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Abstract

Child abuse and neglect is a complex problem that needs to be addressed through a multi-disciplinary approach. Nurses internationally have frequent contact with children and are ideally placed to respond to children experiencing abuse and neglect. Nurses' roles can include reporting abuse to child protection services (CPS). This paper reports on one aspect of the findings of a qualitative study exploring Australian nurses' perceptions and experiences of keeping children safe from abuse. Specifically, this paper reports on the theme relating to nurses' experiences of communicating their concerns to CPS and the family. This qualitative study was underpinned by social constructionism with data collected through semi-structured interviews with 21 nurses working with children in Australia. Key findings reported are: 1) 'being heard', 2) 'disappointed, discouraged and disenfranchised' and 3) 'managing tensions between engagement and reporting.' Nurses at times perceived they were not taken seriously by CPS and felt powerless to enact change for children. Nurses subsequently had to decide how and if to discuss their report with families to mitigate negative reactions and maintain engagement. This study highlights the need for more effective multi-disciplinary collaboration between nurses and CPS to promote change for children affected by abuse in Australia.

Introduction

Addressing child abuse and neglect requires a multi-disciplinary approach where professionals work together to promote children's wellbeing. Nurses are one profession who have regular contact with children and are ideally positioned to identify and respond to child abuse. One way that nurses respond to child abuse is through reporting suspected abuse to child protection services (CPS) who subsequently screen cases and determine

whether an intervention is warranted. In countries such as Australia, Canada and the United States of America (USA) reporting child abuse is mandated by law, while in other countries, such as in New Zealand and the United Kingdom it is based on professional judgement (Drake and Jonson-Reid, 2015; Mathews, 2015).

In Australia, legislation that governs reporting, assessment and intervention for child abuse and neglect varies across the eight states and territories. However, in all jurisdictions, legislation is broadly underpinned by three key principles of 1) the child's best interests, 2) early intervention and 3) children and young peoples' participation in decision making (Australian Institute of Family Studies, 2018). All states and territories have mandatory reporting legislation that requires nurses to report child abuse and neglect (Australian Institute of Family Studies, 2017). Accordingly, nurses must report when they have either a reasonable 'belief' or 'suspicion' that a child is experiencing sexual abuse (n=6 jurisdictions) and/or is at risk of harm or death (n=6 jurisdictions) (Australian Institute of Family Studies, 2017). When a report is made to CPS, CPS will assess whether an investigation is warranted, initiate investigations and subsequently intervene when children meet the criteria for statutory protection. Actions that CPS can take include referral to voluntary organisations to support the family, through to removal of the child from parental care. In 2009, the Council of Australian Governments (2009) developed the National Framework for Protecting Australia's Children 2009-2020 which emphasises prevention and early intervention for child abuse and neglect, with statutory CPS reserved for children at risk of significant harm. In this way, lesser concerns for children who are not in immediate or severe danger can be cared for through a whole of community approach (Appleton and Peckover, 2015; Mathews, 2015). Internationally, nurses have many roles in this public health approach to addressing

child abuse, with examples including health visitors in the UK (Cowley *et al.*, 2013) and the Nurse-Family Partnership in the USA (Flowers *et al.*, 2020). Despite a public health approach, the number of children reported to CPS continues to rise, and most children who are notified receive no intervention beyond an initial assessment (Drake and Jonson-Reid, 2015; Featherstone *et al.*, 2016).

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

Nurses are the largest group of health professionals and are often involved in reporting abuse and neglect to CPS. However, nurses may perceive a lack of knowledge and professional conflict over the decision to report, especially when parents are also the nurse's clients (Lines *et al.*, 2017). Nurses may continue working with families after making a report, and need to decide how or if they will discuss their decision to report with parents. It is not known how nurses communicate their concerns about abuse and neglect to CPS and

how or if they communicate these same concerns with parents. Consequently, this paper reports on the third of four themes identified from a qualitative study that aimed to explore nurses' perceptions and experiences of keeping children safe from abuse. The four themes from this larger study were established through inductive analysis (numbered for clarity) and are 1) contextualising and defining child abuse (Reference redacted for peer-review), 2) nurse relational skills in addressing child abuse (Reference redacted for peer-review), 3) nurse experiences of communicating concerns of child abuse and 4) nurse views around how systems and hierarchies shape their responses to abuse (reference redacted for peer review). This paper specifically reports on the third theme relating to nurses' perceptions and experiences of communicating and reporting child abuse.

Methods

Framework

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

awareness of child protection practice is necessary because ethnocentric and racist assumptions meant 'child protection' was used to justify oppression and abduction of First Nations people in Australia and worldwide (Human Rights and Equal Opportunity Commission, 1997; Strong-Boag, 2010; Dudgeon *et al.*, 2015). Such practices have resulted in well-documented harm and intergenerational trauma that still impacts upon First Nations people around the world today (Human Rights and Equal Opportunity Commission, 1997; Strong-Boag, 2010).

Ethics

Ethical approval was granted by [XXX University redacted for peer review]. Written consent was obtained from each participant, including permission to audio record their interview. Participants could review their transcript and make changes prior to inclusion in the study.

Participants

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

Data Collection

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

Data Analysis

The first author read and re-read transcripts before exporting into NVivo (version 12) where they were coded inductively. The first author initially used descriptive coding, but changed to process and holistic codes (Saldana, 2016) to better represent the data's complexity. This process produced many codes (n=563). All codes were printed and arranged on poster paper to enable visualisation of the whole dataset (Gibbs, 2014). At this point, codes were physically arranged and rearranged by similarity until four clear themes became evident. This process was led by the first author supported with regular consultation and direct input from the remaining authors. Throughout this process, codes with equivalent meanings were merged into single representative codes. The authors met frequently throughout data analysis to ensure that codes and developing themes were reflective of the data.

Findings

Participants

Participants (n=21) practised in three main settings, paediatrics (n=7), child health (n=10) and community (n=2). The remaining participants (n=2) had backgrounds in both child health and paediatrics. In Australia, paediatric nurses typically work in acute care, while child health nurses have a role similar to health visitors in the United Kingdom. Conversely, community nurses do not have a nationally consistent role, but community nurses in this study worked for non-government organisations. See Table 1 for details of participants' primary role within their organisation.

Themes

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

Being Heard

Nurses believed their role was to present 'facts' or 'evidence' (P 2, 4, 5, 11, 17, 20, 22) when reporting abuse to CPS. Nurses typically considered facts or evidence to be objective,

precise and verifiable events they had personally encountered rather than perceptions or subsequent conclusions (P2, 3, 5, 7, 10, 11, 15, 20, 21). Participant 15 explained: '*I've just gotta present all the situation and the features and my concerns*.' Nurses recognised it was not their role to speculate about what may have occurred: '*you can only give very factual statements, it's not up to us to say how they sustained those injuries'* (P 21). In the state of South Australia, where the majority of participants practised (n=19), legislation states nurses must report if they *'suspect on reasonable grounds'* that a child is at risk of abuse or neglect (Children and Young People (Safety) Act 2017 (SA)). However, participants' experiences of being dismissed by CPS meant nurses felt they needed 'evidence' (P2, 4, 5, 17, 20) from which to argue their suspicions. For example, Participant 2 explained her thought process when deciding whether to report: *'[I] hesitate and go 'well, hold on a second. Do I have the evidence to fight back to them [CPS] over this?''* Similarly, Participant 4 reflected on an experience where she had decided not to report: *'I think should I have reported it, and why didn't I? I think it was that decision 'well, I've no evidence, this is really just hearsay.''* This demonstrates that despite the legal requirement to report if one '*suspect[s] on reasonable grounds*' (Children and Young People (Safety) Act 2017 (SA)), participants still felt 'evidence' was essential.

When nurses provided what they saw as factual reports, some nurses (P3, 5, 6, 8, 22) felt the likelihood of action hinged on how seriously CPS took their concerns. For example, Participant 5 outlined how *'they would actually verbally discount you as you're reporting, saying comments like 'is that all you're reporting?' or 'this doesn't sound so serious.'* As a result, some nurses reported firmly advocating for the child to try and communicate the seriousness of the situation. Participant 10 recalled: *'I've almost felt like I've really had to*

fight the case… because [CPS are] a bit dismissive of what I'm saying.' This demonstrates nurses' experiences of being discounted when CPS have specific thresholds for intervention and subsequently reconstruct situations differently to nurses. In contrast, nurses who had witnessed the situation had a greater sense of urgency which they felt needed to be communicated effectively.

Nurses had strategies to ensure they were heard such as planning their report in advance. For example, Participant 9 wrote down and read out her concerns without pausing to prevent interruptions and opportunities for discounting: '*I would always write it out before I rang, and I would read it point by point so they couldn't interrupt me'*. Other nurses carefully chose their words to ensure the level of urgency would be understood: '*I was very wise towards the end as to how to say things… maybe it's because they're social workers and they don't have the medical knowledge and if you present it as being alarming they often took notice of it'* (P8). In Australia, CPS staff are typically social workers with different professional backgrounds to nurses, meaning situations nurses perceived as serious were not automatically interpreted this way by CPS (Tung *et al.*, 2019; Williams *et al.*, 2019). For example, Participant 10 felt she had to outline the consequences of poor infant growth, explaining that: '*saying 'I'm worried baby's not gaining enough weight', that's probably not enough. You need to actually say 'and if baby doesn't start gaining weight the vital organs are going to be compromised*.' Thus, some nurses (P 6, 10, 22) saw their role as educating CPS around how children's health needs can influence their risk of harm.

Two participants (3 & 10) in senior positions also saw their role as educating inexperienced staff in making an effective report. For example, Participant 3 explained how staff were

educated and supported in the process of reporting: *'the team leaders will… coach them through what to say to actually get their point across so that they [CPS] will take it seriously'* (P 3). This shows nurses saw reporting abuse as an important skill to convince CPS that their concerns were legitimate.

Disappointed, discouraged and disenfranchised

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

Despite negative perceptions, nurses still recognised their legal duty to report. Even when nurses felt they had insufficient evidence, they preferred to report than have a child harmed (P2, 3, 4, 5, 6, 11, 22). This was demonstrated by Participant 3 who explained: *'I would rather err on the side of caution, than not do anything and see a child come to harm.'* When doing so, nurses placed the accountability for decision-making back onto CPS: Participant 6:

'I do always go on the side of, if it doesn't sit right with me, I'll do it [make a notification] because then they [CPS] can decide if it really is an issue.'

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

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

working closely with CPS and was able to explain that there was no collusion, but rather individual professionals who each held concerns about the child's safety.

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

Managing tensions between engaging and reporting

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

Nurses were typically open about their role in mandatory notification of abuse and neglect, with nurses in child health and community home visiting settings explicitly discussing their report with families (n=11). In this way, these nurses promoted openness by explaining to families they would aim to discuss any concerns prior to reporting. Participant 19 gave an example of what she might say to a family: *'if I have any concerns, I do have to let child protection know, but I what I would do is if at all possible I'd talk to you about it first*'. On

some occasions, nurses indicated that simply raising concerns with a parent might resolve the issue without the need to report. Participant 1 gave an example of this: '*mum had an air-conditioning unit right next to the crib so heat was blasting onto baby… she thought she was keeping baby warm but it really was a bit overheating… I wouldn't have notified about that, that's more about education… but if I came the next time and she was still doing that, then I might [make a report] … coz baby's not safe.'*

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

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

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

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

In anticipation of potential negative reactions from families, nurses described mitigating strategies such as reframing reporting as a positive. For example, Participant 3 would

explain to families: *'if we do this [report] we can support you to actually get to the point where this [issue] is no longer happening, or you're better resourced, or you feel like you can cope with parenting.'* Similarly, Participant 20 emphasised the role of CPS in building parental capacity: '*I'm not reporting because I don't think you're capable… I'm reporting because I want you to get the services involved who can help you*.' Participant 15 used a similar strategy which involved being with and supporting the family in an urgent situation. At this time, Participant 15 described how a broken door needed immediate attention to prevent a toddler running onto the street: *'we told her [mother] straight out, 'we have to report this' and we didn't leave that house, we gave her our phone [and] got her to ring [government department] and said, 'we need to have a lock put on this door'.* Through this approach, Participant 15 successfully addressed safety concerns by being with the mother and empowering her to enact change.

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

Discussion

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

Nurses' perceptions of not being taken seriously by CPS in this study are comparable to nurses' experiences with other professionals, such as doctors. Historically, the nursing profession developed as helpers of the medical profession whereby nurses unquestioningly followed the orders of doctors (Ehrenreich and English, 2010). This is further compounded by the conceptualisation of nursing as 'women's work' undertaken primarily by women who may be socialised into 'appropriate' gender roles of subordination to men (Roberts, 2006). Even in recent times, nurses work in 'caring' for clients continues to be constructed as less important than 'curing' work of doctors (Treiber and Jones, 2015). Although submission to doctors is no longer necessary, nurses' oppression is maintained by the hierarchical healthcare system which sustains the status quo and socialises nurses into their identities (Roberts, 2006; Ward, 2009). Unfortunately, ongoing oppression means nursing knowledge may be devalued with potentially fatal results. For example, nurses were the first to raise

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

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

sufficient knowledge to identify and respond to child abuse, if they do not believe their expertise is valuable, this may form a barrier to action. Further research is needed to identify whether discussion-based education that addresses participant feelings, and/or education underpinned by the HBM can produce sustained behaviour change and improve outcomes for children. Evaluations of educational interventions also need to include consideration of the cultural diversity of the Australian nursing workforce and multiple ways of understanding childhood, parenting and child abuse.

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

neglect is linked to their sociocultural contexts, and this is further discussed in (reference redacted for peer review.

Nurses' perceptions of powerlessness calls for greater multi-disciplinary collaboration between nurses and CPS. Existing research shows nurses often perceived lack of confidence in responding to abuse and neglect (Lines *et al.*, 2017), which is likely to be augmented if continually experiencing dismissive reactions from CPS. Recent research has demonstrated that greater alignment in organisational 'mission and methods' was associated with higher perceived collaboration between CPS and nurses working within the Nurse-Family Partnership program (Tung *et al.*, 2019). For example, nurses felt collaboration was strongest when CPS used a similar strengths-based approach that supported families to stay together (Tung *et al.*, 2019). This suggests differences in disciplinary approaches between participants and CPS may have contributed to perceived communication difficulties. Unfortunately, poor communication and collaboration between different professionals and agencies is an ongoing issue and has been identified as a contributing factor in several child deaths (House of Commons Health Committee, 2003; Fraser, 2013; Johns, 2015). Some authors (Walsh, 2019; Williams *et al.*, 2019) have suggested multi-disciplinary education that facilitates networking across disciplines may promote shared understandings, while others have developed an inter-disciplinary framework for educating pre-service professionals with the goal of establishing a shared language and culture of collaboration (Grant *et al.*, 2018). Further research is needed to determine whether these approaches can effectively promote collaboration and lead to better outcomes for children.

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

Nevertheless, both child health and paediatric nurses experienced uncertainty and lack of control when discussing, or deciding whether to discuss, concerns about abuse and neglect with families. This included anxieties around how families might react and how/if CPS would respond. Although nurses were aware of relevant guidelines, the application of guidelines is based upon individual judgement within unique social and organisational contexts (Munro, 2018). Furthermore, guidelines are produced and enacted in health systems that perpetuate

structural inequalities and institutional racism (Burnett *et al.*, 2020; Gerlach and Varcoe, 2020); both of which contribute to disadvantage which is linked to child abuse. In this context, the findings suggest that nurses need ongoing support to critically reflect on the quality of their decision-making (Munro, 2018) and to develop inclusive practices that address root causes of disadvantage, marginalisation and inequality (Burnett *et al.*, 2020). For nurses, this may include education around the use of critical reflection to develop practice, and the provision of time and organisational support to facilitate application of these skills. However, when current organisational culture promotes blame and 'fixing' individual professionals rather addressing the complex circumstances surrounding decision-making and marginalised families in crisis (Leigh, 2017), education alone is unlikely to be enough.

Study Limitations

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

Conclusions

Nurses have an important role in communicating cases of child abuse and neglect to CPS so children and families can receive appropriate support. This study showed nurses recognised the importance of their role, but often believed they were not taken seriously by CPS and felt powerless to enact change for the child. At the same time, nurses were weighing up how and if to share their intention to report to CPS with families to minimise negative reactions. This occurred within a context of uncertainly around how/if CPS would intervene,

and how families might react. Consequently, there is a need for more effective collaboration between nurses and CPS to promote better communication and coordination of responses. Further research is needed to explore whether discussion-based and multidisciplinary education could address nurses' perceptions of powerlessness and promote shared understandings between nurses and CPS. Although education may go some way to addressing nurses' concerns, this needs to occur within the broader context of organisational culture change.

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