Safeguarding children at risk of maltreatment: Role of the Australian Child and Family Health Nurse

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Statement of Originality

This is to certify that to the best of my knowledge, the content of this thesis is my own work. The thesis is an account of research undertaken from 2014 to 2019 during enrolment at the University of Sydney. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

Belinda Mawhinney
Abstract

Introduction
In the Australian state of New South Wales, Child and Family Health Nurses (CFHNs) are community-based specialist nurses working with families that have children under five years of age. When working from a universal health service, they are placed in a position of profound responsibility to prevent child maltreatment. Research interest is growing in the ways that services are responding to meet this preventative objective as part of the public health approach to child protection.

Aim
The aim of the study was to examine CFHN practice when faced with the task of responding to child maltreatment within the parameters of a universal health service. What actions are used by nurses to continually support families through the process of considering, suspecting, and reporting child maltreatment? Practice strategies used to retain families in voluntary family support services were explored. Practice drivers, such as education and training, were also examined.

Methods
A sequential exploratory mixed methods research design using McCurdy and Daro’s (2001) conceptual model of the Integrated Theory of Parent Involvement was used. A cohort of 129 CFHNs completed a comprehensive questionnaire in phase 1. Qualitative data from focus group discussions with 27 participants were collected in phase 2.

Results
Participants were experienced, knowledgeable and confident in their practice. They commonly sought consultation with management and peers to guide practice. Little variation was found in the frequency of practice when families disengaged from the service. Qualitative findings showed that the emotional toll on nurses working with
families had implications in all phases of family involvement even when engagement was fractured. An extension to the Model of Parent Involvement was proposed to consider ways to reconcile service delivery when families disengage hastily.

Conclusion

The study has contributed valuable knowledge to the safeguarding practice used with families in the early intervention and prevention of maltreatment. Engagement of families with multiple and complex needs relies on practice that is also multifaceted, advanced and flexible. The formulation of a practice response to respond to suspected child maltreatment requires nurses to integrate knowledge and confidence by drawing on experience, education, policy and support to meet the needs of the families accessing universal health services.
Acknowledgements

The motivation behind this thesis was to detail the practices of the nursing specialists, the Child and Family Health Nurses. As a social worker, I have been fortunate to work alongside nurses for much of my career. The profession, as a collective workforce, often features strong, intelligent (mostly) women, who are fierce advocates for the families with which they work. Working with families with multiple and complex issues that place children at risk of abuse and neglect can be the most challenging context in which to practice as a social worker. It is a credit to the nursing profession to have long been considered well placed to prevent child abuse and neglect. It became my goal to examine the elements of practice that uphold this status.

My supervisory team, Associate Professor Jennifer Fraser and Dr Melissa Kaltner, have provided much personal, professional and academic guidance throughout my candidature, for which I will forever be grateful. I enjoyed the formation of our working relationship in the initial phase of my enrolment and looked forward to our meetings in my backyard. This relationship created a strong foundation that was able to endure the tyranny of distance when I moved 500 km down the road from Sydney two years into my candidature. Like the nurses in this study, I am not sure how to reconcile the ending of our current working relationship. I must also express great appreciation to Judith Fethney, biostatistician extraordinaire at the Susan Wakil School of Nursing and Midwifery (The University of Sydney). Somehow, you helped me grasp data in a way I never thought possible. Thank you for meeting me week after week to facilitate my learning before I reached full capacity of my pregnancy and could no longer fit behind the desk. Sincerely, thank you.

This thesis was edited by Elite Editing, and editorial intervention was restricted to Standards D and E of the Australian Standards for Editing Practice.
I was extremely fortunate to have been awarded The University of Sydney Britton Craigie Scholarship for AU$15,000 in 2018. This award made a tremendous difference to accelerating my completion and alleviating the financial pressures we endure during this long and persistent drought.

Further, some important players on my team made this hope a reality. One is my partner, Anthony, whom I met quite literally the day before my enrolment commenced. If there was one person in the world who looked forward to this thesis being submitted (sometimes more than me), it would be him. He has spent hours talking through the words on the page and the ideas behind them. I will forever be grateful for his support and understanding, through often very trying times. I am not sure I have the leverage to award him a de facto doctorate, but I can safely say he is the most knowledgeable farmer I know when it comes to child maltreatment and the practices of nurses.

Throughout my candidature, I transitioned from a stepmother to a mother. Somehow, I have maintained my ‘best friend’ status afforded to me by my toddler, Frankie. Mum and Dad always have and continue to offer me everything they have available to support me and made the return to candidature with a four-month-old as seamless as I could have hoped. My drive and determination to achieve can only ever be attributed to my parents, even if they can often be perplexed about my need to return, yet again, to university.

At times, I found it difficult to reconcile that families ultimately would not to be a direct feature of my thesis. However, I am hopeful that this thesis will appeal to the significant number of nurses who work with families and serve as influencers to make improvements to the safety, welfare and wellbeing of children through their work
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<tbody>
<tr>
<td>ACE</td>
<td>Adverse Childhood Events</td>
</tr>
<tr>
<td>ACPCHN</td>
<td>Australian Confederation of Paediatric and Child Health Nurses</td>
</tr>
<tr>
<td>CAN</td>
<td>Child abuse and neglect</td>
</tr>
<tr>
<td>CFHN</td>
<td>Child and Family Health Nurse</td>
</tr>
<tr>
<td>CFHNS</td>
<td>Child and Family Health Nursing Service</td>
</tr>
<tr>
<td>CWU</td>
<td>Child Wellbeing Unit</td>
</tr>
<tr>
<td>DVRS</td>
<td>Domestic Violence Routine Screening</td>
</tr>
<tr>
<td>FACS</td>
<td>Family and Community Services (Department of)</td>
</tr>
<tr>
<td>FRS</td>
<td>Family Referral Service</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>MRG</td>
<td><em>Mandatory Reporter Guide</em></td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>NUM</td>
<td>Nurse Unit Manager</td>
</tr>
<tr>
<td>SHHV</td>
<td>Sustained health home visiting</td>
</tr>
<tr>
<td>UHHV</td>
<td>Universal health home visiting</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

1.1 Chapter Introduction

Early intervention and prevention of child abuse and neglect (CAN) can ameliorate the devastating effects of adverse childhood experiences. The impact is significant not only for individuals but also for their families and communities, and a timely response by frontline practitioners can play a critical role in safeguarding children against maltreatment. These practitioners often encounter families whose needs are both multiple and complex. A practice response is required that not only considers the possibility of child maltreatment through identification, but also must extend to responding with the intention of preventing further maltreatment or should intervene early. A high standard of practice is needed from frontline practitioners, who are often considered well placed to meet this expectation.

Many elements contribute to the practices required, with much of the literature focused on specialist services and agencies that are designed to specifically work with families in which children are at risk of harm. Most notably, statutory child protection agencies feature among the dominant discourses of practice, with Social Work also rating highly as a discipline often considered synonymous with child protection. Although not newcomers to this practice arena, the nursing profession has long been considered well placed to identify and respond to CAN. Internationally, nurses are employed within public health services to work with families with young children and deliver either a universal or a targeted service. Central to service delivery in the Australian state of New South Wales are the nursing specialists, Child and Family Health Nurses (CFHNs).

Nurses play a critical role in responding to families with multiple and complex needs. Therefore, nurses face multiple challenges in their safeguarding efforts (Peckover
This thesis examines the knowledge, skills and practices of CFHNS working within a universal health home visiting (UHHV) service. More specifically, each of these factors is considered in the context of responding to a family with CAN vulnerabilities. In addition, an exploration of practice is contextualised in the management and conclusion of service delivery, where a family is perceived to be disengaged. Further drivers of practice, such as policy, tertiary education and workplace training, are also examined as key contributors to practice.

The first chapter of the thesis will introduce key concepts that are featured throughout the mixed methods study. The background of the study is outlined first, which includes an overview of the child protection and wellbeing system in which the current study is located. Specific key concepts and definitions associated with the target population, that is, families with multiple and complex needs, are presented and followed by details pertinent to the Child and Family Health Nursing Service (CFHNS). The notion of families disengaging from services is also introduced since this features throughout the thesis as a practice challenge for CFHNS. The chapter concludes with establishing the knowledge gap that is addressed by the scope of the current study. The study aims and objectives as well as the significance of the research are each described. The position of the researcher in relation to the study is also outlined. Finally, an overview of the thesis is detailed through a summary of the functions of each chapter featured in the thesis.

1.2 Background

The aim of this study was to examine the role that public health services and, in turn, the nursing speciality of CFHNS, play in the identification and response provided to families with child protection or wellbeing concerns. Public health services operate within the broader human services sector and have designated roles and responsibilities
in the prevention of CAN. In the Australian state of New South Wales (NSW), a Special Commission Inquiry into Child Protection Services (The Inquiry) was conducted from 2007 to 2008. The parameters of The Inquiry sought to challenge the notion that the statutory child protection agency alone was responsible for child safety. The Inquiry applied a broader frame of reference to include the human services sector and advocated that no single organisation has the ability or capacity to keep children safe. In response to The Inquiry, a reform was initiated, referred to as ‘Keep Them Safe: A shared approach to child wellbeing’ (herein referred to as KTS; 2014), which served as a call to action for the human services sector to actualise the principles of making child protection and wellbeing everyone’s business.

Key elements of the KTS reform are outlined to set the context of this study. A critical recommendation implemented from the reform was a change in the state child protection legislation, the Children and Young Persons (Care and Protection) Act 1998 (herein referred to as The Act). The Act was amended in 2010, which saw the introduction of risk of significant harm (ROSH) as the trigger for response from the statutory child protection agency, the Department of Family and Community Services (herein referred to as FACS). Any child protection concern suspected to be below the threshold of significance does not have the associated legal duty to be reported. Nevertheless, an alternative reporting structure was established by way of Child Wellbeing Units (CWUs). The CWUs were initially established in four main government organisations of the NSW: Police Service, the FACS (for agencies such as Housing; Aging Disability and Home Care; and Juvenile Justice), Department of Education and Communities (for publicly funded schools) and NSW Health. The reform broadened the scope of responsibility for child maltreatment, and the CWUs served as
internal mechanisms to build the capacity of the workforce to more effectively fulfil the remit of not only identifying CAN, but also fulfilling the response function.

1.3 Families with Multiple and Complex Needs

The term ‘families with multiple and complex needs’ used throughout this thesis refers to families that have risk factors linked with CAN. The most commonly cited examples of such risk factors are parental mental health, parental drug use and family and domestic violence. These risks can be compounded for parents who have experienced their own adverse events in childhood, which can lead to long-term trauma (Bromfield, Lamont, Parker, & Horsfall, 2010) that can later influence their parenting capacity. In the practice setting of the current study, families with multiple and complex needs are commonly referred to as vulnerable families, which is a simplified term for a family with identified vulnerabilities. This simplification potentially minimises the extent to which families are affected by the complexity implicit in this term, whereas the complexity is often cumulative. It can be insidious and cause detrimental outcomes for children (Bromfield et al., 2010).

Responding to families with multiple and complex needs can be challenging for professionals. Based on a theoretical examination of interdisciplinarity and complexity, Klein (2004) argues that the fundamental difficulties for professionals responding to needs of a family are associated with the variability of vulnerabilities. Risk can arise without predictability and when presented in tandem with other difficulties, knowing how to best navigate service delivery requires advanced skill. Much of the circumstances surrounding families can be dynamic and uncertain, requiring the professional to master the ‘art of managing complexity’ (Klein, 2004, p. 4). Approaching risks, and in effect families with multiple and complex needs, requires a departure from traditional problem-solving practices, such as reporting the concern to a
statutory child protection agency. Much more is required of services, and the professionals at the frontline of service delivery, to deliver a response intended to prevent CAN. Despite this growing expectation regarding professionals, there continues to be a lack of evidence that details the many and varied elements of practice required to respond to this presenting complexity.

1.4 Prevention of Child Abuse and Neglect

Many in the field (Lonne, Scott, Higgins & Herrenkohl, 2019) consider that a public health model is central to the prevention of CAN. As such, far reaching implications exist for many professionals working in preventative services (Parton, 2019). Services that are located within this model range from primary prevention to a tertiary response (Australian Institute of Family Studies, 2017a). The following table provides an overview of each level of service delivery anchored against the escalating risk of abuse. The current study is focused on the CFHNS, which offers both a universal primary prevention function as well as an early intervention function where CAN is suspected.

Table 1.1

Types of Public Health Interventions

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Primary prevention (universal)</td>
<td>Activities that target the whole population and seek to prevent child abuse and neglect before it happens. For example, legislative change to ban corporal punishment, media campaigns to increase knowledge of child development and maternal and child health services, offered to all parents, which provide information about child development and care.</td>
</tr>
<tr>
<td>Secondary prevention or early intervention (selective)</td>
<td>Activities that seek to prevent child abuse and neglect before it happens, when there are warning signs that child abuse and neglect is likely to occur or</td>
</tr>
</tbody>
</table>

5
when a particular group is at high risk of child abuse and neglect. For example, home visiting programs that provide support to vulnerable families or intensive family support for families where there is substance misuse.

| Tertiary response (indicated/targeted) | Activities that take place with people affected by child abuse and neglect to minimise the effects of that abuse and neglect and prevent it from recurring. Statutory child protection services fall into this category. For example, a child being placed in Out of Home Care. |


### 1.5 Defining the Child and Family Health Nursing Service

The CFHNS in NSW operates across the continuum of public health interventions. The universal element that offers a primary health check to all families of newborns can be extended towards an early intervention service where CAN is suspected. CFHNS also have carriage of tertiary response, for example through the delivery of health checks for children in out of home care. CFHNS is the government funded public health service and is available to all families with children under the age of five years. This service employs CFHNs. These nursing specialists are registered nurses with postgraduate qualifications in child and family health (NSW Health, 2011). Across Australia, equivalent positions exist, but the title has four variations. NSW, South Australia and Tasmania consistently use CFHN. The equivalent title in Western Australia is Community Child Health Nurses, and in Northern Territory and Queensland, it is Child Health Nurses. In Victoria and the Australian Capital Territory, it is Maternal and Child Health Nurses. Internationally, further iterations include Health Visitor (United Kingdom), Plunkett Nurse (New Zealand) and Public Health Nurses (Canada and Japan). Although variations in the job title exist across jurisdictions, nurses
working in child and family health are one of the predominant services in the prevention of CAN, given the universality of service delivery.

The current study focused on the practices of CFHNs working in a universal service rather than those employed for the tertiary-level sustained health home visiting (SHHV) programs. Practice is influenced by numerous drivers; therefore, each driver considered relevant to the study is outlined as further background for this thesis. Namely, the drivers are universal and targeted intervention, the family partnership model and aspects of the health policy referred to as the Safe Start Guidelines. The last section addresses a specific practice challenge, although one that is not limited to this service. Families who disengage from the service can have multiple and complex needs, particularly when vulnerabilities have been identified and risks of CAN are suspected. This is a particularly contentious area of practice that has undergone closer examination since the establishment of the CWU. The central tenets of this practice issue are described in Section 1.6 although these are examined in greater detail throughout the thesis to offer clarity to guide future nursing practice.

1.5.1 Universal and targeted intervention

Universal and preventative service delivery is the foundation of a public health model for prevention of CAN (Scott, Lonne, & Higgins, 2016). Within this model, UHHV is one example of a service designed with a preventative function. The UHHV featured in the current study is delivered by nurses and is accessible to all families within the first two weeks of an infant’s life. Primarily, the service is delivered at home and can be extended beyond the initial universal visit if the need is identified. The intention of this visit is to assess and respond by way of intervention to support parents in the early days of infancy. UHHV is conducted by CFHNs who offer service delivery within the family home based on the practice principle of partnerships (NSW
Department of Health, 2009). Although NSW Health also delivers targeted programs, for example, SHHV, the scope of the current study was invested in exploring the service response from the UHHV workforce.

The model of care central to this study is grounded in universalism, but a closer analysis would best describe this model as proportionate universalism (Cowley et al., 2015), also referred to as progressive universalism (Hogg, Kennedy, Gray & Hanley, 2013) with CFHNs adjusting the dosage of contact based on the level of vulnerability. The evolution of service delivery has resulted in nursing practice being required to not only prevent child maltreatment but through the process of risk identification, nurses are subsequently faced with working with a family where an intervention is required to respond to suspected abuse. Where child maltreatment is suspected and reported to the statutory child protection agency, families may not receive a statutory response. Thus, in some circumstances progressive universalism is arguably being extended to the point of a tertiary response without the sanction. This a complex and nuanced topic which is critical background context for the current study as nurses encounter further challenges when such systemic gaps filter through to the frontline of nursing practice.

As previously noted, vulnerability itself is complex and clinicians manage the family’s vulnerabilities that have existed, and possibly will exist, beyond their involvement with a family. Despite the hypothesis that nurses are well placed to identify and respond to child maltreatment, they struggle with uncertainty about the practice response to vulnerability. Operating from a universal model of care means a reliance on nurses to determine the best response to presenting needs. Consequently, practices can vary, and little evidence is available for the efficacy of proportionate universalism. The challenges of maintaining both a supportive role and having professional responsibilities to identify and respond to suspected child maltreatment have been
illuminated across the maltreatment literature (for example, Peckover, 2013 and Peckover & Appleton, 2019). Moreover, nurses need not only identify suspected child maltreatment, they are further required to identify families who need an increased dosage of public health nursing (Peckover, 2013). A more detailed exploration of these challenges has received recent research attention. For example, a qualitative study conducted in Scotland involved interviews with health visitors and mothers and found a favoured outcome for the reorientation of policy for public health nursing to align with progressive universalism (Hogg, Kennedy, Gray & Hanley, 2013). Though positive, some of the more nuanced findings of this study suggested that the move away from universal service delivery involved some complicating factors. For example, the authors reported that some nurses felt the shift had resulted in practice deviating from the policy intended to direct practice and services were delivered at the discretion of the nurse. A further finding touched on the confusion amongst the workforce as the focus of service delivery shifted away from prevention towards an early intervention response. These complicating factors may possibly be addressed through education for the professionals, as suggested by the authors, though it is likely the complexity of this realignment may require a multi-faceted change management approach if it is to engage the workforce during this transition.

**1.5.2 Family Partnership Model**

Working in partnership with families is the core philosophy of the CFHNS. Prior to the introduction of the family partnership model (developed by Davis, 2007), health practitioners tended to operate from an expert approach by which clients identified problems and health practitioners attempted to solve them. In contrast, the family partnership model emphasises the formation of a relationship between health professionals and the family to create an effective working relationship. It reorients the
service from a consumer model in which the family is a passive recipient of the service to a more active dynamic that includes the family as an equal partner in the relationship. This evolution in practice has been considered one of the most significant paradigm shifts for the profession (NSW Health, 2011) and is the contemporary practice principle for CFHNs in NSW.

Practice grounded in family partnership relies heavily on the personal attributes of the practitioner, drawing on skills such as active listening and support for families to find their own solutions (Keatinge, Fowler, & Briggs, 2007). However, in the experience of the researcher within the context of the current study, when faced with multiple and complex problems practitioners can feel overwhelmed and challenged. The partnership with a family is susceptible to strain and knowing how best to respond to suspected child maltreatment can rely on the personal attributes and capacity of the individual practitioner. The nexus between a partnership approach to practice and the requirements associated with the identification and response to suspected child maltreatment is the centrepiece of this study.

### 1.5.3 Safe Start Guidelines

Multiple and complex problems can be extrapolated in various ways. According to the state health policy and guidelines used by the public health organisations involved in this study, vulnerability is used to unpack complexity. Seven domains of vulnerabilities have been identified, which range from vulnerabilities in the child, either parent, within the family through to environmental risk factors (NSW Health, 2009). In practice, vulnerability does not occur in isolation; rather, vulnerability is considered in context. Therefore, the presence of vulnerabilities is evaluated against resilience and risks are considered against protective factors. Ultimately, the determination of risk is categorised from levels one to three (see Figure 1.1), which informs the frequency of
service delivery to a family. Given that risk is dynamic, so too are the levels of care, which can therefore be adjusted throughout service delivery. The designated CFHN determines the level of care based on an ongoing assessment of need. Put simply, the frequency of contact increases with increased risk to the health or welfare of the child. Figure 1.1 depicts the levels of care applied by participants in the current study and reflects the previously described public health approach to child protection.

![Figure 1.1. Levels of care from NSW Department of Health. (2009). From NSW Health/Families NSW Supporting Families Early Package – maternal and child health primary health care policy (p. 16), by NSW Department of Health, 2009.

1.6 Family Engagement

   Relationship-based practice relies on a partnership alliance between professionals and families, which can lead to quality assessments (Howe, 2010). Despite being grounded in a family partnership model, frequently, families end the partnership with nurses prematurely, which disrupts the alliance and leaves nurses uncertain about the practice response required. The initial scope of this study was anchored to this uncertainty. There are divergent views about whether or not a child
A protection report is warranted when engagement is not achieved. Given the voluntary basis from which the CFHNS is delivered, there is some contradiction that families could be considered resistant or non-compliant when they choose whether to accept or decline the service. Involuntary clients are more typically associated with statutory child protection agencies (see Platt, 2012; Shemmings, Shemmings, & Cook, 2012) where families are reluctant to engage with a service that holds the legal power to remove children. It is not surprising then that nursing services are facing the dilemma of working from a relationship base where families are seen as equal partners yet where the risk of CAN is suspected, and some families do not engage with the CFHNS to ameliorate these risks, there is uncertainty about how to respond.

Missed health care appointments are common (see Perron et al., 2010), although no published data on refusal rates of UHHV are provided by the CFHNS. Determining whether a family is engaged with a service is often measured through occasions where appointments are either attended or missed. However, when children are the centrepiece of the missed appointment, often, they miss an opportunity to receive health care. The losses are more complex, and the outcome is potentially more critical for infants. The reliance of young children on a parent or carer to attend health care appointments has prompted an alternative stance that clearly depicts this reliance. In Australia, reference to ‘failure to attend’ is a common term that refers to missed appointments, and the literature from the United Kingdom uses the term ‘did not attend’. An alternative ‘was not brought’ (C. Powell & Appleton, 2012) is considered a more accurate term that addresses the fact that young children do not attend health care appointments. No guidelines for health practitioners specifically outline the duty of care to an infant located within a family whose parents are resisting offers of support. Limited literature addresses this aspect, particularly from a perspective of universal health care.
Meanwhile, key lessons can be drawn from the literature beyond that which is focused on universal health care.

The literature on engagement can be drawn from a range of practice settings, including counselling and statutory child protection agencies through to health services. Irrespective of the practice setting, relationships between professionals and families is central to engagement (La Placa & Corylon, 2014), However, Calder (2008) argues that the application of a partnership approach in practice is far more complex than the premise implies. Thus, the absence of an easy step-by-step guide for practitioners can maintain a stance of uncertainty that inhibits a clear sense about the ways in which they can proceed. Critical importance is placed on relationships built on trust in which there is an awareness of authority and negotiation is exercised, with each of these viewed as ways to enhance the relationship (Cooper, Hetherington, & Katz, 2003). Insights can be gained from other studies that explore parental engagement from the perspective of service users.

For example, an Australian-based study by Winkworth, McArthur, Layton, Thomson and Wilson (2010) recruited parents who perceived they were not connected with services. The findings showed the lack of engagement was attributed to explanations such as lack of awareness or purpose of the service; a sense of disconnect with the services; a perception that service providers were judgemental and critical; and participants’ belief that needs were unmet, and hence, there was a lack of trust in the service.

Other studies, such as that of Wallbank, Meeusen and Jones (2013), applied a gap analysis to the course curriculum of nursing and midwifery programs offered in the Midlands of the United Kingdom to explain that health professionals require specific skills and knowledge to work with vulnerable families resistant to service engagement
and emphasised the importance of a tertiary education curriculum designed to address these learning objectives. Engagement is a critical aspect of working with a family, but it is a learned skill that is not necessarily prescriptive, which can result in some nurses practicing from a position of uncertainty, and the impact on practice is unknown from an empirical perspective.

1.7 Knowledge Gap

Much of the literature published about the role of health services and child protection practices is associated with mandatory reporting (Feng & Levine, 2005; Mathews & Bross, 2008; Raman, Holdgate & Torrens, 2011; Schweitzer, Buckley, Harnett & Loxton, 2006), or specialist services deployed to work with families with multiple and complex service needs, such as SHHV programs (e.g. Kardamanidis, Kemp, & Schmied, 2009; Kemp et al., 2011). In the absence of a significant evidence base, the practices of CFHNS appear to be driven primarily by organisational policy, tertiary education, workplace training and competency standards developed by apex nursing bodies.

Over time, the expectations placed on services across the human services sector have given rise to a greater onus on agencies, such as public health organisations, to contribute to the prevention of CAN. The duty to protect has shifted away from the sole focus on statutory child protection agencies and more broadly encompasses interagency partners who routinely deliver services to families in which children are at risk of CAN. Although expectations have undoubtedly changed, there is a gap in knowledge about how this expectation has been translated in a practice setting. Beyond mandatory reporting of suspected CAN, there is a gap in the existing evidence base that explores whether and how health practitioners, such as the CFHNS, are confident, knowledgeable and adequately skilled to respond to families with multiple and complex needs. CFHNS
are educated and trained to a high standard of postgraduate tertiary education (Fowler, Schmied, Psaila, Kruske, & Rossiter, 2015). Preparation through tertiary education prior to joining the workforce can contribute to foundational knowledge, although the extent to which this acts as a driver to practice is unclear.

Hence, the literature on practice responses to CAN was reviewed to scope existing knowledge and the review is presented in Chapter 2. The review initially uncovered the discourse about mandatory reporting, which is often the initial consideration in outlining the practice response to a presenting concern. However, the literature review aimed to extend to address the broader range of themes relevant to the practice of nurses beyond mandatory reporting. The CFHN workforce has long been considered well placed to both identify and respond to CAN. The current study has been designed to explore the practices that support this argument.

1.8 Position of the Researcher

Prior to commencing the study, I had worked alongside nurses for much of my Social Work career. I often remarked at the skills and abilities of the nursing workforce, particularly those working with families with children under five years of age. I felt inspired by the workforce, who navigated significant systemic changes to continually adapt their practice to continue working with families as best they could. In the years preceding the current study, I observed and partnered with the CFHNS to work through a period of uncertainty when nurses had been charged with a greater responsibility of not only identifying CAN but also needing to respond to such risks within the constraints of UHHV.

Not being shy of a challenge, I set about partnering with the CFHNS to explore practice responses associated with families with identified psychosocial risk factors who do not engage with the service. Ambitiously, I proposed to work in partnership with a
small group of CFHNs who were interested in research and quickly found myself in research design territory with four motivated novice researchers. The role of this group of novice researchers was limited for many reasons, although most prevalent were the challenges associated with balancing an active clinical role against research activities.

A research report (Mawhinney, Tutt, Dunlop, Harnett, & Marsh, 2016) was released as a result of the collaboration of a small research group and was issued to both participating organisations. The project has been scaled up to formulate the backbone of this thesis. Since completing the research project, I have remodelled the data collected and revised the literature reviewed, and I present the findings in this thesis.

My personal perspective has changed remarkably since the inception of the study, most notably owing to becoming a mother. The influence of this life-changing event has deepened my thinking about the issues to hand—what it means to be a family with multiple and complex needs; to simultaneously respond to the everchanging needs of an infant, pre-teenager and teenager; and to experience adverse events, such as living on a farm during a drought. I became a service user of the CFHNS and other parenting support services. I have also extended and challenged my own practice understanding through consulting with several statutory child protection services. Collectively, these experiences continued to shift my understanding and challenge my own knowledge about the advanced skills, knowledge and attributes required to be used in unison when working with families where risks of CAN are suspected. These shifts occurred more rapidly during data analysis, and my thoughts tended to become more consolidated once frequent night waking and infancy developed into toddlerhood, resulting in much clarity, which is hopefully reflected throughout this thesis.

My commitment to CFHNs has remained a constant since the inception of this idea. I have always maintained that the premise of nurses being well placed to respond
to families with child abuse vulnerabilities is unchallenged. However, I have observed that nurses themselves find it difficult to articulate the complexity of their practice. At its heart, addressing this issue was the objective of this thesis.

1.9 Outline of Thesis Chapters

Chapter 1 presents the introduction to the study. This chapter outlines the background of the study in relation to the human service system as the context of the study and defines the core concept of families with complex needs as the targeted population central to this study and the CFHNs as the participants of this mixed methods study. The study is further outlined in relation to the identified knowledge gap in the available literature, the aim and objectives of the study as well as the significance of the study detailed in this thesis. The position of the researcher was also introduced in Chapter 1.

Chapter 2 details the literature reviewed, which is presented according to 10 themes: identification, assessment, responding to child maltreatment, monitoring families, competency, policy, clinical supervision, education and training, nursing practice (or nurse intervention) and management structure. This chapter also identifies systemic drivers of practice, for example, competencies for Child Health Nurses as established by the Australian Confederation of Paediatric and Child Health Nurses (ACPCHN, now known as Australian College of Children & Young People’s Nurses, hereafter, ACCYPN) in 2016.

Chapter 3 presents the research methodology used in the study. The study design adopted a pragmatic approach and applied the conceptual model of the Integrated Theory of Parental Involvement developed by McCurdy and Daro (2001).

Chapter 4 outlines the research design and methods used in phase one. The study was conducted in two public health organisations of metropolitan Sydney.
Chapter 5 reports results of survey data from phase one. The results present the frequency of practices associated with the identification and response to suspected child maltreatment. Self-reported confidence across three practice scenarios is also reported, along with the role that education and training has played in equipping nurses with the required knowledge to work in partnership with families with complex and multiple problems.

Chapter 6 outlines the focus group design and methods used in phase two. Details of participants’ characteristics and recruitment strategies are provided. Data were analysed using thematic analysis, which is described in this chapter.

Chapter 7 reports the findings of focus group discussions from phase two. Data were analysed using interpretative description, and findings are presented through thematic analysis. The ‘conceptual model of the Integrated Theory of Parental Involvement’ (McCurdy & Daro, 2001) was again used as a framework for this study. Three stages of family engagement with the service were identified: (a) intent to enrol, (b) enrolment and (c) retention. An extension to this model is proposed through findings that suggest there is a further phase, one in which the nurse family partnership ends, referred to as the conclusion stage.

Chapter 8 integrates the findings of both phases of the study. An enhancement to the Model of Parental Involvement, entitled the Framework and Drivers of Practice with families with multiple and complex needs is proposed. Study strengths and limitations are outlined, along with implications for practice, and future research directions are outlined.

Chapter 9 concludes the thesis. Each of the stages of parent involvement are considered, and the nuances of nursing practice are presented.
1.10 Chapter Summary

This chapter provided the background to the study by describing the practice setting and context of the current study. Key concepts of service delivery were outlined to provide additional context because they are featured throughout both phase one and phase two in this mixed methods study. Families with multiple and complex needs are the target population of the CFHNS and the service system is intended to respond to such needs. However, if the service system is unable to meet these needs, families cease to access the service, often leaving CFHNs with a prevailing uncertainty about the extent of their duty of care. This is a significant and frequently encountered clinical matter, and little is known about the response required to ameliorate the vulnerabilities that first made the family eligible for an extension of the UHHV service. This thesis critically examines the available literature and presents a mixed methods study design to describe the contemporary practices, knowledge and confidence of CFHNs when working with families with CAN vulnerabilities.
Chapter 2: Literature Review

2.1 Chapter Introduction

This chapter provides a critical review of the available literature in relation to registered nurses and their practices associated with the and the identification and response to CAN. Across the globe, nurses are involved in various roles and work across many settings in protecting children and young people from abuse and neglect. Some areas of the literature feature a plethora of peer-reviewed research articles that, when taken together, provide evidence for practice. Other areas of practice have received less attention. The following literature review draws this vast literature together to provide a critical analysis of the work that nurses perform in protecting children.

A systematic approach was adopted in the search strategy, which generated a body of evidence reflective of the vast aspects of practice required to respond to families with multiple and complex needs. The literature review is framed by the following themes: (a) identification, (b) assessment, (c) responding to child maltreatment, (d) monitoring families, (e) competency, (f) policy, (g) clinical supervision, (h) education and training and (i) systemic drivers of practice.

2.2 Scope of the Literature Review

The aim of this literature review was to identify the published research available that focused on those aspects of nursing practice that centre on CAN. The review incorporated research from 2007 until the most recent publications in 2019. The early 2000s was a period of review and revision of the public health approach. At the time of the study, any studies prior to these shifts in focus were thus not included. Literature that positioned the nurses’ role as part of the public health approach was a fundamental premise of the current study. Literature reviewed within the 2007 to 2019 timeframe
saw the term child maltreatment has featured more commonly than CAN. Throughout this thesis, the terms are used interchangeably. The review maps recent empirical literature and a selection of grey literature that addressed the practices of nurses.

In Australia and elsewhere, nurses are mandated by law to report the suspicion or knowledge of CAN. This topic has continued to receive valuable research attention for some time. Most recently, a legal analysis completed by Mathews (2019) resulted in a taxonomy of mandatory reporting duties for child sexual abuse following the Royal Commission into Institutional Responses to Child Sexual Abuse. Although this contribution to the field is useful, there continues to be a gap in knowledge about the practices of nurses beyond the task of mandatory reporting. The professional practice of nurses is guided by law and policy. Policy is informed mostly by evidence for practice, but not consistently. There is still a long way to go in terms of implementing evidence for practice and indeed in establishing enough evidence to deliver best practice. Nevertheless, it was the purpose of this review to bring this complex literature together to investigate the practice of nurses in safeguarding children at risk of maltreatment.

The published literature in the field of child protection by nurses is complex. Nurses work with children and families in both community and hospital settings, and preparation for their role in protecting children from CAN varies. Despite these variations, nurses are frequently posited as well placed to identify and respond to child maltreatment (Appleton & Cowley, 2008; Browne, 1995; NSW Health, 2011; Pietrantonio et al., 2013; Scott, 1992; Smith, 2004; Taylor, Baldwin, & Spencer, 2008). The following review sought to examine this proposition through an analysis of the literature.

Conducting a literature review in this field is not without challenges. One challenge is the varied professional titles used for nurse specialists working with
children and families in a community setting. Australia alone uses four different variations on the title across the eight jurisdictions: **Child and Family Health Nurses** (used in South Australia, NSW and Tasmania), **Community Child Health Nurses** (Western Australia), **Child Health Nurses** (Northern Territory and Queensland) and **Maternal and Child Health Nurses** (Victoria and ACT). Internationally, there is further diversity, such as the Health Visitor designation in the United Kingdom and Plunkett Nurse in New Zealand. Consequently, the search strategy used (see Table 1.1) applied permutations as well as the more general title of nurse to optimise the results. Although these job titles vary with considerable range, the functions of the role have the common focus of working with families with children from birth to five years. An extended, but vitally important, responsibility also held by these nursing specialists is to identify and respond to child maltreatment.

A further challenge in conducting this review was the broad range of themes addressed in the studies. The safeguarding practice of nurses is a broad topic, and no clearly defined categories emerged from the initial stages of the review process. This made it difficult to formulate a cohesive review (Cowley et al., 2013). Despite this difficulty, the literature review identified eight key elements of nursing practice related to child maltreatment.

Nursing practice guided by a specific program or intervention, compared with practice that does not operate from such a foundation, is likely to be different. Put simply, without a program that prescribes dosage and intervention, nurses experience more freedom in delivering a family-centred practice response. The current study purposefully recruited participants whose work did not exclusively follow a program and placed greater emphasis on nurses working from a UHHV program. Therefore,
literature included for the review does not feature studies that define practice by a specific program model of care.

Each of the review themes listed in Section 2.1 was structured within the framework of parental involvement that McCurdy and Daro (2001) developed (Section 6.9 for further details). The framework identifies factors that influence practice when working with families, which range from: (a) individual factors relevant to the family themselves, (b) provider factors of the professional, (c) program characteristics of the service and organisation and (d) neighbourhood factors, such as social determinants. Two factors were particularly relevant to this literature review, namely, provider factors and program characteristics. Accordingly, the themes identified through the literature review are presented against these two factors. The term provider factors refers to skills, knowledge and access to education either as a prelude to qualifying as a nurse or through later opportunities to attend workplace training once employed. Program characteristics include policy implementation and organisational support mechanisms, such as access to quality clinical supervision.

2.3 Search Strategy

A search of the literature was conducted using a systematic approach and the following databases: OVID (Medline and PsycInfo), Scopus and CINAHL. Table 2.1 presents the search terms and outcomes. Search terms were selected based on each of the elements listed above. The population group was children, and an additional lens of child abuse/maltreatment/welfare, risk and wellbeing was used. A further element incorporated into the search strategy was nursing practice, and not family characteristics or prevalence of abuse. A combination of search terms was needed to capture the international literature on specialist nursing roles. Lastly, a timeframe was set to consider publications from 2007 onwards for including recent developments in the
scope of the review, rather than charting the discourse of child protection systems within which nurses’ practice.

Table 2.1

*Literature Search Terms*

<table>
<thead>
<tr>
<th>Database</th>
<th>Search Terms</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medline</td>
<td>child*, health, maltreat*, maternal, nurs*, primary, visitor*, wellbeing, primary health care, health visitor.</td>
<td>561</td>
</tr>
<tr>
<td>PsycInfo</td>
<td>child*, health, maltreat*, maternal, nurs*, primary, visitor*, wellbeing, primary health care, health visitor, child welfare, child abuse, child maltreat*, child wellbeing.</td>
<td>166</td>
</tr>
<tr>
<td>Scopus</td>
<td>Child abuse or child maltreatment or child neglect, “high risk famili*” or risk, knowledge or confidence or education and training or practice.</td>
<td>612</td>
</tr>
<tr>
<td>CINAHL</td>
<td>Primary health nurse or community health nursing or community health nurse or health visitor or nurse public health, child welfare or child abuse or child maltreat* or child wellbeing.</td>
<td>487</td>
</tr>
</tbody>
</table>

A total of 1,826 references were identified in the collective search strategy (refer to Figure 2.1). The title and abstract of all references were initially reviewed and flagged for further review. Articles were then obtained and reviewed in full prior to consideration for inclusion by the thesis author. Full reference details and abstracts were then reviewed for relevance by two academic supervisors for agreement. Table 2.2 outlines the inclusion and exclusion criteria.
Table 2.2

*Criteria for Literature Review*

<table>
<thead>
<tr>
<th>Included</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empirical literature</td>
<td>Commentary, book review and editorials</td>
</tr>
<tr>
<td>Publications from 2007</td>
<td>Child abuse/maltreatment prevalence studies</td>
</tr>
<tr>
<td>Workforce focus</td>
<td>Family focus</td>
</tr>
<tr>
<td>Practice of nurses in various clinical settings (e.g. Emergency Department, Paediatric care and community settings)</td>
<td>Program-specific practice of nurses (operating in specific models of care, such as sustained home visiting or family–nurse partnership)</td>
</tr>
<tr>
<td>Provision of child maltreatment education and training to workforce</td>
<td>Provision of education to parents and carers</td>
</tr>
<tr>
<td>Knowledge and confidence (including competence) of nurses identifying and/or responding to child maltreatment</td>
<td>Studies primarily addressing mandatory reporting</td>
</tr>
</tbody>
</table>

The Joanna Briggs Institute Tools (2016) were applied to the articles to determine the quality of each. These critical appraisal tools are specifically designed for application to individual study designs. The tools applied in this review are the Cross-Sectional Studies (Joanna Briggs Institute, 2016a), Critical Appraisal Tools for Qualitative Research (Joanna Briggs Institute, 2016b), Systematic Reviews (Joanna Briggs Institute, 2016c). and Text and Opinion (Joanna Briggs Institute, 2016d).
2.4 Mandatory Reporting

The topic of mandatory reporting has increasingly dominated the literature since the introduction of child protection legislation (Feng & Levine, 2005; Mathews & Bross, 2008; Schweitzer et al., 2006). Australia is a federated nation, and each state and territory now has some form of mandatory reporting legislation for nurses. Mandatory reporting is only one aspect of the role of nurses in responding to child maltreatment. Although the literature on mandatory reporting has played an important role in advancing the knowledge of this one aspect of child protection practice, studies that have solely focused on this field of research were excluded from this literature review. A summary of mandatory reporting is presented in this section of the thesis to provide a contemporary position of this practice.

In jurisdictions that record the source of CAN reports, nurses can be observed to have made a substantial proportion of notifications made by health professionals (Mathews, Bromfield, Walsh & Vimpani, 2015). In NSW, CFHNs are registered nurses, and unlike in other jurisdictions, the legislation does not specifically name them as mandated to report in the Children and Young Persons (Care and Protection) Act 1998. Rather, nurses fulfil the category of a person who delivers health care. State government health policy refers to ‘all health workers’ as carrying mandatory reporting responsibilities, alongside many other responsibilities. Further, the current overarching directives for the NSW Health workforce stipulate that health professions must recognise and respond to vulnerabilities, as well as fulfil a range of other responsibilities, including the amelioration of CAN (The Child Wellbeing and Child Protection Policies and Procedures of NSW Health, 2013).
This position asserts the task at hand for health professionals has evolved beyond the mandatory reporting responsibilities outlined in previous policies. In fact, the scope of responsibilities is extensive and includes collaborating within health services and with other agency partners; advocating for application of the Mandatory Reporter Guide (MRG) an online decision-making tool; accessing assistance from the CWU; encouraging proactive follow-up activities with FACS after a child protection report is made; and participation in child protection training. CFHNs are mandated to report CAN, although the expectations extend much beyond this practice, given that policy outlines the broader scope of practice responsibilities. However, little is known about the experience of nurses in applying these responsibilities with families.

Mandatory reporting has received great research attention. During the scoping phase of this study, initial reviews of the literature in this field were dominated by studies that focused on mandatory reporting. Studies reviewed tended to examine reporting behaviours, such as failing to report to statutory authorities, rather than the broader practices utilised when responding to suspected abuse or neglect (Feng & Levine, 2005; Jones et al., 2008; Lazenbatt & Freeman, 2006; Paavilainen & Tarkka, 2003; Raman et al., 2011; Schweitzer et al., 2006; Sege et al., 2011). More recent offerings include a meta-synthesis of literature by McTavish et al. (2017), who have analysed the findings of 42 studies. The meta-synthesis showed that a shift in the scope of studies has commenced. Among the findings were several implications relevant to practice, which included the importance of early discussions with families about the limitations on confidentiality during engagement and the importance of responding to disclosures of child maltreatment with sensitivity and empathy and without being judgemental.
Although most of the publications reviewed during the scoping review focused primarily on mandatory reporting, two exceptions were identified. Foster, Olsen-Dorff, Reiland and Budzak-Garza’s (2017) publication that did include mandatory reporting behaviours was included because of its broader consideration of additional practices that complement the action of reporting CAN. Next, Pietrantonio et al. (2013) had formulated a range of strategies to be deployed by health professionals by drawing on the evidence base of empirical studies. Therefore, these two studies were included in the review.

The literature on mandatory reporting has played a pioneering role in advancing the knowledge of child protection. Nevertheless, studies that had solely focused on this theme were excluded from this literature review.

2.5 Emerging Themes from the Literature Review

Sections 2.6 and 2.7 will cluster the themes that emerged from the findings of the 26 studies included using thematic analysis (Braun & Clarke, 2006). Multiple themes were considered by several studies and hence have been referred to under each theme relevant to the study scope. In case a detailed description of a study has been outlined in this chapter, it is detailed once, and therefore, each theme needs to be viewed as one strand of the broader tapestry of the literature reviewed. The themes identified through the literature review are presented against two factors relevant to this review: provider factors and program characteristics. The literature review was updated in 2019, and the findings of the updated review are presented in Sections 2.8 to 2.11.

2.6 Provider Factors

2.6.1 Identification of child abuse and neglect

review, considered the key practice elements in identifying evidence-based strategies applied within the practices of health visitors to effectively identify child maltreatment, specifically neglect. Elements included assessing for risk factors of child maltreatment that may be present at a child or parent level and indicators that may evidence the presence of risk; conversely, the absence of signs of abuse can result in practitioners overlooking abuse in instances where a degree of resilience is demonstrated in the face of adversity. The degree to which parents engage or avoid services can also be an important factor to analyse when identifying neglect. Applying assessment tools, deploying joint home visiting (involving two agencies or disciplines), clinical supervision and interagency training were considered assets when identifying neglect. Similarly, Land and Barclay (2008) found that collaborative efforts between disciplines and agencies were important for the practice of nurses featured in their small qualitative study of participants working in community-based nursing roles in the Northern Territory of Australia. When taken together, the studies indicate that the identification of child maltreatment is underpinned by numerous elements associated with indicators or signs that overtly suggest child abuse may have occurred or is likely to occur. The identification of such signs warrants an assessment, which is further explored in the following section.

2.6.2 Assessment of child abuse and neglect

Once indicators of CAN are identified and maltreatment is suspected, sound skills in assessment are required. A critical finding in studies that consider nursing practices and core skills required to practice effectively in safeguarding children is, as best described by Taylor et al. (2017, p. 563), the capability to ‘assess, recognise and respond in contentious situations’. The skill of assessment was explored in numerous
studies and has been further examined in relation to assessment skills and through the
lens of engagement.

Assessment skills have been found to be a core practice in child maltreatment
identification and response (Ho & Gross, 2015; Paavilainen & Flinck, 2013; Schols, De
Ruiter, & Ory, 2013; Selbie, 2009). Schols et al. (2013) examined the practices of
frontline professions of teachers (n = 17) and health care professionals (n = 17) working
in the Netherlands. Findings were presented against a framework of the Integrated
Change model, which proposed that the greater capabilities a person has, the more
likely action will be taken. For the cohort of health professionals (six physicians and 11
nurses), the authors described several factors as ‘cues to action’ analogous to the
identification and assessment of child maltreatment. The process of identifying risk was
unpacked by participants in the presence and absence of indicators of abuse explored in
the focus groups.

This exploration highlighted complexity in practice from the outset and
emerging concerns, ranging from overt physical indicators to more subtle behaviours
and possibly professional intuition that may have triggered consideration of
maltreatment. Deficits in knowledge of normative child development among
participating nurses were reported, although this is not quantified by the authors and
thus should be considered with caution. The authors argued that strategies designed to
improve knowledge fail to consider the other influences on practice, such as access to
consultation and support or personal attitudes. One participant considered the influence
of perception in relation to risk, suggesting risk is viewed subjectively. Other studies
have considered this issue in greater depth. Ho and Gross (2015) concluded that the
subjectivity of risk assessment may contribute to varied practices in identification and
reporting of child abuse, an argument similar to that of Schols et al. (2013). More
research is needed to disentangle some of the contradictions and provide further support to the findings.

Engaging families draws on the skills of the provider and is key to conducting an assessment. Health visitors in a small study by Selbie (2009) believed that many factors are to be considered outside the assessment. The Selbie study was conducted at the same time as the national evaluation of the Common Assessment Framework, which according to Selbie had been reportedly received poorly by health visitors in the United Kingdom. Selbie found several emerging practice themes, ranging from personal skills of coordination, observation and communication through to the skills of engaging, and commitment to working, with families. These aspects were considered instrumental in the ability to conduct assessments, despite the critique levelled at the Common Assessment Framework. Emphasis was placed on engaging families and the value of this relationship has on the quality of assessment, upholding existing arguments articulated by field experts. Therefore, engaging families is considered another critical element of nursing practice.

Engagement with families in service delivery was another theme that emerged as a provider factor. Alonso-Marsden et al. (2013) conducted a sophisticated analysis that examined initial and retained engagement with families in relation to family risk factors. Using data obtained from 2,279 birth records in North Carolina, the study considered correlations between risk factors identified in infants against family demographics from a sample of clients accessing a universal health care service. Two intervals of contact with families were also considered. The first interval was initial engagement, which occurred during the postnatal hospital admission, and the second was a home visit, which was conducted between three to eight weeks in the postnatal phase and constituted what was described by the authors as follow-through. Successful
engagement at interval one was reported for 77.4% of eligible participants (n = 1,765). A follow-through appointment was successfully completed with the majority (85.3%) of families. Analysis showed that the higher the risk, the more likely a follow-up appointment was made.

However, families with fewer risks were more likely to complete the follow-through appointment compared with those who agreed to the scheduled visit. The authors emphasised that the practice considerations of such a finding required professional commitment to making efforts to facilitate visits subsequent to the initial point of enrolment. They also emphasised that if clarity about the purpose of the service was not offered at the point of engagement or if the perception was that accepting services was equivalent to poor parenting or being monitored for child maltreatment, these factors were likely to have a considerable influence on a family’s willingness to engage in the service. This study highlights critical considerations for practitioners engaging with families.

Assessment skills are a further critical element of practice and are reliant on the ability to assess maltreatment concerns, in the context of other variables, such as child development; to discuss identified concerns with families; and to engage families not only through initial contact, but also by sustaining engagement over time. Each of these elements contribute to the assessment process.

2.6.3 Responding to child maltreatment

Nursing practice includes a range of skills and tasks that contribute to the overall practice of responding to child maltreatment. The skills of communication are one of key skills according to a study of paediatric nurses (n = 10) conducted in Ireland by Barrett, Denieffe, Bergin and Gooney (2017). The study explored the views of nurses about caring for children with non-accidental injuries. Working with children where
child maltreatment is suspected has a significant personal impact on the professionals involved. Exercising skills in self-reflection was also highlighted in this study as participants considered the impact of their own personal life experiences in relation to their professional role. This was a valued characteristic that had direct benefits for ensuring effective clinical practice.

Nuances in engagement and assessment were examined that found participants had articulated a clear sense of duty in fulfilling child protection responsibilities. This was not through overt actions. Rather, Barrett et al. (2017) described that participants made subtle or inadvertent efforts to gather information, rather than conducting targeted lines of enquiry that were considered appropriate to the role and consistent with policy guidance. Participants in the study were willing to obtain some context around the injury that caused hospital admission. Similar studies were not found to have reported this factor. Other skills identified in this study included impartial reporting, documentation and advocacy for the child. Limited confidence was found in relation to providing evidence for prosecution. Possessing clinical experience was viewed as beneficial to practice, as was collegial support. Training and education were considered essential to support the practice of nurses. However, a unique finding of Barrett et al. was the report from participants that they had a sense of never fully feeling confident to work with children with child maltreatment injuries despite extensive training. This qualitative study explored the challenges for nurses in this practice arena, both on a provider level and within the context of working with a family. In doing so, it advanced knowledge of the complexity of nursing practice and the integration of skills and tasks required to respond to child maltreatment.

Discussions with families that feature concerns about CAN rely on communication skills of the provider. Several studies reviewed explored such
discussions as examples of responses to child maltreatment. An investigative study that compared the practices of health care professionals with those of primary school teachers in the Netherlands considered the influence of confidence and competence against the legal obligations attributed to each profession (Schols et al., 2013). For example, the cohort of teachers in their study did not hold a legal obligation to directly report child abuse, whereas the health care professionals did. Consequently, it was probable that the skill and experience of discussing concerns with families would be greater in a profession that was required to report child abuse. The authors suggested the value of training in enhancing communication skills of frontline practitioners regardless of legal obligations. This skill was also highlighted in the National Clinical Nursing Guideline for Identifying and Intervening in Child Maltreatment within the Family in Finland (Paavilainen & Flinck, 2013). This Guideline was developed to incorporate findings from 77 empirical studies considered in a systematic review. The guidelines argued that identification and assessment are at the foundation of effective practice. Further direction is given around professionals engaging in discussions with families, which expands to include child development, parenting, risk factors and child maltreatment. The authors recommend a pragmatic approach to conducting such discussions, balanced against relevance to the service being delivered. Ultimately, the ability to discuss concerns with families is fundamental to safeguarding practice.

Discussions about child maltreatment need a closer examination to adequately grasp the challenges associated with the task at hand. For some providers, the possibility of needing to speak about suspicions of CAN is daunting and requires specific guidance to appease the sense that such discussions require expertise. Pietrantonio et al. (2013) proposed that when working with parents, health professionals should adopt a range of strategies to positively craft a practice response to CAN. The authors consider such
discussions can be equated with breaking bad news, a familiar concept encountered in various health care settings, such as oncology. Pietrantonio et al. encouraged health practitioners to guide such discussions using ‘SPIKES’. SPIKES’ refers to strategies used to guide a discussion with families when abuse is suspected. Namely, these strategies are setting, perception, invitation, knowledge, emotion and summary. Each of these strategies is extrapolated according to the authors and, where indicated, a reference has been included as cited in the Pietrantonio et al. article.

**Setting** refers to using an environment in which privacy is optimised and interruptions are avoided. Early discussions about limitations on confidentiality in relation to mandatory reporting obligations are important, particularly when CAN risks are suspected and discussions with parents about such concerns are required (Davidov et al., as cited in Pietrantonio et al., 2013).

**Perception** relates to the parent’s understanding about the situation at hand, such as a presentation to the hospital following an incident that resulted in an injury to a child. Health practitioners who demonstrate patience and a willingness to engage in conversations that allow parents to explain their perception have been found to positively influence the outcomes of these discussions (Baile et al., as cited in Pietrantonio et al., 2013). Fundamentally, the relationship between the health professional and family holds great importance (Drake, and Dumbrill & Maiter, as cited in Pietrantonio et al., 2013). The authors emphasise health professionals are not just conveying concern and information about the required action; rather, the family must also be given the opportunity to convey their own concerns and have such worries addressed.

**Invitation** is associated with creating opportunities for the family to be actively involved in the mandatory reporting process. Pietrantonio et al. (2013) suggested that
although consent is not required, health practitioners should have open and honest conversations with families to convey concerns and the obligations of reporting child protection, where possible. The authors argue that such an approach can maintain, rather than erode, the working relationship with the family.

Knowledge relates to the content of discussions and communication styles, which should be simple and relevant. Pietrantonio et al. (2013) discourage blunt communication styles. The fifth principle of SPIKES is emotions, which refers to the emotions displayed by families and the importance of health professionals acknowledging and validating such responses. The last two elements are strategies and summary, terms used to collectively describe the overarching approach of health practitioners being respectful and non-judgemental.

The relationship between the professional and family is central to SPIKES, and therefore, there is an alignment between this approach and the nurse family partnership central to the current study. Although the principles that underpin SPIKES are each likely to be important strategies of such conversations, research is required to evaluate the practical applications of such an approach when used in the context of child maltreatment.

2.6.4 Monitoring families

There have been contentions for many years around the practice of nurses involving a monitoring function. In a qualitative study conducted with health visitors in Ireland, Kent, Dowling and Byrne (2011) reported that participants (n = 10) grappled with the function of ‘monitoring’ families. Reluctance to claim a monitoring role conflicted with the image of ‘friendly’ care and support. Nursing is almost alone among professional groups to enjoy the trust of the public. It facilitates family engagement with their services. Alignment between the health visitor workforce and the objective of
monitoring families was proposed to be an unwelcomed drift in the roles and responsibilities of this workforce, according to Kent et al. This, coupled with a reported lack of confidence in executing the task of monitoring and a view that monitoring fails to assure safety and protection from harm for children, suggested multiple issues were at play in understanding the range of tasks associated with monitoring. Kent et al. revealed the divergent views among health visitors about the role they played in relation to child maltreatment. The authors recommended role definition and national practice standards to guide service delivery to families as two potential strategies to address the divergent views among the workforce in their study. These conclusions need further testing.

2.6.5 Practice competency

The competency of individual nurses was the subject of a cross-sectional study conducted in Taiwan by Chen, Huang, Lu and Feng (2015). The study examined the competency of community-based nurses practicing in child maltreatment. Recruitment of 650 community nurses in Taiwan resulted in 588 participants completing The Child Abuse Competency Questionnaire that examines practice components, such as knowledge (17 questions), skills (31 items) and team collaboration (five items). The participants held considerable experience, and the average was almost 16 years (SD 8.91); however, participants’ experience of suspecting abuse and subsequently failing to report was more common (5.9%) than actual experience in reporting child maltreatment (4.6%). Completion of training or education, either during qualification attainment (31.4%) or in the workplace (33.2%), was reported; however, low levels of satisfaction regarding course content was reported in both settings by most participants. The average correct response rate on child abuse knowledge questions was 12.5 (SD 4.09) out of a possible 17 true or false questions. Chen et al. reported greater accuracy in the
identification of indicators of physical abuse, but less so with more subtle indications associated with other types of abuse, such as neglect.

The skill-based questions used a 6-point Likert scale using the highest number to represent the greatest degree of agreement with a named skill. Participants were found to be moderately skilled and had an average score of 118 (SD 27.35, range 31–186). The questionnaire also examined practice competency in relation to team collaboration, using the same Likert scale, and participants had an average response score of 19.5 (SD 4.97, range 7–42). Experience and child maltreatment competencies showed a negative correlation in that nurses with considerable years of service reported feeling less competent. Overall, this study found a moderate level of competency when measured across knowledge, skill, empowerment, team collaboration and self-reflection, despite a significant number of years of experience. Low satisfaction rates regarding education and training were considered drivers of competency, and therefore, evaluated education was proposed as a solution to address competencies.

2.7 Program Characteristics

2.7.1 Policy

Policy is intended to dictate programs and service delivery, but a divide often exists between policy and the real world in which practice occurs (Condon, 2011). Condon (2011) examined the effects of policy change on the reorientation of service delivery in the context of targeted service delivery for disadvantaged pre-school aged children in the United Kingdom. Twenty-five health visitors employed in health visitor or specialist roles across the United Kingdom participated in the study. Participants possessed considerable experience and had an average of 18 years clinical experience. The study indicated variations in practice when contrasted with policy expectations. The findings showed that some participants moderated services to meet perceived demand.
For example, some participants reported providing a more comprehensive universal service than policy directs. This illustrates the complex relationship between the intentions of service delivery against the autonomy of nurses and the families with which they work. More studies on the integrity of service delivery are needed.

Contentions exist between the policy directives that require health professionals to screen clients to identify risk factors for abuse during the initial contact with the service. Resistance to this practice has been attributed to the concern by health practitioners that client engagement may be compromised by prioritising the assessment of risk (Condon, 2011). Where services are being reoriented and calibrated towards a safeguarding function, resistance has been detected among nurses and their reluctance is evident when they are required to change practice (King, 2015). The emotional impact on nurses working in a context in which practice is directed to change through policy can be burdensome. King (2015) found that one of the unintended consequences of policy shifts to practice was low morale among the workforce. Participants in this small (n = 16) qualitative study reported feeling their practice had been criticised and unvalued. They interpreted this feeling, coupled with shifts in service delivery, as an erosion of previous efforts, which led to growing concerns about staff retention and the future capacity of the workforce to deliver the services described in policy. King advocated that attending to staff throughout the process of policy development and implementation was crucial, given the pivotal role played by a workforce such as health visitors.

Once a shift in service delivery has occurred and safeguarding is placed on the agenda, the experience of the workforce in fulfilling this role does not become simpler. In a recent study, Saltmarsh and Wilson (2017) used a qualitative study design to explore the practices of neo-natal nurses (n = 10) in relation to responding to child
maltreatment. As with their community-based home visiting nursing counterparts, neo-
natal nurses were illustrated in this study as feeling conflicted when reflecting on the
child protection practice component required in their role. The study, set in New
Zealand, described the practice nuance of both recognising and responding to child
protection concerns in families with infants in neo-natal care as a ‘dance’. Saltmarsh
and Wilson described a dynamic process integrating different elements into the practice
of this acute nursing speciality. The metaphor ‘dancing around families’ was used by
the authors to illustrate the movement of roles in relation to the infant (ranging from
nurturing to risk identification), engagement with the family and the professional tasks
associated with risk response.

2.7.2 Clinical supervision

Studies have found strong evidence that organisations are responsible for
providing clinical supervision to professionals, which demonstrates that supervision is a
key strategy to promote effective safeguarding practice (Akehurst, 2015; Dauber,
Ferayorni, Henderson, Hogue, Nugent & Alcantar, 2017; Kent et al., 2011; Taylor et al.,
2017). Moreover, delivering supervision to respond to the emotionally demanding
aspects of nursing practice was found to have great value (Reeves, Drew, Shemmings &
Ferguson, 2015; Rooke, 2015; Taylor et al., 2017). The benefits of supervision are that
is has been found to improve worker satisfaction, promote wellbeing and prevent
compassion fatigue (Taylor et al., 2017).

The emotional aspect of safeguarding practice was examined in a unique study
conducted in the United Kingdom by Reeves et al. (2015). The study applied eye
movement technology to measure the emotional response of participants engaged with
an online training program. The training was based on simulated home visits. The study
found sadness was identified as the prevalent emotional response for the small cohort (n
5) of health visitors who participated in this study. Using a small sample size of participants has its limitations, but there is merit in more broadly considering the inevitable range of emotional responses one would reasonably expect to express in response to a family with identified safety concerns about children. This study offered some evidence to validate not only the range of emotions expressed through eye movement in response to client interactions but also the implications of not responding to the associated emotional needs of the workforce. Supervision was a valued means of taking care and supporting the workforce, but a great emphasis was placed on applying a reflective function to supervision with the intention of enabling participants to explore the emotional impact of their practice, which in turn has benefits to the service received by families (Reeves et al., 2015). Although many of the reviewed studies had small sample sizes, the emergence of supervision as a core support strategy to specialist nurses in safeguarding was apparent across studies.

Collegial support was a further aspect considered essential to effective practice. This complex and stressful practice setting is fundamentally emotionally demanding, which necessitates a response on an individual level to offer emotional support. Colleagues can be a valued source of support to absorb the emotional impact of working with vulnerable families (Rooke, 2015). Locating nurses within a supportive peer work environment can allow opportunities such as debriefing and simple casework advice through to coaching with complex cases and the practical demonstration of clinical skills, such as challenges faced by families and peers, and each of these opportunities contribute to effective safeguarding practice (Rooke, 2015).

2.7.3 Education and training

Education and training in child maltreatment prevention featured as both a subject of study and recommendation for future investment in the workforce (Akehurst,
More specific training strategies were featured in recent studies, such as that by Barrett et al. (2017) who recommended the use of case studies as learning tools. Some understanding about nursing practice in the United States in relation to child maltreatment was offered by Hornor and Herendeen (2014) through the development of ‘The Nurse Practitioner Survey’. Although the sample size was considerable (n = 136) and the response rate of 42% moderate, only simple descriptors of the different aspects of nurse practitioner practice, such as clinical settings, were included in the survey and it had little detail pertaining to the complexity and scope of clinical tasks executed in responding to child maltreatment.

Participants reported delivering clinical care across all abuse types, although differences were noted depending on the clinical care setting. For example, outpatient-based care saw encounters most frequently with children who were subjected to sexual and physical abuse. The study further highlighted that the role of nurses in the sample extended beyond clinical care to incorporate conducting research and education. Although education and training commonly feature as recommended practices from empirical evidence, the limited descriptors of practice beyond reporting suspected abuse highlight the ongoing gap in knowledge about the exact practice that occurs in the context of responding to child maltreatment.

Training has evolved from in-person to online training. Bressem et al. (2017) designed a study on the ‘Early Preventive Intervention and Child Protection’ program, an online training program developed in Germany. This program was designed for social and health care professionals working to prevent child maltreatment and offers a sophisticated package of learning topics. The study sample included a large cohort of participants (n = 1,294), who had an average of 11 years of practice experience, from a
range of professionals from child, family and health care services, one of which is nursing. The course content and delivery strategies highlight innovation and a promising model for future education.

The online training package contained visual recordings of child–parent dyads, which participants are required to observe for the purpose of interpretation of child behaviour and the corresponding response of the parent. This level of sophistication in training is relatively new to the field. The course design and content were intended to assist in imparting the knowledge to participants to inform future assessment practices. The second innovation of this program was the use of technology to access the content. One advantage of this platform was unrestricted access, compared with other traditional face-to-face modes of education in which participant numbers for enrolment are capped. Another benefit was the self-directed learning style, which can overcome a diverse range of barriers and inhibitors for participants that may prevent training completion.

Further, access to free training was also a potentially valuable element for the success of this training. The program also featured an online community of practice for participants to communicate about the course, reinforcing the findings of other studies included in this review that stress the value of collegial support. Although a final report is yet to be published (Bressem et al., 2017), preliminary findings from the pre-training questionnaire flag some thought-provoking considerations. Pre-training knowledge results indicated 24 knowledge items. The items include defining core concepts, such as intuitive competencies of parents and preventative intervention delivered by services, true or false statements about legal provisions to respond to alleged abuse, identification of maltreatment and a range of items centred on the influence of parenting styles on attachment.
On average, participants answered 14 questions correctly. Diversity in professions completing the questionnaire may offer some insights into the widely varied skill and knowledge sets possessed by the many professions working in child maltreatment prevention. Questionnaire items related to the child–parent dyad were reportedly steady across professions, with just over half (56%) of the participants correctly identifying the subtlest infant cues based on observing images of infants and categorising signs of communication (e.g. sign of avoidance, of approach or of self-regulation). A significant correlation was found between years of experience and knowledge, which supports the hypothesis that experience supports knowledge.

Assessments of maternal responsiveness suggested a more concerning finding, given a mean of less than one in four responses being correct. Although well placed to respond to families with children at risk of maltreatment, the fact that professionals do not possess sound knowledge about topics such as the correlation between maternal behaviour and infant attachment suggests there is a clear opportunity to enhance the knowledge base of child, family and health care professionals, such as those participating in the study. There was prevailing uncertainty about assessment skills possessed by some participants, which the authors suggested may indicate that other influencers also need consideration rather than a pure focus on skill acquisition. In summary, preliminary evaluations of the program were favourable and present promising opportunities to strengthen specific elements of practice in child maltreatment prevention through the development and delivery of training and education programs.

In another recent study set in New Zealand, Saltmarsh and Wilson (2017) found that participants lacked adequate training and education, both of general knowledge and additional specialist training relevant to the clinical context. The role of training was
credited by the authors as being a foundation to confidence and capability in safeguarding children. This finding is in contrast with the findings of Barrett et al. (2017), who reported that some professionals never felt prepared to respond to child maltreatment regardless of training. Foster et al. (2017), in a moderately scaled study, recruited a cohort of health care professionals (n = 114) from a major hospital in the United States to complete a survey to determine different facets of child protection practices. The survey was an adapted version of the Teacher Reporting Attitudes Scale developed by Walsh, Rassafiani, Mathews, Farrell and Butler (2010). Nurse practitioners comprised 17% of the participants. Although the study scope primarily focused on the attitudes of health care professionals towards child maltreatment in relation to their mandatory reporting roles, the study examined other practice considerations that satisfied the inclusion criteria applied to this literature review.

The study found that the majority of participants screened for child maltreatment either during the initial contact with families or where clinically indicated. Half the participants reported high levels of comfort both in assessing risk through direct questions posed to families and subsequently discussing any emerging risks. Less than half the participants reported feeling prepared to perform these practices because of training, suggesting training had not adequately prepared the majority of participants. Signposting families for additional support was a common practice response for 80% of participants in case abuse or maltreatment had occurred, although this was a far less frequent response for families where risk factors (43%) or historic abuse had been reported (40%). Less than half of the sample reported high levels of knowledge about community support options suitable for families. The study also found participants were moderately confident of the ability of the child protection agency’s efficiency in responding to reports. Participants further identified a desire for additional training, in
particular, to assist with discussing concerns with families. Training was found to enhance the commitment and comfort in the practices associated with risk identification and response although no explicit references were made to course content, and hence, it is difficult to draw strong conclusions on the training efficacy.

2.8 Systemic Drivers of Nursing Practice

In addition to the literature reviewed thus far, the following concepts have been outlined, which offer greater context relevant to the studies presented in this thesis. As previously presented (see Sections 2.7.3 and 2.11.3), education and training are critical aspects that prepare nursing practice. The need for advanced knowledge and skills in addition to supervision and support to undertake the work required to respond to CAN has been asserted (Drea et al., 2014). Training must be meaningful to assist practice development and can be a strategy to enhance worker confidence (Raman et al., 2011).

There is a growing argument that training needs are specific and require a bespoke response to address specific knowledge deficits, such as identifying specific types of abuse, for example, neglect (Fraser et al, 2010; Feng & Levine, 2005) or nuanced practice responses to escalating vulnerabilities or risks (Wallbank et al, 2013).

Alternatively, there is an argument that these challenges are inherent to the work of risk identification and response (Briggs et al., 2010; Condiffe, 2008). Undoubtedly, once knowledge is gained through training it must be reinforced to optimise practice (Lazenbatt, 2010).

Several drivers that influence nursing practice underpin tertiary education and workplace training. Competencies for Child Health Nurses, Standards of Practice, Child and Family Health Nursing Professional Practice Framework and the National Standards of Practice for Maternal and Child and Family Health Nurses were featured
as examples of such drivers. Each of these drivers are outlined in the following section. All references were appraised against the practice principle of responding to CAN.

2.8.1 Competencies for Child Health Nurses

The ACPCHN released a document in 2006 outlining the competencies for specialist Paediatric and Child Health Nurses, which sought to assist with optimising the role of nurses in the health care industry. These detailed set of competencies addressed five domains of practice, although reference to child protection is limited to compliance with mandatory reporting obligations. This gap highlights an incompatibility (or lag) between actions that the service system requires of nurses and actions that the professional entities advocate. Subtle inferences that could apply to child protection practice could be argued against statements such as ‘assesses, communicates and documents the family’s response to the care of their child and refers as appropriate’ (ACPCHN, 2006, p. 17).

Domain two specifically addresses education, although despite the research evidence (which is domain five) that emphasised the importance of education and training on the practice response of nurses where CAN is suspected, the competencies missed the opportunity to advocate that nurses should access education on this topic. An evaluation of the competencies found that these were not well known in the practice arena, and nor was there evidence of effective application (Hutton, 2009). Although the competencies have not been positively evaluated in terms of traction within the workforce, a valuable consideration is extended to the lacklustre approach towards CAN as a practice responsibility of nurses.

2.8.2 Standards of Practice

More recently, the revised Confederation released Standards of Practice under the ACCYPN (2016), which provide a more detailed descriptor of practices associated
with CAN. The *Standards* suggest there is increased synergy between the evidence base and professional nursing bodies, such as the college, that advocate nurses take on practices that not only fulfil mandatory reporting, but also ‘recognises and acts on situations that compromise the safety of children and young people’ (ACCYPN, 2016, p. 7). Shifting the realm of nursing practice beyond the task of mandatory reporting is a closer alignment with the evidence base.

**2.8.3 Child and Family Health Nursing Professional Practice Framework 2011–2016**

The current study was conducted in the Australian state of NSW, and therefore, the Child and Family Health Nursing Professional Practice Framework (NSW Health, 2011) is considered a driver of the nursing practice of the participants in the current study. The framework builds on the policy foundation of the ‘Families First’ strategy, which continues to be another significant influencer on programs delivered by NSW Health. Fundamentally, this framework is built on the relationship that exists between nurses and the families in receipt of the service (see Chapter 1, Section 1.5.2 Family Partnership Model). Child safety is a paramount concern in the framework, and it by far offers the greatest detail and emphasis on the practices of nurses in relation to child protection and wellbeing.

Examples of the core elements of practice outlined in the framework include early intervention and collaborative, multidisciplinary care that is coordinated and efficient in delivery. There are three areas of practice, one of which is focused on family assessment and surveillance for emotional health and wellbeing. This practice area explicitly outlines knowledge requirements for risk prevention and early intervention, such as ‘identifying and responding to risk of harm of infant/child’ (NSW Health 2011, p. 14). This framework was designed to support workforce development of the CFHNs,
and its strong emphasis on the child protection aspects of nursing practice is arguably one of the key drivers of optimum practice.

The capability of CFHNs to balance the service delivery requirements (e.g. assessing for vulnerabilities), against the principles of partnership and feeling ethically compelled to continue service delivery with the intention of monitoring families (more specifically, the children at risk of harm) is a complex practice context that requires a greater understanding. CFHNs find the tasks at hand difficult (Fowler, Rossiter, Bigsby, Hopwood, Lee & Dunston, 2012). The expectation is that nurses possess the advanced skills required to navigate a sensitive discussion with families about parental behaviour and its impact on children. The current study has examined this notion from the perspective of the nursing workforce deployed into the homes of families, and thus effectively charged with the responsibility of preventing CAN.

2.8.4 National Standards of Practice for Maternal and Child and Family Health Nurses

The national apex body for nurses working in maternal, child and family health is Maternal, Child and Family Health Nurses Australia. It released The National Standards of Practice for Maternal, Child and Family Health Nurses (Grant, Mitchell, & Cuthbertson, 2017). Interspersed throughout the Standards are practices that specifically address the assessment of risk and subsequent responses that move beyond the traditional practice response of mandatory reporting. For example, Standard Six articulates an example of the practice required to fulfil the objective of safe, appropriate and responsive care as ‘addresses identified unsafe situations or situations that place the child at risk of harm or neglect and enacts appropriate interventions, including mandatory reporting’ (Grant et al., 2017, p. 16). This is a primary exemplar that
demonstrates the evolution of nursing practice in the context of working with families where CAN is suspected.

Over time, the professional organisations have shifted the emphasis of aspects of nursing practice that fulfil the premise that nurses are well placed to identify and respond to CAN to align with the evidence base. This section has provided examples of several potential drivers of practice, presented chronologically to highlight the shift that has occurred over time. The current study considers this shift was foundational to the current practice described throughout this thesis.

In Australia, *the Child Protection and Nursing and Midwifery Education Curriculum Standards* (Briggs et al., 2010) outlines standards intended to prepare nurses and midwives with the knowledge and skills required to prevent maltreatment and enhance wellbeing in children. In comparison to other drivers of practice, the Standards built on the premise that nursing practice is far greater than mandatory reporting and is a call to action for nurses that although they may understand not all children have a risk of CAN, they must be willing to act when required, and be willing to recognise families with vulnerabilities and to subsequently provide a practice response through intervention.

### 2.9 Study Aim

Based on a review of the literature, the study aim was set to explore the practices of CFHNs when working with families with CAN vulnerabilities. More specifically, the study aimed to detail practice responses from nurses working from a UHHV service and to show the way in which practice is adapted when families disengage from the service. Drivers of practice were examined, such as self-reported confidence, organisational
policy, tertiary education and workplace training, to determine how these each influence practice.

2.10 Study Objectives

This mixed methods study was framed by the overarching question: “What actions are used by nurses to continually support families through the process of considering, suspecting, and reporting child maltreatment?” The following research questions in Table 2.3 were applied to phase one.

Table 2.3

Phase One Research Questions

<table>
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<th>Quantitative Research Questions: Phase One</th>
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<tr>
<td>Quantitative RQ1. How knowledgeable are CFHNS in relation to their mandatory CAN reporting responsibilities?</td>
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<tr>
<td>Quantitative RQ2. What are the practice responses of CFHNS when managing families with complex service needs?</td>
</tr>
<tr>
<td>Quantitative RQ3. How do CFHNS engage and respond to families with complex service needs?</td>
</tr>
<tr>
<td>Quantitative RQ4. What is the role of education and training in preparing CFHNS for complex care offered to vulnerable families?</td>
</tr>
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Following the sequential exploratory research design used in the study, the research questions for phase two were determined following preliminary analysis of survey results and are therefore are presented later in this thesis (see Chapter 5).

2.11 Significance of the Study

Responding to families with multiple and complex service needs requires advanced skills, knowledge and confidence. Anecdotally, practice uncertainty permeates discussions with CFHNS when exploring the ways to best respond to such families. The nascent literature base relevant to this uncertainty lacks the details required to affirm and develop the practices of professionals assigned responsibility to prevent CAN. One of the prevailing circumstances generating much uncertainty is the
cohort of families lost to follow-up because efforts to engage them in service delivery fall short of retention in service delivery. Whether unwilling or unable, these families can become invisible to the human service system, and opportunities to prevent statutory child protection agency involvement are limited. This study design was built on this as a foundation, but it more broadly examined drivers of CFHN practice when responding to families with CAN vulnerabilities.

2.12 Update of the Literature Review (2017 to 2019)

The initial literature review completed during the study design was revised and repeated in May 2017, and the results of the review have already been presented in this chapter. A final literature review was conducted in May 2019 in preparation for the conclusion of this study. The search strategies previously detailed (see Section 2.3, Table 2.1) were applied, but the date range was limited to 2017–2019. The search found 376 references of which 45 were screened as eligible for full review. To supplement the existing literature review, a further 23 empirical studies were analysed and are presented in the following sections. Analyses are presented under the themes of provider factors related to nursing practice, including the specific clinical task of identification, and program characteristics related to management structure and supervision and, lastly, to workplace training.

2.13 Provider Factors

2.13.1 Nurse intervention

An argument that has emerged from empirical literature is that nursing practice extends beyond the legal responsibilities of mandatory reporting. This was the foundational stance taken by a study of nursing practice set in Canada conducted by Einboden, Rudge and Varcoe (2019). A critical discourse analysis of text, which included guidelines, legislation and text transcribed from interviews with registered
nurses (n = 21), highlighted that practice responses are nuanced and extend far beyond the action of making a child protection report. The study examined nursing practice more broadly and considered issues such as context, for example, that suspected abuse or neglect was likely to occur in a relational context with families. It is within this context that some participants expressed feeling conflicted about reporting and considered this as only one possible response to child protection concerns.

Further, some participants perceived concern about child safety was often symptomatic of an underlying issue that required attention, and that within the context of a formed long-term working relationship, a nurse can be well positioned to work with the family to address such underlying problems rather than responding to the problem of abuse that is considered the focus of child protection services (Einboden et al., 2019). Although nurses often worked closely with families and formed relationships based on trust, the authors deduce that nurses are often overlooked as being experts in child protection and often seek the counsel of other professions, such as social workers, who receive specialised training. An unintended consequence of a service system that encourages one discipline to consult another may well undermine the possibility of nurses asserting expertise in child protection.

There is a gap in knowledge about the scope of nursing practice expected when faced with child maltreatment. Hornor et al.’s (2017) study is important for its explicit illustration of the practices of paediatric nurse practitioners. A risk assessment survey was developed for the study, which included 23 items that specifically outlined practices, such as direct questioning of children as well as parents about risk factors. For example, participants rated the frequency at which they would ask a child about discipline from their parent or educate a child about private parts on the body. This was followed by a question about any occurrences of the child being touched on their private
parts. Participants were also surveyed about parental risk factors that were highlighted in other empirical studies, such as the Adverse Childhood Events (ACE) study. The ACE study found that exposure to violence and abuse during childhood may lead to drug and alcohol use and mental health concerns in adulthood. Surveys that detail specific practice considerations and demonstrate evidence-based practice, such as the study by Hornor et al., make significant contributions to the evidence base about the range of complex clinical tasks required to both assess and respond to child maltreatment. Hornor et al. found that many participants were not adequately screening for child maltreatment. The study and the tool developed for data collection both make considerable inroads to articulating nurse interventions required to conduct a quality comprehensive assessment with families.

Several published literature reviews were included in this updated review, which are each briefly summarised to capture key advancements in the field. Most recently, Harding, Davison-Fischer, Bekaert and Appleton (2019) published an integrative review. The review centred on the role of school nurses and the prevention of child maltreatment in children and young people. Analyses of 21 studies found examples of distinct practices, which included direct support and reporting to child protection services, and indirect practices, such as monitoring and interagency communication. Many themes were similar, and in some cases the same, to the practice context of CFHNs working with families that have children under five years as opposed to school-aged children. These themes related to identification and assessment of suspected child maltreatment, interagency collaboration, training and supervision and barriers to prevention of child maltreatment. Trust was presented as a separate theme and presents as a valuable offering relevant to the current study. Harding et al. (2019) reported that trust was the focal point of almost half of the studies reviewed. Influencing factors on
trust relevant to the school nurse role included accessibility for students to seek out the nurses, transparency about confidentiality limitations, confidence and competency of the nurses and their demonstrated investment in engagement. Reporting suspicions of child abuse to a child protection service was highlighted by several studies as a threat to trust between the nurse and client, but this concern was always attributed to the perspective of the nurse rather than explored from the client perspective. Arguably, each of these elements could apply to a range of nurse roles, including that of the CFHN.

Wilkinson (2019) wrote a commentary on the integrative review by Harding and colleagues (2019). The commentary recommended an interagency approach to education and training to overcome the barriers in practice for school nurses when agencies endeavour to work together to support families at risk.

The collaboration between Lines, Grant and Hutton has culminated in both an integrative and a scoping review, which were published in 2016 and 2018 respectively. The scoping review found that keeping children safe was a key focus for nurses (Lines et al., 2018). The comprehensive review made a welcome contribution to the topic by examining literature that addresses the preventative aspects of nursing practice in the context of postnatal home visiting. A point of difference from the literature included in the review outlined in this thesis chapter is that Lines et al. included studies that addressed the outcomes for families in receipt of the nursing intervention. Therefore, the literature they reviewed includes a broader base of clinical settings for nursing, such as the SHHV literature.

Practices delivered with an objective of prevention included educating families about risks, and intervention was associated with tasks such as assessment, developmental screening, role modelling and signposting; education was also applied
during the intervention phase (Lines et al., 2018). Studies that reported intervention following abuse tended to refine practice responses to a more holistic response to the family and the complex effects associated with abuse. The scoping review identified a study set in Japan by Kobayashi, Fukushima, Kitaoka, Shimizu and Shimanouchi (2015), which reported that intervention delivered by public health nurses after occurrence of abuse specifically attended to the tasks of assessment of the family’s needs as well as resources, established a relationship of trust and played a role in managing the risk factors that had contributed to the abuse. Lines et al. (2018) argued that the relationship formed between nurses and families is in itself a dimension of nursing intervention, albeit one that is difficult to quantify. In summary, the scoping review supported the findings of the literature reviewed within this thesis, which argues that the practices required by nurses to both identify and respond to abuse and neglect are nuanced.

Families with complex service needs require a complex practice response. However, the literature that explicitly details what these practices are continues to have gaps. A recent qualitative study conducted with primary health care nurses in Sweden found that the practices of nurses were emotionally influenced, both for the parent suspected to have abused or neglected who may feel humiliated by the suspicion and the nurse themselves who may feel threatened or fearful about the possible response of anger from parents (Dahlbo, Jakobsson, & Lundqvist, 2017). A pervasive sense of uncertainty was expressed by some participants, and the uncertainty was felt about the possibility of abuse. At times, this may lead to nurses thinking about families beyond business hours. Honest communication was an essential practice for nurses in this study, which enabled the development of a trusting working relationship between nurse and family. Despite being fearful of an angry response from a parent, few participants had
encountered such a response, which was attributed to open and honest communication. Consultation with colleagues was also found to be an element of practice in the study. Consultation, as well as feedback following a child protection report and access to supervision, were all considered essential for nursing practice when working with families where abuse is suspected. Despite the small sample size (n = 8) of the Swedish study, the themes generated from analysis are echoed across several other studies highlighted in this review.

Advancements to the application of the Finnish National Nursing Guideline for Identifying and Intervening in Child Maltreatment (see Section 2.6.2 Assessment, for initial details about the Guideline) were examined in a study that compared two cohorts of nurses, one based in Finland where the guidelines were developed, and the other a cohort of public health nurses in Japan (Suzuki et al, 2017). Of interest to this literature review, a range of nurse interventions were described and evaluated in the study through survey of skill and knowledge. Participants were initially asked general practice questions related to topics such as child development and parenting practices, for example, in response to a child who displayed challenging behaviour. Next, participants were surveyed about practices specific to suspected child maltreatment. Examples of practices included initiating direct conversations about suspicion of abuse, responding through support to child and parent (as separate items), alongside the indirect tasks of making a child protection report and maintaining accurate documentation. Other items in the survey addressed collaborative practice and consultation with peers or managers. Although the Guideline appeared to lack traction in Japan, the emphasis on nurse intervention specific to suspected child maltreatment suggests that some practice conventions are associated with nurses who specialise in working with families with young children, irrespective of the practice jurisdiction.
2.13.2 Identification of child abuse and neglect

The use of validated instruments to screen for the identification of child abuse was another theme from the updated literature review. In a small-scale study conducted by Carson (2018) in the United States, an instrument used to screen for child maltreatment was tested in a paediatric emergency department by a cohort of 14 participants. Escape was the validated instrument tested in this study. Participants initially received a 20-minute education session about physical abuse of children and instructions on the use of Escape. The second phase of the study saw participants apply the screening instrument. Although the education component led to a significant increase in knowledge and confidence, the study failed to link improvements to the actual identification of abuse. Further, the study was small in scale, but the absence of improvements to direct clinical practice suggest that the use of instruments in the identification of child abuse require further research attention.

A second instrument used to identify child maltreatment was located from the updated literature review. The Child Abuse Potential Inventory is a validated tool used with families by professionals, and this formed the basis of a study conducted in Finland by Lepistö, Ellonen, Helminen and Paavilainen (2016). The study was a follow-up case control study that primarily focused on families accessing universal maternal care; however, the authors proposed key findings that bear great relevance to nursing practice. The professionals involved with this study were public health nurses, equivalent to the CFHNs in the Australian state of NSW. Lepistö et al. recommended the use of the Child Abuse Potential Inventory to assist nurses in systematically assessing the risk of CAN. The inventory is detailed and enables a health professional to examine a range of factors that may contribute to child maltreatment. A strong finding
from this study is that unpacking the complexity of a family by using a tool as a guide is a reliable means of identifying risk.

Lepistö et al. (2016) deduce that the practice of identification must also be accompanied by an understanding of the context for each family, rather than simply marking off risk factors. Flexible practice responses are required to meet the unique needs of each family, and the primary method of achieving this objective is through conversations about risk in the context of family circumstances. The authors explained that the use of validated tools is one aspect of this practice and that when coupled with ongoing discussions with families about the changes the families experienced, both are critical in responding to the actual needs and preventing maltreatment. Moreover, the use of a screening tool need not be limited to the identification of risk factors but is considered a starting point for ongoing assessment and response provided to families.

2.14 Program Characteristics

2.14.1 Management structure

A study set in Ireland that Austin and Holt (2017) conducted found that a sample of senior managers of public health nurses, Social Work managers and managers from the non-government sector collectively agreed that the work of frontline professions, such as nurses and social workers, was stressful and that workers are at risk of vicarious trauma. The study highlighted the vitality of access to supports to process such trauma, for example, through supervision and collegial support. Further, it argued for designated safeguarding senior managers in recognition of the specialist and challenging work required of disciplines, such as nurses, who in turn require their own specialised support when delivering service to vulnerable families.
2.14.2 Clinical supervision

Supervision has continued to be a fundamental requirement for nurses working with vulnerable families. Smikle (2017) focused specifically on supervision designed to address safeguarding and child protection for nurses in the health care sector. Fundamentally, supervision was considered vital to quality service provision and allows a designated time and opportunity for nurses to critically reflect and discuss families with multiple and complex needs. Smikle argued that whereas training is an opportunity for knowledge acquisition, supervision provides an opportunity for such knowledge to be applied and integrated into a practice setting. Smikle presented the findings of a safeguarding supervision training program delivered over five days in London. Participants reported an increase in confidence and identified further benefits in relation to practice improvements, whereby nurses were able to be reoriented to child-centred practice and engagement of families was also central to supervisory discussions. Conversely, Smikle also found barriers that challenge the implementation of safeguarding supervision, which reflects the complexities of supervision itself. For example, participants articulated the emotional undercurrents that arise in supervision, such as supervisees expressing a fear response or underlying attitudes and beliefs that conflict with the role of the nurse. Despite the barriers that may interfere with organisations implementing supervision that is intentionally focused on safeguarding, Smikle reasserts that supervision is a non-negotiable requirement for effective safeguarding practice.

2.14.3 Education and training

Nursing educational programs within tertiary education and workplace training have evolved over time and notable advancements were highlighted in this final literature review. An emerging area of development in education and training was found
in the literature by way of including findings from the ACE study within programs. Several studies reviewed in this iteration of the literature review found that the ACE study has been integrated into the nursing curriculum in tertiary settings in the United States (Gill, Zhan, Rosenberg, & Brekenridge, 2019) and workplace training (Bachmann & Bachmann, 2018). Other studies utilised multiple methods of access to training to meet the needs of frontline health professionals in emergency departments to improve the practices of recognition and response (see Flemington & Fraser, 2017). Moreover, other studies have reiterated the experience of some nursing workforces, such as paediatric nurses, which continue to report a lack of education to prepare for working with child maltreatment (Lavigne, Portwood, Warren-Findlow, & Hubbard, 2017).

Sonney, Willgerodt, Lindhorst and Brock (2018) evaluated the use of a range of training materials for health professionals in an interprofessional context. The training program revolved around a complex case study specifically designed to elicit the identification and response to child maltreatment, as well multidisciplinary collaboration to respond to complex presentations of child maltreatment. At the conclusion of the two-hour training session, participants reported enhanced understanding about the roles and responsibilities of their counterpart disciplines and improved confidence in assessing and responding to complex presentations. A more discrete learning opportunity was also highlighted in the study with participants discussing in depth a range of practice response options, including the possibility of discussing concerns and intention of reporting to child protection services with the family, and ways of retaining the family in service delivery.

Interprofessional collaboration was also a key theme in a two-phase study of school nurses that Jordan, MacKay and Woods (2017) conducted. Phase one featured an
evidence-based training program delivered in person with a pre- and post-evaluation questionnaire on knowledge and skill completed by participating school nurses (N = 174). Phase two used focus groups to explore practice nuances associated with working with children who have been maltreated, with a particular emphasis on interprofessional collaboration. Significant improvements in confidence and knowledge were reported by participants following attendance at the training program. Interagency collaboration and communication emerged as a dominant finding from focus group discussions, with particular emphasis placed on the collective efforts of both the school nursing workforce and child protection services. Well-functioning interprofessional relationships are an important aspect of identifying and responding to child maltreatment; thus, opportunities to strengthen these relationships are possible through a shared learning environment, as highlighted by Sonney et al. (2018), or through learning opportunities that address working effectively in collaboration with other services, as found by Jordan et al. (2017).

Bachmann and Bachmann (2018) included a study of ACE in workplace training to improve the identification of maltreatment and risk factors associated with abuse and the subsequent likelihood of making a child protection report (Bachmann & Bachmann, 2018). Training that was informed by the ACE study was found to be a strong predictor of child protection reports of suspected abuse. Gill et al. (2019) developed a conceptual framework that advanced the argument for integrating ACE findings into the nursing curriculum. The framework proposed that five aspects were required to fulfil the integration, which ranged from promoting awareness of ACE among health professionals to specific concepts relevant to interventions with families, for example, toxic stress reduction and resilience promotion. Systemic concepts also featured in the framework, and recommendations included ACE-informed policy and service delivery
grounded in trauma-informed care whereby services recognise the impact of trauma and embed this knowledge in service delivery and practice.

In addition, Gill et al. (2019) argue that the simple inclusion of ACE into the curriculum falls short of reaching the full potential that can be achieved with a systematic integration, which can fundamentally advance existing nursing practice. The advancement of nurse education and training has great potential to enhance existing programs to prepare nurses for practice and to further develop their skills in the workplace to more effectively meet the multiple and complex needs of parents who have experienced adverse events during childhood.

Flemington and Fraser (2017) conducted a prospective cohort study of health professionals, including nurses, practicing in emergency departments of a tertiary paediatric hospital in Vietnam. The study considered the influence of a workplace training program on knowledge, attitudes and practice and, in particular, on reporting child maltreatment. The program utilised a combination of modes to deliver the training, including a two-day workshop, in-service training and a Safe Children Vietnam workbook for participants to use that supplemented the training. The study found that participants improved their ability to identify child maltreatment and reported an attitudinal shift that acknowledged the seriousness of maltreatment on having engaged with the training program. Other findings indicated that reporting practices remained stable; however, this result was attributed to other systemic drivers.

Evaluating the efficacy of training for health professionals was the subject of a study based in Japan that Tanoue et al. (2017) conducted. The study analysed a pre- and post-training questionnaire completed by a cohort of health professionals, including nurses as one-third of the participants. The mode of training was a 45-minute lecture. The study found that a combination of training and practice experience that involved
encounters with child maltreatment, rather than simply years of practice, is the most effective combined strategy to improve the skills and knowledge required to prevent, identify and respond to child maltreatment.

Visscher and van Stel (2017), in a study set in the Netherlands, used a mixed methods study design to examine the practice variations in child maltreatment prevention practices between nurses (n = 772) and doctors (n = 332). A cross-sectional survey outlined five topics that ranged from communication skills, expertise in identification of risk factors and indicators of child maltreatment, collaboration, prevention of abuse and neglect and, lastly, opportunities for improvement.

Communication was rated as the greatest area of reported competence for nurses, followed by expertise.

However, communication in relation to confidence to discuss child maltreatment with families was one of the lowest-scored topics, as was working with uncooperative families. Among the findings were some insightful results that address the element of fear expressed by professionals. In fact, almost all participants confirmed feeling fearful, most often of damaging the working relationship with the family, making an incorrect assessment or an aggressive response from parents. Overall, Visscher and van Stel (2017) found that the scores for practice indicated in this study are inadequate if optimum practice in this arena is to be achieved.

The inclusion of CAN within the nursing curriculum was found by Tweedlie and Vincent (2019) to be an opportunity for transformational learning. Participants (n = 9) on clinical placement where nurses worked with families in a community setting were found to experience emotional responses, such as shock and feeling upset regarding the occurrence of maltreatment to infants. Other participants felt afraid for their own personal safety when conducting home visits. Of greatest concern to Tweedlie and
Vincent were reports of anger from participants, as was the use of language that was judgemental, rather than empathetic, towards families.

The study highlighted that exposure to child maltreatment through a lecture format alone does not enable students to process their own thoughts and feelings about responding to abuse and neglect; therefore, being able to learn in a way that facilitates critical reflection can enable transformational learning. Critical reflection was used throughout coursework to promote ongoing opportunities for nurses to process their own personal responses to critical incidents, such as suspecting child maltreatment. For some nurses in training, there may have been no prior consideration that children are maltreated. Therefore, the study recommended that critical reflection can allow individuals to challenge their existing world view and assumptions and broaden their thinking to consider not only the possibility of child maltreatment but also the manner in which they, in turn, will respond to such a possibility.

Further, Tweedlie and Vincent (2019) advocated that safeguarding training be delivered with, and by, those from other disciplines, such as Social Workers, to facilitate in broadening learning to consider maltreatment from a range of perspectives. Qualifying nurses must also have an opportunity to process their own emotional response to child maltreatment through critical reflection and debriefing so that practice is sensitive and empathetic. The nurses must have an awareness of personal views and a resolve to avoid strong emotional responses, such as anger, which need to be managed to avoid practices being underpinned by negative influences that, in turn, are projected onto families.

A systematic review on interventions specifically delivered to children and families exposed to domestic violence highlighted uncertainty among health professionals in relation to both practice and their role (Turner et al., 2017). The review
analysed 18 studies that primarily focused on practitioners as participants, most of which were conducted in paediatric settings in the United States. The review included interventions delivered to individuals, as service providers, and systemic interventions. Overall, individual interventions related to training, which led to improved knowledge and competence for up to one year, but further strategies are recommended to achieve sustained knowledge retention and, ultimately, improved practice competence. The review advocated strategies such as the use of combined learning modes, experience-based opportunities and discussions to apply knowledge in a practice setting. Updates following training to boost knowledge retention, as well as access to specialised local support services and protocols that guide practice interventions, were all considered valid strategies.

2.15 Additional Literature from Other Sources

Further to the updated literature review, another key development in the field prompted a review of additional literature. A doctoral thesis by Einboden (2017) has reinforced the premise that nurses are well positioned by further extrapolating that such positioning requires increased autonomy when responding to CAN. The thesis was contextualised in Canada, and it argued that where nursing positions have been depleted, despite the evidence that supports the preventative abilities of nursing intervention, resource redistribution to enhance nurses’ presence in the community health sector was vital in actualising the full potential of nurses in child protection.

Einboden (2017) argued that systems calibrated towards investigations and substantiations fail to consider the continuum of CAN. Einboden extended an acknowledgement to the system reform in NSW (detailed in this thesis; see Chapter: Introduction, Section 1.2 Background), which has recalibrated the human services sector towards an interagency response to child abuse prevention. Despite this,
indications from evaluations conducted in early years of this reform highlight the
evidence base that counters the argument for interagency collaboration and highlights
the pitfalls of working together (Valentine & Hilferty, 2012). The emphasis on nursing
practice in Canada, when considered with the other literature published in recent years,
indicates a growing momentum on the critical role of nursing practice in the prevention
and intervention CAN.

2.16 Summary of Literature Review

The literature reviewed has bought to attention several key themes, which have
been addressed throughout this chapter. The overarching theme of provider factors
highlighted a subset of topics that included identification, assessment, responding to
child maltreatment, monitoring families and competency. Program characteristics
related to policy, clinical supervision and education and training. The final literature
review conducted involved the synthesis of a further 23 studies, which lead to two
additional themes of nursing intervention and a recommendation for management
structure within programs factors. Further, a doctoral thesis was reviewed, which
reinforced the nuances of nursing practice based on a study set in Canada.

Although some themes have received much research attention, such as
assessment, certain other themes are yet to benefit from such attention, for example, the
ongoing work with families, which is referred to as monitoring. Each theme has yielded
some evidence taken from the international literature, even though often considered
within a limited scope. Meanwhile, the practice reality for nurses commands an
integration of each of these themes simultaneously. It stands to reason that an
exploration of the multiple facets of nursing practice is needed to gain insight into the
nursing practice that occurs in the context of responding to child maltreatment. Other
drivers can influence nursing practice, in addition to the empirical evidence base. The
following section turns to consider the grey literature on systemic drivers of nursing practice.

2.17 The Current Study

The literature reviewed and presented thus far has made it apparent that the practices of nurses in fulfilling a safeguarding or child abuse prevention function are multifaceted. Some practice themes have been the subject of many studies, whereas other themes have been relatively unexamined. The analysis of published literature has highlighted a gap in knowledge about the extent of these practice complexities since no single study has adequately explored the range of practices required to formulate a preventative response. The literature shows there are many influences on practice, such as knowledge and confidence as well as the role of education and training. With this in mind, the following study design has integrated themes from the literature reviewed to explore the intricacies of practices deployed by the nursing speciality of CFHNs in the practice setting of UHHV.

The profession of the CFHN has experienced many significant changes in the 10 years prior to the commencement of the current study. These changes ranged from the reorientation away from an expert model to one of partnership to significant changes to systems and practice associated with the implementation of Supporting Families Early (Safe Start Guidelines) and the Keep Them Safe Reform (see Section 1.2). Broader preparation for practice through tertiary education and workplace training also reflects dispersed content with and the lack of adoption of regulation or standards to create a sense of cohesion across Australia.

2.18 Chapter Summary

This chapter detailed the literature and practice background for nurse intervention in CAN. The review used a contemporary timeframe because the current
study aims to make a significant contribution to the empirical evidence on contemporary nursing practice related to child maltreatment. Despite the fundamental challenges associated with conducting a literature review on the broad and complex topic of identification and response to child maltreatment from the nursing profession, this chapter presented the themes that emerged from a review of 26 studies from the initial literature review that was supplemented by a further 23 references from the updated literature search. Studies were presented using the relevant themes of (a) identification, (b) assessment, (c) responding to child maltreatment, (d) monitoring families, (e) competency, (f) policy, (g) clinical supervision and (h) education and training. The updated review extended these themes to include studies that addressed nurse intervention and an example of a program characteristic related to a management structure of a designated safeguarding lead role within the nurse workforce. Other pre-existent themes were supplemented with updated literature related to identification, clinical supervision and education and training, which continued to feature in the literature. The focus of the review broadened in acknowledgement that other potential drivers of practice should be viewed as background to the current study. The influence of nursing organisations, such as Maternal, Child and Family Health Nurses Australia, and health organisations, such as NSW Health, is clear; both are direct drivers of practice and thus required inclusion in the literature review.

All themes identified from an analysis of empirical evidence have been infused into this study. The following chapter will address the study methodology used.
Chapter 3: Methodology

3.1 Chapter Introduction

This chapter details the pragmatic approach and the theoretical framework of engagement that were used to inform the study. A description of the process used to engage the support of service managers and nurses as stakeholders during the scoping phase is described, along with personal reflections about the relationship between researcher and participants. The study is contextualised in a practice setting of two metropolitan public health organisations in the Australian state of NSW. The chapter also presents the study methodology.

3.2 Pragmatism

Pragmatism has been influential in making an intentional difference to practice (Goldkuhl, 2012). A pragmatic lens was used in the current study. Goldkuhl (2012) argued that through conceptualising and effective explanations, such knowledge can inform practices globally. The current study is set in the Australian state of NSW, and therefore, the state child protection legislation and its human service system act as points of reference throughout the study since these were relevant to the practice context of the participants in the sample. Regardless, the results will have broad application to the field in both future practice and further research.

Morgan (2014) applied John Dewey’s Concept of Inquiry as a basis for research, which used five stages to systematically approach research. Dewey’s philosophical offerings were published from 1910 onwards, but Morgan has enabled a contemporary application of this approach to the field of mixed methods research. Figure 3.1 shows an adaptation of the stages developed by Morgan which are then applied to the current study to illuminate this approach to highlight the link between beliefs and actions.
<table>
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<tr>
<th>Number</th>
<th>Steps in Inquiry</th>
<th>Description</th>
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| 1.     | Recognising a situation as problematic | - Limited empirical research on the practices of CFHN working in universal health care in response to vulnerable families  
- Prevailing practice response to families who do not engage in service: report to statutory child protection agency |
| 2.     | Considering the difference it makes to define the problem one way rather than another | - Consider advocating for policy change to influence practice  
- Consider gathering data to explore a broad spectrum of practices in working with families who do and do not engage in service and use this evidence to advocate for policy change |
| 3.     | Developing a possible line of action as a response to the problem | - Develop study design to incorporate critical aspects of practice, such as knowledge, confidence, practice and education and training.  
- Apply a mixed methods study design to optimise data collection |
| 4.     | Evaluating potential actions in terms of their likely consequences | - Statistical analysis of quantitative results from phase one  
- Thematic analysis of qualitative findings from phase two |
| 5.     | Taking actions that are felt to be likely to address the problematic situation | - Disseminate results and findings of current mixed methods study  
- Present study outcome to stakeholders |

*Figure 3.1. Dewey’s concept of inquiry. Adapted from ‘Pragmatism as a Paradigm for Social Research’, by D. L. Morgan, 2014, *Qualitative Inquiry*, 20(8), 1045–1053 (p. 1047).*

### 3.3 Theoretical Framework: Engagement

One of the most important concepts that binds contemporary practices of CFHNs is the act of engagement between the nurse and family. Fundamentally, voluntary engagement is the guiding principle of practice for CFHNs. Families choose
whether to accept or decline the services on offer and in fact are free to do so (Daro & Karter, 2019). This lays a complex foundation for nurses who carry the obligation to offer a non-sanctioned service to all families of newborns. Engagement is considered from a variety of perspectives that are laid out in this section by considering the argument for complexity supported by the literature. The following section considers engagement from the perspective of the nurse, the child and the family and then explores the application of engagement to the practice setting.

The complexity of engagement requires further examination from the perspective of the nurse. Efforts to engage one client through another are an added element to the complexity. In this instance, the nurse directs engagement to the parent to reach the infant and operates on the assumption that the parent will act in the best interest of their child. However, when such efforts are unsuccessful and the parent does not engage with the service, an infant who ceases to receive a child health nursing service faces immediate consequences. At this point, it is worth considering that engagement is tenuous and complex. In response to this premise, Goodall and Montgomery (2014) formulated a theoretical argument based on parental engagement with schools. They argued that engagement should be viewed as a continuum that ranges from involvement to engagement. The authors proposed that engagement was not static and nor a task that can be marked as complete. Therefore, engagement is fluid and can vary over time. Further, Goodall and Montgomery propose engagement built on a partnership approach should consider that this relationship formation occurs as a triad between the practitioner, parent and child rather than as a dyad between the practitioner and parent. This notion distinguishes the child as separate from the family (see Featherstone, Morris, & White, 2013 for further debate). Both arguments set out by Goodall and Montgomery about engagement being continuous and children being a
valuable party to the partnership while based in an education setting are considered valuable to the current study.

A second perspective on engagement that extends the vitality of efforts being child focused is set in the United Kingdom’s National Health Service. C. Powell and Appleton (2012) proposed health services should use the term ‘was not brought’ in place of ‘did not attend’ (as previously introduced in Section 1.6). This shift more appropriately assigned responsibility of access to health care to the parent rather than the infant. According to Appleton and Powell, the intention behind this proposed change was to remind health care professionals that proactive follow-up should be made to ensure the child subject of the health service is appropriately perceived as central to this missed opportunity for health care.

At this stage, engagement has been described as a continuum, rather than a specific task, which should focus on children. To build on this notion, it is reasonable to suggest that even when engagement is tenuous the professional must maintain a focus on the child. Revising the term used when families do not access health care, rather than seeing a missed appointment as a failure, is a refreshing view.

An array of complex factors has been suggested to influence parental engagement. Empirical evidence has suggested maternal demographic differences for engaging and non-engaging parents (McCurdy et al., 2006). Based on these findings, McCurdy et al. (2006) developed a parent involvement theory for home visiting services. Engagement was the central premise of the theory. Other studies have indicated that many other factors influence engagement, such as previous experiences with services or a lack of understanding about the purpose of service (Winkworth et al., 2010). A relationship has been reported between maternal wellbeing and dosage of the home visiting program (Flemington & Fraser, 2016). Other investigations have found
that parental suspicion and stigma influence engagement (La Placa & Corlyon, 2014). More recently, Daro and Karter (2019) have argued families are disinterested in what services are offering or are not prepared to comply with service requirements. When taken together, it is clear many factors are at play when considering engagement from the perspective of the parent, particularly when parents play a critical role in delivering health care to a child.

Engagement is accepted as a critical aspect of contemporary CFHN practice. Empirical evidence found that influences on maternal engagement are heterogeneous (Flemington & Fraser, 2016), and hence, the current study did not seek to further explore the correlations between these influences and engagement. Rather, the current study sought to add to the existing literature by accepting this premise and exploring the relationship between engagement and practice.

Assessments that consider the possibility of child maltreatment are key to identifying risks of abuse. Causal pathways to CAN are complex (Munro, Taylor, & Bradbury-Jones, 2014), and often, multiple and complex risks contribute to maltreatment (Bromfield et al., 2010). Therefore, the practices required to respond to these risks can be similarly complex. Assessment is a core clinical task for CFHNs that assists in the identification of child maltreatment. However, assessment requires families to first be engaged. In turn, engagement with a family can play a vital role in responding to either prevent or mitigate CAN. Although the notion of engagement has been outlined as a complex process, without parental engagement there is no opportunity to assess or intervene and facilitate change.

Engagement facilitates the opportunity to conduct an assessment. However, in a practice setting emphasis is also placed on the need for practitioners to conduct conversations about risks for maltreatment rather than simply identify risks in the
assessments require sensitivity to avoid intrusiveness, which has been found to compromise engagement (Harris, 2012).

Engagement that draws on a relationship-based approach is preferred, as outlined by Turney (2012), who argued that the formation of a relationship with a parent must be based on genuine engagement to allow sound decision-making. That is, forming a relationship that is built on honesty and respectful uncertainty will better inform an assessment and decisions made about further intervention as opposed to a professional accepting a parent’s explanation that suggests disguised compliance (Munro, 2011). Similarly, Howe (2010) maintained that optimising safety for children considered at risk of abuse and neglect is reliant on a well-formed relationship with the family. Although Turney and Howe both developed these arguments in Social Work, these concepts are compatible with the nursing profession’s affiliation with relationship-based approaches, such as the nurse–partnership. Genuine engagement that offers parents recognition, respect and reciprocity (Turney, 2012) is not the panacea for maltreatment but provides a pragmatic foundation for practice responses when forming a relationship with vulnerable families, even when the family seems unwilling to accept the service.

Engagement must be given due consideration by practitioners and service managers alike, particularly when offering a service to families who may be hard to
reach (Thoburn, 2010). Families considered hard to reach are also perceived as likely to be difficult to change. The role of universal services is vital in the public health model of child abuse prevention, as is the vitality of maltreatment identification. In turn, the practice response when CAN concerns arise requires equal importance.

The practices of CFHNs are anchored in the family partnership model that calls upon the health professional to work along with the family, rather than taking an expert or dogmatic approach (Keatinge et al., 2007). However, maintaining a partnership with a family when a response to indicators of child maltreatment is warranted requires advanced practice skills. Bringing together each stage of engagement outlined within this section and integrating into a practice setting as examined in phase one, the current study aimed to describe the skills and practice used with families across three varied scenarios in which engagement and risk are considered to varying degrees. Moreover, this study sought to explore whether changes to practice occur when family engagement has not been achieved and child protection concerns exist.

### 3.4 Locating the Current Study in a Practice Context

The child protection system in which the study was completed had undergone significant reconstruction in the year preceding the study (as previously introduced in Chapter 1, Section 1.2). The nascent system had broadened in scope to include wellbeing as part of the child protection continuum. In turn, the police, Education and Health services had operationalised CWUs. Each CWU maintained its own database, which documented contact from their respective workforces that was initiated when risks of harm or concerns were identified. Over time, each agency was able to analyse and interpret these data. From a health service perspective, a picture of wellbeing started to develop in relation to the families accessing health services. Moreover, a greater understanding also began about the practices being used by the workforce to respond to
the families. This allowed organisations to create a more detailed understanding about the burden of child maltreatment and the ways in which services responded to this burden. Moreover, this understanding emerged against a clear delineation within the human services system that wellbeing concerns were below the threshold of risk of significant harm, meaning there would be no statutory obligation to respond to these occurrences.

The challenges associated with engaging families with children either suspected, or at risk, of harm are multifactorial and have real implications for practice across the human services sector. In the NSW setting, a specific practice dilemma emerged from contacts with the CWU from the community nursing workforce. The CWU had described an emerging practice whereby a family who met the service criteria as ‘vulnerable’ and had ‘failed to attend appointments’ would consequently be discharged from the service and this information was then being referred to the CWU. However, the operational scope of the CWU did not extend to contacting families, and hence, the purpose of such a contact remained unclear to the CWU. This usual practice for the community-based nurses had previously been unexamined. However, in light of the specific practice dilemma being raised for consideration, an examination of this practice was required and incited the current study.

3.5 Engagement of Service Managers

The researcher was not only a PhD candidate but was also employed as the Coordinator of Child Wellbeing within a public health organisation during the scoping phase of the study. In this capacity, a meeting was convened with CFHNS’ service managers to examine service systems and nursing practices related to responding to child protection and wellbeing concerns. Exploratory discussions unearthed a prevailing practice whereby a family that did not engage with the CFHNS was discharged; then,
the family was subsequently reported to the statutory child protection agency (Family and Community Services, referred to throughout the thesis as FACS).

However, after the inception of the CWU, nurses had begun referring to the CWU because matters reported to FACS required a suspicion of risk of significant harm, which may not be reached if a family has not engaged in service to allow an assessment. Anecdotal accounts indicated this reporting practice was a direct result of a policy that directed that families were to be discharged from a service if they failed to attend three scheduled appointments. The phrase ‘three strikes and you’re out’ was commonplace within the health sector, but no specific health policy could be cited that included this directive at the time of discussions. Nevertheless, discussions concluded that despite there being no clear origin of this practice, there was frequent application in a health setting including that of the CFHNs.

The complexity of engagement has been examined earlier in this chapter. However, limited studies have been conducted in the context of UHHV in Australia. The stakeholder meeting resulted in agreement to undertake further investigations to describe the practices of CFHNs in response to families with CAN vulnerabilities from a context of UHHV.

3.6 Methodology

The clinical practices required to meet the complex needs of families require a similarly complex response reliant on a culmination of advanced practice skills. The methodology applied to the current study warranted sophistication to capture not only the usual (homogenous) practices deployed by nurses in this context, but also of those divergent (heterogenous) practice responses to broaden the scope of understanding of all practices. Therefore, the study applied a mixed methods research design to explore the self-reported knowledge, practices, confidence, barriers to practice, tertiary education
and workplace training of CFHNs in relation to practice applied when working with families with CAN vulnerabilities. The study was conducted using a mixed methods design strategy referred to as ‘sequential exploratory’ (Creswell, Plano Clark, Gutmann, & Hanson, 2003), which involved collecting quantitative data initially and analysed followed by qualitative data collection and analysis.

Data were gathered in two phases using the exploratory sequence. Phase one gathered quantitative data using a questionnaire, and phase two gathered qualitative data using focus groups. This mixed methods approach draws on the strengths of both the quantitative and qualitative aspects of data collection and ultimately seeks to provide a deeper insight (Zhang & Cresswell, 2013). This study design was selected for two reasons. The first applied to the scale of the questionnaire that was distributed in phase one. An estimated cohort of 160 eligible participants were identified during the scoping phase. The sample size potentially offered a broad spectrum of responses; therefore, using a connecting approach to phase two allowed focus group discussions to develop a greater descriptive understanding of practices identified in phase one. Phase two allowed for a peer group setting to discuss preliminary analysis of phase one results and catered for discussions that explored the possibilities of consensus and descent among participants.

Contemporary mixed methods theorists refer to an emerging approach to mixed methods research as multilevel mixed methods (Headley & Plano Clark, 2019). The multilevel mixed methods approach involves a study that addresses multiple levels related to practice, explores how these levels relate and determines relativity to the current study. In relation to the current study, the overall construct of nursing practice was considered on two levels and data were collected on both levels. The first was individual practice, which was explored through self-reported practices using a
questionnaire. The second dimension was team-based practice, for example, case reviews and clinical group supervision, and focus group discussions were used to simulate team-based discussions.

The mixing in mixed methods research has been the topic of much debate (see Johnson, Onwuegbuzie & Turner, 2007), and a range of views consider the stage in which mixing in a mixed methods study is performed. In an analysis of definitions of mixed methods research presented by 19 leaders in the field, Johnson et al (2007) proposed that mixing can occur during data collection, data collection and analysis or at all stages of the study, as is the case with the current study. For the purpose of the current study, mixing occurred at three stages. Namely, mixing occurred during the survey data collection because the questionnaire used both closed (binary) and open-ended items (Likert scale responses and open text responses) to generate data. The second was conducted during qualitative data collection in which focus group participants were invited to discuss quantitative results and interpret emergent practice concepts. This stage invited participants to examine the possible integration and divergence of data obtained in study one. The third occasion of mixing occurred during the analysis and integration of both quantitative and qualitative data (presented in Chapter 8). This stage of mixed methods can be prone to ‘messiness’ (Sanscartier, 2018) in relation to the possibility that data gathered using quantitative or qualitative methods are not aligned. Since this study aimed to explore homogeneous and heterogenous practices, the integration of data has been examined during analysis, rather than overlooked.

3.7 Chapter Summary

This chapter outlined the methodology used in the study. Using a pragmatic approach, this study draws on the theory of engagement to describe the background to
the study. Empirical research on engagement served as a precursor to the study, which allowed the current study to explore the practices of CFHNs when responding to CAN. A mixed methodology study design was used to incorporate both qualitative and quantitative data. The study was conducted in two phases. Phase one involved a comprehensive questionnaire designed specifically for the current study, and phase two gathered qualitative data through focus group discussions. The following four chapters will sequentially present phase one methods and results (Chapters 4 and 5) and then phase two methods and findings (Chapters 6 and 7).
Chapter 4: Phase One Methods

4.1 Chapter Introduction

This chapter presents the methods used in phase one of the study. The eligibility criteria are outlined, along with the questionnaire design and ethics approval followed by data collection and methods of analysis.

4.2 Eligibility Criteria

Participants were drawn from a sample of currently employed CFHNs working in clinical and administrative (managerial) roles. The sample of participants was required to possess knowledge and insight into the topic, in addition to being available and motivated to convey a self-reflective account of practice (Etikan, Musa, & Alkassim, 2016). Across Australia, more than 305,000 individuals were employed in nursing and midwifery (Australian Institute of Health and Welfare, 2015) at the time of the study. The national workforce data on nurses and midwives reported the workforce was predominately female, with almost half of the workforce aged over 50 years (Australian Institute of Health and Welfare, 2015). The nurse and midwifery workforce category consisted of 5,444 CFHNs, whose average age was 49.9 years and among whom 1% were male. Other studies that have reported sociodemographic data found that, on average, a quarter of the workforce had acquired more than 20 years of experience (Schmied, Fowler, Rossiter, Homer, & Kruske, 2014).

Eligibility for phase one was set based on current employment in the two participating CFHNS. Nurse Unit Managers (NUMs), Clinical Nurse Specialists, Clinical Nurse Consultants and CFHNs from the services were invited to participate. Purposive sampling was used in phase two. Eligibility for phase two was the same as that for phase one, and all participants in phase one were eligible to participate in phase two.
The following research questions in Table 4.1 were used, as previously detailed for the quantitative data collection phase.

Table 4.1

*Phase One Research Questions*

<table>
<thead>
<tr>
<th>Quantitative Research Questions: Phase One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative RQ1. How knowledgeable are CFHNs in relation to their mandatory CAN reporting responsibilities?</td>
</tr>
<tr>
<td>Quantitative RQ2. What are the practice responses of CFHNs when managing families with complex service needs?</td>
</tr>
<tr>
<td>Quantitative RQ3. How do CFHNs engage and respond to families with complex service needs?</td>
</tr>
<tr>
<td>Quantitative RQ4. What is the role of education and training in preparing CFHNs for complex care offered to vulnerable families?</td>
</tr>
</tbody>
</table>

4.3 Questionnaire Design

The ‘Responding to Vulnerable Families Questionnaire’ (Appendix A) was designed to examine the self-reported knowledge, confidence, practices, education and workplace training of CFHN. The questionnaire was adapted from four existing questionnaires in published studies conducted in Australia (Fraser et al., 2010; Raman et al., 2011; Schweitzer et al., 2006) and the United Kingdom (Wallbank et al., 2013). Permission was gained from the lead author of each tool. Practice details were based on the NSW child protection system at the time. For example, an alternative reporting system required all NSW Health employees to refer suspected risk of harm to the CWU and report risk of significant harm to FACS (Australian Institute of Family Studies, 2017b).

4.4 Questionnaire Items

4.4.1 Participant sociodemographic data

Participant sociodemographic of age, qualifications, parent status and years of clinical experience as a nurse and a CFHN were gathered.
4.4.2 Mandatory reporting knowledge

Mandatory reporting knowledge, ethical obligations and reporting behaviours were determined using binary items. Two items used open text responses. The first item sought a description of ‘other’ reporting behaviours to identify any variations from usual reporting practices. The second sought a description of decision-making when CAN was suspected and not reported. Mandatory reporting of suspected risk of significant harm is a legal obligation of all people delivering health care in NSW under the Children and Young Persons (Care and Protection) Act 1998. Therefore, three items were included to measure knowledge of mandatory reporting responsibilities.

4.4.3 Confidence in practice when working with vulnerable families.

The scale of confidence used a 7-point Likert scale, which ranged from 1, ‘extremely not confident’, to 7, ‘extremely confident’. Nine clinical tasks were listed under the confidence item. Six of the items related to assessment skills, such as the identification of indicators of abuse that reflect the categories of abuse reportable under the NSW Children and Young Persons (Care and Protection) Act 1998. One item related to the completion of the Domestic Violence Routine Screening (DVRS) tool because CFHNs were directed to complete the tool (NSW Health Policy, 2006). Two items related to practice behaviours of reporting CAN. The final scaled response in the item asked about standard practices of care, which was intended to represent the total practice response of the preceding individual tasks.

4.4.4 Clinical management of child abuse and neglect

A free-text response was provided for participants to describe typical clinical management when CAN is suspected.
4.4.5 Frequency of usual practice

Three items were used to determine practice in three scenarios. The same 7-point Likert scale was used for all three items; the seven responses were merged and reported in the results as three categories. ‘Never’, ‘rarely’ and ‘sometimes’ were merged into a single response category of ‘low frequency’. Responses categorised as ‘moderate frequency’ consisted of the responses ‘frequently’ and ‘very frequently’. Likert responses listed in the questionnaire as ‘extremely frequently’ and ‘always’ were categorised as ‘high frequency’.

The three scenarios were (a) frequency of practice with vulnerable families, (b) frequency of practice with engaged vulnerable families and (c) frequency of practice with disengaged vulnerable families.

A subscale of frequency in practice was applied to determine application of clinical tasks across three scenarios. Each of the practices in the subscale reflect optimal practices. Details of the concern were not depicted based on the assumption that all participants had encountered a vulnerable family with a child protection concern and operated from the premise that concern is symbiotic with vulnerability.

4.4.6 Descriptive commentary

Descriptive commentary was sought from participants, in relation to (a) increased contact reasons, (b) ideal practice, (c) practice barriers with disengaged families and (d) decision-making barriers. The first two of these items were included as supplementary to the frequency of practice, frequency of practice with disengaged vulnerable families and decision-making barriers was asked as a single item. Data were categorised, and frequency was determined.
4.4.7 Education and training.

Participants were asked to report their perception of whether education and training had prepared them for practice when working with vulnerable families. Both tertiary education and in-service training were explored. Binary and categorical response options were used.

- Tertiary education
  
  Participants were asked whether the topic of CAN was addressed in their tertiary education within course lectures, workshops/seminars or assigned readings. The four possible responses to these options were ‘Yes’, ‘No’, ‘Not addressed’ and ‘Can’t recall’. Responses of ‘not addressed’ or ‘can’t recall’ were merged and reported in results as ‘no’.

- Workplace training
  
  Participants were asked whether their workplace provided adequate access to training to facilitate working with vulnerable families, and binary response options were provided. Additional questions addressed reporting CAN, assessing practice competencies, recognising vulnerability increases, building relationships and identifying reasons that families disengage. Categorical options were provided: ‘Yes’, ‘No’ and ‘Unsure’.

- Practice competencies
  
  Practice competencies for CFHNs (for background, see Chapter 2, Section 2.8.1 Competences for Child and Family Health Nurses) are assessed within the workplace, and therefore were featured in the questionnaire as a workplace training question.

4.5 Questionnaire Pilot Test

A pilot test of the questionnaire was conducted. Five nurses participated in the pilot. They were instructed to complete the questionnaire and later provide feedback.
about the items. Subsequently, amendments were made to remove duplication of sections to improve clarity of content. The estimated time to complete the questionnaire following the pilot test was set at 45 minutes.

4.6 Ethics Approval

Ethics approval was obtained from Royal Prince Alfred Hospital Ethics Committee, the Lead Human and Research Ethics Committee in Sydney Local Health District (SLHD) before the study commenced (see Appendix B). An additional ‘Site Specific Assessment’ application was approved by South Western Sydney Local Health District (SWSLHD) Ethics Committee because two community health service centres in SWSLHD were used for data collection in both phases. The locations were Bankstown Community Health Centre and Rosemeadow Community Health Centre. An amended ‘Site Specific Assessment’ form was submitted following a change to one of the meeting locations. Initial approval was granted to conduct the study at Fairfield Community Health Centre, which was changed to Bankstown Community Health Centre. A ‘Site Specific Assessment’ application was also completed for Croydon in SLHD where both phase one and two data were collected.

4.7 Participant Recruitment

Participants were recruited from two health service districts located in metropolitan Sydney. The NUMs nominated each location as the site of the monthly sector meetings. These meetings yielded the greatest opportunity to maximise participation since nurses were required to attend these meetings for administrative and professional development purposes. Participant information and consent forms to participate in phase two were issued to any participant willing to participate. All consenting participants were subsequently extended an invitation via email to attend the focus group discussion.
Participating nurses were practicing either in UHHV or in sustained home visiting. Nurses employed to deliver sustained home visiting did not exclusively work in the sustained model, with a 60/40 split between sustained home visiting and UHHV. Both modes of service delivery require screening for child abuse risk. The sustained home visiting service employed five full-time equivalent CFHNS, alongside allied health positions.

**4.8 Data Gathering Methods**

Phase one data collection involved the distribution of a nine-page printed document. Participants were also issued a Survey Participant Information Sheet (see Appendix C). A total of 129 participants completed the questionnaire. Therefore, the response rate was 81% (n = 129/160). An additional 41 information packs were issued for distribution to nurses absent from the designated meetings used for data collection. The information pack included a questionnaire, a Survey Participant Information Sheet, a focus group participation consent form for staff (Appendices D and E) and a postage-paid self-addressed envelope for the return of completed documents. Despite follow-up emails sent to NUMs to encourage nurses to complete the questionnaire, only six were completed and returned from across the three sites. The questionnaire was distributed to participants in person by the researcher in three locations between February and March 2015 during team meetings. One hour was allocated in each meeting for the questionnaire distribution, collection and focus group recruitment. Further details about data collection are presented according to each of the sites.

**4.9 Data Collection**

*Site A*

Forty-five questionnaires were issued at Site A. An additional 12 questionnaire packs were issued to account for absent staff. Approximately 45 minutes was allocated
to the data collection, including briefing prior to the questionnaire distribution, time allowed for completion and any additional questions asked at the conclusion. Most participants completed the questionnaire within 20 minutes and up to eight participants took an additional 10 to 15 minutes to complete the survey. Once surveys were completed and returned, a further opportunity was offered to participate in study two. Fifteen nurses consented to participate in the focus group.

**Site B**

Thirty-three questionnaires were distributed, completed and returned at Site B. An additional 10 questionnaire packs were issued to account for absent staff. Site B included participants from three of the five different sectors operating in the health organisation.

Approximately 45 minutes was allocated to the data collection, including briefing prior to the questionnaire distribution, time allowed for completion and any additional questions asked at the conclusion. Compared with participants at Site A, participants at Site B completed the questionnaire in less time; most participants completed the questionnaire in 15 minutes. Only three participants required additional time of up to 10 minutes. Results from this site tended to reflect a higher rate of blank responses than those from the other two sites.

From the total sample, seven nurses consented to participate in the focus group. Participants from Site B were pooled with Site C since one focus group was created for nurses for each participating health organisation.

**Site C**

Forty-nine questionnaires were issued at Site C and one was returned by the meeting facilitator, who identified she was not employed by the CFHNS. A total of 19 questionnaire packs were issued to the NUM and Clinical Nurse Educator to account for
absent nurses. In total, 46 questionnaires were completed and returned, with two participants advising that they opted to complete the survey together since they perceived that working with vulnerable families ‘didn’t really relate to the work we do’. Most participants completed the questionnaire in 20 minutes.

Following the briefing and questionnaire distribution, one participant requested that an announcement be made that participation in the study was optional and should anyone choose to leave there would be no consequences. Although this information was provided in the participant information sheet, the message was reiterated.

Nine nurses consented to participate in the focus group in study two. When combined with Site B, a total of 16 participants chose to participate. Two NUMs also agreed to participate in the third focus group designed to capture the views of the collective management group across both participating health organisations.

4.10 Data Analysis

Data were manually entered into an Excel spreadsheet. Each completed questionnaire was allocated a reference number for the purpose of accuracy in data entry. The reference number included a site reference and sequential numbering. Once all responses were transcribed, the data were checked and cleaned three times to ensure accuracy and to minimise human error. The data were imported from Excel to SPSS version 22 (2013) for analysis.

Binary responses were consistently coded using 0 to denote a ‘yes’ response and 1 to denote a ‘no’. Where ‘unsure’ was listed as an option, a 2 was assigned. The item related to age had categorical options, grouped into six categories (‘under 25’, ‘25 to 30’, ‘31–40’, ‘41–50’, ‘51–60’, ‘61+’). ‘Number of years of practicing’ was linear rather than categorised. Missing values were assigned a 99 entry. Some participants
wrote additional comments against questions; all comments were transcribed for the purpose of analysis.

4.10.1 Scale development

Four scales were developed for the questionnaire items of (a) confidence, (b) frequency, (c) frequency of usual practice with families engaged with CFHNS and (d) frequency of usual practice with families not engaged with CFHN services.

A **Confidence Scale** was developed with nine different practice examples and each practice was rated against a 7-point Likert scale. The highest score of 7 indicated a participant was ‘extremely confident’; conversely, the lowest score of 1 indicated a participant was ‘extremely not confident’. This scale assessed the confidence nurses have in performing specific clinical tasks.

A **frequency of practice** scale was developed to measure the frequency with which nurses used certain practice behaviours under each of three circumstances. The first involved working with families with an identified concern, the second related to families engaged in service delivery and the third involved families that were not engaged. Nine different practice examples were stated, and each practice was rated against a 7-point Likert scale. The score of 7 indicated a participant undertook a task with extreme frequency; 1 indicated a participant conducted a practice with extreme infrequency.

Basic descriptive statistics (mean item score, SD and 95% CI) were calculated for each item. An overall mean was also calculated for each of the four items. Total mean scores were adjusted for the number of valid items. Inspection of 95% confidence intervals was undertaken to identify variance of statistical significance. Scales were developed on conceptual relevance, and their internal consistency was assessed using
Cronbach’s alpha for each scale, with alpha greater than 0.70 indicating acceptable reliability (Gliem & Gliem, 2003).

4.10.2 Differences in confidence based on education, training and management of care

Differences in overall total confidence between participants who reported undertaking education or training were explored based on (a) tertiary education, (b) workplace training and (c) management of care for a child suspected to have been abused or neglected. Statistical significance for the \( t \)-tests was set at <.05.

The \( t \)-tests were conducted based on the following hypotheses:

- There is a relationship between tertiary education qualifications and practice confidence.
- There is a relationship between workplace training and practice confidence.
- There is a relationship between confidence in management of care and the overall confidence score.

4.11 Chapter Summary

This chapter outlined the methods applied in phase one, such as design, data gathering and analysis. The next chapter will present the results from phase one.
Chapter 5: Phase One Results

5.1 Chapter Introduction

This chapter presents the results from the analysis of the questionnaire responses in phase one.

5.2 Questionnaire Results

Questionnaires were completed and returned by 129 participants, indicating a response rate of 81%. Table 5.1 presents the sociodemographic profile of the participants, and Table 5.2 presents participant data according to years of experience in relation to nursing and specialist qualifications.

Table 5.1

Sociodemographic Profile of Participants (n = 129)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Range</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range (n = 126)</td>
<td>25–30 years</td>
<td>4 (5)</td>
</tr>
<tr>
<td></td>
<td>31–40 years</td>
<td>16 (12)</td>
</tr>
<tr>
<td></td>
<td>41–50 years</td>
<td>34 (26)</td>
</tr>
<tr>
<td></td>
<td>51–60 years</td>
<td>58 (45)</td>
</tr>
<tr>
<td></td>
<td>61 years and over</td>
<td>14 (11)</td>
</tr>
<tr>
<td>Parent</td>
<td>Yes</td>
<td>108 (83)</td>
</tr>
<tr>
<td>Level of Education</td>
<td>Undergraduate degree</td>
<td>9 (7)</td>
</tr>
<tr>
<td></td>
<td>Postgraduate qualification</td>
<td>105 (81)</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>6 (5)</td>
</tr>
<tr>
<td>Years of Experience</td>
<td>&lt; 5 years</td>
<td>38 (33)</td>
</tr>
<tr>
<td></td>
<td>6–10 years</td>
<td>30 (27)</td>
</tr>
<tr>
<td></td>
<td>11–15 years</td>
<td>46 (40)</td>
</tr>
<tr>
<td></td>
<td>16–20 years</td>
<td>26 (23)</td>
</tr>
<tr>
<td></td>
<td>21 years and over</td>
<td>86 (78)</td>
</tr>
</tbody>
</table>
Table 5.2

*Years of Nursing Experience (n = 127)*

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>Nursing n (%)</th>
<th>Child and Family Health Nursing n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5 years</td>
<td>5 (5)</td>
<td>33 (28)</td>
</tr>
<tr>
<td>6–10 years</td>
<td>8 (7)</td>
<td>22 (20)</td>
</tr>
<tr>
<td>11–15 years</td>
<td>16 (15)</td>
<td>30 (25)</td>
</tr>
<tr>
<td>16–20 years</td>
<td>14 (13)</td>
<td>12 (10)</td>
</tr>
<tr>
<td>21 years and over</td>
<td>64 (60)</td>
<td>22 (18)</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>24.29 (10.73)</td>
<td>12.84 (9.04)</td>
</tr>
</tbody>
</table>

Almost half of the sample was aged between 51 and 60 years (45%). All but one was female and 81% were parents. Participants had nursing experience in both general nursing (M = 24.29 years, SD = 10.73) and as specialists in Child and Family Health Nursing (M = 12.84, SD = 9.04). Most had a postgraduate qualification (81%). Twenty-six participants provided additional detail in relation to their qualifications, which ranged from Child and Family Health Nursing (including Graduate Certificate, Diploma and Graduate Diploma), Midwifery, other health qualification and unspecified Master’s degrees. At the time of data collection, only one male was employed as a CFHN, and therefore, gender was excluded in testing to avoid easy identification and breach of confidentiality. Based on the sociodemographic profile and comparison with national data and cited studies, there were variations that suggest the sample was representative in terms of gender and age, although the distribution of participants based on years of experience was lower in the current study in comparison with that in national data.

### 5.3 Mandatory Reporting Knowledge

All participants correctly indicated having a mandatory responsibility to report knowledge and suspicion of CAN. All but one participant confirmed CFHNs have an ethical/professional responsibility to report. Table 5.3 illustrates the agencies they
indicated they would report to. Most participants correctly identified their mandated
duty to report suspected CAN to FACS (88%, n = 114) or CWU (91%, n = 117).

Table 5.3

*Reporting Agencies (n = 129)*

<table>
<thead>
<tr>
<th>Participant Response</th>
<th>FACS n (%)</th>
<th>Education n (%)</th>
<th>CWU n (%)</th>
<th>Police n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>114 (88)</td>
<td>3 (2)</td>
<td>117 (91)</td>
<td>36 (28)</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>126 (98)</td>
<td>0</td>
<td>13 (10)</td>
</tr>
<tr>
<td>Unsure/Did not complete</td>
<td>15 (11)</td>
<td>0</td>
<td>12 (9)</td>
<td>80 (62)</td>
</tr>
</tbody>
</table>

Among the participants, 22% (n = 29) detailed additional reporting practices,
and 15% (n = 19) identified they would report to the Nurse Unit Manager (NUM).

Other responses referred to application of the MRG; consulting with a colleague;
presenting at vulnerable families’ case review meeting; and obtaining further
information from a General Practitioner. Further, 93% (n = 120) of participants had
experience in reporting CAN to either FACS or the CWU during their career. During
the 12 months prior to completing the questionnaire, 60% (n = 77) had reported CAN.

5.3.1 Suspecting and not reporting child abuse and neglect

In all, 17% (n = 27) of participants confirmed that they had suspected child
abuse or neglect and decided not to report at some point during their career. A small
proportion of 5% (n = 6) of participants reported having failed to report in the past 12
months. Table 5.4 presents their reasons for not reporting based on the open text
responses.
Table 5.4

Reasons for Failing to Report CAN (n = 27)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of experience or confidence</td>
<td>5 (19)</td>
</tr>
<tr>
<td>Statutory agency already working with family</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Assumed another professional would report</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Compliance with government policy (e.g. recommendation from Mandatory Reporter Guide)</td>
<td>4 (15)</td>
</tr>
<tr>
<td>Anticipated lack of responses from statutory agency</td>
<td>3 (11)</td>
</tr>
<tr>
<td>Fear of consequences from family</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Team-based decision</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Referred to Child Wellbeing Unit</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Conducted further assessment and excluded risk of harm</td>
<td>1 (4)</td>
</tr>
</tbody>
</table>

5.4 Confidence in Practice When Working With Vulnerable Families

The confidence item was tested with simple distribution and frequency analysis using SPSS. The 7-point Likert scale response categories used in this item were merged into three categories. ‘I am extremely NOT confident’, ‘I am very NOT confident’ and ‘I am not confident’ were merged into a single response category of ‘Not Confident’. Responses of ‘I am neither confident nor not confident’ were categorised as ‘Neither’. The third category ‘Confident’ included the responses ‘I am confident’, ‘I am very confident’ and ‘I am extremely confident’. The results are displayed in Table 5.5.
Table 5.5

Confidence in Working with Vulnerable Families (n = 129)

<table>
<thead>
<tr>
<th>Feature</th>
<th>Not Confident n (%)</th>
<th>Neither n (%)</th>
<th>Confident n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>4 (3)</td>
<td>9 (7)</td>
<td>116 (90)</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>6 (5)</td>
<td>21 (16)</td>
<td>102 (79)</td>
</tr>
<tr>
<td>Neglect</td>
<td>6 (5)</td>
<td>12 (9)</td>
<td>111 (86)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>19 (15)</td>
<td>38 (29)</td>
<td>72 (56)</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>6 (5)</td>
<td>15 (11)</td>
<td>108 (84)</td>
</tr>
<tr>
<td>Complete DVRS</td>
<td>5 (4)</td>
<td>5 (4)</td>
<td>119 (92)</td>
</tr>
<tr>
<td>Suspected ROSH</td>
<td>6 (5)</td>
<td>10 (8)</td>
<td>113 (87)</td>
</tr>
<tr>
<td>Report CAN</td>
<td>5 (4)</td>
<td>4 (3)</td>
<td>120 (93)</td>
</tr>
<tr>
<td>Manage care</td>
<td>11 (8)</td>
<td>32 (25)</td>
<td>86 (67)</td>
</tr>
</tbody>
</table>

Note. DVRS = Domestic Violence Routine Screening; ROSH = Risk of Significant Harm; CAN = Child Abuse and Neglect.

Across all clinical tasks, most participants reported being confident in identifying the different types of abuse (excluding sexual abuse), completing the DVRS, determining risk of significant harm and appropriately reporting CAN. Participants reported the least confidence in identification of sexual abuse and care management of a child suspected to have been abused or neglected, reported in Table 5.5 as ‘manage care’.

5.5 Management of Suspected Child Maltreatment

Almost three-quarters (n = 93) of the sample of participants described management of suspected child maltreatment. The practices identified in their responses ranging from the most frequent to least frequent are presented in Table 5.6. Each participant detailed multiple examples of practice in various combinations; each theme was assigned a value of 1. Consequently, the total frequency of practices reported in Table 5.6 exceeds the number of participants in the sample. The most frequently identified practice was referral to the CWU or reporting to FACS. Other practices
frequently nominated were referral to support services and consultation with the NUM or colleague. ‘Other’ represented responses that did not identify a specific practice.

Table 5.6

**Typical Care Management Practices (n = 93)**

<table>
<thead>
<tr>
<th>Practice Response</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to CWU or FACS</td>
<td>67 (72)</td>
</tr>
<tr>
<td>Refer to support service</td>
<td>39 (42)</td>
</tr>
<tr>
<td>Consultation with NUM or colleague</td>
<td>29 (31)</td>
</tr>
<tr>
<td>Engagement</td>
<td>25 (27)</td>
</tr>
<tr>
<td>Apply MRG</td>
<td>21 (23)</td>
</tr>
<tr>
<td>Monitor/follow-up</td>
<td>20 (22)</td>
</tr>
<tr>
<td>Discuss at case review meeting</td>
<td>12 (13)</td>
</tr>
<tr>
<td>Follow policy or guidelines</td>
<td>11 (12)</td>
</tr>
<tr>
<td>Increase contact</td>
<td>8 (9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Response</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document</td>
<td>7 (8)</td>
</tr>
<tr>
<td>Work collaboratively (with another discipline or agency)</td>
<td>7 (8)</td>
</tr>
<tr>
<td>Assess</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Contact police</td>
<td>4 (4)</td>
</tr>
<tr>
<td>Exchange information</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Discuss at clinical supervision</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Work in partnership with family</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Create paper file</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

*Note. A total of 93 out of 129 participants (72%) responded to this question.*

### 5.6 Frequency of Usual Practice

This section reports about the three items in the questionnaire that explored practice responses based on frequency. Each item has been analysed using SPSS to determine simple distribution and frequencies. Table 5.7 reports the frequency of clinical tasks applied when working with families with CAN vulnerabilities. Table 5.8 presents a comparison of frequencies for usual practice with families engaged with CFHNS compared with that for families not engaged with the service.
Table 5.7

*Frequency of Usual Practice (n = 129)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Low Frequency n (%)</th>
<th>Moderate Frequency n (%)</th>
<th>High Frequency n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional judgement</td>
<td>3 (2)</td>
<td>42 (33)</td>
<td>84 (65)</td>
</tr>
<tr>
<td>Consultation with co-worker</td>
<td>3 (2)</td>
<td>50 (39)</td>
<td>76 (60)</td>
</tr>
<tr>
<td>Consultation with NUM</td>
<td>4 (3)</td>
<td>44 (34)</td>
<td>81 (63)</td>
</tr>
<tr>
<td>Consultation with colleague</td>
<td>1 (1)</td>
<td>39 (30)</td>
<td>89 (69)</td>
</tr>
<tr>
<td>MRG</td>
<td>6 (5)</td>
<td>51 (39)</td>
<td>72 (56)</td>
</tr>
<tr>
<td>Policy compliance</td>
<td>4 (3)</td>
<td>39 (30)</td>
<td>86 (67)</td>
</tr>
<tr>
<td>Refer to CWU</td>
<td>4 (3)</td>
<td>67 (52)</td>
<td>58 (44)</td>
</tr>
<tr>
<td>Report to CS</td>
<td>8 (6)</td>
<td>72 (56)</td>
<td>49 (37)</td>
</tr>
<tr>
<td>Apply training</td>
<td>8 (6)</td>
<td>70 (54)</td>
<td>51 (40)</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>8 (6)</td>
<td>53 (41)</td>
<td>68 (53)</td>
</tr>
<tr>
<td>Case review</td>
<td>4 (3)</td>
<td>43 (33)</td>
<td>82 (64)</td>
</tr>
<tr>
<td>Refer to FRS</td>
<td>27 (21)</td>
<td>67 (52)</td>
<td>35 (28)</td>
</tr>
<tr>
<td>Additional report to CS</td>
<td>3 (2)</td>
<td>50 (39)</td>
<td>76 (58)</td>
</tr>
</tbody>
</table>

The most frequently cited practices reported were consultation with a colleague, application of professional judgement and consultation with the NUM. The least frequent practice reported by one fifth of participants was a referral to the Family Referral Service (FRS).
Table 5.8

*Frequency of Usual Practice With Families Comparing Engaged With Non-Engaged (n = 129)*

<table>
<thead>
<tr>
<th>Reported Usual Practice</th>
<th>Low Frequency</th>
<th>Moderate Frequency</th>
<th>High Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Refer to CWU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>3 (2)</td>
<td>63 (49)</td>
<td>63 (49)</td>
</tr>
<tr>
<td>Non-engaged</td>
<td>4 (3)</td>
<td>46 (36)</td>
<td>79 (61)</td>
</tr>
<tr>
<td>Report to CS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>6 (5)</td>
<td>67 (52)</td>
<td>56 (43)</td>
</tr>
<tr>
<td>Non-engaged</td>
<td>4 (3)</td>
<td>64 (50)</td>
<td>61 (47)</td>
</tr>
<tr>
<td>Family Partnership Informed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>3 (2)</td>
<td>37 (29)</td>
<td>89 (69)</td>
</tr>
<tr>
<td>Non-engaged</td>
<td>12 (9)</td>
<td>40 (31)</td>
<td>77 (61)</td>
</tr>
<tr>
<td>Work Collaboratively</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>1 (1)</td>
<td>54 (42)</td>
<td>74 (58)</td>
</tr>
<tr>
<td>Non-engaged</td>
<td>6 (5)</td>
<td>54 (42)</td>
<td>69 (53)</td>
</tr>
<tr>
<td>Case Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>5 (4)</td>
<td>45 (35)</td>
<td>79 (61)</td>
</tr>
<tr>
<td>Non-engaged</td>
<td>6 (5)</td>
<td>50 (39)</td>
<td>72 (56)</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>8 (6)</td>
<td>72 (55)</td>
<td>49 (38)</td>
</tr>
<tr>
<td>Non-engaged</td>
<td>14 (11)</td>
<td>63 (49)</td>
<td>46 (36)</td>
</tr>
<tr>
<td>Discuss with NUM/colleague</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>1 (1)</td>
<td>36 (28)</td>
<td>92 (71)</td>
</tr>
<tr>
<td>Non-engaged</td>
<td>3 (2)</td>
<td>38 (30)</td>
<td>88 (68)</td>
</tr>
<tr>
<td>Increase contact with family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged</td>
<td>3 (2)</td>
<td>50 (39)</td>
<td>76 (59)</td>
</tr>
<tr>
<td>Non-engaged</td>
<td>8 (6)</td>
<td>54 (42)</td>
<td>67 (52)</td>
</tr>
</tbody>
</table>
A further two questions were asked in the item as regards families not engaged with the service. The first related to the organisational policy for ‘failure to attend’ with half of the participants applying this practice very frequently. The second question addressed the practice to engage with another discipline to provide the option for a joint assessment/appointment with half the participants reporting this occurs at a rate of moderate frequency. Overall, this item showed that discussing a case with a colleague or NUM was the most likely practice response. Conversely, participants were less inclined to discuss a family at clinical supervision. Comparatively, practice did not seem to vary significantly whether families were engaged or had disengaged from the service (as determined by the participant).
5.7 Open-Ended Responses

Within the questionnaire, participants were invited to provide a description about practice using open-ended responses. Responses were analysed and categorised, and the frequency distribution is presented in Table 5.9.

Table 5.9

*Open-Ended Questionnaire Responses*

<table>
<thead>
<tr>
<th>Item</th>
<th>Category</th>
<th>Descriptive</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased Contact Reason (n = 122)</td>
<td>Intervention</td>
<td>Support</td>
<td>99 (77%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Educate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Policy compliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complete Ages and Stages Questionnaire</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surveillance</td>
<td>Monitor</td>
<td>51 (40%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Observe</td>
<td></td>
</tr>
<tr>
<td>Ideal Practice (n = 90)</td>
<td>Systems Improvement</td>
<td>Referral to another service</td>
<td>19 (15%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved referral processes</td>
<td>28 (31%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Broader eligibility to SHHV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Collaboration</td>
<td>Family Partnership approach</td>
<td>27 (21%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intra- or inter-agency coordination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual Practice</td>
<td>Supportive</td>
<td>20 (15%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accessible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ethical</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Approachable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confident</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Protective</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Resourceful</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knowledgeable</td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Category</td>
<td>Descriptive</td>
<td>Frequency</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Practice Barriers disengaged families (n = 93)</td>
<td>Systems Improvement</td>
<td>Failure response from statutory agency ‘Failure to attend’ policy</td>
<td>23 (25%)</td>
</tr>
<tr>
<td></td>
<td>Collaboration</td>
<td>Willingness of family to engage Limited collaboration between services Poor communication</td>
<td>44 (34%)</td>
</tr>
<tr>
<td></td>
<td>Individual Practice</td>
<td>Confidence Diverse practices used to contact family Delicate balance of multiple contact attempts balanced with the parent’s choice to accept or decline service</td>
<td>28 (22%)</td>
</tr>
<tr>
<td>Decision-making barriers (n = 98)</td>
<td>Systems Improvement</td>
<td>Limitations operating from a voluntary service model Failure response from statutory agency Policies reduce autonomy of practitioners Threshold of risk limits eligibility of vulnerable families to access support</td>
<td>32 (25%)</td>
</tr>
<tr>
<td></td>
<td>Collaboration</td>
<td>Willingness of family to engage Limited collaboration between services</td>
<td>75 (58%)</td>
</tr>
<tr>
<td></td>
<td>Individual Practice</td>
<td>Confidence Experience Worried about impact of practice on family Tenuous engagement with family Limited time Competency Emotional impact</td>
<td>59 (46%)</td>
</tr>
</tbody>
</table>
5.8 Scales

Tables 5.10 to 5.13 report the means and confidence intervals for each of the four scales of (a) confidence, (b) frequency, (c) usual practice with families engaged with CFHN services and (d) usual practice with families not engaged with CFHN services.

The Cronbach’s alpha for the Confidence Scale in Clinical Tasks was 0.95, Frequency was 0.92, Engaged families was 0.91 and Non-engaged families was 0.92. Assumptions for normality, based on visual inspection of histograms, the association between the skew statistic and the standard error of skew (Tabachnick & Fidell, 2013) were deemed appropriate.

5.9 Confidence Scale

This scale assessed the confidence nurses have in performing specific clinical tasks. Results for the Confidence Scale are shown in Table 5.10. For seven of the nine items, the mean item confidence scores were around 5 or more, which equated to ‘I am confident’ on the Likert scale, with ‘Complete the DVRS’ being the most confident item (M = 5.76, SD = 1.19). Two practices had lower levels of confidence: the practice of ‘appropriately manage the care of a child you suspect has been abused or neglected’ (M = 4.87, SD = 1.15), and lower again was the practice of identifying sexual abuse (M = 4.55, SD = 1.04). On average, the sample of participants reported being confident in their practice with families with CAN vulnerabilities (Total Confidence M = 5.15, SD = 0.86).
Table 5.10

_Mean and Confidence Intervals for Confidence Scale_

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Mean (SD)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Abuse</td>
<td>5.19 (0.88)</td>
<td>5.04, 5.35</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>5.02 (0.96)</td>
<td>4.85, 5.18</td>
</tr>
<tr>
<td>Neglect</td>
<td>5.16 (0.95)</td>
<td>4.99, 5.32</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>4.55 (1.04)</td>
<td>4.36, 4.73</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>5.12 (0.97)</td>
<td>4.96, 5.29</td>
</tr>
<tr>
<td>Complete DVRS</td>
<td>5.76 (1.19)</td>
<td>5.55, 5.97</td>
</tr>
<tr>
<td>Suspected ROSH</td>
<td>5.24 (1.03)</td>
<td>5.06, 5.42</td>
</tr>
<tr>
<td>Report CAN</td>
<td>5.40 (1.01)</td>
<td>5.22, 5.57</td>
</tr>
<tr>
<td>Manage Care</td>
<td>4.87 (1.15)</td>
<td>4.66, 5.08</td>
</tr>
<tr>
<td>Total mean Confidence</td>
<td>5.15 (0.86)</td>
<td>5.00, 5.30</td>
</tr>
</tbody>
</table>

*Note. 1 = Extremely NOT confident; 7 = Extremely confident. CI = confidence interval.*

5.10 Frequency Scale

This scale measured the frequency with which nurses engaged with certain practice behaviours. Table 5.11 presents results of the mean and confidence intervals of each practice as well as the total mean frequency calculated for this item. In general, mean item scores were located around a score of 5, corresponding to ‘very frequently’ on the Likert scale used in the questionnaire. The highest mean score for frequency of practice was for ‘Comply with policy’ (M = 5.45, SD = 1.59), and the lowest mean score was for ‘Refer to FRS’ (M = 3.75, SD = 1.54). On average, nurses very frequently engaged with the practices listed in the item (Total Frequency M = 4.92, SD = 1.11).

An additional calculation of mean frequency of practice was conducted and indicated compliance with NSW Health Policy Directives/health organisation policy (n = 5.45) had the greatest mean frequency followed by the presentation of concerns at case review meetings (n = 5.3). However, it is important to note the variation in both items was minor (n = 0.15).
Table 5.11

Mean and Confidence Interval for Frequency Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Mean (SD)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional judgement</td>
<td>5.28 (1.53)</td>
<td>5.01, 5.55</td>
</tr>
<tr>
<td>Consultation with others</td>
<td>4.94 (1.40)</td>
<td>4.69, 5.18</td>
</tr>
<tr>
<td>Consultation with NUM</td>
<td>5.16 (1.51)</td>
<td>4.90, 5.43</td>
</tr>
<tr>
<td>Consult with colleague</td>
<td>5.23 (1.31)</td>
<td>5.00, 5.46</td>
</tr>
<tr>
<td>Apply MRG</td>
<td>4.92 (1.57)</td>
<td>4.64, 5.20</td>
</tr>
<tr>
<td>Comply with policy</td>
<td>5.45 (1.59)</td>
<td>5.17, 5.73</td>
</tr>
<tr>
<td>Refer to CWU</td>
<td>4.46 (1.53)</td>
<td>4.19, 4.73</td>
</tr>
<tr>
<td>Report to FACS</td>
<td>4.24 (1.48)</td>
<td>3.98, 4.50</td>
</tr>
<tr>
<td>Apply professional development</td>
<td>5.25 (1.32)</td>
<td>5.02, 5.48</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>4.71 (1.62)</td>
<td>4.42, 4.99</td>
</tr>
<tr>
<td>Present at case review</td>
<td>5.30 (1.52)</td>
<td>5.03, 5.57</td>
</tr>
<tr>
<td>Refer to FRS</td>
<td>3.75 (1.54)</td>
<td>3.47, 4.02</td>
</tr>
<tr>
<td>Additional report to FACS</td>
<td>5.17 (1.63)</td>
<td>4.88, 5.45</td>
</tr>
<tr>
<td>Total mean Frequency</td>
<td>4.92 (1.11)</td>
<td>4.73, 5.11</td>
</tr>
</tbody>
</table>

Note. 1 = Never, 7 = Always. CI = confidence interval.

5.11 Usual Practice (Families Engaged in Service) Scale

This scale assessed actions nurses usually take as regards engaged families with CAN vulnerabilities. Table 5.12 presents results and shows that most practices achieved a mean score around the value of 5, corresponding to ‘very frequently’ on the Likert scale used for this item. The practice most often applied was ‘Consult with colleague or NUM’ (M = 5.56, SD = 1.36) and the least reported practice was ‘Report to FACS’ (M = 4.37, SD = 1.51). On average, nurses very frequently engaged with the practices detailed in the questionnaire (Total Usual practice M = 4.96, SD = 1.18).
Table 5.12

Mean and Confidence Interval for Usual Practice (Families Engaged in Service)

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Mean (SD)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to CWU</td>
<td>4.69 (1.53)</td>
<td>4.41, 4.96</td>
</tr>
<tr>
<td>Report to FACS</td>
<td>4.37 (1.51)</td>
<td>4.10, 4.64</td>
</tr>
<tr>
<td>Practice collaboration</td>
<td>4.83 (1.31)</td>
<td>4.60, 5.07</td>
</tr>
<tr>
<td>Family partnership informed practice</td>
<td>5.35 (1.52)</td>
<td>5.08, 5.61</td>
</tr>
<tr>
<td>Present at case review</td>
<td>5.37 (1.57)</td>
<td>5.09, 5.65</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>4.40 (1.56)</td>
<td>4.12, 4.68</td>
</tr>
<tr>
<td>Consultation with colleague or NUM</td>
<td>5.56 (1.36)</td>
<td>5.32, 5.80</td>
</tr>
<tr>
<td>Increase frequency of contact</td>
<td>5.03 (1.46)</td>
<td>4.77, 5.29</td>
</tr>
<tr>
<td>Total mean Usual Practice</td>
<td>4.96 (1.18)</td>
<td>4.76, 5.16</td>
</tr>
</tbody>
</table>

Note. 1 = Never, 7 = Always. CI = confidence interval.

5.12 Usual Practice (Families Disengaged) Scale

This scale assessed the nurses’ usual practices when responding to a vulnerable family not engaged with the CFHN service. Results of the mean and confidence intervals are shown in Table 5.13. As with the item responding to families engaged with CFHN, the most frequent practice was ‘Consult with colleague or NUM (M = 5.57, SD = 1.47). The least frequent practice was to engage with another discipline to provide the family an option to conduct a joint assessment or appointment (M = 4.28, SD = 1.68). Overall, nurses in the sample averaged a rate of being ‘very frequently’ engaged in the listed practices (Total usual practice M = 4.91, SD 1.26).
Table 5.13

Mean and Confidence Intervals for Usual Practice (Families Not Engaged With Service)

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Mean (SD)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to CWU</td>
<td>5.15 (1.60)</td>
<td>4.86, 5.43</td>
</tr>
<tr>
<td>Report to FACS</td>
<td>4.74 (1.66)</td>
<td>4.44, 5.04</td>
</tr>
<tr>
<td>Family partnership informed practice</td>
<td>5.21 (1.77)</td>
<td>4.89, 5.53</td>
</tr>
<tr>
<td>Practice collaboration</td>
<td>4.91 (1.60)</td>
<td>4.62, 5.20</td>
</tr>
<tr>
<td>Present at case review</td>
<td>5.16 (1.72)</td>
<td>4.85, 5.47</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>4.43 (1.76)</td>
<td>4.12, 4.75</td>
</tr>
<tr>
<td>Consultation with NUM/colleagues</td>
<td>5.57 (1.47)</td>
<td>5.31, 5.83</td>
</tr>
<tr>
<td>Apply FTA Policy</td>
<td>4.72 (1.97)</td>
<td>4.37, 5.07</td>
</tr>
<tr>
<td>Increase frequency of contact</td>
<td>4.82 (1.67)</td>
<td>4.52, 5.13</td>
</tr>
<tr>
<td>Joint assessment</td>
<td>4.28 (1.68)</td>
<td>3.98, 4.59</td>
</tr>
<tr>
<td>Total mean Usual Practice (non-engaged)</td>
<td>4.91 (1.26)</td>
<td>4.69, 5.13</td>
</tr>
</tbody>
</table>

Note. 1 = Never, 7 = Always. CI = confidence interval.

5.13 CAN Education and Training

The following section reports participants’ perception of education and training to prepare for practice when working with vulnerable families. Lastly, the relationship between educational preparation and confidence in practice was tested using a series of four $t$-tests.

5.13.1 Tertiary education

Preparation for reporting and responding to CAN was reported by 66% (n = 83) of the participants. Conversely, a smaller proportion of participants, that is, 47% (n = 61), reported tertiary education had prepared them for working with vulnerable families.
5.13.2 Workplace training

In terms of access to training in the workplace, 88% (n = 113) of participants agreed their workplace provided adequate access to training that supported their practice with vulnerable families. A declining rate of agreement was found across other workplace training topics. Training to assist in making CAN reports was confirmed by 78% (n = 101) of the sample; 66% (n = 85) agreed training enabled recognition of increased vulnerability, and 58% (n = 75) reported training addressed building relationships with vulnerable families. Less than half the sample viewed training as having equipped them to understand the reason that families do not engage with CFHN services or support services (n = 57, 44% and n = 60, 47% respectively).

Open-ended responses were provided by 17% (n = 22) of participants and potential workplace education topics were recommended. These included:

- capacity building of clinical skills, such as assessments, working collaboratively, discussing concerns with families, counselling, working with families in the absence of disclosed abuse and decision-making in relation to mandatory reporting;
- topic-specific sessions, such as focusing on domestic violence, trauma-informed practice, sexual abuse, CWU policies and statutory decision-making; and
- resourcing issues (time and cost)—one participant who reported access to training was often partially self-funded by the nurses and attended in personal time.

Most participants indicated that workplace training assisted them in working with vulnerable families. Training that addressed topics such as understanding the reasons that families do not engage with services received less favourable responses, and less than half of participants perceived it to be adequate. Additional comments
indicated that although these topics have been addressed via workplace education, ongoing education and refresher sessions were areas of need.

5.13.3 Practice competencies

In all, 64% (n = 82) of participants indicated that they considered practice competencies (*Competency Standards for Child and Family Health Nurses*, Child and Family Health Nurses Association, 2009) of CFHNs in relation to working with vulnerable families were being adequately assessed in the workplace. Further, 16% (n = 21) of participants suggested strategies to address how competencies could better enable working with vulnerable families. Their responses are presented in Table 5.14.

Table 5.14

Recommended Improvements to Practice Competencies

<table>
<thead>
<tr>
<th>Recommended Improvements to Practice Competencies</th>
<th>Workplace support (focus on early career or was recently appointed CFHN)</th>
<th>Engaging Clinical Nurse Educators to support nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Utilising education and training opportunities (e.g. in-services and forums)</td>
<td>Development of referral pathways and resources (such as flowcharts)</td>
</tr>
<tr>
<td></td>
<td>Individualised approach for nurses who have identified a learning need or interest</td>
<td>Enhancement of resources to allow time and costs associated with attainment of competencies</td>
</tr>
</tbody>
</table>

5.14 Differences in Confidence Based on Education, Training and Management of Care

The results of the four *t*-tests performed to determine the significance of difference in total confidence scores for the group of participants who reported undertaking education or training are reported in Table 5.15. There were no statistically significant differences in confidence.
Table 5.15

*Education and Training and Total Confidence Scores*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Mean (SD)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did tertiary education address CAN?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>99</td>
<td>5.13 (0.88)</td>
<td>.77</td>
</tr>
<tr>
<td>No</td>
<td>28</td>
<td>5.18 (0.79)</td>
<td></td>
</tr>
<tr>
<td>Did tertiary education address CAN reporting?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>99</td>
<td>5.34 (1.08)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>28</td>
<td>5.57 (0.74)</td>
<td>.30</td>
</tr>
<tr>
<td>Did workplace training address CAN?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>113</td>
<td>5.12 (0.86)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>5.46 (0.91)</td>
<td>.25</td>
</tr>
<tr>
<td>Did workplace training address CAN reporting?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>101</td>
<td>5.41 (1.02)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>5.60 (0.84)</td>
<td>.56</td>
</tr>
</tbody>
</table>

Two further *t*-tests were performed on the specific practice of ‘appropriately manage the care of a child you suspect has been abused or neglected’ from within the scale of confidence. The first *t*-test found no statistically significant difference (\(p = .75\)) in relation to tertiary education aimed at preparing CFHNS to work with vulnerable families. Further, no statistically significant difference (\(p = .99\)) was found between participants in the sample who had reported their workplace training addressed working with vulnerable families and those who did not.

A final *t*-test found that the total mean score of frequency of practice with families not engaged with the service was higher for participants who considered workplace training had addressed the topic of the reasons that families do not engage with CFHN service compared with the group of participants who reported workplace training had not addressed the topic (\(p = .042\)).
5.15 **Chapter Summary**

This chapter presented the results of the comprehensive questionnaire used in phase one. Results revealed high rates of knowledge for mandatory reporting responsibilities and reporting practices by CFHNs. The participants were generally experienced CFHNs who had high self-rated confidence in clinical tasks when working with vulnerable families. The frequency in which practices are applied with families does not appear to vary significantly when comparing engaged and disengaged families. That is, the usual nursing practices used with families are consistent and do not vary once the family becomes disengaged. No statistically significant differences between confidence and education or confidence and workplace training. However, there was a statistically significant relationship between frequency of practice with families not engaged with the service and workplace training, when training had addressed the concept of the reasons that families do not engage with CFHN service ($p = < .05$).

Analysis of data from phase one informed the research questions in phase two. Chapter 6 presents the methods applied in phase two of the study, and Chapter 7 presents the phase two findings.
Chapter 6: Phase Two Methods

6.1 Chapter Introduction

This chapter presents the methods used in phase two (qualitative data collection) of the study. Details of the research goals, design, methods, participant characteristics (including relationship between researcher and participants), participant recruitment, focus group approach and data analysis are provided. A pragmatic approach was used for the overall mixed methods study (see Chapter 3: Section 3.6 Methodology). Focus group discussions were employed to gain insight into practice and recruitment was commenced at the conclusion of data collection in phase one. These discussions were guided by information gained in phase one. A detailed account of the thematic analysis conducted in phase two is provided to achieve transparency and rigour (Braun & Clarke, 2006).

6.2 Approach to Inquiry

The study in both phases was guided by the pragmatic approach. The qualitative research design in phase two was constructed and reconstructed and an iterative approach was applied (Maxwell, 2013). The specific questions used to gather qualitative data in phase two were developed once phase one data were analysed and practices emerged that required further exploration.

6.3 Research Goals

Focus group discussions were selected as the method of data collection, involving participants from phase one of the study to gain insight into the practice nuances identified in phase one. Of interest were the variations found in usual practice when working with families at risk of child maltreatment who were either engaged or not engaged with the CFHN service. Focus group discussions about CFHN practices and the generation of qualitative data were considered a valued extension of the
quantitative analysis. The following sections report the data collection strategies and analyses used in this qualitative study.

6.4 Methods

6.4.1 Research design overview

The focus group questions were grounded in interpretive description. Questions suited to an interpretive description require, first, a descriptive intention reliant on inductive reasoning to create theories based on a specific phenomenon (Thorne, 2008). Hence, theories are presented as themes developed through specific discussions about practice findings using inductive reasoning. Then, interpretation occurs through contextualising such theories into the field of practice with all the complexities inherent within this system (Thorne, 2008). In the current study, this construction drew on the subjective experiences of practicing CFHNs who agreed to participate in the focus groups. Thorne (2008) has argued that interpretive description is more than just a description of conversations with participants. Rather, interpretation allows for the data to also be contextualised against the implications of such findings. Therefore, interpretive description invites researchers to observe beyond themes to reconstruct a phenomenon for considering an alternative stance (Thorne, 2008).

Qualitative research questions for phase two (see Table 6.1) were developed based on the analysis of results from phase one. Four lines of enquiry were determined from the analysis. RQ1 was developed based on the results of mandatory reporting knowledge that one-fifth of the participants reported child maltreatment to the NUM. RQ2 was designed to explore the skill of discussing concerns with families, which was identified in the literature review as needing closer examination to gain a better understanding about the challenges in this practice. Risk of disengagement is commonly cited as a consequence of having such conversations; therefore, RQ3 invited participants
to consider this practice against the concept of engagement. Increased contact with vulnerable families was found to be a common practice among the sample of participants; therefore, a line of enquiry was devised to explore it further. RQ4 prompted a discussion about terminating service delivery in response to a family who has disengaged from the service. This was based on the phase one results, which identified that a practice barrier to working with disengaged families was the application of policy and emotional toll associated with concluding a service.

Table 6.1 lists the questions used for phase two chronologically according to the sequence used during each of the three focus group discussions.

Table 6.1

*Phase Two Research Questions*

<table>
<thead>
<tr>
<th>Qualitative Research Questions: Phase Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative RQ1. Can you describe the practice of consulting with the Nurse Unit Manager when reporting vulnerable families either to the Child Wellbeing Unit or FACS?</td>
</tr>
<tr>
<td>Qualitative RQ2. Can you describe how child protection concerns are raised with a family and how this may affect continued engagement with the family?</td>
</tr>
<tr>
<td>Qualitative RQ3. Can you describe how Child and Family Health Nurses support families?</td>
</tr>
<tr>
<td>Qualitative RQ4. Can you describe the practice response of discharging a vulnerable family since they are not engaged with the CFHN service?</td>
</tr>
</tbody>
</table>

A fifth question was posed to the group to identify the strengths of current practice. A solution-focused approach was based on positive psychology and, in the context of this study, was used to enable a clearer view of solutions among a problem or set of problems that may have emerged throughout the focus group discussions. This pragmatic approach to critically reframe an issue through emphasis on strengths and resilience (McAllister, 2003) invited participants to conclude the focus group discussions with an opportunity to see the strengths of existing practice amidst the complexity of practices when working with vulnerable families.
6.5 Positioning of the Researcher

Reflexivity in qualitative research acknowledges the role of the researcher in the research itself. Articulating the influencing factors on the study by examining the positioning of the researcher is a valuable consideration in the field (Palaganas, Sanchez, Molintas, & Caricativo, 2017). In this study, the most overt influencer was the relationship between the discipline of the researcher (social work) and the focus of the study (nursing practice). Investigating nursing practice as a social worker brought a unique influence on the study and its analysis. Notwithstanding the fundamental approach to the study of pragmatism, viewing the practice issues associated with responding to families with CAN vulnerabilities from the perspective of a social worker was important, particularly in relation to qualitative data collection and analysis.

Thorne, Kirkham and MacDonald (1997) have argued that researchers must be explicit in outlining such influences, not to eliminate them, but indeed to be transparent about these effects.

The social work profession has long been considered a key contributor to the service response to child maltreatment, whether that be from a health service, statutory agency or a non-government organisation. The social work history of the researcher spanned 20 years of working between health services and statutory agencies, both in Australia and the United Kingdom. Further, the supervision team for the doctoral thesis involved one supervisor, a nurse and academic, and the other supervisor, a psychologist. This interdisciplinary supervision team allowed hybrid ideas to flow as the study developed. The lens of data analysis while influenced by thematic analysis and interpretive design, was fundamentally anchored in the views and language of a social worker.
6.5.1 Researcher–participant relationship

The researcher–participant relationship also influenced the positioning of the researcher. The researcher has a 10-year history of working with the participating service, as mentioned previously in this thesis (see Chapter 1, Section 1.8). In effect, participants included close colleagues and, in some instances, supervisees (in the context of clinical group supervision) among the cohort of participants. As the chief investigator of the study, the researcher gathered data during both phases, which included facilitation of focus group discussions in phase two. A combination of professional experience and established working relationships enhanced the study design since the researcher was familiar with workforce practices prior to the study. In fact, it was these two factors that propelled the initial study design. The researcher was motivated to articulate the complex and advanced clinical practice of nurses using the direct voice and perception of the subject workforce. Further, a desire to share the practice wisdom of these nurse specialists and contribute to the knowledge base about the critical role nurses play in identifying and responding to child maltreatment was the most significant driver of the study.

Collectively, the pre-existing working relationship between researcher–participant and familiarity with practice played a critical role in positioning the researcher. The effects of conducting qualitative research when there are pre-existing relationships between the researcher and participant have received scant attention in the literature, particularly in relation to recruitment (McDermid, Peters, Jackson, & Daly, 2014). Potential effects were mitigated using strategies such as seeking formal consent during recruitment, reiterating the voluntary nature of participation and preserving the right to withdraw from participating in the study without consequence (McDermid et al., 2014).
6.6 Participant Recruitment

6.6.1 Recruitment process

Recruitment of focus group participants occurred during data collection in phase one, which occurred from February to March 2015. All participants were offered a focus group participation consent form for staff (see Appendices D and E) once they returned a completed questionnaire to the researcher. That is, an opportunity for participants was extended, although each participant self-selected to be involved in phase two having completed the questionnaire, and no incentives were offered. Emphasis was placed on the voluntary nature of participation to mitigate the sense of obligation or feeling of coercion (McDermid et al., 2014).

All focus group discussions were scheduled to be held within standard business hours in the same location used for phase one data collection. The factors of both time and location were stated to all potential participants. In accordance with the approved protocol, subsequent email correspondence was used to confirm the meeting date and time, which resulted in several participants either not responding or indicating they were unavailable to attend. Many participants were enthusiastic to participate in phase two, which suggested there was little hesitation to engage in a more detailed discussion in person about the topic. The motivation and commitment of participants observed in both phases were considered a strength of the study.

Group design was considered optimal against the measures of size considering that experts recommend between six and 12 participants, timing ranging from one to two hours and frequency of meetings to achieve data saturation ranging from three to six times, according to Onwuegbuzie, Dickinson, Leech and Zoran (2009). Based on these principles, a minimum cohort for group size was set between the parameters of six and 12 and data were collected across three focus groups. The details of participant
selection are outlined in the following section. As the sole facilitator of the focus group discussions and given that focus groups were a more direct experience in engaging with the participants, nurses who had not previously worked closely with the researcher appeared to display some initial hesitation compared with those who had, who seemingly spoke candidly. Participants with less years of experience also seemed to be less willing to contribute to the peer discussion, although they responded well when actively engaged to comment about the topic at hand.

The researcher applied concepts of ethical mindfulness in facilitating focus group discussions, such as being reflexive. Reflexivity is considered a central tenant to methodological rigour; however, Guillemin and Heggen (2009) argued that reflexivity also plays a key role in the application of ethics in research. Ethical rigour was achieved by exercising mindfulness from the study inception and throughout thesis construction. Applying reflexivity allowed consideration of ethics as the study progressed. Practically speaking, frequent supervision meetings with a reflective focus between the researcher and research supervisors were utilised to facilitate critical thinking and ethical mindfulness. Awareness, either through personal reflections or the supervisors’ observations, were managed and potential influences of bias were considered and addressed.

6.6.2 Participant selection

Completed consent forms were returned by 39 participants, and 27 nurses ultimately participated across three separate focus group discussions. Over-recruitment was applied to allow for intended or unintended absenteeism, such as unplanned work-related or personal issues or inability to attend a scheduled session.

The first focus group was conducted with NUMs from both organisations with seven of the eight eligible NUMs who had consented to participating. Group two
involved the CFHNS from the eastern health organisation, and 12 of the 15 consenting participants were able to attend the scheduled focus group. The third focus group discussion was facilitated with participants from the CFHNS from the western health organisation. Initially, 16 nurses consented to participation in focus group three; however seven participated. All three focus groups had consenting participants who were unable to attend the groups because of various reasons.

The range of clinical experience as a CFHNS was reported by participants and ranged from two years to 27 years. Some participants identified gaps in years practicing, and other participants identified a return to practice occurring in the previous five years.

6.7 Data Collection

6.7.1 Strategies

The purpose of the focus groups was to explore results from phase one; therefore, research questions for focus group discussions expanded on existing overarching research questions developed for the whole study and isolated a sub-theme from the preliminary analysis of quantitative data. Discussions were prompted by five questions, each developed in relation to the overarching research questions of the study. The discussions served to collect further data to supplement and enrich questionnaire findings. A semi-structured focus group discussion technique was applied, and five sub-themes were used to inform the framework to guide all three focus group discussions. The researcher facilitated these discussions.

Focus group discussions were conducted on three occasions in June and July 2015 with a total of 27 participants. Focus group one had 12 participants, focus group two had eight participants and focus group three had seven. The discussions were held in three community health centres also used as locations for the questionnaire data collection. The discussions were each facilitated using descriptive questions to promote
group discussion. Each focus group was scheduled for 90 minutes. Complete transcripts ranged from 46 to 68 pages, which is within the expected range according to Krueger, as cited by Onwuegbuzie et al. (2009). Participants were encouraged to discuss their individual thoughts about each of themes among the focus group. Each of the research questions was introduced throughout the focus group at the natural conclusion of each theme to ensure the group covered all themes identified for discussion.

A directed approach was used to facilitate the discussions. During the introduction, emphasis was placed on obtaining the participants’ views of practice barriers highlighted in the questionnaire and the objective of nominating possible solutions. Written consent to participate in the focus groups had initially been obtained during questionnaire distribution in phase one. However, a revision was required to include specification of agreeing to the audio recording. Therefore, written consent was again obtained at the outset of the focus group meeting. Data collection was addressed, and the opportunity for participants to ask questions about data storage was provided at the outset of all three discussions.

Views were sought throughout the discussions to include reference points of consensus and dissent. During the introduction of each meeting, participants were advised that while themes would be presented for discussion, they were encouraged to share common or divergent practices and viewpoints (R. A. Powell & Single, 1996). Opportunities to explore differing views were sought throughout the focus group discussions in that participants were invited to share views that may have been in opposition to the preceding discussion point at the end of a theme before moving on to another topic. For example, ‘Does anyone have a different opinion or experience?’ was frequently asked before proposing the next topic.
6.7.2 Recording and transforming

Focus group discussions were audio recorded using the ‘Livescribe’ program and back-up recording on Dictaphone. The author of the thesis kept minimal notes to assist with keeping track of key points of discussion and potential lines of further discussion, rather than being distracted by gathering additional data, which were being captured by the audio recording. The outcome of discussions was transcribed into written text using a fee-based offsite service. The transcription service was operating in line with an agreement with NSW Health, which included compliance with confidentiality. The transcriptions were reviewed by the researcher for accuracy and participant de-identified. This process was conducted repeatedly throughout analysis to achieve familiarisation with the data (Braun & Clarke, 2006). Braun and Clarke (2016) recommend it is essential that additional time is spent reviewing the transcript beyond the necessity of checking for accuracy when transcription has been outsourced.

Transcript-based analysis was selected as the most rigorous form of analysing data from focus groups (Onwuegbuzie et al. 2009). Immersion in the data occurred at several points throughout the study. The first was immediately following the supply of transcripts, for the purpose of accuracy, when a review of the audio and transcript occurred. The second was at the time the audio recordings were reviewed during the preliminary analysis stages; then, subsequent analyses occurred using the transcripts. Coding was completed by hand, and each transcript was reviewed three times to achieve complete data immersion. Data were synthesised, theorised and recontextualised, as advocated by Thorne and colleagues (1997).

6.8 Data Analysis

Thematic analysis was performed to generate findings from the focus group data from each focus group. Thematic analysis offers flexible analysis of qualitative data.
The flexibility of this approach can be examined in more depth when considering the emergence of themes developed by the researcher. Unlike quantitative approaches, proportions are not explicitly valued in qualitative analysis. That is, the proportion or numeric value of a theme is not considered more or less important if mentioned more (or less) frequently than another. The development of themes used in this study applied six stages to achieve sound thematic analysis (Braun & Clarke, 2006). Table 6.2 presents these six stages used for the thematic analysis in phase two.

Table 6.2

<table>
<thead>
<tr>
<th>Phase</th>
<th>Process Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarising yourself with your data:</td>
<td>Transcribing data (if necessary), reading and re-reading the data and noting down initial ideas.</td>
</tr>
<tr>
<td>2. Generating initial codes:</td>
<td>Coding interesting features of the data in a systematic fashion across the entire dataset and collating data relevant to each code.</td>
</tr>
<tr>
<td>3. Searching for themes:</td>
<td>Collating codes into potential themes, gathering all data relevant to each potential theme.</td>
</tr>
<tr>
<td>4. Reviewing themes:</td>
<td>Checking whether the themes work in relation to the coded extracts (Level 1) and the entire dataset (Level 2), generating a thematic ‘map’ of the analysis.</td>
</tr>
<tr>
<td>5. Defining and naming themes:</td>
<td>Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.</td>
</tr>
<tr>
<td>6. Producing the report:</td>
<td>The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back the analysis to the research question and literature and producing a scholarly report of the analysis.</td>
</tr>
</tbody>
</table>


Emergent themes were noted throughout these stages of analyses. Once themes were identified, interpretive description techniques were used to guide the process of reviewing the data. Interpretive description is a qualitative approach best described by Thorne (2008) as a technique that creates an opportunity to deconstruct existing
knowledge about a topic and ‘to generate new insights that shape new inquiries as well as applications of “evidence” to practice’ (p. 35). The process of interpretive description is not reliant on a prescriptive set of rules; rather, the researcher is guided through the experience of interpreting findings using a sequence of synthesis, theorising and recontextualising. Thorne (2008) emphasised that interpretive description does not simply result in findings; rather, it proposes options. Braun and Clarke (2006) recommended that researchers should apply flexibility during analysis, rather than subscribing to a definitive rulebook. Thus, the themes analysed in the current study used an inductive approach, meaning the findings presented do not necessarily neatly fit within the set of discussion topics used to guide focus group discussions. This approach is described as a ‘data-driven’ (Braun & Clarke 2006, p. 83) or low-inference approach (Sandelowski, as cited in Kim, Sefcik, & Bradway, 2017). Interpretation occurred once data were analysed and coded for potential themes. The researcher completed all data coding and analyses, thus achieving internal consistency (Kidd & Parshall, 2000).

Coding was performed manually by using the analytic technique of interpretive description. The appeal of this technique is based on the objective of generating knowledge that is usable and requires engagement ‘in both ethereal abstraction of theorising and the earthbound concrete realities of the practice context’ (Thorne et al., 1997, p. 175). The decision to identify themes using a latent, rather than at a semantic level, allowed interpretive description to inform the findings presented in the following chapter. This technique allowed findings to offer a deeper insight beyond the offerings of a description. Subsequent discussions of each theme presented within this thesis allowed further consideration of these concepts against existing knowledge (Braun & Clarke, 2006).
Validity in qualitative data analysis can be achieved by including the viewpoint of dissenters and facilitates a greater understanding about the phenomena central to the study (Onwuegbuzie et al., 2009). Further, Thorne et al. (1997) asserted that including dissenting opinions from the data provides insight into the reasons that a concept does not work, as opposed to the reasons it does. Data from each of the focus groups featured at least one, although often several, participants who expressed an alternative point of view. Thus, conscious attempts were made to reach out to, and engage with, participants who were less forthright in expressing their views.

In effect, the data reflect the collective views and opinions of an issue within the group. Throughout the focus groups discussions, the researcher acting as facilitator was mindful of observing group dynamics through interactions and non-verbal cues to ensure space was created for participants who were making attempts to speak although their voice was being drowned out by others. For example, in one group the researcher asked:

What about people who have less experience, I mean you don’t have to comment if you don’t particularly want to, but I’m just curious, I just want to give you an opportunity to comment if you want to about this particular topic.

The findings to follow in the next chapter reflect the divergence in responses expressed across the focus group discussions.

6.9 Conceptual Model of the Integrated Theory of Parental Involvement

The conceptual model of the Integrated Theory of Parental Involvement (see Figure 6.1) developed by McCurdy and Daro (2001) proposed that family engagement with a family support service was influenced by four domains, namely, ‘individual characteristics of the parent and family, provider attributes, program characteristics, and
neighbourhood characteristics’ (p. 113). This model was used to frame the focus group findings, with emphasis on provider attributes and program characteristics. These, McCurdy and Daro argued, have the greatest influence on retention. Participants also discussed perceptions about the individual characteristics of families and parents. These feature throughout the qualitative findings presented in Chapter 7: Phase Two Findings.

Figure 6.1. Conceptual model of the Integrated Theory of Parental Involvement.


Attempts to determine ‘provider factors’ that influenced attrition published through the 1980s and 1990s failed to consistently find the provider factors of the professionals that influenced parent involvement. Factors such as gender, age, education and training were thought to be among the characteristics of professionals. Studies conducted towards the 2000s assumed a more interactive focus and considered the influences of aspects that the authors term ‘provider factors’ and ‘individual characteristics’ related to the family as client, which found that communication approaches and a shared view on the presenting issue (McCurdy & Daro, 2001) were more likely to play a role than factors such as gender or age.
McCurdy and Daro (2001) developed the conceptual model to represent a cohesive framework for researchers to consider the interactions between all four domains. These exist, it was argued, at three critical points when delivering a support service for families. Each domain of parent involvement has a degree of influence when (a) enrolment is proposed, (b) during the enrolment stage and (c) during retention (see Figure 6.1). The framework was developed at a time when research had focused more specifically on attrition, which was subsequently not incorporated in the model. The following qualitative findings chapter will address the stages of enrolment and retention with an additional focus on when the nurse–family relationship terminates prematurely.

6.10 Chapter Summary

This chapter outlined the methods used for qualitative data collection and analysis. Primarily, the chapter detailed how focus group discussions were used to actualise research goals. Reflexivity was explored through the interaction between researcher and participants, as well as the means through which participants were recruited. Phase two used discussions in focus groups to explore practice concepts proposed from phase one. The following chapter presents the qualitative findings of phase two. In summary, thematic analysis was conducted using interpretive description techniques.

Chapter 7: Phase Two Findings

7.1 Chapter Introduction

This chapter presents the findings from the phase two focus group discussions. Focus group data were analysed without the use of computer software. An interpretive description of the findings from the thematic analysis of the data is presented. Themes were developed from an analysis of the entire data set as recommended by Braun and Clarke (2006). Direct quotations have been included to capture the voice of participants.
Reference to the source of the quotations is provided as Focus Group 1 (FG1), Focus Group 2 (FG2) and Focus Group 3 (FG3). Results are presented as follows in accordance with the standards for qualitative research reporting recommended by Levitt et al. (2018).

The ‘conceptual model of the Integrated Theory of Parental Involvement’ (McCurdy & Daro, 2001; see Figure 6.1, Chapter 6) provided the framework for this study. Three stages of family engagement with the service were identified: (a) intent to enrol (b) enrolment and (c) retention. The findings of their study have suggested there is a further phase, namely, when the nurse–family partnership ends, referred to as the conclusion stage. For the purpose of this chapter, the findings of phase two have been categorised as the enrolment stage, the retention stage and the conclusion stage. This chapter details the ways in which the nurses who were working with families with complex assessment and child protection service needs responded to the movement of the families through these stages of engagement. Thus, the findings are presented as themes within each of these three stages. Specific reference to the domains of individual, provider and program factors are also outlined. Individual factors are associated with the family, provider factors represent the stance of the nurse and the program factors relate to the CFHNS.

7.2 The Enrolment Stage

The enrolment stage featured individual and provider factors. Forming partnerships was the key theme that emerged from the domain individual factors, and within the domain of provider factors the theme that emerged was honesty in the relationship.

7.2.1 Domain: Individual factors

Theme—Forming partnerships
Forming a nurse–family partnership during enrolment was discussed as an important feature of the focus group discussion. Creating a partnership with the family was discussed as a key enabler to identifying concerns for the family. Nurses felt that being open and honest with the family about the purpose of the service, in terms of risk identification and response, was critical during enrolment. Over time and with experience, nurses indicated that although initial conversations about risks may be denied by a family, over time a family may feel more prepared to conduct such conversations at future opportunities. However, an exception to this notion was when the risk of significant harm was suspected. Then, it would take priority above the objective of family engagement.

The requirement for nurses to complete a standard clinical screening tool for domestic violence during initial contact with families was provided as one such practice example. Some nurses felt the timing of this clinical task was less than ideal, particularly for participants who believed that families were less inclined to disclose violence without an established working relationship with the nurse. Others pointed out that even if risks may be denied, there is benefit in having asked the questions during the first contact since this clearly demonstrated to the family that risk identification was within the scope of nursing practice.

It’s much more comfortable to be able to tell someone something like that if you’ve already mentioned prior your, at, say the first visit about confidentiality and your duty of care that whatever they say is in confidence except if there’s a serious safety concern then it’s you know, you are a mandatory reporter. (FG1) They might tell you in three years’ time down the track, you know, when you’re seeing them for the third baby, and then, they tell you that they’re actually in a DV (domestic violence) relationship; they tell you when they’re ready. (FG3)
Effective engagement of families predicts retention in the program (or service). Participants were able to make it clear for families during enrolment to ensure the safeguarding function of the nurse was clear from the outset. For example, completing the DVRS tool during enrolment made mothers aware that risk assessment was part of the service. This approach reinforced to families that the scope of nursing practice includes risk identification as a form of child maltreatment prevention. Before discussing concerns, completing clinical tasks, such as psychosocial screening, were viewed as essential foundations to such discussions.

Moreover, nurses felt this may reduce the threat of ending the nurse–family partnership because of conducting such a conversation. Participants believed that being honest about these obligations allowed families to decide whether to disclose sensitive information, such as where CAN risks were present. Another participant added that families felt discouraged or reluctant to disclose sensitive information without first establishing a nurse–family partnership.

7.2.2 Domain: Provider factors

Theme—Honesty in relationships

A commonly held belief was that it was essential to outline the mandatory reporting responsibilities of nurses during the enrolment phase when families are first receiving a CFHNS. Introducing a nurse’s duty of care was a precursor to any subsequent discussions that may be required if child protection or wellbeing concerns arise and a report or referral is required.

Honesty is vital, like if they are honest with the families they tell them, ‘I’m the mandatory reporter, this is what this means’, whatever, and yeah, with vulnerable families they have an honest conversation and very rarely will those families disengage because I think they value that honesty. (FG2)
A common view was that discussing child protection concerns directly with families was a standard practice, particularly in recent years when practice improvements had emerged. A shift in expectations within the service had urged nurses to proactively broach the subject of being a mandatory reporter prior to subsequent conversations about risk when a child protection report was required. For participants who had been practicing for many years, this was a notable shift in practice. Advising managers of child protection reports also became standard practice over time. Participants indicated that one of the objectives of consultation with a manager in part was to allow managers to direct nurses and reinforce the importance of such discussions. A second component allowed managers to have oversight about families with complex needs that may come to light. For example, if FACS were to initiate contact and desire to speak to a specific nurse to gather more information, the NUM would be aware of the background information to assist.

It just became part of our practice in our team to run it past the NUM, have a discussion with her about making any notification or any phone calls to CWU as to why, what their plan is, what the nurse’s plan is to follow-up and what maybe is the outcome from the phone conversation that they had as well. (FG3)

Participants held mixed views about the timing of discussions around suspected risk of CAN with families, which ranged from being essential to occur during the initial contact with the family through to having the conversation out of necessity only if concerns emerged. A participant in favour of making this practice known during initial contact described a sense of empowerment for families in knowing that this could inform their decision about the information they would disclose to the nurse knowing a child protection report may be made if risk of harm or significant harm was suspected.
7.3 The Retention Stage

7.3.1 Domain: Individual factors

Theme—Motivation to change

In the opinion of participants, the experience of families and the way they received nurses influenced their willingness to continue working with the service when risks were suspected or identified. Participants debated the potential consequences of disclosing risk, from the viewpoint of the family. A range of views were expressed that included a belief that families may experience a sense of regret about sharing information if a child protection report is made. Some views opposed the general consensus that direct discussions with families about suspected risk had strengthened the nurse–family relationship. In fact, some participants advocated that some families preferred this direct approach, which became evident when the family would subsequently request to exclusively meet one nurse with whom such a conversation had occurred.

Motivating a change in behaviour within families to mitigate the risk of CAN requires advanced practice skills for nurses to effectively intervene. Practice responses that demand a change in parenting illuminated some contention and were difficult for participants to articulate clearly. The concept of issuing an ultimatum as a means to motivate change was explored, although there was reluctance among participants in response to the use of the word ultimatum. Variations on the term were tried, such as threat, accruing a similar disdain. In practice, it was inferred the intention was not to intimidate a family; rather, it was used to spell out the consequence of unresolved risk: ‘So I don’t think it’s used as, and the Nurses certainly wouldn’t use it as a threat and say “Oh yeah, I’m going to get you to do this by threatening a notification”’ (FG2).
The possibility of a child protection report being made was described by one participant to motivate change with some families. The participant used an example of an infant with inadequate weight gain, which is a serious concern for infants. The participant described, ‘You have to be pretty tough about that sort of thing…’ (FG2).

Where concerns continued without measurable improvement, then parents were advised a child protection report would be made:

And even give ultimatums to people, I mean it sounds ridiculous, but ‘I’ll be back in 2 days’ time’… Then I will be making a report to Community Services because you are not looking after this child. (FG2)

7.3.2 Domain: Provider factors

Nurses described grappling with the complex needs of families and ways in which they were able to respond to risks while retaining families in the service.

Theme—The art of managing complexity

Important attributes required by nurses reinforced in this practice area included confidence, a genuine and pleasant demeanour and being non-judgemental. Confidence was perceived as being instrumental to enable nurses to effectively grapple with the complex needs of families:

It’s just being confident isn’t it, confident in the way that you approach them. (FG2).

And I guess experience too, like, if you’ve had previous experiences where you know the strategies that have worked—and have had good outcomes—then, that’s helpful as well. (FG2)

And you’ve had those conversations. And I don’t mean to make light of it but to be quite pleasant about it rather than serious, but this is how it is like, the conversation style and everything. (FG2)
An approach based on openness and honesty was an important communication style, and such approaches were reported by participants as being well received by families. However, through shared examples of how participants talked about concerns, mandatory reporting responsibilities were embedded throughout the discussion.

I have actually spoken to a family and said that I was concerned because there was domestic violence in the family towards the mother. …I said, ‘Look, I’m obliged to make a report and I am concerned that this (domestic violence) may have an effect on the child. And it also obvious there is a detrimental effect to you as a mum, and as a new mum’. And I told her I was going to make a report to the Child Wellbeing Unit. Mm, and she seemed to take it quite well. (FG1)

Nursing experience, particularly when gained through working with vulnerable families, was valued and thought to have a direct influence on confidence. An exploration of the link between experience and clinical competence found that reassurance, support, coaching or the opportunity to observe a more skilled nurse were valid ways to support nurses and promote confidence. Participants who described positive outcomes for families they had worked with appeared more confident compared with participants who reported having limited practical experience working in the field. Intervention was considered successful not only when an improvement was observed within the family, but even more so when a family had continued to accept the service after the nurse had made a child protection report. Making a child protection report was viewed as a potential threat to engagement with families. The practice implications for nurses once a risk of significant harm report was made is further outlined in the practice strategies.

Personal qualities of nurses were also seen as influencers on follow-up, both positively and negatively. The desire to ‘fix things’ was discussed as a potential barrier
to practice since some nurses carried a great sense of responsibility for resolving the complex issues experienced by families. This proved to be difficult for nurses who were required to manage a substantial caseload, and when encountering a family with multiple and complex issues, they described a desire to want to hold the family, provide ongoing support and to some extent offer families a sense of sharing the load. For instance, ‘Some people’s problems aren’t fixable, sometimes they just are, but sometimes they just need to share what’s happened and just so, I don’t know, share the load type thing that you can’t necessarily fix…’ (FG3).

The practice wisdom of other participants offered assurance that the extent to which a nurse can offer support eventually has an end point. For some participants, the relationship with families ended when families themselves ceased to accept the service, rather than when the nurse determined that the service objectives had been achieved. In some instances, families with particularly complex service needs were allocated two nurses as a strategy to alleviate the pressure on nurses who find it difficult to maintain boundaries. Access to clinical supervision was advocated as a means of burnout prevention and was observed to add value in managing when the nurse–family partnership ends prematurely.

The skills required to rise and meet the complex needs of families were explored through various practical applications. Assessment skills in risk identification and the capacity to deliver support services once risk was identified and reported necessitated a more nuanced practice strategy to retain the nurse–family relationship.

Also, not … throwing them (the family) in the deep end and you know being able to offer some help, whether it’s a referral to another service or you know ‘I’m going to follow you up’ and having that real genuine ability, genuine-ness
and desire to have a relationship with that client, a professional relationship, and help them out and not judge them. (FG2).

Nurses needed to deliver services that were culturally competent, according to the communities they serviced. Practice skills that reflected cultural awareness were viewed with varied success with families. For example, a participant stated that when working with families from a culture in which the male in the household predominately made decisions, the nurse would initiate direct contact with the father for concerns to be addressed. This approach was presented as a successful practice strategy that had resulted in ongoing service delivery and improvements to the safety of children.

That’s a bit of a strategy now… perhaps ask the dad and or could dad give your number and say, ‘I would like to talk to your husband about this’. Because they are really quite powerful people…. (FG2)

Skills identified as being important in supporting families included listening to families; forming a partnership and creating a trusting relationship to enable the nurse to provide advice or facilitate risk disclosure; validation of the life experiences of families; engagement in conversations; being caring; expressing empathy; and advocacy to access support for families.

Grappling with the complex needs of families, nurses reported a need for support, which was frequently secured via consultation with their manager. Overall, the objectives of consultation related to decision-making accountability, transparency in actions taken and managerial oversight of case management. Other objectives were to promote reflective practice, to assist in making quality child protection reports, to gain reassurance regarding clinical assessment, to benefit from coaching, to gather further ideas or strategies to deploy in responding to child protection or wellbeing risks or to seek additional information from other services, such as the CWU. The motivation to
consult ranged from personal choice to the perception that the nurse needed to comply with policy. Consultation was perceived as standard practice, but one perception was that consultation would more likely occur in the context of child protection, or risk of significant harm concerns, rather than below-the-threshold concerns; however, this was not a commonly held view, which indicates that participants had varied expectations.

Confidence and experience among nurses were not found to be predictors of NUM consultation since this was reportedly a standard practice. However, there were lively discussions about the link between clinical experience on confidence in practice, and some participants disputed that nurses with less experience required more oversight and that, conversely, nurses with greater experience did not. This view was hotly contested and indicated that the extent to which nurses are expected to seek consultation varied. The purpose behind such consultations also become blurred because it was difficult to determine whether consultation was associated with presenting risks rather than a matter of individual competency.

Unsurprisingly, participants reported variations in their own experience of a consultation, although mostly this was reported in relation to either making a risk of significant harm report to FACS or child wellbeing referral to the CWU. For example, a nurse seeking advice and guidance would consult prior to making a report, whereas a nurse motivated by accountability would inform their NUM a report had already been made. Either way, the practice of NUM consultation was included in the series of actions taken with a variation to the order in which a consultation occurred:

I feel it’s more important to make the notification rather than discuss it with my NUM first if my—I’ve done the MRG, I’ve spoke to the Wellbeing Unit and it’s telling me the report should be made, then I’ll make a report. On saying that, I will always discuss it with my manager at some point. (FG1)
Other strategies, such as consultation with colleagues (e.g. Social Workers), access to clinical supervision and opportunity to present families with complex needs to a case review meeting were also identified as strategies to conduct consultation.

The purpose of consultation varied, and some participants reported they would inform, rather than consult, their manager. The objective of any consultation between a NUM and nurse was not intended to question or challenge clinical decision-making. Rather, there was a common goal in reflecting on practice:

I really enjoy, like, just sharing, even if it is minor because maybe I’ve got my own way of looking at things, she’s got her own way of looking at things and when we put our thoughts together, it kind of opens the way of how we should actually progressing with that case. (FG3)

Managers would not discourage any nurses from reporting even if their own professional opinion differed:

I would always support them to make a report, I would never ever say, ‘Don’t make a report because that’s the one that is going to turn up dead’. If I think that they should make a report and they don’t, I would probably harass them a bit … Eventually I would say if you don’t make a report, I will if it’s that bad. (FG2)

Theme—Responses to risk

- Versatility

Versatility in program factors played a vital role in retention in the service. For example, a participant described a practical example in which concerns were high owing to a history of domestic violence, and hence, the frequency of contact from the participant was also high. After five home visits, the participant offered future visits to be conducted at the health clinic rather than at the family home. Although there was no overt discussion about the safety considerations, the client had advised the participant
that her husband had been reviewing the infant’s health record (commonly referred to in this practice setting as the ‘Blue Book’) and had noted the nurse’s details, which prompted the nurse to offer an alternative appointment location.

I said, ‘Do you think it’s better than in future if you come and see me at the clinic?’ And so she did, she had no appointment, she rocked up to see me at the clinic and she rocked up in the clothes she was in with the baby and decided to then leave her husband… . (FG3)

• Working through risks

For families where vulnerability was identified, a targeted intervention was delivered in accordance with organisational policy as a framework for practice. Participants described this in terms of offering ‘increased contact’, meaning that additional services would be delivered as an extension of the universal health home visit. Retaining families for the purpose of delivering services, although a common practice response, was intricate. First, the method of increased contact was flexible, according to some participants, and it involved telephone contact with families or other services involving the family and home visits or clinics appointments offered, depending on the presenting issues. Follow-up was more rigid for other participants who were unable to provide follow-up unless it was conducted in a clinic. Telephone contact was the most common method of increased contact, and participants discussed this was a more manageable mode of follow-up, from a caseload management perspective.

Intervention was described through examples such as assessment and monitoring infant development, addressing feeding issues and conducting broader assessments, which included assessing parent–child interaction, home environment and other family factors. Examples of specific clinical tasks associated with family support included
consultation with the CWU or General Practitioner (GP); referral to another service; conduct of developmental checks; provision of sleep and settling advice; encouragement of self-care in parents; improvement of parent–child interactions; and coordination of a case conference.

And we also give them (the family) information…about their children, about child development, the appropriateness of milestones give them the latest evidence-based research information. (FG3)

Nurses recognised an informal function of being a case manager for families, often in response to service fragmentation or a lack of experience among workers in other services:

Our work, a lot of it is case management… because we know that FACS are often over-burdened… (FG1)

That’s essentially what we do even at a universal home visit. So even though everybody talks about sustained doing case management, I think we all do at some point and so that support is… case management. (FG3)

Because we’re doing it because other people aren’t stepping up and saying, ‘I’m actually the case manager’…So, you sort of tend to take over that role because you can see nobody else is doing it and it’s all haphazard. (FG1)

Although there was a degree of agreement that nurses did have a case management function, other participants rejected this notion. Objections were based on principle that case management was not a responsibility of nurses, despite the increasing tendencies to fulfil this role when servicing families with complex needs. Concerns also related to views that any further extension of this role was not sustainable, given the time requirements and existing demand on the service, since the workload of nurses was
already perceived to be heavy. For example, ‘I think at the moment we’re absolutely doing that… it’s just ridiculous… having full caseloads every day and then we’re still kind of trying to case manage really vulnerable families’ (FG1).

Local services were a valued addition to the family support service system and played a role in alleviating some pressure on the CFHNs.

I had a family for two years that I felt I was hitting my head against a brick wall to get services, because they needed letters of diagnosis and the mother wouldn’t attend appointments, so it was really frustrating. And 50% of my visits were surveillance for that family ‘cause there was so many safety issues that were not significant risk of harm, even though DOCS (Department of Community Services) knew of them and had been referred many times, they weren’t classified as significant but they were dangers. And very uneducated poor parenting skills. Yeah, but if I’d have had the Family Referral Service, then it would have saved me a lot of phone calls and frustrating referrals that didn’t go anywhere. (FG1).

Increased contact with a family had a range of objectives, and the reasons to continue service delivery for a family were broad. For example, participants reported that increased contact was influenced by the nurse’s own anxiety or concern about children within a family, meaning that the concern carried a sense of responsibility for the nurse to have more frequent contact: ‘Sometimes it’s the Nurse’s anxiety of going back’ (FG2). Intervention through the provision of support was an example of increased contact that was considered valuable by participants and family alike:

I actually had an email from a client thanking me about a staff member being able to go out and visit as frequently as she did…she said this person got her
through those months and she was probably teetering on the edge of depression or whatever and, yeah, just that person got her through. (FG2)

She said, ‘You used to come and visit me’. I said, ‘Yeah, I know, I remember’.

She said, ‘You know what, I wouldn’t have got through those few years without you’. I said, ‘That’s lovely to hear’. Because, to be honest, I didn’t think I did anything; I’d just go around and say, ‘How are you going?’ and then feed a baby or something like, just nothing... leave again and say, ‘Alright, I’ll see you next week’. So, you think you’re doing nothing… (FG2)

Signposting families to other support services was an alternative to intervention through increased contact, particularly where other services were considered well placed to respond to certain presenting issues. For example, referral to a playgroup to mitigate social isolation may have been recommended rather than increased contact with a nurse. Targeted intervention allowed nurses to refer to other specialist services to meet the needs of the family, such as a mental health referral. Participants discussed that families were often willing to accept the CFHNS and the support associated with the nursing intervention, whereas they may have been less willing to accept a referral to other services that were intended to address a factor that was negatively affecting the family. Interestingly, one participant attributed the reluctance to accept referral to another service to ‘because they’re (other services) the people that do the confronting work and that’s what they’re (clients) scared of” (FG3).

Intervention that provided families a positive experience of access to health care was important for some participants, particularly if a family had previously had a negative encounter. Nurses considered they played a key role in modelling attachment to families throughout their intervention. This was particularly important if concerns had been identified about parenting capacity. Promotion of community connectedness,
such as linkages for families to playgroups and support groups, was also offered by one participant as a further example of support. Another participant added this can often serve as a strategy to monitor at-risk families.

- Keeping a watchful eye

The purpose of ongoing service delivery to monitor families was a contested practice strategy. A participant asserted that increased contact was not a means to monitor families on behalf of FACS, which several participants agreed was not their role. A collective sense of frustration was expressed by participants at the perceived lack of action from FACS and a sense that CFHNs were expected to carry out safety checks:

They’ve (FACS) been rung up and asked, ‘Could you (the nurse) go and see (a family), you know we’ve had a report about this client, you know, I’m a bit – could you?’ And I’ve said, ‘No, sorry I’m not…my role is not child protection… that’s not my role, I’m not willing to do that’. And she did say, ‘Oh, okay, fair comment’… you have to actually be clear about what your role is. (FG1)

Participants believed that FACS ceased working with a family once it was established a CFHNS was involved:

We’ve actually had the opposite situation where FACS were trying to pull out [another participant added: ‘Always’]. And we were absolutely saying, ‘You cannot pull out’, and so, in the end we played that card and said, ‘We are no longer seeing this family, they don’t want us. We are out, they are yours’ and they stayed in and then we reengaged with the family. But we had to play that card with FACS. (FG2).

The unique focus of nurses on children was important, because many other adult-focused services do not necessarily prioritise the needs of the infant. This focus
was considered an aspect of supporting a family. Further discussion led to identifying other sources of advice, such as through the Health CWU or the FRS. Changes to information exchange provisions had improved working together with other services. A range of objectives underpinned the purpose of monitoring families. Examples included preventing the need for FACS to intervene or, conversely, ensuring its continued involvement since FACS had not provided a response to the reported risks, assisting families declined referrals to other services, advocating for the baby and sometimes for reasons that were difficult for participants to identify:

Because, often, it’s that gut feeling I think, I think that half the time if you ask the clinician they wouldn’t be able to put a finger on what it is, but they have enough experience and they have a gut feeling that says there is something not right here and I just want to go back and build a bit more of a relationship with the family, check out what’s going on, keep an eye on the baby. (FG2)

The objective of increased contact to conduct surveillance was discussed with a perception that surveillance had a different scope to monitoring. Initially, several participants agreed with the statement. Others questioned the meaning behind the word surveillance with clarification from the researcher that the word was used in multiple questionnaire responses. A mixed sense remained of whether this term was suitable, and one participant considered it was a less preferable word than support. Another participant reiterated that any ongoing support would be discussed with the NUM.

Once agreement was reached and the term surveillance was accepted, clarification from participants emphasised that surveillance was not conducted on behalf of FACS, which seemed to be important to participants. There was some objection to the choice of word but agreement about the function of follow-up indeed having a surveillance objective. One participant, with reinforcement from several other
participants, added that if a CFHN is concerned about a family and wants to obtain further information, then surveillance may be one practice response. Emphasis was placed on circumstances whereby the CFHNS may be the only service the family has engaged with that can influence further follow-up.

- Finding a voice

Knowing exactly what to say and how to say it when discussing concerns with a family requires knowledge and practical experience. Whether the risks were above or below the threshold, nurses reported it was routine to discuss concerns directly with families. The way in which concerns were identified influenced how practice responses unfolded. Concerns that emerged from a clinical assessment required a different approach than cases in which a direct disclosure of abuse occurred, because nurses were required to bring the concerns to light for the purpose of discussion rather than responding to a specific piece of information. Where risk was suspected rather than overtly present, further information could be gathered from other agencies to determine the possibility of CAN or the presence of risk factors. This was an opportunity to work with other services and this action was considered a practical means of gathering knowledge to prepare for a discussion.

A practical example was described by a participant who shared an account about a client who had minimised historical concerns about domestic violence that had previously been documented following a hospital presentation. Since health services share information about common clients, the participant was able to use a direct approach with the family to verify the information and determine the current severity of risk: ‘With vulnerable families, they have an honest conversation and very rarely will those families disengage because I think they value that honesty. Then, they chose what they tell that staff member or not’ (FG2).
Using a transparent communication style was considered best practice. However, the practice reality meant that transparency had to be balanced against the need to preserve safety of the worker. Ultimately, nurses wanted to reassure families that their intention was to offer support, even if that meant a risk of significant harm report was made:

Um, obviously we do try to be as transparent as we can be but sometimes it isn’t appropriate in terms of our own safety and the safety of the kids as well. Quite often, you know, you have to sort of consider whether between making, you know, informing the family you’re going to make a report and the report being made and whether FACS acts on it or not, whether the child’s going to be safe with the parents knowing that, with a lot of our complex clients. But a lot of the time, it is just about trying to, yeah, get them support and let them know that that’s your intention and that your intentions are trying to support them with their child and their child’s safety as best that you can. (FG3)

- Holding the family

Working with a family once a child protection report was made necessitated a specific style of service delivery, which drew on the personal attributes and practice skills of the nurse. A clear explanation to families about the supportive function of the statutory child protection agency was one strategy to maintain retention to the service and alleviated the worry for some families who feared their children may be handed into the care of the agency. The subjective experience of a family of the child protection agency was also considered a predictor of retention, meaning the subjective view a family had about the role of FACS would determine whether or not they were willing to continue to accept the service after a report was made.
The action taken following a child protection report, rather than the report itself, was seen as a more significant predictor of retained engagement. Nurses discussed that making a child protection report was a means of seeking family support. Among participants, a collective sense was that although the nurse hoped to seek supportive intervention for a family, the response that followed from the statutory child protection agency was unpredictable and at odds with this intention. One participant expressed feeling disheartened at the uncertainty of outcome following a child protection report, saying, ‘You’re so well intentioned and either nothing happens or too much happens; I don’t know’ (FG3). The participant further added that the outcome of a report reflected on the nurse who made the report and described feeling like ‘a mouthpiece for another organisation’, which was met with agreement.

- When nurses are at risk

Delivering a service within the homes of families highlighted worker safety considerations. Risks associated with additional and unknown people being present during home visits made it difficult for nurses to assess risks to safely conduct a home visit. For example, a participant reported an experience of visiting a family home that had a sex offender residing; however, despite ongoing communication with the child protection agency, this information had not been shared. This was disappointing for the nurse, who felt this was a failure on the part of the agency. Nurses were frustrated to learn that information relevant to risk was not consistently disclosed by other agencies, particularly in circumstances when home visits were being conducted.

Worker safety was a consideration when discussing concerns, particularly when the discussion involved telling a family that a child protection report was to be made. Whether or not families were informed remained an individual decision for nurses. Additional background information, such as risks associated with violence and use or
access to weapons, was considered a vital determinant in deciding whether to inform a family. One participant clarified they do not routinely inform families regarding child protection reports if domestic violence is an identified risk factor:

I always used to think I would do that all the time, until I learnt that that wasn’t going to always be safe to do, to tell them that you’re reporting. I like to tell them that I’m making a FACS report because of this reason and we need to get these supports in place, but there has been a situation where I didn’t share because I was concerned about my own safety and that’s what changed my mind. (FG1).

Nurses used various strategies to manage worker safety, such as conducting joint home visits with two nurses or offering clinic-based appointments where duress systems were in place. One participant shared an example that a home visit was cancelled owing to domestic violence risks being identified; therefore, the parent was advised the appointment was re-arranged for the clinic. The participant stated, ‘Obviously, our client is a priority, but staff safety’s the first priority’ (FG1).

7.3.3 Domain: Program factors

Three themes emerged from the domain of program factors. These were (a) the purpose of the program, (b) unlocking the capacity to respond and (c) trust among professionals.

Theme—Purpose of program

The scope of practice for nurses was broad, and clinical presentations included families who experienced risks such as social isolation, domestic violence and parental mental health; further, the mother’s high score on the Edinburg Depression Scale or The infant’s poor weight gain were cited as scenarios for retaining the service. The purpose of service delivery in response to these factors was unclear at a program level, because
such decisions seemed to occur on a case-by-case basis and were heavily influenced by the decision made between nurse and manager. Clarity about the reasons that targeted intervention was offered seemed important. However, decisions driven by worker anxiety clouded the purpose of continued involvement of the CFHNS. There was uncertainty about potential benefits to families who received increased frequency of the service based on the worker’s worry, as opposed to the assessed needs of the family. One participant added that such instances potentially benefited families, citing an example where increased contact motivated by her own underling concern was welcomed by a family as a means of feeling supported. Personal preference and variations in practice among nurses was apparent in discussions, and some increased contact responses involved single follow-up throughout comprehensive intervention:

It’s very personal, I think it’s, yeah, very personal(ly) driven, given that there are some people who just like to do a really good job as they see it and go back and make sure everything is fine and the baby is fine before they move on. (FG2)

Decisions about subsequent follow-up visits were also considered against the capacity of the service to meet key performance indicators (e.g. delivery of universal health home visits). Participants who reported not needing approval to increase contact described that experience and clinical skills were valid means of independently determining whether a family required further contact. Experienced nurses made this decision autonomously. Despite some contrasting views on this issue, there was a sense of comradery, good humour and appreciation of differences among participants. A case example was presented to highlight how follow-up support may be offered:

So, support for us, I mean, some people would see support as like for a family that maybe doesn’t have transport, she’s had a caesar, she’s got 2 other kids and needs to, I don’t know, maybe the baby hadn’t put on weight… so, they feel that
the mother or the family can’t get to a clinic so they might, you know, that’s one avenue of support so that they will take it out to her rather than them needing to move out of their home. (FG2)

Inequity in service delivery was reported as a consequence of increased contact and raised concerns. Participants were uncertain about the value of increased contact as a standard practice response. One participant posited that more nurse intervention does not always meet the needs of the family. Despite attempts to reconcile this concern further group discussion was unable to do so.

**Theme—Unlocking the capacity to respond**

Given that nurses identified the need for access to support when working with vulnerable families, in turn, programs offered support through case review meetings. Case reviews were conducted at a team level within the program; these were described as an opportunity to consult with colleagues as well as managers and were intended to support nursing practice specifically in relation to working with families with complex service needs. At its best, a case review meeting allowed nurses to present a narrative about a family, which outlined the risks and explored the nurse’s capacity to respond.

Participants evaluated the case review meeting (refer to Section 1.5.3 Safe Start Guidelines in Chapter 1 Introduction for further background) with a detailed and dynamic approach to the discussion which generated much insight into this forum.

They’re an opportunity to discuss concerns and raise alerts. (FG1)

For other people to have an input. And listen to what other people do and think, oh, yeah. Yeah, so it sorts of helps your practice, I guess, looking at what other people do. (FG1)

Conversely, some participants expressed strong dissatisfaction with case review meetings, and one participant claimed, ‘I hate it’ (FG3). Criticisms related to the timing
of the meeting (since it was not considered timely to wait until the monthly meeting was held to present a complex issue) as well as the time it took away from delivering a service to families (some meetings lasted for two hours or more). Other views questioned the value of presenting multiple complex cases, since participants stated that content presented was often forgotten and not always seen as relevant to the whole team. Families with complex issues are presented in detail, largely owing to a sense of obligation because case review meetings were specifically established for supporting nurses to present complex clinical matters. However, the sample of participants had a directive that all families with the highest risk factors were required to be presented each month. For nurses who delivered care to many families with high risk, the requirement on them to present families month after month was an additional pressure to that of servicing the family.

Doubt was expressed about the consultative function of case presentation, especially where nurses did not seek or welcome input about their care. One participant described feeling deflated after some meetings and emphasised the importance of interactions within this setting needed ‘to be respectful of other practitioners and also support each other and recognise each other’s strengths’ (FG1).

A sense of duty appeared to propel case presentations rather than a sense of purpose or value, ‘We have to because they’re level three, we have to; it’s more like a matter of that’s the policy, they’re level three, we have to discuss them at our meeting’ (FG3). Each case review meeting operated with a different inclusion criterion, and some meetings included presentation of families engaged with a sustained home visiting program whereas others did not.

Even just to discuss level of care, like does this client really need to be a level two client? You know, is it really necessary that, you know, you’re doing all this
for them or is it just you kind of clinging on to them? And I think as a new member as well, I find it, obviously sometimes they’re really dry and kind of long-winded and that’s annoying, but I do find it really helpful and I think also for my own confidence in presenting a client as well and being able to talk about them and share about them as well, so for me personally, you know, generally I find them helpful. (FG3)

Some participants found there was a duplication in consultation with discussions that occurred prior to, and then again at, case review meetings. One participant noted, ‘Nobody waits for the case review meeting’ (FG3). This line of discussion concluded with a suggestion there should be guidelines for practice at case reviews to set parameters and determine when and why a case needs to be presented. Participants noted some value, particularly for newly appointed nurses to gain knowledge about local services, level of care allocation and associated frequency of contact with vulnerable families and an opportunity to enhance skill of case presentation and confidence in this clinical task.

**Theme—Trust among professionals**

Working with other services was discussed as having practice implications when delivering a CFHNS. Nurses were particularly critical of their statutory agency counterparts and often expressed frustrations when attempting to work together. This tension was most acute when discussing expectations of service scope felt by the sample of participants. Overwhelmingly, there was a belief that FACS had unreasonable expectations of the role of the CFHN. In practice, participants reported FACS caseworkers made requests of nurses to monitor children at risk and this request was viewed with contempt. However, participants also empathised with the constraints on FACS. For example, the recent legislative changes that limited the scope of practice,
workforce issues that were perceived to feature a high rate of staff turnover and the risk of burnout coupled with an inexperienced workforce were also considered challenges for FACS.

One participant highlighted that by contrast, the CFHN workforce was stable and had experienced nurses, which may have influenced the perception about the capacity of the nurses to play a greater role in responding to families, much beyond what the nurses themselves perceived was within their scope of practice. There was a perception that these contrasted workforce demographics may have contributed to the tendency for CFHNS to be considered a case manager of a family; however, not everyone agreed that this was a well-placed responsibility for nurses. Some participants expressed much greater support for the practice of FACS caseworkers and cited positive collaborative efforts demonstrated by examples of regular communication or inclusion at case conferences. However, a point they reiterated was that a request by a FACS caseworker to the CFHN to attend a home visit could be declined if the CFHN felt this was not an appropriate request; this issue occurred frequently.

When increased service delivery was offered, the involvement of other services and any potential overlaps or gaps in service delivery were considered. The practical application of nurses being considered well placed to identify and respond to CAN was tested in the field, particularly when families’ needs were complex and required intervention from a range of different services. Considerations about the services that were better placed to respond to the complex needs of a vulnerable family were not clear-cut. Over-servicing families was a concern for some participants, who experienced that frequently signposting families to ‘yet another service’ was in fact burdensome for the families.
Some participants stressed that assessments must include direct questions about the involvement of other services. One participant shared a case example of incidentally discovering that six additional services were working with one family. A further consideration was the focus of each service should be reviewed to ensure that if multiple services are involved, a focus on children is maintained. Another participant qualified that communicating with other services can assist in identifying any gaps or overlaps in service delivery.

Practice strategies, such as liaison with other services already involved with the family, assisted with applying an interagency response to support families. This practice was perceived as a positive example of responding to families and was well supported among participants. Ongoing communication with other services enabled nurses to keep an eye on families they were worried about. This shift in perception away from working with other services as being problematic to be a positive practice experience saw the discussion highlight many examples of collaborative success. One participant shared a case example of collaboration with mental health professionals, whereby contact with the family was closely coordinated between health professionals and modulated to respond to the declined or improved mental health status. The participant reported positive feedback from the family, who felt well supported by this collaborative response.

The involvement of other services was also viewed by some as an obstacle to continued service delivery. In the context of working with a family when other services are similarly involved to address vulnerabilities, further discussion occurred to examine the role and function that a CFHN service offers the family. One participant reiterated there is a perception that other services’ involvement negates the need for CFHNs. Offering the mainstream universal health service through primary health checks was
considered a basic level of care whether or not other services were involved. The scope of other services involved was highlighted by one participant as being a key determinant for the nurse role or intervention. The focus for a nurse working with vulnerable families was described as being focused on the family as a whole unit to ensure everyone is well supported and child safety is ensured. Within this function of family support is the objective of conducting developmental checks and assessment of risk. Working with families up until a child is five years old provides ongoing opportunities to respond where risk is identified:

And I guess with all of that, one of the spiels that a lot of the nurses use is, ‘You know, we would like to see you for the Blue Book checks but we are happy to see you in between if you have any concerns’. We will ask you to see you in between if we have any concerns, and so, if you have a vulnerable family, until those concerns are alleviated or sort of as [participant A] says taken care of in terms of being referred families. Then, you are going to stay, you’re going to stay on the scene whether that’s a clinic appointment, home visit or a phone call. So, while there are concerns around whatever they may be, be it from the parent or the Nurse, then I think that we are there. (FG2)

7.4 The Conclusion Stage

7.4.1 Domain: Provider factors

Theme—Uncertain endings

Uncertainty may be experienced by nurses at the conclusion of the nurse–family relationship. This is especially so when the family concludes the relationship prematurely. The service model is based on the voluntary engagement of families, which can require some attempts to reach out to the family, particularly where concerns have been identified:
So, those really vulnerable families, we probably make more than two phone calls and one letter; we need to make quite a few phone calls; some people would even call around and put a note under the door to see if they were still living there. If there was a FACS worker, we would ring them and see if they had seen them. Like we do make quite a bit of effort if they are a really vulnerable family like, certainly the Nurses will say to me, ‘I can’t find them there’, if not there, I’ll ring them, the Community Services and find out from their worker what’s happened… (FG2)

Genuine concern for the safety of children when families are difficult to contact was found. Some participants reported a sense of disappointment and sadness and being upset:

I think it’s quite difficult for some Nurses, some people are happy like, ‘Phew, I don’t have to bother anymore’, but some are really, ‘I’m so concerned about that family or that kid’, like really, quite sad, yeah, just would really like to get in there and help. (FG2)

You do feel like a bit of a failure at times. (FG1)

I think when it doesn’t feel good for me is one’s where it’s I’ve been working with them for a long time… Working for a long time, and then, they just kind of like vanished into the ether. This one just—she just vanished…it was one text message to say, ‘No, I’m not available today, I’ve moved house, I don’t know my new address yet’. (Then) Phone number was disconnected, no address, nowhere to go and those ones when there was a lot of things in place… we felt like we were getting somewhere, we felt like there was a little shift…{Researcher: ‘so how did that feel?’} and that felt really awful. That felt really awful. (FG1)
But if you are gravely concerned, you can do, ask police to do a child welfare check or discuss back with your manager and say, or someone else, if yeah, and just say, ‘Look, I still have concerns’. Like, is it my issues or is there something else I can do. (FG1)

In well-established nurse–family partnerships, if families were perceived to be actively engaged in service and then became uncontactable, it elicited feelings of anxiety, disappointment and concern. Feelings of frustration, dread and a sense of loss were expressed. One participant highlighted that uncertainty played a critical role and complicated the emotional response: ‘It’s the uncertain worry is the thing that sort of gets you…’ (FG1).

For some nurses, the need to accept that no service was involved with a vulnerable family was difficult because there was no one to monitor a child suspected to be at risk of harm:

It’s not necessarily about fixing the situation, but it’s about knowing that there are kids out there who in the clinician’s opinion may or may not be being looked after to whatever level they’ve deemed necessary and who is going to be there to watch them …It’s that emotion that I think the nurses struggle with is the letting go of those families where they know there is nobody else around. There is no one else keeping an eye on them or that child. (FG2)

Consultation with a NUM most frequently occurred when a family had concluded with the service (with no explanation offered) and the nurse needed to discharge the family. The extent of the risk was not always associated with the extent of concern expressed by nurses, on the contrary. Families that had concerns about parental depression, anxiety or social isolation were cited by some participants as causing greater worker anxiety. The purpose of managerial consultation in these instances was
perceived to be an opportunity to reflect on action taken and accept that no further intervention could be offered:

It’s voluntary, time to stop, you’ve done the report, you’ve written everything you need to on CERNER, you’ve done all the numerous, more contacting than what is actually our policy to do because you’re concerned and you want to stay engaged with this family. You have done all that is possible in your role, you have done it. (FG3)

**Theme—Letting go**

In contrast, nurses also held that parents have the right to choose whether to engage with the service, that it was and should be their choice to remain in the relationship. Indeed, since demand for the service was high, as families left the service it made way for other, more willing families to engage. Responses ranged from ‘I don’t have any guilt in that if I can’t engage them, I can’t engage them’ (FG1) and indifference, ‘I can only talk for myself and maybe I sound heartless, but it doesn’t worry me’ (FG1) through to relief ‘It is not as if you are looking for work’ (FG1).

Further:

Sometimes it can feel really good because you’ve just, you can’t, you’ve had enough and you just can’t keep going and you can’t handle the constant contact of, you know, not turning up. Sometimes it just, it feels like that’s the right thing to do. (FG3)

Once attempts to reach a family that had decided to no longer engage in the service had been exhausted, it is documented, and the case is closed:

So, if you’ve seen them and they’ve either vanished off the radar, well, there’s not a lot you can do, you just have to let Family and Community Services know. If they choose not to see you and even though you feel that you might be able to
support them in some way, then you just have to let them know that they don’t, you know, and I usually let the client know that I do need to let Family and Community Services know that you don’t want to engage with us anymore, that you’ve got these other services. And I do, and you just have to let them go.

(FG1)

Another participant reported that even with a sense of relief, a shadow of doubt might sometimes linger:

I don’t need to worry about them anymore, I’ve made that report, I’ve done all those things. And other times, yeah, you’re thinking, you know, I hope I don’t see that kid on the news. I hope he’s not found in a suitcase… (FG3)

In response to uncertainty, nurses talked about the way in which reporting was used as a response. Reports made to the child protection authorities depended on circumstances surrounding the premature termination in the nurse–family partnership, irrespective of the phase of service delivery. One practice scenario involved direct discussions between the nurse and family about concerns:

We don’t say ‘If you don’t engage…’, but I think that if families have said to me ‘We’re doing something else’ or this is going on and I say, ‘Look, I’m really worried’; sometimes, if I feel safe to tell them I’m really worried and if I don’t see you then another like child protection may contact you or another group because you know, we want to ensure that you know, you’re all healthy and safe. (FG1)

The alternative practice scenario lacked clarity about informing families, and the opportunities to discuss these concerns with families in these instances was less frequent. Participants reported it was either not possible (where families were uncontactable), was missed (where nurses avoided such discussions) or was not
included in discussions among the sample of participants. The researcher directly asked whether families would be advised of a child protection or wellbeing report, and most participants agreed this would occur some of the time:

Obviously, we do try to be as transparent as we can be, but sometimes it isn’t appropriate in terms of our own safety and the safety of the kids as well. Quite often, you know, you have to sort of consider whether between making, you know, informing the family you’re going to make a report and the report being made and whether FACS acts on it or not, whether the child’s going to be safe with the parents knowing that, with a lot of our complex clients. (FG3)

These practice decisions on whether to inform a family about a child protection report or wellbeing referral remained in the nurse’s hands. Participants argued there was a degree of discretion and the decision would be considered on a case-by-case basis, rather than a standard or consistent practice. One participant clarified reports to FACS would only be made for families who had been identified as having vulnerabilities to a significant extent. Another participant added that if concern was high, a police welfare check may also be requested.

Despite being able to cite practice examples that upheld the belief, an implicit expectation was that upon making a child protection report at this phase of service delivery action would be taken by FACS or the CWU:

Somewhere in the Child Protection System that a notification has been made that we are no longer involved with this family. So, if a notification comes in from somewhere else, they go, ‘Oh shit, no one else is involved, we better do something’. (FG2)
It’s so they don’t slip so the family doesn’t slip through the net like they’ve slipped through our net but FACS then has the ultimate responsibility then. (FG3)

I think the reporting gives as to that puzzle we were talking about earlier, making sure that there is another piece of the puzzle been added but at the same time as well, if there is no puzzle there and this the first piece, at least I know I’ve done everything I can do and that includes making notification to the Wellbeing Unit or wherever that notification is deemed necessary. (FG2)

The practice of some participants indicated that once a report had been made, a discussion about the consequences of the report may arise if the family had been contacted by FACS and subsequent contact with the family had occurred:

She (client) said, ‘Oh, you know, I’ve had DOC’s come on my door, I can’t believe it’. I said, ‘Well, just so you know, I rang them, I actually made a report because you declined Brighter Futures, you declined this, this and this and these were my concerns’ – and she went, ‘Oh, actually, it’s pretty good because they’re actually going to help me, they’re going to organise some in-home child care and they’re going to do this and this’ – so it ended up being a real positive thing…(FG3).

Making a child protection report for families who choose not to accept the CFHNS caused some confusion for the families themselves. One participant reported being questioned by families about the reasons a child protection report was made on the basis a CFHNS was declined. The participant replied, ‘We are just reporting our concerns’ (FG3).

Some participant responses reflected an inaccurate perception about the function of services, for example, a participant stated that a CWU referral allowed for the CWU
to maintain contact with a family who has disengaged when in fact the CWU does not have contact directly with families. Whereas the purpose of making a child protection report based on a family ceasing to engage with the CFHNS was considered necessary by some nurses, it was less clear what implication this had on the children at risk within the family. Child safety was of paramount importance, and a child protection report was perceived to be one way of advocating for this priority. When describing the reason behind a child protection report in this circumstance, one participant insisted child safety ‘supersedes their parenting rights and choice to engage in our service’ (FG1).

Therefore, the right of the child to safety was given much greater emphasis than that of the parent’s right to choose whether or not to enrol with the CFHNS. There was a mixed response as to whether families were routinely advised that failure to engage with the CFHN would result in a report to FACS and most participants stated it would depend on the situation. An obligation to inform FACS was cited by some nurses when families disengaged where their details had been listed on a family case plan. Whether or not nurses felt reassured or confident after making a child wellbeing referral or child protection report or whether, in fact, this was a sound practice response was debated without any clear sense of commitment either way.

Additional strategies used to manage occurrences of families who ceased engagement with the CFHN included presenting the family at the team case review meeting or consulting with the NUM. Consultation with a colleague to debrief, or with the NUM to identify additional suggestions to make attempts to engage a family (such as knocking on the door of the family home) was a reported practice. Other options included attending playgroups that families are known to attend, contacting the next of kin, or other services (e.g. schools or the GP) for sharing concerns about a family and advising the CFHN services is no longer working with a family. Clinical supervision
was highlighted as an important means to assist in maintaining professional boundaries between the nurse and families, and promoting self-care. However, the practical application of boundary setting was difficult:

And that’s why we need supervision and that’s why we have those boundaries because, otherwise, you end up taking that home and that I think you learn over a while so that you’ve still got that empathy but you’re able to actually really helpfully go okay, I can’t do anything else, I just have to let that go and that’s why supervision is so important for us and knowing what your boundaries are, because we all struggle with that. (FG3)

Alternative practice strategies were available, such as to offer families the opportunity to work with an alternative nurse if there were any disruptions to the relationship between an individual nurse and family. Disruptions were considered possible where a child protection report was made or following a direct discussion with parents about child protection risks. Participants felt conflicted about how to best satisfy their duty of care for the children in these families. This was further compounded by the experience of some participants who had been involved in critical incident reviews conducted by the organisation in which nursing practice and managerial decisions had been critiqued. If engagement in service was maintained following a child protection report, participants identified a need to regain the family’s trust, offer reassurance and provide ongoing support to assist with addressing the vulnerability subject of the report.

7.4.2 Domain: Program factors

Theme—Drawing the line

The central barrier is that voluntary engagement is needed. Universal health services are not sanctioned. For some of the participating nurses, this was a key consideration. Nurses have a strong commitment to wanting to help families, especially those with complex needs, and feel a moral obligation to do so. But they are also aware
that the suspicion of risk for child maltreatment does not constitute the right to intervene outside of the legal requirement. That is, unless the child/children are deemed to be at risk for serious harm then they cannot continue to engage with a family that chooses to withdraw.

‘you have to draw the line between wanting to engage with them (families) and their choice not to’ (FG1).

Further discussion revealed that nurses had differing opinions of what the policy for follow up is. On the one hand some talked about how they felt supported by policy to spend time making follow up phone calls and sending emails to families lost to follow up. They saw it as best practice. On the other hand there were nurses who preferred to spend more time with families who are willing to engage.

Far more phone calls and text messages than the standard two and the standard letter. You hang on to them for weeks. (FG3)

Indeed, for those nurses who subscribed to the belief that time spent on follow up was a minimum requirement, additional practices were also considered as part of their practice repertoire. This included but was not confined to making unscheduled home visits, leaving a note for the family requesting contact, for example. It also included contacting other agencies outside of health such as child protection authorities. These additional efforts were employed for the most complex families who had not been sanctioned to a parenting program of support but were visited as part of a universal service. This ties in with the findings from both qualitative and qualitative phases of this study. The fact that families with very complex needs are not necessarily offered secondary or tertiary health services and their support falls to the universal services. In turn, nurses are required to deploy advanced practices that have an early intervention rather than a preventative focus. In some instances, the suspected child maltreatment
may have already occurred which extends practice beyond early intervention to a response ordinarily given by a statutory child protection practitioner.

When concerns or risks remain for vulnerable families, contact would be made with the CWU. Many participants agreed the objective of this call was to fulfil their duty of care. One participant added that once a report is made to FACS advising that a family has disengaged from CFHN, a perception is that responsibility then sits with FACS to take action depending on whether or not a report meets the risk of significant harm threshold. Perception about whether this prompted a response from FACS were mixed. Acceptance that a family had disengaged from the service was a challenge for some participants, although reflections about the family maintaining this right were noted by the nurses.

Program capacity to offer follow-up to families with vulnerabilities was raised as a further consideration in relation to staffing and caseloads. Staffing limitations often created pressure within teams to proactively follow-up families with identified vulnerabilities. Therefore, where families had been reluctant to accept the CFHN service, some participants described other strategies could be used to provide options to families to access the service in different ways that were less resource intensive. Clinic-based follow-up appointments were a favoured option and seeking NUM permission to conduct a subsequent home visit was another option, depending on existing service demand and resourcing. Follow-up with other support services involved with a family was another practical example.

We’ve started to do quite a bit of work with the playgroups and sort of having an adult set of eyes on a family in a different sort of environment, so, if they have any concerns or worries they can contact you and share them with you if you’ve
made that referral to their playgroup, just so you can work together a bit more. (FG3)

From a service delivery point of view there are structural issues that impact directly upon the barrier of engagement. These are related again to the way in which universal services are delivered versus the expectation of working with families with complex needs. For example, a referral for a clinic visit will be arranged at the end of an initial home visit by the universal home visiting service. Clinic services are not set up for case management. A family with complex needs and known risk factors for child maltreatment is unlikely to engage in such a service and it is up to the nursing staff to create a service where trusting relationships can develop.

We’ll get them to come to the clinic, so then, if they don’t come then that whole scenario goes ..., maybe if you had of gone back out once more and if things were then worse and you identified that...(FG3)

They don’t tell you stuff, but you know there’s stuff going on. They more or less tell you because you’re the third person they’ve seen in six months and they’re like, ‘Well, you don’t really have any relationship with me, why would I tell you anything?’ (FG3)

You’re trying to squash appointments in for your universals, it’s then with somebody different so it’s not continuity of care. (FG3)

Enhancing the service profile with families and other services to promote a greater understanding and appreciation for the role that CFHNs play with families was considered an important step forward for the service. Participants had mixed views about the perception of program characteristics, but one participant proposed the potential value in there being some uncertainty about the role in offering an unfiltered
opportunity to build a rapport with families through delivering a clinical task, such as weighing their baby, which may lead to supporting a family with vulnerabilities such as domestic violence. There was a commonly held view that the CFHNs must retain the perception of being a parent support service.

I think that child and family health nurses suffer from an image problem, like even in the child and family health brochure nowhere is it mentioned that we deal with vulnerable families—so who’s counting that? Midwives don’t know that we do that, they just think we weigh babies. (FG1)

Meanwhile, despite the fragmentation and discontinuous care provision, nurses can feel that they make a difference to families. They may even see positive outcomes for families, giving them reason for persistence with attempts to continue service delivery:

you’ve worked with those families, you’ve made those referrals and you’ve had them come back and you can see those improvements…that’s what keeps you going. (FG3)

### 7.5 Summary of Qualitative Findings

An overall summary follows before critical discussion of findings is presented (in Chapter 8). Findings from each of the three stages of the model go some way in disentangling the complexity of the nurses’ practice. The formation of partnerships between a nurse and a family during enrolment was found to be crucial in creating a foundation for future conversations, particularly in case risk was identified or suspected. The study found effective engagement required nurses to explicitly explain to families the purpose and limitations of their role. This approach created a bridge to the retention stage.
Once a relationship was formed, nurses upheld honesty in the relationship with families, both through consistently declaring mandatory reporting responsibilities to all families and through subsequently discussing risks with specific families who warrant such a response. Retention was suggested to be the most intricate phase of practice. Retaining families in service delivery required nurses to grapple with the complex needs of families, which was found to be challenging on both a personal and provider level. The desire to resolve such complexity is in itself a complicated matter and requires nurses to truly come to terms with the messy and complex nature of this practice. Purposeful intervention guided by consultation and collaboration with other services were hallmarks of well-considered program factors that enabled nurses to connect with their capacity to respond to the complex needs at hand.

The inevitable end point with families need not be when a child turns five years old and the service concludes. Rather, participants indicated that families with complex needs frequently cease to accept services well before objectives are met. This is a far cry from the formation of partnership that is aimed to be established during enrolment. The practice response required from nurses is that they must be versatile, but ultimately strive to work through the worries at hand. Increasing the frequency of contact with families was a standard practice response in working with families with complex needs. Nurses maintained their own satisfaction, in addition to satisfaction observed from families receiving this response with positivity, irrespective of the type or purpose of intervention.

In some instances, nurses felt compelled to keep a watchful eye on families. CFHNs have a unique focus and expertise about children, which is a valuable contribution to care being delivered to a family with complex needs, and nurses play a role in safeguarding not only the children, but the whole family unit. However,
surveillance was felt to be less valuable to families. Staying engaged with a family owing to risks was key to ongoing service delivery during retention. This is compounded by the limitations of the statutory child protection which means vulnerable families with complex and multiple needs may only receive a service response from a universal service. In such circumstances, nurses find themselves in a position of response, well beyond the public health positioning of prevention or even early intervention. Yet, the ability to voice concerns around the risk of child maltreatment remained elusive for some participants. The ability to facilitate such sensitive conversations, be they about a concern or a report (and in some instances, both) was suggested to be difficult although frequently encountered in this practice setting. Retaining relationships with these families while nurses navigated these experiences was difficult, even more so when the safety of the nurse was also jeopardised. Balancing child safety against nurse safety is a problem raised by participating nurses in this study.

During the conclusion stage, nurses were often faced with uncertainty at the unexpected ending of a partnership with a family. This often gave rise to a flurry of activity in an attempt to either reach a difficult-to-reach family or to report concerns to another service for action. For others, letting go symbolised the end of the partnership, irrespective of whether it ended at the hands of the family or the nurse. However, even then, moments of doubt emerged and the true struggle with the messiness of risk is captured. Complexity, it would seem, exists both within the families and the workforce. Missed opportunities to convey concern to families featured as a descriptor of practice, and the emphasis of such discussions circled around reporting. Further, inaccurate perceptions among providers about the responsibilities of other agencies actively involved in the human services system raised speculation about the efficacy of the
practice response of reporting families who cease to accept services. Throughout this complex area of practice, nurses conveyed genuine concern and hope for families with complex needs, even if it was not the nurses themselves that were able to facilitate the improvement.

7.6 Chapter Summary

This chapter provided a detailed analysis of qualitative data obtained from focus group discussions. The following chapter will present an integrated discussion of both phases one and two.
Chapter 8: Integration and Discussion

8.1 Chapter Introduction

In this chapter, quantitative results and qualitative findings are integrated and discussed. Previously published evidence reviewed in Chapter 2 is considered against the findings of the current study. Key findings are presented according to individual factors, provider factors, program factors and systemic drivers. The findings discussed are from a practitioner, not a client, perspective. The findings are discussed and then a recommendation is made for a framework of practice for working with families with multiple and complex needs. Further practice and research implications are outlined. Finally, the strengths and limitations of the study are identified.

8.2 Study Objectives

This mixed methods study was framed by qualitative and quantitative objectives. Research questions centred around the concepts of knowledge, practice, engagement, response, education, training, consultation, discussing concerns, supporting families and ending the nurse–family partnership when a family does not engage in service delivery. A synthesis of findings from the study are discussed using the conceptual model of the Integrated Theory of Parental Involvement (Daro & McCurdy, 2001) of individual factors, provider factors and program factors. Systemic drivers of practice, a theme developed from the literature review, is also applied to the study findings.

8.3 Key Findings

8.3.1 Individual factors

8.3.1.1 Forming partnerships

The formation of the nurse–family partnership is vital to the retention of families, and engagement with, and commitment to, families are considered key influences on the practice responses of nurses (Alonso-Marsden et al., 2013; Selbie,
Since the current study did not obtain data from families, individual factors are drawn from the perception of families as detailed by the nursing participants. Empirical evidence has deduced that families require clarity about the purpose of the service during enrolment since without it, families are unwilling to accept the service (Winkworth et al., 2010). Further, the partnership between nurse and family must be built on trust (Einboden et al., 2019). However, the current study uncovered that some nurses perceive families to ultimately hold the power in deciding whether to accept or decline the service, without consideration of the role of the provider. The actions or choices of families were often described using blame, attributing explanations for being unable to engage the family to the family themselves, for reasons such as changing telephone numbers and frequently moving to a new house. Families were often seen to have a much greater influence on non-engagement compared with the nurses themselves, which contradicts the nurse–family partnership philosophy that underpins the service. In fact, families were seen to be the greatest obstacle in collaboration, more so than the other services. Nurses sometimes used different strategies to try to reach families with complex needs; however, overall, the role of providers was absent from responses.

8.3.1.2 Motivation to change

Undoubtedly, the degree to which parents engage or avoid services can also be an important factor to analyse when identifying risk of harm (Akehurst, 2015). The prevailing practice barriers identified in the study reinforced the importance of reflection about the individual factors, that being the target population serviced by health policy consists of families with multiple and complex needs. Shifting the paradigm to consider a family deemed to not be engaged in the service towards the possibility that the service is not meeting the needs of the family may open a broader
conversation that further challenges the notion that universal health services, such as CFHNS, are well placed to respond to CAN.

The current study found that families often end the nurse–family partnership prematurely, although the reason for doing so remains unknown from the family’s perspective. What is known from the current study is that services delivered to families are in part reliant on the adults being motivated to change and accept the service being offered.

On the balance of individual factors contributing to the overall picture of CAN prevention, despite operating from a voluntary service model it is apparent that when a family is not actively engaged in a partnership with a nurse, mandatory reporting requirements compel child protection reports or child wellbeing referrals to be made about such occurrences. These actions are often taken in the absence of a clearly considered assessment of harm in the hope that statutory child protection service will respond. However, this is often not the case. Although the partnership between nurse and family is built on a foundation of trust, this study has not evidenced that the partnership extends to informing families that a child protection report will be made if the family does not accept the CFHNS.

8.3.2 Provider factors

8.3.2.1 Experience

The sample of participants had a significant degree of experience at the time of the study. On average, participants had almost 25 years nursing experience and 13 years as specialists in Child and Family Health Nursing. Most participants had obtained postgraduate qualifications across a variety of sub-speciality areas. Years of experience can be a complicated measure, and evidence can be found that both supports its relationship with confidence (Bressem et al., 2016) and denies its bearing on
competency (Chen et al., 2015). Most of the survey participants had encountered child maltreatment throughout their careers, with two-thirds reporting this to be the case within the 12 months prior to data collection. It is probable that a greater proportion of the sample were able to draw on their own experience beyond the nominated timeframe of a year. This study found several factors influenced the ability of a nurse to complete clinical tasks, referred to in the study as practices. Experience was found to have the greatest impact on practice, along with the provider attribute of confidence.

8.3.2.2 Knowledge

Participants were knowledgeable on the mandatory reporting requirements as well as the ethical obligations to report CAN. All participants correctly identified themselves as mandatory reporters and confirmed a professional/ethical responsibility for reporting suspicions of CAN. Coupled with this finding was the tendency to frequently seek counsel from their manager once CAN was suspected as an adjunct to their reporting practice. Reporting guidance in the current study setting is accessible via the MRG, which had been introduced in the organisation four years prior to data collection for the current study. However, the participating nurses reported seeking guidance from managers more frequently than from the MRG.

8.3.2.3 Confidence

Confidence is a personal attribute of providers, which plays a significant role in retaining a family in service delivery. This study measured self-reported confidence; it explored the relationship of confidence with self-reported practice and found participants were generally confident across all practice domains, although slightly less so when integrating practices to manage care for children who had been subjected to CAN and when identifying child sexual abuse. Across the sample of nurses, confidence was high, as was the frequency of usual practices. Although experience was often
correlated with knowledge, other studies have found that even when accuracy in knowledge was confirmed, participants often doubted their skills (Bressem et al., 2016). Conversely, this study found experience, knowledge and confidence were all positively correlated.

Further, other studies have shown that nurses can be resistant to accepting the safeguarding function of their role (Saltmarsh & Wilson, 2017), but the current study did not find any evidence to indicate this form of resistance. Some resistance was found towards the specific task of case management. However, this perspective was attributed to work pressures and constraints on time rather than an inherent conflict with the nurse playing a role in risk identification and response. Moreover, some empirical evidence suggests that certain professions never achieve a high level of confidence when working with children (Barrett et al., 2017), but the current study did not find this to be the case, particularly in relation to the tasks of risk identification.

8.3.2.4 Reporting practices

The current study found nurses to be knowledgeable about their mandatory reporting. However, when this knowledge was applied to the alternative reporting system, there were some variations in this finding. The study found a high level of accuracy in reporting suspected CAN to FACS (88%) or CWU (90%). Predominately, practice guidance in this health setting has been obtained from policy. Empirical evidence has previously found the correlation between policy and practice to be dubious. Further, certain studies have indicated that the unintended consequences of implemented policy can in fact result in a surge in dissatisfaction among the workforce (Condon, 2011; King, 2015), particularly in relation to the increasing roles and responsibilities of safeguarding (Saltmarsh & Wilson, 2017). However, the current study tells a different story: policy plays a significant role of influencing practice in the
context of significant systemic change. It is reassuring that efforts to implement these systemic changes appear to have made their way to the standard practice responses of nurses in this study.

The current study identified a small proportion of nurses who had suspected CAN and decided not to report. Self-reported compliance with reporting suspected abuse was higher in this study compared with those previously published in similar settings. CFHNs have adapted practices to comply with the alternate reporting system introduced several years prior to the study, with guidance predominately gained through health policy. The current study found a higher rate of reporting in the 12 months prior to the study than previous studies that had similarly investigated the mandatory reporting behaviour of nurses. For example, Fraser, Matthews, Walsh, Chen and Dunne (2010) reported that approximately 20% of participants in their study had suspected and not reported CAN. The current study found only 5% had suspected and not reported CAN in the twelve months prior to the study. Reasons for not reporting suspected child maltreatment included a lack of experience or confidence had the strongest correlation with failing to report, along with the perception that existing statutory agency involvement meant a subsequent report was not required. Assumptions that others would report or that the statutory organisation would not respond were also commonly cited reasons for not reporting suspected CAN.

Some evidence indicated that policy had influenced practice of not reporting, given that some participants referred to collaborative decision-making in teams and following government policy by either completing the MRG or referring lower-level concerns to the Health CWU. Each of these examples was viewed as a reason for suspecting and not reporting. Participants reported policy played an important role in their practice, and it is likely that policy has such an influence because much of the
services delivery program is outlined in policy, rather than a specific manual or training package. For example, health policy directs that families for whom below-the-threshold risks are suspected should be referred to the Health CWU.

Reporting practices also varied from that expected on the basis of previous literature. Some participants reported that the police were an option when reporting CAN concerns. Almost one-third of participants indicate reporting to the police on suspecting CAN, which had been listed in the questionnaire as an incorrect practice response based on policy guidelines. However, focus group discussions allowed reasons for contacting the police to emerge. Some participants described that where immediate safety concerns are identified, the police were an option available to ensure safety. Therefore, it is not entirely inaccurate to respond ‘yes’ to this question in those circumstances. Despite this view, policy in the study setting makes it clear that contacting the police where risk, or risk of significant harm, is suspected does not alleviate mandatory reporting responsibilities. Reporting to the statutory agency or a CWU are the only two actions nurses may take that satisfy this legal requirement.

Although a small proportion (2%) of participants indicated they would report CAN to the Department of Education, such reporting is not sufficiently prevalent to considerably affect practice. It is possible the practice of information exchange with prescribed bodies, such as the Department of Education, outlined in the NSW child protection legislation, may be considered by this cohort as reporting concerns rather than the technical definition of mandatory reporting. However, this would not satisfy the legal requirements of mandatory reporting.

8.3.2.5 Complex practice responses

The complexity of practices required to respond to families where CAN was suspected was nuanced. There is growing research interest that argues a child protection
report is only one possible response of a nurse (Einboden et al., 2019). In fact, recent research has advanced knowledge of nursing practice to safeguard children (Hornor et al., 2017). The current study has further addressed the identified gaps in the evidence by offering a more detailed description of practices beyond existing knowledge. The study found that families with complex service needs require a complex practice response.

Nurses reported needing to satisfy specific needs of the family to successfully enrol and then retain a family in the service. The likelihood of enrolment has been reported to increase if the provider, in this instance the nurse, demonstrates competency and skills of emotional intelligence, such as empathy (McCurdy et al., 2006). The current study found participants expressed genuine concern about the families with which they worked. The emotional toll of working with families with multiple and complex needs was evidenced throughout the current study. Emotional implications for nurses occur in all phases of family involvement, from enrolment to conclusion.

Opportunities to strengthen the confidence and practices of participants were found to be associated with skill acquisition to actively engage families with complex needs, assess CAN and have a solid knowledge of community support options to assist families. Inadequate screening for child maltreatment has previously been found to be a practice deficit that requires remediation (Hornor et al., 2017).

Increased contact with a vulnerable family and the practice of increasing contact was found to be the most common occurrences. Participants described a range of practices from support to engagement, but they fell short of overtly stating the practice of working with the identified risks for the purpose of risk reduction. The comments from participants offer a rich description of practice responses that collectively seek to deliver a response to vulnerable families to mitigate the risk of CAN within the confines of a non-statutory child protection service, often in the absence of a statutory
child protection interagency partner. The data make a significant contribution to the existing research by illustrating the many and varied means CFHNs use to respond to the suspected CAN from a progressive universal service model. This finding supports the existing literature, which maintains nurses are well placed to identify and respond to CAN. Further, the manner in which this service is effectively delivered in practice terms is better understood through this finding. In effect, it is possible to argue that this specialist nursing workforce is ‘holding the risk’.

Signposting to another service may infer that the CFHN service ceases to deliver a service to the vulnerable family, although it is difficult to draw conclusions from this dataset. Certainly, the practice of signposting families to support services has been found to be a positive aspect of nursing practice in the prevention of CAN (Lines et al., 2018).

At a provider level, the study found evidence that nurses were motivated and committed to delivering a meaningful service to families valuing accessibility, support and ethical practice.

8.3.2.6 Assessment skills

Provider factors, that is, factors from the perspective of the nursing workforce, are one of the most effective predictors of retention (McCurdy & Daro, 2001). The current study found that the provider factors associated with skills such as assessment, risk identification and other tasks included in the overall response to CAN are each perceived as essential in working with families in this context. Assessment skills are a core practice in child maltreatment identification and response (Carson, 2018; Ho & Gross, 2015; Hornor et al., 2017; Lines et al., 2018; Paavilainen & Flinck, 2013; Schols et al., 2013; Selbie, 2009; Taylor et al., 2017). However, indicators of risk are not always overt, and it is the subtler indicators that can be difficult to identify (Barrett et
Therefore, the task of risk identification is not always obvious and requires a degree of knowledge skill and application in a practice setting. Lepistö et al. (2017) argue that use of a screening tool may extend beyond risk identification and be applied more broadly to assessment and response. The current study found a high level of confidence in regard to risk identification across all types of abuse, except for a slight reduction in the proportion of participants less likely to report confidence against the identification of child sexual abuse and management of care to a child suspected to have been abused or neglected.

Initiating direct discussions about risk of harm were found to be a challenging aspect of practice for some participants in the current study, as has been established in other studies (Foster et al., 2017; Paavilainen & Flinck, 2013; Schols et al., 2013). Honest conversations about concerns are considered essential to practice and have been attributed with reducing the likelihood of anger from parents (Dahlbo et al., 2017). Increasing the comfort of nurses towards a more consistent, rather than exceptional, practice response will enhance the capability of a service to provide intervention that addresses and mitigates contributing factors for abuse. The combined efforts of knowledge acquisition through training, reinforcement through policy and accessing supervision and consultation to explore efficacy will collectively assist nurses in further strengthening their practices in this context.

Risk identification was found to be a further example of complex practice responses described by nurses working with families with complex needs (Akehurst, 2015). This study found that risk identification was one aspect of practice regarding which participants possessed a high level of confidence. In comparison to the relatively high confidence reported against single tasks of risk identification, participants in the current study were less confident when it came to integrating practices to collectively
enact management of care. Most participants identify CAN risks predominately through making child protection reports, signposting families to other support services or through consulting with their manager. In addition to the specific skills of identification and assessment, other skills, such as collaboration between disciplines and agencies (Land & Barclay, 2008), effective communication skills (Paavilainen and Flinck, 2013) and the capacity to respond to maltreatment, are each vital in direct work in child maltreatment prevention with families (Akehurst, 2015; Ho & Gross, 2015; Paavilainen & Flinck, 2013; Schols et al., 2013; Selbie, 2009; Taylor et al., 2017). A degree of homogeneity was found across the sample of nurses, which may be reasonably associated with the provision of universal child and family health services.

8.3.2.7 Management of care

Intervention following abuse, described in this study as typical management of care, relies on multiple factors. The current study’s finding on the formation of a relationship between the nurse and family grounded in trust was consistent with those of other studies (e.g. Harding et al., 2019; Kobayashi et al., 2015). Trust, coupled with performing specific intervention tasks, such as assessing the family’s needs and resources as well as playing a role in addressing the risk factors that influenced abuse, were each critical practice responses required when managing care of suspected CAN. The current study suggests that managing care requires multiple tasks conducted either directly or indirectly with the family. Tasks conducted directly with families included engaging families in ongoing service delivery, discussing concerns contributing to risk, monitoring families for the purpose of follow-up and increasing contact. Indirect tasks included reporting risk of significant harm, referring risk of harm to the CWU, referring families to other support services, consulting the manager or colleagues, applying the MRG to guide decision-making, discussing at case review meetings and following
policy or guidelines. Despite varying confidence among participants in undertaking these tasks, the majority were able to articulate a range of practices that they drew on to deliver care.

Engaging families with multiple and complex needs has received increased attention, and the current study provides further insights. Alonso-Marsden et al. (2013) emphasised the importance of articulating the purpose of service delivery to families as a means of facilitating engagement beyond the initial appointment. Put simply, a family will not attend a follow-up appointment if the purpose of that meeting is unclear. Services must note this aspect when considering issues such as non-attendance at scheduled visits, rather than maintain a one-sided view that considers the family non-compliant or labels the family as failing to attend.

Although some aspects of practice are clear, the function of nurses monitoring families is less clear. Kent et al. (2011) found a tension between the objectives of working with families in a supportive capacity and visiting them for surveillance. Participants in the current study suggested that increased contact was the most common practice response in cases when child maltreatment concerns were evident and that targeted intervention strategies were used, including support, education, signposting to other services and service retention (meaning the nurse just continued visiting). The intent of this contact was to monitor the family and ongoing risk. Whether this purpose of service retention was clearly and honestly conveyed to families did not emerge from data analysis, and it is possible that if it is not conveyed, families will conclude the nurse–family partnership.

Practices most frequently applied in managing CAN concerns included consultation with a colleague or NUM, policy compliance, application of professional judgement and verbally presenting a family at a case review meeting. Missed
opportunities in usual practice tended to be tasks that were associated with recent
system changes, such as referring to the FRS, applying the MRG or referring to the CWU, which were less frequent compared with reporting to FACS and peer or managerial consultation. No statistically significant practice variations were found when comparing the practice response of working with families who were engaged with the service versus those not engaged. Preference for consultation was again reported by participants, who were found to be less inclined to access clinical supervision as a means of supporting their practice. The current study found the sample workforce to be heavily reliant on consultation; however, little is known about the quality and quantity of this consultation, or outcomes for families.

Further, Saltmarsh and Wilson (2017) describe nurse practices in terms of ‘dancing around families’ (pp. 2244), but this study proposes the dance is much more interactive and is in fact with, rather than around, families. Nurses described adjusting dosage of contact in response to identified needs and taking action on various tasks, such as signposting families to additional family support services as a means of responding to an identified need. This practice response suggests nurses are dynamic when responding to families with complex needs.

In summary, the practice responses required to respond to families with complex need required a comprehensive and adaptable range of practice responses. Each clinical task in isolation does not necessarily require an advanced level of skill. However, integrating a combination of these skills in response to the complex presenting issues is the point at which the complex service response emerges. The essential tasks of assessment and risk identification are required as a preface to the more complex phase of retaining a family in service delivery. Experience and confidence are important influencers on practice; however, it is the task of bringing together multiple aspects of
practice into the dimension of case management that is most complex. The overall response to CAN first requires a nurse to demonstrate to the family that they are competent and caring towards the family. Second, nurses are required to complete a range of direct and indirect tasks that move beyond the limits of mandatory reporting practices. Although the study found participants were not as confident in managing care as they were in risk identification or mandatory reporting, it is able to make a valuable contribution to the empirical evidence through rich practice descriptions, which demonstrate a range of tasks need to be performed when responding to families with complex needs.

Concluding the nurse–family partnership can be troublesome, particularly when unexpected and abrupt. Ultimately, CFHNs need to uphold principles of open and honest dialogue and trust with families, which are vital in the enrolment stage. They must not lose sight of these principles in the context of integrating a multitude of practice responses for providing care to families with multiple and complex needs. For some, the practice of making a child protection report after families have, in the nurses’ mind, concluded the relationship prematurely, may offer some semblance of closure that is otherwise unattainable.

8.3.3 Program factors

8.3.3.1 Clinical supervision

Organisations may absorb some of the emotional toll of safeguarding through the provision of clinical supervision (Akehurst, 2015; Dauber et al., 2017; Reeves et al., 2015; Rooke, 2015; Taylor et al., 2017). However, the current study found that access to clinical supervision as a provider factor was less frequently used as a practice response when typically managing care for a family when a child has been abused or neglected. Mandatory reporting or signposting families to other support services were more
common practices for most participants. Nurses’ responses were often underscored by emotional challenges, such as worry and concern, associated with working with families. Although it is well documented in the literature as being a critical practice when providing services to families with complex needs (Botham, 2013; Smikle, 2017; Wallbank & Wannacott, 2015), the current study did not find optimum use of clinical supervision.

Frequency of practice responses did not vary significantly based on whether families were engaged with the service or not. The study consistently found participant preference for discussing a case with a colleague or NUM and were less inclined to discuss a case at clinical supervision. Clinical supervision is commonly considered a key strategy to support professionals, particularly those disciplines charged with safeguarding responsibilities (Akehurst, 2015; Dauber et al., 2017; Kent et al., 2011; Taylor et al., 2017). However, the current study found mixed results in terms of access to supervision being relevant to support practice when challenges emerge. These may have been missed opportunities for many participants, who reported they did not access supervision as a strategy to influence practice responses to families, particularly in case attempts to retain the family in the service were unsuccessful. Overall, evaluations of supervision were positive and access, for this sample of participants, was a nominated strength of the current service system. Given the evidence that suggests that supervision can reduce compassion fatigue (Reeves et al., 2015), efforts should be made to ensure access and scope of supervisory sessions in the study context are meeting their potential.

Self-reflection was a valued characteristic, which has direct benefits to effective clinical practice (Barrett et al., 2017). Supervision and consultation are both strategies
that can facilitate nurses’ reflection on their practices and were both found to be routine aspects of practice in the current study.

8.3.3.2 Collaboration

The study found that collaborative effort between services was the priority area for improvement. Working collaboratively with other agencies was also not found to be a common practice response. Despite being the central tenant of the KTS Reform, this aspect of systemic change is yet to be evidenced in the practices of CFHNs and in many ways supports the argument that interagency responses to CAN are problematic (Valentine & Hilferty, 2012). Existing empirical evidence recommends collaborative efforts in safeguarding practice (Land & Barclay, 2008). Certainly, the desire to work in a collaborative manner was one of the ways in which participants described optimum practice, although this is at odds with the findings that indicated collaboration occurred infrequently. Collaboration, both with other agencies and the families themselves, was considered one of the practice barriers with complications abounding from the voluntary model of service provision based on which the participants work. Despite the commitment to working with other agencies, the working relationships are not functioning well, which is a barrier to effective interagency efforts.

8.3.3.3 Consultation

Consultation with colleagues was proved to be a support to practice in the existent literature (Rooke, 2015) and was also found to be a source of support in the current study. Although consultation with managers was a requirement, nurses reported value and reassurance were obtained from this interaction. The updated literature reviewed in Chapter 2 found that access to support from managers played such a critically important role in supporting practice (Austin & Holt, 2017). The current study has also found this to be so in the current setting. Consultation tended to be applied as
an adjunct practice to mandatory reporting and was viewed as a valued contribution to practice.

8.3.3.4 Case reviews

The systematic literature review did not identify any literature in relation to case reviews, but evidence suggests that using a ‘fit-for-purpose’ meeting format can aid in the practice of case presentation in a group setting (Woodman, Gilbert, Glaser, Allister, & Brandon, 2014). This format includes applying a systematic method of identifying cases, which does not rely on an individual clinician’s willingness to present a case and clearly determines the objectives, for example, joint decision-making or shared learning. The current study highlighted that although the service had a system in place for case identification, it resulted in an unwieldy volume of cases for discussion at each monthly meeting. Further, in recent years the service had been party to a case review of a critical incident whereby a perceived failure to report child protection concerns had been levelled as a criticism against this service. Consequently, emphasis was placed on practice improvement to demonstrate the service had accepted this and changed practice. Further research activity is warranted to explore how policy is implemented or evaluated in this practice setting.

Improvements to the case review meetings were made in one of the participating health organisations following focus group discussions in phase two. For example, attendance at meetings was diversified and consultants became active participants in case discussions about shared families who had been the subjects of an incident that was likely to have increased risk for the child/children within the family. The researcher attended case review meetings to provide advice and guidance about child protection or wellbeing concerns in a professional role as Coordinator, Child Wellbeing, and senior clinicians from the local mental health service attended on a
regular basis. Decision-making in groups has been criticised in the literature for its limitations. Evidence points out that some of these limitations are inefficiency and often do not generate an outcome or decision much different from what a manager would have concluded (Amason, Thompson, Hochwarter, & Harrison, 1995). The literature base on decision-making presents a rival position that may challenge the existing processes, such as team-based case reviews that are stipulated in health policy. Despite this, team-based decision-making remains a feature of contemporary health services.

Effective safeguarding systems must have a mechanism to ensure managers have a strong understanding of the experiences of frontline staff and, in turn, the clients (Horwath & Morrison, 2011). In effect, this case review model achieved this with NUMs well positioned to appraise not only service demand, but also to hear the challenges of interagency collaboration and workload associated with nurses offering supporting to families with multiple and complex child protection vulnerabilities. Further, CFHNS can be considered well placed to respond to vulnerable families, but the NUMs are also well placed to influence service delivery to ensure vulnerable families are receiving a service that responds to their needs (Horwath & Morrison, 2011).

### 8.3.3.5 Universal service

Program factors, such as the UHHV model operating in alignment with progressive universalism whilst still being grounded in voluntary engagement principles, offer an added complexity to servicing families with complex needs. The study found that efforts to engage hard to reach families was juxtaposed against the choice inherent in offering a voluntary service. Without a mandate, participants felt unable to enforce follow-up with families who chose to conclude the service. Conversely, the standard practice response in such circumstances involved making a risk of significant harm report to FACS or risk of harm referral to the CWU. The study
found that although such actions are taken, it rarely results in a response from FACS, and where action is taken, nurses felt worried about what action could be taken. The intersection of practice between agencies, particularly where nurses were working with FACS, was often described as a challenging area of practice. Collaboration with this agency is an essential requirement of interagency efforts to respond to risk, but nurses had difficulties establishing positive working relationships with caseworkers.

The current study found that although nurses had some discomfort around the descriptor of monitoring, they confirmed this is one aspect of practice when risk is suspected. A common view was that the role of nurses extended to maintain contact with families, often through increased contact, to ensure families were engaged with a service. The study found that where no services were involved with families, nurses held genuine concern about the safety of families. Conversely, Kent et al. (2011) found that health visitors in Ireland lacked confidence in the task of monitoring and believed that this was not an effective means to assure safety and protection from harm.

8.3.4 Systemic drivers

8.3.4.1 Competency

The current study explored the role of practice competencies as an influencer on practice. Most participants in this study considered the competencies used to assess CFHN practice (Competency Standards for Child and Family Health Nurses, Child and Family Health Nurses Association, 2009) adequately assessed practice in relation to vulnerable families, even though the competencies do not overtly assess these practices. It remains unclear what prompted this high response rate, particularly when considered alongside the one-fifth of participants who indicated uncertainty when responding to this item. Possibly, when asked about competencies the participants considered the clinical skills assessment, which certainly covers many aspects of practice relevant to
child safeguarding. Four systemic drivers of practice were identified for CFHNs featured in this study; however, it would seem that this collective range of drivers may generate some confusion among nurses rather than reinforce practice expectations.

8.3.4.2 Education and training

Education and training for the workforce are valued commodities in safeguarding practices (Akehurst, 2015; Barrett et al., 2017; Bressem et al., 2016; Chen et al., 2015; Foster et al., 2017; Land & Barclay, 2008; Saltmarsh & Wilson, 2017). Education and training are frequently considered an essential aspect of preparedness for nurses to both identify and respond to child maltreatment. Based on the literature reviewed and presented in Chapter 2 (Literature Review), the empirical evidence has notable gaps and studies accept training as an important commodity without providing a deeper understanding of its relationship to other influences on practices, such as the personal attributes of the practitioner. The current study found that tertiary education had addressed CAN for most of the participants, but less than half felt prepared for working with families with complex needs.

Conversely, participants’ responses were more favourable about access to workplace training to address CAN. However, there was a reduced degree of satisfaction in the application of training to address the complexity associated with families who do not engage with services or where vulnerability increased. Education and training were not found to influence the confidence levels of nurses to effectively manage care for children where CAN was suspected. Positively, a correlation was found between nursing practice of nurses who had received workplace training about families disengaged from the service. This suggests that training can effect the practice of nurses.
Despite the efforts of workplace training addressing CAN, the total mean score for confidence was not statistically significant when comparing those who reported CAN was addressed with those who did not believe CAN was addressed. Thoburn (2010) argues that training for practitioners working with families must address assessment skills, although, more specifically, emphasis must be placed on asking families targeted questions that explore issues that potentially contribute to abuse and neglect. Workplace training would be well placed to deliver topics that address the skills required to navigate difficult conversations, including screening for risks and addressing risks. Drawing on the learnings from the current study, forming an open and honest relationship between the nurse and family requires nurse confidence which can be increased if the content is specific and designed to address practice issues, such as where families have disengaged from services. Put simply, targeted and specific training content enhanced self-reported practice with families.

In addition, that studies place importance on education and training in child maltreatment (Akehurst, 2015; Barrett et al., 2017; Bressem et al., 2016; Chen et al., 2015; Foster et al., 2017; Land & Barclay, 2008; Saltmarsh & Wilson, 2017) is a positive development, but training must be specific and demonstrate advancement in skills, knowledge and confidence. Moreover, training delivered to health practitioners, such as nurses, should be specifically designed with the health setting in mind (Foster et al., 2017). Delivering programs that do not strengthen the participants’ practice is an ineffective use of resources and does little to improve the outcomes for families with complex needs.

Training programs have been found to improve the skills of participants when a combination of learning techniques is incorporated (Flemington & Fraser, 2017; Tanoue et al., 2017; Turner et al., 2017). Offering an accessible and sophisticated education
program, such as the e-learning program by Bressem et al (2017) or a curriculum based on the ACE study (Bachmann & Bachmann, 2018; Gill et al., 2019), is an ideal strategy to meet the diverse learning needs of a workforce, which can be implemented and evaluated at scale. Bressem et al. found that participants apply training to practice with moderate frequency, which suggests there is an opportunity to explore and build on the elements of training that are successful in this setting. Transformational learning that applies critical reflection (Tweedlie & Vincent, 2018) has also been found to make a significant contribution to safeguarding practice.

Participants reported a generally positive experience of some aspects of tertiary education assisting with their practice with vulnerable families, although less so in preparation to engage with vulnerable families. This deficit in knowledge may well result in varied practice responses that draw on an individual’s competency to both identify and then subsequently respond to suspected risk of harm. Certainly, existing evidence argues insufficient education and training will reduce the confidence and competency of practitioners (Saltmarsh & Wilson, 2017).

Policy spells out the procedural requirements, whereas training has an important function in influencing practice. This places great importance on policy and the need for content to draw on existing evidence to promote a culture of best practice, as well as the need for quality assurance measures to be in place to ensure the linkages between training and practice are being made. This study found that participants do not report that they frequently draw on knowledge from training when responding to families with complex needs, certainly not as much as they rely on peer or management consultation. This is likely a missed opportunity, particularly as nurses advocated for additional access to training that specifically addressed challenging practice circumstances. Applying theory and knowledge to practice is an aspect of education that has been
previously examined (Bressem et al., 2017); therefore, workplace training on topics associated with CAN should measure if and how this integration is occurring to ensure training is meeting the needs of the workforce.

Tertiary education is one source of knowledge, but it too should be considered not only a means of providing a foundational knowledge base to enable nurses to feel prepared as they enter the workforce but also must accurately reflect the evolving role nurses play in the identification and, increasingly, the response to child maltreatment. Workplace training should extend such foundations but must also recognise any discrepancies for nurses who have been employed for many years as postgraduates, considering those nurses with more years of experience may not have benefitted from a curriculum that addressed CAN.

In summary, tertiary education can assist in preparing nurses for the workforce, considering that extension of learning occurs through workplace training. The efficacy of both learning opportunities is difficult to evaluate because providers will access education in many and varied combinations. Clearly, it is necessary to design content that adequately reflects the complex needs of families being encountered by nurses, particularly in workplace settings, because it is a much more consistent means of accessing professional development for the workforce. These strategies may reinforce the practice required of nurses in fulfilling their child protection and wellbeing responsibilities, well beyond the task of mandatory reporting. The current study suggests that training alone is not the panacea for practice but can support nursing practices in working with vulnerable families.

8.4 Discussion

This study sought to explore the practices of nurses who work with families with complex needs from a universal service model. Over time, nurses working in UHHV
services have been required to deliver targeted intervention to families who access this primary health care service and align with progressive universalism. Although SHHV programs have been progressively delivered across Australia, gaps exist in both access and eligibility to these programs. Consequently, families with complex needs who are ineligible or unable to access SHHV programs are reliant on the UHHV programs to access health care for children from birth to five years.

Much of the empirical evidence on health home visiting as a strategy to prevent CAN is associated with sustained home visiting defined by programs that guide intervention delivered by specialist nurses. Conversely, universal health home visitors have a primary health care function and hence deliver service by combining child health and development screening and a form of child maltreatment early intervention, though in some instances maltreatment may have already occurred. This latter aspect of practice is the context of the current study.

CFHNs in the universal service setting have been increasingly required to deliver a service to families with complex needs with little speciality training or program structure. Operating from principles of progressive universalism without additional funding or resources has placed significant pressure on services to deliver care designed for all to be adapted for targeted intervention service intended, but not specifically designed, to meet the needs of families in which children under 5 years of age are at risk of abuse and neglect. The study has significantly contributed to advancing existing knowledge about the practices of this nursing speciality through an exploration of knowledge, confidence, practice, education and training in the context of working with vulnerable families.
8.5 Recommendation: Framework of Practice for Working With Families With Multiple And Complex Needs

A proposed framework has been developed as an extended model for parental involvement with a family support service (McCurdy & Daro, 2001), in this case the CFHNS. The following figure has proposed a framework for working with families with multiple and complex needs (see Figure 8.1).
Figure 8.1. Framework of Practice for working with families with multiple and complex needs.

Therefore, this descriptive study recommends extending the framework of the conceptual model of the Integrated Theory of Parental Involvement developed by Daro and McCurdy (see Section 6.9 in Chapter 6). Based on the results of this study, a fourth dimension may be considered in addition to those of the original Daro and McCurdy framework (see Figure 6.1), which extends from retention to conclusion where families may conclude the relationship prematurely or where service delivery goals are achieved. The proposed framework (see Figure 8.1) recognises the conclusion stage is a key phase of parental involvement. Uncertain endings for nurses can be a difficult state of mind and navigating ways of letting go of families with multiple and complex needs is difficult, particularly where the nurse–family partnership ends before mitigating the identified vulnerabilities.

8.6 Implications: Practice

The following practice implications are identified. Each implication is outlined within the framework of practice for working with families with multiple and complex
needs to consider practice opportunities at each phase of parental involvement. A fourth implication is also outlined in relation to workplace training.

8.6.1 The enrolment stage

Once a family accepts the service, engagement efforts require flexibility and versatility to reach families in a meaningful way. When a service is intended to deliver child maltreatment prevention from a partnership approach, it stands to reason that service delivery should reflect these principles. Ensuring the service is accessible to all families, particularly those identified as at risk of child maltreatment, needs to be prioritised if the service is to effectively achieve engagement and retention of a family during the enrolment phase.

Once a family receives the first contact from the service, it is important to have a clear conversation about engagement and the consequences of disengagement. Put simply, families need to be clearly informed that if concerns are identified a nurse may make a child protection report or referral to the CWU based on non-engagement. The intention of such a conversation is to enable parents to make considered decisions about engagement and for nurses to convey concerns that may be compounded by disengagement.

8.6.2 The retention stage

Nurses need to discuss identified concerns clearly and honestly with families in a timely and respectful way. The perception that such direct conversations may jeopardise engagement contradicts existing evidence that strongly indicates formulating a relationship based on trust requires honesty.

Access to supervision focused on families with multiple and complex needs may assist retention of families. Supervision is considered a forum to explore practice responses with vulnerable families at all stages, and particularly where retention is
fragile. Implementing an evidence-based model of supervision designed as fit for purpose may be key to unlocking the capacity to work through challenges to retention.

Overall, clinical tasks should not only seek to identify risk factors of child maltreatment, but also respond in way that mitigates these risks.

8.6.3 The conclusion stage

Service systems are recommended to develop a process that considers closure with families from a partnership approach, rather than focusing on child protection reports as the primary focus. Applying a triad to the partnership model (Goodall & Montgomery, 2014) may well offer opportunities for programs to evaluate existing processes that determine the action to be taken when a family has indicated that it has declined the service. For example, writing to a family to convey concerns about disengagement from the service and inviting a parent to reconsider engagement may well result in a twofold benefit. One, communicating honestly may serve as motivation for the parent/s to re-engage. Two, the letter may offer a sense of closure for the nurse, which may in part alleviate the emotional toll for nurses.

8.6.4 Education and training

The fourth and final category of practice implication is related to workplace training. An opportunity currently exists to utilise workplace training to address contemporary challenges experienced by nurses when working with families with multiple and complex needs. Workplace training can improve practice when the content is relevant. Two potential learning topics include communicating with a family about risk of child maltreatment and concluding service delivery with a family that has disengaged from the service.
8.7 Implications: Future Research

The current study has placed the workforce of nurses as the focal point in exploring practice responses to families with complex needs. Future research should be focused on the experience and views of families themselves, which would present an opportunity that has been absent from empirical evidence. Research that seeks to engage those eligible (including those who decline or prematurely conclude service delivery) for a universal health service intended to prevent child maltreatment would be a welcome contribution to the field. Considering nursing practice and other factors highlighted in this study as drivers of practice from the service user’s perspective would validate the findings of studies such as this one.

Research activity on evaluations of services that assess accessibility, rather than redirecting access as a measure of a family’s limitation or deficit, are currently unexplored. Examining how accessible a service is through the eyes of a parent of a family with multiple and complex needs would be a valuable contribution to the discussion. Further activity on policy implementation and evaluation in this practice setting would also add to the knowledge base.

8.8 Study Strengths

Several elements that strengthened the current study. The interest and commitment of the CFHNS to the study enabled a clear connection between items measured throughout the study being closely aligned with the practice setting. Engaging the service managers of two metropolitan CFHN workforces allowed for a significant sample size of 129 participants in phase one. Further, being allocated time within professional development forums to collect data also positively influenced the high response rate. A significant expression of interest from eligible participants for joining focus group discussions in phase two also suggests a high degree of motivation among
them to explore practice responses. Overall, the willingness of the service to both contribute and participate strengthened the findings of the current study.

The scope of the current study broadly considered many factors that contribute to nursing practice. The past offerings of empirical evidence that focused primarily on mandatory reporting has evolved and the recent meta-synthesis of literature by McTavish et al. (2017) highlighted that studies are broadening in scope to consider other issues, such as engagement communications skills. The current study has advanced the knowledge of nursing practice and captured a contemporary practice framework in detail to provide a more comprehensive understanding of nursing practice. Further, it has demonstrated the range of drivers that influence the CFHNS delivered to families with multiple and complex needs.

8.9 Study Limitations

However, it is acknowledged that the study also has a number of limitations. The first limitation is a pre-existing relationship between the researcher and participants. The second limitation related to the participants.

First, the pre-existing working relationship between the researcher and the participants may have affected the study. Given the role of the researcher within the organisation, the risk for social desirability is recognised. Alternatively, participants may have felt inhibited about exposing practices or views that could have deviated from the standard practice responses offered by other participants.

The second limitation was the absence of participation of families eligible for the CFHNS, which could be one of the more significant limitations. A case study design was used in by Appleton and Cowley (2008) in their study set in the United Kingdom which combined data from health visitors and clients in an examination of the critical attributes of nursing practice when completing assessments. Recent studies, for
example, an Australian study that examined the views of parents as regards access to universal child and family health services (Rossiter et al., 2019), suggest that research activity to address this knowledge gap is increasing. However, the purpose of the current study was to explore nursing practice through the eyes and words of nurses themselves. An opportunity exists for future research to apply a family-centred approach to research design to invite families to have a voice in their own experiences about accessing the CFHNS, particularly families who terminate the working relationship prematurely.

8.10 Chapter Summary

The purpose of this study was to explore the knowledge and practices of CFHNs when responding to families with complex needs. This study was built on the belief that nurse specialists, such as CFHNs, are well placed to identify and respond to child maltreatment. The practice components that applied to families with complex needs were explored in this thesis. Over time, there has been increasing focus on the roles and responsibilities of health practitioners and the function of their practices to identify and respond to suspected CAN. Much of the empirical evidence to date has focused on practices of nurses delivering SHHV programs. This study focused specifically on this nursing speciality of CFHNs with the objective of advancing existing knowledge of the practices of this workforce.

The study found that although the nursing workforce is typified as being knowledgeable, experienced and confident, nurses found responding to families with complex needs a complex process of integrating many factors into safeguarding practice. Practice responses required to meet the complex needs of families are not linear, and hence, nurses must bring together aspects of their own personal knowledge, attributes and skills and contextualise these among the provider factors set by the
UHHV setting within which they operate. These factors are complex in isolation, and when brought together with the individual factors of the families themselves highlight an even richer tapestry of challenges and opportunities through which nurses are required to weave their response.

The proposed Model of Parental Involvement must consider the conclusion stage equally important as the phases of enrolment and retention. Uncertain endings can be difficult for nurses and findings ways of letting go of families with multiple and complex needs is difficult, particularly where the nurse–family partnership ends before mitigating the identified vulnerabilities. The current study outlined the provider and program factors that underpin the nursing practices across all phases of parent involvement. This chapter has presented a further phase of parent involvement by considering conclusion as a key phase of parental involvement. The following chapter will conclude this thesis.
Chapter 9: Conclusion

Recognition of the complex needs of families seen by CFHNs in Australian universal services has resulted in an evolution of their role and service delivery towards a service model of progressive universalism. This study explored this role in relation to not only identifying, but also more broadly responding to, risk of child maltreatment. The nurses in the study were found to have integrated a range of skills, knowledge and competence to meet the needs of families that have children suspected to be at risk of harm. The nurses were knowledgeable, experienced and confident across a range of practices associated with responding to families with multiple and complex needs. The study applied the conceptual model of the Integrated Theory of Parental Involvement (McCurdy & Daro, 2001) to examine the key drivers of practice. The study has proposed an extension to the framework, which argues for a further phase of conclusion that occurs once service delivery ends. This final thesis chapter considers the key study findings against this extended framework, starting with family engagement during enrolment, followed by the phase of retention through to conclusion.

The formation of a partnership between a nurse and a family during enrolment is critical. Partnerships grounded in direct and honest communication facilitate the enduring possibility of addressing risks or concerns by way of open discussions with the family. However, if nurses consider addressing risks or suspicions of abuse and neglect in isolation rather than as part of engagement, it can prove problematic. Actively engaging a family and addressing concerns once identified allow complex situations to be responded to, rather than avoided. Practice that contributes to effective engagement leads to retention of families in service delivery; thus, it is crucial that nurses are prepared to address suspected risk of maltreatment from the outset of relationship formation and in all phases of parental involvement.
During enrolment, nurses are likely to inform families that there is a legal duty to fulfil the mandatory reporting responsibilities. In fact, mandatory reporting responsibilities are well established in contemporary nursing practice, and evidence generated by this study supports that practices are being extended. This extension incorporates the broader range of tasks required to optimise the possibility of intervening in response to suspected child maltreatment. The study found that nurses undertake clinical tasks integral to promoting child wellbeing with a high degree of frequency and confidence. A key feature of practice when CAN is suspected includes consultation with others, such as colleagues and managers, and is confirmed in this study as standard practice. Arguably, the importance of managers maintaining oversight of practice prevails as a strength of the program, rather than a limitation for the provider. Although an experienced, confident and knowledgeable workforce, the participants in this study place great importance on the shared approach to child wellbeing and protection.

**Retention** of families in continuous service delivery relies on bringing together the individual factors associated with families, such as motivation to change or willingness or ability to stay engaged with the service, alongside the provider factors associated with the workforce charged with service delivery. Examining the individual factors in the absence of the role of provider may unintentionally place greater responsibility on the family for engagement, rather than considering the skills of the provider (Platt, 2012). Individual factors, such as families presenting with their own unique complexities, are pertinent, but it is the nurses that need to configure a practice response that seeks to respond to the array of concerns and fluctuating risks within a family. The ‘art of managing complexity’ (Klein, 2004) emerged as a key learning from the study with multiple contributions to this artform. Although confidence is key to
nursing practice, other attributes, such as being non-judgemental and genuine, are also of great importance. In fact, forming nurse–family relationships based on honesty and trust is not only crucial in the initial phase of enrolment but in all phases of involvement with the family.

Safeguarding practice that operates within narrow parameters of mandatory reporting and signposting families to other services could be extended. Extensions are possible through experiences such as witnessing positive outcomes from peers, which led to enhancements to practice competency. Strategies such as coaching and observing peers’ practice with families are also considered positive drivers of practice that enhance competency. The need to accept the personal limitations that ultimately prevent creating change in a family is clearer for some nurses, but this clarity does not necessarily eradicate the emotional toll aroused by this line of work. Clinical supervision is found to be under-utilised by nurses in this study, despite its proven value (Botham, 2013; Wallbank & Wannacott, 2015). Clinical supervision is an effective tool to address the underlying emotional burden and uncertainty that some nurses experience. Supervision that restores a nurse’s wellbeing can lead to improved capacity and scope of practice to better respond to families. Further, workplace training that reflects typical practice challenges can further contribute to practice and reinforce the synergy between practice and the evidence base. When combined, supervision and training support the integration of knowledge, skill and confidence required by safeguarding practice. Ultimately, safeguarding children requires the capacity of professionals to be reflective to comprehend and adapt techniques used to actively engage the family rather than emphasising the individual factors of the family.

Responding to families with multiple and complex needs requires nursing practice to be versatile, working through risks by adjusting the intensity of contact with
families to offer purposeful contact, role modelling positive responses to infant need, and to offer support either from the nurse or by signposting to another service. Keeping a watchful eye on families is nuanced, with utmost importance placed on families and nurses both needing to have a clear understanding of the purpose of this contact, to optimise retention of families in the service. Nurses must find a voice to address risks once identified and engage in practices that hold families to maintain involvement and support, beyond the reporting of suspected CAN. Consideration must also be extended to nurses, who themselves can be at risk of harm from families. Program factors require services to be clear of their purpose in preventing CAN. The capacity of the workforce to respond to suspected CAN requires mechanisms, such as clinical supervision and case review, to unlock the capacity of nursing practice intended to respond to CAN risk.

As the nurse–family partnership ends in the conclusion stage, providers are faced with uncertain endings when families cease to accept the services being offered. Reconciling this, for some, is difficult and often without resolve. Finding a way to let go of families with multiple and complex needs is difficult. Comparisons have been made between the counsellor–family dyad and statutory child protection worker–family dyad (see Howe, 2010). The current study proposes a similar comparison for CFHNs as the nurses find themselves in a partnership with a family, which ultimately concludes. Obtaining closure during this phase can become complicated by unexpected endings. At a program level, processes are required to complete the nurse–family relationship, which often results in a child protection report or child wellbeing referral being made where CAN risks are suspected. It is possible the execution of this final task offers a sense of containment or closure for nurses who may otherwise be left feeling anxious, holding onto a concern about an infant in a family typified by uncertainty and complexity. However, an opportunity exists whereby services can offer closure to the
partnership formed between a nurse and a family that moves beyond a process and considers the basis on which the working relationship starts.

In conclusion, this study describes a contemporary practice framework for nurses intended to respond to families where CAN is suspected at varying degrees of risk of child maltreatment.

Practice and research implications were outlined that can inform further advancement to this valuable topic. The examination of practices to safeguard children deepens the level of understanding behind the adage that nurses are indeed well placed to respond to families with multiple and complex needs.
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Appendices

Appendix A: Responding to Vulnerable Families Questionnaire

1. Demographic details
   Age: Under 25 □ 25-30 □ 31-40 □ 41-50 □ 51-60 □ 61+ □
   Level of Education:
     Undergraduate degree: □
     Postgraduate qualification: □
     Other □
     Please state ___________________________________________________________________

   Number of years practicing:
     □ Nurse ______________
     □ Child and Family Health Nurse ______________

   Do you have children of your own? Yes □ No □
## Theme: Reporting

2. **We are interested in your knowledge of mandatory reporting procedures.**

   Please indicate your response to the following by ticking the appropriate box.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>As a Child and Family Health Nurse, do you have mandatory reporting responsibility for reporting suspicion of child abuse or neglect?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>As a Child and Family Health Nurse, do you have professional/ethical responsibility for reporting suspicion of child abuse or neglect?</td>
<td></td>
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</table>

3. **We are interested in knowing to whom you would report if you suspect child abuse and neglect.**

   Please indicate your response to the following by ticking the appropriate boxes.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Department of Family and Community Services (Community Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Education Department</td>
<td></td>
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<tr>
<td>C</td>
<td>Health Child Wellbeing Unit</td>
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<td></td>
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<tr>
<td>D</td>
<td>Police</td>
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<tr>
<td>E</td>
<td>Other please state:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. **We are interested in your reporting behaviour.**

Please circle your response to the following.

<table>
<thead>
<tr>
<th></th>
<th>Ever (circle Yes or No)</th>
<th>In past 12 months (circle Yes or No)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>Have you personally reported child abuse or neglect to Department of Family and Community Services (Community Services) or the Child Wellbeing Unit?</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Have you suspected child abuse or neglect, but decided not to report to Department of Family and Community Services (Community Services) or the Child Wellbeing Unit?</td>
<td>Yes</td>
</tr>
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</table>

If you have suspected child abuse or neglect and decided not to report, can you please describe what your decision was based on? Think about any systemic issues, case issues and/or personal issues.
Theme: Practice

5. In your opinion, how confident are you to carry out the following?

<table>
<thead>
<tr>
<th></th>
<th>I am extremely NOT confident</th>
<th>I am very NOT confident</th>
<th>I am not confident</th>
<th>I am neither confident nor not confident</th>
<th>I am confident</th>
<th>I am very confident</th>
<th>I am extremely confident</th>
</tr>
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<tbody>
<tr>
<td>A</td>
<td>Appropriately identify indicators of physical abuse.</td>
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<td>B</td>
<td>Appropriately identify indicators of emotional abuse.</td>
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<tr>
<td>C</td>
<td>Appropriately identify indicators of neglect.</td>
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<td>D</td>
<td>Appropriately identify indicators of sexual abuse.</td>
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<td>E</td>
<td>Appropriately identify indicators of domestic violence.</td>
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<td>F</td>
<td>Complete the Domestic Violence Routine Screening tool.</td>
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<td>G</td>
<td>Determine whether a concern meets the Risk of Significant Harm for reporting suspected child abuse or neglect.</td>
<td></td>
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<tr>
<td>H</td>
<td>Appropriately report suspected child</td>
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</table>
abuse or neglect.

I  Appropriately manage the care of a child you suspect has been abused or neglected (see also below)

J  Please tell us how you typically manage the care of child you suspect has been abused or neglected:
6. We are interested in understanding what factors guide your decision making when working with vulnerable families.

Thinking about vulnerable families where you have identified a concern.

Please tell us how frequently the following occurs in your everyday practice.

<table>
<thead>
<tr>
<th></th>
<th>Never 1</th>
<th>Rarely 2</th>
<th>Sometimes 3</th>
<th>Frequently 4</th>
<th>Very frequently 5</th>
<th>Extremely frequently 6</th>
<th>Always 7</th>
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<tbody>
<tr>
<td>A</td>
<td>Professional Judgment</td>
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<tr>
<td>B</td>
<td>Consultation with other professionals who work with children</td>
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<tr>
<td>C</td>
<td>Consultation with my Nurse Unit Manager</td>
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<tr>
<td>D</td>
<td>Consultation with a colleague</td>
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<td>E</td>
<td>Applying the Mandatory Reporter Guide (MRG)</td>
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<td>F</td>
<td>Follow NSW Health Policy Directives/Local Health District Policy</td>
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<tr>
<td>G</td>
<td>Contact the Child Wellbeing Unit</td>
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<tr>
<td>H</td>
<td>Report to Department of Family and Community Services (Community Services)</td>
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<td>I</td>
<td>Implementing knowledge from</td>
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<td></td>
<td>professional development and training</td>
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<td>J</td>
<td>Discuss case in Clinical Group Supervision</td>
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<td>K</td>
<td>Present concerns at Case Review (alerts) meeting</td>
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<td></td>
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<tr>
<td>L</td>
<td>Refer to the Family Referral Service</td>
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<tr>
<td>M</td>
<td>If a report has been made by a colleague or myself previously then I would make a further report (where required)</td>
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</table>
7. We are interested in your usual practice when working with a vulnerable family who are engaged with CFHN and new concerns arise.

Please tell us what actions you may take in these instances.

<table>
<thead>
<tr>
<th></th>
<th>Never 1</th>
<th>Rarely 2</th>
<th>Sometimes 3</th>
<th>Frequently 4</th>
<th>Very frequently 5</th>
<th>Extremely frequently 6</th>
<th>Always 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Refer concerns to the Child Wellbeing Unit</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>B</td>
<td>Report concerns to Community Services</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>C</td>
<td>Work collaboratively with another agency or worker</td>
<td></td>
<td></td>
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<tr>
<td>D</td>
<td>Work within a Family Partnership informed practice</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>E</td>
<td>Present the family at Case Review (alerts) meeting</td>
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<tr>
<td>F</td>
<td>Discuss case in Clinical Supervision</td>
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<td></td>
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</tr>
<tr>
<td>G</td>
<td>Discuss case with colleague or my Nurse Unit Manager</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Increase frequency of contact with family (see below for comments)</td>
<td></td>
<td></td>
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<tr>
<td>I</td>
<td>Please tell us what the purpose of your increased contact with the family may achieve?</td>
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<td>J</td>
<td>Please describe what you would like your practice to look like?</td>
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</tbody>
</table>
8. We are interested in your usual practice when working with a vulnerable family who is NOT engaged and you have concerns.

Please tell us what actions you may take in these instances.

<table>
<thead>
<tr>
<th></th>
<th>Never 1</th>
<th>Rarely 2</th>
<th>Sometimes 3</th>
<th>Frequently 4</th>
<th>Very frequently 5</th>
<th>Extremely frequently 6</th>
<th>Always 7</th>
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<tbody>
<tr>
<td><strong>A</strong></td>
<td>Refer concerns to the Child Wellbeing Unit</td>
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<td><strong>B</strong></td>
<td>Report concerns to Community Services</td>
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<tr>
<td><strong>C</strong></td>
<td>Work within a Family Partnership informed practice</td>
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<td><strong>D</strong></td>
<td>Work collaboratively with another agency or worker</td>
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<tr>
<td><strong>E</strong></td>
<td>Present the family at Case Review</td>
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<tr>
<td><strong>F</strong></td>
<td>Discuss case in Clinical Supervision</td>
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<tr>
<td><strong>G</strong></td>
<td>Discuss case with colleague or my Nurse Unit Manager</td>
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<tr>
<td><strong>H</strong></td>
<td>Apply Failure to Attend Policy and discharge client</td>
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<tr>
<td><strong>I</strong></td>
<td>Increase attempts to contact family (see below for comments)</td>
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</tr>
<tr>
<td><strong>J</strong></td>
<td>Engage with another</td>
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<tr>
<td>discipline to provide option for joint assessment/appointment</td>
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**K** Please add further comments about this practice issue, including barriers.
Theme: Practice Barriers

9. The question below seeks your views about barriers to decision making.

What factors or circumstances make it difficult for you to make decisions when working with vulnerable families?
10. Education & Training

We are interested in understanding how education and training may have assisted in your practice of working with vulnerable families. The following questions ask about your initial training with the following section asking about your workplace education.

Tertiary Education

i. Was child abuse or neglect addressed in your education (please mark as many as appropriate)?

- [ ] not addressed
- [ ] can’t recall
- [ ] yes, in course lectures
- [ ] yes, in assigned readings
- [ ] yes, in workshops/seminars
- [ ] other, please specify

ii. Do you feel your education adequately addressed child abuse or neglect reporting?

- [ ] Yes
- [ ] No
- [ ] Unsure

iii. Do you feel your education adequately addressed working with vulnerable families?

- [ ] Yes
- [ ] No
- [ ] Unsure

Workplace Education

i. Does your workplace provide adequate access to education and training to assist in your role as a Child and Family Health Nurse working with vulnerable families?

- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>If no, what would you suggest are potential learning topics?</th>
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<tbody>
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</tbody>
</table>

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ii. Do you feel your education adequately addressed child abuse or neglect reporting?
   Yes □   No □   Unsure □

iii. Does your workplace adequately assess practice competencies of Child and Family Health Nurses in relation to working with vulnerable families?
   Yes □   No □   Unsure □

<table>
<thead>
<tr>
<th>If no, what would you suggest are ways to address this?</th>
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</thead>
<tbody>
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</tbody>
</table>

iv. Do you feel your workplace education adequately addressed recognition of when vulnerability increases?
   Yes □   No □   Unsure □

v. Do you feel your workplace education adequately addressed how to build relationships with vulnerable families?
   Yes □   No □   Unsure □

vi. Do you feel your workplace education adequately addressed understanding why families do not engage with our service?
   Yes □   No □   Unsure □
vii. Do you feel your workplace education adequately addressed understanding why vulnerable families do not engage with support services?

   Yes ☐       No ☐       Unsure ☐

Thank you for taking the time to complete this survey. Better understanding knowledge, beliefs, attitudes and practices of working with vulnerable families will help us to ensure the ongoing high quality of our service and potential opportunities for improvements.
Appendix B: Approval Letter From Ethics Committee

29 October 2014

Ms B Mawhinney
Co-ordinator
Child Wellbeing and Clinical Projects
Croydon Community Health Centre
24 Liverpool Road
CROYDON NSW 2132

Dear Ms Mawhinney,

Re: Protocol No X14-0275 & HREC/14/RPAH/361 - “Child and Family Health Nursing Service: Responding to families with child abuse and neglect vulnerabilities (CFHN)”

The Executive of the Ethics Review Committee, at its meeting of 23 October 2014, considered your correspondence of 7 October 2014. In accordance with the decision made by the Ethics Review Committee, at its meeting of 17 September 2014, ethical approval is granted.

The proposal meets the requirements of the National Statement on Ethical Conduct in Human Research.

This approval includes the following:

- NEAF (AU/1/074A110)
- Protocol (Version 1.0, 20 August 2014)
- Survey Participant Information Statement for Staff (Master Version 2.1, 7 October 2014)
- Focus Group Participation Consent Form for Staff (Master Version 1, 22 August 2014)
- Questionnaire form for Staff (Master Version 1, 24 August 2014)
You are asked to note the following:

- This letter constitutes ethical approval only.

- You must NOT commence this research project at ANY site until you have submitted a Site Specific Assessment Form to the Research Governance Officer and received separate authorisation from the Chief Executive or delegate of that site.

On the basis of this ethics approval, authorisation may be sought to conduct this study within any NSW public health organisation and/or within any private organisation which has entered into an appropriate memorandum of understanding with the Sydney Local Health District, Sydney Local Health Network or the Sydney South West Area Health Service.

The Committee noted that authorisation will be sought to conduct the study at the following sites:

- Croydon Community Health Centre
- Fairfield Community Health Centre
- Rosemeadow Community Health Centre

- This approval is valid for four years, and the Committee requires that you furnish it with annual reports on the study’s progress beginning in November 2015. If recruitment is ongoing at the conclusion of the four year approval period, a full re-submission will be required. Ethics approval will continue during the re-approval process.

- This human research ethics committee (HREC) has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review and is constituted and operates in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research and the CPMP/ICH Note for Guidance on Good Clinical Practice.

- You must immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.

- You must notify the HREC of proposed changes to the research protocol or conduct of the research in the specified format.

- You must notify the HREC and other participating sites, giving reasons, if the project is discontinued at a site before the expected date of completion.

- If you or any of your co-investigators are University of Sydney employees or have a conjoint appointment, you are responsible for informing the University’s Risk Management Office of this approval, so that you can be appropriately indemnified.
Where appropriate, the Committee recommends that you consult with your Medical Defence Union to ensure that you are adequately covered for the purposes of conducting this study.

Should you have any queries about the Committee’s consideration of your project, please contact me. The Committee’s Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Sydney Local Health District website.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

The Ethics Review Committee wishes you every success in your research.

Yours sincerely,

[REDACTION]

Lesley Townsend
Executive Officer
Ethics Review Committee (RPAH Zone)

HERG/EXCOR14-11
Appendix C: Survey Participant Information Sheet

Child and Family Health Nursing Service: Responding to Families with Child Abuse and Neglect Vulnerabilities Sydney Local Health District and South Western Sydney Local Health District

Survey Participant Information Statement for Staff

Dear Child and Family Health Nurses,

We would like to better understand your knowledge and practices in responding to families with vulnerabilities.

Whilst there is significant literature in relation the function of mandatory reporting, we are interested in broadening our thinking by asking you about your practices – particularly in relation to how you respond to vulnerable families.

We would like you to consider filling out this questionnaire to provide us with information on your knowledge about child abuse and neglect; your practice of responding to vulnerable families and how education and training may have contributed to your current practice.

We understand this topic may raise some challenging questions. The questionnaire includes important themes and your honesty in participating and responding to the questions will assist us in identifying good practice. The questionnaire may also assist in identifying opportunities to strengthen practice and the broader service of Child and Family Health Nurses in working with vulnerable families.

The project co-ordinator of this study is Ms Belinda Mawhinney, Co-ordinator Child Wellbeing and Clinical Projects for Sydney Local Health District. The project has been developed in partnership with Child and Family Health Nurses in Sydney and South Western Sydney Local Health District.

What is involved?

If you agree to be in this study, you will be asked to complete an anonymous survey. You can do this on the paper copy provided or online (insert web address). If you are interested in participating further, there is an opportunity to also participate in a focus group looking at some of the keys themes we identify from the questionnaire responses in more detail. There will be three focus groups including five participants: one for SLHD CFHN clinicians; one for SWSLHD CFHN clinicians and a third group of combined NUMs (or delegates) from SLHD and SWSLHD. The focus groups will be used to develop practice improvement strategies and are not intended to focus on specific practices of one individual.

There are no costs or risks associated with being involved in this study.

How will this information be used?

The information collected from the survey and focus groups will be used to inform our knowledge about existing practices and potential challenges that could be improved to support the services
delivered to vulnerable families. We hope this will assist in supporting your practice and ultimately the service families receive from Child and Family Health Nurses.

Results from this study will be presented back to you to provide you with information about practice themes and inform future service delivery. We may also publish the study in a relevant health journal. You will not be identified in any presentation or publication.

Benefits

This study aims to enhance our understanding of the strengths and challenges for Child and Family Health Nurses working with vulnerable families. The study may assist in improving our response to vulnerable families in Sydney and South Western Sydney Local Health Districts.

Confidentiality

All personal information collected through the survey will be kept anonymous and will be protected under current NSW privacy legislation. Any person with access to personal information is bound by a duty of confidentiality. No comments made by you will be individually identifiable in any of the presentations/reports or publications arising from this study.

Withdrawal from this study

Participation in this study is completely voluntary. If you do not wish to participate in this study, your right to decline will be respected and will not affect your current or future relationships with Sydney Local Health District or the South Western Sydney Local Health District. You are also free to withdraw from the study at any time without any prejudice.

Further Information

This information sheet is for you to keep. If you have any questions or would like to discuss this study in further details please feel free to contact Ms Belinda Mawhinney, Research Project Coordinator on 02 9378 1334 or Belinda.mawhinney@sswah.nsw.gov.au.

Other researchers involved in this study are

1. Alison Tutt, Clinical Nurse Specialist, Child & Family Health Nursing: Camperdown Sector
2. Kim Dunlop, Clinical Nurse Specialist, Child & Family Health Nursing: Croydon Sector
3. Melissa Harnett, Clinical Nurse Specialist, Child & Family Health Nursing: Canterbury Sector

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney Local Health District. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X14-0275.

The conduct of this study [name of hospital] has been authorised by the [name of Local Health District]. Any person with concerns or complaints about the conduct of this study may also contact the Research Governance Officer [or other officer] on [telephone number] and quote the protocol number X14-0275.
Thank you for considering participating in this study. This information sheet is for you to keep.

If you are interested in participating in a focus group to discuss practice themes of responding to vulnerable families, please complete the consent form with your contact details.
Appendix D: Focus Group Participation Consent Form for STAFF

(SLHD)

Child and Family Health Nursing Service: Responding to Families with Child Abuse and Neglect Vulnerabilities: Sydney and South West Sydney Local Health District

Focus Group Participation Consent Form for STAFF

I (participant’s full name)....................................................................................

agree to take part in the abovementioned study as described in the Participant Information Statement attached to this form.

- I have read and understood the Participant Information Statement, which explains the aim of the study, what is involved, and any possible risks.
- Before signing this Consent Form, I have been given the opportunity to ask any questions and clarify aspects of the study I did not understand. I acknowledge that I am satisfied with the responses I received and the study has been explained to me to my satisfaction.
- I understand that my decision whether or not to take part in the focus group will not affect my present or future relationship with Sydney Local Health District or South Western Sydney Local Health District.
- I understand that if I decide to take part in the focus group, I am free to withdraw my consent at any time without prejudice.
- I understand that if I choose to participate in the focus group, the confidentiality of comments I make in the focus group cannot be guaranteed as other participants will be present.
- Should I choose to participate in the focus group, I give consent to any statements I make in the focus groups being directly quoted in any arising reports/publications provided no identifying information is published. I understand that my privacy and confidentiality will be protected.
- I understand that the result of the study may be published, however I will not be identified.
- I agree to the audio recording of the focus group discussions.
- I agree to the use of de-identified quotations in any report or publication arising from this research.
- I understand that if I have any questions about my participation in this study, I can contact the Principal Investigator, Ms Belinda Mawhinney, Co-ordinator: Child Wellbeing and Clinical Projects, Sydney Local Health District on 02 9378 1334 or email belinda.mawhinney@sswhs.nsw.gov.au and she will be happy to answer them.
- I acknowledge that I have been given a copy of the Participant Information Statement and this Consent Form.
- I understand that the conduct of this study at Croydon Health Centre has been authorised by the Sydney Local Health District and if I have any concerns or complaints about the conduct of this study I may contact the Research Development Office on 02 (02) 9515 6766 or Sharon.Falleiro@sswhs.nsw.gov.au and quote project number HREC/14/RPAH/361.

☐ I agree to take part in the focus group by providing my contact details to be considered for inclusion in focus group discussions (please tick)

Name:
Appendix E: Focus Group Participation Consent Form for STAFF

(SWSLHD)

Child and Family Health Nursing Service: Responding to Families with Child Abuse and Neglect Vulnerabilities: Sydney and South West Sydney Local Health District

Focus Group Participation Consent Form for STAFF

I (participant’s full name).................................................................

agree to take part in the abovementioned study as described in the Participant Information Statement attached to this form.

- I have read and understood the Participant Information Statement, which explains the aim of the study, what is involved, and any possible risks.

- Before signing this Consent Form, I have been given the opportunity to ask any questions and clarify aspects of the study I did not understand. I acknowledge that I am satisfied with the responses I received and the study has been explained to me to my satisfaction.

- I understand that my decision whether or not to take part in the focus group will not affect my present or future relationship with Sydney Local Health District or South Western Sydney Local Health District.

- I understand that if I decide to take part in the focus group, I am free to withdraw my consent at any time without prejudice.

- I understand that if I choose to participate in the focus group, the confidentiality of comments I make in the focus group cannot be guaranteed as other participants will be present.

- Should I choose to participate in the focus group, I give consent to any statements I make in the focus groups being directly quoted in any arising reports/publications provided no identifying information is published. I understand that my privacy and confidentiality will be protected.

- I understand that the result of the study may be published, however I will not be identified.

- I agree to the audio recording of the focus group discussions.

- I agree to the use of de-identified quotations in any report or publication arising from this research.

- I understand that if I have any questions about my participation in this study, I can contact the Principal Investigator, Ms Belinda Mawhinney, Co-ordinator: Child Wellbeing and Clinical Projects, Sydney Local Health District on 02 9378 1334 or email belinda.mawhinney@sswahs.nsw.gov.au and she will be happy to answer them.

- I acknowledge that I have been given a copy of the Participant Information Statement and this Consent Form.

- I understand that the conduct of this study at Croydon Health Centre has been authorised by the Sydney Local Health District and if I have any concerns or complaints about the conduct of this study I may contact the Research Development Office on 02 9515 6766 or Sharon.Falleiro@sswahs.nsw.gov.au and quote project number HREC/14/RPAH/361.

☐ I agree to take part in the focus group by providing my contact details to be considered for inclusion in focus group discussions (please tick)