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Title: Integrative review: nurses' roles and experiences in keeping children safe.

ABSTRACT

Aim: To identify nurses' role and experiences of keeping children safe.

Background

Approaches to preventing, identifying and responding to child abuse and neglect have moved towards a multidisciplinary approach where all professionals are expected to contribute to the goal of keeping children safe. Frequently in contact with children and families, nurses well positioned to contribute to keeping children safe from abuse and neglect. Much has been published around nurses' experiences of their role in keeping children safe but this literature has not yet been synthesised to determine the challenges and potential scope of this role.

Design

Integrative review following an Integrative Review framework.

Data Sources

Studies were identified through a search of the electronic databases CINAHL, Medline, Web of Science, Scopus and Informit to identify literature published between 2005 - 2015.

Review Methods

All the studies were critically appraised for methodological quality using the Critical Skills Appraisal Programme. Data from each study was extracted and categorised according to the review aims and the study's major findings.

Results

Inclusion criteria were met in 60 studies. Three main findings were identified including nurses' insufficient knowledge, need for validation and improved communication and balancing surveillance and support for vulnerable families.

Conclusions

Nurses have many roles and experiences in keeping children safe but often felt they did not have the knowledge, skills and support to take action in this area. Further research is needed to understand why nurses feel inadequate and disempowered to advocate and intervene on the behalf of children at risk of abuse or neglect.

Keywords: integrative review, child abuse, nurses, mandatory reporting, nurse's role, safeguarding, child maltreatment, child welfare, child.

SUMMARY STATEMENT

Why is this review needed?

- Child abuse and neglect is a major global public health issue.
- Recent strategies to address child abuse and neglect emphasise a community-wide response that expects healthcare professionals to be involved in the prevention, identification and response to child abuse and neglect.
- Nurses are in frequent contact with children and families, but little is known about how they experience their role and the challenges they may face in keeping children safe.

What are the key findings?

- Nurses perceived a lack of knowledge and confidence to effectively respond to child abuse and neglect.
- These deficits meant they relied on other professionals to guide them in responding to suspicions of child abuse or neglect.
- Nurses were often dissatisfied with the responses of colleagues and child protection services and frequently did not believe that a positive outcome would be achieved for the child.

How should the findings be used to influence policy/practice/research/education?

- Nurses want additional support to help them to fulfil their ethical and legal duties in keeping children safe from abuse and neglect.
- Further research is needed to understand why nurses are underprepared to safeguard children.

- Consideration needs to be given to whether current education and training is adequate or if another response is warranted.

INTRODUCTION

Child abuse is prevalent globally with one quarter of all adults reporting a history of childhood physical abuse and an additional 41,000 children annually recorded as victims of homicide (World Health Organisation 2014). The definitions of child abuse vary among countries and jurisdictions, but include physical abuse, sexual abuse, psychological abuse and neglect (Williams & Weeks 2014). The effects of child abuse are not restricted to childhood as the impacts can extend into adult life. Adults who were victims of abuse during childhood often experience increased mental health problems, greater contact with the criminal justice system, decreased educational attainment, reduced economic wellbeing and poorer personal relationships (Currie & Widom 2010, Sugaya *et al.* 2010, Allwood & Widom 2013, Covey *et al.* 2013, Easton *et al.* 2013).

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

BACKGROUND

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

One of the key differences between child protection systems internationally is the role of nurses in reporting of child abuse. In countries such as the United States of America, Canada and Australia nurses are legally required to report child abuse (Mathews 2015). In other countries such as the United Kingdom and New Zealand there is generally no legal requirement to report abuse, although nurses may still be ethically obliged to intervene (Royal College of Nursing 2014, New Zealand

Government 2012). In addition to reporting child abuse, nurses as a professional group are in an ideal position to identify families experiencing challenges to parenting and engage with families and services to promote children's safety and wellbeing (Tinker *et al.* 2010, Her Majesty's Government 2015). Nurses are recognised as core to supporting families and children in paediatric nursing environments and through programs such as universal home visiting where they are able to assess and promote the health and wellbeing of families (Fraser *et al.* 2014). Nurses working with adults may be indirectly involved with children and able to identify the needs of children at risk of abuse due to adult problems. In these roles, nurses are urged to take a child-centred approach to maintain the safety and wellbeing of children in their care (Munro 2011, Her Majesty's Government 2015).

THE REVIEW

Aim

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

Design

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

Search methods

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

Search outcome

All results from the database searches were exported into Endnote 7 where duplicates were removed. The titles and abstracts of remaining articles were screened for relevance based on the inclusion/exclusion criteria (Table 1) and irrelevant studies were discarded. Studies of all research designs were included in the findings in accordance with Whittemore and Knafl's integrative review design. Next, the first author screened the remaining papers by reading the full-text to determine eligibility and discussed their eligibility with the remaining authors. Six additional studies were identified during this stage by reading the reference lists of the included studies from the database searches. Overall, 60 studies met the inclusion criteria and were included

in this review (Table 2 and Supplemental Online Table 1). The process of selection is outlined in Figure 1.

Table 1: Inclusion and exclusion criteria

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

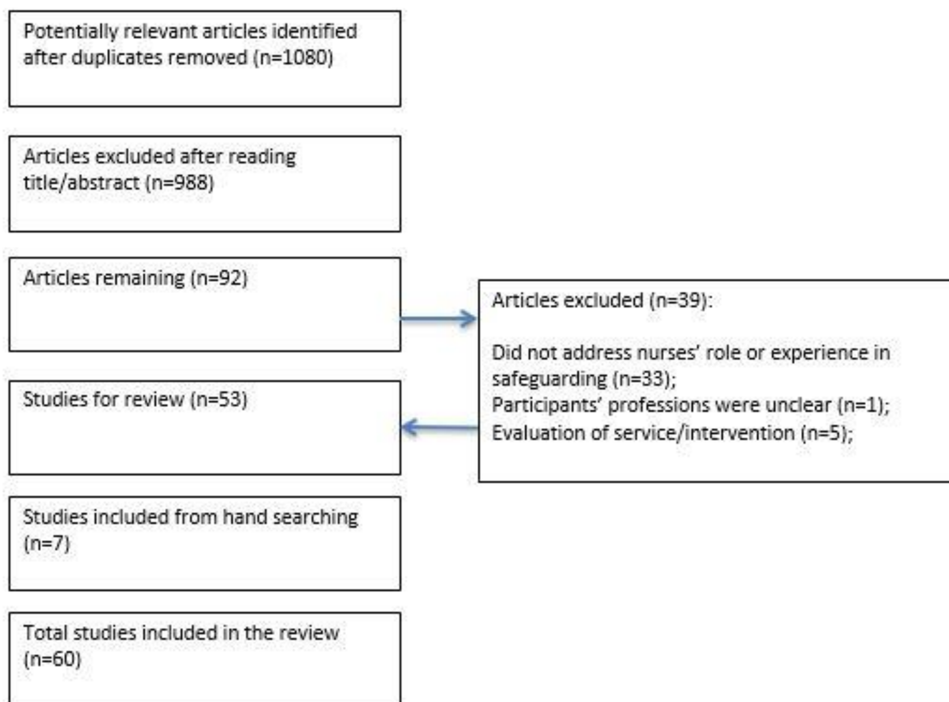

Figure 1: Flow diagram of study selection

Quality appraisal

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

Methodological quality was generally high in the majority of studies (n=57), although three studies had only moderate rigour. Due to moderate to strong methodological rigour of all studies, none were excluded on the basis of inadequate rigour. The most common weakness of the qualitative studies was failure of the researcher to explicitly

consider impacts of the researcher-participant relationship, while the most frequent weakness of quantitative designs was small or non-representative samples. See Supplemental Online Table 2 for supporting information about the specific methodological rigour of the included studies.

Data abstraction

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

Data synthesis

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

RESULTS

The 60 studies were located predominantly in developed countries (n=48) and/or included exclusively nurses as the professional group under investigation (n=43). Many studies recruited nurses from a cross-section of practice settings (n=18), while other studies specifically investigated nurses working in home visiting (n=13), community health centres or schools (n=12), or hospital settings (n=14). A small number of studies (n=3) also addressed adult mental health nurses and their contributions to keeping their clients' children safe. The three main findings relating to nurses' roles and experiences in safeguarding children were around 'insufficient knowledge', 'validation and communication' and 'balancing surveillance and support'. The finding 'insufficient knowledge' was supported by the most studies (n=44), while 'validation and communication' and 'balancing surveillance and support' were from 35 and 25 studies, respectively. Supplemental online table 3 demonstrates which studies contributed to each of these major findings.

Insufficient knowledge

Although the majority of nurses were aware of their legal or ethical obligation to report child abuse and neglect (Glasser & Chen 2006, Lazenbatt & Freeman 2006, Land & Barclay 2008, Tingberg *et al.* 2008, Raman *et al.* 2012, Davidov & Jack 2013, Mathews *et al.* 2008), the underreporting of child abuse and neglect was identified in several studies (Lazenbatt & Freeman 2006, Lee *et al.* 2007, Mathews *et al.* 2008, Ben Natan *et al.* 2012, Raman *et al.* 2012, Schols *et al.* 2013, Herendeen *et al.* 2014). Nurses frequently cited insufficient knowledge of child abuse and neglect as a barrier to identifying and responding to child abuse and neglect (Glasser & Chen 2006, Lazenbatt & Freeman 2006, Lee *et al.* 2007, Tingberg *et al.* 2008, Louwers *et al.* 2012, Francis *et al.* 2012, Raman *et al.* 2012, Schols *et al.* 2013, Houlihan *et al.*

2013, Herendeen *et al.* 2014, Borimnejad & Fomani 2015). Unfortunately, obtaining adequate information about reporting requirements was not always as simple as accessing the relevant policy or procedure. Some nurses did not know where to access reporting procedures (Louwers *et al.* 2012), while others perceived policies were too vague or otherwise unhelpful in clinical decision-making (Lazenbatt & Freeman 2006, Land & Barclay 2008, Tingberg *et al.* 2008, Schols *et al.* 2013, Rowse 2009b).

Although most nurses (49-86%) had received some training around their role as a mandated reporter of child abuse (Yehuda *et al.* 2010, Fraser *et al.* 2010, Ben Natan *et al.* 2012, Raman *et al.* 2012, Herendeen *et al.* 2014, Rolim *et al.* 2014, Hackett 2013) many nurses still desired ongoing professional development in areas of child protection (Crisp & Lister 2006, Lazenbatt & Freeman 2006, Lee *et al.* 2007, Land & Barclay 2008, Tingberg *et al.* 2008, Yehuda *et al.* 2010, Houlihan *et al.* 2013, Whittaker *et al.* 2015). However, there were some exceptions including surveys of Taiwanese (n=1400) and Brazilian nurses (n=104) indicating that 80 per cent and 86 per cent, respectively, had not participated in any child abuse training (Feng & Levine 2005, Moreira *et al.* 2013). In general, nurses desired education that was specific to their clinical speciality. For example, health visitors wanted more information about assessing parent-infant attachment (McAtamney 2011) while adult mental health nurses requested education around communicating with young children (Houlihan *et al.* 2013).

Gaps in nurses' knowledge were apparent even among studies that did not specifically investigate nurses' perceived knowledge and educational needs. For example, some nurses did not maintain a child focus, but instead considered parental intent and

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

Validation and communication

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

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

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

hospital-based nurses who perceived a need to ‘convince’ the physician of the legitimacy of their concerns before any action could be taken (Feng & Levine 2005, Rowse 2009a, Feng *et al.* 2010, Francis *et al.* 2012).

Although child protection services may seem the most appropriate avenue to discuss child protection concerns, nurses did not always consult directly with them. Nurses reported frustrations around the process of consulting with child protection services who were seen as difficult to contact or unhelpful in addressing the child’s needs (Feng *et al.* 2005, Lazenbatt & Freeman 2006, Mathews *et al.* 2008, Rowse 2009a, Eisbach & Driessnack 2010, Schols *et al.* 2013). Many nurses were troubled by the lack of feedback following reports they made to child protection services (Land & Barclay 2008, Tingberg *et al.* 2008, Maddocks *et al.* 2010, Schols *et al.* 2013, Herendeen *et al.* 2014, Rowse 2009b). Nurses often cared deeply for the children and their families and became disheartened when they did not know what, or if anything was being done to assist the family (Land & Barclay 2008, Kent *et al.* 2011, Kraft & Eriksson 2015). As a result, many nurses lacked faith that the child protection services would take appropriate action on behalf of the child.

Nurses also reported poor communication between agencies involved in providing care for vulnerable children and families. In some cases this was due to concerns around confidentiality of families’ information (Land & Barclay 2008, Reupert & Maybery 2014). Other nurses described how poor communication could place nursing staff into dangerous situations during home visiting if they were not informed of potential safety risks like domestic violence (Land & Barclay 2008, Selbie 2009). At other times, optimal co-ordination of services was reduced because the lack of

information exchange meant that no single person was clear on exactly what services were being provided to the family (Schols *et al.* 2013). For example, one public health nurse recounted a situation where a family had been referred from agency to agency, only to eventually be referred back the public health nurse who had commenced the referral process (Selbie 2009). The large number of agencies involved with some families lead to them being given conflicting information from different professionals (Reupert & Maybery 2014). Nurses' lack of confidence in their own professional judgements led to overreliance on senior colleagues' opinions around validity of nurses' concerns. These consultations with senior colleagues often took the place of communication with child protection services, which nurses frequently did not trust to effectively safeguard the child.

Balancing support and surveillance

The qualitative studies identified that nurses valued building trust and rapport with vulnerable families to initiate and maintain positive therapeutic relationships (Selbie 2009, Browne *et al.* 2010). Nurses reported that trust and rapport with families led to greater engagement with health services, especially for families who might be suspicious of services (Browne *et al.* 2010, Selbie 2009, McAtamney 2011, Reupert & Maybery 2014). However, not all nurses believed that safeguarding children was their responsibility. For example, Crisp and Lister (2006) found that nurses tended to believe that child protection should be the responsibility of health visitors and reported that some nurses declined requests to be interviewed citing that child protection was not part of their role. Similarly, some mental health nurses in the United Kingdom had difficulty balancing the emotional needs of their adult clients against the safety of clients' children and subsequently decided to remain impartial

towards the children (Maddocks *et al.* 2010). This is consistent with Houlihan, Sharek and Higgins' (2013) study of 114 psychiatric nurses which found that over half (57%) the respondents asked if their client had children, but only about a third (36%) documented this finding. Conversely, Korhonen et al. (2010) found that of 331 mental health nurses, most (95%) regularly gathered information about parental status from their clients, but nurses who were parents themselves better understood the needs of children and were more likely to meet with children to assess their needs.

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

However, this strategy was acknowledged as potentially risky if families realised they were being watched and withdrew from services (Francis *et al.* 2012).

In addition to the adverse consequences of reporting of abuse on nurse-family relationships, nurses also voiced concerns over the potential for negative personal outcomes. In more extreme cases, nurses were aware of situations where family members had made threats against nurses who were believed to have made a report of abuse (Feng *et al.* 2005, Lee *et al.* 2007, Land & Barclay 2008, Kraft & Eriksson 2015, Borimnejad & Fomani 2015). While these fears may be well founded based on the clinical examples provided, nurses were also worried about having to give evidence in court (Land & Barclay 2008, Rolim *et al.* 2014, Rowse 2009b) and the potential for litigation should they report abuse that was later not substantiated (Mathews *et al.* 2008, Fraser *et al.* 2010). The potential for adverse outcomes following mandatory reporting appeared to be particularly enhanced in Taiwanese nurses due to the cultural norms around childrearing as family business that should not be interfered with (Feng *et al.* 2005, Chen *et al.* 2015).

Nurses also experienced conflict between their role of supporting families through positive therapeutic relationships when parents were alleged perpetrators of severe abuse (Tingberg *et al.* 2008, Rowse 2009a) or caused harm through substance abuse (Maguire 2013, Murphy-Oikonen *et al.* 2010). Nurses reported distress over the effects of parental behaviour on children, which led to feelings of frustration, anger or disgust towards the parent/s (Tingberg *et al.* 2008, Murphy-Oikonen *et al.* 2010, Maguire 2013). Nurses frequently placed the sole blame for the child’s pain and distress on the parents, which meant the nurses experienced emotional and ethical

barriers to engaging with these parents in meaningful ways (Rowse 2009b, Tingberg *et al.* 2008, Maguire 2013, Whittaker *et al.* 2015). Although nurses clearly understood the nature of their responsibility in caring for both the abused and abuser, their emotional response was a barrier to providing care to both parties. Nurses considered their role in reporting child abuse and neglect as punitive rather than a positive response with potential to safeguard the child. Thus nurses faced ethical dilemmas when deciding whether to intercede on behalf of the child by making a report, or whether to preserve their image of a caring, helping professional.

DISCUSSION

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

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

consistency around the type or amount of training required (Kenny 2015). However, even nurses who had attended training showed perceived and measurable knowledge gaps.

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

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

In the wider literature, insufficient knowledge and confidence in interpreting signs of abuse and neglect is also prevalent among professionals working with children in other fields including education, psychology and medicine (Kenny 2004, Markenson *et al.* 2007, McKee & Dillenburger 2009, Goldman 2010, Pelisoli *et al.* 2015). While there is evidence that educational programs may increase professionals' knowledge, they did not always influence professionals' interpretation of signs of abuse and proposed course of action (Botash *et al.* 2005). Kenny (2015) contended that while it may be relatively straightforward to increase professionals' knowledge through education, in practice-based professions such as nursing, both knowledge *and* skill-based clinical competence is essential.

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

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

Due to perceived and actual knowledge deficits, nurses experienced a lack of confidence in their professional judgements around children at risk of abuse and neglect leading to an overreliance of colleagues' opinions. Discussions with colleagues often took the place of liaison with child protection services. At times nurses received adequate support from their colleagues, but when they did not, nurses were unsure of the optimal course of action and subsequently failed to act on behalf of the child. Nurses often felt the need to seek support from colleagues due to the ambiguity that was present in situations where a child was at risk. Ambiguity is inherent in to the field of child protection due to the complexity of families and the impossibility of predicting the future (Munro 2011). Although inaction or lack of support from other professionals to help nurses make decisions about children at risk is clearly a problem, it is most concerning that nurses as autonomous professionals do have the confidence, knowledge, skills and commitment to take the lead when a child is at risk.

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

IMPLICATIONS FOR PRACTICE, EDUCATION AND RESEARCH

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

judgements required to enact safeguarding practices in community and clinical settings. Additional research would help identify whether education instead of training would enhance nurses' confidence and practices around keeping children safe.

Strengths and limitations

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

CONCLUSION

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

empowered to advocate for children and to determine if education rather than training would augment their practice.

References

Allwood, M.A. & Widom, C.S. (2013) Child abuse and neglect, developmental role attainment, and adult arrests. *Journal of Research in Crime and Deilnquency,* **50**(4), 551-578.

Appleton, J.V. & Cowley, S. (2008) Health visiting assessment-unpacking critical attributes in health visitor needs assessment practice: A case study. *International Journal of Nursing Studies,* **45**(2), 232-245.

Ben Natan, M., Faour, C., Naamhah, S., Grinberg, K. & Klein-Kremer, A. (2012) Factors affecting medical and nursing staff reporting of child abuse. *International Nursing Review,* **59**(3), 331-337.

Borimnejad, L. & Fomani, F.K. (2015) Child abuse reporting barriers: Iranian nurses' experiences. *Iranian Red Crescent Medical Journal,* **17**(8), e22296.

Botash, A.S., Galloway, A.E., Booth, T., Ploutz-Snyder, R., Hoffman-Rosenfeld, J. & Cahill, L. (2005) Continuing medical education in child sexual abuse: cognitive gains but not expertise. *Archives of Pediatric Adolescent Medicine,* **159**, 561-566.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology,* **3**, 77-101.

Browne, A.J., Hartrick Doane, G., Reimer, J., MacLeod, M.L.P. & McLellan, E. (2010) Public health nursing practice with 'high priority' families: the significance of contextualizing 'risk'. *Nursing Inquiry,* **17**(1), 26-37.

Bryant, J.K. & Baldwin, P.A. (2010) School counsellors' perceptions of mandatory reporter training and mandatory reporting experiences. *Child Abuse Review,* **19**, 172-186.

Chen, Y.W., Huang, J.J., Lu, T.H. & Feng, J.Y. (2015) Clinical competency in child maltreatment for community nurses in Taiwan. *International Journal of Nursing Practice,* **21**, 21-26.

Council of Australian Governments (2009) National framework for protecting Australia's children 2009-2020.

Covey, H.C., Menard, S. & Franzese, R.J. (2013) Effects of adolescent physical abuse, exposure to neighborhood violence, and witnessing parental violence on adult socioeconomic status. *Child Maltreatment,* **18**(2), 85-97.

Crisp, B.R. & Lister, P.G. (2006) Nurses' perceived training needs in child protection issues. *Health Education,* **106**(5), 381-399.

Critical Skills Appraisal Programme (2013) CASP Checklists.

Currie, J. & Widom, C.S. (2010) Long-term consequences of child abuse and neglect on adult economic well-being. *Child Maltreatment,* **15**(2), 111-120.

Davidov, D.M. & Jack, S.M. (2013) Nurse home visitors' perceived awareness of mandatory reporting requirements: Pregnant women's and children's exposure to intimate partner violence. *Journal of Advanced Nursing,* **70**(8), 1770-1779.

Davidov, D.M., Nadorff, M.R., Jack, S.M. & Coben, J.H. (2012) Nurse Home Visitors' Perspectives of Mandatory Reporting of Children's Exposure to Intimate Partner Violence to Child Protection Agencies. *Public Health Nursing,* **29**(5), 412-423.

Dekker, S. (2002) *The field guide to human error investigations,* Ashgate.

Easton, S.D., Renner, L.M. & O'Leary, P. (2013) Suicide attempts among men with histories of child sexual abuse: examining abuse severity, mental health, and masculine norms. *Child Abuse & Neglect,* **37**, 380-387.

Eisbach, S.S. & Driessnack, M. (2010) Am I Sure I Want to Go Down This Road? Hesitations in the Reporting of Child Maltreatment by Nurses. *Journal for Specialists in Pediatric Nursing,* **15**(4), 317-323.

Feng, J., Chen, S.J., Wilk, N.C., Yang, W.P. & Fetzer, S. (2009) Kindergarten teachers' experience of reporting child abuse in Taiwan: Dancing on the edge. *Children and Youth Services Review,* **31**, 405-409.

Feng, J.Y., Fetzer, S., Chen, Y.W., Yeh, L. & Huang, M.C. (2010) Multidisciplinary collaboration reporting child abuse A grounded theory study. *International Journal of Nursing Studies,* **47**(12), 1483-1490.

Feng, J.Y., Jezewski, M.A. & Hsu, T.W. (2005) The meaning of child abuse for nurses in Taiwan. *Journal of Transcultural Nursing,* **16**(2), 142-149.

Feng, J.Y. & Levine, M. (2005) Factors associated with nurses' intention to report child abuse: A national survey of Taiwanese nurses. *Child Abuse & Neglect,* **29**(7), 783-795.

Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. & Smith, C. (2015) Better systems, better chances: a review of research and practice for prevention and early intervention. Australian Research Alliance for Children & Youth, ACT, Australia.

Francis, K., Chapman, Y., Sellick, K., James, A., Miles, M., Jones, J. & Grant, J. (2012) The decision making processes adopted by rurally located mandated professionals when child abuse or neglect is suspected. *Contemporary Nurse,* **41**(1), 58-69.

Fraser, J.A., Mathews, B.W., Linping, K.A. & Dunne, M. (2010) Factors influencing child abuse and neglect recognition and reporting by nurses: a multivariate analysis. *International Journal of Nursing Studies,* **47**(2), 146-53.

Fraser, S., Grant, J. & Mannix, T. (2014) The role and experience of child and fmaily health nurses in devleoped countries: a reivew of the literature. *Neonatal, Paediatric & Child Health Nursing,* **17**(3), 2-10.

Gilbert, R., Fluke, J., O'Donnell, M., Gonzalex-Izquierdo, A., Brownell, M., Gulliver, P., Janson, S. & Sidebotham, P. (2012) Child maltreatment: variation in trends and policies in six developed countries. *Lancet,* **37**(9), 758-772.

Glasser, S. & Chen, W. (2006) Survey of a pediatric hospital staff regarding cases of suspected child abuse and neglect. *Israel Medical Association Journal,* **8**(3), 179-183.

Goldman, J.G.D. (2010) Australian undergraduate primary school student-teachers' responses to child sexual abuse and its mandatory reporting. *Pastoral Care in Education,* **28**(4), 283-294.

Hackett, A.J. (2013) The role of the school nurse in child protection. *Community Practitioner,* **86**(12), 26-29.

Her Majesty's Government (2015) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children.

Herendeen, P.A., Blevins, R., Anson, E. & Smith, J. (2014) Barriers to and consequences of mandated reporting of child abuse by nurse practitioners. *Journal of Pediatric Health Care,* **28**(1), e1-7.

Ho, G.W.K. & Gross, D.A. (2015) Pediatric Nurses' Differentiations Between Acceptable and Unacceptable Parent Discipline Behaviors: A Q-Study. *Journal of Pediatric Healthcare,* **29**(3), 255-264.

Houlihan, D., Sharek, D. & Higgins, A. (2013) Supporting children whose parent has a mental health problem: An assessment of the education, knowledge,

confidence and practices of registered psychiatric nurses in Ireland. *Journal of Psychiatric and Mental Health Nursing,* **20**(4), 287-295.
Jones, R., Flaherty, E.G., Binns, H.J., Price, L.L., Slora, E., Abney, D., Harris, D.L., Christoffell, K.K. & Sege, R.D. (2008) Clinicians' description of factors influencing their reporting of suspected child abuse: reprot of the child abuse reporting experience study research group. *Pediatrics,* **122**(2), 259-266.
Kenny, M.C. (2004) Teachers' attitudes towards and knowledge of child maltreatment. *Child Abuse & Neglect,* **28**, 1311-1319.
Kenny, M.C. (2015) Training in repoting of child maltreatment: where are we and where we need to go. In *Mandatory reporting laws and the identification of severe abuse and neglect*(Mathews, B. and Bross, D. C. eds.), pp. 327-346.
Kent, S., Dowling, M. & Gobnait, B. (2011) Community nurses' child protection role: views of public health nurses in Ireland. *Community Practitioner,* **84**(11), 33-6.
Koetting, C., Fitzpatrick, J.J., Lewin, L. & Kilanowski, J. (2012) Nurse practitioner knowledge of child sexual abuse in children with cognitive disabilities. *Journal of Forensic Nursing,* **8**(2), 72-80.
Korhonen, T., Pietilä, A.M. & Vehviläinen-Julkunen, K. (2010) Are the children of the clients' visible or invisible for nurses in adult psychiatry? - A questionnaire survey. *Scandinavian Journal of Caring Sciences,* **24**(1), 65-74.
Kraft, L.E. & Eriksson, U.-B. (2015) The School Nurse's Ability to Detect and Support Abused Children: A Trust-Creating Process. *Journal of School Nursing,* **31**(5), 353-62.
Land, M. & Barclay, L. (2008) Nurses' contribution to child protection. *Neonatal, Paediatric and Child Health Nursing,* **11**(1), 18-24.
Lazenbatt, A. & Freeman, R. (2006) Recognizing and reporting child physical abuse: a survey of primary healthcare professionals. *Journal of Advanced Nursing,* **56**(3), 227-236.
Lee, P.Y., Fraser, J.A. & Chou, F.H. (2007) Nurse reporting of known and suspected child abuse and neglect cases in Taiwan. *Kaohsiung Journal of Medical Sciences,* **23**(3), 128-137.
Lewin, D. & Herron, H. (2007) Signs, symptoms and risk factors: health visitors' perspectives of child neglect. *Child Abuse Review,* **16**, 93-107.
Louwers, E.C.F.M., Korfage, I.J., Affourtit, M.J., De Koning, H.J. & Moll, H.A. (2012) Facilitators and barriers to screening for child abuse in the emergency department. *BMC Pediatrics,* **12**.
Maddocks, S., Johnson, S., Wright, N. & Stickley, T. (2010) A phenomenological exploration of the lived experience of mental health nurses who care for clients with enduring mental health problems who are parents. *Journal of Psychiatric and Mental Health Nursing,* **17**(8), 674-682.
Maguire, D.J. (2013) Mothers on methadone: Care in the NICU. *Neonatal Network,* **32**(6), 409-415.
Markenson, D., Tunik, M., Cooper, A., Olson, L., Cook, L., Matza-Haughton, H., Trelber, M., Brown, W., Dickson, P. & Foltin, G. (2007) A national assessment of knowledge, attitudes, and confidence ofp rehospital providers in the assessment and management of child maltreatment. *Pediatrics,* **119**(1), e103-e108.
Mathews, B. (2015) Mandatory reporting laws: their origin, nature, and development over time. In *Mandatory reporting laws ans the identification of severe child abuse and neglect*(Mathews, B. and Bross, D. C. eds.) Springer.

Mathews, B., Fraser, J., Walsh, K., Dunne, M., Kilby, S. & Chen, L. (2008) Queensland nurses' attitudes towards and knowledge of the legislative duty to report child abuse and neglect: results of a state-wide survey. *Journal of law and medicine,* **16**(2), 288-304.

McAtamney, R. (2011) Health visitors' perceptions of their role in assessing parent-infant relationships. *Community Practitioner,* **84**(8), 33-37.

McKee, B.E. & Dillenburger, K. (2009) Child abuse and neglect: training needs of student teachers. *International Journal of Educational Research,* **48**, 320-330.

Moreira, G.A.R., Vasconcelos, A.A., Marques, L.A. & Vieira, L.J.E.S. (2013) Training and knowledge of professionals of the health family team on reporting mistreatment of children and adolescents. *Revista Paulista de Pediatria,* **31**(2), 223-230.

Munro, E. (2005) Improving practice: child protection as a systems problem. *Children and Youth Services Review,* **27**, 375-391.

Munro, E. (2011) The Munro Review of child protection: final report. Her Majesty's Stationary Office, United Kingdom.

Munro, E. & Fish, S. (2015) Hear no evil, see no evil: understanding failure to identify and report child sexual abuse in institutional contexts.

Murphy-Oikonen, J., Brownlee, K., Monetlpare, W. & Gerlach, K. (2010) The experiences of NICU nurses in caring for infants with neonatal abstinence syndrome. *Neonatal Network,* **29**(5), 307-313.

New Zealand Government (2012) The white paper for vulnerable children. Vol. 1 Wellington, New Zealand.

Office of the High Commissioner for Human Rights (1990) Convention on the rights of the child.

Pabis, M., Wronska, I., Slusarska, B. & Cuber, T. (2011) Paediatric nurses' identification of violence against children. *Journal of Advanced Nursing,* **67**(2), 384-93.

Pelisoli, C., Herman, S. & Dell'Aglio, D.D. (2015) Child sexual abuse research knowledge among child abuse professionals and laypersons. *Child Abuse & Neglect,* **40**, 36-47.

Raman, S., Holdgate, A. & Torrens, R. (2012) Are our Frontline Clinicians Equipped with the Ability and Confidence to Address Child Abuse and Neglect? *Child Abuse Review,* **21**(2), 114-130.

Reupert, A. & Maybery, D. (2014) Practitioners' experiences of working with families with complex needs. *Journal of Psychiatric and Mental Health Nursing,* **21**(7), 642-651.

Rolim, A.C.A., Moreira, G.A.R., Gondim, S.M.M., Da Silva Paz, S. & De Souza Vieira, L.J.E. (2014) Factors associated with reporting of abuse against children and adolescents by nurses within primary health care1. *Revista Latino-Americana de Enfermagem,* **22**(6), 1048-1055.

Rowse, V. (2009a) Children's Nurses' Experiences of Child Protection: What Helps? *Child Abuse Review,* **18**(3), 168-180.

Rowse, V. (2009b) Support needs of children's nurses involved in child protection cases. *Journal of Nursing Management,* **17**(6), 659-666.

Royal College of Nursing (2014) Safeguarding children and young people - every nurses' responsibility.

Schols, M.W.A., De Ruiter, C. & Öry, F.G. (2013) How do public child healthcare professionals and primary school teachers identify and handle child abuse cases? A qualitative study. *BMC Public Health,* **13**(1), 807.

Scott, D. & Fraser, J. (2015) Mandatory reporting of child abuse and neglect by health professionals. In *Mandatory reporting laws and the identification os severe abuse and neglect*(Mathews, B. and Bross, D. C. eds.) Springer, The Netherlands, pp. 381-393.

Selbie, J. (2009) Health visitors' child protection work: exploratory study of risk assessment. *Community Practitioner,* **82**(5), 28-31.

Sugaya, L., Hasin, S.D., Olfson, M., Lin, K.H., Grant, B.F. & Blanco, C. (2010) Child physical abuse and adult mental health state: a national study. *Journal of Traumatic Stress,* **25**(2), 215-222.

Tingberg, B., Bredlöv, B. & Ygge, B.M. (2008) Nurses' experience in clinical encounters with children experiencing abuse and their parents. *Journal of Clinical Nursing,* **17**(20), 2718-2724.

Tinker, E., Postma, J. & Butterfield, P.G. (2010) Barriers and facilitators in the delivery of environmental risk reduction by public health nurses in the home setting. *Public Health Nursing,* **28**(1), 35-42.

Whittaker, A., Williams, N., Chandler, A., Cunningham-Burley, S., McGorm, K. & Mathews, G. (2015) The burden of care: a focus group study of healthcare practitioners in Scotland talking about parental drug misuse. *Health & Social Care in the Community*.

Whittemore, R. & Knafl, K. (2005) The integrative review: updated methodology. *Journal of Advanced Nursing,* **52**(5), 546-553.

Williams, L.M. & Weeks, E.G. (2014) Defining and measuring child maltreatment. In *Child abuse and neglect worldwide: Volume 1 Understanding, Defining and Measuring Child Maltreatment*(Conte, J. R. ed. Praeger, California, pp. 9-36.

Wilson, P., Barbour, R.S., Graham, C., Currie, M., Puckering, C. & Minnis, H. (2008) Health visitors' assessments of parent-child relationships: A focus group study. *International Journal of Nursing Studies,* **45**(8), 1137-1147.

World Health Organisation (2010) Violence prevention: the evidence. Malta.

World Health Organisation (2014) Child maltreatment.

Yehuda, Y.B., Attar-Schwartz, S., Ziv, A., Jedwab, M. & Benbenishty, R. (2010) Child abuse and neglect: Reporting by health professionals and their need for training. *Israel Medical Association Journal,* **12**(10), 598-602.

Supplemental Online Table 1

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

Korhonen et al. 2010 Finland	To examine the interaction that mental health nurses have with children of their clients.	Quantitative, cross-sectional questionnaire of mental health nurses (n=331) working in psychiatric inpatient and outpatient units.	The majority of nurses gathered information about client's children (95-96%) and asked about potential behavioural problems (80%). Most nurses ensured children had a safe adult to care for them when the parent was hospitalised (76-85%). Nurses who were parents themselves or had more years of experience were more likely to consider the needs of children.
Kraft & Eriksson 2015 Sweden	To explore how school nurses detect maltreated children and initiate support.	Qualitative, approach using a grounded theory approach to guide the analysis. Two focus groups with school nurses (n=23) with at least 3 years of experience were conducted.	School nurses developed trusting relationships with children to facilitate identification of abuse. School nurses described initial intuitions that lead them to further monitor and subsequently advocate for particular children. School nurses worried about damaging relationships with children and parents when asking sensitive questions or reporting abuse.
Lewin & Herron 2007 England	To explore health visitors' perceptions of child neglect signs, symptoms and risk factors.	Quantitative, cross-sectional survey of health visitors (n=92) who also taught at university.	Health visitors ranked parental behaviours as the highest priority indicators followed by child, parent and environmental characteristics. Health visitors pointed out that no individual factor should be considered in isolation to families' overall situations. Health visitors' assessment of the significance of indicators was consistent with the judgements of other professional groups.
Lazenbatt & Freeman 2006 Ireland	To investigate the self-reported ability of health professionals to recognise and report child physical abuse.	Quantitative, cross-sectional survey of health professionals working in the community; clinical nurses (n=139), general practitioners (n=147) and dentists (n=133).	Participants were aware of mechanisms for reporting but desired further multi-disciplinary education. Child abuse was not always reported due to lack of clear guidelines, concerns about negative consequences and lack of confidence in child protection services. Clinical nurses were most willing to become involved in identifying and managing abuse.
Louwers et al. 2012 The Netherlands	To assess the quality of child abuse detection in emergency departments (ED) with the aim to define facilitators/barriers to screening for child abuse.	Qualitative, using semi structured-interviews (n=27) with senior physicians (n=9), hospital board members (n=6), ED nurses (n=6) and ED managers (n=6).	Participants did not always report abuse and had difficulty addressing topic of suspected child abuse with parents. Many participants were not aware of their ED's child abuse protocol and felt they had insufficient educational preparation. Lack of resources and high staff turnover were barriers to maintaining good standards of practice.
Maddocks et al. 2010 United Kingdom	To explore mental health nurses' lived experience of caring for parents with enduring mental health problems.	Qualitative, interpretive phenomenology using semi-structured interviews with qualified mental health nurses (n=6).	Nurses disagreed upon how involved they should be with clients' children, citing lack of knowledge and unit facilities as barriers. Some nurses believed they should remain impartial to clients' children to avoid compromising the therapeutic relationship. When nurses did want to raise a child safety concerns, they had difficulty communicating with other agencies.
McAtamney 2011 Scotland	To explore health visitors' perceptions of their role in supporting parent-infant relationships.	Qualitative, interpretative phenomenology using semi-structured interviews with health visitors (n=12) working in three different community centres.	The baby was the key to health visitors' assessments but they also considered multiple other factors. Health visitors believed they had a major role in supporting the mother by building relationships, educating, listening and referrals. Health visitors felt professional competency increased through on-the-job experience but desired further education around attachment.

Pabis et al 2010 Poland	To evaluate paediatric nurses' assessment and diagnostic skills and interventions used for child maltreatment.	Quantitative, cross-sectional survey of paediatric registered nurses (n=160) in two children's hospitals in Poland.	Most nurses (86%) had encountered child abuse in their clinical practice, with neglect being most common. Nurses could identify a range of signs and symptoms of abuse including physical, behavioural and psychological effects. Most nurses (72%) tried to intervene to help children experiencing abuse.
Pakis et al. 2015 Turkey	To determine the awareness of healthcare professionals about child abuse and negligence.	Quantitative, cross-sectional survey of health professionals (physicians and nurses) working in four hospitals in Turkey.	Around half (55%) of physicians and a third (32%) of nurses had encountered a case of child abuse. The most common reasons for not reporting child abuse were concerns about the legal process (58%) and lack of knowledge (36%). Almost half (46.8%) were not aware of their organisation's child abuse procedures and mean knowledge score was 21 out of a possible 32.
Reijnders et al. 2008 The Netherlands	To identify if ED physicians and nurses, forensic physicians and interns are competent in describing, recognising and determining the possible causes of injuries.	Quantitative, cross-sectional survey of forensic physicians (n=104), ED physicians (n=79), ED nurses (n=84) and ED interns (n=97) in the Netherlands.	Forensic physicians scored much higher than other groups while interns scored the lowest; ED physicians and ED nurses scored equally well. Outline haematomas and blisters were more frequently recognised than tramline bruising, bite mars and petechiae.
Rowse 2009a England	To explore the experiences and feelings of nurses and midwives working with children who were subject of a child protection investigation.	Qualitative, interpretive phenomenology using semi-structured interviews with nurses (n=13) and midwives (n=2) working in community or hospital settings.	Nurses intuitively perceived signs of abuse but experienced doubt and anxiety when colleagues disagreed. Nurses were concerned about how other professionals would judge their actions, which influenced nurses' support-seeking behaviours. Nurses wanted more feedback and discussion with colleagues to help them understand what actions were being taken.
Rowse 2009b England	To explore the experience of nurses working in a hospital paediatric department who had involvement in child protection cases.	Qualitative, interpretive phenomenology using semi-structured interviews with nurses (n=13) and midwives (n=2) working in community or hospital settings.	Nurses knew how to access relevant child abuse policies/procedures but had difficulty applying them to clinical situations. Nurses were frustrated that their concerns were not always taken seriously by child protection services. Nurses felt unsupported, uninformed and vulnerable during legal proceedings.
Schols et al. 2013 The Netherlands	To investigate frontline professionals; experiences with child abuse detecting and reporting.	Qualitative, focus groups with primary school teachers (n=15), school principals (n=1), child healthcare physicians (n=6) and child healthcare nurses (n=11).	Nurses used their intuition to identify possible cases of abuse and then asked questions to gain more information. Participants tried to help children by closely monitoring families and encouraging parents to accept voluntary help. Participants preferred to seek support from colleagues due to dissatisfaction with coordination and quality of child protection services.
Selbie 2009 United Kingdom	To identify factors that enable health visitors to identify, analyse and manage risks to children.	Qualitative, modified grounded theory approach using semi-structured focus groups (n=2) and an interview (n=1) with health visitors.	Standardised assessment tools were not perceived to be helpful to assess individualised risk of families. Health visitors built long-term relationships with families to facilitate trust and promote ongoing risk assessment. Lack of information sharing between agencies made risk assessment difficult and meant no one took overall responsibility for children's wellbeing.

Taylor et al. 2009 Scotland	To measure health visitors' professional judgements of 'good enough' mothering and parenting.	Quantitative, cross-sectional factorial survey of health visitors (n=70).	Health visitors focus on a narrow range of factors to make predictions about mothering and parenting quality. Health visitors' judgements were significantly influenced by parental boundary setting, housing situation and health behaviours, but not family context, maternal age, medical history and child behaviour. Some knowledge deficits in health visitors understanding of acceptable sleep routine for children were present.
Tingberg et al 2008 Sweden	To identify nurses' experiences in encountering abused children and their parents.	Qualitative critical incident technique using interviews with paediatric nurses (n=11) working in a large paediatric hospital.	Nurses felt conflicted between their role of policing the parents but providing optimal care for the child. Nurses desired more education, additional psychological support and increased feedback from child protection services. Nurses knew they should report child abuse, but a lack of clear policies/procedures made this difficult.
Whittaker et al. 2015 Scotland	To explore experiences of healthcare professionals providing parenting support for drug-using parents.	Qualitative, focus groups with health professionals including health visitors (n=4), child protection advisor (n=1), mental health nurses (n=5), midwives (n=4), general practitioners (n=3) and a psychiatrist (n=1).	All professionals reported their practice was driven by a child protection model rather than a family support model. Professionals experienced challenges building trusting relationships with families while continuing to monitor children's wellbeing. A perceived culture of blame, poor interagency communication and lack of resources prevented professionals from supporting effective parenting.
Wilson et al. 2007 Scotland	To identify how health visitors identify difficulties in the early parent-child relationship.	Qualitative, focus groups with health visitors (n=24).	Health visitors could identify both evidence-based risk factors and more ambiguous signs. Health visitors developed ongoing relationships with families to contextualise risk factors over a period of time. Health visitors reported little formal training around assessing infant-parent relationships and developed knowledge through clinical experience.
Northern America			
Adams 2005 United States of America	To investigate how frequently advanced practice nurses assess and document known risk factors for child abuse and neglect.	Quantitative, cross-sectional survey of advanced practice nurses (n=52) working in a variety of clinical settings.	Nurses assessed ten of the twenty risk factors for parenting difficulties more than 50% of the time. However, eight risk factors were assessed less than 40% of the time. Nurses with higher qualifications and/or experience were more likely to report abuse.
Browne et al. 2010 Canada	To examine the working relationships between high-priority families and Public Health Nurses (PHN) in rural and remote areas.	Qualitative, interpretive approach informed by hermeneutic using semi-structured interviews and focus groups with public health nurses (n=32), lay home visitors (n=3), family care givers (n=20) and fieldnotes from observations of PHNs' practices (n=6).	PHNs sought to remain non-judgemental and understand the families' situations contextualising individual circumstances. Openness and honesty in their therapeutic relationships meant PHNs pre-empted unsafe conditions. PHNs aimed to keep families together by focusing on strengths but were clear that children's safety was not negotiable.
Davidov et al. 2012a United States of America	To identify and describe issues related to mandatory reporting of intimate partner violence (IPV) within the context of home visitation.	Qualitative, secondary analysis of data collected from another project that interviewed mothers (n=20), held focus groups with community home-visiting nurses (n=25) and interviews with community stakeholders (n=?).	Nurses believed their role as a mandated reporter impacted upon the therapeutic relationship by reducing trust and leading to avoidance. Some participants suggested that open and honest communication with families would reduce feelings of mistrust. Nurses desired further education around mandatory reporting policies and procedures to guide their decision-making.

Davidov et al. 2012b United States of America	To identify if home visitors attitudes to mandatory reporting of children's exposure to IPV.	Quantitative, cross-sectional web-based questionnaires sent to nurses (n=534) working in the Nurse-Family Partnership program in 32 US states.	Most (55%) nurses agreed they should report children's exposure to IPV but considered it could harm the nurse-client relationship. The majority of nurses (92%) agreed that mandatory reporting of IPV could protect children and/or make it easier for the woman to seek help (67%).
Davidov 2013 United States of America	To examine nurse home visitors perceived awareness of mandatory reporting requirements around pregnant women and children's exposure to IPV.	Quantitative, cross-sectional web-based questionnaires sent to nurses (n=534) working in the Nurse-Family Partnership program in 32 US states	Some nurses (23%) were unsure if there was a legal requirement to report IPV against a pregnant woman. Similarly, 18% of nurses were unsure if there was a legal requirement to report IPV against a woman holding a young child. Nurses prioritised the clients' wishes about reporting lower when the child was physically present during the IPV.
Eisbach & Driessnack 2010 United States of America	To describe the process of reporting child maltreatment from the perspective of paediatric nurses.	Qualitative, descriptive approach using grounded theory to guide the analysis. Participants were school nurses (n=10) or paediatric nurse practitioners (n=13).	Nurses were confident reporting objective evidence of abuse, but were concerned about being wrong when evidence subjective. When nurses were unsure, they continued to monitor the child and provided additional support. Nurses experiences of child protection services had been negative which discouraged them from referring children in the future.
Finn 2011 United States of America	To describe forensic nurses' perceptions of the context of receiving child abuse disclosures.	Narrative analysis of interviews with forensic nurses working in emergency departments (n=14), clinics (n=14) schools (n=2) and forensic units (n=2).	A child-friendly environment helped the child feel comfortable to share their experiences. Nurses highlighted the need to build trust and rapport with children through active listening. Nurses felt was important to demonstrate they believed the child and could handle hearing about the abusive experiences.
Herendeen et al 2014 United States of America	To examine paediatric nurse practitioners (PNPs) experiences in identifying and managing child abuse cases.	Quantitative, electronic cross-sectional survey of members of the National Association of PNPs (n=604).	Most PNPs had seen a case of child abuse but some had not reported every child with suspicious injuries. After reporting abuse, most PNPs believed the child experienced a positive outcome, but some PNPs had seen children sustain further injury due to inadequate action. Only around half of PNPs felt adequately prepared for their role in screening for child abuse.
Ho & Gross 2015 United States of America	To examine paediatric nurses' views on acceptable versus unacceptable discipline behaviours.	Quantitative, cross-sectional Q methodology with paediatric nurses (n=48) with at least 2 years of paediatric experience working at Johns Hopkins Hospital.	Nurses generally agreed that severe physical punishment causing obvious injury was unacceptable. Nurses were divided as to whether physical punishment or inciting of fear and uncertainty were more severe punishments. Nurses who were older, had their own children or had child abuse training were more likely to perceive physical punishment as unacceptable.
Horner & Herendeen 2014 United States of America	To describe the practice characteristics of advanced practice nurses (APNs) in the area of child maltreatment.	Quantitative, descriptive cross-sectional survey of lead APNs (n=136) working in children's hospitals and advocacy centres across all of the USA.	APNs in child protection were involved in clinical practice, research and education. Most APNs had a role in education other APN students, nurses, nursing students, medical students and physicians about child abuse. Most APNs had been required to testify in court as expert witnesses.

Koetting et al. 2012 United States of America	To describe the knowledge level of nurse practitioners (NPs) regarding symptoms of child sexual abuse in children with cognitive disabilities.	Quantitative, cross-sectional survey of family NPs and paediatric NPs (n=43) working in Missouri or Illinois.	Most NPs felt uncomfortable performing a clinical examination for child sexual abuse and did not know their organisation's policy about screening for child sexual abuse. Many NPs could not correctly identify anatomical structures of normal prepubescent female genitalia. Some NPs misdiagnosed normal findings or did not understand significance of abnormal findings.
Maguire et al. 2012 United States of America	To describe neonatal intensive care unit (NICU) nurses' lived experiences with caring for infants with Neonatal Abstinence Syndrome (NAS).	Qualitative, phenomenological method using semi-structured interview with NICU nurses (n=16) from a single NICU.	Nurses were distressed by the suffering of infants with NAS but were unable to comfort the infants. Nurses had difficulties communicating with the parents due to erratic, manipulative or aggressive behaviours. The discharge of infants caused nurses to worry about parents' ability to meet the high-needs of infants with NAS.
Murphy-Oikonen et al. 2010 Canada	To explore the experiences of NICU nurses who care for infants with NAS.	Qualitative, computer-assisted open-ended questionnaire completed by NICU nurses (n=14) working in a single regional NICU.	Nurses cared about the infants but were frustrated by the time taken for the infants' high need for non-technical care. Nurses had difficulty empathising with the mothers who they blamed for the infants' NAS. Nurses were distressed when infants with NAS were left to cry due to absent parents and heavy nursing workloads.
South America			
Moreira et al. 2013 Brazil	To analyse training and knowledge of professionals in the family health team on reporting the mistreatment of children and adolescents.	Quantitative, cross-sectional survey of professionals (n=9 physicians, n=26 nurses, n=16 dentists) working in family health teams.	Most participants had not attended training but they generally still knew where and how to report abuse. Attending training was associated with increased reporting of abuse. Some participants did not report every case of abuse they had encountered.
Rolim et al. 2014 Brazil	To analyse factors associated with juvenile abuse reporting by nurses working in primary health care (PHC).	Quantitative cohort cross-sectional survey of nurses working in PHC (n=616) in 85 cities.	Most nurses had not encountered a case of abuse, but those who had frequently did not make a report. Nurses who had access to reporting forms and knowledge of where to report were much more likely to report. Nurses who believed reporting abuse was beneficial and were not concerned about legal involvement were much more likely to report.
Souza Aragao et al. 2013 Brazil	To analyse how cases of violence against children and adolescents are approached by primary care nurses	Qualitative approach using semi-structured interviews with primary health nurses (n=8) working in socially vulnerable urban area.	Nurses believed their role was only to refer cases of violence against young people on to other professionals. Nurses were hesitant to report violence via official channels due to concerns about generating community mistrust. Nurses felt limited in their ability to manage violence against children due to their lack of knowledge.
Middle East			

Ben Natan et al 2012 Israel	To examine the reporting of child abuse and whether theory of planned behaviour succeeds in predicting nursing and medical staff reporting of suspected child abuse.	Quantitative, cross-sectional self-report questionnaire of nursing and medical staff (n=185) that regularly treat children in a large hospital and community centre.	Some participants had encountered child abuse but not reported it, commonly for fear of legal implications. Knowledge about child abuse was generally low, but higher knowledge was not associated with increased reporting of abuse. Subjective beliefs and personal characteristics influenced the likelihood of reporting child abuse.
Ben Yehuda et al. 2010 Israel	To study health professionals' experiences of identifying and reporting suspected cases of child abuse and neglect.	Quantitative, cross-sectional self-report questionnaire from a convenience sample (n=95) of doctors, nurses, psychologists and social workers attending a national conference on child abuse and neglect.	Most participants had experiences with child abuse or neglect over the past year. Although the majority of respondents had previously participated in workshops about child abuse, they still desired further training. The need for training was not associated with gender, age, years of professional experience or context of practice.
Borimnejad et al. 2015 Iran	To explore Iranian nurses' experiences about reporting child abuse.	Qualitative, content analysis of semi-structured interviews with nurses (n=16) who had direct experiences caring for children who had been abused.	Nurses felt they did not have the necessary knowledge of child abuse legislation. Nurses encountered challenges such as deciding whether a report would benefit children, or lead to poorer outcomes by angering parents. Nurses perceived flaws in the legislation that meant some children were not adequately protected.
Glasser & Chen 2006 Israel	To assess knowledge about hospital policy, attitudes and actual behaviour of hospital staff in cases of suspected child abuse and neglect.	Quantitative, cross-sectional survey of a convenience sample (n=82) of doctors, nurses and social workers at a children's hospital.	Most participants were aware of their organisation's policy for managing child abuse or neglect. Participants generally agreed that their profession had a responsibility to manage family violence. Many participants were uncomfortable discussing suspicions of abuse with the child or the parent, commonly due to lack of training.
China			
Chen et al. 2015 Taiwan	To identify community nurses' level of competency and examine relationships between nurses' characteristics and clinical competency.	Quantitative, cross-sectional descriptive correlational study using a questionnaire of community nurses (n=588).	Some nurses had encountered abuse but did not report; a common reason for not reporting was lack of evidence. Most nurses could identify signs of abuse, but were less able to identify signs of neglect. Few nurses were comfortable with their role as an advocate for abused children.
Feng et al. 2005 Taiwan	To explore nurses' experiences and perspectives regarding child abuse.	Qualitative, semi-structured interviews with nurses (n=18) working in an emergency department (n=8) or paediatric unit (n=10).	Nurses did not have a clear idea of the definition of child abuse. Nurses were unsure of their legal responsibility to report child abuse and would often wait for physicians to take the lead. Nurses were deterred from reporting child abuse by Chinese cultural norms of child rearing, fear of reprisals from the family, lack of faith in child protection services and high workloads.
Feng et al. 2010 Taiwan	To explore the experiences and perspectives of professionals working with other disciplines when reporting child abuse.	Qualitative, guided by grounded theory. Interviews (n=21) were conducted with physicians (n=5), nurses (n=5), social workers (n=6) and teachers (n=5).	Multidisciplinary communication tended to be one way; professionals passed information on but did not provide feedback. As a result, participants did not trust other professionals and were unsure if the child was receiving assistance. Participants viewed physicians as the leader in identifying and managing child abuse.

Feng & Levine 2005 Taiwan	To determine the experiences of Taiwanese nurses with a new child abuse reporting law and to assess attitudinal correlates of nurses' intention to report.	Quantitative, cross-sectional survey of registered nurses aged 18 or older working in paediatric, psychiatric and emergency care units.	Most nurses had never encountered child abuse; some nurses had encountered child abuse but did not report. Reasons for not reporting included lack of faith in authorities and feeling uncertain about the evidence. Although most nurses had not received education about child abuse, they were generally aware of their mandatory reporting duties.
Ko & Koh 2007 Korea	To examine the extent various characteristics of child sexual abuse situation variables and background characteristics of nurses affect perceptions of the definition of child sexual abuse.	Quantitative, vignette design questionnaire of nurses working in hospitals (n=503) and schools (n=526).	Nurses' personal characteristics accounted for negligible difference in their perceptions of the seriousness of sexual abuse. Factors that had the greatest influence on nurses' perceptions were intrusiveness of the act and victim resistance. Nurses perceived sexual abuse of adolescents to be more serious that sexual abuse of younger children.
Lee et al. 2007 Taiwan	To examine the influence of nurses' perceptions, attitudes and knowledge on suspecting and reporting child abuse and neglect.	Quantitative, cross-sectional surveys of registered nurses (n=238) from emergency units, paediatric units and community centres.	Many nurses did not know how to report child abuse and had not received training in this area. Many nurses had failed to report abuse due to lack of knowledge or fear of intimidation. Participants' perceptions, attitudes and knowledge of child abuse influenced their likelihood of reporting abuse.
Thamlikitkul et al. 2009 Thailand	To explore how psychiatric nurses care for school aged sexually abused children admitted to psychiatric wards.	Qualitative, grounded theory using semi-structured interviews with psychiatric nurses (n=12) working in psychiatric hospital wards.	Nurses' first priority was to establish trust and build relationships with the abused children. Nurses provided holistic care by conducting a comprehensive assessment of the child and their physical, emotional and social needs. Nurses then helped children return to normal life by developing the child's self-care and socialisation skills.
Australia and New Zealand			
Francis et al. 2012 Australia	To understand the circumstances and decision-making processes of mandated professionals employed in rural communities.	Qualitative, exploratory descriptive approach informed by grounded theory using interviews doctors (n=1), nurses (n=7), police officers (n=2) and teachers (n=6).	Participants were aware of the signs of child abuse and would ask the family questions to confirm or alleviate their concerns. Participants would often watch, wait and consider the bigger peicture until they had enough evidence to act. Participants sought support from colleagues to help them identify and manage child abuse.
Fraser 2007 Australia	To explore experiences of neonatal nurses who care for infants of drug-dependent parents.	Qualitative, semi-structured interviews with nurses (n=32) from four different neonatal units.	Nurses experienced caring for infants with neonatal abstinence syndrome time-consuming and emotionally draining. Poor communication and staffing issues reduced nurses' ability to care for families in a structured and coordinated manner. Nurses experienced a tension between caring for the infant and caring for the parents who were seen as the source of the infant's problems.
Fraser et al. 2010 Australia	To examine the relationship between nurse characteristics, training, knowledge and attitudinal on reporting child abuse and neglect.	Quantitative, cross-sectional survey of registered nurses (n=930) working with children and families in all practice settings.	Many nurses had previously reported abuse, but some nurses had suspected but not reported abuse. Many nurses had received training in child abuse but this did not alter perceptions of the seriousness or possibility of harm. Nurses who had training, worked in a metropolitan area and were parents themselves were more likely to report abuse.

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

Supplemental Online Table 2

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

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

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

Glasser & Chen 2006	Y	Y	N	Y	Unclear	Y	Y	Y	Y	Y
Herendeen et al. 2014	Y	Y	N	Unclear	Unclear	Y	Y	Y	Y	Y
Ho & Gross 2015	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hornor & Herendeen 2014	Y	Y	N	Unclear	Y	Y	Y	Y	Y	Y
Houlihan et al, 2012	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ko & Koh 2007	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Koetting et al. 2012	Y	Y	N	Y	Unclear	Y	Y	Y	Y	Y
Korhonen et al. 2010	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lee et al. 2007	Y	Y	N	Y	Unclear	Y	Y	Y	Y	Y
Lewin & Herron 2007	Y	Y	N	Y	Y	Y	Y	Y	Y	Unclear
Lazenbatt & Freeman 2006	Y	Y	N	Unclear	Y	Y	Y	Y	Y	Y
Mathews et al. 2008	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Moiera et al. 2013	Y	Y	N	Y	Y	Y	N	Y	Y	Y
Pabis et al. 2010	Y	Unclear	Y	N	Y	Y	Y	Y	Y	Y
Pakis et al. 2015	Unclear	Y	Y	N	Y	N	Y	Y	Y	N
Reijinders et al. 2008	Y	Y	Y	Y	Unclear	N	Y	Y	Y	Y
Raman et al. 2011	Y	Y	Unclear	Y	Y	Y	Y	Y	Y	Y
Rolim et al. 2014	Unclear	Y	Y	Unclear	Y	Y	Y	Y	Y	Y
Taylor et al. 2009	Y	Y	Y	Y	Unclear	Y	Y	Y	Y	Y
Yehuda et al. 2010	Y	Y	N	N	Unclear	Y	Y	Y	Y	Y

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

Supplemental Online Table 3: Studies contributing to the findings

Finding	Sources
Insufficient knowledge	(Adams 2005, Feng et al. 2005, Feng and Levine 2005, Crisp and Lister 2006, Glasser and Chen 2006, Lazenbatt and Freeman 2006, Coles and Collins 2007, Fraser et al. 2007, Ko and Koh 2007, Lee et al. 2007, Land and Barclay 2008, Mathews et al. 2008, Reijnders et al. 2008, Tingberg et al. 2008, Rowse 2009b, Taylor et al. 2009, Eisbach and Driessnack 2010, Feng et al. 2010, Fraser et al. 2010, Korhonen et al. 2010, Maddocks et al. 2010, Murphy-Oikonen et al. 2010, Yehuda et al. 2010, McAtamney 2011, Ben Natan et al. 2012, Davidov et al. 2012a, Koetting et al. 2012, Louwers et al. 2012, Raman et al. 2012, Appleton et al. 2013, Aragão et al. 2013, Davidov and Jack 2013, Hackett 2013, Houlihan et al. 2013, Maguire 2013, Moreira et al. 2013, Schols et al. 2013, Herendeen et al. 2014, Rolim et al. 2014, Borimnejad and Fomani 2015, Chen et al. 2015, Ho and Gross 2015, Pakiş et al. 2015, Whittaker et al. 2015)
Validation and communication	(Feng et al. 2005, Feng and Levine 2005, Crisp and Lister 2006, Lazenbatt and Freeman 2006, Fraser et al. 2007, Lewin and Herron 2007, Appleton and Cowley 2008, Land and Barclay 2008, Tingberg et al. 2008, Wilson et al. 2008, Rowse 2009a, Rowse 2009b, Selbie 2009, Taylor et al. 2009, Browne et al. 2010, Eisbach and Driessnack 2010, Feng et al. 2010, Maddocks et al. 2010, Mahoney 2010, Kent et al. 2011, McAtamney 2011, Pabis et al. 2011, Ben Natan et al. 2012, Davidov et al. 2012b, Francis et al. 2012, Aragão et al. 2013, Schols et al. 2013, Herendeen et al. 2014, Hornor and Herendeen 2014, Reupert and Maybery 2014, Borimnejad and Fomani 2015, Chen et al. 2015, Kraft and Eriksson 2015, Pakiş et al. 2015, Whittaker et al. 2015)
Balancing support and surveillance	(Coles and Collins 2007, Fraser et al. 2007, Appleton and Cowley 2008, Tingberg et al. 2008, Wilson et al. 2008, Selbie 2009, Thamlikitkul et al. 2009, Browne et al. 2010, Eisbach and Driessnack 2010, Maddocks et al. 2010, Murphy-Oikonen et al. 2010, Finn 2011, Kent et al. 2011, Davidov et al. 2012a, Davidov et al. 2012b, Francis et al. 2012, Louwers et al. 2012, Aragão et al. 2013, Hackett 2013,

	Maguire 2013, Schols et al. 2013, Reupert and Maybery 2014, Borimnejad and Fomani 2015, Kraft and Eriksson 2015, Whittaker et al. 2015)(Feng, 2005)