'How Can We Work Together?' Nurses Using Relational Skills to Address Child Maltreatment in Australia: A Qualitative Study

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ABSTRACT

Background: Nurses working with children often encounter child maltreatment. Nurses' roles in mandatory reporting are well-documented, but less is known about additional ways nurses respond to child maltreatment. This is important because children experiencing less extreme maltreatment may have unmet needs without receiving a child protection intervention.
Objectives: This paper reports one key finding from a qualitative study exploring nurses' perceptions and experiences of keeping children safe from maltreatment. Specifically, it reports nurses' perspectives of their relational skills used to support children experiencing maltreatment.
Design and methods: Qualitative inductive thematic analysis followed by a secondary analysis using a social constructionist framework. Data were collected through in-depth, semi-structured interviews and data saturation was achieved. Transcripts were inductively analysed with support of NVivo software.
Participants: Registered nurses ($n = 21$) working with children in Australia.
Results: Nurses saw relational practice as core to addressing child maltreatment. Key themes were: 1) 'Walking the line': relationships in the context of surveillance, 2) 'You are a good mum': focusing on the positives and 3) Seeing and being the voice of the child.
Conclusions: Nurses are uniquely positioned to identify and respond to child maltreatment through relational practices. Nurses maintained therapeutic relationships with parents to ensure ongoing access to vulnerable children. Although nurses recognised the importance of a child-centred approach, its enactment was varied and required ongoing critical reflection. This highlights the importance of supporting nurses to develop, maintain and continually improve their relational practices to enhance outcomes for children.

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Contribution of the paper

What is already known:

- The value of addressing child maltreatment through a whole-of-community approach is increasingly being recognised.
- Nurses have frequent contact with children and families, and depending upon local legislation, are legally and/or ethically obliged to intervene such as reporting to child protection services.

- Nurses also address child maltreatment through other strategies, including prevention and early intervention, but these aspects of their role are poorly understood.

What this paper adds:

- Nurses used skilled relational practices to engage parents whilst promoting children's safety and wellbeing in complex and dynamic situations.
- Tensions arise between maintaining a child-centred approach whilst preserving access to children through therapeutic relationships with parents.
- The complexity of nurses' practices means we need to recognise and support nurses' unique contributions to promote better outcomes for children.

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Introduction

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

Nurses contribute to this broader whole-of-community approach to keep children safe. For example, keeping children safe, or safeguarding, is a recognised part of health visitors' roles in the United Kingdom (Fraser, Grant, & Mannix, 2014; Peckover & Appleton, 2019) and it is increasingly becoming part of child and family health nursing in Australia (Fraser, Hutchinson, & Appleton, 2016). Similarly, a recent literature review across multiple practice settings demonstrated that nurses' roles included identification, early intervention and addressing the effects of maltreatment (Lines, Grant, & Hutton, 2018). Although nurses have many roles in helping to keep children safe, nurses across multiple settings frequently experience anxiety and uncertainty when faced with the complexities of child maltreatment (Barrett, Denieffe, Bergin, & Gooney, 2017; Dahlbo, Jakobsson, & Lundqvist, 2017; Kraft, Rahm, & Eriksson, 2017; Lines et al., 2017). Unfortunately, it is difficult to know how to best equip and support nurses to keep children safe because the precise nature and scope of nurses work in this area is poorly researched and largely invisible (Peckover & Appleton, 2019).

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

Methods

Framework

This qualitative research was underpinned by a social constructionist approach. A social constructionist approach recognises knowledge as located within specific sociocultural conditions and social practices as located within specific sociocultural conditions and social practices as located within specific sociocultural conditions and social practices as located within specific sociocultural conditions (Burr, 2015). In child protection, social practices are especially apparent because parenting and childrearing practices vary across social and historical contexts. For example, childrearing practices 'change with fashion' (Furedi, 2002) because they are embedded within prevailing attitudes of 'normal' parenting (Scott & Swain, 2002). In the context of this research, a social constructionist approach recognises the ways that nurses keep children safe are culturally situated and embedded within daily practices.

Design

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

Data collection

The first author (female) collected the data, and is a clinician (registered nurse with experience in paediatric nursing) and PhD candidate with previous qualitative research experience. Interviews (60–90 min long) were conducted face-to-face (n = 15), via telephone (n = 5) or through Skype (n = 2) based on participant location and preferences. Interviews occurred from August 2016 until August 2017. At the commencement of each interview, the first author summarised the study's purpose, obtained written consent and addressed participant questions. Interviews were guided by an interview guide; example questions can be found in Table 1. This interview guide was developed from a recent literature review (redacted for peer review) but not pilot tested because it was meant to be a broad guide only. Data saturation began to occur at interview 17. An additional five booked interviews were conducted providing more nuanced information about nurses' experiences in different contexts.

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

Table 1
Example interview questions.

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

Data analysis

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

Findings

Twenty-one nurses who work with children agreed to have their transcripts included in this study. Participants (all female) had from 10 to 40 years of experience in nursing and worked with children at the time of the research. Participants typically practiced in metropolitan locations (n = 18 metro, n = 3 rural/remote) in three Australian states (n = 19 South Australia, n = 1 Queensland, n = 1 Victoria). Participants' main roles were in child and family health (CH, n = 10), paediatrics (P, n = 7), combined child and family health and paediatrics (CH & P, n = 2) and other community settings (C, n = 2). In the Australian context, child and family health nurses work in clinics and family homes in a similar role to health visitors in the United Kingdom. Paediatric nurses typically work in acute care, and all paediatric nurse participants worked in specialist paediatric wards or units. Nurses working in Australian community settings other than child and family health do not have a nationally consistent role, but community nurses in this study worked for welfare-focused organisations. Please refer to Table 2 for more information on the respective roles of these nurses in Australia.

This manuscript reports on just one theme from the qualitative study. Please see Fig. 1 for a visual overview of the relationships between the themes identified in the broader study, and the theme and associated subthemes addressed within this manuscript.

The key theme addressed by this manuscript outlines how relational practice was central to how nurses engaged and maintained positive relationships with families to address concerns about child maltreatment.

The subthemes presented are 1) 'Walking the line': relationships in the context of surveillance, 2) 'You are a good mum': focusing on the positives and 3) Seeing and being the voice of the child. Throughout the findings, we refer to Table 3 which summarises, describes and defines key relational skills reported by nurses in this study.

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

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

Nurses' close contact with families meant they could observe for signs of maltreatment. When families noticed nurses' surveillance, child health nurses in particular drew families' attention towards the more positive, friendlier aspects of their nursing role. For example, Participant 12 (CH) explained when she noticed something potentially concerning, she started by asking "tell me your story" [that] doesn't come across so threatening.' Other nurses emphasised the importance of keeping the family together, as opposed to the perceived role of child protection in child removal: 'how can we work together so that your child does stay with you?' (P 15, CH). In this way, nurses actively constructed their role as friendly and approachable (see Table 3, point 1) rather than rather than the eyes and ears of child protection services.

Although being friendly and approachable was important, nurses had to balance being friendly against prioritising children's health and safety. Family disengagement was 'always a significant worry when raising child protection concerns' (P 6, P) but sometimes necessary to ensure children's safety. At the beginning of the therapeutic relationship, nurses often delayed bringing up mildly concerning issues (P 5, 9 & 11). 'You've got ten concerns, if you list off those concerns to the parent… you're probably not going to be developing that rapport' (P 5, CH & P). Nurses believed if they established an ongoing relationship with the family, child safety concerns could be addressed over time. Alternatively, if nurses confronted the family on the first interaction, they knew families might completely disengage so nobody could continue working with the child. However, nurses reported attending to urgent safety concerns straightaway regardless of the potential impact on the relationship (see Table 3, point 5). For example, Participant 12 (CH) observed a firearm in a home, and immediately discussed this with the family and reported to child protection services.

Table 2
Comparison of paediatric, community and child health nurses in Australia.

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

[a] The Australian Qualifications Framework (AQF) is the national policy in Australia that regulates the education and training sector to provide quality assurance and enable alignment with international qualification frameworks (AQF Council, 2013). Level 5 is a diploma (required for an enrolled nurse), Level 7 is a bachelor degree (registered nurse) and Level 8 is a graduate certificate or graduate diploma (specialist child health nurse) (AQF Council, 2013).
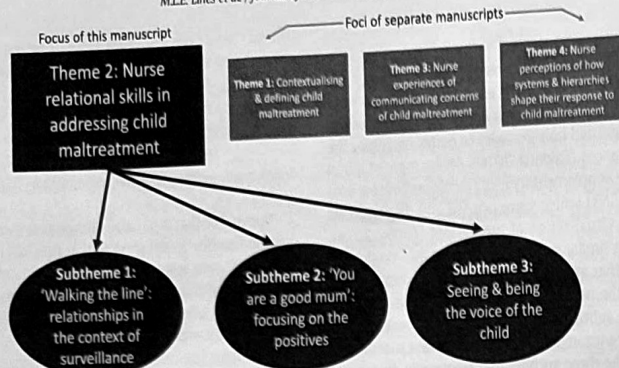
Fig. 1. Visual representation of themes and subthemes.

In community or child health settings, nurses tried to engage or re-engage families who were reluctant to be involved in ongoing care (see Table 3, point 2). Participant 1 (C) explained that one method involved making repeated contact and waiting until the family was ready: 'we just kept... sending messages... or popping round and leaving a note and really letting her [mother] know that we were still here' (P 1, C). However, this had limitations as nurses did not want families to feel harassed: 'you've gotta walk the line between ... trying to get them to engage and ... stalking them.' (P 11, CH). In some situations, nurses were able to leverage support of cultural consultants to build trust in culturally diverse populations, for example: 'to have the Aboriginal cultural consultant there, it really breaks down those barriers' (P 22, CH). This shows that nurses balanced engagement with families against the risk that persistence could drive the family away.

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

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

maintaining a therapeutic relationship with families whilst involved in surveillance for child maltreatment.

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

This theme outlines how nurses focused on the positive aspects of situations to maintain therapeutic relationships with parents whilst still addressing child protection concerns. One strategy nurses used to shift away from a negative outlook was showing empathy towards parents' backgrounds and/or current situations. On the surface, this strategy could seem 'parent' rather than child-centred, but nurses deliberately used this strategy to enact change for children (see Table 3, point 3). For example, many nurses, especially those in child health settings, recognised that the ability to tactfully discuss concerns with parents was key to establishing ongoing engagement (see Table 3, point 2). Participant 3 (CH) provided an illustration of different strategies and their perceived effects: '[if you say] I think your child's unsafe so I'm going to notify,' the parent's going to go 'oh yeah, get stuffed', but if you're saying 'you're being the best parents that you can be but there's just a few issues here and here. We really want to work with you to support you.' Similarly, Participant 10 (CH) outlined what she might say to a mother when she had concerns about a child's safety: 'You can say 'I know you want the best for your child but what I'm seeing is that there's lots of things going on for you and it's making it hard for you.'' In doing so, Participant 10 recognised challenges the parent might be facing, whilst simultaneously acknowledging the situation is not acceptable for the child.

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

Table 3
Characteristics and skills displayed by nurses to keep children safe.

Characteristic/skill	Description	Indicative quotes from participants
1. Friendliness and approachability Subtheme(s): 1	Ability to present self as friendly and supportive to build rapport and facilitate ongoing engagement with families who may otherwise be invisible to services. Nurses used their skills and personal characteristics to create a therapeutic relationship that demonstrates to the family they are trustworthy and willing to focus on the family's concerns (Rorden, 2010). This occurred within the context of surveillance for abuse and neglect.	I showed empathy so I said 'that sounds like a really difficult situation for you to have to move to another city. I'm really sorry you've been through that' (P 2, P). I think I have a way of coming across [that] I hope [is] not very threatening... (P 11, CH). I think that, that really comes with those interpersonal skills those communication skills building a relationship and for the family to really know that you're walking the walk with them (P 1, C). Sometimes by having that discussion like you would, you know if you had a coffee with a friend and they would say 'oh my teenager did this' and you say 'that's okay, you know most teenagers do that' ... then that's a conversation that's real isn't it (P 19, CH).
2. Balancing engagement and disengagement Subtheme(s): 1 & 2	The client-helper relationship is key to maintaining family engagement; it requires proficient interpersonal skills to establish and maintain relationships with families who may themselves lack effective relational skills (Davis & Day, 2010). Balancing engagement and disengagement involves the capacity to balance strategies and actions to engage families against the risk of intimidating families and permanently driving them away. Maintaining family engagement is important so concerns about child abuse can be identified, monitored and addressed as needed through family support and/or involvement of child protection services.	'A lot of people were suspicious in the beginning but because we're there for a year and if we can show that it's to their advantage, that we're actually starting to open doors' (P 8, C). Quite often the parents of the children we're working with have been the victims of that same kind of upbringing so they haven't got a lot of trust, particularly for government workers, and they can be very frightened that their children are going to be removed from them so there's a whole range of reasons why families don't want to let you in (P 12, CH). We'd already built in some mental health supports that she started to access and then pulled out from, and the Aboriginal cultural consultant who also tried to engage her with the Aboriginal health services... so there'd been lots of efforts to actually engage her, not necessarily in our health services but in perhaps a more culturally acceptable health service (P 22, CH).
3. Identification of the positives in any situation. Subtheme(s): 2	Ability to identify what parents are doing well in any situation to build and maintain rapport with parents. This can help parents build trust and confidence to become more willing to address their shortcomings. For example, as stated by Davis and Day (2010): 'If helpers are known and trusted to look for and comment upon the positives, then parents are less likely to be threatened by the negatives...' (p. 120). This involves a strengths-based approach where the nurse searches out strengths and resources that the client may be struggling to use or even unaware of (Egan, 2010).	It's pointing out what they [family] are doing right, showing them what's good because I found once I make them feel good about themselves then they will do good again because it feels good (P 9, CH). We said to her [mother], if you're accepting social work referrals it shows that you want to change, you want to improve (P 15, CH). The fact was they [family] actually came to clinic, so that to me was a win, they'd actually made the effort to come under their own steam (P 22, CH).
4. Ability and willingness to tactfully discuss concerns with parents. Subtheme(s): 3	Ability and willingness to discuss concerns with parents that is timely, empathetic, tactful, effective and facilitates ongoing engagement where possible. This often involves firstly listening to the parents to understand their perspectives and experiences before discussing risks to children (Egan, 2010).	I go in to work with the family, meet them where they're at, see what their issue is this week, 'okay how can we unpack that', 'what can we do about that' you know... what do they wanna do about it? (P 19, CH). Sometimes it's the way you say it, I think being a little bit careful about not coming across too judgmental but still getting the message across. (P 22, CH). Firstly, get in with the parents to sympathise with them, but then talk about how the baby's feeling and how they might have experienced that moment (P 11, CH). If you get to know a family a little bit you get to be able to ask them more of the tougher questions. We don't tend to do that a lot on that first visit... [because] anyone who you're meeting for the first time does not want to be quizzed and questioned about various things (P 12, CH).
5. Willingness to act when there are clear dangers to children. Subtheme(s): 1 & 3	Willingness and confidence to intervene when there are clear dangers to children's safety and wellbeing. This could involve discussing immediate concerns with parents, but also involving other agencies such as child protection services where discussing concerns is inadequate or unsafe.	[The mother] was right up in her [child's] face screaming at her and she [nurse] went in and she said 'excuse me, this is not appropriate...you need to stop this right now' (P 2, P). The key to it, is being engaged, being non-judgmental but not being afraid to step in and say 'well, we need to do something about this because I'm concerned about the safety of your child' (P 3, CH). I did a home visit one day and there was a gun leaning against the wall in the house so they [the family] were just led into being able to have a conversation about that (P 12, CH).
6. Responsive attitude towards ongoing professional development Subtheme(s): 3	Individual professionals never have all the answers to every problem, and their knowledge can be incomplete or out of date (Davis & Day, 2010). Rather than aiming to have expert knowledge in child protection, nurses should instead have an attitude that simultaneously acknowledges: 1) the importance of continually developing one's knowledge, 2) the impossibility of ever knowing everything, but 3) the importance of acting anyway to promote best outcomes for children.	If there's a [knowledge] gap or we come across something that we're feeling uncomfortable about, [it's important that] nurses [are] proactive in requesting, 'look, how do I get counselling' or 'how do I approach this scenario' or 'this is difficult, I feel out of my depth here' (P 7, P). We all experience new things every day. We can't say 'well, you know, I'm not experienced in that so I'm not going to do it'. I mean that's just - to me that's [an] excuse... If you are concerned that that child is unsafe it is your duty of care to that child to... seek support and follow through. (P 3, CH). I think sometimes... [discussing with experienced staff] can help you sort of clarify your own thoughts and particularly for junior staff... they might not be so confident in their... own assessment of the situation. Somebody who has a bit more [experiences]... might be able to help clarify it and guide them in how they should manage it (P 4, P).
7. Reflective practice Subtheme(s): 3	Reflective practice involves reviewing one's own values, assumptions and considering the broader issues that are relevant to practice (Atkins & Schutz, 2013). For nurses who work with children, this is key to	I thought 'well, I've missed the opportunity now. If it happens again, I know how I'm going to respond' (P 2, P). There's been times where I haven't really been that worried about a family

Table 3 (continued)

Characteristic/skill	Description	Indicative quotes from participants
	maintaining a child-centred approach and identifying when own attitudes/behaviors do not represent a child-centred approach and how this may subsequently impact upon the children they care for.	and then I've taken it to case review and the psychologist or social worker's asked five questions and… they've made me think about things really differently… you really need to be reflective and make sure that other people's views can influence your practice. (P 5, CH). 'We all need to know ourselves as a person [and] what our issues are' (P 7, P).
8. Listening to children Subtheme(s): 3	Ability to listen to children and consider what they say through a developmental lens. This requires knowledge of child development to understand how children may think and act according to their age and stage of development.	If you're practicing reflective practice… [you recognise that] you're never complete and perfect, you just keep developing (P 11, CH). [Children] will tell you… through behaviors, through sensory issues you know, so you've gotta be able to read… or listen to that when it's not a verbal [message] (P1, C). [You've] got to take the age into consideration as well…. I think if a child is saying 'I don't want to live at home' then there is a good reason for it and you should be taking that seriously (P4, P). We know that children that are abused definitely have delayed development so we're looking for that in every baby that we see - not the abuse but the development (P 12, CH). You need to know… the milestones and you need to know the behaviors of each age group so that you can pick when something's not normal (P 18, P).
9. Maintaining a child-centred approach Subtheme(s): 3	Commitment to ensuring one's practice is consistent places children's needs first and foremost in the context of adults' problems. A child-centred approach recognises the power asymmetry between children and adults, and views children as individuals with their own rights (Coyne et al., 2016; Munro, 2011).	I think it's just holding the child at the centre of what we do (P 1, C). For me the ultimate goal is to keep the child safe so they're my priority (P 4, P). It's easy to get caught up in the drama of the parent… but it's really important to think about the child because they can get lost in it sometimes as well (P 11, CH). You've gotta put the baby at the centre of it… you still would be considering those other things but you wouldn't be considering them without what's the impact on the baby who's at the centre of it (P 22, CH).

Subtheme 3: seeing and being the voice of the child

Although nurses wanted to maintain positive relationships with families, they recognised children's safety was a separate priority through a child-centred approach (see Table 3, point 9). This was highlighted by Participant 4 (CH) and 20 (CH), respectively: 'the ultimate goal is to keep the child safe, and I always think to myself… are they [children]… absolutely safe right now?' However, the extent to which nurses were child-centred was not the same, nor static for any individual nurse. Even nurses who articulated child-centred views were aware they could easily lose that focus without ongoing application of reflective practice to ensure children's needs were prioritised (see Table 3, point 7). These nurses were appreciative of colleagues who brought them back to see the child's perspective. For example, Participant 10 (CH) explained that case reviews were an opportunity to reflect and remind colleagues to focus on the child: 'our case conference discussion is so important, to kind of go 'hang on where's the baby at? Is the baby still thriving? Have we checked baby's development?' So sometimes… we haven't talked at all about the baby' (P 10, CH). Although most participants ($n = 20$) explicitly stated the child was their priority, this was not always internalised and consistently applied. In one instance, Participant 18 (P) was more concerned about parental intent than impact on the child: 'people will see this behavior and they may take it that you [parent] are intentionally hurting your child.'

Some nurses, especially child health nurses, described specific strategies to promote a child-centred approach (Table 3, point 9). For example, Participant 11 (CH) used perspective taking to look at situations from the child's eyes: 'I literally try and look through the eyes of that child, like as an infant in a bassinette I think of lying there and looking up, what are the faces, what do I see, what do I hear?' (P 11, CH). Nurses then communicated what the child might be experiencing in a tactful and understandable way (see Table 3, point 4). For example, some participants interpreted what children communicated through behavior and play and fed this back to parents. This was clear in Participant 12's approach to educating a new mother about her baby's attachment behaviors: 'I might say to the mum 'look at how he's looking at you. He's really trying to make eye contact with you and get to know you" (P

12, CH). Although nurses preferred to use indirect techniques such as speaking for the child to communicate children's perceived needs, some situations were obviously dangerous, and nurses addressed these immediately (see Table 3, point 5). For example, Participant 22 (CH) explained: 'If it's really clearly going to be harmful, then I need to say it outright.' In this example, like the earlier situation of a firearm in a home, nurses reported addressing immediate risks promptly and directly.

In contrast to child health nurses, some paediatric nurses felt uncomfortable addressing their concerns with parents, for example Participant 2 (P) explained: 'I… feel uncomfortable telling people how to parent. I don't think it's my place'. Similarly, Participant 4 (P) discussed how she felt the philosophy of family-centred care could prevent paediatric nurses from intervening: 'it's so ingrained that the parent knows their child better than anybody else, so it's sometimes hard… for a nurse to say 'well, actually, maybe you should try doing it this way." Some paediatric nurses feared parents could react negatively to their involvement: 'You will have tears, or you will be told where to go in a not-so-nice way' (P 18, P). This suggests some paediatric nurses may not be equipped or prepared to discuss concerns about parental behaviors with families, and it may not be within their scope of practice. For example, Participant 13 (P) outlined how nurses might promote the wellbeing of a baby whose mother was using illicit substances: 'nurses would probably… reiterate about safe feeding and… hygiene for children, all those sorts of things, but I think most of the other parts are out of our scope [of practice].'

Despite the inherent difficulties of promoting change for children at risk of harm; nurses acknowledged this as an essential part of their role, which requires a responsive attitude towards professional development needs and opportunities (see Table 3, point 6). For example, Participant 7 (P) highlighted that there is not necessarily a single approach to discussing maltreatment with parents: 'it is uncomfortable sometimes to talk about some of this stuff, it's not easy and there isn't a perfect way.' This was particularly evident when nurses were addressing suspicious injuries: 'it's not an easy space to work in at times, particularly if… you can see harm on the child and you want to… explore that' (P 12, CH). Instead, exploring concerns with parents was considered a

progressively developed skill: 'the more we do it, the better we become at it' (P 7, P). Nurses gained confidence to discuss their concerns over time, as outlined by Participant 8 (C) who routinely checked whether infants had a safe sleeping environments: 'towards the end [of the program] we were able to feel confident to do things like go into bedrooms and check out [the safety of] cots. In the beginning I would never have done that.' These insights from participants demonstrate that although addressing situations of possible maltreatment may initially feel uncomfortable, nurses can develop these skills with appropriate support.

Overall, nurses agreed listening to children was important (see Table 3, point 8) but reported challenges in doing so. For example, children's communication was not necessarily verbal, but included behavior and play, meaning 'you can listen, but then how do you know what it is that you're hearing?' (P 1, C). Sometimes it was necessary to explore children's views because developmental stages meant children interpreted events differently to adults. For example Participant 21 (P) encountered a school-aged child who misunderstood what would happen after fracturing his arm: 'he's hysterical… everything's disposable in society and so when it's broken you put it in the rubbish bin, and he thought we were going to put his arm in the rubbish bin.' Participant 21 recognised that school-age children are usually concrete thinkers and have achieved logical reasoning but not abstract thought (Peterson, 2014). This example highlights the importance of understanding children's voices within a developmental context. Nurses also explained it was not up to them to determine the validity of children's stories: 'if the child is coming to you with these kind of stories… you do take it at face value and report what you managed to find out.' (P 11, CH).

Discussion

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

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

Although most (n-20) participants articulated the importance of putting children's needs first, actually doing so could be difficult due to the complexities of navigating actual or potential parental reactions. Nurses practice within specific sociocultural contexts that affect their actual and perceived roles in addressing child maltreatment, which in

turn influence how parents might respond. Although individuals actively construct their social positions and identities, they are to some extent products of the societies in which they live (Burr, 2015). For nurses, this means that they are constantly negotiating and renegotiating relationships with families in the context of socially constructed community perceptions and organisational norms which govern their roles.

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

Other key societal factors that affect nursing roles and practices are the settings and models of care under which nurses work. For example, in Australia, child health nurses use a primary health care approach (Grant, Mitchell, & Cuthbertson, 2017) whilst paediatric nurses typically work in acute care settings which emphasise a biomedical approach (Fraser, Waters, Forster, & Brown, 2017). Primary health care is a holistic approach that addresses social and environmental conditions contributing to health and illness (Talbot & Verrinder, 2014) whilst a biomedical approach focuses on how physiological function or dysfunction affects the body as a whole (Baum, 2015). These separate approaches are reflected in the language of the specialist standards for nurses working with children in Australia. For example, in the National Standards of Practice for Maternal, Child & Family Health Nurses, the language focusses not only on the child and family, but also on the broader social environment including the social determinants of health (Grant et al., 2017). Conversely, the Standards of Practice for Children and Young People's Nurses which apply to paediatric nurses acknowledge the importance of primary healthcare, but do not consistently use the language of primary healthcare (Australian College of Children & Young People's Nurses, 2016). As social practices and knowledge are located within specific sociocultural contexts (Burr, 2015), it could be that nurses' perceived levels of comfort and subsequent practices in addressing parenting stem from organisational cultures and models of care. These different practice orientations of paediatric nurses and child health nurses have implications for their respective roles and scopes of practice in identifying, addressing and following up parental behaviors and social circumstances impacting children.

In addition to the influence of organisational norms such as models of care, nurses were active agents in constructing their own identities in the eyes of families. Nurses were aware of the socially constructed negative images of healthcare professionals who survey and monitor families (Aston et al., 2015), and so used covert strategies to assess for child maltreatment. Nurses attempted to construct their role as supportive and friendly, but existing literature suggests this predisposes nursing skills to being seen as 'simple and easy' in comparison to specialised biomedical skills (Aston et al., 2015). The application of highly competent relational skills in difficult and complex situations to address child maltreatment (summarised in Table 3) demonstrates nurses' application of relational practice.

Relational practice has been explained as the enactment of effective, responsive and ethical nursing care in the context of nurse-client

relationships (Doane & Varcoe, 2007). However, relational practice is highly complex and requires nurses to negotiate a multitude of interrelated factors including personal characteristics, client expectations, workload demands, organisational priorities and prevailing ideologies against their perceived professional role (Doane & Varcoe, 2007). The value of nurses' unique relational practices in addressing child maltreatment has also been argued by several other recent studies (see for example Einboden, 2017; Einboden, Rudge, & Varcoe, 2019; Mawhinney, 2019; Williams, Ayele, Shimasaki, Tung, & Olds, 2019). In the current study, the highly developed skills demonstrated by participants were likely due to their considerable expertise (most participants worked in nursing for at least 10 years; mean = 24.6 years, range = 10–40 years). As such, the complexity and expertise underlying nurses' relational practices needs to be more widely recognised to facilitate nurses' capacity to enact change for children at risk of maltreatment.

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

Limitations

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

Conclusion

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

CRediT authorship contribution statement

Ms Lauren Elizabeth Lines: Conceptualization, Investigation, Writing - original draft. **Julian Maree Grant:** Writing - review & editing, Supervision. **Alison Hutton:** Writing - review & editing, Supervision.

Declaration of competing interest

The authors have no conflict of interest to declare.

References

Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., ... Randel, P. (2015). The power of relationships: Exploring how public health nurses support mothers and families during postpartum home visits. *Journal of Family Nursing*, 21(1), 11–34. https://doi.org/10.1177/1074840714561524.

Atkins, S., & Schutz, S. (2013). Developing skills for reflective practice. In C. Bulman, & S. Schutz (Eds.), *Reflective practice in nursing* (5th ed.). West Sussex, UK: John Wiley & Sons Inc.

Australian College of Children & Young People''s Nurses (2016). Standards of practice for children and young people's nurses. Retrieved from https://www.accypn.com.au/knowledge-centre/standards-of-practice/.

Australian Government Department of Health (2019). National action plan for the health of children and young people 2020-2030. Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/4815673E283EC1B6CA2584000082EA7D/$File/FINAL%20National%20Action%20Plan%20for%20the%20Health%20of%20Children%20and%20Young%20People%202020-2030.pdf.

Australian Institute of Family Studies (2018). Australian child protection legislation. Retrieved from https://aifs.gov.au/cfca/publications/australian-child-protection-legislation.

Australian Qualifications Framework Council (2013). *Australian qualifications framework* (2nd ed.) Retrieved from https://www.aqf.edu.au/sites/aqf/files/aqf-2nd-edition-january-2013.pdf.

Barrett, E., Denieffe, S., Bergin, M., & Gooney, M. (2017). An exploration of paediatric nurses' views of caring for infants who have suffered nonaccidental injury. *Journal of Clinical Nursing*, 26(15–16), 2274–2285. https://doi.org/10.1111/jocn.13439.

Baum, F. (2015). *The new public health* (4th ed.). Melbourne, Australia: Oxford University Press.

Burr, V. (2015). *Social constructionism* (3rd ed.). East Sussex, UK: Routledge.

Coyne, I., Hallstrom, I., & Soderback, M. (2016). Reframing the focus from a family-centred to a child-centred care approach for children's healthcare. *Journal of Child Health Care*, 20(4), 494–502. https://doi.org/10.1177/1367493516642744.

Dahlbo, M., Jakobsson, L., & Lundqvist, P. (2017). Keeping the child in focus while supporting the family. *Journal of Child Health Care*, 21(1), 103–111. https://doi.org/10.1177/1367493516686200.

Davis, H., & Day, C. (2010). *Working in partnership: The family partnership model.* London: Pearson Education.

Doane, G. H., & Varcoe, C. (2007). Relational practice and nursing obligations. *Advances in Nursing Science*, 30(3), 192–205.

Egan, G. (2010). *The skilled helper: A problem-management and opportunity-development approach to helping* (10th ed.). Belmont, USA: Brooks/Cole Cengage Learning.

Einboden, R., Rudge, T., & Varcoe, C. (2019). Beyond and around mandatory reporting in nursing practice: Interrupting a series of deferrals. *Nursing Inquiry*, 26(2). https://doi.org/10.1111/nin.12285.

Einboden, R. D. (2017). *Nowhere to stand: A critical discourse analysis of nurses' responses to child neglect and abuse.* (Doctor of Philosophy) University of Sydney.

Fraser, J., Waters, D., Forster, E., & Brown, N. (Eds.). (2017). *Paediatric nursing in Australia: Principles for practice* (2nd ed.). Cambridge, UK: Cambridge University Press.

Fraser, J. A., Hutchinson, M., & Appleton, J. V. (2016). Nurses' experiences of home visiting new parents in rural and regional communities in Australia: A descriptive qualitative study. *Journal of Children's Services*, 11(3), 204–216. https://doi.org/10.1108/jcs-07-2015-0023.

Fraser, N. (2013). Final overview report of serious case review re Daniel Pelka. Retrieved from https://cscb-new.co.uk/downloads/Serious%20Case%20Reviews%20-%20exec.%20summaries/SCR_Archive/Coventry%20SCR%20-%20Daniel%20Pelka%20(2013).pdf.

Fraser, S., Grant, J., & Mannix, T. (2014). The role and experience of child and family health nurses in developed countries: A review of the literature. *Neonatal, Paediatric & Child Health Nursing*, 17(3), 2–10.

Fuller, T. (2014). Beyond investigations: differential response in child protective services. In J. E. Korbin, & R. D. Krugman (Eds.), *Handbook of child maltreatment*. Dordrecht, Netherlands: Springer.

Furedi, F. (2002). *Paranoid parenting: Why ignoring the experts may be best for your child.* Chicago, USA: Chicago Review Press.

Gibbs, G. R. (2014). Chapter 19: using software analysis in qualitative analysis. In U. Flick (Ed.), *The SAGE handbook of qualitative data analysis*. London: Sage Publications Ltd.

Government of South Australia: Attorney-General''s Department (2017). Children and young people (safety) Act 2017. Retrieved from https://www.legislation.sa.gov.au/LZ/C/A/CHILDREN%20AND%20YOUNG%20PEOPLE%20(SAFETY)%20ACT%202017/CURRENT/2017.25.AUTH.PDF.

Grant, J., Mitchell, C., & Cuthbertson, L. (2017). National standards of practice for maternal, child & family health nurses in Australia. Retrieved from http://www.mcafhna.org.au/Resources.aspx#52611-standards.

Her Majesty's Government (2018). Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf.

Johns, M. (2015). Inquest into the death of Chloe Lee Valentine. Retrieved from http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/613/VALENTINE%20Chloe%20Lee.pdf.

Kettle, M., & Jackson, S. (2017). Revisiting the rule of optimism. *The British Journal of Social Work*, 47(6), 1624–1640. https://doi.org/10.1093/bjsw/bcx090.

Kraft, L. E., Rahm, G., & Eriksson, U. -B. (2017). School nurses avoid addressing child sexual abuse. *Journal of School Nursing*, 33(2), 133–142. https://doi.org/10.1177/1059840516633729.

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

Lines, L. E., Hutton, A. E., & Grant, J. (2017). Integrative review: nurses' roles and experiences in keeping children safe. *Journal of Advanced Nursing*, 73(2), 302–322. https://doi.org/10.1111/jan.13101.

Mawhinney, B. (2019). *Safeguarding children at risk of maltreatment: Role of the Australian child and family health nurse.* (Doctor of Philosophy) Sydney: The University of Sydney Retrieved from https://ses.library.usyd.edu.au/bitstream/handle/2123/21885/Mawhinney_BL_thesis%20%281%29_Redacted.pdf?sequence=4&isAllowed=y.

Munro, E. (2011). The Munro review of child protection: Final report. A child-centred system. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf.

Nyland, M. (2016). Child protection systems royal commission report: The life they deserve. Retrieved from https://www.agd.sa.gov.au/sites/g/files/net2876/f/complete_report_child_protection_systems_royal_commission_report.pdf?v=1494388953.

Peckover, S., & Appleton, J. V. (2019). Health visiting and safeguarding children: A perfect storm? *Journal of Health Visiting*, 7(5), 232–238. https://doi.org/10.12968/johv.2019.7.5.232.

Peterson, C. C. (2014). *Looking forward through the lifespan: Developmental psychology* (6th ed.). Frenchs Forest, Australia: Pearson.

Rorden, J. (2010). Communication and therapeutic relationships. In M. Barnes, & J. Rowe (Eds.), *Child, youth and family health: Strengthening communities* (pp. 74–89). Chatswood, New South Wales: Churchill Livingstone, Elsevier.

Runyan, D. K. (2015). Chapter 2: who is maltreated and how mandated reporting might help. In B. Mathews, & D. C. Bross (Eds.), *Mandatory reporting laws and the identification of severe child abuse and neglect.* Dordrecht, Netherlands: Springer.

Saldana, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). London, UK: SAGE Publications Inc.

Scott, D., & Swain, S. (2002). *Confronting cruelty: Historical perspectives on child protection in Australia.* Melbourne: Melbourne University Press.

Shields, L. (2017). All is not well with family-centred care. *Nursing Children and Young People*, 29(4). https://doi.org/10.7748/ncyp.29.4.14.s15.

Shields, L., Pratt, J., & Hunter, J. (2006). Family centred care: A review of qualitative studies. *Journal of Clinical Nursing*, 15(10). https://doi.org/10.1111/j.1365-2702.2006.01433.x.

Smith, J., Shields, L., Neill, S., & Darbyshire, P. (2017). Losing the child's voice and "the captive mother": An inevitable legacy of family-centred care? *Evidence-Based Nursing*, 20, 67–69. https://doi.org/10.1136/eb-2017-102700.

Talbot, L., & Verrinder, G. (2014). *Promoting health: The primary health care approach* (5th ed.). Chatswood, Australia: Churchill Livingstone, Elsevier.

Uniacke, S., Browne, T. K., & Shields, L. (2018). How should we understand family-centred care? *Journal of Child Health Care*, 22(3), 460–469. https://doi.org/10.1177/1367493517753083.

Williams, V. N., Ayele, R., Shimasaki, S., Tung, G. J., & Olds, D. (2019). Risk assessment practices in home visiting nurses and child protection caseworks in Colorado, United States: A qualitative investigation. *Health and Social Care in the Community*. https://doi.org/10.1111/hsc.12773.