession more broadly perceives their role in safeguarding, or if they even believe they have a role. Furthermore, some activities nurses undertake with the intent of safeguarding may not improve children's lives. For example, in the prologue I highlighted a situation in which a paediatric nurse berated a mother because her baby appeared dirty and unkempt. It is possible this paediatric nurse believed her actions were safeguarding by bringing the baby's needs to the mother's attention. In actuality, the nurse's actions drove the mother away and left the baby alone in hospital. The underlying reasons for his condition could then remain hidden, unexplored and unaddressed. As such, there is a need to critically examine practices that nurses believe are safeguarding and what impact these have on children and families. At the practice level, this could include ongoing critical reflection by nurses individually and with their colleagues to examine their practice and explore whether they are facilitating positive outcomes for children.

Discussion point 3: Enhancing interprofessional communication and collaboration

Barriers to communication and collaboration were major challenges for nurses working to keep children safe from abuse and neglect. Perceptions of not being heard, valued or included compounded by a lack of feedback from CPS were significant concerns (Lines, Hutton, & Grant, under review). As discussed in Chapter 8, this could stem from the socially constructed roles of the nursing profession originating from 'helpers' of doctors. Remnants of this view persist, with nurses' caring work conceptualised as 'women's work', and valued less highly than the 'curing' work of doctors (Treiber & Jones, 2015). The hierarchical health care system perpetuates nurses' subordinate roles through ongoing socialisation into nursing roles and identities (Roberts, 2006; Ward, 2009). As a result, nurses' views may be given less weight than those of other professionals (Lines et al., 2020b).

Nurses can feel disheartened and powerless when their concerns about children's safety are dismissed (McTavish et al., 2017; Sigad et al., 2019). Furthermore, a lack of effective communication and collaboration between professionals can result in children and families receiving disjointed services that do not meet their needs (Gui, Chen, & Pine, 2018; Harvey, Hornsby, & Sattar, 2015; Milaney, Lockerbie, Fang, & Ramage, 2019). Poor information sharing and working together for the best interests of children has been highlighted as a major barrier in effectively responding to child abuse and neglect (Basheer, 2019; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017). One possible strategy to improve communication and collaboration between different professionals includes the implementation of 'partnership working', like in the UK. Partnership working has not been clearly defined, but broadly refers to working collaboratively across organisational boundaries to achieve jointly agreed aims (Cook, 2015). In the context of safeguarding, this means organisations must move from working independently towards cooperation to achieve jointly agreed child-centred goals (Her Majesty's Government, 2018).

In Australia, action has already been taken to improve the way services work together; such actions include implementation and/or updating of information sharing guidelines for vulnerable children. Nevertheless, nurses in this study did not consistently find information sharing guidelines useful (Lines et al., 2020b), and it is unknown whether information sharing guidelines have resulted in measurable outcomes for children. Rapid changes in child protection systems and processes in Australian have provided little opportunity for robust evaluations (Herbert & Bronfield, 2017). Despite extensive searching, evaluations of Australian interventions to promote information sharing and multi-agency working provided limited evidence of measurable outcomes for children. The outcomes that were available were mainly in the form of qualitative evaluation from clients, professionals and other stakeholders (see for example Allen Consulting Group, 2011; Marshall, Ziersch, & Hudson, 2008; Northern Territory Government, 2017). Furthermore, extrapolation from similar initiatives in other countries are unlikely to be valid due to vastly different legal, welfare and healthcare systems (Cleaver, Maras, Oram, & MacCallum, 2019). Further research is needed in the Australian context to explore which interventions and initiatives might produce measurable outcomes for vulnerable children so resources can be invested effectively.

Child protection reform is underway in Australia prompted by multiple inquiries, namely the Child Protection Systems Royal Commission Report (2016) and the Royal Commission into Institutional Responses to Child Sexual Abuse (2017). System level child protection reforms are important, but on their own are generally insufficient to produce local practice level change (Turnell, Munro, & Murphy, 2013; Venables, 2019). Criticisms of previous child protection reforms in Australia include lack of investment in workforce development or building an evidence base for interventions, producing a 'yawning gap between policy requirements and day-to-day practice' (Basheer, 2019; Nyland, 2016). There are many local factors that can prevent policy enactment in daily practice so ongoing evaluation and local adaptations are imperative to ensure reforms achieve their goals.

One such local factor is poor interorganisational collaboration; this is a problem that impedes responses to child abuse and neglect internationally. Known challenges to interorganisational collaboration include risk averse cultures and barriers to interprofessional communication (Nyland, 2016). For example, Keeley et al. (2015) identified that a risk averse culture and fear of breaching confidentiality were overriding reasons to avoid sharing information about vulnerable children. Similarly, barriers to interdisciplinary communication arise because all professionals have different educational preparation, professional experiences and ideological views (Nyland, 2016; Tchernegovski et al., 2017). Consequently, there is a need to develop a shared understanding and approach amongst all professions who work with children (Fox et al., 2015). In this way, professionals can use the same language and ways of working to more effectively collaborate to achieve shared outcomes for vulnerable children (Grant et al., 2018). This will require on-going investment and commitment to preparing and developing the workforce of all professionals who work with children.

Discussion point 4: Critiquing and moving beyond compliance cultures

Socially constructed organisations, professional hierarchies and philosophies of care had a significant influence on nurses' responses to child abuse and neglect. Although the aim of health and welfare organisations is to promote the interests of those they serve, nurses' experiences suggested these aims were not always achieved. For example, organisational policies and procedures did not necessarily improve children's safety and wellbeing, while a culture of following rules meant policies and procedures were often applied uncritically without consideration of their intended outcomes (Lines et al., 2020b). Furthermore, the biomedical model

194

of healthcare typically employed in Western health contexts meant there was a greater focus on physical health, while social determinants that contributed to child abuse and neglect were ignored or given lower priority. Overall, nurses perceived that systems and hierarchies could inhibit their capacity to keep children safe from abuse and neglect if applied indiscriminately and without flexibility.

Procedural compliance in the name of keeping children safe is not unique to this study. In 2009, Parton outlined that ensuring systems and services are sensitive and responsive to children is our 'biggest challenge'. This was later supported by Munro's (2011) review of child protection systems in the UK which concluded that we need to move from compliance towards a system that is truly child-centred and responsive. More recent studies indicate procedural compliance is an ongoing issue in the UK (see for example Gibson, 2016; Leigh, 2017a, 2017b, 2019; Smith, Cree, et al., 2017). The tendency for child protection systems to become compliance focussed is not limited to the UK, but has been identified in other countries including Kenya (Cooper, 2012), New Zealand (Ministry of Social Development, 2016; Smith, 2011) and Australia (Harrison, Harries, & Liddiard, 2014; Lonne & Parton, 2014; Munro & Fish, 2015). The lack of focus on children can happen when adherence to legislation is used to 'eschew authentic responsibility for children's well-being' (Cooper, 2012), or as a false sense of security that children are being protected (Stanley & Russell, 2014). Overreliance on policy can also arise from good intentions, such as when policies meant to maintain procedural fairness begin to overshadow children's needs and wishes (James & Lane, 2018). The complexity lies within balancing policies that exist to protect vulnerable children with the enactment of a child-centred approach in highly complex and changing situations (James & Lane, 2018).

It seems that making the system more 'child-centred' at the frontline is not a consistent or explicit priority in current Australian child protection reforms. For example, the original National Framework for Protecting Australia's Children 2009-2020 (Council of Australian Governments, 2009) does not outline the need for system-wide reform to increase child-centredness. The Third Action Plan begins to outline the importance of a 'child-centred' approach, but uses inconsistent language to refer to this concept (for example child safe culture, child safe environment, child friendly, child safe, child aware) and does not define these terms (Council of Australian Governments, 2015). Furthermore, the language and key priorities of the current Fourth Action

Plan 2018-2020 do not continue the aim of making systems more child-centred, although it does outline the implementation of the *National Principles for Child Safe Organisations* (Australian Human Rights Commission, 2018; Council of Australian Governments, 2018) developed under the Third Action Plan.

The National Principles for Child Safe Organisations (National Principles) were developed in response to recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse to 'provide a nationally consistent approach to embedding child safe cultures within institutions that engage with children' (Australian Human Rights Commission, 2018). As a result, the National Principles are part of a broader strategy to prevent and respond to child abuse within institutions rather than taking a comprehensive societal approach to safeguarding children. The National Principles make important steps towards safeguarding children within Australian institutions, such as implementing a learning culture where staff are encouraged to learn from good practice (Australian Human Rights Commission, 2018, p. 3). However, key terms such as a 'child safe culture' and 'child-centred' are still not defined, leaving them open to interpretation. Furthermore, some concepts seem to perpetuate a compliance culture, such as the expectation that leaders should 'champion and model compliance with policies and procedures' and the requirement for audits that 'provide evidence of how the organisation is child safe' (Australian Human Rights Commission, 2018, p. 18). This is problematic because as Munro and Fish (2015) highlighted, simply following procedures does not protect children. Consequently, the same organisational culture of following rules rather than responding to children's needs is likely to persist if not explicitly addressed.

Possible strategies to address the widespread culture of uncritically following procedures have been proposed. This includes promoting organisational cultures that recognise adverse outcomes still occur even when professionals make responsible and informed decisions (Munro, 2018; Race & O'Keefe, 2017). In the current risk-averse system, individuals become scapegoats for broader problems which obscures the complexity and interplay of contributing factors (Woods, Dekker, Cook, Johannesen, & Sarter, 2010). Instead of perpetuating a system that unfairly scapegoats individuals without addressing underlying systemic problems, professionals need confidence that they will be judged by reasonable standards that take into account only information available at the time (Munro, 2018). Professionals need to build a child-centred culture which focuses on the

quality of decision-making within dynamic therapeutic relationships with families rather than rigid systems that cannot account for all possible situations (Parton, 2009). For example, there is emerging evidence that relationship-based approaches are especially effective in engaging Aboriginal families who are overrepresented in Australian CPS (Cortis, Smyth, Wade, & Katz, 2018; McAuliffe et al., 2016).

Child protection reforms can provide new structures and opportunities for the ways professionals keep children safe. However, the most difficult work lies in changing the way professionals enact these policies within their daily practice (Turnell et al., 2013). In the hierarchical structure of child protection systems, managers and supervisors are 'keepers of culture', meaning their actions and interactions set 'group norms' for the team (Venables, 2019). Some qualitative studies provide emerging evidence that leadership interventions can promote cultural change in organisations involved in safeguarding (Cortis et al., 2018; Stanley & Russell, 2014; Turnell et al., 2013; Venables, 2019). These interventions require leaders to establish and role model alternative values, such as being slow to assign blame (Turnell et al., 2013) and promoting a culture of learning (Stanley & Russell, 2014). Amidst reforms and flux in child protection systems in Australia, this is an opportune time to implement leadership that promotes child-centred cultures within organisations that have become increasingly compliance focussed over time.

At the level of individual professionals, such as nurses, there needs to be support to develop skills to enact child-centred approaches within changing organisational cultures. The enactment of a child-centred approach can be complex. For example, nurses within this study encountered other professionals who did not enact child-centred approaches, and nurses themselves reflected upon instances when they did not maintain a child-centred approach (Lines et al., 2020a, 2020b). This in part could be because enacting child-centred approaches in the context of complex and dynamic situations requires reflection on own values/beliefs, critical thinking and creative solutions (Munro, 2018). Child-centredness also requires that professionals make decisions based on their own judgements rather than relying solely on policy/procedures which do not cover all possibilities (Race & O'Keefe, 2017). If nurses are to develop these practices, they need confidence that they are supported by a leadership that models and promotes child-centred approaches to safeguarding.

Strengths and limitations

This study explored the perceptions and experiences of nursing working with children in Australia about how they keep children safe from abuse and neglect. There is limited existing research about the ways that nurses address child abuse and neglect, and only a small subset of this research was conducted in the Australian setting.

There are some limitations that must be considered when interpreting and applying the research findings. Firstly, the relatively small sample size (n=21) of nurses primarily from one Australian state means that transferability of the findings to other contexts is unclear. For example, nurses were from paediatric, child health and welfare-based community settings, and may have different experiences from nurses working in other child-specific settings like schools or mental health. Similarly, their experiences may not reflect nurses who encounter children in services that are not child-specific, such as services for adults who are also parents. However, data saturation was achieved (see Chapter 3) and there were broad similarities between the findings of this study and the wider literature relating to professionals and keeping children safe, suggesting that some transferability is likely.

The author's background as a paediatric registered nurse enhanced data collection by promoting an emic perspective stemming from shared disciplinary knowledge. This meant participants did not have to explain basic principles, such as the Australian healthcare system or child growth and development. However, because the author did not work directly with participants or necessarily have a strong knowledge of their unique practice settings, it was essential to ask participants for in-depth information of their roles within their organisations. The author perceived that these shared backgrounds promoted rapport without being so close to participants that automatic assumptions about their roles, perspectives and experiences.

Chapter Summary

In this chapter, the key findings from the research were summarised, critiqued and discussed using a social constructionist framework. The key points demonstrated the need for changes to nurse education, professional standards/guidelines, interprofessional education, government policy and

organisational culture across all organisations involved with children and young people. The next chapter provides an overall summary of these points and highlights proposed changes so the nursing profession can be effectively mobilised to improve outcomes for children in Australia.

CHAPTER 10: SUMMARY AND RECOMMENDATIONS

Chapter 10 provides a final summary and rationale for recommendations arising from this research. Each recommendation is followed by an explanation and justification which identifies specific recommendations for future research, education, policy and practice.

Recommendation 1

Research is needed to highlight key nursing expertise for safeguarding children, followed by identification of effective ways to develop this expertise so it produces measurable change for children.

Nurses practice within specific sociocultural conditions that are maintained and gradually changed over time (Burr, 2015); these sociocultural conditions influence nurses' daily responses to child abuse and neglect. While people actively construct their social positions and identities, they are invariably influenced by their social environments (Gergen, 2015). For nurses, this includes the effects of public policy, organisational practices and families' socially constructed expectations. At this stage, nurses' specific roles in safeguarding are largely invisible which has implications for nurses' everyday practice such as allocation of time, support and resources for safeguarding work. Although this study has begun to identify how nurses working with children respond to child abuse and neglect, further research is needed to outline the full scope of knowledge, skills and attitudes that underpin nurses' work.

If there is a more comprehensive understanding of nurses' skills, nurses can be prepared and supported through ongoing professional development to improve and maintain these skills over time. One example of nurses' interventions that are invisible is in the area of mandatory notifications. According to the Australian Institute of Health and Welfare (2019), the category of 'medical/health personnel' comprises around 13 per cent of mandatory notifications of child abuse to Child Protection Services (CPS), but it is not reported how many were substantiated. It is also unclear how many 'medical/health personnel' were nurses, and so it is unknown how many nurses are making mandatory notifications or what the outcomes are for children. This information is needed to give visibility to nurses' safeguarding work. Access to information about the outcomes of notifications would also provide valuable feedback to nurses about the value of

their notifications, or alternatively the importance of implementing additional strategies to support children in the absence of a CPS response.

Mandatory reporting is one nursing role that is invisible in Australian Institute of Health and Welfare statistics, but nurses do much more to keep children safe. This study has demonstrated the application of relational, communication and decision-making skills in complex and dynamic situations to safeguard children. These skills are largely unrecognised so it is important to increase their visibility in government policy, organisational policy and professional guidelines. Official recognition of nursing expertise in safeguarding children is essential because it highlights the complexity of practices that nurses undertake and can justify investment in developing nurses' skills. Further research is needed to determine which approaches are most effective at equipping nurses to enact change for vulnerable children as there is currently limited evidence linking educational interventions with measurable changes in children's lives.

Recommendation 2

Policy documents and professional standards need to be amended to clearly outline expectations of safeguarding for different professional roles, including nurses, using the specific language of safeguarding.

If child protection in Australia is to become 'everyone's responsibility' through a public health approach (Council of Australian Governments, 2009), attention needs to be given to specific roles that nurses have in safeguarding. This study and many others (reviewed in Lines et al., 2018) show that nurses already promote the overarching health, safety and wellbeing of children, but these activities are not named and positioned as 'child protection' or safeguarding. 'Child protection' refers to protecting children at risk of serious harm (Her Majesty's Government, 2018), but many nursing interventions prevent or mitigate risks to children before they become child protection issues. The language of safeguarding is not widely or consistently used in Australian policy documents and professional standards meaning it is difficult to capture the safeguarding interventions that nurses and other professionals undertake. It is also unclear whether the nursing profession more widely believes it has a role in safeguarding, and what this role might be. There needs to be recognition of the broader safeguarding interventions of nurses who work with children, so nurses receive the appropriate recognition, time and support to enact these practices.

This will help nurses and their colleagues understand and articulate nurses' unique contributions so they can work together effectively to make a difference for vulnerable children.

Recommendation 3

Child protection reforms need to incorporate strategies to improve frontline interdisciplinary collaboration, followed up with evaluation of whether these strategies produce measurable change for children.

Child protection reform in Australia is moving towards a broader approach of preventing child abuse and neglect by supporting all children and families. However, it is not certain this will result in changes for children without the provision of support to frontline professionals, including nurses, to work collaboratively toward the best interests of children. Attention needs to be given to evaluating interventions that promote partnership working, including the experiences of frontline workers around how they perceive and enact partnership approaches. To facilitate interdisciplinary collaboration, there must be investment in workforce development to promote shared understandings, goals and ways of working with vulnerable children for all professionals working with children (Grant et al., 2018). Importantly, these strategies need to be followed with research to explore whether there are measurable outcomes for children, so time and resources are invested effectively.

Recommendation 4

System-wide cultural change is needed to promote and sustain child-centred practices across all organisations that work with children.

Nurses in this study recalled ways in which systems and organisations inhibited their capacity to enact change for children. In part, this was due to procedural compliance at the expense of a child-centred approach. Current child protection reforms partially acknowledge the importance of implementing child-centred approaches, but top-down reforms are insufficient to produce change for children. This has been consistently demonstrated by more than forty years of reforms (Turnell et al., 2013). For example, current organisational cultures promote compliance with procedures in the name of protecting children, but in doing so fail to keep a focus on the needs and wishes of children. Although system reform may provide institutional frameworks for daily practices, socially

constructed norms and practices within organisations that are maintained by collective social interactions (Gergen, 2015). Institutions regulate collectively agreed upon ways of acting through monitoring and disciplining individuals to conform to organisational norms (Foucault, 1995), such as strict procedural compliance.

Consequently, even if the structure of child protection systems is changed through reform, this does not necessarily change nurses' day-to-day social practices and collective ways of working. There needs to be change within the social interactions of the organisation that move from rewarding individuals who indiscriminately follow policy, to those who demonstrate judicious application of a child-centred approach. This change will require organisational leadership that rewards and supports nurses who enact child-centred approaches. Similarly, individual nurses need opportunities to develop and maintain child-centred practices, especially because consistently maintain child-centredness is complex and requires ongoing critical reflection (Lines et al., 2020a; Race & O'Keefe, 2017). Leadership and cultural change is needed not only for the nursing profession, but all professions working with children because of the multidisciplinary nature of safeguarding. System-wide cultural change is a huge undertaking, but this shift in thinking is necessary for systems and organisations to become genuinely child-centred and promote positive outcomes for children.

Concluding statement

This qualitative study explored the perceptions and experiences of Australian registered nurses working with children about their role in keeping children safe from abuse and neglect. A social constructionist lens underpinned the study to contextualise how broader social and cultural factors influenced nurses' perceived roles and experiences. Key findings demonstrated that nurses are actively involved in responding to child abuse and neglect and this required the enactment of specific attitudes, knowledge and skills. Nurses' practices were found to be strongly influenced by their personal and professional backgrounds, interprofessional relationships, family relationships and the systems and structures of health and welfare systems. At times, nurses were not cognisant of the influence of these factors which formed the structures of their daily realities, but nurses also articulated examples of how social and cultural factors impeded their capacity to respond to children. This study has provided important insights into areas for changes to nursing

education and practice, but also broader system wide responses to child abuse and neglect. Importantly, the complexity of nurses' practices highlights the need for greater education, support and recognition of nurses' roles in safeguarding. For this to be effective in enacting change for children, developments in the nursing profession need to be underpinned by widespread policy and system change. This includes greater interprofessional collaboration with shared goals and organisational cultures that reward professionals for working in a child-centred manner. Most importantly, these changes must be followed with robust evaluations to assess to what extent they are effective or can be adapted to produce positive outcomes for vulnerable children in Australia.

APPENDICES AND REFERENCES

Appendix 1 – Summary of studies included in literature review 1: integrative review: nurses' roles and experiences in keeping children safe

Appendix 2 – Critical appraisal of studies included in literature review 1: integrative review: nurses' roles and experiences in keeping children safe

Appendix 3 – Studies contributing to the major findings of literature review 1: integrative review: nurses' roles and experiences in keeping children safe

Appendix 4 - Summary of studies included in literature review 2: how do nurses keep children safe from abuse and neglect, and does it make a difference? A scoping review.

Appendix 5 – Summary of nurse effects on measures of abuse and neglect: literature review 2: how do nurses keep children safe from abuse and neglect, and does it make a difference? A scoping review

Appendix 6 – Summary of studies from literature August 2015 to present: literature review 1 (update)

Appendix 7 – Summary of studies from literature September 2017 to present: literature review 2 (update)

Appendix 8 – Example participant recruitment flyer

Appendix 9 – Letter of introduction

Appendix 10 – Information sheet for participants

Appendix 11 – Consent form for participants

Appendix 12 – Interview guide

Appendix 13 – Excerpt from researcher's reflective journal: reflection on interview one 2/08/2016 2-3:30pm

Appendix 14 - Examples of descriptive, process and holistic codes

Appendix 15 – Photographs of examples of initial manual arrangement and grouping of codes

Appendix 16 – Mind map of developing themes

Appendix 17 – Supplementary file: examples of initial coding and how they formed the final codes; Theme 1: Sociocultural contexts shaping nurses' perceptions of child abuse and neglect

Appendix 18 – Supplementary file: examples of initial coding and how they formed the final codes; Theme 2: 'How can we work together?': keeping children safe through therapeutic relationships

Appendix 19 – Characteristics and skills displayed by nurses to keep children safe

Appendix 20 - Supplementary file: examples of initial coding and how they formed the final codes; Theme 4: Systems and hierarchies shaping nurses' responses to child abuse and neglect

Appendix 1: Summary of studies included in literature review 1: Integrative review: nurses' roles and experiences in keeping children safe

Authors, Date & Location	Aim	Methodology, Methods & Participant Description	Findings
Europe			
Appleton et al. 2013 England	To examine health visitor assessments of mother-infant interactions.	Mixed-methods, questionnaires and video taping of mothers and infants (n=17), and then assessing health visitors' (n=12) responses to the videos of mother-infant interactions.	Health visitors did not have detailed theoretical knowledge of attachment theory and mother-infant relationships. There was large variability between the health visitors' assessment of the quality of mother-infant relationships. Health visitors used multiple sources of information to guide assessments but predominantly considered mothers' behaviours.
Appleton et al. 2008 England	To examine how health visitors make assessments in their daily practice.	Qualitative, case study design informed by constructivist methodology using observation and interviews with health visitors (n=15) and interviews with clients (n=53).	Health visitors emphasised importance of building relationships to enable ongoing and holistic assessments of complex families. Health visitors viewed supporting parents as an early-intervention/prevention strategy for safeguarding children. Health visitors had difficulty describing their work, as much of their practice was intuitive.
Coles & Collins 2007 South Wales	To investigate health visitors' perceptions about barriers and facilitating factors for preventing accidental and non-accidental head injuries (NAHIs) in infants.	Qualitative, focus groups with health visitors (n=22).	Health visitors did not always have knowledge about prevention of head injuries in infants. sensitivity and universal provision of NAHIs is needed to prevent blame and stigmatisation. Health visitors wanted to spend more time promoting health and preventing injuries rather than reacting to existing problems.
Crisp & Lister 2007 Scotland	To explore nurses' perceptions of their skills, knowledge, roles, responsibilities and training needs to identify cases of child abuse.	Mixed methods, cross-sectional questionnaires of nurses (n=667) followed by in-depth group and individual interviews with nurses (n=99) at all levels of service delivery.	Health visitors had most extensive involvement in safeguarding children and so received most concentrated training. Most nurses identified specific training needs, but nurses with less involvement in safeguarding considered training a lower priority. Managers were often the first port of call for child protection issues and required training so they could support their staff.
Hackett 2013 Scotland	To explore school nurses' perceptions of their role in child protection.	Qualitative, semi-structured interviews with school nurses (n=6).	School nurses felt their role in child protection was unclear and poorly defined. School nurses valued the contribution of their life experiences, personal characteristics and experiential learning. All school nurses had received training, but they desired training specific to their role.
Houlihan et al. 2013 Ireland	To examine psychiatric nurses' education, knowledge, confidence and practice regarding support needs of children whose parent has a mental illness.	Quantitative, cross-sectional questionnaire of registered psychiatric nurses (n=114) from a mental health service.	Half of participants had education about mandatory reporting but only a fifth (21%) had education about assessing parent-child relationships. Most nurses felt they did not have necessary knowledge and confidence to support children of parents with mental illnesses. Some nurses did not routinely assess (59%) or document (77%) children's needs.
Kent et al 2011 Ireland	To present findings from a qualitative study that investigated views of Public Health Nurses (PHNs) on their role with pre-school children.	Qualitative, semi-structured interviews with PHNs (n=10) who provide health care to pre-school children.	PHNs wished to prevent child abuse by increasing family support but were limited by high caseloads. PHNs were uneasy about their role in monitoring a family for abuse, seeing their role as a supportive, friendly role. PHNs referred cases of child protection to social workers but were often dissatisfied with the intervention and lack of feedback.

| Korhonen et al. 2010

Finland	To examine the interaction that mental health nurses have with children of their clients.	Quantitative, cross-sectional questionnaire of mental health nurses (n=331) working in psychiatric inpatient and outpatient units.	The majority of nurses gathered information about client's children (95-96%) and asked about potential behavioural problems (80%). Most nurses ensured children had a safe adult to care for them when the parent was hospitalised (76-85%). Nurses who were parents themselves or had more years of experience were more likely to consider the needs of children.
Kraft & Eriksson 2015

Sweden | To explore how school nurses detect maltreated children and initiate support. | Qualitative, approach using a grounded theory approach to guide the analysis. Two focus groups with school nurses (n=23) with at least 3 years of experience were conducted. | School nurses developed trusting relationships with children to facilitate identification of abuse.
School nurses described initial intuitions that lead them to further monitor and subsequently advocate for particular children.
School nurses worried about damaging relationships with children and parents when asking sensitive questions or reporting abuse. |
| Lewin & Herron 2007

England | To explore health visitors' perceptions of child neglect signs, symptoms and risk factors. | Quantitative, cross-sectional survey of health visitors (n=92) who also taught at university. | Health visitors ranked parental behaviours as the highest priority indicators followed by child, parent and environmental characteristics.
Health visitors pointed out that no individual factor should be considered in isolation to families' overall situations.
Health visitors' assessment of the significance of indicators was consistent with the judgements of other professional groups. |
| Lazenbatt & Freeman 2006

Ireland | To investigate the self-reported ability of health professionals to recognise and report child physical abuse. | Quantitative, cross-sectional survey of health professionals working in the community; clinical nurses (n=139), general practitioners (n=147) and dentists (n=133). | Participants were aware of mechanisms for reporting but desired further multi-disciplinary education.
Child abuse was not always reported due to lack of clear guidelines, concerns about negative consequences and lack of confidence in child protection services.
Clinical nurses were most willing to become involved in identifying and managing abuse. |
| Louwers et al. 2012

The Netherlands | To assess the quality of child abuse detection in emergency departments (ED) with the aim to define facilitators/barriers to screening for child abuse. | Qualitative, using semi structured-interviews (n=27) with senior physicians (n=9), hospital board members (n=6), ED nurses (n=6) and ED managers (n=6). | Participants did not always report abuse and had difficulty addressing topic of suspected child abuse with parents.
Many participants were not aware of their ED's child abuse protocol and felt they had insufficient educational preparation.
Lack of resources and high staff turnover were barriers to maintaining good standards of practice. |
| Maddocks et al. 2010

United Kingdom | To explore mental health nurses' lived experience of caring for parents with enduring mental health problems. | Qualitative, interpretive phenomenology using semi-structured interviews with qualified mental health nurses (n=6). | Nurses disagreed upon how involved they should be with clients' children, citing lack of knowledge and unit facilities as barriers.
Some nurses believed they should remain impartial to clients' children to avoid compromising the therapeutic relationship.
When nurses did want to raise a child safety concerns, they had difficulty communicating with other agencies. |
| McAtamney 2011

Scotland | To explore health visitors' perceptions of their role in supporting parent-infant relationships. | Qualitative, interpretative phenomenology using semi-structured interviews with health visitors (n=12) working in three different community centres. | The baby was the key to health visitors' assessments but they also considered multiple other factors.
Health visitors believed they had a major role in supporting the mother by building relationships, educating, listening and referrals.
Health visitors felt professional competency increased through on-the-job experience but desired further education around attachment. |
| Pabis et al 2010

Poland | To evaluate paediatric nurses' assessment and diagnostic skills and interventions used for child maltreatment. | Quantitative, cross-sectional survey of paediatric registered nurses (n=160) in two children's hospitals in Poland. | Most nurses (86%) had encountered child abuse in their clinical practice, with neglect being most common.
Nurses could identify a range of signs and symptoms of abuse including physical, behavioural and psychological effects.
Most nurses (72%) tried to intervene to help children experiencing abuse. |

Pakis et al. 2015 Turkey	To determine the awareness of healthcare professionals about child abuse and negligence.	Quantitative, cross-sectional survey of health professionals (physicians and nurses) working in four hospitals in Turkey.	Around half (55%) of physicians and a third (32%) of nurses had encountered a case of child abuse. The most common reasons for not reporting child abuse were concerns about the legal process (58%) and lack of knowledge (36%). Almost half (46.8%) were not aware of their organisation's child abuse procedures and mean knowledge score was 21 out of a possible 32.
Reijnders et al. 2008 The Netherlands	To identify if ED physicians and nurses, forensic physicians and interns are competent in describing, recognising and determining the possible causes of injuries.	Quantitative, cross-sectional survey of forensic physicians (n=104), ED physicians (n=79), ED nurses (n=84) and ED interns (n=97) in the Netherlands.	Forensic physicians scored much higher than other groups while interns scored the lowest; ED physicians and ED nurses scored equally well. Outline haematomas and blisters were more frequently recognised than tramline bruising, bite mars and petechiae.
Rowse 2009a England	To explore the experiences and feelings of nurses and midwives working with children who were subject of a child protection investigation.	Qualitative, interpretive phenomenology using semi-structured interviews with nurses (n=13) and midwives (n=2) working in community or hospital settings.	Nurses intuitively perceived signs of abuse but experienced doubt and anxiety when colleagues disagreed. Nurses were concerned about how other professionals would judge their actions, which influenced nurses' support-seeking behaviours. Nurses wanted more feedback and discussion with colleagues to help them understand what actions were being taken.
Rowse 2009b England	To explore the experience of nurses working in a hospital paediatric department who had involvement in child protection cases.	Qualitative, interpretive phenomenology using semi-structured interviews with nurses (n=13) and midwives (n=2) working in community or hospital settings.	Nurses knew how to access relevant child abuse policies/procedures but had difficulty applying them to clinical situations. Nurses were frustrated that their concerns were not always taken seriously by child protection services. Nurses felt unsupported, uninformed and vulnerable during legal proceedings.
Schols et al. 2013 The Netherlands	To investigate frontline professionals; experiences with child abuse detecting and reporting.	Qualitative, focus groups with primary school teachers (n=15), school principals (n=1), child healthcare physicians (n=6) and child healthcare nurses (n=11).	Nurses used their intuition to identify possible cases of abuse and then asked questions to gain more information. Participants tried to help children by closely monitoring families and encouraging parents to accept voluntary help. Participants preferred to seek support from colleagues due to dissatisfaction with coordination and quality of child protection services.
Selbie 2009 United Kingdom	To identify factors that enable health visitors to identify, analyse and manage risks to children.	Qualitative, modified grounded theory approach using semi-structured focus groups (n=2) and an interview (n=1) with health visitors.	Standardised assessment tools were not perceived to be helpful to assess individualised risk of families. Health visitors built long-term relationships with families to facilitate trust and promote ongoing risk assessment. Lack of information sharing between agencies made risk assessment difficult and meant no one took overall responsibility for children's wellbeing.
Taylor et al. 2009 Scotland	To measure health visitors' professional judgements of 'good enough' mothering and parenting.	Quantitative, cross-sectional factorial survey of health visitors (n=70).	Health visitors focus on a narrow range of factors to make predictions about mothering and parenting quality. Health visitors' judgements were significantly influenced by parental boundary setting, housing situation and health behaviours, but not family context, maternal age, medical history and child behaviour. Some knowledge deficits in health visitors understanding of acceptable sleep routine for children were present.
Tingberg et al 2008 Sweden	To identify nurses' experiences in encountering abused children and their parents.	Qualitative critical incident technique using interviews with paediatric nurses (n=11) working in a large paediatric hospital.	Nurses felt conflicted between their role of policing the parents but providing optimal care for the child. Nurses desired more education, additional psychological support and increased feedback from child protection services. Nurses knew they should report child abuse, but a lack of clear policies/procedures made this difficult.

Whittaker et al. 2015 Scotland	To explore experiences of healthcare professionals providing parenting support for drug-using parents.	Qualitative, focus groups with health professionals including health visitors (n=4), child protection advisor (n=1), mental health nurses (n=5), midwives (n=4), general practitioners (n=3) and a psychiatrist (n=1).	All professionals reported their practice was driven by a child protection model rather than a family support model. Professionals experienced challenges building trusting relationships with families while continuing to monitor children's wellbeing. A perceived culture of blame, poor interagency communication and lack of resources prevented professionals from supporting effective parenting.
Wilson et al. 2007 Scotland	To identify how health visitors identify difficulties in the early parent-child relationship.	Qualitative, focus groups with health visitors (n=24).	Health visitors could identify both evidence-based risk factors and more ambiguous signs. Health visitors developed ongoing relationships with families to contextualise risk factors over a period of time. Health visitors reported little formal training around assessing infant-parent relationships and developed knowledge through clinical experience.
Northern America			
Adams 2005 United States of America	To investigate how frequently advanced practice nurses assess and document known risk factors for child abuse and neglect.	Quantitative, cross-sectional survey of advanced practice nurses (n=52) working in a variety of clinical settings.	Nurses assessed ten of the twenty risk factors for parenting difficulties more than 50% of the time. However, eight risk factors were assessed less than 40% of the time. Nurses with higher qualifications and/or experience were more likely to report abuse.
Browne et al. 2010 Canada	To examine the working relationships between high-priority families and Public Health Nurses (PHN) in rural and remote areas.	Qualitative, interpretive approach informed by hermeneutic using semi-structured interviews and focus groups with public health nurses (n=32), lay home visitors (n=3), family care givers (n=20) and fieldnotes from observations of PHNs' practices (n=6).	PHNs sought to remain non-judgemental and understand the families' situations contextualising individual circumstances. Openness and honesty in their therapeutic relationships meant PHNs pre-empted unsafe conditions. PHNs aimed to keep families together by focusing on strengths but were clear that children's safety was not negotiable.
Davidov et al. 2012a United States of America	To identify and describe issues related to mandatory reporting of intimate partner violence (IPV) within the context of home visitation.	Qualitative, secondary analysis of data collected from another project that interviewed mothers (n=20), held focus groups with community home-visiting nurses (n=25) and interviews with community stakeholders (n=?).	Nurses believed their role as a mandated reporter impacted upon the therapeutic relationship by reducing trust and leading to avoidance. Some participants suggested that open and honest communication with families would reduce feelings of mistrust. Nurses desired further education around mandatory reporting policies and procedures to guide their decision-making.
Davidov et al. 2012b United States of America	To identify if home visitors attitudes to mandatory reporting of children's exposure to IPV.	Quantitative, cross-sectional web-based questionnaires sent to nurses (n=534) working in the Nurse-Family Partnership program in 32 US states.	Most (55%) nurses agreed they should report children's exposure to IPV but considered it could harm the nurse-client relationship. The majority of nurses (92%) agreed that mandatory reporting of IPV could protect children and/or make it easier for the woman to seek help (67%).
Davidov 2013 United States of America	To examine nurse home visitors perceived awareness of mandatory reporting requirements around pregnant women and children's exposure to IPV.	Quantitative, cross-sectional web-based questionnaires sent to nurses (n=534) working in the Nurse-Family Partnership program in 32 US states	Some nurses (23%) were unsure if there was a legal requirement to report IPV against a pregnant woman. Similarly, 18% of nurses were unsure if there was a legal requirement to report IPV against a woman holding a young child. Nurses prioritised the clients' wishes about reporting lower when the child was physically present during the IPV.
Eisbach & Driessnack 2010 United States of America	To describe the process of reporting child maltreatment from the perspective of paediatric nurses.	Qualitative, descriptive approach using grounded theory to guide the analysis. Participants were school nurses (n=10) or paediatric nurse practitioners (n=13).	Nurses were confident reporting objective evidence of abuse, but were concerned about being wrong when evidence subjective. When nurses were unsure, they continued to monitor the child and provided additional support. Nurses experiences of child protection services had been negative which discouraged them from referring children in the future.

Finn 2011 United States of America	To describe forensic nurses' perceptions of the context of receiving child abuse disclosures.	Narrative analysis of interviews with forensic nurses working in emergency departments (n=14), clinics (n=14) schools (n=2) and forensic units (n=2).	A child-friendly environment helped the child feel comfortable to share their experiences. Nurses highlighted the need to build trust and rapport with children through active listening. Nurses felt was important to demonstrate they believed the child and could handle hearing about the abusive experiences.
Herendeen et al 2014 United States of America	To examine paediatric nurse practitioners (PNPs) experiences in identifying and managing child abuse cases.	Quantitative, electronic cross-sectional survey of members of the National Association of PNPs (n=604).	Most PNPs had seen a case of child abuse but some had not reported every child with suspicious injuries. After reporting abuse, most PNPs believed the child experienced a positive outcome, but some PNPs had seen children sustain further injury due to inadequate action. Only around half of PNPs felt adequately prepared for their role in screening for child abuse.
Ho & Gross 2015 United States of America	To examine paediatric nurses' views on acceptable versus unacceptable discipline behaviours.	Quantitative, cross-sectional Q methodology with paediatric nurses (n=48) with at least 2 years of paediatric experience working at Johns Hopkins Hospital.	Nurses generally agreed that severe physical punishment causing obvious injury was unacceptable. Nurses were divided as to whether physical punishment or inciting of fear and uncertainty were more severe punishments. Nurses who were older, had their own children or had child abuse training were more likely to perceive physical punishment as unacceptable.
Horner & Herendeen 2014 United States of America	To describe the practice characteristics of advanced practice nurses (APNs) in the area of child maltreatment.	Quantitative, descriptive cross-sectional survey of lead APNs (n=136) working in children's hospitals and advocacy centres across all of the USA.	APNs in child protection were involved in clinical practice, research and education. Most APNs had a role in education other APN students, nurses, nursing students, medical students and physicians about child abuse. Most APNs had been required to testify in court as expert witnesses.
Koetting et al. 2012 United States of America	To describe the knowledge level of nurse practitioners (NPs) regarding symptoms of child sexual abuse in children with cognitive disabilities.	Quantitative, cross-sectional survey of family NPs and paediatric NPs (n=43) working in Missouri or Illinois.	Most NPs felt uncomfortable performing a clinical examination for child sexual abuse and did not know their organisation's policy about screening for child sexual abuse. Many NPs could not correctly identify anatomical structures of normal prepubescent female genitalia. Some NPs misdiagnosed normal findings or did not understand significance of abnormal findings.
Maguire et al. 2012 United States of America	To describe neonatal intensive care unit (NICU) nurses' lived experiences with caring for infants with Neonatal Abstinence Syndrome (NAS).	Qualitative, phenomenological method using semi-structured interview with NICU nurses (n=16) from a single NICU.	Nurses were distressed by the suffering of infants with NAS but were unable to comfort the infants. Nurses had difficulties communicating with the parents due to erratic, manipulative or aggressive behaviours. The discharge of infants caused nurses to worry about parents' ability to meet the high-needs of infants with NAS.
Murphy-Oikonen et al. 2010 Canada	To explore the experiences of NICU nurses who care for infants with NAS.	Qualitative, computer-assisted open-ended questionnaire completed by NICU nurses (n=14) working in a single regional NICU.	Nurses cared about the infants but were frustrated by the time taken for the infants' high need for non-technical care. Nurses had difficulty empathising with the mothers who they blamed for the infants' NAS. Nurses were distressed when infants with NAS were left to cry due to absent parents and heavy nursing workloads.
South America			
Moreira et al. 2013 Brazil	To analyse training and knowledge of professionals in the family health team on reporting the mistreatment of children and adolescents.	Quantitative, cross-sectional survey of professionals (n=9 physicians, n=26 nurses, n=16 dentists) working in family health teams.	Most participants had not attended training but they generally still knew where and how to report abuse. Attending training was associated with increased reporting of abuse. Some participants did not report every case of abuse they had encountered.

| Rolim et al. 2014

Brazil	To analyse factors associated with juvenile abuse reporting by nurses working in primary health care (PHC).	Quantitative cohort cross-sectional survey of nurses working in PHC (n=616) in 85 cities.	Most nurses had not encountered a case of abuse, but those who had frequently did not make a report. Nurses who had access to reporting forms and knowledge of where to report were much more likely to report. Nurses who believed reporting abuse was beneficial and were not concerned about legal involvement were much more likely to report.
Souza Aragao et al. 2013

Brazil | To analyse how cases of violence against children and adolescents are approached by primary care nurses | Qualitative approach using semi-structured interviews with primary health nurses (n=8) working in socially vulnerable urban area. | Nurses believed their role was only to refer cases of violence against young people on to other professionals.
Nurses were hesitant to report violence via official channels due to concerns about generating community mistrust.
Nurses felt limited in their ability to manage violence against children due to their lack of knowledge. |
| **Middle East** | | | |
| Ben Natan et al 2012

Israel | To examine the reporting of child abuse and whether theory of planned behaviour succeeds in predicting nursing and medical staff reporting of suspected child abuse. | Quantitative, cross-sectional self-report questionnaire of nursing and medical staff (n=185) that regularly treat children in a large hospital and community centre. | Some participants had encountered child abuse but not reported it, commonly for fear of legal implications.
Knowledge about child abuse was generally low, but higher knowledge was not associated with increased reporting of abuse.
Subjective beliefs and personal characteristics influenced the likelihood of reporting child abuse. |
| Ben Yehuda et al. 2010

Israel | To study health professionals' experiences of identifying and reporting suspected cases of child abuse and neglect. | Quantitative, cross-sectional self-report questionnaire from a convenience sample (n=95) of doctors, nurses, psychologists and social workers attending a national conference on child abuse and neglect. | Most participants had experiences with child abuse or neglect over the past year.
Although the majority of respondents had previously participated in workshops about child abuse, they still desired further training.
The need for training was not associated with gender, age, years of professional experience or context of practice. |
| Borimnejad et al. 2015

Iran | To explore Iranian nurses' experiences about reporting child abuse. | Qualitative, content analysis of semi-structured interviews with nurses (n=16) who had direct experiences caring for children who had been abused. | Nurses felt they did not have the necessary knowledge of child abuse legislation.
Nurses encountered challenges such as deciding whether a report would benefit children, or lead to poorer outcomes by angering parents.
Nurses perceived flaws in the legislation that meant some children were not adequately protected. |
| Glasser & Chen 2006

Israel | To assess knowledge about hospital policy, attitudes and actual behaviour of hospital staff in cases of suspected child abuse and neglect. | Quantitative, cross-sectional survey of a convenience sample (n=82) of doctors, nurses and social workers at a children's hospital. | Most participants were aware of their organisation's policy for managing child abuse or neglect.
Participants generally agreed that their profession had a responsibility to manage family violence.
Many participants were uncomfortable discussing suspicions of abuse with the child or the parent, commonly due to lack of training. |
| **China** | | | |
| Chen et al. 2015

Taiwan | To identify community nurses' level of competency and examine relationships between nurses' characteristics and clinical competency. | Quantitative, cross-sectional descriptive correlational study using a questionnaire of community nurses (n=588). | Some nurses had encountered abuse but did not report; a common reason for not reporting was lack of evidence.
Most nurses could identify signs of abuse, but were less able to identify signs of neglect.
Few nurses were comfortable with their role as an advocate for abused children. |
| Feng et al. 2005

Taiwan | To explore nurses' experiences and perspectives regarding child abuse. | Qualitative, semi-structured interviews with nurses (n=18) working in an emergency department (n=8) or paediatric unit (n=10). | Nurses did not have a clear idea of the definition of child abuse.
Nurses were unsure of their legal responsibility to report child abuse and would often wait for physicians to take the lead.
Nurses were deterred from reporting child abuse by Chinese cultural norms of child rearing, fear of reprisals from the family, lack of faith in child protection services and high workloads. |

Feng et al. 2010

Taiwan | To explore the experiences and perspectives of professionals working with other disciplines when reporting child abuse. | Qualitative, guided by grounded theory. Interviews (n=21) were conducted with physicians (n=5), nurses (n=5), social workers (n=6) and teachers (n=5). | Multidisciplinary communication tended to be one way; professionals passed information on but did not provide feedback.
As a result, participants did not trust other professionals and were unsure if the child was receiving assistance.
Participants viewed physicians as the leader in identifying and managing child abuse. |
| Feng & Levine 2005

Taiwan | To determine the experiences of Taiwanese nurses with a new child abuse reporting law and to assess attitudinal correlates of nurses' intention to report. | Quantitative, cross-sectional survey of registered nurses aged 18 or older working in paediatric, psychiatric and emergency care units. | Most nurses had never encountered child abuse; some nurses had encountered child abuse but did not report.
Reasons for not reporting included lack of faith in authorities and feeling uncertain about the evidence.
Although most nurses had not received education about child abuse, they were generally aware of their mandatory reporting duties. |
| Ko & Koh 2007

Korea | To examine the extent various characteristics of child sexual abuse situation variables and background characteristics of nurses affect perceptions of the definition of child sexual abuse. | Quantitative, vignette design questionnaire of nurses working in hospitals (n=503) and schools (n=526). | Nurses' personal characteristics accounted for negligible difference in their perceptions of the seriousness of sexual abuse.
Factors that had the greatest influence on nurses' perceptions were intrusiveness of the act and victim resistance.
Nurses perceived sexual abuse of adolescents to be more serious that sexual abuse of younger children. |
| Lee et al. 2007

Taiwan | To examine the influence of nurses' perceptions, attitudes and knowledge on suspecting and reporting child abuse and neglect. | Quantitative, cross-sectional surveys of registered nurses (n=238) from emergency units, paediatric units and community centres. | Many nurses did not know how to report child abuse and had not received training in this area.
Many nurses had failed to report abuse due to lack of knowledge or fear of intimidation.
Participants' perceptions, attitudes and knowledge of child abuse influenced their likelihood of reporting abuse. |
| Thamlikitkul et al. 2009

Thailand | To explore how psychiatric nurses care for school aged sexually abused children admitted to psychiatric wards. | Qualitative, grounded theory using semi-structured interviews with psychiatric nurses (n=12) working in psychiatric hospital wards. | Nurses' first priority was to establish trust and build relationships with the abused children.
Nurses provided holistic care by conducting a comprehensive assessment of the child and their physical, emotional and social needs.
Nurses then helped children return to normal life by developing the child's self-care and socialisation skills. |
| **Australia and New Zealand** | | | |
| Francis et al. 2012

Australia | To understand the circumstances and decision-making processes of mandated professionals employed in rural communities. | Qualitative, exploratory descriptive approach informed by grounded theory using interviews doctors (n=1), nurses (n=7), police officers (n=2) and teachers (n=6). | Participants were aware of the signs of child abuse and would ask the family questions to confirm or alleviate their concerns.
Participants would often watch, wait and consider the bigger peicture until they had enough evidence to act.
Participants sought support from colleagues to help them identify and manage child abuse. |
| Fraser 2007

Australia | To explore experiences of neonatal nurses who care for infants of drug-dependent parents. | Qualitative, semi-structured interviews with nurses (n=32) from four different neonatal units. | Nurses experienced caring for infants with neonatal abstinence syndrome time-consuming and emotionally draining.
Poor communication and staffing issues reduced nurses' ability to care for families in a structured and coordinated manner.
Nurses experienced a tension between caring for the infant and caring for the parents who were seen as the source of the infant's problems. |
| Fraser et al. 2010

Australia | To examine the relationship between nurse characteristics, training, knowledge and attitudinal on reporting child abuse and neglect. | Quantitative, cross-sectional survey of registered nurses (n=930) working with children and families in all practice settings. | Many nurses had previously reported abuse, but some nurses had suspected but not reported abuse.
Many nurses had received training in child abuse but this did not alter perceptions of the seriousness or possibility of harm.
Nurses who had training, worked in a metropolitan area and were parents themselves were more likely to report abuse. |

Land & Barclay 2008 Australia	To investigate if dilemmas arise for nurses in their mandated requirement to report suspected child abuse and the effectiveness of their role.	Qualitative, exploratory semi-structured interviews with child health, paediatric and school nurses (n=10) with at least 2 years experience working with children and families.	All nurses acknowledged their role in keeping children safe and responsibility to report abuse. Nurses had difficulty deciding what and when to report due to perceived lack of clarity of procedures. Nurses were frustrated at lack of interdisciplinary communication and were concerned about possible negative outcomes of reporting abuse.
Mahoney 2010 New Zealand	To identify the role of the PHN with children who live with a parent with a mental illness.	Qualitative, focus groups interviews (n=2) with PHNs (n=8) working in both rural and urban primary mental health.	PHNs advocated for children by initiating referrals and ensuring the child's school was involved. High levels of clinical expertise were required to accurately assess the mental health needs of individual family members. PHNs believed it was imperative to evaluate their own perceptions and assumptions of mental illness.
Mathews et al. 2008 Australia	To describe nurses attitudes, knowledge and practices of mandatory reporting.	Quantitative, cross-sectional survey of registered nurses (n=930) working with children and families in all practice settings.	Many participants had reported child abuse, but some participants had suspected child abuse but not reported it. Almost all nurses knew they must report neglect, physical and sexual abuse, but some did not know they must report emotional abuse. Nurses were generally able to correctly identify vignettes that required mandatory report but had knowledge deficits in other areas.
Raman et al 2011 Australia	To examine knowledge, confidence and practice of child protection among frontline clinicians.	Quantitative, cross-sectional survey of doctors and nurses working in emergency departments and general practice.	Most participants understood their statutory and professional responsibilities to report child abuse. Participants were more confident identifying physical abuse or neglect, but less confident identifying sexual or emotional abuse. Training had been provided to most participants, but they felt this had not adequately prepared them.
Reupert & Maybery 2014 Australia	To identify problems practitioners faced when working with families with complex needs.	Qualitative, discovery-orientated approach using interviews (n=21) and focus groups (n=3) with social workers, youth workers and mental health nurses working for an organisation providing services to parents with substance abuse or mental health issues.	Participants reported that families often faced numerous problems that required input from multiple agencies. Participants saw their job as a 'balancing act' – balancing the competing needs of children and parents without taking sides. It was important to focus on families' strengths and goals to enable a focus on achievements.

Appendix 2: Critical appraisal of studies included in literature review 1: integrative review: nurses' roles and experiences in keeping children safe

Qualitative studies, Key: (Y=Yes, N=No, Unclear)

Authors and date	1. Clear statement of research aims?	2. Qualitative methodology appropriate?	3. Research design appropriate to address aims?	4. Recruitment strategy appropriate?	5. Data collected in a way that addressed research aims?	6. Relationship between researcher and participants considered?	7. Ethical issues been considered?	8. Data analysis sufficiently rigorous?	9. Clear statement of findings?	10. Research valuable?
Appleton & Cowley 2008	Y	Y	Y	Y	Y	Unclear	Y	Y	Y	Y
Aragao et al. 2013	Y	Y	Y	Unclear	Y	Unclear	Y	Unclear	Y	Y
Borimnejad et al. 2015	Y	Y	Y	Unclear	Y	Unclear	Y	Y	N	Unclear
Browne et al. 2010	Y	Y	Y	Unclear	Y	Unclear	Unclear	Y	Y	Y
Coles & Collins 2007	Y	Y	Y	Unclear	Y	Unclear	Y	Y	Y	Y
Davidov et al. 2012	Y	Y	Y	Unclear	Y	Unclear	Unclear	Y	Y	Y
Esibach & Driesnack 2010	Y	Y	Y	Y	Y	Unclear	Y	Unclear	Y	Y
Feng et al. 2005	Y	Y	Y	Unclear	Y	Unclear	Y	Y	Y	Y
Feng et al. 2010	Y	Y	Y	Y	Y	Unclear	Y	Y	Y	Y
Finn 2011	Y	Y	Y	Y	Y	Unclear	Y	Y	Y	Y
Francis et al. 2012	Y	Y	Y	Y	Y	Unclear	Y	Y	Y	Y
Fraser 2007	Y	Y	Y	Unclear	Y	Unclear	Y	Unclear	Y	Y
Kent et al. 2011	Y	Y	Y	Y	Y	Unclear	Y	Unclear	Y	Y
Kraft & Eriksson 2015	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Land & Barclay 2008	Y	Y	Y	Y	Y	Unclear	Y	Y	Y	Y
Louwers et al. 2012	Y	Y	Y	Unclear	Y	Unclear	Y	Y	Y	Y
Maddocks et al. 2010	Y	Y	Y	Y	Y	Y	Y	Unclear	Y	Y
Maguire 2013	Y	Y	Y	Unclear	Y	Unclear	Y	Unclear	Y	Y
Mahoney 2010	Y	Y	Y	Unclear	Y	Unclear	Y	Y	Y	Y
McAtamney 2011	Y	Y	Y	Y	Y	Unclear	Y	Y	Y	Y

Qualitative studies (cont.)

Authors and date	1. Clear statement of research aims?	2. Qualitative methodology appropriate?	3. Research design appropriate to address aims?	4. Recruitment strategy appropriate?	5. Data collected in a way that addressed research aims?	6. Relationship between researcher and participants considered?	7. Ethical issues been considered?	8. Data analysis sufficiently rigorous?	9. Clear statement of findings?	10. Research valuable?
Murphy-Oikonen et al. 2010	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Reupert & Mayberry 2014	Y	Y	Y	Unclear	Y	Unclear	Y	Y	Y	Y
Rowse 2009a	Y	Y	Y	Unclear	Y	Y	Y	Unclear	Y	Y
Rowse 2009b	Y	Y	Y	Unclear	Y	Y	Y	Unclear	Y	Y
Selbie 2009	Y	Y	Y	Unclear	Y	Unclear	Y	Unclear	Y	Y
Schols et al. 2013	Y	Y	Y	Y	Y	Unclear	Y	Y	Y	Y
Thamlikitkul et al. 2015	Y	Y	Y	Unclear	Y	Unclear	Y	Y	Y	Y
Tingberg et al. 2008	Y	Y	Y	Unclear	Y	Unclear	Y	Y	Y	Y
Wilson et al. 2008	Y	Y	Y	Unclear	Y	Y	Y	Y	Y	Y
Whittaker et al. 2015	Y	Y	Y	Unclear	Y	Unclear	Y	Y	Y	Y

Quantitative studies, Key: (Y=Yes, N=No, Unclear)

Authors and date	1. Did the study address a clearly focussed issue?	2. Was the method appropriate to research question?	3. Was the sample size and recruitment appropriate?	4. Was the outcome accurately measured to minimise bias?	5. Were ethical issues considered?	6. Have the authors identified important confounding factors or limitations?	7. Are the results clearly presented?	8. Are the results precise?	9. Are the findings believable?	10. Can the results be applied to another context?
Adams 2005	Y	Unclear	N	Y	Unclear	Y	Y	Y	Y	Y
Ben Natan et al. 2012	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chen et al. 2015	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Davidov et al. 2012	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Davidov et al. 2013	Y	Unclear	Y	Y	Y	Y	Y	Y	Y	Y
Feng & Levine 2005	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Fraser et al. 2009	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Glasser & Chen 2006	Y	Y	N	Y	Unclear	Y	Y	Y	Y	Y
Herendeen et al. 2014	Y	Y	N	Unclear	Unclear	Y	Y	Y	Y	Y
Ho & Gross 2015	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hornor & Herendeen 2014	Y	Y	N	Unclear	Y	Y	Y	Y	Y	Y
Houlihan et al, 2012	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ko & Koh 2007	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Koetting et al. 2012	Y	Y	N	Y	Unclear	Y	Y	Y	Y	Y

Quantitative studies (cont.)

Authors and date	1. Did the study address a clearly focussed issue?	2. Was the method appropriate to research question?	3. Was the sample size and recruitment appropriate?	4. Was the outcome accurately measured to minimise bias?	5. Were ethical issues considered?	6. Have the authors identified important confounding factors or limitations?	7. Are the results clearly presented?	8. Are the results precise?	9. Are the findings believable?	10. Can the results be applied to another context?
Korhonen et al. 2010	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lee et al. 2007	Y	Y	N	Y	Unclear	Y	Y	Y	Y	Y
Lewin & Herron 2007	Y	Y	N	Y	Y	Y	Y	Y	Y	Unclear
Lazenbatt & Freeman 2006	Y	Y	N	Unclear	Y	Y	Y	Y	Y	Y
Mathews et al. 2008	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Moiera et al. 2013	Y	Y	N	Y	Y	Y	N	Y	Y	Y
Pabis et al. 2010	Y	Unclear	Y	N	Y	Y	Y	Y	Y	Y
Pakis et al. 2015	Unclear	Y	Y	N	Y	N	Y	Y	Y	N
Reijinders et al. 2008	Y	Y	Y	Y	Unclear	N	Y	Y	Y	Y
Raman et al. 2011	Y	Y	Unclear	Y	Y	Y	Y	Y	Y	Y
Rolim et al. 2014	Unclear	Y	Y	Unclear	Y	Y	Y	Y	Y	Y
Taylor et al. 2009	Y	Y	Y	Y	Unclear	Y	Y	Y	Y	Y
Yehuda et al. 2010	Y	Y	N	N	Unclear	Y	Y	Y	Y	Y

Mixed methods studies: (Y=Yes, N=No, Unclear)

Authors and date:	1. Did the study address a clearly focussed issue with clear statement of research aims?	2. Was design appropriate to research question?	3. (a) Was the sample size and recruitment appropriate? (b) Was recruitment strategy appropriate?	4. Was outcome accurately measured to minimise bias? Was Data collected in a way that addressed research aims?	5. Ethical issues considered?	6. Have authors identified confounding factors and researcher-participant relationship?	7. Results clearly presented?	8. Are results precise with a rigourous data analysis?	9. Are findings clearly stated and believable?	10. Is research valuable and applicable to another context?
Appleton et al. 2013	Y	Y	Y	Y	Y	N	Y	Unclear	Y	Y
Crisp & Lister 2006	Y	Y	Y	Y	Unclear	Unclear	Y	Unclear	Y	Y

Appendix 3: Studies contributing to the major findings of literature review 1: integrative review: nurses' roles and experiences in keeping children safe

Finding	Sources
Insufficient knowledge	(Adams, 2005; Appleton et al., 2013; Aragão, Ferriani, Vendruscollo, Souza, & Gomes, 2013; Ben Natan et al., 2012; Borimnejad & Fomani, 2015; Chen et al., 2015; Coles & Collins, 2007; Crisp & Lister, 2006; Davidov, Jack, Frost, & Coben, 2012; Davidov & Jack, 2013; Eisbach & Driessnack, 2010; Feng et al., 2010; Feng et al., 2005; Feng & Levine, 2005; Fraser, Barnes, Biggs, & Kain, 2007; Fraser et al., 2010; Glasser & Chen, 2006; Hackett, 2013; Herendeen et al., 2014; Ho & Gross, 2015; Houlihan et al., 2013; Ko & Koh, 2007; Koetting et al., 2012; Korhonen et al., 2010; Land & Barclay, 2008; Lazenbatt & Freeman, 2006; Lee et al., 2007; Louwers, Korfage, Affourtit, De Koning, et al., 2012; Maddocks et al., 2010; Maguire, 2013; Mathews et al., 2008; McAtamney, 2011; Moreira et al., 2013; Murphy-Oikonen et al., 2010; Pakiş, Demir, Bektaş, Altun, & Yıldırım, 2015; Raman et al., 2012; Reijnders et al., 2008; Rolim et al., 2014; Rowse, 2009b; Schols et al., 2013; Taylor, Lauder, Moy, & Corlett, 2009; Tingberg et al., 2008; Whittaker et al., 2015; Yehuda et al., 2010)
Validation and communication	(Appleton & Cowley, 2008; Aragão et al., 2013; Ben Natan et al., 2012; Borimnejad & Fomani, 2015; Browne et al., 2010; Chen et al., 2015; Crisp & Lister, 2006; Davidov, Nadorff, et al., 2012; Eisbach & Driessnack, 2010; Feng et al., 2010; Feng et al., 2005; Feng & Levine, 2005; Francis et al., 2012; Fraser et al., 2007; Herendeen et al., 2014; Hornor & Herendeen, 2014; Kent et al., 2011; Kraft & Eriksson, 2015; Land & Barclay, 2008; Lazenbatt & Freeman, 2006; Lewin & Herron, 2007; Maddocks et al., 2010; Mahoney, 2010; McAtamney, 2011; Pabis et al., 2011; Pakiş et al., 2015; Reupert & Maybery, 2014; Rowse, 2009b; Schols et al., 2013; Selbie, 2009; Taylor et al., 2009; Tingberg et al., 2008; Whittaker et al., 2015; Wilson et al., 2008)
Balancing support and surveillance	(Appleton & Cowley, 2008; Aragão et al., 2013; Borimnejad & Fomani, 2015; Browne et al., 2010; Coles & Collins, 2007; Davidov, Jack, et al., 2012; Davidov, Nadorff, et al., 2012; Eisbach & Driessnack, 2010; Feng et al., 2005; Finn, 2011; Francis et al., 2012; Fraser et al., 2007; Hackett, 2013; Kent et al., 2011; Kraft & Eriksson, 2015; Louwers, Korfage, Affourtit, De Koning, et al., 2012; Maddocks et al., 2010; Maguire, 2013; Murphy-Oikonen et al., 2010; Reupert & Maybery, 2014; Schols et al., 2013; Selbie, 2009; Thamlikitkul, Yunibhand, & Chaiyawat, 2009; Tingberg et al., 2008; Whittaker et al., 2015; Wilson et al., 2008)

Appendix 4: Summary of studies included in literature review 2: how do nurses keep children safe from abuse and neglect, and does it make a difference? A scoping review.

Intervention name or description. Authors, publication date and location.	Study design and outline of intervention. Summary of nurses' role(s).	Evidence to support or refute efficacy of the intervention.
Home Visiting Interventions		
Home visiting for high-risk families United Kingdom **Barlow et al. 2007**	RCT (n=131) with a range of pregnant women experiencing multiple vulnerabilities with the aim of promoting positive parenting and parent-infant interactions. Health visitors visited families on a weekly basis for 18 months; unclear exactly what intervention health visitors delivered. Health visitors were trained in the Family Partnership Model.	Women in intervention group more sensitive to babies (p= .04) and babies more cooperative (p= .02). No statistically significant difference in mothers' Edinburgh Postnatal Depression Score at 2 months. More infants breastfeed up to six months (not statistically significant). Non-significant difference that there would be child protection issues (17% intervention versus 15% in control and whether the child would be on placed on the child protection register or be removed from home (6% vs 0%).
Family Care and Parents Under Pressure Australia **Flemington et al. 2015**	Retrospective case note review of mothers (n=40) who had been enrolled in a nurse home visiting program to examine the relationship between maternal involvement in a home visiting program and effects on maternal depression and adjustment to parenting role. Nurses visited mothers who had a history of mental illness or intimate partner violence. Participants received home visiting weekly until the infant was 6 weeks and then fortnightly until the infant was 6 months old. Exact role of nurse unclear, but goals broadly addressed enhancing adjustment to the parenting role.	Greater involvement with home visiting program led to improved maternal responsivity (HOME responsivity) and suitability of the home environment (HOME Inventory), despite deteriorating maternal depressive symptoms (Edinburgh Postnatal Depression Score).
Home Visit Service for New-borns (HVSN) and Home Visit Service for all Infants (HVSI). Aichi, Japan **Fujiwara et al. 2012**	Self-report questionnaires administered to mothers (n=936) to assess whether the home visit program reduced parenting stress and increased social capital. Nurses or community staff visited mothers with young babies with the aim of boosting social capital and reducing parenting stress. The program included infant and maternal health-checks, listening to mothers' concerns, and connecting with services as required.	No substantial reduction in parenting stress at 6 months (parental stress scale) in either group. No significant increase in social trust.
Family home visiting program Midwest USA **Garcia et al. 2013**	Retrospective cohort study of Latina women (n=680) to evaluate ratings of knowledge, behaviour and mental health status after a nurse home visiting intervention. Public health nurses visited mothers weekly to at least monthly using the Omaha System to prevent or identify illness and restore health.	N= 158 of the mothers had mental health problems; these mothers received more visits than mothers without mental health problems. Over the period of home visiting, mothers had improved knowledge, behaviour and status as rated using the Omaha system.
Toward Better Beginnings Minnesota, USA **Guthrie et al. 2008**	Non-randomised control trial (intervention n=33, control n=39) investigating whether a short-term intervention could improve parenting attitudes and home environments. The role of nurses was to encourage positive infant-parent interactions through video-taping of parent-infant interactions and discussion of video tapes with parents in home visits. Visits occurred twice per month for one hour until the infant was three months old.	Intervention group had increased responsivity and provision of age appropriate learning materials for their infants (p=.05). Intervention group had higher levels of parenting knowledge as measured on the Adult-Adolescent Parenting Inventory (p=.01).
Long-term nurse home visitation programme Sydney, Australia	RCT with mothers (n=208) living in a disadvantaged area to determine whether a sustained nurse home visiting intervention could family health outcomes and reduce health and developmental disadvantage for vulnerable children.	Mothers more emotionally and verbally responsive to children at 12 and 24 months; but no changes to other aspects of the home environment. Overseas-born and first-time mothers more likely to report positive experience of being a mother.

Kemp et al. 2013 **Kemp et al. 2011**	Child and family health nurses visited families for two years following birth. The nurses delivered a structured program in which individual visits were tailored to the mothers' needs.	More mothers reported their health to be significantly better at 4-6 weeks postpartum.
Nurse Family Partnership Memphis, Tennesee **Kitzman et al. 2010**	RCT to test the effects of home visiting on children's (n=743) substance use, behavioural adjustment and academic achievement at 12 years of age. Nurse Family Partnership model implemented into a public system of obstetric and paediatric care in an economically disadvantaged, primarily African American population. Nurses aimed to improve pregnancy outcomes, children's health and development and enhance parents' life chances though a tailored home visiting intervention.	At 12 years of age, children were less likely to have used cigarettes, alcohol or marijuana (p=.04) and reported fewer externalising behaviours (p=.02) and had higher GPAs (p=.03).
Public Health Nurses Japan **Kobayashi et al. 2015**	Self-report questionnaire of public health nurses (n=205) who cared for families where there was observed child abuse or neglect. The aim of the study was to highlight changes in family functioning and circumstances of abuse and neglect after receiving support from a public health nurse. Nurses working in public health centres who were caring for families where there was high risk of or confirmed abuse or neglect.	Reduced severity of abuse/neglect, and improved family functioning after public health nurse intervention.
Nurse Family Partnership program New York, USA **Eckenrode et al. 2016**	RCT (n=251 mothers) investigating whether a nurse home visiting intervention to would reduce child maltreatment fifteen years later in families where there was low-to-moderate domestic violence. The intervention was comprised of home visiting by nurses, which focussed on health-behaviours during pregnancy and the early years, parental care to children and maternal life-course development (i.e. education, employment).	First-born children had 4.52 times fewer substantiated maltreatment reports than the control. This was mediated by a reduction in numbers of subsequent births and mother's use of public assistance.
VoorZorg: Dutch Nurse-Family Partnership **Mejdoubi et al. 2015** **Mejdoubi et al. 2013**	RCT of nurse home visiting for young, disadvantaged families (n=460) in the Netherlands. The aim of the intervention was to determine the effect of home visiting on child maltreatment and intimate partner violence. Families received 10 nurse visits during pregnancy, 20 in first year of child's life, 20 in the second year of child's life.	Fewer child internalising behaviours, but no change in externalising behaviours at 24 months. Fewer child protection reports (19% in control versus 11% in intervention). Reduced levels of physical assault but no impact on other forms of violence (i e. psychological, sexual) at two years post-intervention.
Maternal and child health clients of public health agencies Minnesota **Monsen et al. 2010**	Exploratory, descriptive study from four country public health departments of home visiting services to low-income high risk maternal child health clients. Public health nurses visited the families and conducted assessments using the Omaha System which is a standardised problem orientated framework to address client concerns.	34 out of the 40 problems identified in the Omaha system had a statistically significant improvement (p=.05). For example, there were reductions in 'abuse', 'neglect' and 'mental 'health' as categories
Nurse-led intensive home visiting program for first-time teenage mums (Building Blocks) England **Robling et al. 2016**	Non-blinded RCT comparing usual care (n=822) with the family nurse partnership (n=823). Mothers were up to 19 years old and were recruited at <25 weeks gestation and visited by specifically recruited and trained family nurses. Families were provided with up to 64 structured visits based on the Family Nurse Partnership program	No change in smoking rates or timing of second pregnancy. Increased used of EDs in treatment group.
South Australian Family Home Visiting (SA-FHV) to socially disadvantaged families Adelaide, Australia **Sawyer et al. 2013**	Non-randomised control trial of socially disadvantaged mothers (n=428 intervention group, comparison group n=239) to investigate the effects of a postnatal home-visiting program. Nurses provided home visiting to socially disadvantaged mothers in metropolitan Adelaide after their child's birth with the aims of improving mother-infant relationships, providing anticipatory guidance and connecting families with community supports.	Mothers in intervention group had greater improvement in parenting stress and satisfaction with their parental role. Smaller increase in infant sleep problems in intervention group. Otherwise, no statistically significant difference in use of child and parent services, child accidents.

South Australian Family Home Visiting (SA-FHV) to rural families Rural South Australia **Sawyer et al. 2014**	Non-randomised control trial of socially disadvantaged mothers (n=225 intervention group, comparison group n=239) to investigate the effects of a postnatal home-visiting program. Nurses provided home visiting to socially disadvantaged mothers in metropolitan Adelaide after their child's birth with the aims of improving mother-infant relationships, providing anticipatory guidance and connecting families with community supports.	No statistically significant differences to maternal or child outcomes.
Sustained home visiting Sydney, Australia **Stubbs & Achat 2016**	Descriptive service evaluation of a nurse home visiting program delivered to disadvantaged families (n=118) to increase family engagement with community networks and improve infant health outcomes. Nurses provided home visiting to families with significant risk factors until the child's third birthday. Visits were flexible, but aimed to promote parents' knowledge and parental self-efficacy, and improve children's health safety and wellbeing.	Nurses provided approx. 1 hour a fortnight with each family and provided mainly emotional support and education. Families reported improved participation in community networks but no change in feelings of closeness with another person. Self-report of better coping, confidence and understanding family. No improvement in health-related behaviours.
Prenatal and infancy home visits by nurses. Memphis, Tennessee, USA. **Olds 2007**	RCT with n=743 primarily black women with socio-demographic risk factors to assess whether the program would affect children's school grades and behaviour. Nurses attended home visits pre and postnatally for 2 years post-partum. Nurses followed pre-prepared guidelines that aimed to improve the health and wellbeing of the woman, health and development of the child and facilitate parental life-course development (i.e. education and employment plans).	Women had longer intervals between births of first and second children (approx. 40 vs 34 months, p=0.002), and lower reliance on food stamps (6.98 vs 7.8 months per year, p=0.017) but not welfare (3.4 vs 4 months per year, p=0.1117). No statistically significant effect on miscarriages, abortions, stillbirths, incarceration, depression, employment or relationship status. Some positive effects on children's reading and math achievement. No change in mothers' or teachers' reports of disruptive behaviour.
Minding the Baby Connecticut, USA **Ordway et al. 2014** **Sadler et al. 2013**	Prospective pilot study with longitudinal follow-up with first-time mothers (n=132) with multiple risk factors. A paediatric nurse practitioner and a social worker provided weekly home visiting to families until the child was two years of age. The aim of the program was to enhance parental reflective functioning. Specific role of the nurse practitioner within this intervention was not stated.	Parental reflective functioning unchanged overall, but improved in higher-risk mothers. Less child externalising behaviour Fewer instances of rapid repeat pregnancy No change in mothers' mental health Improved infant attachment quality at 12 months. Children more likely to be up-to-date with immunisations and health checks at 12 months, but not 2 years.
Nurse Family Partnership (NFP) Appalachian region, New York **Zielinski et al. 2009**	RCT with women (n=137) who were pregnant with their first child and had at least one factor that placed their child at risk of health and developmental problems. The aim was to determine whether the Nurse Family Partnership influenced the timing of verified reports of child maltreatment. Nurses visited women primarily from disadvantaged backgrounds with the aim of reducing risks for child abuse and neglect. The nurses' role involved improving pregnancy outcomes, improving children's health and development and improving mothers' economic self-sufficiency.	Children in the intervention group were older when the first child protection report was made; more children (81% vs 58%) reached 15 without a child protection report. After age 8, there were no first-time reports to CPS in the intervention group.
Sexual Abuse Interventions		
Sexual Assault Nurse Examiners (SANE) in the paediatric emergency department Connecticut **Bechtel et al. 2008**	Retrospective case note review (n=114 medical records) to evaluate whether the use of SANEs improves the care of children and adolescents who have experienced sexual assault. SANEs are specialist nurses who work with medical staff to assess and manage the care of children and young people presenting with a history or suspected sexual assault. Not on the qualifications or training the SANEs have.	Children who received care from the SANE were more likely to have a document genitourinary examination (78 vs 41%, p= <.001), have STI testing (78 vs 41%, p= .001), receive pregnancy prophylaxis (82 vs 64%, p= .025) and receive referral to a rape crisis centre (95% vs 19%, p= <.001).

Sexual Assault Nurse Examiner (SANE). USA **Golding et al. 2015**	2x2x3 between-participants design; n=252 participants read a fictional criminal trial summary for a child sexual assault to examine factors that influence jurors' decision-making processes, including the effects of a SANE involvement. The role of a SANE in cases of child sexual assault include physical examination of the child, preparing forensic evidence and testifying in court.	Participants up to ten times more likely to render guilty verdicts when SANE testified versus no-medical testimony. SANE perceived as more credible than RN; participants three times more likely to render guilty verdict with SANE testimony than non-specialist RN.
Paediatric sexual assault nurse examiner (P-SANE) program. Midwest USA **Horner et al. 2012**	Retrospective medical and legal record review of cases of paediatric (aged 1-20 years) sexual assault (n=464) to compare quality indicators before and after introduction of a P-SANE to a paediatric emergency department. The role of the P-SANE was to provide specialist assessment of sexual assault victims inclusive of documentation of the examination, collecting forensic evidence, prophylaxis of STIs and pregnancy and providing appropriate psychosocial support.	After implementation of P-SANE role there was: Improved detection/documentation of physical injuries (20 vs 34%, p=.006). Improved assessment of pregnancy status (47 vs 59%, p=.03) and chlamydia evaluation (80 vs 95%, p=<0.0001). Similar quality of forensic evidence and judicial outcomes.
School based sexual abuse prevention education program Nigeria **Ogunfowokan & Fajemilehin 2012**	Quasi-experimental study with girls (n=200) aged 13-24 years attending public high schools in Nigeria to determine whether it could influence their knowledge and attitudes towards sexual abuse. An educational intervention about sexual abuse was delivered by a nurse and supported by a research assistant in 30 minute intervals over a period of ten days.	Significant effects on knowledge of girls in intervention group but not on their attitudes.
Paediatric forensic nurse examiner (FNE) programs Midwestern USA **Patterson et al. 2009**	Quasi-experimental, non-equivalent comparison cohort design of children who received examination s by a FNE program (n=95) or another facility (n=54). The FNE had completed approved training and received clinical preceptoring.	Compared to the control group, FNEs saw more younger children (56% less than 6 years old vs 46%), where children may not be able to effectively communicate. FNE more likely to submit evidence to crime lab, but still typically negative for DNA evidence. FNE cases more likely to result in a successful guilty plea bargain or conviction (36% vs 29%).
Physical Abuse Interventions		
Hudson Valley Shaken Baby Initiative New York **Altman et al. 2011**	Program evaluation (n=20 hospital sites) to assess whether an educational program could successfully prevent abusive head injuries in babies. Maternity nurses implemented the program in hospitals and were involved in encouraging parents to access the educational materials and acknowledge the commitment statement to refrain from shaking their baby. The materials included a custom-designed leaflet and short video outlining the dangers of shaking infants and how to cope with infant crying.	Decreased frequency of abusive head injuries (reduced by 75 %, P= .03); regions outside intervention area were unchanged. At six-month follow-up, most parents (98 %) remembered watching the video about injuries from shaking a baby. Fifty-six per cent of parents could recall a situation of infant crying where the information helped them cope.
Pennsylvania Shaken Baby Syndrome Prevention Program Pennsylvania, USA **Dias et al. 2017**	Non-randomised study to determine whether a state-wide intervention could reduce the incidence of abusive head trauma in infants and young children (n=1,180,291 parents). The role of nurses was to deliver a short intervention to families that involved a video, pamphlet and discussion about the dangers of shaking a baby.	No changes in hospitalisation rates of shaken baby syndrome. Of parents surveyed at 7 months (n=146), most reported recalling the information when their baby was crying (74-79%).
Education to prevent abusive head trauma in infants (Period of PURPLE Crying) Kamagaya City, Japan **Fujiwara 2015**	Non-randomised self-report questionnaire of mothers (n=1594) to compare mothers who were exposed to different levels of the intervention to determine the impact of educational interventions to prevent abusive head trauma in infants. Mothers received either no intervention, one intervention or two interventions that were intended to provide education about shaken baby syndrome and ways to manage infant crying. Parents watched an educational DVD during a prenatal class and public health nurses distributed a pamphlet postnatally. Community home visiting	Mothers' knowledge of techniques to manage crying and dangers of shaking a baby increased. There was a stronger impact on mothers' knowledge when they had received both interventions rather than just one. Mothers in intervention group less likely to share information about infant crying with other caregivers.

	staff collected information about exposure to the intervention during home visiting when the infant was four months.	
Perinatal Shaken Baby Syndrome Prevention Program (PSBSPP) Montreal, Canada **Goulet et al. 2008**	Interviews and questionnaires of nurses (n=69) and parents (n=263) to determine nurses' and parents' opinions of the adequacy of an educational program about shaken baby syndrome. The nurses worked in perinatal units in two hospitals and they were trained to use cue cards to educate parents about the dangers of shaking babies, normal crying behaviours and strategies to deal with crying in a 5-10 minute intervention.	Most (57%) parents believed they learned from the intervention and found their action plan useful (98%). Most parents (94%) believed that the nurse's role in delivering the information was essential. After returning home, 80% of parents reporting thinking about the cue card information, but most did not think about them often (55%). All nurses were satisfied or highly satisfied with their training; many (70%) felt it was not easy to find an appropriate time for the intervention because it required both parents' presence.
Systematic screening and detection of child abuse in ED South Holland, The Netherlands **Louwers et al. 2012**	Intervention cohort study that screened children (n=104,028 aged 0-18years) who attended an ED at one of seven hospitals using a brief, structured tool. The aim was to determine whether implementation of a screening checklist could improve the detection rate of child abuse. Nurses were expected to fill out a brief checklist to screen for abuse; nurses at four of the seven hospitals received training via an interactive workshop about interviewing techniques (no further details) .	The screening rate for abuse increased twice as much in the intervention hospitals. Out of the children screened, the detection rate of significant higher in those who were screened than not screened (0.5 vs 0.1%, p<0.001).
Period of PURPLE Crying intervention Midwest city in USA **Reese et al. 2014**	Non-experimental, post-test design with (n=211) and nurses (n=47) to evaluate the effects of the program on mothers' knowledge of the dangers of shaking infants and the use of settling techniques at 2 months post intervention. Mothers received an educational intervention to help them respond to infant crying with the aim of reducing the incidence of shaken baby syndrome. Nurses received training and then delivered education to parents using the acronym PURPLE to outline normal infant crying and ways to respond.	Most (76%) of mothers rated the usefulness of the education as 9 or 10 out of ten. More than half of mothers correctly answered all questions relating to the dangers of shaking an infant (54%) and crying (57%). Fifty-one per cent of mothers could remember one or more soothing techniques and 58% had used a soothing technique.
Period of PURPLE Crying intervention North Carolina, USA **Zolotor et al. 2015**	Pre and post intervention comparison of phone calls to a parent help line and analysis of abusive head trauma rates. Parents of newborns (n=405,060) received an educational intervention to help them respond to infant crying with the aim of reducing the incidence of shaken baby syndrome. Nurses received training and then delivered education to parents using the acronym PURPLE to outline normal infant crying and ways to respond.	Decreased number of parent phone calls to nurse helpline about baby crying (20% for infants <3mo, 12% for infants <3 months). No change in state cases of abusive head trauma.
Other interventions		
SEEK (Safe Environment for Every Kid) model of pediatric primary care. USA **Dubowitz et al. 2012**	RCT (n=18 private practices with n=1,119 mothers) to investigate whether the SEEK intervention could reduce child maltreatment in a low-risk population. Paediatricians and nurse practitioners implemented the SEEK model after attending a four-hour training session. The SEEK intervention involved brief assessment and initial intervention for certain social problems that affect children's wellbeing (i.e. depression, substance abuse, major stress, IPV).	Mothers in SEEK reported less psychological aggression (p=0.006) and minor physical assaults (p=0.19) towards their children at baseline and 12 months later. No statistically significant difference in abuse/neglect concerns documented in medical record. No statistically significant difference in reports of abuse/neglect to child protection services.
Runaway Intervention Programme (RIP) Canada **Edinburgh & Saewyc 2009**	Program evaluation of runaway intervention program delivered to n=21 adolescents. Advanced practice nurses offered home-visiting and case management to adolescents (10-14 years) who had experienced extra-familial sexual abuse. Visits initially occurred four times per month and then tapered off over the period of a year. Nurses assisted with activities tailored to the adolescent such as screening for STIs and pregnancy, connecting with community services and health promotion.	Decreased chlamydia infections (55% down to 15%). No pregnancies. All participants re-enrolled in school. Risky behaviours and runaway episodes appeared to decrease (difficult to assess due to varying definitions). All participants used some form of contraception during part of the program. One hospitalisation due to suicidal ideation, one hospitalisation due to substance dependency.

Baby Steps United Kingdom **Hoggs et al. 2015**	Program evaluation of parents who participated in a perinatal education program (n=148 surveys, n=51 interviews, n=>200 pre/post tests, n=28 follow-up surveys). Intervention can be delivered by nurses, midwives and children's services' professionals and aims to improve the wellbeing of disadvantaged families as they prepare for their child's birth. Intervention is inclusive of fathers and is based on positive relationships and engagement with families.	Parents felt they had acquired new knowledge about parenting Parents felt that they had decreased anxiety and depressive symptoms Parents experienced increased confidence Parents felt they experienced a more positive relationship with their baby and partner
Intervention to improve wellbeing of grandmothers raising grandchildren South-eastern USA **Kelley et al. 2010**	Longitudinal pre-test, post-test (n=529 grandmothers) of an intervention that aimed to improve the wellbeing of grandmothers who were legal carers for their grandchildren. Nurses were accompanied by social workers and visited the grandmothers monthly or bi-monthly for 12 months. The focus of these visits was on the grandmothers' physical and mental health and the nurse conducted health assessments, identified client goals and addressed health concerns as required.	Grandmothers experienced an increase in emotional role functioning, general health, vitality, social functioning, and mental health as measured by the Short Form-36 General Health Survey (SF-36). There was no significant increase in grandmothers' physical functioning.
123Magic Parenting Program Japan **Kendall et al. 2013**	Exploratory, quasi-experimental study to investigate whether a parenting program (n=49 mothers) influenced parenting self-efficacy and stress. The 123Magic parenting program was facilitated a public health nurse in a public nursery school. The aim of the program was to teach parents techniques to reduce undesirable behaviour and encourage positive behaviour in their children.	Mothers reported that they saw changes in the way the responded to their child and in their ability to control their emotions. Mothers had increased parenting self-efficacy (TOPSE) and reduced parenting stress scores (PSI).
Families and School Together (FAST) babies Canada **McDonald et al. 2009**	Mixed methods, programme evaluation (pre/post test) of adolescent mothers (n=128) who along with their families participated program. The aim of the program was to engage adolescent mothers in a socially inclusive experience to enhance mother-infant bonds, increase positive parenting and social support. Nurses worked with a social worker and occupational therapist to facilitate the group sessions that encouraged cross-generational interactions, baby-friendly activities, mother-baby massage and peer-support.	Adolescent parents reported improvements in self-confidence, relationship with their baby and decreases in parenting stress. Grandmothers reported improved family functioning and reduced conflict. Qualitative feedback showed that the adolescent parents felt their baby enjoyed the activities and interactions with other children.
Infant massage and parenting enhancement program Florida, USA **Porter et al. 2015**	Three group RCT (n=62 massage and parenting education 1, n=37 parenting education only, 2, n=39 control) investigating whether an infant massage intervention integrated into a multi-dimensional parenting enhancement program could improve mental health outcomes, degrease parental stress, improve self-esteem and mother-infant interactions in mothers who were recovering from substance-abuse. Nurses taught mothers infant massage, infant appropriate play activities and led discussions about childcare practices to mothers recovering from substance abuse.	Both intervention groups had decreased in depressive symptoms (Beck Depression Inventory) and reduced parenting stress (Parenting Stress Index). No differences in self-esteem, attachment or mother-infant interactions.
Residential early parenting centres Melbourne, Australia **Rowe and Fisher 2010**	Prospective cohort design to examine the impact of a residential early parenting program (n=153 mothers with babies <12 months) on maternal mental health and infant behaviour disturbance at one and six months post-discharge. The residential program was staffed by maternal and child health nurses and early childhood professionals to provide support, education and role-modelling in group and individual settings.	At one month post intervention, mothers felt less worried, sad and irritable, and felt their levels of energy and ability to think clearly had improved. Infant crying/fussing had reduced and were sleeping for longer. Maternal confidence increased (94% fairly or very confident at six months post discharge).

Appendix 5: Summary of nurse effects on measures of abuse and neglect: literature review 2: how do nurses keep children safe from abuse and neglect, and does it make a difference? A scoping review

Effect	Studies	Summary of effects (statistically significant, if relevant)
Direct measures of abuse and neglect		
Reports to child protection services	Barlow et al. 2007,	No change.
	Dubowitz et al. 2012,	No change.
	Eckenrode et al. 2016,	Fewer substantiated reports.
	Mejoubi et al. 2015,	Fewer reports.
	Sadler et al. 2013,	No change in active child protection cases.
	Zielinski et al. 2009.	Longer time until first report; fewer overall reports.
Severity of abuse/neglect	Kobayashi et al. 2015	Reduced severity of abuse/neglect.
Detection of abuse	Louwers et al. 2012	Five times higher rate of detection of abuse.
Parental reports of violence	Dubowitz et al. 2012	Less psychological & physical aggression towards children (maternal report).
	Mejdoubi et al. 2013	Reduced victimisation and perpetration of intimate partner violence.
Abuse/neglect documented in medical record.	Dubowitz et al. 2012	No change in abuse/neglect documented in medical record
	Robling et al. 2016	Higher rates of documented abuse/neglect.
Non-accidental injury (child)	Altman et al. 2011	75% decrease in abusive head injury incidence.
	Dias et al. 2017	No change in hospitalisation for abusive head injury.
	Zolotor et al. 2015	No change in incidence of abusive head injury.
Risk factors for abuse and neglect		
Knowledge and attitudes	Altman et al. 2011	Most parents could recall intervention (head injury prevention)
	Dias et al. 2017	Most parents could recall intervention (head injury prevention)
	Fujiwara et al. 2015	Increased maternal knowledge of crying and dangers of shaking a baby.
	Goutlet et al. 2008	Most parents felt information and action plan was useful (head injury prevention).
	Guthrie et al. 2008	Increased parenting knowledge.
	Hogg et al. 2015	Increased parenting knowledge.
	Ogunfowokan & Fajemilehin 2012	Increase in girls' knowledge of sexual abuse; no change in attitudes.
	Reese et al. 2014	Most parents recalled intervention and had increased knowledge of head injury prevention.
Self-efficacy; maternal confidence; parental stress	Fujiwara et al. 2012	No change in in parental stress.
	Hogg et al. 2015	Increased parental confidence.
	Kendall et al. 2013	Reduced parental stress; increased self-efficacy.
	Kemp et al. 2012	Mothers felt more able to care for themselves and their baby.
	McDonald et al. 2009	Improved self-confidence, decreased parental stress.
	Porter et al. 2015	Reduced parental stress.
	Rowe & Fisher 2010	Increased maternal confidence.
	Sawyer et al. 2014	No change in parental stress or satisfaction with parenting role.
	Sawyer et al. 2013	Reduced parental stress; greater satisfaction with parenting role.
	Stubbs & Achat 2016	Most parents felt better able to cope
Home environment	Flemington et al. 2015	Improved suitability of home environment
	Guthrie et al. 2008	Improved suitability of home environment
	Medjoubi et al 2015	Improved suitability of home environment
Birth spacing	Olds et al. 2007	Longer pregnancy spacing.
	Sadler et al. 2013	Longer pregnancy spacing.

	Robling et al. 2016	No change in pregnancy spacing
Parental responsivity	Flemington et al. 2015	Increased maternal responsivity.
	Guthrie et al. 2008	Increased maternal responsivity.
	Kemp et al. 2011	Increased maternal responsivity.
	Porter et al. 2015	No change in attachment or maternal responsivity.
	Ordway et al. 2014	No change in parental reflective functioning.
	Sadler et al. 2013	High risk mothers had improved reflective functioning.
Parental social trust and community connectedness	Fujiwara et al. 2012	No change in social trust.
	Stubbs & Achat 2016	Increased participation in community groups.
Parent/carer physical and mental health.	Flemington et al. 2015	Increased maternal depressive symptoms
	Hogg et al. 2015	Reduced anxiety and depressive symptoms
	Kelley et al. 2010	Increased perceived health.
	Kemp et al. 2012	Increased perceived health, no change in objective measures.
	Porter et al. 2015	Reduced maternal depressive symptoms.
	Sadler et al. 2013	No difference in maternal depressive symptoms or psychological distress
	Rowe & Fisher 2010	Improved maternal mood.
Substance Use	Olds et al. 2007	Lower substance use (mothers).
	Robling et al. 2016	No change in smoking (mothers).
	Sawyer et al. 2014	No change in alcohol or tobacco use (mothers).
	Sawyer et al. 2013	No change in alcohol or tobacco use (mothers).
Functioning	Kelley et al. 2010	No change in perceived physical functioning.
	Kobayashi et al. 2015	Improved family functioning.
	McDonald et al. 2009	No change in mothers' family functioning; grandmothers perceived lower family conflict.
Reliance on welfare	Olds et al. 2007	Lower reliance on food stamps; no change in welfare use.
Child health and wellbeing outcomes		
Sexual health	Edinburgh & Saewyc 2009	Reduced STIs and no pregnancies (adolescent).
Infant/child behaviour	Barlow et al. 2007	Infant more cooperative.
	Kitzman et al. 2010	Reduced internalising behaviour, unchanged externalising behaviour.
	Mejdoubi et al. 2015	Reduced internalising behaviour, unchanged externalising behaviour.
	Rowe & Fisher 2010	Reduced infant crying and fussing; improved infant sleep.
	Ordway et al. 2014	Reduced externalising behaviour.
Infant/child physical and mental health.	Kemp et al. 2011	Improved mental development for children of psychologically distressed mothers.
	Sadler et al. 2013	Improved attachment relationships at 12 months. More infants up-to-date with screening & immunisation at 12 months, but not 24 months.
	Sawyer et al. 2014	No change in infant health.
	Sawyer et al. 2013	Small change in infant sleep; otherwise no change.
	Edinbrugh & Saewyc 2009	Decreased risky behaviour (adolescent).
	Olds et al. 2007	Lower infant mortality.
Substance use	Kitzman et al. 2010	Lower substance use (child).
Child educational success	Kitzman et al. 2010	Higher GPAs.
	Olds et al. 2007	Higher GPAs.
Rates of breastfeeding	Barlow et al. 2007	No change
Service use and quality		
Judicial outcomes (SANE)	Golding et al. 2015	Guilty verdict more likely when SANE testified (mock juror).

	Horner et al. 2012	No change in judicial outcomes.
	Patterson & Campbell 2008	Guilty verdict more likely when SANE involved.
Quality of care	Bechtel et al. 2008	More likely to receive appropriate interventions post-sexual assault.
	Horner et al. 2012	More likely to receive appropriate interventions post-sexual assault.
Service use	Sawyer et al. 2013	No change in service use.
	Sawyer et al. 2014	No change in service use.
	Zolotor et al. 2015	Fewer phone calls to parent help line about infant crying.

Appendix 6: Summary of studies from literature August 2015 to present: literature review 1 (update)

Key: CAN=Child Abuse and Neglect; CHC=child health care; CPS=child protection service; DVA=Domestic Violence and Abuse; GP=general practitioner; HCP=health care professional; HV=health visitor; NAI=non-accidental injury; NFP=nurse family partnership; NP=nurse practitioner; SA=sexual abuse.

Authors, Date & Location	Aim	Methodology, Methods & Participant Description	Findings
Barrett et al. (2017) Ireland	To explore paediatric nurses' views of caring for infants who have suffered nonaccidental injury (NAI).	Qualitative, framework approach, semi-structured interviews with inpatient paediatric nurses (n=10).	Nurses experienced difficult relationships with families; hid strong negative emotions and advocated for child. Nurses maintained professionalism; cared for parents & child through observation & documentation. Nurses relied on collegial support; saw NAI cases as learning opportunities.
Chan et al. (2020) Hong Kong	To assess nurses' knowledge and perceptions of child protection, examine factors associated with intention to report and explore their views on implementing mandatory reporting in Hong Kong.	Quantitative, cross-sectional online survey of nurses (n=91) working in Hong Kong.	Most nurses had no pre-service (52%) or workplace training (n=86%); most felt their training was inadequate (68-76%) Mean knowledge score was 6.6 (out of 13) with most (89%) nurses incorrectly believing child maltreatment typically results in child removal. Wide consensus that protecting children was part of a nurses' professional responsibility with nurses largely supportive of the proposal to implement mandatory reporting
Ceccucci (2018) USA	To evaluate nurse practitioners' (NPs) current approach and self-reported competence in the care of sexually abused (SA) children in the primary care setting.	Quantitative, cross-sectional survey of NPs (n=110) who were members of a state nursing organisation.	Few NPs (25%) felt competent assessing for suspected SA, most preferred to refer children (77%) & wanted more training (78%); Only 80% 'usually' reported suspected SA. Half (52%) felt reporting was beneficial, 20% felt it would cause family disengagement.
Dahlbo et al. (2017) Sweden	To describe child health care (CHC) nurses' experiences when encountering families in which child maltreatment was identified or suspected.	Qualitative, content analysis, interviews with CHC nurses (n=8).	Nurses experienced difficult relationships with families; mistrust and potential damage to therapeutic relationship; Nurses kept an open mind & discussed concerns with colleagues. Nurses disappointed they were not more involved so they could receive feedback and learn.
Drinkwater et al. (2017) England	To explore how and why general practice clinicians document domestic violence and abuse (DVA) in families with children.	Qualitative, telephone interviews (n=54) with GPs (n=42) and practice nurses (12).	Many clinicians not confident documenting DVA; half had experience, and few had training. Variable practice around where DVA was documented (i.e. record of perpetrator, children, victim, multiple). Clinicians concerned DVA record might be seen by perpetrator so hid documentation.
Einboden et al. (2019) Canada	To explore mandatory reporting within the context of British Columbia legislation and how nurses navigate legislation to address concerns of child abuse.	Qualitative, analysis of guidelines relating to child protection and interviews with nurses (n=21).	Nurses had limited resources; CPS implemented siloed and short-sighted responses ignoring pending issues. Nurses not convinced that reporting helped the child; concerned families would disengage and receive no support.

			Reporting abuse only one of many possible interventions; nurses had practical strategies to support families.
Foster et al. (2017) USA	To investigate health care professionals' (HCPs) attitudes making a child maltreatment report in a multi-speciality hospital.	Quantitative, cross-sectional survey of HCPs (n=114) from a large hospital; (n=68 medical staff, n=28 nurses, n=20 other).	Felt mostly or very comfortable asking families about maltreatment (57%). Fewer (44%) felt mostly or very prepared/trained, or knowledgeable about community resources (37%).
Gibbs et al. (2019) New Zealand	To examine the lived experience of nurses who care for children and their families admitted to hospital with non-accidental head injury (NAHI).	Qualitative, hermeneutic phenomenology, interviews with nurses working in hospitals (n=6).	Caring for children with NAHI different to other head injuries; different protocols and relational complexities. Nurses distanced themselves from investigations to remain non-judgemental and advocates for child; Mistrust of family/caregivers meant nurses felt unable to implement family-centred care.
Hornor et al. (2017) USA	To describe paediatric nurse practitioner (PNP) practice behaviours related to screening and providing anticipatory guidance for child maltreatment.	Quantitative, cross-sectional survey of PNPs (n=243) who were members of a professional organisation.	Many PNPs do not routinely screen for child abuse and risk factors; especially SA. Half of PNPs routinely discussed discipline (47%) and infant crying (53%). Few PNPs routinely ask about domestic violence (12%); 41% ask only if reason to suspect domestic violence.
King (2016) Scotland	To explore health visitors accounts of assessment and judgement in health visiting in the context of policy change and an increased focus on risk, which is reshaping practice.	Qualitative, semi-structured interviews with health visitors (HV), n=16.	HV assessed cleanliness of home, relationships & routines of mother/baby and physical indicators of health; HVs emphasised relational and communication skills; aware of potential stigmas attached to their judgements. HVs developed assessment skills experientially to look at multiple layers of complex situations.
King (2018) Scotland	To explore how policy change, in the form of Hall 4, was shaping health visiting (HV) practice and being experienced by families.	Qualitative, fieldwork involving informal discussions with policy-makers & practitioners, and semi-structured interviews (HV n=16 & mothers n=20).	HVs and mothers understood vulnerability broadly; could be any challenging parenting experience. Policy definition of 'risk' was through socioeconomic status & inequality silenced other forms of vulnerability; HVs given limited resources to support women not 'at risk'; Explicit focus on 'at-risk' mothers further marginalises them.
Kraft et al. (2017) Sweden	To explore the ability of the school nurses to detect and support sexually abused children.	Qualitative, secondary analysis of focus group interviews with school nurses (n=23).	School nurses preferred not to mention sexual abuse; critical of selves for not following up past suspicions. School nurses reported uncertainty when faced with possible signs of SA, needed courage and more knowledge. School nurses had strong emotional reactions to sexual abuse and distanced themselves with euphemisms.
Kuruppu et al. (2018) Australia	To explore general practitioner (GP) and practice nurse (PN) experiences and perceptions of mandatory reporting of child abuse.	Qualitative, thematic analysis of interviews (n=17) with GPs (n=12) and PNs (n=5).	Participants uncertain about mandatory reporting requirements; described inconsistent practices. Emotions influenced reporting, such as fear of adverse relational outcomes or previous negative experiences. Reporting seen as not useful and 'daunting'.

			Perceived poor organisation support and education.
Lavigne et al. (2017) USA	To explore the perceptions of child maltreatment among inpatient paediatric nurses.	Quantitative, cross-sectional survey of inpatient paediatric nurses (n=80).	Most had received adequate training (59%) and felt confident to identify child abuse (88%). However, some (25%) received no training and/or were not familiar with relevant state laws (40%).
Li et al. (2017) China	To assess HCPs knowledge, attitudes and perceived behaviour around identifying, assessing and reporting child maltreatment.	Quantitative, cross-sectional survey of healthcare professionals (n=877), doctors (n=536), nurses (n=281) and managers (n=60).	HCPs had limited knowledge of potential signs of abuse; few had training (3%). Most confident protecting child's privacy (71%), but some 30% not confident with medical examination. Most willing to report, but perceived lack of knowledge (77%); some (n=63) felt reporting was not part of their role.
Maul et al. (2019) Pakistan	To (1) explore challenges faced by HCPs when managing cases of abuse, (2) explore cultural beliefs and how these shape practice and (3) identify training needs.	Qualitative, in-depth interviews with hospital-based HCPs (n=15), (doctors (n=8), nurses (n=6) and security guard (n=1)).	HCPs experienced challenges with communication, fear of impacts and believing it is not their responsibility. HCPs perceived lack of action from social organisations and poor law enforcement. HCPs based assessments of physical abuse on own beliefs of physical discipline. HCPs wanted more training; had limited opportunities to access training in child abuse after preservice education.
Newman and Vasey (2020) United Kingdom	To explore the experience of nurses involved in safeguarding work and identify the systems they access for emotional support.	Qualitative, phenomenological study, in-depth semi-structured interviews (n=8) with specialist children's nurses and general nurses who work with children in hospital settings.	Nurses felt pressure to be on constant lookout for child abuse and neglect. Safeguarding was perceived as anxiety provoking, stressful and poorly coordinated. Nurses accessed multiple support through informal discussions with colleagues and more formally from designated safeguarding teams. Formal debriefing was perceived as a useful way to reflect, learn and share emotions.
Nouman, Alfandari, Enosh, Dolev, and Daskal-Weichhendler (2020) Israel	To investigate how community HCPs manage their mandatory reporting duty and what factors affect their reporting behaviour.	Qualitative, in-depth semi-structured interviews with HCPs (n=18) working in community settings across 14 sites in seven cities in Northern Israel. HCPs were paediatricians (n=7), nurses (n=5), social workers (n=4), physiotherapists (n=1) and occupational therapists (n=1).	Participants knew how to report, but experienced anxiety doing so often due to fear of mistakes (n=8). Many participants (n=13) did not received feedback about the child so they could reflect on their practice.
Patrick et al. 2020 United Kingdom	To identify and address the barriers of reporting safeguarding concerns amongst a hospital team.	Quantitative, cross-sectional surveys with three consecutive groups (Group 1 n=100, Group 2 n=100, Group 3 n=76) attending safeguarding training. Training content was adapted based on feedback from Group 1. Participants were HCPs including nurses, but breakdown by profession was not provided.	Most participants felt safeguarding training was adequate, some felt they required additional training to increase confidence. Most (95%) participants perceived a lack of feedback on child outcomes, so were never sure if their interventions was beneficial. Most common barrier to reporting was lack of certainty and concern for safety of child and self (the participant).
Saltmarsh and Wilson (2017) New Zealand	To explore the processes neonatal intensive care nurses used in their child protection role with preterm infants.	Qualitative, Glaserian grounded theory, in-depth semi-structured interviews with neonatal intensive care nurses (n=10).	Nurses drew upon personal and professional experiences to identify at-risk neonates. Nurses experienced sense of ownership and protectiveness towards neonate i.e. 'my baby.' Nurses had varying relationships with 'dodgy' families; could either promote or discourage family engagement.

			Ultimately had to trust that family and system would support the baby on discharge despite doubts.
Sigad et al. (2019) **Israel**	To provide an insider's view and analysis of how Israeli healthcare professionals give meaning to their experiences related to child abuse and neglect.	Qualitative, social constructivist, interviews with HCPs (n=20), doctors n=11, administrators n=2, nurses n=5 & social workers n=2.	Participants experienced uncertainty when working with the complexities and ambiguities of child abuse. Saw their role as a pioneer; they were advocates for children in the context of poor systemic support.
Sundler et al. (2019) **Sweden**	To describe school nurses' experiences of suspecting, identifying, and reporting child abuse and compare them with respect to (a) years of experience, (b) age of nurse and (c) pupil population size.	Quantitative, cross-sectional survey, convenience sample of school nurses (n=233) attending national conference.	Most school nurses had suspected child abuse (96%) and made reports (84%). Many school nurses had concerns about honour-related violence (54%) and/or sexual abuse (57%). More experience school nurses more likely to have suspected and reported abuse. Participants wanted more education around child abuse.
Svard (2016) **Sweden**	To 1) explore the extent to which HCPs report cases of children at risk to social services and extent to which they do not report; To 2) analyse the extent to which possible factors influence the decision to report.	Quantitative, cross-sectional survey of HCPs (n=295), physicians (n=72), nurses (n=119), nurse assistants (n=70) and social workers (n=34).	Physicians & social workers most likely to report; some respondents had never reported (nurse assistant 89%; nurse 68%). Feeling unsure about assessment had most influence on decision to report. Access to guidelines & routines did not necessarily increase reporting rates.
Taylor, Smith, et al. (2016) **Scotland**	To establish whether there was a relationship between communicative role and emotion work of HV and lack of visibility, identify what impact this has on professional-wellbeing and supports.	Qualitative, hermeneutic phenomenology, interviews with health visitors (HV) (n=10).	HV felt professionally isolated in complex situations; Formal supervision not helpful; instead discussed cases with trusted colleagues. Felt stressed, overwhelmed & overworked in attempting to maintain perceived professional standards. Had to manage complex emotions to stay child centred.
Tchernegovski et al. (2017) **Australia**	To examine clinicians' experiences when working with parents and identify strategies they found to be effective.	Qualitative, phenomenology, interviews with mental health (MH) clinicians (n=11), n=2 MH nurses.	Participants developed strategies to manage difficult conversations about parenting and risks to children. Uncertainty/lack of information made decisions difficult; support from colleagues was essential. Disappointment arose from lack of support and time delays from CPS.
Tiyyagura et al. (2015) **USA**	To understand the stakeholder perspectives of the program and to explore factors influencing implementation.	Qualitative, interviews with community stakeholders (n=27), child abuse and neglect (CAN) champions, CAN experts, managers and social workers (n=3 nurses).	Participants appreciated access to CAN experts to help with uncertain cases. Participants valued networking to improve interagency communication and build professional relationships.
Tung et al. (2019) **USA**	To identify factors that influence the ability of the Nurse-Family Partnership (NFP) and CPS to collaborate in serving high-risk mothers.	Qualitative, interviews with NFP, CPS workers and community partners.	NFP and CPS reported strongest collaboration when working with families served by both programs. There was misalignment between CPS and NFP goals, with CPS adversarial and NFP strengths-based. CPS and NFP had different definitions and conceptualisations of risk and safety.
Wallstrom, Persson, and Salzmann-Erikson (2016)	To describe nurses' experiences and reflections regarding their work with children in families with parental substance abuse.	Qualitative, qualitative descriptive approach, interviews with nurses (n=7).	Nurses felt their role was to report adverse circumstances to social services. Nurses assessed children's behaviour and built upon children's support networks.

			Nurses faced tensions between promoting children's wellbeing and keeping families together.
Sweden			
Whittaker et al. (2015) **Scotland**	To explore the views and experiences of HCPs in relation to providing parenting support for drug-using parents.	Qualitative, focus groups (n=4) with multidisciplinary HCPs (n=18), including GPs (n=3), community midwives (n=4), health visitors (n=5), addiction nurses (n=5) and a psychiatrist (n=1).	Practice driven by a child protection focus; risk management rather than strengths-based approach. HCPs had difficulty describing their work in parenting support; felt their role was around monitoring and referral. HCPs described drug-using parents as inherently risky, damaged, dishonest and inadequate.
Wideman et al. (2019) **USA**	To improve understanding of rural nurse home visiting in the US through a qualitative evaluation of case files from the Nurses for Newborns agency.	Qualitative, content analysis of rural nurse home visitation case files from the Nurses for Newborns agency. Nurses for Newborns provides nurse home visiting services pre and postnatally vulnerable mothers. Case records (n=433 families) were qualitative analysed from three separate rural counties.	Nurses commonly encountered family vulnerabilities of poverty, housing, maternal mental health, substance abuse and lack of resources. Nurses perceived that rural location exacerbated access to resources, especially as transport was often unavailable to families. Nurses had to be flexible with professional boundaries due to lack of resources (i.e. telephones, transport) and their personal residence in the community.
Williams et al. (2019) **USA**	To report risk assessment findings from a study that explored interorganisational collaboration between Nurse Family Partnership (NFP) and Child Protection Services (CPS) in Colorado.	Qualitative, in-depth interviews (n=112) with NFP nurses (n=50) and CPS workers (n=62).	NFP practice not standardised; used nursing judgement; CPS instead had formalised processes. No shared understanding of risk: NFPs did not differentiate between risk & safety, CPS did. NFPs saw inconsistencies in CPS definition of 'reportable' and worried how reporting affected client relationship.

Appendix 7: Summary of studies from literature September 2017 to present: literature review 2 (update)

Key: CFH=Child and Family Health; CPS=Child Protection Services; ED=Emergency Department; EHD=Early Head Start; NFP=Nurse Family Partnership; NHV=Nurse Home Visiting; NP=Nurse Practitioner; RCT= Randomised Controlled Trial; PAT=Parents as Teachers; PTSD=Post Traumatic Stress Disorder; SANE=Sexual Assault Nurse Examiner.

Intervention name or description. Authors, publication date and location.	Study design and outline of intervention. Summary of nurses' role(s).	Evidence to support or refute efficacy of the intervention.
Home visiting interventions		
Family Connects program North Carolina, USA **Dodge et al. (2019)**	RCT of the Family Connects program to assess its implementation and impacts when provided by a community agency (n=936 births). Family Connects is a universal public health intervention underpinned by a systems- based approach to supporting families following the birth of a child. It aims to promote healthy development in early childhood. Nurses provided mothers with one to three home visits and used motivational interviewing to assess and clarify families' needs and provide referrals to pre-identified community agencies as applicable.	Nurses identified and provided referrals for high needs in 42% of families; 83% of families took up the referral. Intervention group had 44% lower rates of investigation by CPS and lower rates of potential maternal anxiety or depression (18 vs 26%). Mothers receiving intervention had fewer ED visits for higher risk babies, attended recommended postnatal follow-up (90% vs 83%) but had more ED visits for maternal health.
Right@home Australia **Goldfeld et al. (2019)** **Goldfeld et al. (2018)**	RCT of Nurse Home Visiting (NHV) delivered via universal CFH services for pregnant women experiencing adversity (n=722 total). Nurses were qualified child and family health nurses (postgraduate qualifications) and completed family partnership model training. Program nurses undertook additional 13hrs training (online and face-to-face) and had opportunity to undertake monthly group supervision (1 hr).	Intervention group had more regular child bedtimes, increased home safety, increased warm parenting, less hostile parenting, and increased parental involvement.
Nurse-Family Partnership Memphis, USA **Kitzman et al. (2020)**	RCT of the Nurse-Family Partnership with low-income first-time pregnant mothers (n=742) exploring impacts on pregnancy outcomes, child health and development and parental health and life course. Women were offered free transportation for prenatal care and child developmental screening (control n=514) or prenatal and infant nurse home visiting (up to infant age 2 years) plus transportation and screening (intervention, n=228). Nurses worked towards program aims by developing a trusting relationship, getting to know mothers' aspirations and concerns and provided referrals as required. This study reported on the impacts of the Nurse Family Partnership on the cognitive, academic achievements and behaviour of 18-year-old firstborn youth (n=629).	Higher rates of high-school graduation with honours in intervention group. Youth born to the most vulnerable mothers had better math scores and emotional recognition compared with control group; other measures unchanged (sustained attention, risky decision-making, high school graduation). Female youth had fewer criminal convictions compared with control group; other measures were unchanged (internalizing/externalising, total behavioural problems or substance use, male criminal convictions).
Pennsylvania Nurse-Family Partnership (NFP), Parents as Teachers (PAT) and Early Head Start (EHS) programs. Pennsylvania, USA **Matone et al. (2018)**	Mixed-methods, entropy-balanced retrospective cohort analysis of families enrolled an early childhood home visiting services (NFP n=8736, PAT n=851, EHS n=866). Interviews with clients (n=76) and staff (n=74); specific details of nurse roles and program aims not stated.	Children significantly more likely to experience episode of abuse than comparison. Qualitative data suggested: 1. abuse perpetrated by individuals other than primary carer (i.e. individual not enrolled in program). 2. There was lack of support for from other services, including CPS.
Nurse Family Partnership (NFP) United Kingdom **Paine et al. (2020)**	Pragmatic, non-blinded RCT comparing usual care to the NFP. The NFP supported vulnerable young mothers and first-born children through specialist nurse home visiting. This study reported on outcomes relating to mothers' propensity to discuss internal emotional states during mother-child interactions when the child was aged 24 months.	No change in mothers' use of internal emotional state language between the NFP and control group.

South Australian Nurse Home Visiting (SANHV) programme South Australia **Sawyer et al. (2019)**	Quasi-experimental, natural experiment of progressive rollout of NHV in three regions (metro n=175, rural n=79, comparison n=91). Community nurses visited families 34 times until the child was 2 years old based on the Nurse Family Partnership Model.	No change in children's outcomes at 5 years (school readiness, quality of relationship with parents and externalising/internalising behaviours).
Australian Nurse Family Partnership Program for Aboriginal infants Central Australia **Segal et al. (2018)**	Retrospective and prospective cohort study with pregnant Aboriginal women in Central Australia (intervention n=291, control n=563).	Children in families who received intervention were significantly less likely to be involved with CPS, especially in younger or first-time mothers.
Minding the Baby Connecticut, USA **Slade et al. (2020)**	Cluster, two-group RCT testing the effects of the Minding the Baby program with young families (n=156) attending two community health centres. Families were in medically underserved populations, mostly living at or below the poverty line and from diverse cultural and ethnic backgrounds. Home visitors (nurses and social workers) visited mothers weekly from late pregnancy until the child was aged 12 months, when subsequent visits occurred fortnightly. The aim of the program was to improve developmental, health and relationships outcomes in vulnerable families with their first child.	Mothers in intervention group had higher levels of reflective functioning. Infants in intervention group were more likely to be securely attached. No difference mothers' depressive or PTSD symptoms, and no difference in the likelihood of mother-baby dyads having disrupted affective communication
Sexual abuse interventions		
Runaway Intervention Program Minnesota, USA **Bounds et al. (2019)**	Longitudinal, repeated measure design to retrospectively assess effects of the Runaway Intervention Program on trauma responses in runaway youth (n=362) who experienced sexual assault/exploitation. Nurse Practitioners (NPs) with training in trauma-informed care implemented the program under ongoing guidance and supervision. NPs provided individualised support including assessment, education, goal setting, medical care, referrals, emotional support and parental support/education.	Young people experienced decreased emotional distress, suicidal ideation/attempts and self-injury at 3, 6 and 12 months.
Other interventions		
Parenting and Life Skills Intervention for Teen Mothers Boston, USA **Cox et al. (2019)**	RCT with adolescent mothers (intervention n=72, control n=68) to explore whether an interactive parenting and life skill program could improve parenting and reproductive outcomes. The program (5 structured one-hour interactive sessions) was delivered by a nurse and/or social worker over the infant's first 15 months, Staff had 'ongoing training' and met weekly to discuss progress and participant feedback.	Mothers experienced improved self-esteem, caretaking ability, acceptance of the infant and preparedness for mothering. Repeat pregnancy at 36 months was significantly lower. Qualitative feedback from mothers was universally positive.
Group Family Nurse Partnership (gFNP) United Kingdom **Barnes et al. (2017)**	RCT with parallel-arms and prospective economic evaluation of nurse-led group support for young mothers during pregnancy and 12 months post-partum. Two nurses (one also a midwife) experienced with delivery of FNP jointly facilitated interactive group sessions with pregnant mothers through to infant 12 months of age. The nurse-midwife also provided routine antenatal care with a focus on self-awareness and self-efficacy, and routine infant health checks.	No difference in likelihood of child maltreatment. Only difference was in breastfeeding with women in intervention group more likely to breastfeed to 6 months.
Period of PURPLE Crying Program British Columbia, Canada **Barr et al. (2018)**	Retrospective-prospective surveillance of a 3-dose primary, universal education program on infant abusive head trauma (n=354,477 infants). Program materials were introduced by nurses or midwives in hospital and then followed up within 2 weeks and underpinned by a public awareness campaign. Nurses worked on maternity wards or public health offices and were trained by two full-time educators through updates and new-nurse training.	35% reduction in admissions for abusive head trauma for <24 month old infants

Appendix 8: Example participant recruitment flyer

Participants needed for research investigating how children's nurses keep children safe from abuse and neglect

<u>What is the purpose of this study?</u>

The aim of this study is to explore how nurses keep children safe from abuse and neglect so we can identify how the nursing workforce can be supported and empowered to improve outcomes for children. This study has been approved by Flinders University Social and Behavioural Research Ethics Committee [no. 7296].

<u>Am I eligible to participate?</u>

You are eligible to participate in this research study if:

- You are a registered nurse who provides nursing care to children in Australia, AND
- You have had at least one experience caring for a child about whom there were child protection concerns in the course of your professional duties.

<u>What does participation in this study involve?</u>

Participants will be invited to attend a face-to-face interview (Adelaide residents) or a telephone/Skype interview (other areas) with the primary researcher (Lauren Lines). This interview would last approximately 60-90 minutes.

<u>How can I get involved?</u>

For further information about this study, you can contact the primary researcher (Lauren Lines) via email: lauren.lines@flinders.edu.au

Appendix 9: Letter of introduction

Alison Hutton
Associate Professor
School of Nursing and Midwifery
GPO Box 2100
Adelaide SA 5001
Tel: 08 8201 3429
Fax: 82761602
CRICOS Provider No. 00114A

28/06/2016

LETTER OF INTRODUCTION

Dear Sir/Madam

This letter is to introduce Lauren Lines who is a PhD student in the School of Nursing and Midwifery at Flinders University. She will produce her student card, which carries a photograph, as proof of identity.

She is undertaking research leading to the production of a thesis or other publications on the subject of, "Children's nurses' perceptions and experiences of keeping children safe from abuse and neglect".

She would like to invite you to assist with this project by agreeing to be involved in an interview in which you would be asked questions on this topic. No more than 60 to 90 minutes on one occasion would be required.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Since Lauren intends to make a tape recording of the interview, she will seek your consent, on the attached form, to record the interview and to use the recording or a transcription in preparing the thesis, report or other publications, on condition that your name or identity is not revealed.

It may be necessary to make the recording available to a transcription service for transcription, in which case you may be assured that such persons will be asked to sign a confidentiality agreement which outlines the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on (08) 8201 3429 or e-mail alison.hutton@flinders.edu.au

Thank you for your attention and assistance.

Yours sincerely

Associate Professor Alison Hutton RN PhD
Associate Dean (Research)
School of Nursing and Midwifery

> *This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 7296). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au*

Appendix 10: Information sheet for participants

Ms Lauren Lines
School of Nursing and Midwifery
Faculty of Health Sciences

Room: N315b

Sturt Campus, Flinders University
Sturt Road, Bedford Park SA 5042

GPO Box 2100
Adelaide SA 5001

lauren.lines@flinders.edu.au

CRICOS Prov der No. 00114A

INFORMATION SHEET
Interview

Title: Nurses perceptions and experiences of keeping children safe from abuse and neglect.

Researcher:
Ms Lauren Lines
School of Nursing and Midwifery
Flinders University
Email: lauren.lines@flinders.edu.au

Supervisors:
Associate Professor Alison Hutton
School of Nursing and Midwifery
Flinders University
Ph: (08) 8201 3429

Associate Professor Julian Grant
School of Nursing and Midwifery
Flinders University
Ph: (08) 8201 2126

Description of the study:
This study is part of the project entitled '*Nurses perceptions and experiences of keeping children safe from abuse and neglect'.* This project will investigate how nurses who work with children help to keep children safe from abuse and neglect. This project is supported by Flinders University School and Nursing Midwifery.

Purpose of the study:
This project aims to explore perceptions and experiences of how nurses who work with children keep children safe from abuse and neglect. More specifically, this study aims to:

☐ Explore what influences children's nurses' perceptions of their role in keeping children safe,

- Identify factors that influence children's nurses decision-making when children are at risk of abuse and neglect,
- Explore children's nurses' perspectives of how they respond to children at risk of abuse and neglect.

Am I eligible to participate in this study?

You are eligible to participate in this research study if:
- You are a registered nurse who provides nursing care to children in Australia, AND
- You've had at least one professional experience as a registered nurse that involved caring for a child about whom there were concerns around abuse or neglect.

What will I be asked to do?

You are invited to attend a one-on-one interview with the primary researcher (Lauren Lines) who will ask you some questions about your professional experiences of caring for children where there have been child protection concerns. Alternatively, if you are located outside the Adelaide Metropolitan area, you could instead participate in a telephone or Skype interview. The interview will take no longer than 90 minutes. The interview will be recorded using a digital voice recorder to help keep an accurate record of your interview.

After your interview, the audio recording will be transcribed (written-up) by either the researcher or a professional transcription provider. The transcription provider will be required to sign a confidentiality agreement to protect your privacy. You will be emailed a copy of the transcript and at this time, you can decide if the transcript is an accurate representation of your interview experience. You will also have the opportunity to add to or clarify aspects of your transcript if you have additional thoughts to contribute.

What benefit will I gain from being involved in this study?

Although you may not personally benefit from being involved in this study, it is hoped that the results of this study will increase the visibility of the role and experiences of children's nurses in keeping children safe. It is expected that this will lead to a greater understanding of how the nursing profession can best be mobilised and supported to improve outcomes for children at risk of abuse and neglect.

Will I be identifiable by being involved in this study?

The only person who will know your identity is the primary researcher who conducts your interview. It may be possible for other people to identify your participation if you elect to attend an interview in a public or semi-public location; for this reason, anonymity cannot be guaranteed. The transcription provider may be able to identify you from the audio recordings, but they will not disclose your identity due to the confidentiality agreement. The researcher will keep your identity confidential unless required by law to disclose your identity. For example, in the unlikely event that you disclosed malpractice, the researcher would then be required by law to report this information to the Australian Health Practitioners Regulation Agency (AHPRA). You would be informed if the researcher felt that such a report was necessary.

Once the interview has been typed-up and you have had the opportunity to review your transcript, the voice file will then be deleted. Any identifying information will be removed and the typed-up de-identified file stored on a password-protected computer that only the research team have access to. The overall findings of this research will be reported in

2

publications such as journal articles, a PhD thesis and/or conference presentations. You and your employing organisation will not be individually identified in these publications.

Are there any risks or discomforts if I am involved?

The researcher anticipates few risks from your involvement in this study. However, it is possible that you could experience emotional distress upon recounting your professional experiences of caring for children who have been abused or neglected. If you become distressed, you have the option of pausing, postponing or ending your interview without consequence. If you find that the interview experience raises significant personal issues and you would like to discuss these further, it is recommended that you contact Lifeline (ph: 13 11 14), see your general practitioner or access your employee assistance program (EAP), if available. Details of whether your employer offers an EAP can be obtained from your employing organisation. The researcher would be happy to assist you to contact one of these services if required.

How do I agree to participate?

Participation in this study is voluntary. If you decide to participate in this study, please contact the primary researcher (Lauren Lines) via the contact details on page one.

You may decline to answer any questions and you are free to withdraw from the interview at any time without effect or consequences. However, once you have read and given signed approval of your transcript, withdrawal of your data will no longer be possible. This is because once data analysis has commenced, removal of individual participant's data becomes very difficult. A consent form accompanies this information sheet. If you agree to participate please read and sign the form and return it by email or if you prefer, you can return it at the time of your interview.

How will I receive feedback?

Outcomes from the project will be summarised and can be given to you by the primary researcher if you would like to see them.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 7296). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

3

Appendix 11: Consent form for participants

CONSENT FORM FOR PARTICIPATION IN RESEARCH
Interview

Nurses' perceptions and experiences of keeping children safe from abuse and neglect.

I …..

being over the age of 18 years hereby consent to participate as requested in the Information Sheet for the research project on nurses' perceptions and experiences of keeping children safe from abuse and neglect.

1.   I have read the information provided.

2.   Details of procedures and any risks have been explained to my satisfaction.

3.   I agree to audio recording of my information and participation.

4.   I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

5.   I understand that:

  ☐   I may not directly benefit from taking part in this research.

  ☐   I am free to withdraw from the project and am free to decline to answer particular questions. However, after I have approved my interview transcript and the researcher has commenced data analysis, it may not be possible to withdraw information that has already been gathered about me.

  ☐   While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.

  ☐   I may ask that the recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage. However, once I have reviewed and approved my transcript I realise I will no longer be able to withdraw my information.

7.   I have had the opportunity to discuss taking part in this research with a family member or friend.

Participant's signature………………………………………Date………………...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name………………………………..…………………….................

Researcher's signature………………………………..Date……………………

C:\Users\mann0198\Dropbox\Ethics Application PhD\Consent Form Template.doc
Updated 28 June 2006

NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 8 and 9, as appropriate.

8.   I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant's signature…………………………………Date…………………...

2

Appendix 12: Interview guide

Demographics:

- Years of experience as a registered nurse
- Years of experience as a children's registered nurse
- Qualifications
- Any education and training related to keeping children safe?
- Description of your role within your organisation

Interview areas

- Please reflect on your experiences of caring for children where there were concerns about abuse and neglect. Think about one or more times that stood out to you as significant. Tell me about these experiences in any way you like.

Interview prompts

- How did you decide that this was abuse/neglect? What were the red flags for you?
- What did you do? How did you decide what action(s) to take?
- Who was with you at that time? What did they do?
- Did you discuss your concerns with anyone?
- Where did this happen? What were you thinking/feeling at this time?
- Can you tell me more about …..? What was it like for you when…..?
- Reflecting on this experience, is there anything you would do differently?
- How would you describe the culture of your workplace around keeping children safe?
- How do you personally define child abuse and neglect?
- To what extent does this definition apply to multicultural/Indigenous families in Australia?
- As a nurse, how do you see your role in keeping children safe from abuse and neglect?
- In your organisation, what guides your decision making around abuse and neglect?
- Some nurses say that their organisation's child protection policies and procedures are unhelpful or too vague. What do you think about this?
- What factors do you see as influencing your ability to keep children safe from abuse and neglect?
- Some nurses feel they don't have enough knowledge to be confident in their role in keeping children safe. What is your perspective on this?
- When the signs of child abuse or neglect are unclear, some nurses experience a tension between acting on concerns for a child's wellbeing and the chance that their judgement might be wrong. To what extent does this reflect your experiences?
- What would help you in fulfilling your role in keeping children safe?
- Literature suggests that children are often silenced or considered less important than adults. How do you see children's position in society?
- Recent approaches to keeping children safe involve a greater emphasis a 'child-focussed' approach. What have been your experiences with this approach?
- How much do you trust that child protection systems will keep children safe?
- Some nurses have experienced a conflict between their role in caring for families and their role in surveillance for abuse and neglect. What have been your experiences in this area?

Appendix 13: Excerpt from researcher's reflective journal: reflection on interview one 2/08/2016 2-3:30pm

This was my first interview for my research on children's nurses' perceptions and experiences of keeping children safe from abuse and neglect. It was a face-to-face interview and it was conducted in Sturt Campus Library study rooms.

I found that the interview did not turn out quite how I expected in a number of ways. Firstly, I often found that the interviewee did not answer questions in the way I expected – she answered them in a less succinct and round-about way. I think this shows I had certain assumptions about the way my questions 'should' or would be answered. It meant that I was trying to focus on what she way saying and how this related to my research goals the whole time. It is really exhausting listening to someone talk in an interview setting where you need to listen and think about how you can ask the list of 'prescribed' questions and/or identify relevant follow-up prompts to head the direction in the way that is relevant. I think one way I can reduce the amount of mental energy required during an interview would be to know my questions a bit better, but also change the formatting and ordering of my interview question sheet so it is easier to see what questions I've covered and which still remain. The flow of conversation obviously will not necessarily reflect the way that I have ordered my questions, but if I make them easier to read (i.e. bigger font and line spacing) I can see them better and maybe even tick of the ones that I've covered.

The expanded responses that the interviewee gave me meant I had difficulty knowing when to interrupt and redirect the interview to an area I was interested in versus allowing the interviewee to continue by discussing what was relevant to her. I've read about interview techniques which tends to advise against interrupting interviewees when they are talking but sometimes I felt the conversation got further off track than I would have liked. I'll reflect on this further when I transcribe the interview. I might find after transcribing that what I felt was not relevant at the time is relevant after I have the chance to reflect on it. This often happens with media reports and journal articles I read – I don't realise they important or relevant to start with, but upon reflection I realise that they are in some way

I got the impression the interviewee was trying to create a positive impression of [child protection department] despite the common negative view presented in the media. This is interesting and I wondered why she didn't just 'tell it like it is'. I got the feeling she might have been perhaps because she was wanting to create the image of supporting [child protection department] through professional comradery or whether this was more about concerns around displaying negative attitudes towards [child protection department] to me as the researcher. I asked about this later in the interview when she reported a negative experience of reporting about [child protection department]. The example was a worker at [child protection department] was asking the interviewee questions (to the effect of) 'is it really that big a deal?'

when the interviewee was convinced that it was a concern to the child's wellbeing. Although she acknowledged that [child protection department] is a 'broken system', she believes we need have trust in [child protection department] as it is the system that we've got. She seemed to discount the idea that perhaps [child protection department] were not doing a good job, but rather that the worker was perhaps just trying to work out how to record the incident in the best possible way that would lead to a response for the child.

I don't think the interviewee displayed many negative attitudes at all. I'm not sure why this might be, but I wonder if it might be because she was trying to give the answers I expected and/or present a positive view of how child protection works.

There was mention of vicarious trauma and how important it is to look after oneself in the interview. At the time, I wondered to what extent the interviewee was trying to protect me by censoring the stories she told me as I felt the stories were discussed in a non-emotive fashion that still demonstrated an interest in the child's wellbeing. She also discussed the importance of debriefing and clinical supervision to supporting professionals working in child protection. The interviewee spontaneously confirmed her intent was to protect me from vicarious trauma after the interview, expressing concerns about how I would deal with vicarious trauma throughout my research. I reassured her that I had strategies in place and explained what these strategies were. I wonder whether the perceived need to protect me from vicarious trauma might have been related to the way the interviewee positioned me in regards to differences in age and professional experience. I could consider next time whether it might be appropriate to tell the interviewee a bit about my professional experiences so they don't feel the same responsibility to shield me from potentially distressing experiences. This seems to be in contrast with the view as the researcher as the most powerful, but instead the interviewee positioned me as vulnerable and in need of protection. I appreciated that she cared about my wellbeing, but it was interesting that during the ethics application it was focused around how I was caring for the wellbeing of participants so it was an interesting turnaround! I wonder how this might have affected the data.

I noticed that when I asked the interviewee questions like 'what is abuse/neglect' this seemed to be a difficult question for her to answer. She automatically said that she needed to access the relevant policies/procedures. I wonder if this is a problem with my question about abuse – perhaps it needs a better lead-in so the interviewee can think of an answer more readily. Or alternatively, perhaps it is just really difficult to define abuse and neglect and this might be an important finding in and of itself; it may be that nurses have difficulty defining abuse and neglect. This is certainly reflected in the literature around 'good enough' parenting.

There was one misunderstanding during the interview around the concept of therapeutic relationships and what this meant. I think that as a nurse I assumed that another nurse would have the same understanding of a 'therapeutic relationship'. However, I understand therapeutic relationships in the more official and academic sense and as I teach first year nursing students the concept of therapeutic relationships as it is understood in the context of law, nursing ethics and professional boundaries. Whereas the interviewee understood 'therapeutic relationships' to be like 'therapy' or counselling. We clarified this misunderstanding and realised that the interviewee thought of 'therapeutic relationships' as 'relationships' with families but recognised there were definite professional boundaries.

I believed overall that the interviewee had genuine, positive and hopeful attitudes towards the children and families she cares for. She seemed to genuinely care about the families and hopeful that they could achieve the best outcomes for children. Her comment around cultural differences and what constitutes abuse was interesting. Her position was basically that if you live in a country, you have to follow its laws and gave the example of the domestic violence and women's position in society. She also linked this to safe sleeping and how the official position is to recommend against co-sleeping. I immediately wondered about how this might apply to Australia's First People who have not chosen to migrate to Australia but instead had laws imposed upon them by European settlers. However, I felt this might have been a rude question to ask as it implied she was not sensitive to issues around Aboriginal rights and the problems of colonisation. I tried to think of a polite/respectful way to phrase this question, but the conversation had moved on and I didn't get the opportunity to follow-up.

I did forget to ask one question around whether she finds policies/procedures too vague. It did not seem to fit with the flow of the conversation and we ran out of time.

I was well prepared for the interview and I booked a study room in the library (2.2). It was a pleasant physical environment that was warm and sufficiently private and quiet. I brought water with me to offer to the participant. I forgot to bring any tissues, but fortunately that was not a problem. I will be better prepared next time and put them in my pack so they are ready.

Further reflection upon transcription

Now that I'm transcribing (3 days after the interview) there is lots the interviewee said that I don't even remember her saying! I think it's because I was focussing so hard on where to direct the interview and how to word and order my questions that I couldn't focus as much on what the interviewee was saying. I will need to familiarise myself with my questions so less mental energy is spent on this during interviews allowing me to more intuitively direct the flow without thinking about it too hard.

It's also sometimes impossible to know what was said/meant. At one point the interviewee talks about something being 'parents' responsibility. Is this parent's responsibility? Implying one parent, namely the mother. Or parents' responsibility including both parents? We talked a lot about mothers in the interview, so I think she is referring to parents in an inclusive sense when she chose the word 'parents' as opposed to 'mother'.

I'm also seeing areas where I think I should have followed-up on certain points more. But I think it's not possible to follow-up on everything at the time as there's so much going on.

Some questions for me to consider for the future:

- Why might interviewees display primarily positive attitudes towards the subject matter and to what extent does this really reflect their views?
- How does the way the interviewee positions the researcher affect data collection?
- How can I ask questions that might be impolite i.e. pointing out contradictions or discrepancies?
- To what extent are my current interview questions difficult to answer due to their wording or design, versus difficult to answer due to the inability to define abuse/neglect?
- How will my perceptions about the usefulness of the data I obtained change upon transcription and reflection of the interview?
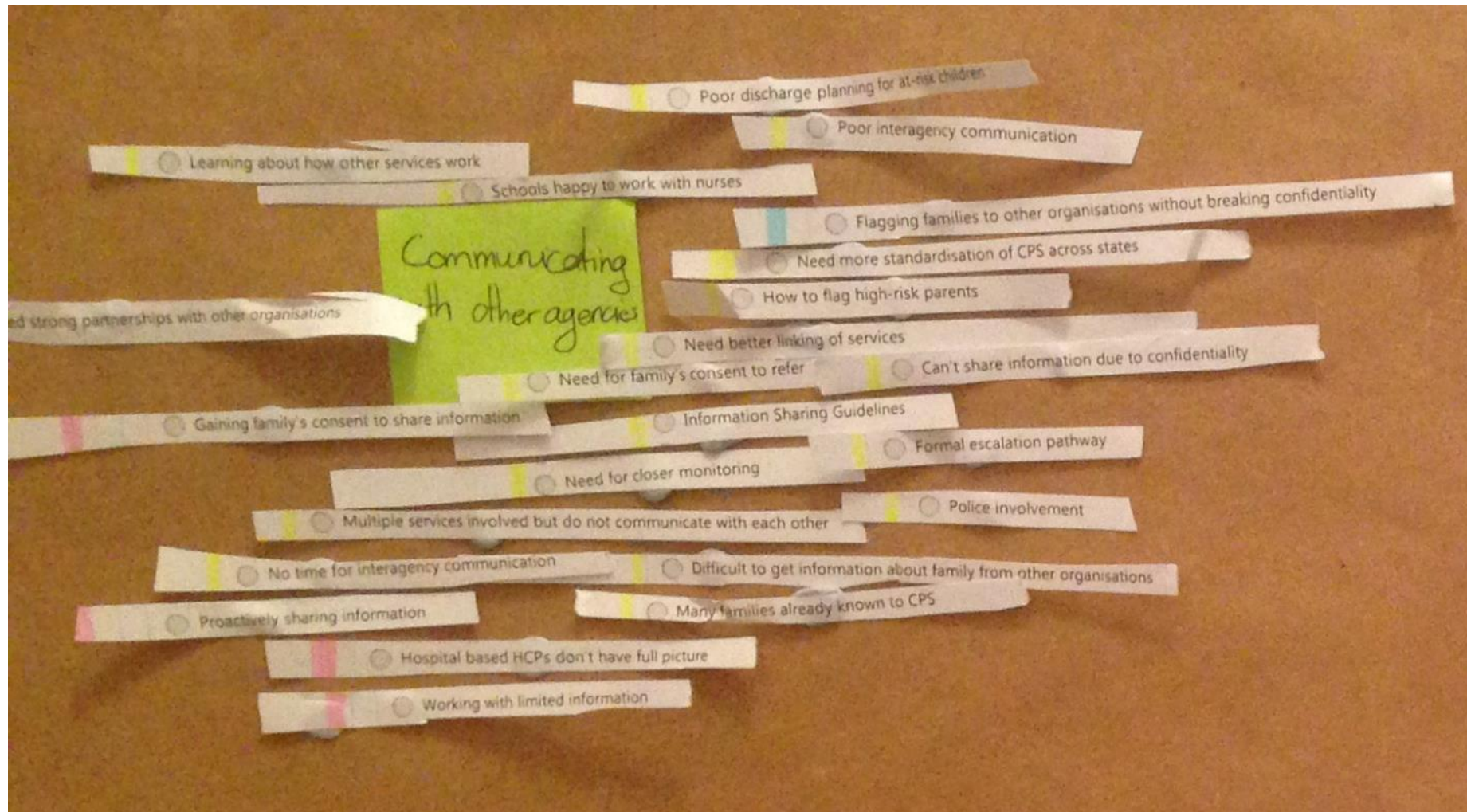
Appendix 14: Examples of descriptive, process and holistic codes

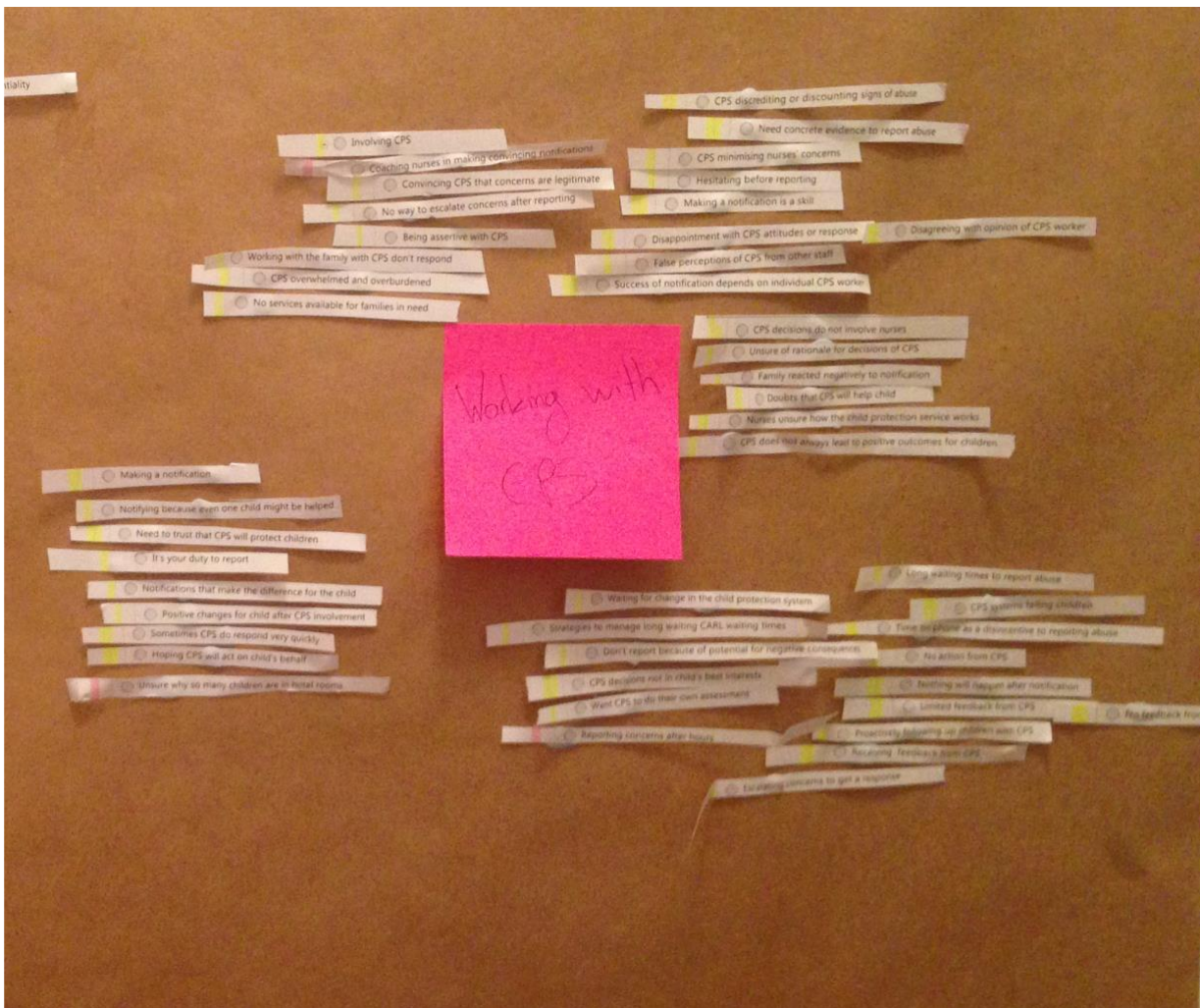| Examples of code	Indicative quotes from the data
Examples of descriptive codes	
Inflexible services	*Even though we have a great service in [location] we also have a very prescriptive service which sometimes doesn't allow for as much flexibility as I would like and that can then limit the amount of time you've got with a family to really get to know them. (Participant 3)* *I think just that it is really complex and it's complex working with those families and those children and that we do have a scope. Sometimes we'd really like to work outside of that. We'd really like to just drop in on a family but we're not allowed to do those things. (Participant 5)*
Sexual abuse	*lots of em sexual abuse and sexual activity within the family. (Participant 1)* *That's again where the child's not being protected and somebody else is coming in and using that child for gratification for their own purposes <inaudible> so there's sometimes that too. (Participant 9)*
Case review	*So in [service] we have - if we get information from the hospital that is - it already identifies high level vulnerability then we take it to a leadership case review and we talk about it to work out what the best pathway is. (Participant 10)* *I do find those conversation with my colleagues like I might talk to them after a visit say 'well let's bring this to case review' and you know, so we do it in a more formal setting as well. (Participant 11)*
Examples of process codes	
Speaking or standing up for the child	*The student nurse said to him 'you've got to be brave. You've got to be strong' and I turned around and I said 'no, actually you don't' and I spoke to the child. I didn't even speak to her, I spoke directly to him and I got his eye contact. Let's call him "Jason". I said 'Jason, no you don't. This is not your responsibility. We have somebody coming to take you into their care, to look after you so that you can be seven-year-old Jason. You don't have to look after your brother and sister, that is not your responsibility and you have every right to behave as a normal seven-year-old would want to behave'. He burst into tears right there and then and I said to him 'I'm just going to sit with you while you cry'. (Participant 2)* *Sometimes it's like, really like speaking for the child so being the child's voice. So you might go, um say if you see them wrap the baby really tightly you might go 'oh dad you've wrapped me up a bit tight there, let my arms out, I wanna get free' so you might use that, that sort of approach so it's not coming from you to them, it's trying to be a voice for the child. (Participant 19).*
Persisting with attempts to contact or engage family	*I have been ringing this family quite frequently [and also] the lab has been, and they don't return the phone calls. Because, and even getting around it where we've used text messaging um where they can see where the call is coming from coz I know that people do avoid private numbers. (Participant 6)* *It's not just a case of 'oh here's this great service, can I refer you? here's the referral.' You've still gotta then think five months down the line like what else are we going to do and put in place. A lot of the time it's just keeping them engaged you know, just yeah and it is, you do probably have to work hard like I'll text the day before their appointment, and text that morning of their appointment. (Participant 20)*
Looking at the positive in any situation	*I think, the little things that you pick up on and then you go 'okay, if I encourage them to change this one thing then the next thing might be something bigger but they can work on that because they've got the confidence of already changing one thing'. (Participant 3)* *They always are doing something right by their kid. They always - even though I've walked in and the house stinks like bloody putrid nappies looks like shit, there will be a glimpse of a moment where that kid will look at her and smile and smile back. Initially I foster that glimpse of what I see is a kid surviving and then I'll work on it slowly after that. (Participant 9)*
Examples of holistic codes	
Child or baby as nurse's focus or priority	*It's about having, having the child at the centre of what, you know, so when we talk about incidents, what's that like for the child? (Participant 1)* *Most importantly we're here for children and it absolutely impacts on children, if parents or children feel that the nurses [are] in, taking obs (observations) and going or they're too busy or too afraid to ask a question that's terrible. (Participant 7)*
Many different ways to parent	*You need to make a judgment call and then, you know, you work with the family. Sometimes it's working with the family to see how better things could be if they did it in a certain way and I think that's reasonable because you want to get the best for the family. You want the family to enjoy their children*

	and enjoy being parents and you don't want them fighting with each other all the time and having that negativity. I don't think that's a bad thing but if you're saying 'well, I do it this way therefore you should do it this way' you shouldn't be in this field. (Participant 3)
	You don't want to be seen as taking over, and you don't want to be seen as only your way is the right way because you want to look at how they've been brought up and challenge them with their thinking. (Participant 15)
What is normal – a different standard of normal	*They [other nurses] discuss how bad it is and I've even had lots of conversations with these nurses saying, you know 'we didn't even see this amount at [health service]. Like this isn't normal, what you're seeing'. Unfortunately, it's this area that we're in and the population that is here.* (Participant 13)
	I think it is about skilled communication not being afraid or awkward to address things, because everything's normal – like in obstetrics they stick women up with their legs in their air or whatever, and that's not a normal position so, but yet obstetricians and midwives get very used to that and making people feel comfortable in that way. (Participant 7)

Appendix 15: Photographs of initial arrangement and sorting of codes into preliminary themes
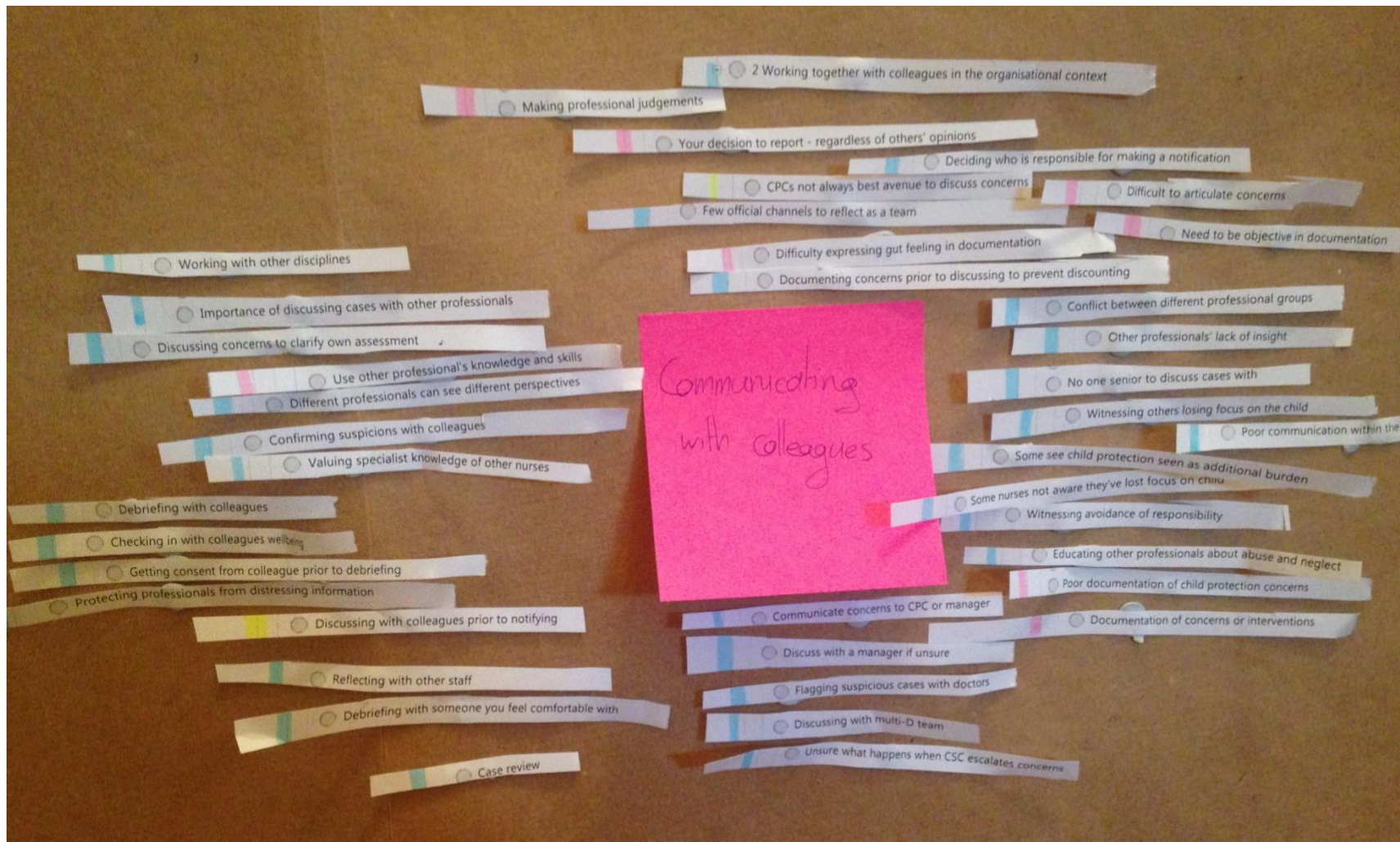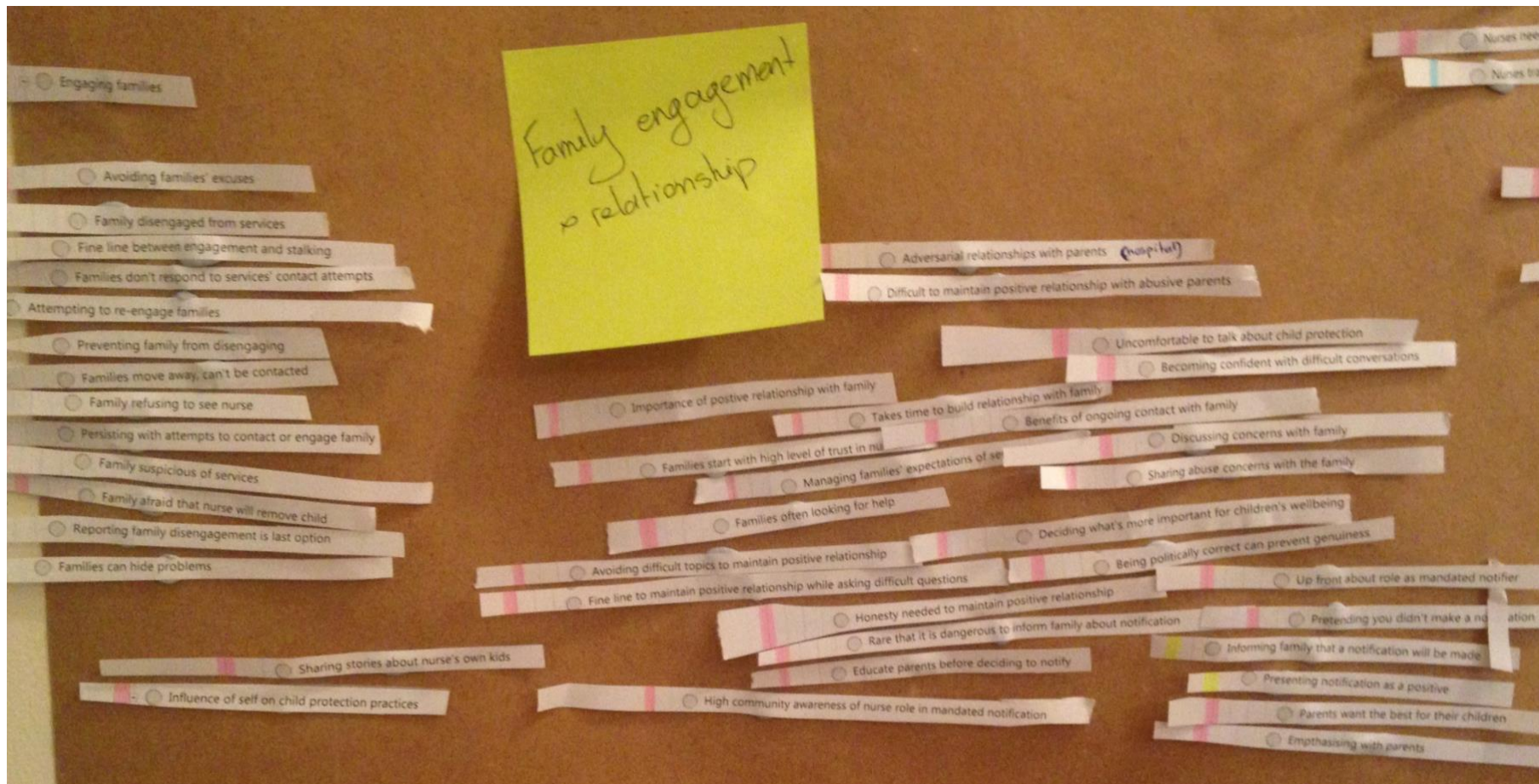
Photograph 1: Communicating with other agencies

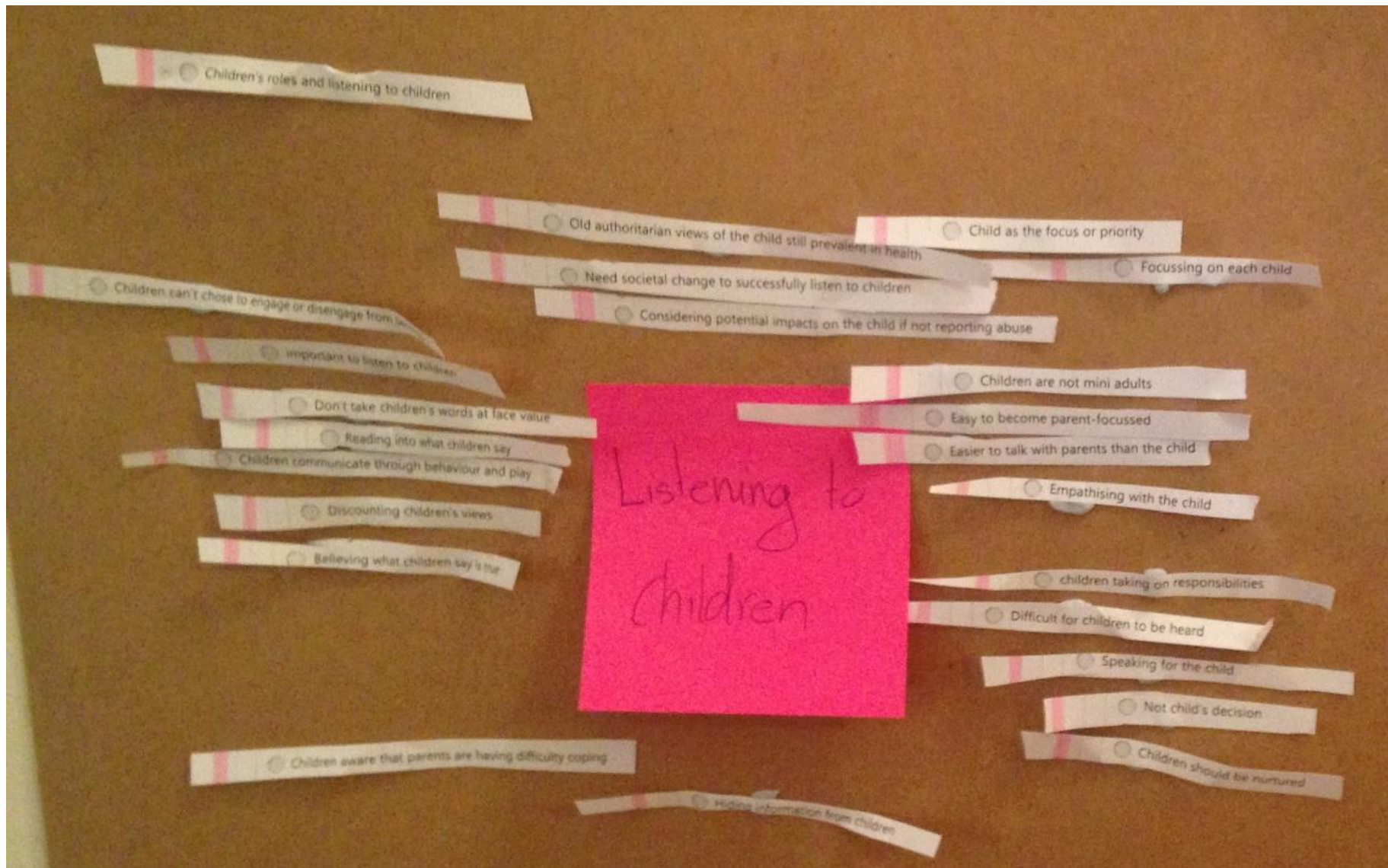Photograph 2: Working with Child Protection Services (CPS)

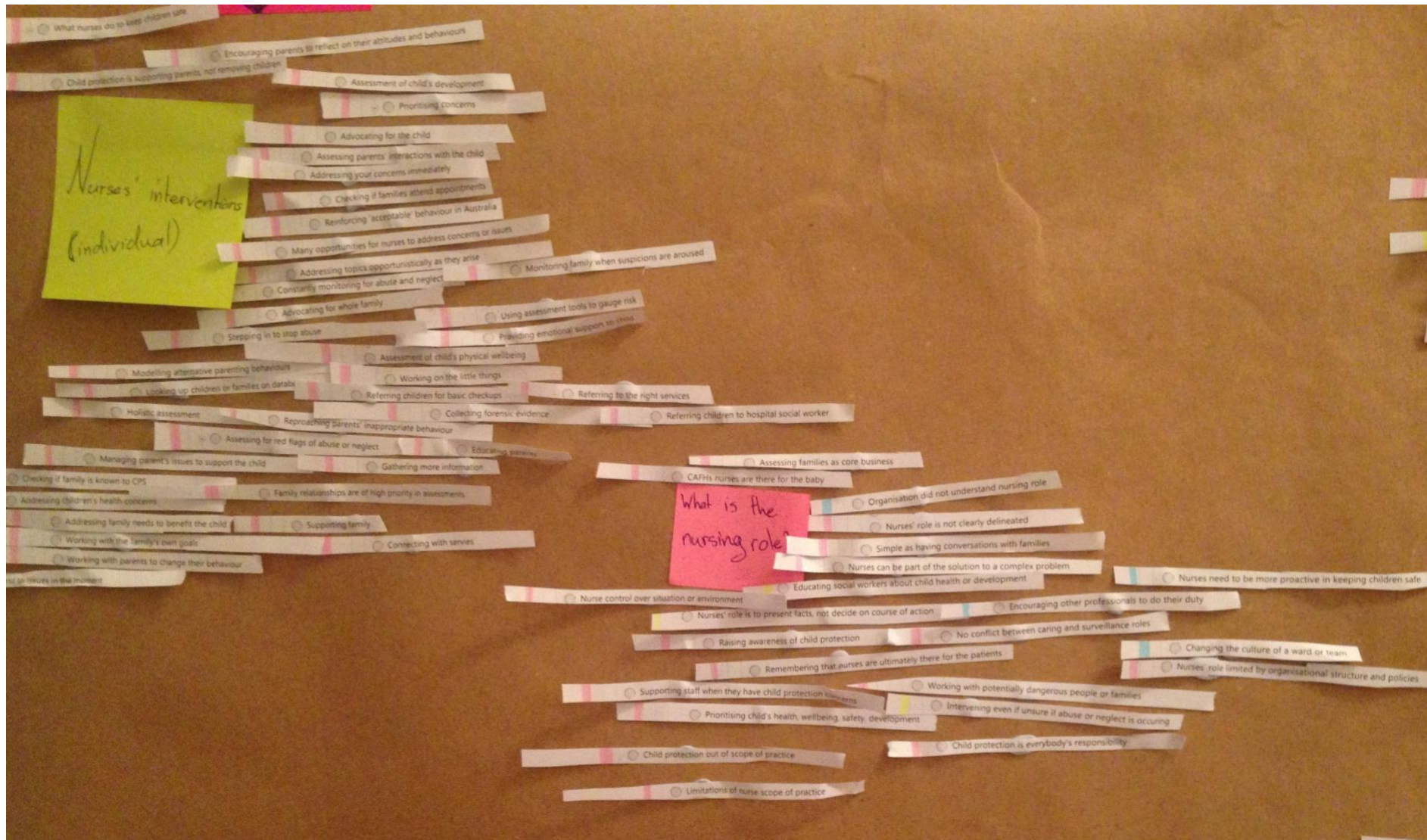Photograph 3: Communicating with colleagues

Photograph 4: Family engagement and relationships

Family engagement & relationship

- Engaging families
- Avoiding families' excuses
- Family disengaged from services
- Fine line between engagement and stalking
- Families don't respond to services' contact attempts
- Attempting to re-engage families
- Preventing family from disengaging
- Families move away, can't be contacted
- Family refusing to see nurse
- Persisting with attempts to contact or engage family
- Family suspicious of services
- Family afraid that nurse will remove child
- Reporting family disengagement is last option
- Families can hide problems
- Sharing stories about nurse's own kids
- Influence of self on child protection practices

- Adversarial relationships with parents (hospital)
- Difficult to maintain positive relationship with abusive parents
- Uncomfortable to talk about child protection
- Becoming confident with difficult conversations
- Importance of positive relationship with family
- Takes time to build relationship with family
- Benefits of ongoing contact with family
- Discussing concerns with family
- Families start with high level of trust in n...
- Managing families' expectations of se...
- Sharing abuse concerns with the family
- Families often looking for help
- Deciding what's more important for children's wellbeing
- Avoiding difficult topics to maintain positive relationship
- Being politically correct can prevent genuiness
- Fine line to maintain positive relationship while asking difficult questions
- Up front about role as mandated notifier
- Honesty needed to maintain positive relationship
- Rare that it is dangerous to inform family about notification
- Pretending you didn't make a no...ation
- Educate parents before deciding to notify
- Informing family that a notification will be made
- High community awareness of nurse role in mandated notification
- Presenting notification as a positive
- Parents want the best for their children
- Empthasising with parents

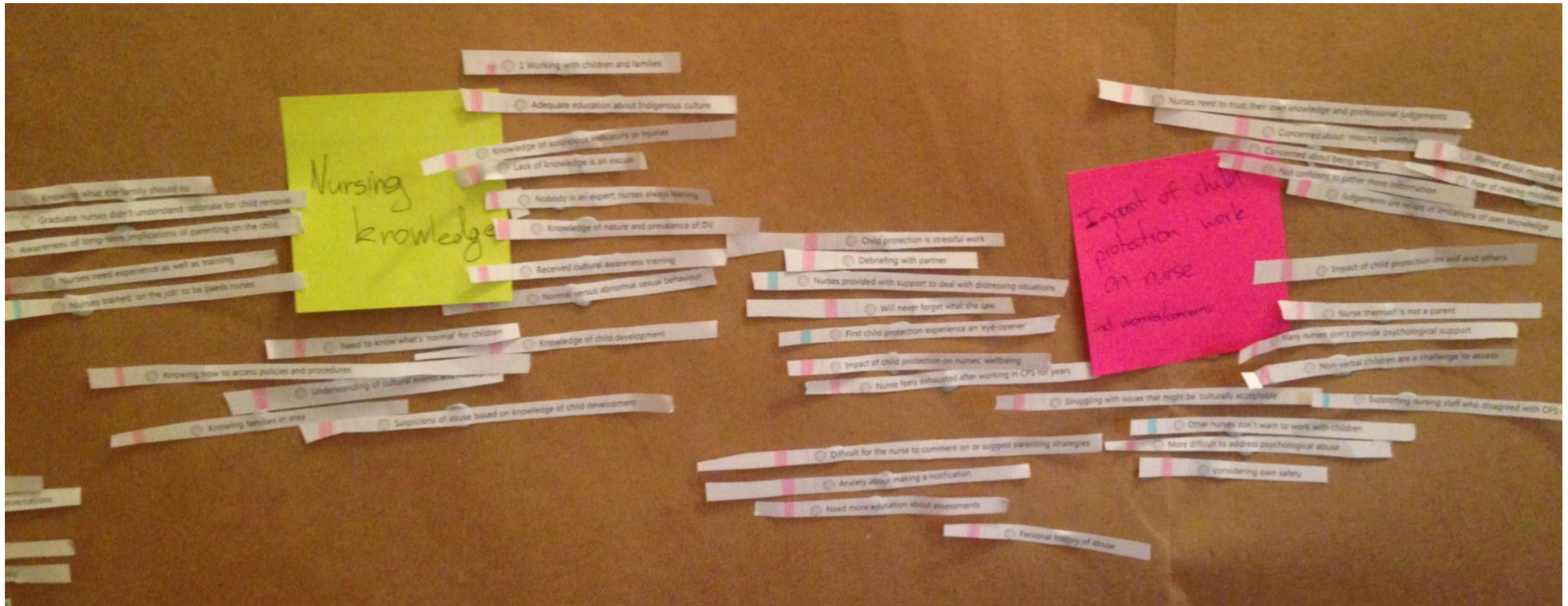- Nurses nee...
- Nurses tra...

254
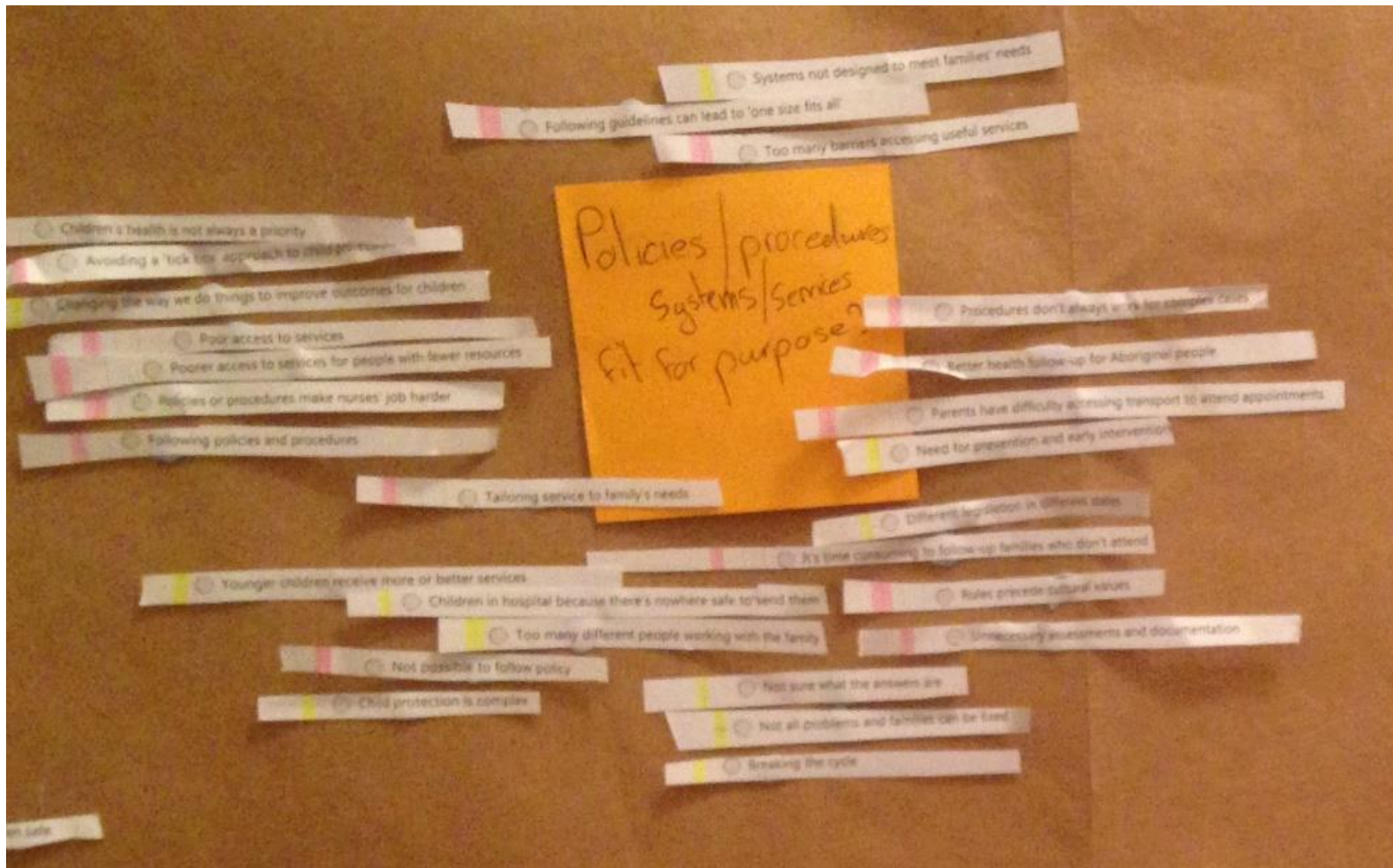
Photograph 5: Listening to children

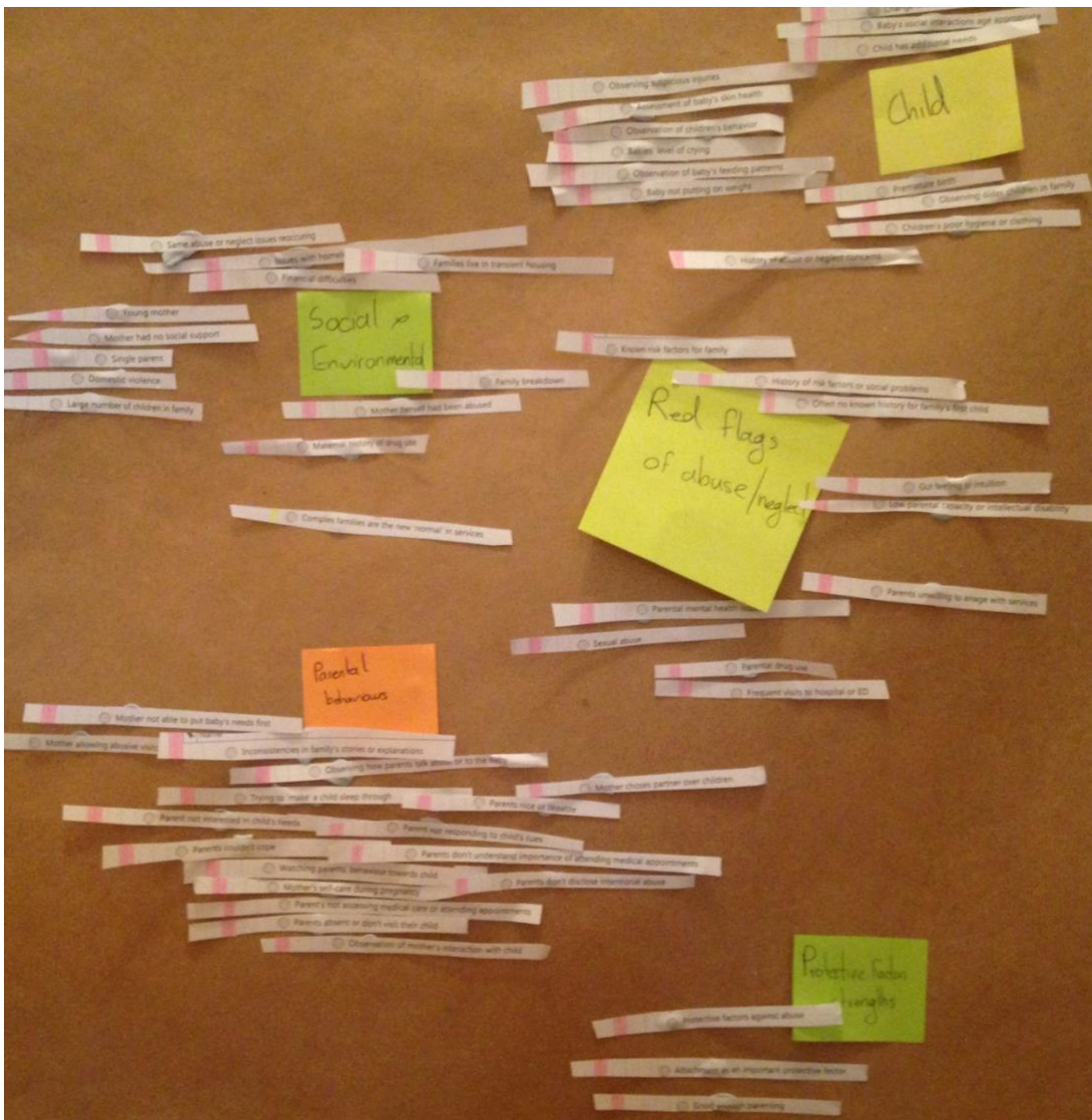Photograph 6: Nursing interventions and nursing role

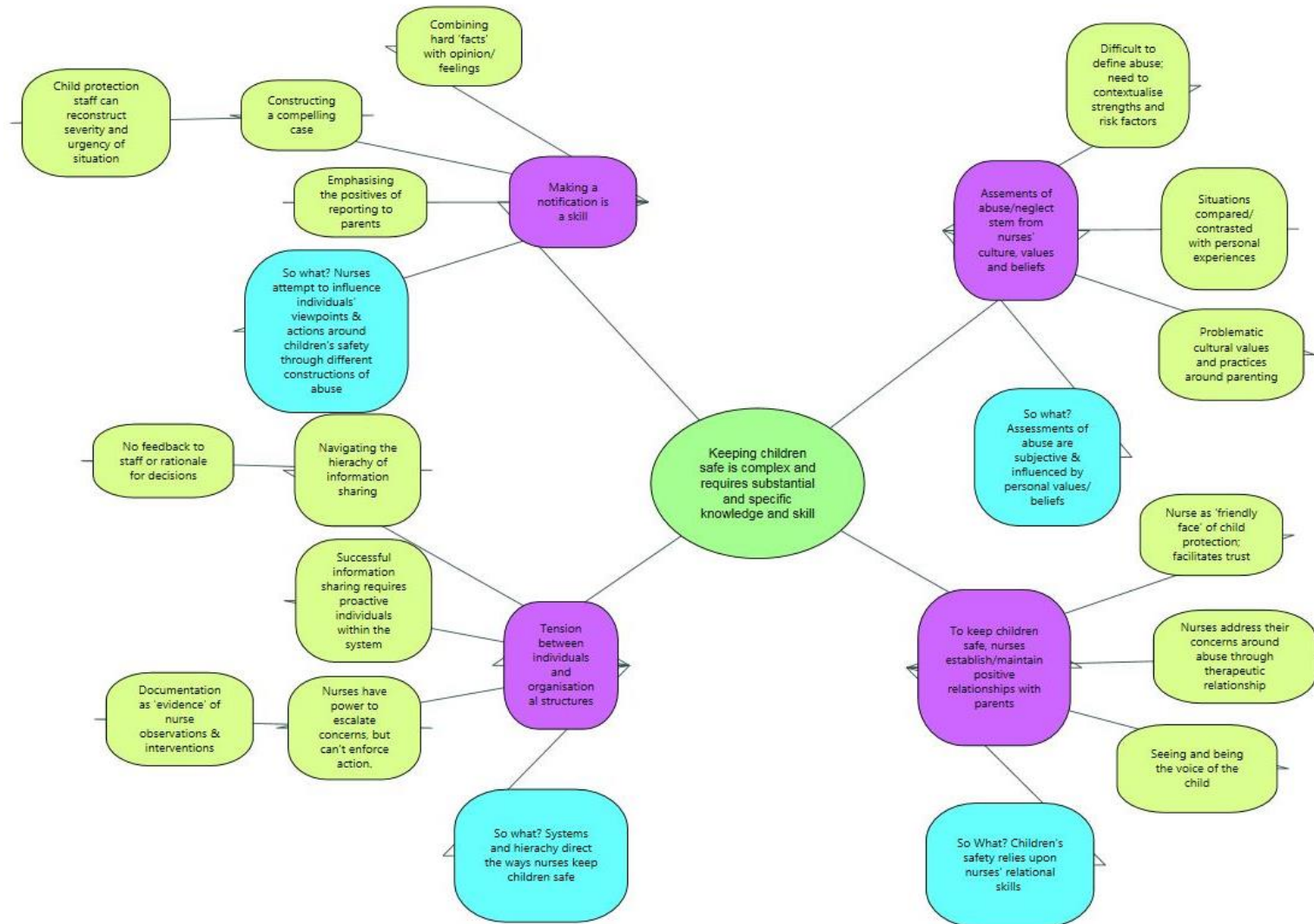Photograph 7: Nursing knowledge and impact of child protection on nurses

Photograph 8: Policies, procedures, systems, services fit for purpose?

Photograph 9: Red flags of abuse & neglect

Appendix 16: Mind map of developing themes

Combining hard 'facts' with opinion/ feelings

Child protection staff can reconstruct severity and urgency of situation

Constructing a compelling case

Emphasising the positives of reporting to parents

Making a notification is a skill

Difficult to define abuse; need to contextualise strengths and risk factors

Assements of abuse/neglect stem from nurses' culture, values and beliefs

Situations compared/ contrasted with personal experiences

So what? Nurses attempt to influence individuals' viewpoints & actions around children's safety through different constructions of abuse

Problematic cultural values and practices around parenting

No feedback to staff or rationale for decisions

Navigating the hierachy of information sharing

Keeping children safe is complex and requires substantial and specific knowledge and skill

So what? Assessments of abuse are subjective & influenced by personal values/ beliefs

Successful information sharing requires proactive individuals within the system

Nurse as 'friendly face' of child protection; facilitates trust

Tension between individuals and organisational structures

To keep children safe, nurses establish/maintain positive relationships with parents

Nurses address their concerns around abuse through therapeutic relationship

Documentation as 'evidence' of nurse observations & interventions

Nurses have power to escalate concerns, but can't enforce action.

Seeing and being the voice of the child

So what? Systems and hierachy direct the ways nurses keep children safe

So What? Children's safety relies upon nurses' relational skills

260

Appendix 17: Supplementary file: examples of initial coding and how they formed the final codes; Theme 1: Sociocultural contexts shaping nurses' perceptions of child abuse and neglect.

Legend: P= Participant

Data Source	Text	Initial Coding	Coding Cluster
P 1	I think you live in a country, you're living under their laws, you know, and as a professional I think that we have to adhere to that as well and that can be quite difficult coz that might not be your own value base, and it might not be that culture's value base so things like, you know, domestic violence it might seem okay one culture for the male to be dominant that the woman has to be, do what he says you know, but that isn't the law of the land.	Rules precede cultural values	Managing issues that might be 'culturally acceptable'
P 2	I have a lot of [cultural group] patients up here and I find that for me personally I actually think that they're not too bad parents. They're actually all right. A lot of people don't give them credit. They attachment parent better than anybody else, any white person up here, I can tell you that.	[cultural group] parenting as superior to white parenting	Diversity of cultural parenting practices
P 5	We tend to try and leave the difficult decisions that might raise child protection concerns in Australian culture to the consultant, to the [cultural group] or [cultural group] cultural consultants, so that they raise the issues. Often it might be safe sleeping or something like that, or something that the consultants are more versed in talking with the parents about but, yeah, it is tricky.	Leaving cultural issues to cultural consultant	Diversity of cultural parenting practices
	Yeah, it's tricky and I think we just try and be aware and try and be respectful, but at the same time we can't not discuss things that raise concerns because we're not of that culture so, yeah, it's tricky.	Unsure if family would accept information from nurse of another culture	Diversity of cultural parenting practices
P 7	A mother carer out in the community were changing a baby's nappy and they thought the baby's genitalia was really um abnormal with a very large clitoris and they thought maybe, because it was an [cultural group] family that was um maybe some sort of abuse or genital mutilation and um so there was a lot of discussion around that and I think um it was really important to have that baby assessed.	Influence of cultural factors	Diversity of cultural parenting practices
	I certainly think that we know that well the [cultural group] population are really adversely impacted in terms of numbers and adversity and poverty and numerous factors and then the whole broadness of kinship is very, very different.	Culture and child protection	Diversity of cultural parenting practices
	[Cultural group] societies who've you know, grown up in refugee camps in [country] that are very, very violent and come here for a different life and the male dominance having a very different role.	Culture and child protection	Managing issues that might be 'culturally acceptable'
P 9	Yeah, they know the difference. [Cultural group], they're great. The only thing with them is that they like to sleep with their baby and they can be quite - like again in our lovely, western cultural world of being careful what you say in front of your baby and all that kind of stuff, they use a lot of terms like 'you dirty little thing' and stuff like that in their own language, so I broach that a bit down the track. I first of get the mother and baby together and then when the kid starts working out it's a bad word I say 'maybe we should change that to 'cheeky' or...' but they're good mums.	They're a good mum or good dad	Diversity of cultural parenting practices

	[Cultural group] were very quick with discipline and they'd hit them across the head and on the legs and felt that was normal, so that's the other thing. A lot of them come over here with - what we outlawed in the last 20 years they're still doing, like the belt across the legs with a belt.	Use of harsh physical discipline in some cultural groups	Managing issues that might be 'culturally acceptable'
P 17	We know culture causes lots of different people to parent very differently and that might be the component that you focus on. Is it the cultural aspects of it, I mean we know lots of cultures use goats milk instead of taking the baby from breast milk at three months and putting them onto unpasteurised goats milk you know, I've had a lot of families in the community particularly in [suburb] that you're like 'well okay, well let's talk about this' you know, but that's culturally what they do, and so what part of that do you have to take as 'okay, well that's just culture and we have to deal with that' and what part of that is 'let's think about how we educate them differently'	Culture and child protection	Diversity of cultural parenting practices
P 22	I know, for example a lot of [cultural group] families and it's just the cultural thing they do smack and sometimes they smack on the face and they pick them up by the arm and it's just a cultural thing, um and having worked a little bit when I worked in [city] with some [cultural group] families I know we used to say to them, and they were young mums, we used to say to them 'look, it's not really recommended that you smack them it's not good for them and it really doesn't teach them to regulate their own behaviour.'	Use of harsh physical discipline in some cultural groups	Managing issues that might be 'culturally acceptable'

Appendix 18: Supplementary file: examples of initial coding and how they formed the final codes; Theme 2: 'How can we work together?': keeping children safe through therapeutic relationships

Legend: P= Participant

Data Source	Text	Initial Coding	Coding Cluster
P 1	We really need to be careful about how, we do need to look at each child so that's like good to have lots of people around the table not lots, but you know, four of us going 'okay, let's think about mum, think about dad, if granny's involved, you know, what's going on for her or you know, this child 1, 2, 3, 4 whatever	Difficult for children to be heard Focussing on each child	Child or baby as nurse's focus or priority
P 3	You are - no matter what, you are judging because your values are going to be different but I think often it's about maintaining the child's health, wellbeing, development, attachment.	Prioritising child's health, wellbeing, safety, development	Child or baby as nurse's focus or priority
P 4	For me the ultimate goal is to keep the child safe so they're my priority and, yeah, for family centred care I think the priority is the child and keeping them safe.	Children's safety as first priority	Child or baby as nurse's focus or priority
P 7	I think we need to call each other out and saying 'look [name] you seem really tense today' or you know, 'you really gave that person the brush off' and it might be that you're distracted in the moment or whatever but we focus and we have to call that behaviour and say you know, well that's not good enough and that helps to break down that culture so we're all actually here for the children as opposed to being here for 'let's have a nice day.'	Child as focus or priority Witnessing others lose focus on the child	Child or baby as nurse's focus or priority
	I think nurses have a responsibility when things aren't going well to actually challenge some of those behaviours when people are not responding appropriately to escalation. And some people cover it up, they don't want any of it to go outside of this ward or outside of this office, and well that's not something that's child centred or family safe and so for it to be all of our responsibility, we have to share the communication in a very professional way.	Child as focus or priority Witnessing others lose focus on the child	Child or baby as nurse's focus or priority
P 10	I think often in adult services the child gets a bit forgotten. The focus is on whatever the adult is experiencing, and the service is responding to that but there's not often consideration of 'hang on, what does that mean for the children? What support might the children need around that and what parenting support might the adult need to parent their children?'	Witnessing others losing focus on the child	Child or baby as nurse's focus or priority
	Well, we're pretty much focused on the child. I think sometimes, yeah, you can [forget] in the complexity of it, but that's where our case conference discussion is so important, to kind of go 'hang on where's the baby at? Is the baby still thriving? Have we checked baby's development?' So sometimes we do, we get into all this discussion and we haven't talked at all about the baby even though our service is primarily about the baby or the children	Child as focus or priority	Child or baby as nurse's focus or priority
P 12	As I said, our core focus as child health nurses is child health and development. When we're engaging primarily with families a large proportion of that is at the universal contact visit so we're looking at a brand new baby and right from when we first meet a baby we will be monitoring - it will be like on our radar constantly about where they are developmentally, how they're responding emotionally to the people that are important to them in their world, so how they're interacting with their primary care givers, and that developmental lens is constantly on them.	Child as focus or priority	Child or baby as nurse's focus or priority
P 17	It's important for you if you've got any concerns for the child or what's going on, that you actually make the time in your day to speak to the patient, the family and try and get some information and you build that into your time management.	Making time and prioritising child protection concerns	Child or baby as nurse's focus or priority
P 19	I find that's tricky when it's, the children's safety isn't, the child's not at risk of being harmed I don't believe, but some of the things the parents are doing might in a sense be working against the child.	Prioritising child's health, wellbeing, safety, development	Child or baby as nurse's focus or priority

	I also think really from a professional point of view because I'm pretty clear about my boundaries and I think that makes it easier for me to work comfortably because if it's a safety issue, it's a safety issue.	Children's safety as first priority	Child or baby as nurse's focus or priority
P20	It's horrible being direct. I find that hard to be direct but I had to for the safety of the baby that I have to be direct and also that I had been you know, I had been like empathy yep 'I know it's really hard and you're doing a great job' but you know, so this was like weeks afterwards and she [mother] still wasn't interested so that's obvious I had to be direct I knew it was, the relationship was going to be over but I had to for the baby's safety.	Children's safety as first priority	Uncomfortable to talk about child protection Child or baby as nurse's focus or priority
P 22	It's making sure that a) we've prioritised all these appointments that this little boy needs but have also got really good accurate documentation of what we've actually done, who we've actually contacted, um trying to prioritise appointments with hearing assessment, getting them into see the child development - community paediatrician child development, early child development consultant, as well, so everything is being done as much as possible to prioritise that little child's needs and physical needs, and developmental needs to make sure we can try and get some of that support for him and in case they [parents] do jump to another state.	Prioritising concerns	Child or baby as nurse's focus or priority
	I think coz you've gotta put the baby at the centre of it, so I think you still would be considering those other things, but you wouldn't be considering them without what's the impact on the baby who's at the centre of it, if that makes sense?	Child as the focus or priority	Child or baby as nurse's focus or priority

Appendix 19: Characteristics and skills displayed by nurses to keep children safe

Characteristic/skill	Description	Indicative quotes from participants
1. Friendliness and approachability Subtheme(s): 1	Ability to present self as friendly and supportive to build rapport and facilitate ongoing engagement with families who may otherwise be invisible to services. Nurses used their skills and personal characteristics to create a therapeutic relationship that demonstrates to the family they are trustworthy and willing to focus on the family's concerns (Rorden, 2010). This occurred within the context of surveillance for abuse and neglect.	*I showed empathy so I said 'that sounds like a really difficult situation for you to have to move to another city. I'm really sorry you've been through that'* (P 2, P). *I think I have a way of coming across [that] I hope [is] not very threatening...* (P 11, CH). *I think that, that really comes with those interpersonal skills those communication skills building a relationship and for the family to really know that you're walking the walk with them* (P 1, C). *Sometimes by having that discussion like you would, you know if you had a coffee with a friend and they would say 'oh my teenager did this' and you say 'that's okay, you know most teenagers do that'… then that's a conversation that's real isn't it* (P 19, CH).
2. Balancing engagement and disengagement Subtheme(s): 1 & 2	The client-helper relationship is key to maintaining family engagement; it requires proficient interpersonal skills to establish and maintain relationships with families who may themselves lack effective relational skills (Davis & Day, 2010). Balancing engagement and disengagement involves the capacity to balance strategies and actions to engage families against the risk of intimidating families and permanently driving them away. Maintaining family engagement is important so concerns about child abuse can be identified, monitored and addressed as needed through family support and/or involvement of child protection services.	*'a lot of people were suspicious in the beginning but because we're there for a year and if we can show that it's to their advantage, that we're actually starting to open doors'* (P 8, C). *Quite often the parents of the children we're working with have been the victims of that same kind of upbringing so they haven't got a lot of trust, particularly for government workers, and they can be very frightened that their children are going to be removed from them so there's a whole range of reasons why families don't want to let you in* (P 12, CH). *We'd already built in some mental health supports that she started to access and then pulled out from, and the Aboriginal cultural consultant who also tried to engage her with the Aboriginal health services… so there'd been lots of efforts to actually engage her, not necessarily in our health services but in perhaps a more culturally acceptable health service* (P 22, CH).
3. Identification of the positives in any situation.	Ability to identify what parents are doing well in any situation to build and maintain rapport with parents. This can help parents build trust and confidence to become more willing to address their shortcomings. For example, as stated by Davis and Day (2010): '*If helpers are known and*	*It's pointing out what they [family] are doing right, showing them what's good because I found once I make them feel good about themselves then they will do good again because it feels good.* (P 9, CH).

Subtheme(s): 2	*trusted to look for and comment upon the positives, then parents are less likely to be threatened by the negatives…' (p. 120).* This involves a strengths-based approach where the nurse searches out strengths and resources that the client may be struggling to use or even unaware of (Egan, 2010).	*We said to her [mother], if you're accepting social work referrals it shows that you want to change, you want to improve* (P 15, CH). *The fact was they [family] actually came to clinic, so that to me was a win, they'd actually made the effort to come under their own steam* (P 22, CH).
4. Ability and willingness to tactfully discuss concerns with parents. Subtheme(s): 3	Ability and willingness to discuss concerns with parents that is timely, empathetic, tactful, effective and facilitates ongoing engagement where possible. This often involves firstly listening to the parents to understand their perspectives and experiences before discussing risks to children (Egan, 2010).	*I go in to work with the family, meet them where they're at, see what their issue is this week, 'okay how can we unpack that', 'what can we do about that' you know… what do they wanna do about it?* (P 19, CH). *Sometimes it's the way you say it, I think being a little bit careful about not coming across too judgmental but still getting the message across.* (P 22, CH). *Firstly, get in with the parents to sympathise with them, but then talk about how the baby's feeling and how they might have experienced that moment* (P 11, CH). *If you get to know a family a little bit you get to be able to ask them more of the tougher questions. We don't tend to do that a lot on that first visit… [because] anyone who you're meeting for the first time does not want to be quizzed and questioned about various things* (P 12, CH).
5. Willingness to act when there are clear dangers to children. Subtheme(s): 1 & 3	Willingness and confidence to intervene when there are clear dangers to children's safety and wellbeing. This could involve discussing immediate concerns with parents, but also involving other agencies such as child protection services where discussing concerns is inadequate or unsafe.	*[The mother] was right up in her [child's] face screaming at her and she [nurse] went in and she said 'excuse me, this is not appropriate…you need to stop this right now'* (P 2, P).

			The key to it, is being engaged, being non-judgmental but not being afraid to step in and say 'well, we need to do something about this because I'm concerned about the safety of your child' (P 3, CH).
			I did a home visit one day and there was a gun leaning against the wall in the house so they [the family] were just led into being able to have a conversation about that (P 12, CH).
6.	Responsive attitude towards ongoing professional development Subtheme(s): 3	Individual professionals never have all the answers to every problem, and their knowledge can be incomplete or out of date (Davis & Day, 2010). Rather than aiming to have expert knowledge in child protection, nurses should instead have an attitude that simultaneously acknowledges: 1) the importance of continually developing one's knowledge, 2) the impossibility of ever knowing everything, but 3) the importance of acting anyway to promote best outcomes for children.	*If there's a [knowledge] gap or we come across something that we're feeling uncomfortable about, [it's important that] nurses [are] proactive in requesting, 'look, how do I get counselling' or 'how do I approach this scenario' or 'this is difficult, I feel out of my depth here' (P 7, P).* *We all experience new things every day. We can't say 'well, you know, I'm not experienced in that so I'm not going to do it'. I mean that's just - to me that's [an] excuse… If you are concerned that that child is unsafe it is your duty of care to that child to… seek support and follow through. (P 3, CH).* *I think sometimes… [discussing with experienced staff] can help you sort of clarify your own thoughts and particularly for junior staff… they might not be so confident in their… own assessment of the situation. Somebody who has a bit more [experiences]… might be able to help clarify it and guide them in how they should manage it (P 4, P).*
7.	Reflective practice Subtheme(s): 3	Reflective practice involves reviewing one's own values, assumptions and considering the broader issues that are relevant to practice (Atkins & Schutz, 2013). For nurses who work with children, this is key to maintaining a child-centred approach and identifying when own attitudes/behaviours do not represent a child-centred approach and how this may subsequently impact upon the children they care for.	*I thought 'well, I've missed the opportunity now. If it happens again, I know how I'm going to respond' (P 2, P).* *There's been times where I haven't really been that worried about a family and then I've taken it to case review and the psychologist or social worker's asked five questions and… they've made me think about things really differently… you really need to be reflective and make sure that other people's views can influence your practice. (P 5, CH).*

		'we all need to know ourselves as a person [and] what our issues are' (P 7, P). *If you're practicing reflective practice… [you recognise that] you're never complete and perfect, you just keep developing* (P 11, CH).
8. Listening to children Subtheme(s): 3	Ability to listen to children and consider what they say through a developmental lens. This requires knowledge of child development to understand how children may think and act according to their age and stage of development.	*[Children] will tell you… through behaviors, through sensory issues you know, so you've gotta be able to read… or listen to that when it's not a verbal [message]* (P1, C). *[You've] got to take the age into consideration as well…. I think if a child is saying 'I don't want to live at home' then there is a good reason for it and you should be taking that seriously* (P4, P). *We know that children that are abused definitely have delayed development so we're looking for that in every baby that we see - not the abuse but the development* (P 12, CH). *You need to know… the milestones and you need to know the behaviors of each age group so that you can pick when something's not normal* (P 18, P).
9. Maintaining a child-centred approach Subtheme(s): 3	Commitment to ensuring one's practice is consistent places children's needs first and foremost in the context of adults' problems. A child-centred approach recognises the power asymmetry between children and adults, and views children as individuals with their own rights (Coyne et al., 2016; Munro, 2011).	*I think it's just holding the child at the centre of what we do* (P 1, C). *For me the ultimate goal is to keep the child safe so they're my priority* (P 4, P). *It's easy to get caught up in the drama of the parent… but it's really important to think about the child because they can get lost in it sometimes as well* (P 11, CH). *You've gotta put the baby at the centre of it… you still would be considering those other things but you wouldn't be considering them without what's the impact on the baby who's at the centre of it* (P 22, CH).

Appendix 20: Supplementary file: examples of initial coding and how they formed the final codes; Theme 4: Systems and hierarchies shaping nurses' responses to child abuse and neglect

Legend: P= Participant, GP=General Practitioner, CPS=Child Protection Services, DV=Domestic Violence, UR=Unit Record, TL=Team Leader.

Data Source	Text	Initial Coding	Coding Cluster
P 3	We've had our fair share of child deaths here in [location] and we have had contact with [state child advocate], but they investigate the processes that organisations have around families and one of the things that they often talk about is poor communication between services and I agree with them absolutely. It's not for want of trying at times on our behalf but it's also, too, we're all very busy, engaged with really complex families nowadays. Gone are the days where the maternal and child health services were made up with lovely families who just come in and had a chat to the nurse and got their babies weighed and got educated on what was going to happen next, and away they went. Now you've got a huge complexity of things that are going on for families that staff are dealing with so that then puts added strain on the resource that we are. Then communication sort of tends to fly out the window because, you know, you don't necessarily have time, whereas if there was a more structured program that occurred from antenatal right through.	Need better linking of services. No time for interagency communication.	Poor communication practices and processes. Limited time for interagency communication. Need better linking of services.
P 4	I've seen a number of incidents even in the last four months where to me there've been failings and it's been multi-agency failings really. Poor communication between agencies, you know, including our organisation and [child protection service].	Poor interagency communication. CPS does not always result in positive outcomes for children.	Poor communication practices and processes. Doubts that CPS will help the child.
	Well particularly one that we're sort of reviewing at the moment where a child was under the guardianship of the Minister - and it was actually on a rural site - and then it sounds like he developed a really close relationship - you know, really close links with the people who cared for him in that area. Then unfortunately he was moved for one reason or another and the communication - there was a real breakdown in communication between the rural area he was travelling from and then where he came to here and there was a delay in follow up between [child protection service] and [health service] and that was a really poor outcome for him, unfortunately. That's one thing that will stay with me actually for a long time because I think we've really let him down. It's difficult because I know the areas are so hard pressed but there - and there's an ongoing review of that case now and there are other cases that are being sort of looked at alongside it because I don't think that's an isolated event. There are lots where there's just breakdown in communication and I think a lot of it is because they are so stretched, but I think possibly the processes as well. One of the problems with this particular case was actually getting movement with the analysis of what happened because - and somebody actually said in previous cases they have real trouble trying to get involvement of agencies outside of [health department] and trying to get them all in the same room together because everybody just does their own little bit rather than communicating together and I think that's something we really need to work on and do better.	Poor interagency communication.	Poor communication practices and processes. Doubts that CPS will help the child. Need better linking of services.
	Everybody sort of working in isolation and in silos - is it's too easy I think for families to hop between hospitals and not have any follow up.	Need better linking of services. How to flag high-risk parents. Not enough follow-up for at-risk children.	Poor communication practices and processes. Need better linking of services.
	I think we should be sharing the information with or without consent. I think if there's a concern then we have a duty as health professionals to report it and make other people aware. I think there should be a way of informing other hospitals as well so that, you know, if it's somebody who's presented to [hospital] X amount of	Poor interagency communication. How to flag high-risk parents.	Poor communication practices and processes.

	times and then they suddenly present at [hospital], that something flags, but the difficulty is - and one thing I've discovered being in this role is that even within this state everybody has a different UR number depending on which hospital you're in so, yeah, we obviously have a different system at [hospital] and then if you go to [hospital] you've got a completely different UR (unit record) number so again there's no tracking. You know, you could be two completely separate people.	Flagging families to other organisations without breaking confidentiality.	Need better linking of services.
P 7	I can tell when I walk into a ward and it's, you know I can tell the ward will feel different depending on who the TL is, so I think leadership is really, really important and I can walk into the children's ward on some occasions and they can have twenty-two kids that have people coming, lumbar puncture happening, child deteriorating and you know, it feels like a children's ward it's okay, I know it's very busy they're under the pump, the staff are coping and smiling and working, and working at a faster pace but they've moved up into the next gear and are managing, working functionally and supporting one another. There are other days I can walk into the very same team and some of the same nurses on the ground are there, but I will have a different TL and the anxiety and the tension, and control or the over-managing people rather than actually letting people work to their talent within their patient cohort or supporting one another, it's the checking and the whatever, and the rearranging them and giving them a new patient and not really assessing how the team is functioning or flowing or what *their* impact or their anxiety is on the rest of the team.	Influence of team dynamics and leadership on nurses' ability to work.	Poor communication practices and processes.
	I've tried to do a fair bit of work about the relationship between nurses and midwives and social workers, and it's sort of almost a blame, and then a secrecy. I don't know how to say it, but a conflict, a not a good working professional, respectful relationship and I was talking to some of my colleagues and they said they've had similar issues and they've really had to work on the culture of sharing information um and how things are done and I can see both sides as to why that happens um but I think that we all have role to play.	Conflict between different professional groups.	Poor communication practices and processes.
	Maybe there needs to be more interface between [health service] and the child and family nurses who are in the homes and in the communities in coming together with our acute care colleagues sort of, not blaming and whatever, but coming together and we as a group [inaudible] knowing 'gee it's really tough' and 'yeah it's really tough, but if you could tell us that or give us a heads up I can follow up' and together we can achieve so much more than alone, and it's like the social worker or the paediatrician or we come together as a team as a huddle come together as a multidisciplinary team there's lots of layers, but together we can do so much more if we're functioning rather than blocking.	Learning about how other services work.	Poor communication practices and processes.
P 8	Sometimes we'd get a new family referred and we wouldn't know about it, you know, until you hear in the office that something was happening, and you go 'oh, who's that family?' Or a family was - a case had been reported to [child protection service] and we didn't know about it.	Nurses excluded from contributing to safeguarding children. Poor communication within the organisation.	Poor communication practices and processes. Nurses' input and involvement not valued.
	There was a paediatrician at [health service] who was interested but then she moved on and that's what happens in public hospitals, they rotate into another unit and they come out of the hospital and move on so it's very individual. Sometimes we had GPs in the community who we could work with but because we had 2-300km radius, it wasn't always appropriate to be ringing a GP in the north when your client was down at [semi-rural location]. And then all the different hospitals, [hospital] were fantastic, they got to know us but, yeah, we had clients who lived in [semi-rural location], so once again two nurses, all those clients liaising with health professionals to try to build that rapport. There's only so much you can do, and we were both part time.	Need better linking of services.	Poor communication practices and processes. Using informal links and pathways for information sharing. No time for interagency communication.
P 9	Anyway, so there'd been a bit of back history with [child protection service] worker anyway so there was a bit of, let's say, disharmony between the two services; not that there meant to be but there was. The police went out, did a visit and then left, but he - and the same guy that went to [interagency meeting] - cop that went to the [interagency meeting] also had come across this couple again in that incident and sent someone out. He didn't actually see them but he sent someone out to go and talk to them from the family support unit, which they do for domestic violence. So that same cop didn't think he was dealing with the same couple, so I thought	Conflict between different professional groups.	Poor communication practices and processes. Working with limited information. Need better linking of services.

	'well, where's your communication and collaboration? Wouldn't you have thought that there was a bit of a worry here and feed it back to [child protection service] or somebody?'		
	I sent a letter saying, you know 'we'd like to talk to you' that day that I closed [the case], [child protection service] [had closed] it but never told me they'd closed the actual case so they weren't going to be involved. So again, lack of communication and whether you say it's us or them, it's [more so] blamed on them. So it's a whole issue around no communication.	Poor interagency communication. Minimal feedback to staff. Working with limited information.	Poor communication practices and processes. Minimal feedback to staff. Working with limited information.
	That one brought home to me how much information you don't know at the coalface, very much. From a worker, sitting now back listening to this, the frustration is just like why would you not tell the idiot that's in there at the coalface what's going on? What is your problem with sharing that information with her? Like I don't know whether people sometimes think 'oh yeah, give them too much information and they'll get worried.'	Poor interagency communication. Working with limited information.	Poor communication practices and processes. Minimal feedback to staff. Working with limited information.
P 10	We [call] interagency case discussions as well because often these families do have many people working with them, which you would think well, that's great, but sometimes it becomes too messy and no-one's really actually owning the case. Everyone's just doing bits of things and it gets confusing for clients so sometimes we call interagency case conferences and we chat with them and try and come up with a clear plan on who's doing what and, you know, sometimes it's been about actually some services stopping because there's just too, there tends to be a bit of a scattergun approach.	Too many different people working with the family.	Poor communication practices and processes. Need better linking of services.
P 12	One of the [cases] that I referred to that came through today was for a family that we actually had been out and did a home visit in their house only a week ago and I noticed that they've seen a DV situation and a long child protection history that we didn't know anything about so, you know, it puts - you know, that family's vulnerable but it also makes our staff really vulnerable and potentially in an unsafe environment and we need to work better together with all of that for a better outcome for the children particularly and just to maintain our staff's wellbeing and safety.	Poor interagency communication. Working with limited information.	Poor communication practices and processes. Working with limited information.
P 13	We were sort of under the impression that this grandmother who had been boarding for the entire week was going to be taking this baby but then [child protection service] changed their mind and allowed the mother to return and to take the baby so I think that - I think because we don't see what else happens behind the scenes and how a decision can go from one extreme to the next and then we're discharging the baby into this mum's care that hasn't even been able to see the baby for the week.	Limited feedback from CPS. Disappointment with CPS attitudes or response. Hospital based HCPs don't have full picture.	Poor communication practices and processes. Minimal feedback to staff.
	The mum admitted to taking drugs and then the baby tested positive for the drugs so then that was - you know, like I was here and there between shifts but from then my understanding was the next time I came on it came now 'mum is not allowed to be in visiting the baby at all. We are now waiting for dad to get drug tested'. Dad turned out positive but in the meantime the dad's mum had been staying with the baby 24 hours a day, waking up to it and everything. Then as the days went on, we were then told 'yep, mum tested positive. The baby's not going back into mum's care but it may go to the grandma's care but mum may still then have' - she was allowed to come in as a supervised visit with [child protection service] - she never did though - and then, yeah, within a 24 hour turnaround it was 'okay, we're going to allow mum to board at the hospital for one night as long as the mother's grandmother comes in with her and stays because the mother is now going to live with the grandma and the grandma will, you know, basically be there as a support person and take over care if needed'. So I guess they'd put in a support for mum but this grandma was in her 80s so it just seemed absolutely insane to all of us when there was another grandmother, like the baby's grandmother, that was willing to take this baby and doing so well for it and this mum, her four other children had been removed.	Nurses excluded from safeguarding children. Unsure of rationale for decisions of CPS.	Poor communication practices and processes. Nurses input not valued. Minimal feedback to staff.

P 15	I involved the mental health team who done, who tried to contact her [the mother] they didn't call her by her correct name, they called her by a slightly different name well that's, I gave the correct name and of course then they turned up at the house the partner answered and they asked for someone likewise by an incorrect name and he said 'no, she doesn't live here.' So then of course I get this phone call to say 'did I give the right address' and of course, I rang her and I explained how that was the mental health lady who I referred, anyway we did this joint visit together.	Poor interagency communication. Miscommunication and misunderstanding between professionals.	Poor communication practices and processes.
P 18	Yeah, so the ward would do more, have more in that they would have more involvement and unless we actually ring the wards, we don't get any feedback from the wards at all.	No feedback from other parts of organisation.	Poor communication practices and processes. Minimal feedback to staff.
	Sometimes it will be if we're taking a patient up [to be admitted] which is really rare for me coz I'm generally resus, or triage or coordinating, so if I happen to have [allocated] rooms, which would be nice, and I know of someone I will say 'oh by the way, how's this person going' but, and other times it will be 'oh they've gone home' or you'll get again someone on the ward who doesn't know them, 'oh I've never looked after them, I don't know.'	Seeking informal feedback about children or families.	Poor communication practices and processes. Using informal links and pathways for information sharing.
P 19	There was another part of the organisation was involved and they fed something back, and I was like 'well' didn't seem to be fitting with my relationship with the client, so when I went to the client's house I said 'oh, what happened about this? Was there an issue?' like, and from what I'd heard from [the] other party, I thought there was an issue, but they [client] didn't have an issue. I said 'oh' you know, so I asked them more specific questions and it was like 'yeah I know there was something around that', but it wasn't *me*, I was thinking 'oh was it something I said?' Did they misunderstand that, but actually it was really the other part of the organisation, don't know what happened with that. I don't know what conversation happened with the client then, but it gave us the picture that 'oh, there's an issue here but when I went back to the client to see what, is there an issue here? What's happened?' [but] there wasn't.	Miscommunication and misunderstanding between professionals.	Poor communication practices and processes.
	I think in the organisation some of that comes down to time because we don't really have the luxury of, like a lot of people work part-time so you ring and don't hear from them, they're on their day off or you know, so I think that is a huge issue in life in general, but certainly in the organisation.	Poor interagency communication.	Poor communication practices and processes.
	I work part time so if I'm not there when they ring to have a conversation, or they might ring and I'm with a client and then I ring back at the end of the day and you've gotta get out the door coz you've got things you've gotta do too.	Poor interagency communication.	Poor communication practices and processes. Limited time for interagency communication.
	I'd rather just have a phone conversation than have that email which gets so convoluted and people don't read emails properly they usually just read the first point you make and then they scoot on, and you get an email back and you go 'well what about the other part of the question?' and it's just like pick the phone up and clarify.	Poor interagency communication. Miscommunication and misunderstanding between professionals.	Poor communication practices and processes.
P 21	Perhaps it should be a workshop where you can discuss issues that arise from that poor [communication with] nursing staff on the floor, that team relationship between social workers, [child protection service] and the health facility instead of being dependent and having all the decisions made by [child protection service] with no communication and it's not something you agree with.	Poor interagency communication.	Poor communication practices and processes. Nurses' input not valued. Minimal feedback to staff.

References

Adams, B. L. (2005). Assessment of child abuse risk factors by advanced practice nurses. *Pediatric nursing, 31*(6), 498-502.

Adams, C., & Lee-Jones, K. (2017). Sharing personal information in the child protection context: Impediments in the Australian legal framework. *Child & family social work, 22*(4), 1349-1356. doi:10.1111/cfs.12352

Alberth, L., & Büllinger-Niederberger, D. (2015). Invisible children? Professional bricolage in child protection. *Children and youth services review, 57*, 149-158. doi:10.1016/j.childyouth.2015.08.008

Allen Consulting Group. (2011). Operational review of the information sharing protocol between the Commonwealth and Child Protection Agencies. *Report to the Department of Families, Housing, Community Services and Indigenous Affairs.* Retrieved from https://www.dss.gov.au/sites/default/files/documents/op_review_info_sharing_protocol.pdf

Allwood, M. A., & Widom, C. S. (2013). Child abuse and neglect, developmental role attainment, and adult arrests. *Journal of research in crime and delinquency, 50*(4), 551-578. doi:10.1177/0022427812471177

Altman, R. L., Canter, J., Patrick, P. A., Daley, N., Butt, N. K., & Brand, D. A. (2011). Parent education by maternity nurses and prevention of abusive head trauma. *Pediatrics, 128*(5), e1164-e1172. doi:10.1542/peds.2010-3260

ANFPP National Program Centre. (N.D.). Australian Nurse Family Partnership Program. Retrieved from https://www.anfpp.com.au/

Appleton, J. V., & Cowley, S. (2008). Health visiting assessment-unpacking critical attributes in health visitor needs assessment practice: A case study. *International journal of nursing studies, 45*(2), 232-245. doi:10.1016/j.ijnurstu.2006.08.014

Appleton, J. V., Harris, M., Oates, J., & Kelly, C. (2013). Evaluating health visitor assessments of mother-infant interactions: a mixed methods study. *International journal of nursing studies, 50*, 5-15. doi:10.1016/j.ijnurstu.2012.08.008

Appleton, J. V., & Peckover, S. (2015). Chapter 1: Child protection, public health and nursing. In S. Peckover & J. V. Appleton (Eds.), *Child protection, public health and nursing*. Edinburgh: Dunedin Academic Press Limited.

Aragão, A. S., Ferriani, M. G. C., Vendruscollo, T. S., Souza, S. L., & Gomes, R. (2013). Primary care nurses' approach to cases of violence against children. *Revista Latino-Americana de enfermagem, 21*(SPL), 172-179. doi:10.1590/S0104-11692013000700022

Aries, P. (1962). *Centuries of Childhood*. New York: Penguin.

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International journal of social research methodology, 8*(1), 19-32. doi:10.1080/1364557032000119616

Armstrong, K. L., Fraser, J. A., Dadds, M. R., & Morris, J. (2000). Promoting secure attachment, maternal mood and child health in a vulnerable population: A randomized controlled trial. *Journal of paediatrics and child health, 36*(6), 555-562. doi:10.1046/j.1440-1754.2000.00591.x

Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., . . . Randel, P. (2015). The power of relationships: exploring how public health nurses support mothers and families during postpartum home visits. *Journal of family nursing, 21*(1), 11-34. doi:10.1177/1074840714561524

Atkins, S., & Schutz, S. (2013). Developing skills for reflective practice. In C. Bulman & S. Schutz (Eds.), *Reflective practice in nursing* (5th ed.). West Sussex, UK: John Wiley & Sons Inc.

Australian College of Children & Young People's Nurses. (2016). Standards of practice for children and young people's nurses. Retrieved from https://www.accypn.org.au/knowledge-centre/standards-of-practice/

Australian Government Department of Health. (2019). National action plan for the health of children and young people 2020-2030. Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/4815673E283EC1B6CA2584000082EA7D/$File/FINAL%20National%20Action%20Plan%20for%20the%20Health%20of%20Children%20and%20Young%20People%202020-2030.pdf

Australian Human Rights Commission. (2014). The forgotten children: national inquiry into children in immigration detention. Retrieved from https://www.humanrights.gov.au/our-work/asylum-seekers-and-refugees/publications/forgotten-children-national-inquiry-children

Australian Human Rights Commission. (2018). National principles for child safe organisations. Retrieved from https://childsafe.humanrights.gov.au/national-principles/download-national-principles

Australian Institute of Family Studies. (2015). History of child protection services. *CFCA Resource Sheet.* Retrieved from https://aifs.gov.au/cfca/publications/history-child-protection-services

Australian Institute of Family Studies. (2017a). Mandatory reporting of child abuse and neglect. Retrieved from https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect

Australian Institute of Family Studies. (2017b). The prevalence of child abuse and neglect. Retrieved from https://aifs.gov.au/cfca/publications/prevalence-child-abuse-and-neglect

Australian Institute of Family Studies. (2018). Australian child protection legislation. Retrieved from https://aifs.gov.au/cfca/publications/australian-child-protection-legislation

Australian Institute of Health and Welfare. (2018a). *Aboriginal and Torres Strait Islander Stolen Generations and descendants: numbers, demographic characteristics and selected outcomes*. Retrieved from Canberra, Australia: https://www.aihw.gov.au/getmedia/a6c077c3-e1af-40de-847f-e8a3e3456c44/aihw-ihw-195.pdf.aspx?inline=true

Australian Institute of Health and Welfare. (2018b). *Australia's health 2018*. Retrieved from Canberra, Australia: https://www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus-221.pdf.aspx?inline=true

Australian Institute of Health and Welfare. (2019). *Child protection in Australia 2017-18*. Retrieved from Canberra, Australia: https://www.aihw.gov.au/getmedia/e551a2bc-9149-4625-83c0-7bf1523c3793/aihw-cws-65.pdf.aspx?inline=true

Australian Qualifications Framework Council. (2013). Australian qualifications framework. 2nd. Retrieved from https://www.aqf.edu.au/sites/aqf/files/aqf-2nd-edition-january-2013.pdf

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American psychologist, 37*(2), 122-147.

Barbour, R. S. (2014). Quality of data analysis. In U. Flick (Ed.), *The SAGE handbook of qualitative data analysis* (pp. 496-509). London: Sage.

Barlow, J., Davis, H., McIntosh, E., Jarrett, P., Mockford, C., & Stewart-Brown, S. (2007). Role of home visiting in improving parenting and health in families at risk of abuse and neglect: results of a multicentre randomised controlled trial and economic evaluation. *Archives of disease in childhood, 92*(3), 229-233. Retrieved from

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med5&NEWS=N&AN=1706
8074

Barnes, J., Stuart, J., Allen, E., Petrou, S., Sturgess, J., Barlow, J., . . . Elbourne, D. (2017). Randomized controlled trial and economic evaluation of nurse-led group support for young mothers during pregnancy and first year postpartum versus usual care. *BioMed central*. doi:10.1186/s13063-017-2259-y

Barr, R. G., Barr, M., Rajabali, F., Humphreys, C., Pike, I., Brant, R., . . . Singhal, T. (2018). Eight-year outcome of the implementation of abusive head trauma prevention. *Child abuse & neglect, 84*, 106-114. doi:10.1016/j.chiabu.2018.07.004

Barrett, E., Denieffe, S., Bergin, M., & Gooney, M. (2017). An exploration of paediatric nurses' views of caring for infants who have suffered nonaccidental injury. *Journal of clinical nursing, 26*(15-16), 2274-2285. doi:10.1111/jocn.13439

Basheer, J. S. (2019). Finding of inquest. Retrieved from http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/8
24/SINGH%20Heidi%20Eileen%20Roseanne.pdf

Bassot, B. (2016). *The reflective practice guide: an interdisciplinary approach to critical reflection*. Oxford, United Kingdom: Routledge.

Baum, F. (2015). *The new public health* (4th ed.). Melbourne, Australia: Oxford University Press.

Bechtel, K., Ryan, E., & Gallagher, D. (2008). Impact of sexual assault nurse examiners on the evaluation of sexual assault in a pediatric emergency department. *Pediatric emergency care, 24*(7), 442-447. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med6&NEWS=N&AN=1858
0706

Ben Natan, M., Faour, C., Naamhah, S., Grinberg, K., & Klein-Kremer, A. (2012). Factors affecting medical and nursing staff reporting of child abuse. *International nursing review, 59*(3), 331-337. doi:10.1111/j.1466-7657.2012.00988.x

Benziman, G. (2012). *Narrative of child neglect in romantic and Victorian culture*. London: Palgrave Macmillan.

Berger, P., & Luckman, T. (1972). *The social construction of reality*. London, UK: Penguin Books.

Bird, C. (Ed.) (1998). *The stolen children: their stories*. Milsons Point, Australia: Random House Australia.

Borimnejad, L., & Fomani, F. K. (2015). Child abuse reporting barriers: Iranian nurses' experiences. *Iranian red crescent medical journal, 17*(8), e22296. doi:10.5812/ircmj.22296v2

Botash, A. S., Galloway, A. E., Booth, T., Ploutz-Snyder, R., Hoffman-Rosenfeld, J., & Cahill, L. (2005). Continuing medical education in child sexual abuse: cognitive gains but not expertise. *Archives of pediatric adolescent medicine, 159*, 561-566.

Bounds, D. T., Edinburgh, L., Fogg, L. F., & Saewyc, E. M. (2019). A nurse practitioner-led intervention for runaway adolescents who have been sexually assaulted or sexually exploited: effects on trauma symptoms, suicidality, and self-injury. *Child abuse and neglect, 90*, 99-107. doi:10.1016/j.chiabu.2019.01.023

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*, 77-101.

Brice, R. (2011). Four more jailed over kids' beatings, starvation. Retrieved from https://www.abc.net.au/news/2011-02-11/four-more-jailed-over-kids-beatings-starvation/1939814

Brinkmann, S. (2013). *Qualitative interviewing: understanding qualitative research*. New York: Oxford University Press.

Brockliss, L., & Montgomery, H. (2013). Chapter 2: Childhood: a historical approach. In M. J. Kehily (Ed.), *Understanding childhood: a cross disciplinary approach* (2nd ed., Vol. 1). Bristol, UK: The Open University.

Bromfield, L., & Holzer, P. (2008). A national approach for child protection: project report. Retrieved from https://aifs.gov.au/sites/default/files/nch/pubs/reports/cdsmac/cdsmac.pdf

Browne, A. J., Hartrick Doane, G., Reimer, J., MacLeod, M. L. P., & McLellan, E. (2010). Public health nursing practice with 'high priority' families: the significance of contextualizing 'risk'. *Nursing inquiry, 17*(1), 26-37. doi:10.1111/j.1440-1800.2009.00478.x

Bryant, J. K., & Baldwin, P. A. (2010). School counsellors' perceptions of mandatory reporter training and mandatory reporting experiences. *Child abuse review, 19*, 172-186. doi:10.1002/car.1099

Brykczynski, K. A., Crane, P., Medina, C. K., & Pedraza, D. (2011). Intimate partner violence: advanced practice nurses clinical stories of success and challenge. *J Am Acad Nurse Pract, 23*(3), 143-152. doi:10.1111/j.1745-7599.2010.00594.x

Burr, V. (2003). *Social Constructionism* (2nd ed.). East Sussex, UK: Routledge.

Burr, V. (2015). *Social Constructionism* (3rd ed.). East Sussex, UK: Routledge.

Butler-Sloss, E. (1988). *Report of the Inquiry into Child Abuse in Cleveland in 1987*. London: Her Majesty's Stationery Office.

Buus, N., & Agdal, R. (2013). Can the use of reporting guidelines in peer-review damage the quality and contribution of qualitative health care research. *International journal of nursing studies, 50*(10), 1289-1291. doi:10.1016/j.ijnurstu.2013.02.012

Bynum, W. (2008). *History of medicine: a very short introduction*. New York, USA: Oxford University Press Inc.

Bywaters, P., Bunting, L., Davidson, G., Hanratty, J., Mason, W., McCartan, C., & Steils, N. (2016). The relationship between poverty, child abuse and neglect: an evidence review. Retrieved from https://www.jrf.org.uk/file/48920/download?token=2lurHFld&filetype=full-report

Candela, L. (2015). Using contextual curriculum design with taxonomies to promote critical thinking. In S. B. Keating (Ed.), *Curriculum development and evalution in nursing* (3rd ed.). New York: Springer.

Care Quality Commission. (2016). *Not seen, not heard*. Retrieved from https://www.cqc.org.uk/publications/themed-work/not-seen-not-heard

Ceccucci, J. (2018). Evaluating nurse practitioners perceived knowledge, competence, and comfort level in caring for the sexually abused child. *Journal of forensic nursing, 14*(1). doi:10.1097/JFN.0000000000000184

Chan, A. C. Y., Cheng, W. L., Lin, Y. N., Ma, K. W., Mark, C. Y., Yan, L. C., . . . Ho, G. W. K. (2020). Knowledge and perceptions of child protection and mandatory reporting: a survey of nurses in Hong Kong. *Comprehensive child and adolescent nursing, 43*(1), 48-64. doi:10.1080/24694193.2018.1561763

Chen, Y. W., Huang, J. J., Lu, T. H., & Feng, J. Y. (2015). Clinical competency in child maltreatment for community nurses in Taiwan. *International journal of nursing practice, 21*, 21-26. doi:10.1111/ijn.12395

Clark, A., & Gallacher, L. (2013). Chapter 1: Children in and out of place. In A. Clark (Ed.), *Childhoods in context* (Vol. 3, pp. 1-52). Bristol, United Kingdom: Open University Press.

Cleaver, K., Maras, P., Oram, C., & MacCallum, K. (2019). A review of UK based multi-agency approaches to early intervention in domestic abuse: lessons to be learnt from existing evaluation studies. *Aggression and violent behavior, 46*, 140-155. doi:10.1016/j.avb.2019.02.005

Coar, L., & Sim, J. (2006). Interviewing one's peers: methodological issues in a study of health professionals. *Scandinavian journal of primary health care, 24*(4), 251-256.

Coles, L., & Collins, L. (2007). Barriers to and facilitators for preventing shaking and head injuries in babies. *Commmunity Practitioner, 80*(10), 20-24.

Colquhoun, H. (2016). Current best practice for the conduct of scoping reviews. Retrieved from http://www.equator-network.org/wp-content/uploads/2016/06/Gerstein-Library-scoping-reviews_May-12.pdf

Colquhoun, H. L., Levac, D., O'Brien, K. K., Straus, S. E., Tricco, A. C., Perrier, L., . . . Moher, D. (2014). Scoping reviews: time for clarity in definition, methods and reporting. *Journal of clinical epidemiology, 67*, 1291-1294.

Committee on Child Maltreatment Research Policy and Practice for the Next Decade: Phase II. (2014). *New directions in child abuse and neglect research* (A. C. Petersen, J. Joseph, & M. Feit Eds.). Washington: National Academies Press.

Commonwealth of Australia. (2019). *Australian early development census national report 2018: a snapshot of early childhood development in Australia*. Retrieved from Canberra, Australia: https://www.aedc.gov.au/resources/detail/2018-aedc-national-report

Cook, A. (2015). Partnership working across UK public services. *What works Scotland: evidence reivew.* Retrieved from http://whatworksscotland.ac.uk/wp-content/uploads/2015/12/WWS-Evidence-Review-Partnership-03-Dec-2015-.pdf

Cooper, E. (2012). Following the law, but losing the spirit of child protection in Kenya. *Development in practice, 22*(486-497). doi:10.1080/09614524.2012.673554

Cooper, V., & Collins, J. (2008). Children and identity. In J. Collins & P. Foley (Eds.), *Promoting children's wellbeing: policy and practice*. Bristol, UK: The Open University.

Cortis, N., Smyth, C., Wade, C., & Katz, I. (2018). Changing practice cultures in statutory child protection: practitioners' perspectives. *Child & family social work, 24*, 50-58. doi:10.1111/cfs.12580

Council of Australian Governments. (2009). Protecting children is everyone's business: national framework for protecting Australia's children 2009-2020. Retrieved from https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf

Council of Australian Governments. (2015). *Driving change: intervening early. Third three-year action plan*. Retrieved from https://www.dss.gov.au/sites/default/files/documents/12_2015/pdf_third_action_plan_for_protecting_australias_children.pdf

Council of Australian Governments. (2018). Fourth action plan 2018-2020: supporting families, communities and organisations to keep children safe. *National framework for protecting Australia's children 2009-2020.* Retrieved from https://www.dss.gov.au/sites/default/files/documents/01_2019/dss-fourth-action-plan-v6-web-final.pdf

Covey, H. C., Menard, S., & Franzese, R. J. (2013). Effects of adolescent physical abuse, exposure to neighborhood violence, and witnessing parental violence on adult socioeconomic status. *Child maltreatment, 18*(2), 85-97. doi:10.1177/1077559513477914

Cox, J. E., Harris, S. K., Conroy, K., Engelhart, T., Vyavaharkar, A., Federico, A., & Woods, E. R. (2019). A parenting and life skills intervention for teen mothers: a randomized controlled trial. *Pediatrics, 143*. doi:10.1542/peds.2018-2303

Coyne, I., Hallstrom, I., & Soderback, M. (2016). Reframing the focus from a family-centred to a child-centred care approach for children's healthcare. *Journal of child health care, 20*(4), 494-502. doi:10.1177/1367493516642744

Crane, J. (2018). *Child protection in England, 1960-2000: expertise, experience and emotion*. Cham, Switzerland: Palgrave Macmillan.

Crisp, B. R., & Lister, P. G. (2006). Nurses' perceived training needs in child protection issues. *Health education, 106*(5), 381-399. doi:10.1108/09654280610686603

Critical Skills Appraisal Programme. (2013). CASP Checklists. Retrieved from https://casp-uk.net/casp-tools-checklists/

Currie, J., & Widom, C. S. (2010). Long-term consequences of child abuse and neglect on adult economic well-being. *Child maltreatment, 15*(2), 111-120. doi:10.1177/1077559509355316

D'Cruz, H. (2004). *Constructing meanings and identities in child protection practice*. Melbourne, Australia: Tertiary Press.

Dahlbo, M., Jakobsson, L., & Lundqvist, P. (2017). Keeping the child in focus while supporting the family. *Journal of child health care, 21*(1), 103-111. doi:10.1177/1367493516686200

Damashek, A., Drass, S., & Bonner, B. L. (2013). Child maltreatment fatalities related to inadequate caregiver supervision. *Journal of interpersonal violence, 29*(11), 1987-2001. doi:10.1177/0886260513515951

Daubt, H., van Mossel, C., & Scott, S. J. (2013). Enhancing the scoping study methodology: a large, inter-professional team's experience with Arksey and O'Malley's framework. *BMC medical research methodology, 13*(48). doi:10.1186/1471-2288-13-48

Davidov, D. M., Jack, S., Frost, S. S., & Coben, J. H. (2012). Mandatory reporting in the context of home visitation programs: intimate partner violence and children's exposure to intimate partner violence. *Violence against women, 18*(5), 595-610. doi:10.1177/1077801212453278

Davidov, D. M., & Jack, S. M. (2013). Nurse home visitors' perceived awareness of mandatory reporting requirements: Pregnant women's and children's exposure to intimate partner violence. *Journal of advanced nursing, 70*(8), 1770-1779. doi:10.1111/jan.12334

Davidov, D. M., Nadorff, M. R., Jack, S. M., & Coben, J. H. (2012). Nurse home visitors' perspectives of mandatory reporting of children's exposure to intimate partner violence to child protection agencies. *Public health nursing, 29*(5), 412-423. doi:10.1111/j.1525-1446.2011.01003.x

Davidson, J., & Bifulco, A. (2019). *Child abuse and protection: contemporary issues in research, policy and practice*. London, UK: Routledge.

Davidson, P., Saounders, P., Bradvury, B., & Wong, M. (2020). Poverty in Australia - part 1: overview. Retrieved from http://povertyandinequality.acoss.org.au/wp-content/uploads/2020/02/Poverty-in-Australia-2020_Part-1_Overview.pdf

Davidson, P., Saunders, P., Bradbury, B., & Wong, M. (2018). Poverty in Australia 2018. *Poverty in Australia.* Retrieved from https://www.acoss.org.au/wp-content/uploads/2018/10/ACOSS_Poverty-in-Australia-Report_Web-Final.pdf

Davis, H., & Day, C. (2010). *Working in partnership: the family partnership model*. London: Pearson Education.

Deakin, H., & Wakefield, K. (2014). Skype interviewing: reflections of two PhD researchers. *Qualitative research, 14*(5), 603-616. doi:10.1177/1468794113488126

Dekker, S. (2002). *The field guide to human error investigations*. London: Ashgate publishing.

Denzin, N. K., & Lincoln, Y. S. (2013a). Introduction: the discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (4th ed., pp. 1-41). Thousand Oaks, California: Sage.

Denzin, N. K., & Lincoln, Y. S. (2013b). Part II: the art and practices of interpretation, evaluation, and representation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (pp. 345-354). Thousand Oaks, California: SAGE.

Denzin, N. K., & Lincoln, Y. S. (2018). The art and practices of interpretation, evaluation, and representation. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (5th ed., pp. 757-765). Thousand Oaks, California: SAGE.

Department for Child Protection. (2020). Safe and well: supporting families, protecting children. Retrieved from https://www.childprotection.sa.gov.au/child-protection-initiatives/system-reform/safe-and-well

Department of Health. (2012). Health visiting and school nurse programme: supporting implementation of the new service offer: no. 5: safeguarding children and young people: enhancing professional practice - working with children and families. Retrieved from http://media.dh.gov.uk/network/387/files/2012/11/SAFEGUARDING_ENHANCING-PROFESSIONAL-GUIDANCE.pdf

Desai, M. (2010). *A rights-based preventative approach for psychosocial well-being in childhood* (Vol. 3). Dordrecht: Springer.

Dias, M. S., Rottmund, C. M., Cappos, K. M., Reed, M. E., Wang, M., Stetter, C., . . . Klevens, J. (2017). Association of a postnatal parent education program for abusive head trauma with subsequent pediatric abusive head trauma hospitalization rates. *JAMA Pediatrics, 171*(3), 223-229. doi:10.1001/jamapediatrics.2016.4218

Doane, G. H., & Varcoe, C. (2007). Relational practice and nursing obligations. *Advances in nursing science, 30*(3), 192-205.

Dodge, K., Goodman, W. B., Bai, Y., O'Donnell, K., & Murphy, R. A. (2019). Effect of a community agency-administered nurse home visiting program on program use and maternal and infant health: a randomized clinical trial. *JAMA network open, 2*(11). doi:10.1001/jamanetworkopen.2019.14522

Donaldson, L. J., & O'Brien, S. (1995). Press coverage of the Cleveland child sexual abuse enquiry: a source of public enlightenment? *Journal of public health medicine, 17*(1), 70-76.

Drake, B., & Jonson-Reid, M. (2015). Chapter 3: Competing values and evidence: how do we evaluate mandated reporting and CPS response? In B. Mathews & D. C. Bross (Eds.), *Mandatory reporting laws and the identification of severe child abuse and neglect* (pp. 33-60). Dordrecht: Springer Science + Business Media.

Drinkwater, J., Stanley, N., Szilassy, E., Larkins, C., Hester, M., & Feder, G. (2017). Juggling confidentiality and safety: a qualitative study of how general practice clinicians document domestic violence in families with children. *British journal of general practice, 67*(659), e437-e444. doi:10.3399/bjgp17X689353

Dubowitz, H., Lane, W. G., Semiatin, J. N., & Magder, L. S. (2012). The SEEK model of pediatric primary care: Can child maltreatment be prevented in a low-risk population? *Academic pediatrics, 12*(4), 259-268. doi:10.1016/j.acap.2012.03.005

Dudgeon, P., Cubillo, C., & Bray, A. (2015). Stolen generations: the forced removal of First Peoples children in Australia. In C. Newnes (Ed.), *Children in society: politics, policies and interventions* (pp. 50-81). Exeter, United Kingdom: PCCS Books.

Easton, S. D., Renner, L. M., & O'Leary, P. (2013). Suicide attempts among men with histories of child sexual abuse: examining abuse severity, mental health, and masculine norms. *Child abuse & neglect, 37*, 380-387. doi:10.1016/j.chiabu.2012.11.007

Eckenrode, J., Campa, M. I., Morris, P. A., Henderson, C. R., Jr., Bolger, K. E., Kitzman, H., & Olds, D. L. (2017). The prevention of child maltreatment through the Nurse Family Partnership Program: mediating effects in a long-term follow-up study. *Child maltreatment, 22*(2), 92-99. doi:10.1177/1077559516685185

Edgar, D., & Edgar, P. (2008). *The new child: in search of smarter grown-ups*. Melbourne, Australia: Wilkinson Publishing.

Edinburgh, L. D., & Saewyc, E. M. (2009). A novel, intensive home-visiting intervention for runaway, sexually exploited girls. *Journal for specialists in pediatric nursing, 14*(1), 41-48. doi:10.1111/j.1744-6155.2008.00174.x

Egan, G. (2010). *The skilled helper: a problem-management and opportunity-development approach to helping* (10th ed.). Belmont, USA: Brooks/Cole Cengage Learning.

Egerton, T., Diamond, L. E., Buchbinder, R., Bennell, K. L., & Slade, S. C. (2017). A systematic review and evidence synthesis of qualitative studies to identify primary care clinicians' barriers and enablers to the management of osteoarthrisis. *Osteoarthritis and cartilage, 25*, 625-638.

Ehrenreich, B., & English, D. (2010). *Witches, midwives and nurses: a history of women healers*.

Einboden, R., Rudge, T., & Varcoe, C. (2019). Beyond and around mandatory reporting in nursing practice: interrupting a series of deferrals. *Nursing inquiry, 26*(2). doi:10.1111/nin.12285

Einboden, R. D. (2017). *Nowhere to stand: a critical discourse analysis of nurses' responses to child neglect and abuse.* (Doctor of Philosophy). University of Sydney,

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

Escobar, M. A., Pflugeisen, B. M., Duralde, Y., Morris, C. J., Haferbecker, D., Amoroso, P. J., . . . Pohlson, E. C. (2016). Development of a systematic protocol to identify victims of non-accidental trauma. *Pediatric surgery international, 32*, 377-386. doi:10.1007/s00383-016-3863-8

Featherstone, B., Gupta, A., & Morris, K. M. (2016). Let's stop feeding the risk monster: towards a social model of 'child protection'. *Families, relationship and societies*. doi:10.1332/204674316X14552878034622

Featherstone, B., Morris, K., Daniel, B., Bywaters, P., Brady, G., Bunting, L., . . . Mirza, N. (2017). Poverty, inequality, child abuse and neglect: Changing the conversation across the UK in child protection? *Children and youth services review, 97*, 127-133. doi:10.1016/j.childyouth.2017.06.009

Feng, J., Chen, S. J., Wilk, N. C., Yang, W. P., & Fetzer, S. (2009). Kindergarten teachers' experience of reporting child abuse in Taiwan: Dancing on the edge. *Children and youth services review, 31*, 405-409. doi:10.1016/j.childyouth.2008.09.007

Feng, J. Y., Fetzer, S., Chen, Y. W., Yeh, L., & Huang, M. C. (2010). Multidisciplinary collaboration reporting child abuse: A grounded theory study. *International journal of nursing studies, 47*(12), 1483-1490. doi:10.1016/j.ijnurstu.2010.05.007

Feng, J. Y., Jezewski, M. A., & Hsu, T. W. (2005). The meaning of child abuse for nurses in Taiwan. *Journal of transcultural nursing, 16*(2), 142-149. doi:10.1177/1043659604273551

Feng, J. Y., & Levine, M. (2005). Factors associated with nurses' intention to report child abuse: A national survey of Taiwanese nurses. *Child abuse & neglect, 29*(7), 783-795. doi:10.1016/j.chiabu.2004.11.006

Ferguson, C. J. (2013). Spanking, corporal punishment and negative long-term outcomes: a meta-analytic review of longitudinal studies. *Clinical psychology review, 33*(1), 196. doi:10.1016/j.cpr.2012.11.002

Ferguson, H. (2004). *Protecting children in time: child abuse, child protection and the consequences of modernity*. Great Britain: Palgrave Macmillan.

Finn, C. (2011). Forensic nurses' experiences of receiving child abuse disclosures. *Journal for specialists in pediatric nursing, 16*(4), 252-262. doi:10.1111/j.1744-6155.2011.00296.x

Flemington, T., & Fraser, J. A. (2016). Maternal involvement in a nurse home visiting programme to prevent child maltreatment. *Journal of children's services, 11*(2), 124-140. doi:10.1108/JCS-02-2015-0003

Flemington, T., Waters, D., & Fraser, J. A. (2015). Maternal involvement and outcomes in nurse home visiting. *Journal of children's services, 10*(4), 311-323. doi:10.1108/JCS-02-2015-0006

Foresman, G. A., Fosl, P. S., & Watson, J. C. (2016). *The critical thinking toolkit*: Wiley Blackwell.

Foster, R. H., Olson-Dorff, D., Reiland, H. M., & Budzak Garza, A. (2017). Commitment, confidence and concerns: assessing health care professionals' child maltreatment reporting attitudes. *Child abuse & neglect, 67*, 54-63. doi:10.1016/j.chiabu.2017.01.024

Foucault, M. (1995). *Discipline and punish: the birth of the prison* (2nd ed.). New York, USA: Vintage Books.

Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D., & Smith, C. (2015). Better systems, better chances: a review of research and practice for prevention and early intervention. Retrieved from http://www.community.nsw.gov.au/docswr/_assets/main/documents/early_intervention/tab_e_prevention_and_early_intervention_literature_review.pdf

Francis, K., Chapman, Y., Sellick, K., James, A., Miles, M., Jones, J., & Grant, J. (2012). The decision making processes adopted by rurally located mandated professionals when child abuse or neglect is suspected. *Contemporary nurse, 41*(1), 58-69. doi:10.5172/conu.2012.41.1.58

Fraser, J., Waters, D., Forster, E., & Brown, N. (Eds.). (2017). *Paediatric nursing in Australia: principles for practice* (2nd ed.). Cambridge, UK: Cambridge University Press.

Fraser, J. A., Barnes, M., Biggs, H. C., & Kain, V. J. (2007). Caring, chaos and the vulnerable family: Experiences in caring for newborns of drug-dependent parents. *International journal of nursing studies, 44*(8), 1363-1370. doi:10.1016/j.ijnurstu.2006.06.004

Fraser, J. A., Flemington, T., Doan, D. T. N., Hoang, V. M. T., Doan, B. T. L., & Ha, T. M. (2018). Professional self-efficacy for responding to child abuse presentations. *Journal of children's services*. doi:10.1108/JCS-09-2017-0044

Fraser, J. A., Hutchinson, M., & Appleton, J. V. (2016). Nurses' experiences of home visiting new parents in rural and regional communities in Australia: a descriptive qualitative study. *Journal of children's services, 11*(3), 204-216. doi:10.1108/jcs-07-2015-0023

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

Fraser, N. (2013). Final overview report of serious case review re Daniel Pelka. Retrieved from https://cscb-new.co.uk/downloads/Serious%20Case%20Reviews%20-%20exec.%20summaries/SCR_Archive/Coventry%20SCR%20-%20Daniel%20Pelka%20(2013).pdf

Fraser, S., Grant, J., & Mannix, T. (2014). The role and experience of child and family health nurses in developed countries: a review of the literature. *Neonatal, paediatric & child health nursing, 17*(3), 2-10.

Fraser, S., Grant, J., & Mannix, T. (2016). Maternal child and family health nurses: delivering a unique nursing speciality. *Maternal and child health journal, 20*, 2557-2564. doi:10.1007/s10995-016-2081-2

Fryda, C. M., & Hulme, P. A. (2015). School-based childhood sexual abuse prevention programs: an integrative review. *Journal of school nursing, 31*(3), 167-182. doi:10.1177/1059840514544125

Fujiwara, T. (2015). Effectiveness of public health practices against shaken baby syndrome/abusive head trauma in Japan. *Public health, 129*(5), 475-482. doi:10.1016/j.puhe.2015.01.018

Fujiwara, T., Natsume, K., Okuyama, M., Sato, T., & Kawachi, I. (2012). Do home-visit programs for mothers with infants reduce parenting stress and increase social capital in Japan? *Journal of epidemiology & community health, 66*(12), 1167-1176. doi:10.1136/jech-2011-200793

Fuller, T. (2014). Beyond investigations: differential response in child protective services. In J. E. Korbin & R. D. Krugman (Eds.), *Handbook of child maltreatment*. Dordrecht, Netherlands: Springer.

Furedi, F. (2002). *Paranoid parenting: why ignoring the experts may be best for your child*. Chicago, USA: Chicago Review Press.

Gallacher, L., & Kehily, M. J. (2013). Chapter 5 Childhood: a sociocultural aproach. In M. J. Kehily (Ed.), *Understanding childhood: a cross-disciplinary approach* (2nd ed.). Glascow: The Policy Press.

Garcia, C., McNaughton, D., Radosevich, D. M., Brandt, J., & Monsen, K. (2013). Family home visiting outcomes for Latina mothers with and without mental health problems. *Public health nursing, 30*(5), 429-438. doi:10.1111/phn.12054

Garneau, A. B. (2016). Critical reflection in cultural competence development: a framework for undergraduate nursing education. *Journal of nursing education, 55*(3), 125-132. doi:10.3928/01484834-20160216-02

GBD 2015 Child Mortality Collaborators. (2016). Global, regional, national and selected subnational levels of stillbirths, neonatal, infant, and under-5 mortality, 1980-2015: a systematic analysis for the Global Burden of Disease Study 2015. *The lancet, 388*, 1725-1774. doi:10.1016/S0140-6736(16)31575-6

Gergen, K. J. (2015). *An invitation to social construction*. London: SAGE Publications Inc.

Gershoff, E. T., & Grogan-Kaylor, A. (2016). Spanking and child outcomes: old controversies and new meta-analyses. *Journal of family psychology, 30*(4), 453. doi:10.1037/fam0000191

Gibbs, G. R. (2014). Chapter 19: Using software analysis in qualitative analysis. In U. Flick (Ed.), *The SAGE handbook of qualitative data analysis*. London: Sage Publications Ltd.

Gibbs, K., Dickinson, A., & Ramussen, S. (2019). Caring for children with non-accidental head injuries: a case for a child-centred approach. *Comprehensive child and adolescent nursing*. doi:10.1080/24694193.2019.1654039

Gibson, M. (2016). Constructing pride, shame, and humiliation as a mechanism of control: A case study of an English local authority child protection service. *Children and youth services review, 70*, 120-128. doi:10.1016/j.childyouth.2016.09.016

Gilbert, R., Fluke, J., O'Donnell, M., Gonzalex-Izquierdo, A., Brownell, M., Gulliver, P., . . . Sidebotham, P. (2012). Child maltreatment: variation in trends and policies in six developed countries. *Lancet, 37*(9), 758-772. doi:10.1016/S0140-6736(11)61087-8

Gill, T. (2007). *No fear! Growing up in a risk society*. London: Calouste Gulbenkian Foundation.

Gillick v West Norfolk and Wisbech AHA (United Kingdom House of Lords 1985).

Gilmour, J., & Huntington, A. (2014). Power and politics in the practice of nursing. In J. Daly, S. Speedy, & D. Jackson (Eds.), *Contexts of nursing*: Churchill Livingstone.

Given, L. M. (2016). *100 questions (and answers) about qualitative research*. Thousand Oaks, California: SAGE Publications Inc.

Glasser, S., & Chen, W. (2006). Survey of a pediatric hospital staff regarding cases of suspected child abuse and neglect. *Israel medical association journal, 8*(3), 179-183.

Goldfeld, S., Price, A., & Kemp, A. (2018). Designing, testing, and implementing a sustainable nurse home visiting program: right@home. *Annals of the New York academy of sciences, 1419*, 141-159. doi:10.1111/nyas.13688

Goldfeld, S., Price, A., Smith, C., Bruce, T., Bryson, H., Mensah, F., . . . Kemp, L. (2019). Nurse home visiting for families experiencing adversity: a randomized trial. *Pediatrics, 143*.

Golding, J. M., Wasarhaley, N. E., Lynch, K. R., Lippert, A., & Magyarics, C. L. (2015). Improving the credibility of child sexual assault victims in court: the impact of a sexual assault nurse examiner. *Behavioral sciences & the law, 33*(4), 493-507. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=medl&NEWS=N&AN=26294384

Goldman, J. G. D. (2010). Australian undergraduate primary school student-teachers' responses to child sexual abuse and its mandatory reporting. *Pastoral care in education, 28*(4), 283-294. doi:10.1080/02643944.2010.530679

Goulet, C., Frappier, J. Y., Fortin, S., Deziel, L., Lampron, A., & Boulanger, M. (2009). Development and evaluation of a shaken baby syndrome prevention program. *Journal of obstetric, gynecologic and neonatal nursing, 38*(1), 7-21. doi:10.1111/j.1552-6909.2008.00301.x

Government of South Australia: Attorney-General's Department. (2017). Children and young people (safety) Act 2017. Retrieved from https://www.legislation.sa.gov.au/LZ/C/A/CHILDREN%20AND%20YOUNG%20PEOPLE%20(SAFETY)%20ACT%202017/CURRENT/2017.25.AUTH.PDF

Grant, J., Gregoric, C., Jovanovic, J., Parry, Y., & Walsh, K. (2018). Educating professionals who will work with children in the early years: an evidence-informed interdisciplinary framework. *Early years*. doi:10.1080/09575146.2018.1488819

Grant, J., Mitchell, C., & Cuthbertson, L. (2017). National standards of practice for maternal, child & family health nurses in Australia. Retrieved from http://www.mcafhna.org.au/Resources.aspx#52611-standards

Guba, E. G., & Lincoln, Y. S. (2008). Controversies, contradictions, confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research*. Thousand Oaks, California: Sage Publications.

Gubrium, J. F., & Holstein, J. A. (2003). From the individual interview to the interview society. In J. A. Holstein & J. F. Gubrium (Eds.), *Postmodern Interviewing*. Thousand Oaks, California: Sage Publications.

Gui, X., Chen, Y., & Pine, K. H. (2018). Navigating the healthcare service "black box": individual competence and fragmented system. *Proceedings of the ACM on Human-Computer Interaction, 2*. doi:10.1145/3274330

Guthrie, K. F., Gaziano, C., & Gaziano, E. P. (2009). Toward better beginnings: Enhancing healthy child development and parent-child relationships in a high-risk population. *Home health care management and practice, 21*(2), 99-108. doi:10.1177/1084822308322650

Hackett, A. J. (2013). The role of the school nurse in child protection. *Community practitioner, 86*(12), 26-29.

Hacking, I. (1999). *The social construction of what?* United States of America: President and Fellows of Harvard College.

Harrison, C., Harries, M., & Liddiard, M. (2014). The perfect storm: politics, media and child welfare policy making. *Communities, children and families Australia, 8*(2), 29-45.

Harvey, J. H., Hornsby, R. A., & Sattar, Z. (2015). Disjointed service: an English case study of multi-agency provision in tackling child trafficking. *British journal of criminology, 55*, 494-513. doi:10.1093/bjc/azu115

Haskett, M. E., Okoniewski, K. C., Armstrong, J. M., Galanti, S., Lowder, E., Loehman, J., & Lanier, P. J. (2017). Feasibility, acceptability, and effects of a peer support group to prevent child maltreatment among parents experiencing homelessness. *Children and youth services review, 73*, 187-196.

Hendry, A., Snowden, A., & Brown, M. (2017). When holistic care is not holistic enough: The role of sexual health in mental health settings. *Journal of clinical nursing, 27*, 1015-1027. doi:10.1111/jocn.14085

Her Majesty's Government. (2015). Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Her Majesty's Government. (2018). Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

Herbert, J. L., & Bronfield, L. (2017). National comparison of cross-agency practice in investigating and responding to severe child abuse. Retrieved from https://aifs.gov.au/cfca/sites/default/files/publication-documents/47_national_comparison_of_cross-agency_practice_in_investigating_and_responding_to_severe_child_abuse.pdf

Herendeen, P. A., Blevins, R., Anson, E., & Smith, J. (2014). Barriers to and consequences of mandated reporting of child abuse by nurse practitioners. *Journal of pediatric health care, 28*(1), e1-7. doi:10.1016/j.pedhc.2013.06.004

Hillis, S., Mercy, J., Amobi, A., & Kress, H. (2016). Global prevalence of past-year violence against children: a systematic review and minimum estimates. *Pediatrics, 137*(3).

Ho, G. W. K., & Gross, D. A. (2015). Pediatric nurses' differentiations between acceptable and unacceptable parent discipline behaviors: A Q-study. *Journal of pediatric healthcare, 29*(3), 255-264. doi:10.1016/j.pedhc.2014.12.004

Hogg, S., Coster, D., & Brookes, H. (2015). *Baby steps: evidence from a relationships-based perinatal education programme: summary document*. Retrieved from https://www.foundationyears.org.uk/files/2015/02/Summary-report-_baby-steps-evidence-relationships-based-perinatal-education-programme.pdf

Holloway, I., & Galvin, K. (2016). *Qualitative research in nursing and healthcare*(4 ed.). Retrieved from https://ebookcentral-proquest-com.ezproxy.flinders.edu.au/lib/flinders/detail.action?docID=4622920.

Hornor, G., Bretl, D., Chapman, E., Herendeen, P., Mitchel, N., Mulvaney, B., . . . VanGraafeiland, B. (2017). Child Maltreatment Screening and Anticipatory Guidance: A Description of Pediatric Nurse Practitioner Practice Behaviors. *Journal of pediatric health care, 31*(6), e35-e44. doi:10.1016/j.pedhc.2017.05.006

Hornor, G., & Herendeen, P. (2014). Advanced practice nursing in child maltreatment: Practice characteristics. *Journal of pediatric health care, 28*(5), 438-443.e431. doi:10.1016/j.pedhc.2014.02.003

Hornor, G., Thackeray, J., Scribano, P., Curran, S., & Benzinger, E. (2012). Pediatric sexual assault nurse examiner care: Trace forensic evidence, ano-genital injury, and judicial outcomes. *Journal of forensic nursing, 8*(3), 105-111. doi:10.1111/j.1939-3938.2011.01131.x

Houlihan, D., Sharek, D., & Higgins, A. (2013). Supporting children whose parent has a mental health problem: An assessment of the education, knowledge, confidence and practices of registered psychiatric nurses in Ireland. *Journal of psychiatric and mental health nursing, 20*(4), 287-295. doi:10.1111/j.1365-2850.2012.01923.x

House of Commons Health Committee. (2003). *The Victoria Climbie inquiry report*. Retrieved from London:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/273183/5730.pdf

Howard, K. S., & Brooks-Gunn, J. (2009). The role of home-visiting programs in preventing child abuse and neglect. *Future of children, 19*(2), 119-146. doi:10.1353/foc.0.0032

Human rights and equal opportunity commission. (1997). *Bringing them home: national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*. Retrieved from Sydney: https://www.humanrights.gov.au/sites/default/files/content/pdf/social_justice/bringing_them_home_report.pdf

International Council of Nurses. (2009). Prevention of child abuse. Retrieved from http://www.icn.ch/images/stories/documents/publications/fact_sheets/11d_FS-Prevention_Child_Abuse.pdf

International Council of Nurses. (2012). The ICN code of ethics for nurses. Retrieved from http://www.icn.ch/images/stories/documents/about/icncode_english.pdf

James, A. (2007). Giving voice to children's voices: practices and problems, pitfalls and potentials. *American anthropologist, 109*(2), 261-272.

James, A., & Prout, A. (Eds.). (2004). *Introduction* (2 ed.). London: Routledge.

James, H., & Lane, D. (2018). The child's guardian - listening and giving weight to children's views. *International journal of children's rights, 26*, 117-135. doi:10.1163/15718182-02601005

Jenks, C. (2005). *Childhood* (2nd ed.). New York: Routledge.

Jenner, B. M., & Myers, K. C. (2018). Intimacy, rapport, and exceptional disclosure: a comparison of in-person and mediated interview contexts. *International journal of social research methodology, 22*(2), 165-177. doi:10.1080/13645579.2018.1512694

Johns, M. (2015). Inquest into the death of Chloe Lee Valentine. Retrieved from http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/613/VALENTINE%20Chloe%20Lee.pdf

Jones, L., Bellis, M. A., Hughes, K., McCoy, E., Eckley, L., Bates, G., . . . Officer, A. (2012). Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *The lancet, 380*, 899-907.

Jones, R., Flaherty, E. G., Binns, H. J., Price, L. L., Slora, E., Abney, D., . . . Sege, R. D. (2008). Clinicians' description of factors influencing their reporting of suspected child abuse: report of the child abuse reporting experience study research group. *Pediatrics, 122*(2), 259-266. doi:10.1542/peds.2007-2312

Keeley, M., Bullen, J., Bates, S., Katz, I., & Choi, A. (2015). *Opportunities for information sharing: case studies*. Retrieved from https://www.sprc.unsw.edu.au/media/SPRCFile/SPRC_Report__Opportunities_for_Information_Sharing.pdf

Kelley, S. J., Whitley, D. M., & Campos, P. E. (2010). Grandmothers raising grandchildren: Results of an intervention to improve health outcomes. *Journal of nursing scholarship, 42*(4), 379-386. doi:10.1111/j.1547-5069.2010.01371.x

Kemp, L., Harris, E., McMahon, C., Matthey, S., Impani, G. V., Anderson, T., . . . Zapart, S. (2011). Child and family outcomes of a long-term nurse home visitation programme: A randomised controlled trial. *Archives of disease in childhood, 96*(6), 533-540. doi:10.1136/adc.2010.196279

Kemp, L., Harris, E., McMahon, C., Matthey, S., Vimpani, G., Anderson, T., . . . Aslam, H. (2012). Benefits of psychosocial intervention and continuity of care by child and family health nurses in the pre- and postnatal period: Process evaluation. *Journal of advanced nursing, 69*(8), 1850-1861. doi:10.1111/jan.12052

Kempe, C. H., Silverman, F. N., Steele, B. F., Droegemueller, W., & Silver, H. K. (1962). The battered-child syndrome. *Journal of the American Medical Association, 9*(1985), 143-154.

Kendall, S., Bloomfield, L., Appleton, J., & Kitaoka, K. (2013). Efficacy of a group-based parenting program on stress and self-efficacy among Japanese mothers: A quasi-experimental study. *Nursing and health sciences, 15*(4), 454-460. doi:10.1111/nhs.12054

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

Kenny, M. C. (2015). Training in reporting of child maltreatment: where we are and where we need to go. In B. Mathews & D. C. Bross (Eds.), *Mandatory reporting laws and the identification of severe child abuse and neglect* (Vol. 4, pp. 327-346). doi:10.1007/978-94-017-9685-9

Kent, S., Dowling, M., & Gobnait, B. (2011). Community nurses' child protection role: views of public health nurses in Ireland. *Community practitioner, 84*(11), 33-36.

Kettle, M., & Jackson, S. (2017). Revisiting the rule of optimism. *The British journal of social work, 47*(6), 1624-1640. doi:10.1093/bjsw/bcx090

Khalil, H., Peters, M., Godfrey, C. M., McInerney, P., Soares, C. B., & Parker, D. (2016). An evidence-based approach to scoping reviews. *Worldviews on evidence-based nursing, 13*(2), 118-123. doi:10.1111/wvn.12144

Kimpson, S. A. (2005). Stepping off the road: a narrative of inquiry. In L. Brown & S. Strega (Eds.), *Research as resistance: critical, Indigenous, & anti-oppressive approaches* (pp. 73-96). Toronto: Canadian Scholars Press.

King, C. (2016). 'Sticking to carpets' - assessment and judgement in health visiting practice in an era of risk: a qualitative study. *Journal of clinical nursing, 25*(13-14), 1901-1911. doi:10.1111/jocn.13204

King, C. (2018). 'It depends what you class as vulnerable': risk discourse and the framing of vulnerability in health visiting policy and practice. *Families, relationship and societies, 7*(1), 39-54. doi:10.1332/204674316X14651146433955

King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. London, UK: Sage Publications.

Kitzman, H., Olds, D., Knudtson, M. D., Cole, R., Anson, E., Smith, J. A., . . . Conti, G. (2020). Prenatal and infancy nurse home visiting and 18-year outcomes of a randomized trial. *Pediatrics, 144*(6), 82-94. doi:10.1542/peds.2018-3876

Kitzman, H. J., Olds, D. L., Cole, R. E., Hanks, C. A., Anson, E. A., Arcoleo, K. J., . . . Holmberg, J. R. (2010). Enduring effects of prenatal and infancy home visiting by nurses on children: Follow-up of a randomized trial among children at age 12 years. *Archives of pediatrics and adolescent medicine, 164*(5), 412-418. doi:10.1001/archpediatrics.2010.76

Ko, C., & Koh, C.-K. (2007). The influence of abuse situation and respondent background characteristics on Korean nurses' perceptions of child sexual abuse: a fractional factorial design. *International journal of nursing studies, 44*(7), 1165-1176. doi:10.1016/j.ijnurstu.2006.05.009

Kobayashi, K., Fukushima, M., Kitaoka, H., Shimizu, Y., & Shimanouchi, S. (2015). The influence of public health nurses in facilitating a healthy family life for families with abused and neglected children by providing care. *International medical journal, 22*(1), 6-11.

Kociumbas, J. (1997). *Australian childhood: a history*. Sydney: Allen & Unwin.

Koetting, C., Fitzpatrick, J. J., Lewin, L., & Kilanowski, J. (2012). Nurse practitioner knowledge of child sexual abuse in children with cognitive disabilities. *Journal of forensic nursing, 8*(2), 72-80. doi:10.1111/j.1939-3938.2011.01129.x

Korhonen, T., Pietilä, A. M., & Vehviläinen-Julkunen, K. (2010). Are the children of the clients' visible or invisible for nurses in adult psychiatry? - A questionnaire survey. *Scandinavian journal of caring sciences, 24*(1), 65-74. doi:10.1111/j.1471-6712.2009.00686.x

Kraft, L. E., & Eriksson, U. (2015). The school nurse's ability to detect and support abused children: a trust-creating process. *Journal of school nursing, 31*(5), 353-362. doi:10.1177/1059840514550483

Kraft, L. E., Rahm, G., & Eriksson, U.-B. (2017). School nurses avoid addressing child sexual abuse. *Journal of school nursing, 33*(2), 133-142. doi:10.1177/1059840516633729

Kulkofsky, S. (2008). Credible but inaccurate: can criterion-based content analysis (CBCA) distinguish true and false memories? In M. J. Smith (Ed.), *Child sexual abuse: issues and challenges*. New York: Nova Science Publishers, Inc.

Kuruppu, J., Forsdike, K., & Hegarty, K. L. (2018). 'It's a necessary evil': experiences and perceptions of mandatory reporting of child abuse in Victorian general practice. *Australian journal of general practice, 47*(10), 729-733. doi:10.31128/AJGP-04-18-4563

Kvale, S. (2007). *Doing Interviews*. London: Sage Publications.

Kvale, S., & Brinkmann, S. (2009). *InterViews: learning the craft of qualitative research interviewing* (2nd ed.). Thousand Oaks, California: Sage.

Land, M., & Barclay, L. (2008). Nurses' contribution to child protection. *Neonatal, paediatric and child health nursing, 11*(1), 18-24.

Landy, C. K., Jack, S., Wahoush, O., Sheehan, D., & MacMillan, H. L. (2012). Mothers' experiences in the nurse-family partnership program: a qualitative case study. *BMC nursing, 11*(15). doi:10.1186/1472-6955-11-15

Lavigne, J. L., Portwood, S. G., Warren-Findlow, J., & Brunner Huber, L. R. (2017). Pediatric inpatient nurses' perceptions of child maltreatment. *Journal of pediatric nursing, 34*, 17-22. doi:10.1016/j.pedn.2017.01.010

Lazenbatt, A., & Freeman, R. (2006). Recognizing and reporting child physical abuse: a survey of primary healthcare professionals. *Journal of advanced nursing, 56*(3), 227-236. doi:10.1111/j.1365-2648.2006.04030.x

Lee, P., & Chau, F. (2016). A training programme for Taiwan nurses to improve child abuse reporting. *Journal of clinical nursing, 26*, 2297-2306. doi:10.1111/jocn.13447

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

Leigh, J. (2017a). *Blame, culture and child protection*. Basingstoke, UK: Palgrave Macmillan.

Leigh, J. (2017b). Recalcitrance, compliance and the presentation of self: exploring the concept of organisational misbehaviour in an English local authority child protection service. *Children and youth services review, 79*, 612-619. doi:10.1016/j.childyouth.2017.07.016

Leigh, J. (2019). Atmospheres of mistrust and suspicion: theorising on conflict and affective practice in a child protection social work agency. *Qualitative social work, 18*(2), 212-228. doi:10.1177/1473325017707028

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: advancing the methodology. *Implementation science, 5*(69). doi:69.10.1186/1748-5908-5-69

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

Li, S. (2018). The natural history of a doctoral research study: the role of a research diary and reflexivity. In H. T. Allan & A. Arber (Eds.), *Emotions & reflexivity in health & social care field research* (pp. 13-37). Cham, Switzerland: Palgrave, Macmillan.

Li, X., Yue, Q., Wang, S., Wang, H., Jiang, J., Gong, L., . . . Xu, T. (2017). Knowledge, attitudes, and behaviours of healthcare professionals regarding child maltreatment in China. *Child care health and development, 43*, 869-875. doi:10.1111/cch.12503

Liamputtong, P. (2013). *Qualitative research methods*. Melbourne: Oxford University Press.

Lines, L. E., Grant, J., & Hutton, A. E. (2018). How do nurses keep children safe from abuse and neglect, and does it make a difference? A scoping review. *Journal of pediatric nursing, 43*. doi:10.1016/j.pedn.2018.07.010

Lines, L. E., Grant, J. M., & Hutton, A. (2020a). 'How can we work together?' Nurses using relational skills to address child maltreatment in Australia: a qualitative study. *Journal of pediatric nursing, 54*. doi:10.1016/j.pedn.2020.05.008

Lines, L. E., Grant, J. M., & Hutton, A. (2020b). Nurses' perceptions of systems and hierachies shaping their responses to child abuse and neglect. *Nursing inquiry, 27*(3), 941-949. doi:10.1111/nin.1234

Lines, L. E., Hutton, A., & Grant, J. M. (2019). Navigating and negotiating meanings of child abuse and neglect: sociocultural contexts shaping Australian nurses' perceptions. *Health and social care in the community, 28*(3), 941-949. doi:10.1111/hsc.12925

Lines, L. E., Hutton, A. E., & Grant, J. (2017). Integrative review: nurses' roles and experiences in keeping children safe. *Journal of advanced nursing, 73*(2), 302-322. doi:10.1111/jan.13101

Lines, L. E., Hutton, A. E., & Grant, J. M. (under review). Constructing a compelling case: nurses' experiences of communicating abuse and neglect. *Child abuse review*.

Lo Iacono, V., Symonds, P., & Brown, D. H. K. (2016). Skype as a tool for qualitative research interviews. *Sociological research online, 21*(2). doi:10.5153/sro.3952

Lonne, B., & Parton, N. (2014). Portrayals of child abuse scandals in the media in Australia and England: impacts on practice, policy, and systems. *Child abuse and neglect, 38*(5), 822-836. doi:10.1016/j.chiabu.2014.04.020

Louwers, E. C. F. M., Korfage, I. J., Affourtit, M. J., De Koning, H. J., & Moll, H. A. (2012). Facilitators and barriers to screening for child abuse in the emergency department. *BMC pediatrics, 12*. doi:10.1186/1471-2431-12-167

Louwers, E. C. F. M., Korfage, I. J., Affourtit, M. J., Scheewe, D. J. H., van de Merwe, M. H., Vooijs-Moulaert, A., . . . de Koning, H. J. (2012). Effects of Systematic Screening and Detection of Child Abuse in Emergency Departments. *Pediatrics, 130*(3), 457-464. doi:10.1542/peds.2011-3527

Lumsden, K. (2019). Introduction. In K. Lumsden (Ed.), *Reflexivity: theory method, and practice*. Abingdon, UK: Routledge.

Maddocks, S., Johnson, S., Wright, N., & Stickley, T. (2010). A phenomenological exploration of the lived experience of mental health nurses who care for clients with enduring mental health problems who are parents. *Journal of psychiatric and mental health nursing, 17*(8), 674-682. doi:10.1111/j.1365-2850.2010.01582.x

Maguire, D. J. (2013). Mothers on methadone: Care in the NICU. *Neonatal network, 32*(6), 409-415. doi:10.1891/0730-0832.32.6.409

Maguire-Jack, K., & Font, S. A. (2017). Community and individual risk factors for physical child abuse and child neglect: variations by poverty status. *Child maltreatment, 22*(3), 215-226.

Mahoney, L. (2010). Children living with a mentally ill parent: the role of public health nurses. *Nursing praxis in New Zealand, 26*(2), 4-13. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21032970

Manetti, W. (2019). Sound clinical judgment in nursing: A concept analysis. *Nursing forum, 54*(1), 102-110. doi:10.1111/nuf.12303

Mann, S. (2016). *The research interview: reflective practice and reflexivity in research processes*. London, UK: Palgrave, Macmillan.

Manne, R. (2004). Chapter 9: Aboriginal child removal and the quesstion of genocide, 1900-1940. In A. D. Moses (Ed.), *Genocide and settler society: frontier violence and stolen Indigenous children in Australia history* (pp. 217-243). New York: Berghahn Books.

Markenson, D., Tunik, M., Cooper, A., Olson, L., Cook, L., Matza-Haughton, H., . . . Foltin, G. (2007). A national assessment of knowledge, attitudes, and confidence of prehospital providers in the assessment and management of child maltreatment. *Pediatrics, 119*(1), e103-e108. doi:10.1542/peds.2005-2121

Marshall, J., Ziersch, E., & Hudson, N. (2008). Family safety framework: final evaluation report. Retrieved from https://officeforwomen.sa.gov.au/__data/assets/pdf_file/0012/5142/FSF-Evaluation-Final-Report.pdf

Maternal Child and Family Health Nurses Australia. (2017). National standards of practice for maternal, child and family health nursing practice in Australia. Retrieved from http://www.mcafhna.org.au/LinkClick.aspx?fileticket=090uCH0Aymc%3d&tabid=90&portalid=0&mid=531

Mathews, B. (2015a). Mandatory reporting laws: their origin, nature, and development over time. In B. Mathews & D. C. Bross (Eds.), *Mandatory reporting laws and the identification of severe child abuse and neglect*. Dordrecht, The Netherlands: Springer.

Mathews, B. (2015b). A theoretical framework for designing and evaluating strategies to identify cases of serious child abuse and neglect. In B. Mathews & D. C. Bross (Eds.), *Mandatory reporting laws and the identification of severe child abuse and neglect* (pp. 127-156). Dordrecht: Springer.

Mathews, B., & Bross, D. C. (2015). Introduction. In B. Mathews & D. C. Bross (Eds.), *Mandatory reporting laws and the identification of severe child abuse and neglect*. Dordrecht, Netherlands: Springer.

Mathews, B., Fraser, J., Walsh, K., Dunne, M., Kilby, S., & Chen, L. (2008). Queensland nurses' attitudes towards and knowledge of the legislative duty to report child abuse and neglect: results of a state-wide survey. *Journal of law and medicine, 16*(2), 288-304.

Mathews, B., Walsh, K., Dunne, M., Katz, I., Arney, F., Higgins, D., . . . Bates, S. (2016). *Scoping study for research into the prevalence of child abuse in Australia*. Retrieved from https://www.childabuseroyalcommission.gov.au/sites/default/files/research_report_-_scoping_study_for_research_into_prevalence_of_child_sexual_abuse_in_australia_-_causes.pdf

Matone, M., Kellom, K., Griffis, H., Quarshie, W., Faerber, J., Gierlach, P., . . . Cronholm, P. F. (2018). A mixed methods evaluation of early childhood abuse prevention within evidence-based home visiting programs. *Maternal and child health journal, 22*. doi:10.1007/s10995-018-2530-1

Maul, K. M., Naeem, R., Khan, U. R., Mian, A. I., Yousafzai, A. K., & Brown, N. (2019). Child abuse in Pakistan: a qualitative study of knowledge, attitudes and practice amongst health professionals. *Child abuse & neglect, 88*, 51-57. doi:https://doi.org/10.1016/j.chiabu.2018.10.008

Mawhinney, B. (2019). *Safeguarding children at risk of maltreatent: role of the Australian child and family health nurse.* (Doctor of Philosophy). The University of Sydney, Sydney. Retrieved from https://ses.library.usyd.edu.au/bitstream/handle/2123/21885/Mawhinney_BL_thesis%20%281%29_Redacted.pdf?sequence=4&isAllowed=y

Mayall, B. (2018). *Visionary women and visible children, England 1900-1920*: Palgrave Macmillan.

McAtamney, R. (2011). Health visitors' perceptions of their role in assessing parent-infant relationships. *Community practitioner, 84*(8), 33-37.

McAuliffe, D., Tilbury, C., Chenoweth, L., Stehlik, D., Struthers, K., & Aitchison, R. (2016). (Re)valuing relationships in child protection practice. *Journal of social work practice, 30*(4), 365-377. doi:10.1080/02650533.2015.1116437

McDonald, L., Conrad, T., Fairtlough, A., Fletcher, J., Green, L., Moore, L., & Lepps, B. (2009). An evaluation of a groupwork intervention for teenage mothers and their families. *Child & family social work, 14*(1), 45-57. doi:10.1111/j.1365-2206.2008.00580.x

McKee, B. E., & Dillenburger, K. (2009). Child abuse and neglect: training needs of student teachers. *International journal of educational research, 48*, 320-330. doi:10.1016/j.ijer.2010.03.002

McTavish, J. R., Kimber, M., Devries, K., Colombini, M., MacGregor, J. C. D., Wathen, C. N., . . . MacMilan, H. L. (2017). Mandated reporters' experiences with reporting child maltreatment: a meta-synthesis of qualitative studies. *BMJ open, 7*(e013942). doi:DOI: 10.1136/bmjopen-2016-013942

Mejdoubi, J., van den Heijkant, S., van Leerdam, F. J. M., Heymans, M. W., Crijnen, A., & Hirasing, R. A. (2015). The effect of VoorZorg, the Dutch Nurse-Family Partnership, on child maltreatment and development: a randomized controlled trial. *Plos one, 10*(4). doi:10.1371/journal.pone.0120182

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: a guide to design and implementation* (4th ed.). San Francisco, USA: Jossey-Bass.

Mikton, C., & Butchart, A. (2009). Child maltreatment prevention: a systematic review of reviews. *Bulletin of the World Health Organization, 87*(5), 353-361. doi:10.2471/blt.08.057075

Milaney, K., Lockerbie, S. L., Fang, X. Y., & Ramage, K. (2019). The role of structural violence in family homelessness. *Canadian journal of public health, 110*. doi:10.17269/s41997-019-00219-y

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative data analysis: a methods sourcebook* (3 ed.). Thousand Oaks, California: SAGE Publications Inc.

Miller, E. R. (2010). Indeterminancy and interview research: co-constructing ambiguity and clarity in interviews with an adult immigrant learner of English. *Applied linguistics, 32*(1), 43-59.

Minichiello, V., Aroni, R., & Hays, T. (2008). *In-depth interviewing* (3rd ed.). Sydney: Pearson Education Australia.

Ministry of Social Development. (2016). Expert panel final report: investing in New Zealand's children and their families. Retrieved from https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/corporate/expert-panel-cyf/investing-in-children-report.pdf

Montgomery, H. (2013a). Childhood: an anthropological approach. In M. J. Kehily (Ed.), *Understanding childhood: a cross-disciplinary approach*. Bristol, UK: The Policy Press.

Montgomery, H. (2013b). Children and violence. In H. Montgomery (Ed.), *Local childhoods, global issues* (2 ed., pp. 153-203). Bristol, UK: The Open University.

Montgomery, H. (2013c). Interventions and ideologies. In H. Montgomery (Ed.), *Local childhoods, global issues*. Bristol, UK: The Policy Press.

Moore, J., & Riley, L. (2010). Aboriginal mother yarns. In S. Goodwin & K. Huppatz (Eds.), *The good mother: contemporary motherhoods in Australia*. Sydney: Sydney University Press.

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

Morris, A. (2015). *A practical introduction to in-depth interviewing*. London, UK: SAGE Publications Ltd.

Morse, J. (2018). Reframing rigor in qualitative enquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 796-817). Thousand Oaks, California: SAGE.

Mundaly, C., & Goddard, C. (2006). *The truth is longer than a lie: children's experiences of abuse and professional interventions*. London, UK: Jessica Kingsley Publishers.

Munro, E. (2005). Improving practice: child protection as a systems problem. *Children and youth services review, 27*, 375-391.

Munro, E. (2011). The Munro review of child protection: final report. A child-centred system. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

Munro, E. (2018). Decision-making under uncertainty in child protection: creating a just and learning culture. *Child & family social work, 24*(1), 123-130. doi:10.1111/cfs.12589

Munro, E., & Fish, S. (2015). Hear no evil, see no evil: understanding failure to identify and report child sexual abuse in institutional contexts. Retrieved from https://www.childabuseroyalcommission.gov.au/getattachment/620678bb-6c9d-45da-94c3-63c4b40e648f/Hear-no-evil,-see-no-evil

Murphy-Oikonen, J., Brownlee, K., Monetlpare, W., & Gerlach, K. (2010). The experiences of NICU nurses in caring for infants with neonatal abstinence syndrome. *Neonatal network, 29*(5), 307-313. doi:10.1891/0730-0832.29.5.307

Myers, J. E. B. (2006). *Child protection in America; Past, present, and future*. New York: Oxford University Press.

National Health and Medical Research Council. (2018). National statement on ethical conduct in human research. Retrieved from https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018#block-views-block-file-attachments-content-block-1

New Zealand Government. (2012). *The white paper for vulnerable children*. Retrieved from Wellington, New Zealand: http://www.childrensactionplan.govt.nz/resources/white-paper/

Newman, J., & Vasey, J. (2020). Exploring support systems for nurses involved with safeguarding children. *Nursing children and young people*. doi:10.7748/ncyp.2020.e1211

Northern Territory Government. (2017). Review of the Family Safety Framework in the Northern Territory 2017-2017: summary of findings and recommendations. Retrieved from https://territoryfamilies.nt.gov.au/__data/assets/pdf_file/0005/470849/Review-of-the-Family-Safety-Framework-2016-17-Summary-of-findings-and-recommendations.PDF

Nouman, H., Alfandari, R., Enosh, G., Dolev, L., & Daskal-Weichhendler, H. (2020). Mandatory reporting between legal requirements and personal interpretations: community healthcare professionals' reporting of child maltreatment. *Child abuse & neglect, 101*. doi:10.1016/j.chiabu.2019.104261

Nursing and Midwifery Board of Australia. (2016). Registered nurse standards for practice. Retrieved from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

Nursing and Midwifery Board of Australia. (2018). Code of conduct for nurses. Retrieved from https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD17%2f23849&dbid=AP&chksum=ki92NMPa9thp9f9ZhTQNJg%3d%3d

Nyarko, K. (2014). Childrearing, motherhood and fatherhood in Ghana. In H. Selin (Ed.), *Parenting across cultures: childrearing, motherhood and fatherhood in non-Western cultures* (pp. 231-239). Dordrecht: Springer.

Nyland, M. (2016). Child protection systems royal commission report: The life they deserve. Retrieved from https://www.agd.sa.gov.au/sites/g/files/net2876/f/complete_report_child_protection_systems_royal_commission_report.pdf?v=1494388953

O'Reilly, M., & Lester, J. N. (2017). *Examing mental health through social constructivism: the language of mental health*. London, UK: Palgrave, Macmillan.

O'Dell, L., Crafter, S., & Montgomery, H. (2013). Chapter 5: Children and work. In *Childhoods in context* (Vol. 3, pp. 213-262). Bristol, UK: The Open University.

O'Reilly, M. O., & Parker, N. (2012). 'Unsatisfactory saturation': a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative research, 13*(2), 190-197. doi:10.1177/1468794112446106

Oates, J. (2015). Use of Skype in interviews: the impact of the medium in a study of mental health nurses. *Nurse researcher, 22*(4), 13-17.

Oates, K. (Ed.) (2019). *Child protection systems in Australia* (Vol. 8). Cham, Switzerland: Springer.

Office of the High Commissioner for Human Rights. (1990). Convention on the rights of the child. Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

Ogunfowokan, A. A., & Fajemilehin, R. B. (2012). Impact of a school-based sexual abuse prevention education program on the knowledge and attitude of high school girls. *Journal of school nursing, 28*(6), 459-468. doi:10.1177/1059840512446949

Olds, D. L., Eckenrode, J., Henderson Jr, C. R., Kitzman, H., Powers, J., Cole, R., . . . Luckey, D. W. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-years follow-up of a randomized trial. *JAMA, 278*(8), 637-643.

Olds, D. L., Henderson Jr, C. R., Kitzman, H., Eckenrode, J., Cole, R., & Tatelbaum, R. C. (1999). Prenatal and infancy home visitation by nurses: recent findings. *Future of children, 9*(1), 44-64.

Olds, D. L., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K., . . . Bondy, J. (2007). Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial. *Pediatrics, 120*(4), E832-e845. doi:10.1542/peds.2006-2111

OmbudsmanSA. (2014). Information sharing guidelines for promoting safety and wellbeing. Retrieved from https://www.ombudsman.sa.gov.au/wp-content/uploads/New-ISG.pdf

Ordway, M. R., Sadler, L. S., Dixon, J., Close, N., Mayes, L., & Slade, A. (2014). Lasting effects of an interdisciplinary home visiting program on child behavior: preliminary follow-up results of a randomized trial. *Journal of pediatric nursing, 29*, 3-13. doi:10.1016/j.pedn.2013.04.006

Pabis, M., Wronska, I., Slusarska, B., & Cuber, T. (2011). Paediatric nurses' identification of violence against children. *Journal of advanced nursing, 67*(2), 384-393. doi:10.1111/j.1365-2648.2010.05473.x

Paine, A. L., Cannings-John, R., Channon, S., Lugg-Widger, F., Waters, C. S., & Roberts, R. M. (2020). Assessing the impact of a family nurse-led intervention on young mothers' references to internal states. *Infant mental health journal*. doi:10.1002/imhj.21849

Pakiş, I., Demir, F., Bektaş, G., Altun, U., & Yıldırım, S. (2015). Investigation of the awareness and knowledge about child abuse and negligence among doctors and nurses working in the East part of Turkey. *Romanian journal of legal medicine, 23*(2), 151-156. doi:10.4323/rjlm.2015.151

Parry, Y., Maio-Taddeo, C., Arnold, L., & Nayda, R. (2009). *Professionals protecting children and nursing and midwifery education in Australia*. Retrieved from Australian Centre for Child

Protection:
https://dspace.flinders.edu.au/xmlui/bitstream/handle/2328/38812/Parry_Professionals_P2009.pdf?sequence=1&isAllowed=y

Parton, N. (2006). *Safeguarding childhood: early intervention and surveillance in a late modern society*. New York: Palgrave MacMillan.

Parton, N. (2009). How child centred are our child protection systems and how child centred do we want our child protection regulatory principles to be? *Communities, children and families Australia, 4*(1), 59-64.

Parton, N. (2012). Thinking and acting constructively in child protection. In S. L. Witkin (Ed.), *Social construction and social work practice: interpretations and innovations*. New York: Columbia University Press.

Parton, N., & Williams, S. (2019). 'Everybody's responsibility': exploring the challenges of community engagement in child neglect. In B. Lonne, D. Scott, D. Higgins, & T. I. Herrenkohl (Eds.), *Re-visioning public health approaches for protecting children* (pp. 49-64). Cham, Switzerland: Springer Nature.

Patrick, A., Kandiah, T., & Welbury, R. (2020). Can child safeguarding training be improved?: findings of a multidisciplinary audit. *European archives of paediatric dentistry*. doi:10.1007/s40368-020-00513-1

Patterson, D., & Campbell, R. (2009). A comparative study of the prosecution of childhood sexual abuse cases: The contributory role of pediatric Forensic Nurse Examiner (FNE) programs. *Journal of forensic nursing, 5*(1), 38-45. doi:10.1111/j.1939-3938.2009.01029.x

Peckover, S., & Appleton, J. V. (2019). Health visiting and safeguarding children: a perfect storm? *Journal of health visiting, 7*(5), 232-238. doi:10.12968/johv.2019.7.5.232

Peckover, S., & Aston, M. (2018). Examining the social construction of surveillance: a critical issue for health visitors and public health nurses working with mothers and children. *Journal of clinical nursing, 27*, e379-e389. doi:10.1111/jocn.14014

Pelisoli, C., Herman, S., & Dell'Aglio, D. D. (2015). Child sexual abuse research knowledge among child abuse professionals and laypersons. *Child abuse & neglect, 40*, 36-47. doi:10.1016/j.chiabu.2014.08.010

Peräkylä, A., & Ruusuvuori, J. (2013). Analyzing talk and text. In N. K. Denzin & Y. S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (4th ed.). Thousand Oaks, California: Sage.

Peterson, C. C. (2014). *Looking forward through the lifespan: developmental psychology* (6th ed.). Frenchs Forest, Australia: Pearson.

Polit, D. F., & Beck, C. T. (2012). *Nursing research: generating and assessing evidence for nursing practice* (9th ed.). Hong Kong: Wolters Kluwer Health and Lippincott Williams & Wilkins.

Poole, M. K., Seal, D. W., & Taylor, C. A. (2014). A systematic review of universal campaigns targeting child physical abuse prevention. *Health education research, 29*(3), 388-432. doi:10.1093/her/cyu012

Porter, L. S., Porter, B. O., McCoy, V., Bango-Sanchez, V., Kissel, B., Williams, M., & Nunnewar, S. (2015). Blended Infant Massage-Parenting Enhancement Program on Recovering Substance-Abusing Mothers' Parenting Stress, Self-Esteem, Depression, Maternal Attachment, and Mother-Infant Interaction. *Asian nursing research, 9*(4), 318-327. doi:10.1016/j.anr.2015.09.002

Preissle, J., & deMarrais, K. (2015). Teaching reflexivity in qualitative research: fostering a research life style. In N. K. Denzin & M. D. Giardina (Eds.), *Qualitative inquiry and the politics of research*. Walnut Creek, California: Left Coast Press Inc.

Proctor, L. J., & Dubowitz, H. (2014). Child neglect: challenges and controversies. In J. E. Korbin & R. D. Krugman (Eds.), *Handbook of child maltreatment*. Dordrecht, The Netherlands: Springer.

Race, T., & O'Keefe, R. (2017). *Child-centred practice*. London, UK: Red Globe Press.

Raheim, M., Magnussen, l. H., Tveit Sekse, R. J., Lunde, A., Jacobsen, T., & Blystad, A. (2016). Researcher-researched relationship in qualitative research: shifts in positions and researcher vulnerability. *International journal of qualitative studies on health and well-being, 11*. doi:10.3402/qhw.v11.30996

Raman, S., Holdgate, A., & Torrens, R. (2012). Are our frontline clinicians equipped with the ability and confidence to address child abuse and neglect? *Child abuse review, 21*(2), 114-130. doi:10.1002/car.1180

Rees, S., Simpson, L., McCormack, C. A., Moussa, B., & Amanatidis, S. (2019). Believe #metoo: sexual violence and interpersonal disclosure experience among women attending a sexual assault service in Australia: a mixed methods study. *BMJ open, 9*. doi:10.1136/bmjopen-2018-026773

Reese, L. S., Heiden, E. O., Kim, K. Q., & Yang, J. (2014). Evaluation of Period of PURPLE Crying, an abusive head trauma prevention program. *Journal of obstetric, gynecologic and neonatal nursing, 43*(6), 752-761. doi:10.1111/1552-6909.12495

Reijnders, U. J. L., Giannakopoulos, G. F., & de Bruin, K. H. (2008). Assessment of abuse-related injuries: A comparative study of forensic physicians, emergency room physicians, emergency room nurses and medical students. *Journal of forensic and legal medicine, 15*(1), 15-19. doi:10.1016/j.jcfm.2006.06.029

Reupert, A., & Maybery, D. (2014). Practitioners' experiences of working with families with complex needs. *Journal of psychiatric and mental health nursing, 21*(7), 642-651. doi:10.1111/jpm.12149

Roach Anleu, S. L. (2006). *Deviance, conformity & control* (4 ed.). Frenchs Forest, New South Wales: Pearson.

Roberts, S. (2006). Oppressed group behavior and nursing. In L. Andrist, P. Nicholas, & K. Wolf (Eds.), *A history of nursing ideas*. Sudbury, MA: Jones and Bartlett Publishers.

Robling, M., Bekkers, M. J., Bell, K., Butler, C. C., Cannings-John, R., Channon, S., . . . Torgerson, D. (2016). Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial. *Lancet, 387*(10014), 146-155. doi:10.1016/s0140-6736(15)00392-x

Rohde, E., & Domm, E. (2017). Nurses' clinical reasoning practices that support safe medication administration: an integrative review of the literature. *Journal of clinical nursing, 27*, e402-e411. doi:10.1111/jocn.14077

Rolim, A. C. A., Moreira, G. A. R., Gondim, S. M. M., Da Silva Paz, S., & De Souza Vieira, L. J. E. (2014). Factors associated with reporting of abuse against children and adolescents by nurses within primary health care. *Revista Latino-Americana de enfermagem, 22*(6), 1048-1055. doi:10.1590/0104-1169.0050.2515

Rorden, J. (2010). Communication and therapeutic relationships. In M. Barnes & J. Rowe (Eds.), *Child, youth and family health: strengthening communities* (pp. 74-89). Chatswood, New South Wales: Churchill Livingstone, Elsevier.

Rosenblatt, P. C. (2003). Interviewing at the border of fact and fiction. In J. F. Gubrium & J. A. Holstein (Eds.), *Postmodern Interviewing*. Thousand Oaks, California: Sage.

Rowe, H. J., & Fisher, J. R. W. (2010a). The contribution of Australian residential early parenting centres to comprehensive mental health care for mothers of infants: Evidence from a

prospective study. *International journal of mental health systems, 4*. doi:10.1186/1752-4458-4-6

Rowe, H. J., & Fisher, J. R. W. (2010b). Development of a universal psycho-educational intervention to prevent common postpartum mental disorders in primiparous women: a multiple method approach. *BMC public health, 10*. doi:10.1186/1471-2458-10-499

Rowse, V. (2009a). Children's nurses' experiences of child protection: what helps? *Child abuse review, 18*(3), 168-180. doi:10.1002/car.1073

Rowse, V. (2009b). Support needs of children's nurses involved in child protection cases. *Journal of nursing management, 17*(6), 659-666. doi:10.1111/j.1365-2834.2009.00987.x

Royal College of Nursing. (2014). *Safeguarding children and young people - every nurses' responsibility*. Retrieved from https://www.rcn.org.uk/professional-development/publications/pub-004542

Royal Commission into Institutional Responses to Child Sexual Abuse. (2017). Final report. Retrieved from https://www.childabuseroyalcommission.gov.au/final-report

Runyan, D. K. (2015). Chapter 2: who is maltreated and how mandated reporting might help. In B. Mathews & D. C. Bross (Eds.), *Mandatory reporting laws and the identification of severe child abuse and neglect*. Dordrecht, Netherlands: Springer.

Ryen, A. (2003). Cross-cultural interviewing. In J. A. Holstein & J. F. Gubrium (Eds.), *Inside interviewing: new lenses, new concerns* (pp. 429-448). Thousand Oaks, California: Sage Publications.

Sadler, L. S., Slade, A., Close, N., Webb, D. L., Simpson, T., Fennie, K., & Mayes, L. (2013). Minding the baby: enhancing reflectiveness to improve early health and relationship outcomes in an interdisciplinary home-visiting program. *Infant mental health journal, 34*(5), 391-405.

Sahib El-Radhi, A. (2015). Safeguarding the welfare of children: what is the nurse's role. *British journal of nursing, 24*(15), 769-773. doi:10.12968/bjon.2015.24.15.769.

Saldana, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). London, UK: SAGE Publications Inc.

Saldana, J., Leavy, P., & Beretvas, N. (2011). *Fundamentals of qualitative research*. USA: Oxford University Press.

Saltmarsh, T., & Wilson, D. (2017). Dancing around families: neonatal nurses and their role in child protection. *Journal of clinical nursing, 26*, 2244-2255.

Saumure, K., & Given, L. M. (2008). Data saturation. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods*. Thousand Oaks, California: SAGE Publications Inc.

Sawyer, A., Kaim, A. L. E., Mittinity, M. N., Jeffs, D., Lynch, J., & Sawyer, M. G. (2019). Effectiveness of a 2-year post-natal nurse home-visiting programme when children are aged 5 years: Results from a natural experiment. *Journal of paediatrics and child health, 55*(20), 1091-1098. doi:10.1111/jpc.14348

Sawyer, M. G., Frost, L., Bowering, K., & Lynch, J. (2013). Effectiveness of nurse home-visiting for disadvantaged families: results of a natural experiment. *BMJ open, 3*(4). doi:10.1136/bmjopen-2013-002720

Sawyer, M. G., Pfeiffer, S., Sawyer, A., Bowering, K., Jeffs, D., & Lynch, J. (2014). Effectiveness of nurse home visiting for families in rural South Australia. *Journal of paediatrics and child health, 50*(12), 1013-1022. doi:10.1111/jpc.12679

Schols, M. W. A., De Ruiter, C., & Öry, F. G. (2013). How do public child healthcare professionals and primary school teachers identify and handle child abuse cases? A qualitative study. *BMC public health, 13*(1), 807. doi:10.1186/1471-2458-13-807

Scott, D., & Fraser, J. (2015). Mandatory reporting of child abuse and neglect by health professionals. In B. Mathews & D. C. Bross (Eds.), *Mandatory reporting laws and the identification of severe abuse and neglect* (pp. 381-393). The Netherlands: Springer.

Scott, D., & Swain, S. (2002). *Confronting cruelty: historical perspectives on child protection in Australia*. Melbourne: Melbourne University Press.

Segal, L., Nguyen, H., Gent, D., Hampton, C., & Boffa, J. (2018). Child protection outcomes of the Australian Nurse Family Partnership Program for Aboriginal infants and their mothers in Central Australia. *Plos one, 13*(12). doi:10.1371/journal.pone.0208764

Seitz, S. (2016). Pixelated partnerships, overcoming obstacles in qualitative interviews via Skype: a research note. *Qualitative research, 16*(2), 229-235. doi:10.1177/1468794115577011

Selbie, J. (2009). Health visitors' child protection work: exploratory study of risk assessment. *Community practitioner, 82*(5), 28-31.

Shields, L. (2017). All is not well with family-centred care. *Nursing children and young people, 29*(4). doi:10.7748/ncyp.29.4.14.s15

Shields, L., Pratt, J., & Hunter, J. (2006). Family centred care: a review of qualitative studies. *Journal of clinical nursing, 15*(10). doi:10.1111/j.1365-2702.2006.01433.x

Sigad, L. I., Beker, G., Lev-Wiesel, R., & Eisikovits, Z. (2019). "Alone with our interpretations": Uncertainty in child abuse intervention among healthcare professionals. *Children and youth services review, 100*, 206-213. doi:10.1016/j.childyouth.2019.02.027

Silver, C., & Lewins, A. (2014). *Using software in qualitative research*. London: SAGE publications Ltd.

Skinner, C. S., Tiro, J., & Champion, V. L. (Eds.). (2015). *The health belief model*. San Francisco, USA: John Wiley & Sons.

Slade, A., Holland, M. L., Ordway, M. R., Carlson, E. A., Jeon, S., Close, N., . . . Sadler, L. S. (2020). Minding the Baby: enhancing parental reflective functioning and infant attachment in an attachment-based, interdisciplinary home visiting program. *Development and psychopathology, 32*, 123-137. doi:10.1017/S0954579418001463

Smith, J., Shields, L., Neill, S., & Darbyshire, P. (2017). Losing the child's voice and 'the captive mother': an inevitable legacy of family-centred care? *Evidence-based nursing, 20*, 67-69. doi:10.1136/eb-2017-102700

Smith, K. (2016). Reflection and person-centredness in practice development. *International practice development journal, 12*(1). doi:10.19043/ipdj.61.012

Smith, M. (2011). *Report to Hon Paula Bennett, Minister for Social Development and Employment: following an inquiry into the serious abuse of a nine year old girl and other matters relating to the welfare, safety and protection of children in New Zealand*. Retrieved from https://www.beehive.govt.nz/sites/default/files/Smith_report.pdf

Smith, M., Cree, V. E., MacRae, R., Sharp, D., Wallace, E., & O'Halloran, S. (2017). Social suffering: changing organisational culture in children and families social work through critical reflection groups - insights from Bourdieu. *British journal of social work, 47*, 973-988. doi:10.1093/bjsw/bcw087

Spyrou, S. (2018). *Disclosing childhoods: research and knowledge production for a critical childhood studies*. London, UK: Palgrave, Macmillan.

Stanley, T., & Russell, M. (2014). The principal child and family social worker: a Munro recommendation in practice. *Practice: social work in action, 26*(2), 81-96. doi:10.1080/09503153.2014.896889

State of Queensland. (2018). Child protection Act 1999. Retrieved from https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-1999-010

Stubbs, J. M., & Achat, H. M. (2016). Sustained health home visiting can improve families' social support and community connectedness. *Contemporary nurse, 52*(2-3), 286-299. doi:10.1080/10376178.2016.1224124

Sugaya, L., Hasin, S. D., Olfson, M., Lin, K. H., Grant, B. F., & Blanco, C. (2010). Child physical abuse and adult mental health state: a national study. *Journal of traumatic stress, 25*(2), 215-222. doi:10.1002/jts.

Sundler, A. J., Whilson, M., Darcy, L., & Larsson, M. (2019). Swedish school nurses' experiences of child abuse. *The Journal of School Nursing*. doi:10.1177/1059840519863843

Sutherland, N., & Commachio, C. (2000). *Children in English-Canadian society: framing the twentieth century consensus*. Waterloo, Ontario: Wilfrid Laurier University Press.

Svard, V. (2016). "Why don't they report?" Hospital personnel working with children at risk. *Child care in practice, 23*(4), 342-355. doi:10.1080/13575279.2016.1188765

Talbot, L., & Verrinder, G. (2014). *Promoting health: the primary health care approach* (5th ed.). Chatswood, Australia: Churchill Livingstone, Elsevier.

Talbot, L., & Verrinder, G. (2018). *Promoting health: the primary health care approach*. Chatswood, Australia: Elsevier.

Tang, N. (2002). Interviewer and interviewee relationships between women. *Sociology, 36*(3), 703-721.

Taylor, J., Lauder, W., Moy, M., & Corlett, J. (2009). Practitioner assessments of 'good enough' parenting: factorial survey. *Journal of clinical nursing, 18*(8), 1180-1189. doi:10.1111/j.1365-2702.2008.02661.x

Taylor, J., Smith, J., & Taylor, J. (2016). A hermeneutic phenomenological study exploring the experiences health practitioners have when working with families to safeguard children and the invisibility of the emotions work involved. *Journal of clinical nursing, 26*. doi:10.1111/jocn.13486

Taylor, K., & Guerin, P. (2014). *Health care and Indigenous Australians: cultural safety in practice* (2nd ed.). Sydney, Australia: Palgrave Macmillan.

Taylor, S. J., Bogdan, R., & DeVault, M. L. (2016). *Introduction to qualitative research methods: a guidebook and resource* (4th ed.). New Jersey: Wiley & Sons.

Tchernegovski, P., Reupert, A. E., & Maybery, D. J. (2017). How do Australian mental health clinicians manage the challenges of working with parental mental illness? A phenomenological study. *Child & family social work, 23*, 381-389. doi:10.1111/cfs.12426

Thamlikitkul, S., Yunibhand, J., & Chaiyawat, W. (2009). Remolding child: Process of nursing practice for sexually abused children. *Journal of the medical association of Thailand, 92*(6), 787-805. Retrieved from http://www.scopus.com/inward/record.url?eid=2-s2.0-67650410036&partnerID=40&md5=fa40852801a5cb4e881b68a1ca8ca12d

Thiele, L. (2012). Degenerate 'innocents': childhood, deviance, and criminality in nineteenth-century texts. In A. E. Gavin (Ed.), *The child in British literature: literary constructions of childhood, medieval to contemporary* (pp. 131-145). London: Palgrave Macmillan.

Thielen, F. W., ten Have, M., de Graaf, R., Cuijpers, P., Beekman, A., Evers, S., & Smit, F. (2016). Long-term economic consequences of child maltreatment: a population-based study. *European child & adolescent psychiatry, 25*(12), 1297-1305. doi:10.1007/s00787-016-0850-5

Tingberg, B., Bredlöv, B., & Ygge, B. M. (2008). Nurses' experience in clinical encounters with children experiencing abuse and their parents. *Journal of clinical nursing, 17*(20), 2718-2724. doi:10.1111/j.1365-2702.2008.02353.x

Tinker, E., Postma, J., & Butterfield, P. G. (2010). Barriers and facilitators in the delivery of environmental risk reduction by public health nurses in the home setting. *Public health nursing, 28*(1), 35-42. doi:10.1111/j.1525-1446.2010.00887.x.

Tiyyagura, G., Gawel, M., Koziel, J. R., Asnes, A., & Bechtel, K. (2015). Barriers and facilitators to detecting child abuse and neglect in general emergency departments. *Annals of emergency medicine, 5*, 447-454. doi:10/1016/j.annemergmed.2015.06.020

Tonmyr, L., Mathews, B., Shields, M. E., Hovdestad, W. E., & Afifi, T. O. (2018). Does mandatory reporting legislation increase contact with child protection? A legal doctrinal review and an analytical examination. *BMC public health, 18*. doi:10.1186/s12889-018-5864-0

Torrance, H. (2013). Qualitative research, science, and government: evidence, criteria, policy and politics. In N. K. Denzin & Y. S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (pp. 355-380). Thousand Oaks, California: Sage.

Treiber, L., & Jones, J. (2015). The care/cure dichotomy: nursing's struggle with dualism. *Health sociology review, 24*(2), 152-162. doi:10.1080/14461242.2014.999404

Trier-Bieniek, A. (2012). Framing the telephone interview as a participant-centred tool for qualitative research: a methodological discussion. *Qualitative research, 12*(6), 630-644. doi:10.1177/1468794112439005

Tune, D. (2015). Independent review of out of home care in New South Wales: final report. Retrieved from https://www.acwa.asn.au/wp-content/uploads/2018/06/TUNE-REPORT-indepth-review-out-of-home-care-in-nsw.pdf

Tung, G. J., Williams, V. N., Ayele, R., Shimasaki, S., & Olds, D. (2019). Characteristics of effective collaboration: a study of Nurse-Family Partnership and child welfare. *Child abuse and neglect, 95*. doi:10.1016/j.chiabu.2019.104028

Turnell, A., Munro, E., & Murphy, T. (2013). Soft is hardest: leading for learning in child protection services following a child fatality. *Child welfare, 92*(2), 199-216.

Uniacke, S., Browne, T. K., & Shields, L. (2018). How should we understand family-centred care? *Journal of child health care, 22*(3), 460-469. doi:10.1177/1367493517753083

United Nations Children's Fund. (2018). Levels & trends in child mortality: report 2018. Retrieved from https://childmortality.org/wp-content/uploads/2018/12/UN-IGME-Child-Mortality-Report-2018.pdf

Van Mol, C., Maheiu, R., De Clerck, H. M.-L., Piqueray, E., Wauters, J., Levrau, L., . . . Michielsen, J. (2014). Conducting qualitative research: dancing a tango between insider - and outsiderness. In L. Voloder, L. Kirpitchenko, & A. J. Kershen (Eds.), *Insider research in migration and mobility: international perspectives on researcher positioning*. Farnham, UK: Routledge.

van Scoyoc, A., Wilen, J. S., Daderko, K., & Miyamoto, S. (2015). Multiple aspects of maltreatment: moving toward a holistic framework. In D. Daro, A. C. Donnelly, L. A. Huang, & B. J. Powell (Eds.), *Advances in child abuse prevention knowledge: the perspective of new leadership*. Dordrecht, The Netherlands: Springer.

Venables, J. (2019). Practitioner perspectives on implementing an alternative response in statutory child protection: the role of local practice context and leadership teams in shaping practice. *Children and youth services review, 107*. doi:10.1016/j.childyouth.2019.104488

Victoria State Government. (2016). Roadmap for reform: strong families, safe children. Retrieved from https://www.dhhs.vic.gov.au/publications/roadmap-reform-strong-families-safe-children

Von Colln-Appling, C., & Giuliano, D. (2017). A concept analysis of critical thinking: A guide for nurse educators. *Nurse education today, 49*, 106-109. doi:10.1016/j.nedt.2016.11.007

Wald, M. S. (2014). Beyond maltreatment: developing support for children in multiproblem families. In *Handbook of child maltreatment* (Vol. 2). Dordrecht, The Netherlands: Springer.

Wallstrom, R., Persson, R. S., & Salzmann-Erikson, M. (2016). Working with children in families with parental substance abuse. *Journal of psychosocial nursing, 54*(6), 38-44. doi:10.3928/02793695-20160518-06

Walsh, K. (2019). Re-visioning education and training for child protection using a public health approach. In B. Lonne, D. Scott, D. Higgins, & T. Herrenkohl (Eds.), *Re-visioning public health approaches for protecting children* (Vol. 9, pp. 379-396). Cham, Switzerland: Springer.

Walsh, K., Zwi, K., Woolfenden, S., & Shlonsky, A. (2015). School-based education programs for the prevention of child sexual abuse: a Cochrane systematic review and meta-analysis. *Research on social work practice*. doi:10.1177/1049731515619705

Ward, F. (2009). *The door of last resort: memoirs of a nurse practitioner*. New Brunswick, USA: Rutgers University Press.

Westerdahl, F., Carlson, E., Wennick, A., & Borglin, G. (2020). Teaching strategies and outcomes assessments targeting critical thinking in bachelor nursing students: a scoping review protocol. *BMJ open, 10*. doi:10.1136/bmjopen-2019-033214

Whittaker, A., Williams, N., Chandler, A., Cunningham-Burley, S., McGorm, K., & Mathews, G. (2015). The burden of care: a focus group study of healthcare practitioners in Scotland talking about parental drug misuse. *Health and social care in the community*. doi:10.1111/hsc.12249

Whittemore, R., & Knafl, K. (2005). The integrative review: updated methodology. *Journal of advanced nursing, 52*(5), 546-553.

Wideman, E. S., Dunnigan, A., Jonson-Reid, M., Kohl, P. L., Constantino, J., Tandon, M., . . . Tompkins, R. (2019). Nurse home visitation with vulnerable families in rural areas: a qualitative case file review. *Public health nursing*. doi:10.1111/phn.12699

Willacy, M. (2019). The watch house files. Retrieved from https://www.abc.net.au/news/2019-05-13/hold-the-watch-house-files/11046190

Williams, L. M., & Weeks, E. G. (2014). Defining and measuring child maltreatment. In J. R. Conte (Ed.), *Child abuse and neglect worldwide: Volume 1 Understanding, Defining and Measuring Child Maltreatment* (pp. 9-36). California: Praeger.

Williams, V. N., Ayele, R., Shimasaki, S., Tung, G. J., & Olds, D. (2019). Risk assessment practices in home visiting nurses and child protection caseworks in Colorado, United States: a qualitative investigation. *Health and social care in the community*. doi:10.1111/hsc.12773

Wilson, P., Barbour, R. S., Graham, C., Currie, M., Puckering, C., & Minnis, H. (2008). Health visitors' assessments of parent-child relationships: A focus group study. *International journal of nursing studies, 45*(8), 1137-1147. doi:10.1016/j.ijnurstu.2007.07.006

Wood, C. A. (2017). My story of Sal: a critical self-reflective autoethnography revealing whiteness in the classroom. *International journal of multicultural education, 19*(1), 41-59. doi:10.18251/ijme.v19i1.1264

Woodhead, M. (2015). Psychology and the cultural construction of children's needs. In A. James & A. Prout (Eds.), *Constructing and reconstructing childhood: contemporary issues in the sociological study of childhood* (pp. 54-73). New York: Routledge.

Woods, D. D., Dekker, S., Cook, R., Johannesen, L., & Sarter, N. (2010). *Behind human error* (2nd ed.). Great Britain: MPG Books Group.

World Health Organisation. (2010). Violence prevention: the evidence. Retrieved from http://www.who.int/violence_injury_prevention/violence/4th_milestones_meeting/evidence_briefings_all.pdf

World Health Organisation. (2014). Child maltreatment. Retrieved from
http://www.who.int/mediacentre/factsheets/fs150/en/

World Health Organisation. (2016). Child maltreatment: key facts. Retrieved from
http://www.who.int/en/news-room/fact-sheets/detail/child-maltreatment

World Health Organization. (2006). Preventing child maltreatment. Retrieved from
http://apps.who.int/iris/bitstream/10665/43499/1/9241594365_eng.pdf

World Health Organization (WHO). (2018). Global status report on road safety 2018. Retrieved
from https://www.who.int/violence_injury_prevention/road_safety_status/2018/en/

Wulczyn, F., Daro, D., Fluke, J., Feldman, S., & Clodek, C. K. L. (2010). Adapting a systems approach
to child protection: key concepts and considerations. Retrieved from
https://www.unicef.org/protection/files/Adapting_Systems_Child_Protection_Jan__2010.
pdf

Yehuda, Y. B., Attar-Schwartz, S., Ziv, A., Jedwab, M., & Benbenishty, R. (2010). Child abuse and
neglect: Reporting by health professionals and their need for training. *Israel medical
association journal, 12*(10), 598-602.

Zapart, S., Knight, J., & Kemp, L. (2016). 'It was easier because I had help': mothers' reflections on
the long-term impact of sustained nurse home visiting. *Maternal and child health journal,
20*, 196-204. doi:10.1007/s10995-015-1819-6

Zielinski, D. S., Eckenrode, J., & Olds, D. L. (2009). Nurse home visitation and the prevention of
child maltreatment: impact on the timing of official reports. *Development and
psychopathology, 21*(2), 441-453. doi:10.1017/S0954579409000248

Zolotor, A. J., Runyan, D. K., Shanahan, M., Durrance, C. P., Nocera, M., Sullivan, K., . . . Barr, R. G.
(2015). Effectiveness of a statewide abusive head trauma prevention program in North
Carolina. *JAMA Pediatrics, 169*(12), 1126-1131. doi:10.1001/jamapediatrics.2015.2690

Zuriguel Perez, E., Lluch Canut, M. T., Falco Pegueroles, A., Puig Llobet, M., Moreno Arroyo, C., &
Roldan Merino, J. (2015). Critical thinking in nursing: Scoping review of the literature.
International journal of nursing practice, 21(6), 820-830. doi:10.1111/ijn.12347