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Primary health care nurses and their suspicion of child abuse: the importance of relationship-building with families and interdisciplinary networks

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ABSTRACT

Introduction. There is a knowledge gap around the experiences of New Zealand (NZ) primary health care (PHC) registered nurses and nurse practitioners when working with children whom they suspect are being abused or neglected. **Aim.** This study aimed to explore what PHC nurses experience when building and nurturing family and interdisciplinary relationships amidst a suspicion that a child is being abused or neglected. **Methods.** Using contacts and snowballing to recruit participants, 13 PHC nurses working in the Auckland region were interviewed using semi-structured interviews. Gadamerian hermeneutics guided the analysis, with other philosophers drawn on to deepen the analysis. **Results.** Relationship building is precarious due to trust issues, tensions around reporting, and complex power relations. Nurses are central to coordinating interprofessional care. **Discussion.** Building relationships with families, children, and colleagues is fundamental to child protection. It is only by knowing what building and nurturing relationships is like amidst suspicion of child abuse or neglect that those whom nurses work with can understand what this work is like.

Keywords: child abuse, child protection, neglect, nurse, primary health, primary health care, relationships, suspicion of child abuse.

Introduction

Children and their families see nurses more often than any other health professional. In New Zealand (NZ), nurses constitute the largest regulated health workforce (Nursing Council New Zealand [NCNZ][1]) with approximately 15% working in primary health/community settings (Nursing Council of New Zealand [NCNZ][2]). Primary health care (PHC) nurses are therefore well placed to provide home-based care, health promotion initiatives, and surveillance.

PHC nurses are privy to valuable information which places them in an ideal position to detect and respond to child abuse.[3,4] Nurses' relationships with families develop due to the intimate and complex nature of their work.[4] They play a key role in child safeguarding and identifying risks to children and young people.[5] It is essential, therefore, that nurses know how to recognise signs of abuse or neglect.[5–7] Preventing and responding to child abuse is an important part of their role.[8,9] They are, therefore, well placed to assess if children are at risk of abuse and/or neglect. However, little research has been undertaken; thus, little is known about their work. Evidence from the USA[10] and Australia[11] shows that nurses often have first contact with children who have been abused. Furthermore, the trusting relationships they seek to establish means they are well placed to recognise and intervene when they observe signs of child abuse or neglect. Nurses in NZ report concerns to Oranga Tamariki, the social services organisation responsible for children's wellbeing. In Sweden, practice nurses are usually the first point of contact with patients[12] and are therefore in a useful position for identifying child abuse. These nurses play a large role in initial assessments and are usually the first

WHAT GAP THIS FILLS

What is already known: Child abuse is highly prevalent in NZ. Primary health care (PHC) nurses work across a variety of settings, and are therefore more likely than other health professionals to encounter children whom they suspect are at risk. Recognising suspected abuse and the decision making on reporting is challenging, particularly amidst the ethical, moral, and legal complexities.

What this study adds: The relationships PHC nurses in NZ develop with children and their families when they are suspicious of child abuse or neglect, mean they are well placed to lead best practice development on how best to support those with whom they work.

primary care contact for the patient. In community settings and emergency departments, nurses are often the first health professional to recognise child abuse.[4]

In the NZ context, child abuse and neglect costs over $2 billion per year which represents just over 1% of gross domestic product (GDP). Yet, just under 0.1% of GDP is spent on preventive measures.[13] NZ is rated fifth worst for child abuse and neglect out of the 31 Organization for Economic Cooperation and Development (OECD) countries,[14] thus, it is not surprising that PHC nurses are highly likely to work with children whom they suspect have been abused or neglected.

NZ has no legally mandated requirement to report suspected child abuse. Under the *Crimes Act 1961* (NZ), Section 195A[15] those who work or live with children are legally mandated to report a child whom they know is at risk of sexual assault, grievous bodily harm, or death. Under this section of the Act, failure to take reasonable steps to protect the child can result in criminal liability. However, the distinction between suspecting and knowing a child is at risk becomes significant when tested in court. The Crimes Act (substituted Section 59) Amendment Bill[15] is the only Act that focusses specifically on child abuse. This is significant because it has removed the statutory defence of 'reasonable force' to correct a child, commonly known as the 'anti-smacking' legislation. The state has discretionary powers to prosecute those who discipline their children via physical means such as smacking.

Current legislation, namely the Privacy Act Principle 11(f)(ii) of the *Privacy Act 1993* (NZ),[16] addresses the disclosure of information that is necessary to prevent or lessen a serious or imminent threat to the life or health of an individual. This means that an agent, such as an organisation or a health professional (ie a nurse), is able to disclose information that would usually be protected by the Privacy Act when a child is deemed to be at risk of actual or imminent harm. The notifier does not need to fear consequences because this Act affords protection against disciplinary action or prosecution.

This article focuses on empirical data highlighting the early stages of how nurses navigate relationship building in the context of a suspicion of child abuse and neglect. It is beyond the scope of this article to provide the entirety of the findings of this wider study. However, this article draws attention to the critical importance of building and nurturing relationships with children, their families, and interdisciplinary networks amidst the nurse's suspicion of child abuse or neglect. This could be nurses ensuring they remain open to their suspicion in the absence of evidence, building rapport and gaining trust, and to sometimes hiding their concern from a family.

Methods

Gadamerian hermeneutics was used to guide this study and to gain understanding as to what the nursing experience is like working with children whom the PHC nurse suspects may be being abused or neglected. The philosophical underpinnings of Levinas were introduced to further illustrate what this experience was like for PHC nurses. Face-to-face, individual, semi-structured interviews took place with 13 PHC nurses. Open-ended questions were used to explore the nurses' experiences. Recruitment included utilising existing networks, advertisements placed in PHC newsletters, and snowballing. All participants were women, two identifying as Māori, two as Pacific, one as English, and eight as NZ European. All PHC nurses had more than 1 year of post-registration work experience. Participants' areas included general practice, public health, child health, community services, youth and adolescent health, and youth justice. On analysing the data, the authors considered the relatively small sample size sufficient for the study given the high information power within the dataset.[17]

To gain a deeper understanding of PHC nurses' experiences, Gadamerian hermeneutics shaped how this study was conducted and analysed. Hermeneutic research has the potential to uncover complexities that have previously been hidden. A hermeneutic approach provided the framework for collecting the data and driving the findings. The hermeneutic data analysis of writing, reading, and re-writing informed the interpretations and the process of coming to new understandings. Thus, notions from Gadamer's hermeneutics philosophy are used to illuminate insights and new meanings derived from the participants' stories. Gadamerian notions of effective historical consciousness and the hermeneutic circle[18] were drawn upon during data analysis to show how understanding is shaped by nurses' pre-existing knowledge, but how nurses remain open to new understandings. The dataset also showed the importance of relationships. Levinas' philosophical approach to relations are grounded by an ethical call, which compels a responsibility for another when face-to-face.[19] Thus, Levinas' philosophy was used to illuminate insights and new meaning derived from participants' stories.

The author has used the term patients for people receiving care.

The study was granted ethics approval by AUT University Ethics on 27 September 2016 (Reference: 16/317). Participants were assigned pseudonyms.

Results

The PHC nurses interviewed identified as women. They worked across government and non-government organisations. The data analytical process identified two themes: (i) building and nurturing relationships with families and interprofessionally; and (ii) challenges to building and nurturing relationships.

Building and nurturing relationships with families and colleagues

The dataset highlighted that PHC nurses who worked with children who may be at risk of abuse knew relationships were the priority. What appeared to matter most to participants in this study is that nurses got to know the children and families with whom they work. Participants highlighted that it was essential if they were to offer help and support.

The data indicated that the nurses' key responsibility was establishing trust and was the basis of building relationships:

> So much work goes into setting up relationships with families. When you're engaging with families at any level, you have to do a lot of listening and a lot of setting up that relationship, and it's based on trust. (Tania)

Findings indicated that the first time a nurse met a family during a home visit, they were strangers, but the nurse was also a guest. In challenging situations where nurses wanted to observe the environment and assess the risks to children, to be let in they had to develop a relationship and establish trust. Experience told Tania that listening and establishing trust were interdependent. She was not able to build trust without 'a lot of listening'; however, she needed some degree of trust for the family to let her in and allow her to listen to them. Listening without judgement enabled Debbie to connect and build trust:

> … holes in the wall. That's a huge indicator of violence. I would always ask families how this hole came about. So I would just go around the house and would ask: "How did this hole and that hole happen?" When they'd explain, I'd say: "oh, that's interesting" or "that's unusual". People would either talk or not talk. Once I went to a house and counted 16 holes around the double bed. There was no other explanation apart from family violence, so I ended up sitting down and I said to her: "it feels like there's a lot happening in the bedroom, is that to protect the children?" And she said "yes". She said yes because I didn't ask her if it was violence. I just asked about protecting the children. That conversation formed a connection with us. (Debbie)

Although immediately concerned, Debbie is careful not to show it. Her priority is to start building a relationship and develop rapport in order to gain trust and thus protect the children. Debbie's skilful frank approach by asking a direct question acknowledged the woman's need to protect her children and was a significant way of building trust. Having established a relationship, participants highlighted that PHC nurses must work hard to nurture it. Aroha nurtured relationships with Māori families even though having to report any concerns risked breaking their trust:

> If I need to report any concerns, I tell whānau [extended family], and keep them informed throughout the process and let them know what's going to happen. It makes you feel like you've gone against their trust. I keep the communication open and explain the process and make sure I tell them who I'm contacting and what is happening. I use manaakitanga [showing respect and support] when I report concerns, and I nurture the family. (Aroha)

Being transparent and communicating the process of reporting concerns was Aroha's way of helping retain trust, which was necessary in order to nurture the relationship. Using open and honest communication and sharing what she knew throughout the reporting process demonstrates how she uses manaakitanga without imposing personal judgement, thus preserving the mana [status and sense of control over oneself] of whānau and strengthening relationships. Using manaakitanga is something Aroha maintains throughout relationships, with the hope that if she needed to report concerns, trust may not be broken. Relationships were nurtured through openness and transparency:

> We need to be open and transparent and talk about consent and confidentiality every time we meet with a family, and say that we'll refer them to Oranga Tamariki if there's a concern. (Karen)

Although there was the potential to break trust and impact the relationship, making full disclosures to patients and being honest about what would happen if concerns arose helped to ensure transparency and retain trust.

Challenges to building and nurturing relationships interprofessionally

Nurses are pivotal for making referrals and connecting families with relevant service providers. Thus, nurses must be able to build and nurture relationships with other health professionals and agencies when caring for children who

may be at risk of abuse or neglect. Karen once arrived at a home on a school day to talk to a mum about her 9-year-old child missing school. In this exemplar, Karen identified the layers of complexity with building and nurturing relationships during a home visit:

> Mum had mental health, gambling, and drug issues and was at a casino gambling. She had three adult mental health agencies going to see her, but no one had picked up on these kids. There were teenagers sleeping all over the house with another school kid there. The house was nice on the outside but derelict on the inside, with an empty, grimy, and festering fridge. During the visit I had to be careful not to show my shock to the two girls, as they love their mum. I talked to the other agencies working with the family and we all did a referral to [Oranga Tamariki] because if I did the referral alone, they would visit and the mum would deny being at the casino. (Karen)

Karen had not yet built a relationship effective enough for the social worker to trust Karen's account against that of the mother. Without testing this trust, Karen contacted agencies with whom she has already built a sufficient relationship and is confident she has their trust. Such relationships are the means for Karen to achieve the ends of having the social worker involved. In using a multi-agency approach, she hopes to build a trusting relationship over time with the social worker. A possible consequence of not having built a sufficient relationship with the social worker was that her assessment of neglect could be overlooked, and the children could remain in an unsafe environment. However, even without a relationship and the trust of the social worker, Karen had developed ways of helping children at risk by developing skilful engagement with families which enables a nuanced risk analysis. In the following exemplar, Emma had established a relationship with a pregnant mother who had disclosed to Emma that she was not taking insulin for diabetes. However, she was unable to find a way of helping the children she suspected were at risk:

> There were random people in the home when I would visit, and smoking inside the house. A CYFS [now named Oranga Tamariki] social worker investigated the mother and concluded everything was okay. I didn't agree with this outcome … I knew the mother wasn't telling the truth [to the CYFS social worker]. (Emma)

The social worker's response to Emma's concern illustrated that a relationship and trust were developing between them. However, the relationship had not developed sufficiently for the social worker to trust Emma's account against the mother's, even though Emma's concern about the activities occurring in the home remained. However, she was powerless to act further.

Challenges to building and nurturing relationships with families

There are numerous challenges inherent in building and nurturing relationships. The following exemplar provided by a participant draws attention to the multi-faceted challenges faced by nurses working in this context where there is no simple solution:

> I was there to help with the boy's encopresis, but when I got to the house he was out of control. He couldn't sit still, was making weird noises and was acting very immature for his age. His sister was selling his Ritalin, so his behaviour and encopresis soiling was isolating him from his peers. The boy had been suspended from school so many times, they'd moved around a lot and there was no stability. Mum hadn't brought him to any outpatient appointments. I think the boy's soiling was the least of his mum's issues. She just seemed very disconnected. (Megan)

With such complexity, Megan found it hard to build a relationship with the mother and the boy. Across the dataset, it was evident that participants never know what they may encounter when making a home visit. The unexpected and complex nature of the issues in the home were overwhelming for Megan.

The following exemplar illustrates the challenge posed by the reputation of the organisation tasked with intervening and supporting families, which means people are fearful of engagement. This impacted Karen's ability to support families who had complex needs:

> Oranga Tamariki is seen as a punitive system, it's not seen as a 'help people' organisation. They're often dealing with a small percent of people at the end of the spectrum that have the highest needs, so consequently they [Oranga Tamariki] get labelled. So when they're [parents] struggling, there's no way for them to ask for help because Oranga Tamariki are seen as this punitive system. (Karen)

Karen's relationships with families were based on trust and are a crucial means to protect children from further harm. If a perception of Oranga Tamariki is that of being punitive and thus to be avoided, then a family's trust in Karen is not assured. This illustrates the layers of challenges Karen faces across micro (intrapersonal), meso (interprofessional), and macro levels (societal/systems) when building and nurturing relationships amidst a child protection concern.

Discussion

This study begins to address a dearth of literature exploring PHC nurses' suspicion of child abuse or neglect in NZ.[7,20]

This discussion considers the current findings in relation to the wider international literature. The key findings draw attention to the precarious nature of the relationship with families. This precarity pertains to two features of the nascent relationship: (1) building trust is essential and yet can be broken through reporting; and (2) there is a complex power dynamic at play in building relationships with families, because although the nurse has the power to report, the family have the power to decline ongoing contact. The international literature concurs with these findings. In terms of relationships with families, Dahlbo *et al.*[3] confirm that there is an ongoing tension around acting in a non-judgmental way and yet prioritising the child's wellbeing, which may equate with reporting. Sundler *et al.*[21] emphasise the complexity and skills required to recognise and respond to a suspicion of child abuse. They noted that the more expert nurses were in this field, the higher the reporting, primarily through noting tacit cues.

The study also demonstrates that when supporting families, relationships with other health professionals and organisations become important to ensure that support aligns with needs. The current study shows the importance of nurses becoming the care coordination hub, facilitating access to resources and services. Nurses' central role in patient management is detailed by Oldland *et al*.[22] In the child protection context, Jack *et al.*[8] concur that nurses have a unique role to play given the extended time they spend with families across time. Reporting is only one facet of care. However, effective reporting relies on the quality of pre-existing interprofessional relationships. Interprofessionally, reporting may be strengthened or undermined by the professional trust and respect of another's assessment. Sundler *et al.*[21] argue that interprofessional engagement is crucial in responding to a suspicion of child abuse. However, nurses can feel guilt or even shame when ineffective collaboration affects the process of caring for those with whom they work.[23] Requisite support includes professional supervision and ongoing education. Inherent within nurses' relationships are significant multifaceted challenges between the micro, meso, and macro levels of interpersonal, interprofessional, and systems, highlighting how nurses are constantly required to navigate ongoing uncertainty.

The strength of this study is that this is the first NZ study to ask a range of PHC nurses who work with children across all age ranges what it is like to build and nurture relationships with children and their families when child abuse is suspected. A limitation was the small sample size and the inability to recruit Plunket and school nurses.

Key conclusions are that nurses' child protection work is highly complex. Supporting and retaining this workforce is fundamental. Expertise is a vital component of building and nurturing potentially precarious relationships with complicated power dynamics. Nurses are central to care coordination but cannot work in a silo. Effective collaboration is fundamental.

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Data availability. The data that supports this study cannot be publicly shared due to ethical or privacy reasons and may be shared upon reasonable request to the corresponding author if appropriate.

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