



Frameworks That Inform Professionals' Communication and Early Support for Childhood Adversities: A Scoping Review

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Abstract

Adverse experiences during childhood such as family violence, neglect, poverty, poor parental mental or physical health have negative immediate and lifelong impacts on children's health and development. Although many families experience adversities, families experience barriers to seeking support, and many professionals lack confidence to have sensitive conversations with these families. Aiming to inform the development of resources to guide professionals, we undertook a scoping review to (1) identify and describe communication frameworks for professionals and (2) describe if/how they were evaluated. Searches were conducted in Medline, Emcare, PsycInfo, Cumulative Index in Nursing and Allied Health Literature and Scopus from inception to January 2025. Following the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR), we located 15 communication frameworks contained within 33 manuscripts. Key characteristics of the communication frameworks are presented, such as practice setting and intended users, which adversities were addressed and how they were evaluated. There were two broad types of communication framework, those which required professionals to actively screen and respond to family adversities, and those which provided opportunistic guidance and response without explicit screening. Most communication frameworks were in the global north, and many were not evaluated beyond their initial context. We could not locate any communication frameworks embedded within non-health-related settings, and none comprehensively addressed all adverse experiences known to impact children. Nonetheless, this review identified available evidence that can help inform tailoring and development of communication frameworks to build professionals' capacity for early intervention for family adversities.

Keywords

adverse childhood experiences, health workforce, scoping review, parenting

Introduction

Experiences within early childhood (conception to age 5 years) have significant lifelong and intergenerational health, wellbeing and social outcomes (Aguayo & Britto, 2024). Early childhood is a particularly sensitive developmental period due to rapid brain development and increased dependence upon caregivers (Aguayo & Britto, 2024; Draper et al., 2024). Adversities, or Adverse Childhood Experiences (ACEs), that occur during childhood include family experiences of violence, neglect, poverty, parental separation, poor parental mental and/or physical health and marginalisation (Asmussen et al., 2020; Umar et al., 2025). ACEs impact around 50% of children globally and are linked to short- and long-term harm to health, social and economic outcomes (Asmussen et al., 2020; Thurston et al., 2025; Umar et al., 2025).

Parents are responsible for providing safe and caring home environments, but many ACEs are beyond individual parents' control and require outside support (Radey et al.,

2025). For example, parents experiencing poor mental or physical health, insecure housing, family violence and/or marginalisation are influenced by informal supports, formal services and broader sociocultural factors. Furthermore, ACEs are more prevalent in certain populations such as children in statutory care, living in poverty or First Nations¹ children, all who may become caught within intergenerational cycles of disadvantage (Higgins et al., 2022; Madigan et al., 2024). When families experience multiple adversities, it

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increases the likelihood of children experiencing maltreatment, which may lead to child protection intervention, inclusive of child removal (Featherstone et al., 2019; Higgins et al., 2019). Comprehensive prevention and early support for parents is essential to prevent adversities from escalating and mitigate harm to children (Higgins et al., 2022).

National and international policies emphasise responsive parenting and supportive environments as buffers for the impacts of ACEs (Organisation for Economic Co-Operation and Development, 2025; World Health Organization, 2020). When children experience responsive parenting and supportive families and communities, it can mitigate the impacts of ACEs so children can grow healthy and thriving (Higgins et al., 2019). However, when families experience ACEs, they encounter many barriers to seeking support such as stigma, shame, difficulties navigating services and fear of child protection intervention (Khan et al., 2018; Loveday, Balgovind, Hall, Goldfeld, et al., 2023). As such, strategies to facilitate the provision of early support to families experiencing adversities are essential.

One strategy to address ACEs includes standardised screening of children and/or parents. For example, screening for ACEs (Felitti et al., 1998), or specific conditions in targeted populations such as postnatal mental health via the Edinburgh Postnatal Depression Scale (EPDS; Levis et al., 2020). However, simply screening for ACEs has significant limitations because results may be misused to infer individual risk without consideration of resilience factors (Anda et al., 2020). Furthermore, many parents find standardised screening uncomfortable or stigmatising depending upon how it is delivered (Loveday et al., 2022). As such, there is a disconnect between families' needs for early support to mitigate harm to children, and professionals' capacity for sensitive conversations that enable this support (Khan et al., 2018). Instead, professionals need to apply person-centred, culturally sensitive approaches that enable therapeutic and relational responses to parents' needs (Gram et al., 2024).

Health, education and social care professionals regularly engage with children and families and are well-placed to provide non-stigmatising support for family adversities (Higgins et al., 2022; Lines et al., 2025a). As such, primary prevention and early support enable help for families before problems emerge or escalate (Lonne et al., 2020). Primary prevention by professionals can include listening non-judgmentally, validating concerns, anticipatory guidance, encouraging parental self-reflection and navigating referrals (Lines et al., 2020; Lonne et al., 2020). Families with specific needs can be referred for targeted early intervention – for example parental mental health care (Lonne et al., 2020). However, many professionals lack skills and confidence to have discussions with parents about ACEs, and knowledge about early support opportunities (Loveday, Balgovind, Hall, Sanci, et al., 2023). Communications tools and frameworks may help build workforce capacity to have sensitive

discussions with families regarding ACEs and provide links to early supports.

In recognition of the disconnect between parental needs and professionals' capacity, this review asked: What communication frameworks, protocols and guidelines are used by health, welfare and education professionals to inform communication and early support with parents when there are early childhood (0–5 years) ACEs? Specifically, review objectives were to (1) identify and describe communication frameworks for professionals and (2) describe if/how they were evaluated. Review findings will inform the authors' future work to implement, tailor or develop an evidence-informed, communication and early support framework that can equip health, education and social care professionals with confidence and tools to support families experiencing ACEs.

Methods

Given the exploratory aims of this review (identification and description of communication frameworks and their evaluation), a scoping review methodology was selected (Aromataris et al., 2024). This review followed the Joanna Briggs Institute process for conducting scoping reviews (Aromataris et al., 2024), the Arksey and O'Malley (2005) framework and recent methodological updates (Peters et al., 2020). The five steps of the Arksey and O'Malley (2005) framework were: (1) Identification of the research question, (2) Identification of relevant studies, (3) Study selection, (4) Charting the data and (5) Collating, summarising and reporting results. The optional step of consultation (Levac et al., 2010) was not explicitly part of this review, but review findings will inform future co-design research with families and practitioners.

A scoping review protocol was developed and pre-registered on the Open Science Framework database (Lines et al., 2025c).

Identification of the Research Question

The research question was: What communication frameworks, protocols and guidelines are used by health, welfare and education practitioners to inform communication and early support with parents of children 0 to 5 years when there are ACEs? Specifically, the review objectives were to (1) identify and describe communication frameworks for professionals and (2) describe if/how they were evaluated.

Identification of Relevant Studies

A three-step search strategy was undertaken to locate published and unpublished studies. First, an initial limited search of Medline was undertaken by the lead author and a research librarian to identify articles on the topic. Words contained

Table 1. Scoping Review Inclusion and Exclusion Criteria.

Inclusion criteria	Exclusion criteria
Health, welfare or education professionals.	Professionals other than health, welfare or education.
Professionals working with families perinatally or with children aged up to 5 years.	Professionals not working with families perinatally or with children aged up to 5 years.
Professionals working with families experiencing ACEs.	Professionals not working with families experiencing ACEs.
Communication frameworks, toolkits or guidelines that:	Communication frameworks, toolkits or guidelines that do/are not:
• address one or more ACEs. • are applicable perinatally or with children up to 5 years. • have a conceptual evidence base and specific guidance for professionals. • are embedded within existing services.	• address one or more ACEs. • apply perinatally or with children up to 5 years. • have a conceptual evidence base and specific guidance for professionals. • embedded within existing services.
Settings where health, welfare or education services are provided to children, parents and/or families on a voluntary basis.	Involuntary settings (e.g., statutory child protection).
All geographical regions; papers in English.	Papers in languages other than English.
All primary research designs, including quantitative, qualitative and mixed methods. Methodology can be development, implementation and/or evaluation of a framework.	Not primary research (e.g., reviews, policies, opinion papers).

Note. ACEs = Adverse Childhood Experiences.

within the titles and abstracts of relevant articles and index terms were used to develop a full strategy for Medline (Appendix 1). This strategy was translated in Emcare, PsycInfo, Cumulative Index in Nursing and Allied Health Literature and Scopus with the research librarian and undertaken in January 2025; no date restrictions were applied. The full search strategy is presented in Appendix 1.

Studies were included if they presented a framework, toolkit, or guideline to aid professionals in communicating with parents during pregnancy or their child's early years (ages 0–5 years) to offer support for ACEs. All geographical regions and primary research designs were included. Definitions for family adversities were informed by the authors' past work (Lines et al., 2025b) and seminal works on ACEs (Felitti et al., 1998; Karatekin & Hill, 2019). Studies were excluded if they did not describe a framework, toolkit or guideline, were not applicable to ACEs in early childhood, were not primary research or occurred in involuntary settings (e.g. child protection). Studies focused on involuntary settings were excluded because this indicated that ACEs had escalated beyond the initial identification, primary prevention and early support. Full inclusion and exclusion criteria are presented in Table 1.

Study Selection

All citations were uploaded into Covidence review software ($n=12,591$). Duplicates ($n=2,931$) were automatically removed ($n=2,765$), with additional duplicates manually removed ($n=166$) throughout the screening process.

After removing duplicates, titles and abstracts of papers identified in the search ($n=9,660$) were screened independently by any two authors against inclusion and exclusion criteria; discrepancies were resolved by a third author or through discussion. Potentially relevant manuscripts identified by title and abstract screening ($n=318$) were full-text screened by two authors, with discrepancies resolved through discussion.

After full-text screening, 25 manuscripts were identified for inclusion. Backwards and forwards citation screening on these initial manuscripts was performed on through the Scopus database. Potentially relevant additional manuscripts were recorded and also backwards/forwards citation screened. This process led to an additional 17 manuscripts being added into Covidence for screening; 8 were eligible for inclusion in the final review. Most manuscripts identified through backward–forward citation screening were additional studies of communication frameworks already captured in this review. These manuscripts did not appear in the original search because their titles and abstracts did not meet inclusion criteria. Ultimately, no new communication frameworks were identified through backward–forward citation screening. Further screening details are provided in the Preferred Reporting Items for Systematic reviews and Meta-Analyses flowchart in Figure 1.

Charting the Data

All relevant studies, regardless of methodological quality, were extracted and synthesised in line with scoping review

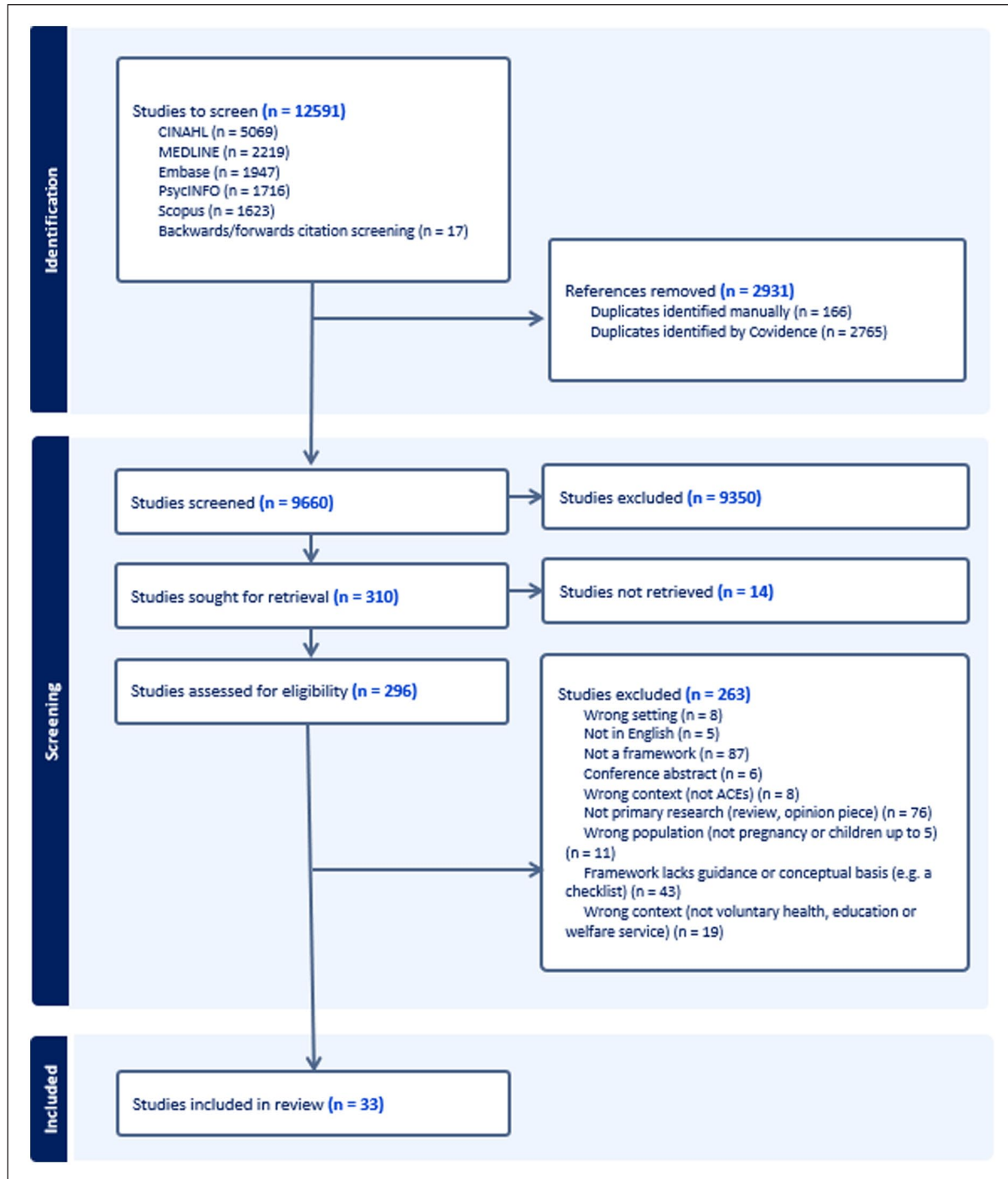


Figure 1. PRISMA diagram.

methodology (Peters et al., 2020). A critical appraisal was not undertaken because this scoping review aimed to identify available evidence rather than providing actionable recommendations to inform practice (Peters et al., 2020). A data extraction template was created by two authors (LL, AW), piloted, and refined in consultation with all authors (Aromataris et al., 2024).

Collating, Summarising and Reporting the Results

Results were reported according to the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines for reporting on scoping reviews. The final structure of review findings was informed by research aims and refined through discussions and mutual agreement of all authors.

Results

Key Findings Summary

Thirty-three manuscripts reported on 15 unique communication frameworks from five countries (United States $n=19$, Canada $n=5$, Australia $n=3$, Sweden $n=3$, United Kingdom $n=3$) published from 2002 to 2024. All manuscripts reported on either development, implementation and/or evaluation of a communication framework that guided professionals to have conversations and initiate responses to ACEs. Overall, the communication frameworks identified represented diverse settings, populations and evaluation measures. However, there was often scant or missing information about key elements of the framework – such as which adversities were addressed or what guidance was available for practitioners. The diversity of communication frameworks along with the level of detail provided made synthesis difficult. A full summary of key study characteristics is presented in Table 2.

Description of Communication Frameworks

Broadly speaking, there were two types of communication framework – those which actively screened and responded to parent/family adversities ($n=11$) and those which provided anticipatory or opportunistic guidance and response without explicit screening ($n=4$). Communication frameworks that actively screened for adversities included standardised tools completed by the practitioner ($n=8$) or parent ($n=3$) embedded within an existing health service. One example of practitioner-led screening was the Routine Universal Service, which screened women for Domestic Violence (DV) using a structured tool with embedded discussion prompts, safety planning and reminders for practitioners (Grafton et al., 2006; Vanderburg et al., 2010). An example of a parent-completed screening was the Parent Screening Questionnaire (PSQ) in the Safe Environment for Every Kid (SEEK) intervention, which parents completed while waiting for their child's primary care visit (Dubowitz et al., 2009). SEEK practitioners subsequently used a Reflect-Empathise-Assess-Plan (REAP) approach to address concerns identified through the PSQ supported by question prompts, tailored handouts and resource lists (Dubowitz et al., 2009).

Communication frameworks without explicit screening ($n=4$) focused on responding to physical discipline or harsh parenting ($n=3$) or anticipatory guidance about the impacts of ACEs on children ($n=1$). One example of a communication framework without explicit screening was No Hit Zone (NHZ) – an organisational policy prohibiting physical discipline of children which required staff to intervene during instances of physical discipline (Bai et al., 2023; Criss et al., 2024; Gershoff et al., 2018). Staff resources for NHZ included verbal scripts and suggested intervention strategies,

while parent resources included handouts and signage in public areas (Bai et al., 2023; Criss et al., 2024; Gershoff et al., 2018). Another example was Dads Matter; a manualised intervention embedded within a postnatal home visiting programme to positively engage fathers to reduce 'harsh parenting' and physical discipline (Guterman et al., 2018, 2023). Unlike communication frameworks focused on education to reduce physical discipline, ACE Conversation was a guided discussion for anticipatory guidance about ACEs in primary care – irrespective of whether ACEs were disclosed (Bodendorfer et al., 2020).

Adversities Addressed

There was significant variability in the adversities addressed across different frameworks, and in some instances within different evaluations of the same framework. A range of adversities were targeted within the 33 manuscripts, including Domestic and Family Violence (DFV; $n=22$), parental mental health ($n=10$), parental substance use/misuse (including alcohol; $n=9$) and harsh punishment or physical discipline ($n=9$). Most ($n=20$) frameworks only addressed one or two adversities, while some ($n=8$) covered a broad range. Some communication frameworks did not explicitly state the adversities they targeted, or they were ambiguous such as 'parental stressors' or 'familial stressors' (Abatamarco et al., 2008, 2018; Scholer et al., 2015). Furthermore, the nuances of interpersonal violence were not consistent, with multiple definitions such as 'domestic violence/abuse' (DVA; Cochrane et al., 2024), 'woman abuse' (Grafton et al., 2006) and 'family violence' (FV; Hooker et al., 2015).

Practice Setting

Communication frameworks were all ($n=15$) embedded into healthcare settings, which varied from primary care clinics to maternal home visiting services and hospitals. None was designed for non-health-focused settings such as early childhood education or community/social care sectors. Typically, communication frameworks comprised of protocols and resources to equip practitioners to assess and respond to adversities with a parent/caregiver during a routine healthcare interaction. Routine healthcare interactions during pregnancy and early childhood occurred in antenatal care ($n=4$), nurse-led primary care including clinic-based and home visiting ($n=6$), physician-led primary care consultations ($n=7$), and paraprofessional community outreach programmes ($n=2$). These numbers include the SEEK programme, which was implemented in both nurse home visiting and physician-led primary care services (Dubowitz et al., 2009; Engström et al., 2022), and the Antenatal Psychosocial Health Assessment implemented in a primary care-based antenatal service (Carroll, 2005). One exception to communication frameworks for individual consultations was the NHZ (Bai et al., 2023; Criss et al., 2024; Gershoff et al., 2018). NHZ was an

Table 2. Summary of Included Studies.

First author, year and location	Framework name and summary	Study focus, design and methods	Adversities addressed	Professions targeted	Description of framework	Outcome measures
Abatamarco et al. 2008 USA	Practicing Safety – child abuse prevention embedded within primary care (family practice)	<i>Implementation</i> Quality Improvement – Multimethod Assessment Process	Maternal mental health, familial stressors, adverse childhood experiences	Physicians and other staff (not specified)	Procedures to be followed during routine family practice appointments packaged as three bundles of tools (Maternal, Infant, and Toddler) addressing common psychosocial challenges. Staff resources included questions, prompts and reminders to screen, provide anticipatory guidance and resources relating to three maternal and infant/toddler health areas	Chart audit of practice change (baseline and monthly) Physician perspectives
Abatamarco et al. 2018 USA		<i>Implementation</i> Quality Improvement – Interrupted time series design. PDSA cycles				Chart audit of practice change Physician perspectives
Zachary et al. 2002 USA	Adapted Verbal HITS (Hurt, Insult, Threaten, Scream) Scale – IPV screening and response embedded within primary care	<i>Evaluation</i> Pre/post test Focus groups	Domestic violence (DV)	Physicians and nurse practitioners	Comprehensive DV protocol informed by local and national guidelines to promote documentation, safety assessment and planning, referral and education for DV based on Verbal HITS Scale. Staff resources included coloured stickers and question prompts in client records, posters/brochures in public areas and a DV coordinator	Practitioner knowledge attitudes, skills and perceptions of curriculum via Massachusetts Medical Society Domestic Violence Seminar Series Baseline and Course Evaluation Survey Practitioner perspectives
Dubowitz et al. 2009 USA	Safe Environments for Every Kid – primary care intervention to address psychosocial risk factors for child maltreatment	<i>Evaluation</i> Cluster RCT	Depression, substance use, major stress, IPV and harsh punishment	Paediatricians	Parents self-complete a brief written questionnaire (PSQ) for targeted risk factors for child maltreatment while waiting for their primary care appointment. If parents screen positive, the practitioner uses a REAP approach to address concerns supported by tailored handouts, resource lists and in some instances a dedicated social worker. Staff resources included printed protocols, coloured stickers and question prompts in client records	Child abuse data from (1) child protection services, (2) client record and Parent-child conflict tactics scale (CTSPC) Pre/post survey of physician attitudes, knowledge, competence, comfort and behaviour

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Table 2. (continued)

First author, year and location	Framework name and summary	Study focus, design and methods	Adversities addressed	Professions targeted	Description of framework	Outcome measures
Dubowitz et al. 2011 USA		<i>Evaluation</i> Cluster RCT	Depression, substance use, major stress and IPV	Paediatricians, nurse practitioners		Pre/post survey of health professional attitudes, knowledge, competence, comfort and behaviour Chart audit of screening and responses to adversities Observation of practice Parent-Child Conflict Tactics Scale (CTSPC) Chart audit for failure to thrive, delayed immunisations, medical noncompliance, repeated injuries and child protection involvement Child abuse data from child protection services Time addressing on psychosocial issues during appointments Physician perspectives Chart audit of families (1) attending appointment, (2) completed SEEK screening, (3) positive for a risk factor, (4) received brief intervention (REAP) and (5) accepted referral
Dubowitz et al. 2012 USA		<i>Evaluation</i> Cluster RCT	Depression, substance use, major stress and IPV	Paediatricians, nurse practitioners		Nurse perspectives Nurse survey of knowledge and attitudes
Eismann et al. 2019 USA		<i>Implementation</i> Feasibility project	Depression, substance use, IPV, food insecurity, harsh punishment and major stress	Physicians and non-clinical staff		Child maltreatment measured by Conflict Tactics Scale Parent-Child version (CTSPC) Costs of SEEK in staff salaries, training, time and materials Cost of child maltreatment to society (estimated)
Engstrom et al. 2023 Sweden		<i>Implementation</i> Convergent mixed-methods	Child safety (not specified), financial worries, depression, major stress, IPV and alcohol misuse	Nurses		
Lane et al. 2021 USA		<i>Evaluation</i> Cost-effective analysis of RCT	Substance use, IPV, depression, major stress, and harsh punishment	Physicians and nurse practitioners		

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Table 2. (continued)

First author, year and location	Framework name and summary	Study focus, design and methods	Adversities addressed	Professions targeted	Description of framework	Outcome measures
Golsater and Andersson 2024 Sweden		<i>Implementation</i> Exploratory mixed-methods	Depression, substance use, major stress and IPV	Nurses and social workers		Nurse and social worker perspectives Rates of SEEK screening and interventions. Nurse management meeting notes Parent perspectives
Golsater et al. 2024 Sweden		<i>Implementation</i> Qualitative	Depression, substance use, major stress, IPV, child safety and economic worries	Nurses and social workers		
Carroll et al. 2005 Canada	Antenatal Psychosocial Health Assessment – screening and response procedures embedded into routine antenatal care	<i>Evaluation</i> RCT	Risk factors for poor postnatal psychological health	Physicians, obstetricians, midwives	Psychological health screen procedure implemented within routine antenatal care appointments. Staff resources included a screening tool, discussion and planning prompts	Detection rates of antenatal psychosocial concerns Women and staff satisfaction
Gershoff et al. 2018 USA	NHZ – organisational policy banning physical discipline of children and requiring staff to intervene	<i>Implementation & Evaluation</i> Pre/post test	Physical discipline	All medical centre staff (clinical and non-clinical)	Organisational policy prohibiting physical discipline of children and requiring staff to intervene upon observing parental use of physical discipline. Staff resources included verbal scripts for intervening and signage/handouts for parents	Parent awareness of NHZ Parent attitudes about NHZ and physical discipline (ATSS) Staff knowledge of NHZ Staff attitudes about NHZ and physical discipline (ATSS)
Bai et al. 2023 USA		<i>Evaluation</i> Pre/post test	Physical discipline	All hospital staff (clinical and non-clinical)		Staff attitudes about physical punishment (ATSS) Staff attitudes and knowledge of NHZ Parents' perspectives of NHZ
Criss et al. 2024 USA		<i>Implementation</i> Qualitative focus groups	Physical discipline	All hospital staff (clinical and non-clinical)	Enhancement to current primary care clinic practices in identification, documentation and referral of families experiencing DVA. Staff resources included communication prompts, complemented with additional specialist roles for client referrals and child advocacy	Observation of training sessions Pre/post-test of clinician preparedness Chart audit (DVA identification) Referrals and contact data from partner agency Clinician, client and child perspectives
Szilassy et al. 2021 United Kingdom	IRIS+ – expansion of routine primary care practice for identification, documentation and referral of families experiencing DVA	<i>Implementation</i> Mixed methods – observation, pre/post-test, interviews, survey	DVA	Clinical and non-clinical primary care staff		

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Table 2. (continued)

First author, year and location	Framework name and summary	Study focus, design and methods	Adversities addressed	Professions targeted	Description of framework	Outcome measures
Cochrane et al. 2024 United Kingdom		<i>Evaluation</i> Model-based cost-utility analysis (Markov model)				Costs associated with abuse (personal and health and justice systems)
Bodendorfer et al. 2020 USA	ACE Conversation – guided conversation providing anticipatory guidance about ACEs in paediatric primary care	<i>Implementation</i> Pre-post test	Adverse childhood experiences	Primary care providers	Implementation of a protocol for a guided conversation about ACEs with parents in routine paediatric primary care – irrespective of disclosure. Staff resources included conversation prompts to raise the topic and provide anticipatory guidance, complemented by a parent handout with information/resources	Clinician and parent perspectives
Guterman et al. 2018 USA	Dads Matter for Home Visiting (DM-HV) – enhancement of existing home visiting programme to positively engage fathers	<i>Development, Implementation & Evaluation</i> Pilot study–quasi-experimental time-lagged design	Not specifically stated – includes harsh parenting/physical abuse	Professional or paraprofessional home visitors	Implementation of a manualised intervention package aiming to positively engage fathers within an existing home visiting programme for families with a child up to 2 years. Staff resources included five modules with guidance for engaging fathers, partnering with parents to set mutual goals and resolving concerns to promote positive co-parenting	Parent–child verbal interactions–LENA Mother–father relationship–PAI Father involvement–Mother and Father Involvement with Infant Scale (MFI) Parent stress–Parenting Stress Index Risk for child abuse & neglect–Parent-Child Conflict Tactics Scale (PC-CTS) Implementation fidelity–Parent Service Log
Guterman et al. 2023 USA		<i>Evaluation</i> Real-world pragmatic clinical trial design with stratified clustered random assignment				Father–worker relationship (Relational Health Index Mentor Scale RHI). Mother–father relationship quality & physical abuse (Relationship Quality Scale) Mother & father risk for physical child abuse (Parent-Child Conflict Tactics Scales PC-CTS)

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Table 2. (continued)

First author, year and location	Framework name and summary	Study focus, design and methods	Adversities addressed	Professions targeted	Description of framework	Outcome measures
Hooker et al. 2015 Australia	Improving Maternal and Child Healthcare for Vulnerable Mothers (MOVE) – best practice domestic violence screening and support embedded into existing maternal health services	<i>Implementation</i> Concurrent embedded mixed method design	Family violence (FV)	Nurses	Implementation of a model of domestic violence screening (parent self-complete) and supportive care into existing maternal child and family health services. Staff resource included nurse-designed clinical tools such as checklist, clinical pathways and guidelines complemented by support from nurse mentors	Nurse attitudes and knowledge about FV (survey and interview)
Hooker et al. 2016 Australia		<i>Implementation</i> Process evaluation in 2-year follow-up of cluster RCT	DV	Nurses		Nurse perspectives of MOVE implementation via survey and interview
Taft et al. 2015 Australia		<i>Implementation & Evaluation</i> Cluster RCT	DV	Nurses		Rates of DV screening, disclosure, safety planning and referrals Prevalence of DV in past 12 months (Composite Abuse Scale) Women reporting harm from DV
Janssen et al. 2002 Canada	Let's Talk – postpartum assessment for IPV in tertiary hospitals	<i>Implementation</i> Evaluation informed by Rogers Theory of Diffusion of Innovation	IPV	Nurses	Implementation of an assessment for IPV in women who are receiving postpartum care in hospital. Staff resources included visual reminders and communication guides (i.e. pocket-sized cue cards, posters) and posters/cue-cards for women in bathrooms	Chart audit of rates of IPV screening Staff perspectives
Mortimore et al. 2021 United Kingdom	ACEs screening in maternity care – screening for ACEs at key points along women's maternity care journey	<i>Development & Implementation</i> Quality Improvement – Mixed Methods	Parental adverse childhood experiences	Midwives	Implementation of an ACE screening tool (parent self-complete) into existing maternity services at specified points throughout each woman's journey to inform care planning for these needs. Staff resources included a bespoke ACE screening tool with discussion and care-planning guides for staff and handouts for parents	Chart audit of rates and frequency of ACE disclosure Staff and parents' perspectives

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Table 2. (continued)

First author, year and location	Framework name and summary	Study focus, design and methods	Adversities addressed	Professions targeted	Description of framework	Outcome measures
Price et al. 2017 USA	Behavioural Health Risk Assessment – screening embedded into existing home visiting referral processes	<i>Development, implementation & evaluation</i> Service evaluation informed by Trans theoretical Model of Change	Depression, substance use and IPV	Community outreach paraprofessionals	Implementation of a brief, triaged assessment linked with further screening and referral tools based on risks identified via within antenatal home visiting referral processes. Staff resources included a structured screening tool with embedded communication, care planning and referral guidance	Chart audit of rates of disclosure and referrals Staff perspectives
Scholer et al. 2015 USA	Play Nicely – multi-media programme for parents about healthy discipline followed by anticipatory guidance with primary care provider	<i>Evaluation</i> Qualitative component of RCT	Physical discipline	Physicians	Play Nicely involved (1) a brief multi-media educational programme for parents about health discipline followed by (2) anticipatory guidance embedded into routine child primary health care. Staff resources included discussion prompts and scripts to support education/anticipatory guidance and information about programme content	Parent perspectives of programme helpfulness
Grafton et al. 2006 Canada	RUCS – screening for all women for DV embedded into postnatal home visiting	<i>Implementation</i> Retrospective pre/post chart audit	DV	Nurses	RUCS involved screening all women in universal and high-risk postnatal home visiting programmes for DV. Staff resources included clinical guideline with discussion prompts, safety planning guides and embedded reminders within the screening tool	Chart audit of rates of DV screening and disclosure Demographic factors associated with screening and disclosure
Vanderberg et al. 2010 Canada	IPV intervention integrated into Nurse-Family Partnership	<i>Implementation</i> Retrospective pre/post chart audit <i>Development</i> Qualitative informed by Intervention Development (Van Meijel et al., 2004)	DV IPV	Nurses Nurses	Manualised intervention to augment standard practice of screening for IPV in socially disadvantaged mothers in the Nurse Family Partnership programme. Staff resources included a clinical pathway to inform decision-making, guidelines for reflective supervision and ongoing coaching	Chart audit of rates of DV screening, disclosure and whether woman was alone Nurse, client and stakeholder perspectives of responding to IPV

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Table 2. (continued)

First author, year and location	Framework name and summary	Study focus, design and methods	Adversities addressed	Professions targeted	Description of framework	Outcome measures
Jack et al. 2019 USA		<i>Evaluation</i> Cluster-based, single-blind RCT	IPV	Nurses		Primary outcome: mothers' quality of life (WHOQOL-BREF) Secondary outcomes: IPV recurrence (Composite Abuse Scale), Posttraumatic stress disorder (4-item SPAN), Depressive Symptoms (PRIME-MD), Alcohol Misuse (TWEAK), Global mental and physical health/wellbeing (Drug Abuse Severity Test, 12 Item Short Form 12 Health Survey) Nurse perspectives (focus groups) at two time points Nurse attitudes toward addressing IPV (Public Health Nurses' Responses to Women Who Are Abused (PHNR) Scale).
Jack et al 2021 USA		<i>Evaluation</i> Explanatory sequential mixed method embedded within RCT	IPV	Nurses		Supervisor and nurse perspectives of factors influencing implementation
Jack et al. 2023 Canada		<i>Implementation</i> Qualitative descriptive embedded within cluster RCT	IPV	Nurses		

Note. Key: ATSS= Attitudes Towards Spanking Scale; CTSPC= Parent-Child Conflict Tactics Scale; DV = Domestic Violence; HITS=Hurt, Insult, Threaten, Scream; IPV = Intimate Partner Violence; FV = Family Violence; PDSA = Plan Do Study Act; RCT = Randomised Control Trial; SEEK = Safe Environment for Every Kid; REAP = Reflect-Empathise-Assess-Plan; NHZ = No Hit Zone; DVA = Domestic Violence and Abuse; LENA = Language Environment Analysis; PAI = Parent Alliance Inventory; RUCS = Routine Universal Comprehensive Screening.

organisation-level strategy aiming to reduce child physical discipline by providing all hospital staff with practical strategies to respond to caregiver use of physical discipline.

Some communication frameworks also incorporated additional personnel who could assist practitioners identify and respond to adversities. For example, some communication frameworks for family violence included an additional family violence liaison worker (Hooker et al., 2015), an onsite family violence coordinator (Zachary et al., 2002) or an advocate/educator and children's worker to follow-up referrals (Cochrane et al., 2024; Szilassy et al., 2021). Other additional resources supporting the communication frameworks included regular supervision meetings for staff, as in the Dads Matter intervention (Guterman et al., 2018, 2023) and a social worker available by telephone to assist staff or clients in the SEEK intervention (Dubowitz et al., 2012). Although Play Nicely did not require additional staff, it comprised of an additional resource of a short video and multimedia activity about healthy discipline which parents completed prior to their appointment (Scholer et al., 2015).

Description of How Communication Frameworks Were Evaluated – Development, Implementation and Evaluation of Effectiveness. Studies reported outcomes relating to either development, implementation and/or evaluation of effectiveness of the communication framework. Due to significant heterogeneity in study design and outcome measures, direct comparisons between studies were difficult. Most studies addressed just one element, specifically development ($n=1$), implementation ($n=14$) or evaluation ($n=10$) of the communication frameworks. A few studies ($n=5$) aimed to measure outcomes relating to multiple phases, such as development and implementation (Gershoff et al., 2018; Mortimore et al., 2021), implementation and evaluation (Taft et al., 2015), or all three phases (Guterman et al., 2018; Price et al., 2017).

Description of Development Outcomes

Outcomes relating to the development of communication frameworks were provided by three of the four studies which aimed to develop a communication framework. These outcomes were staff, parent and/or other stakeholder perspectives (Jack et al., 2012; Mortimore et al., 2021; Price et al., 2017). One study did not report any outcomes relating to development (Guterman et al., 2018). Although there was no explicit use of co-design with service users, some communication frameworks were informed by community perspectives. For example, Szilassy et al. (2021) 'closely engaged' service users from study conception, while Janssen et al. (2002) engaged consumers in the design of their public-facing posters about DV.

Description of Implementation Outcomes

Implementation outcomes included objective measures such as fidelity through chart audits or observations of clinical

practice (Abatamarco et al., 2008, 2018; Eismann et al., 2019; Grafton et al., 2006; Janssen et al., 2002; Mortimore et al., 2021; Price et al., 2017; Szilassy et al., 2021; Taft et al., 2015). For example, documented rates of DV screening and disclosures (Grafton et al., 2006; Vanderburg et al., 2010) or families who identified an adversity and subsequently received support (Eismann et al., 2019). Other measures of implementation included objective and subjective data of practitioner and/or parent perspectives, attitudes, knowledge or awareness of the intervention. For example, implementation of NHZ policy was assessed by measuring staff and parent awareness of the policy (Gershoff et al., 2018).

Although communication frameworks were embedded within existing health services, there was little explicit use of holistic implementation approaches. Only two interventions ($n=3$ studies) used an implementation framework to inform and support sustainable translation into practice – both of which used Normalisation Process Theory (Hooker et al., 2015; Taft et al., 2015). Other studies used Roger's Diffusion of Innovations to inform implementation (Janssen et al., 2002) and the Transtheoretical Model of Change (Price et al., 2017). Despite little explicit use of holistic implementation approaches, discrete implementation strategies were present in many studies, such as leveraging local champions (Eismann et al., 2019; Grafton et al., 2006) and Plan-Do-Study-Act cycles (Abatamarco et al., 2008).

All communication frameworks (Table 2) reported using some form of staff education or training to equip with knowledge and skills to use the communication framework. Many studies provided initial staff training, while others included ongoing follow-up sessions at varying intervals after implementation. For some frameworks, all staff inclusive of non-clinical roles received education (Bai et al., 2023; Cochrane et al., 2024; Criss et al., 2024; Gershoff et al., 2018; Szilassy et al., 2021). Some communication frameworks also incorporated client education as an implementation strategy – for example flyers informing women they would be asked about family violence (Carroll, 2005; Janssen et al., 2002), and posters about healthy child discipline in public-facing areas (Bai et al., 2023; Criss et al., 2024; Gershoff et al., 2018).

Communication frameworks incorporated a variety of resources to support practitioners, including policies, protocols and guidelines to inform practice. For example, SEEK included a brief, self-completed questionnaire (PSQ) which screened parents for experiences of adversities, while practitioners were supported with guidelines and prompts for conversations to address these adversities (Dubowitz et al., 2009, 2011, 2012; Eismann et al., 2019; Engström et al., 2022; Golsäter & Andersson, 2024; Golsäter et al., 2024; Lane et al., 2021). Guidelines were sometimes organised into clusters or bundles of resources to enable practitioners to identify and respond to specific types of parental adversities. Examples included bundles of tools tailored to specific age-related concerns including (a) infant crying, (b) maternal depression and attachment and (c) toddler toilet training

(Abatemarco et al., 2008, 2018), or screening checklists incorporating discussion and question prompts to help professionals understand how to approach sensitive conversations (Bodendorfer et al., 2020; Carroll, 2005; Zachary et al., 2002). Some interventions also incorporated reminders, such as physically locating protocols in examination rooms (Zachary et al., 2002). Professionals were also provided with referral services and pathways to facilitate provision of early support for concerns outside the scope of that profession. For example, SEEK (Dubowitz et al., 2012) described a region-specific directory for staff and handouts for parents to enable professionals to effectively respond to parental adversities.

Description of Evaluation of Effectiveness Outcomes

Evaluation of communication frameworks incorporated a range of parent/caregiver and practitioner outcomes, with a smaller number exploring child outcomes or cost effectiveness. Like studies reporting implementation outcomes, many reporting evaluation outcomes used a medical record audit to determine how many families were assessed for adversities and/or subsequently disclosed (Dubowitz et al., 2009, 2011; Price et al., 2017; Taft et al., 2015). Parent outcomes included a range of validated measures relating to parents' wellbeing or risks for child maltreatment such as the Parent Child Conflict Tactics Scales (CTSPC; $n=4$), Composite Abuse Scale (CAS; $n=2$), Parenting Stress Index ($n=1$), World Health Organisation Quality of Life – Brief Version (WHOQOL-BREF; $n=1$), TWEAK test for alcohol misuse ($n=1$), and Mother-Father Involvement with Infant Scale (MFI; $n=1$). Other non-validated measures of parent outcomes included parents' satisfaction (Carroll, 2005) or perspectives of programme helpfulness (Scholer et al., 2015).

Specific practitioner measures for evaluation of communication frameworks included assessing practitioner attitudes and knowledge relating to the intervention (Bai et al., 2023; Dubowitz et al., 2009; Gershoff et al., 2018; Jack et al., 2021; Zachary et al., 2002). For example, Jack et al. (2021) explored nurses' attitudes towards addressing IPV using the Responses to Women Who Are Abused Scale (PHNR). Other practitioner measures included practitioner perspectives of the communication framework more broadly (Carroll, 2005; Jack et al., 2021; Price et al., 2017), including satisfaction with the procedures for screening and responses to poor post-natal mental health (Carroll, 2005). Practitioner perspectives not measured through established validated surveys included written/online questionnaires, focus groups and interviews.

Only two studies measured child-related outcomes, including child health status through healthcare records (immunisations, failure to thrive, injuries; Dubowitz et al., 2012) and referrals to child protection (Dubowitz et al., 2009). There were also only two studies that explored cost-effectiveness. These were cost-effectiveness of Identification

and Referral to Improve Safety plus (IRIS+) compared with usual care (Cochrane et al., 2024) and evaluation of the cost of SEEK implementation alongside costs to the health system of child maltreatment (Lane et al., 2021). Many communication frameworks were only evaluated at single sites, but IRIS+ and SEEK were more extensively evaluated across multiple sites and settings. This included two studies evaluating the SEEK framework across 18 sites (7 SEEK practices and 11 control practices; Dubowitz et al., 2011, 2012). Similarly, IRIS+ (identifying and responding to DVA) was first assessed for feasibility at three sites (Szilassy et al., 2021) and later pilot tested at seven sites (Cochrane et al., 2024).

Discussion

This review aimed to identify what communication frameworks, protocols and guidelines are used by health, welfare and education practitioners to inform communication and early support with parents when there are early childhood adversities (0–5 years). We identified 15 unique communication frameworks, all which were embedded in healthcare settings in high-income countries. Communication frameworks addressed a wide variety of ACEs, but none comprehensively addressed all adverse experiences known to negatively impact children. Nonetheless, this review identified valuable evidence that can inform tailoring and development of communication frameworks to build professionals' capacity for responding to family adversities. Strengths of this review included the robust scoping review methodology enabling comprehensive mapping of broad range, nature and characteristics of existing research in this topic. We identified some promising communication frameworks that can guide professional practice in some settings and highlighted gaps that require additional research to meet the needs of priority populations. In doing so, we have clearly described a gap in current knowledge that must be addressed to build professionals' capacity for prevention and early support for ACEs in early childhood (Table 3).

Most communication frameworks addressed one or two specific family adversities, such as DFV or parental mental-ill health. Few incorporated more than two adversities, and even fewer comprehensively addressed the range of adversities known to have significant lifelong impacts (Felitti et al., 1998; Karatekin & Hill, 2019). Some variability in the types of adversities could be due to the evolution of ACE research since its origin in 1998 to now recognise a greater number and diversity of ACEs within an international context (Afifi, 2020). Nevertheless, the tendency of communication frameworks to focus on just one or two specific ACEs is important because family adversities are diverse, often co-occurring and have compounding effects when families experience greater numbers of adversities (Asmussen et al., 2020; Felitti et al., 1998). Although it is simpler for professionals to focus on just one or two adversities, it does not reflect families'

Table 3. Critical Findings.

We reviewed research relating to 15 communication frameworks in 33 manuscripts, located in 5 countries.
Most communication frameworks addressed just one or two types of family adversities, and few addressed all types of adversities known to harm children.
All communication frameworks were in high-income, English-speaking countries in the Global North.
All communication frameworks were embedded into healthcare settings; none were in children's education or social care.
Many communication frameworks did not report how or if they used implementation strategies, such as co-design, to facilitate translation into practice.
Most communication frameworks reported some evaluation of their effectiveness, but this was generally limited to a small number of sites and/or was not replicated.

lived experience of multiple needs requiring support from multiple professionals and sectors (Lines, Kakyo, Anderson, Sivertsen, & Hunter, 2025). The ability to incorporate a more holistic conceptualisation of ACEs into a communication framework therefore represents a missed opportunity for early intervention for ACEs.

All studies were conducted in high-income countries in the Global North, with limited participant diversity regarding race, migration status, sexuality, gender, disability, or urban versus rural settings. Four studies that integrated an IPV intervention into the Nurse Family Partnership setting (Jack et al., 2019, 2012, 2021, 2023), which was a service targeting socially disadvantaged first-time mothers. Similarly, Zachary et al. (2002) specified that the intervention was implemented in a low-resource, multicultural urban setting. No other manuscripts reported on socioeconomic status or cultural diversity, and none reported on sexual or gender diversity or the involvement of First Nations peoples. Each of these factors is known to increase barriers to perinatal and early childhood health and social services (Ames et al., 2024; Gizaw et al., 2022; Kelsall-Knight, 2021; Winter et al., 2024) and the likelihood that families experience additional adversities such as discrimination (Fazel et al., 2012; Medina-Martínez et al., 2021). For example, First Nations populations often face greater adversities due to ongoing impacts of colonisation and are overrepresented in child protection systems (Duthie et al., 2019), yet no communication frameworks were designed specifically for or with First Nations peoples. We identified one framework co-designed with First Nations peoples, but it was ultimately excluded due to a focus on cultural safety in hospital rather than addressing ACEs (Flemington et al., 2022). Furthermore, only one communication framework explicitly included fathers (Dad's Matter; Guterman et al., 2018; Guterman et al., 2023) who are also crucial to child health and development. A clear gap therefore exists in developing, implementing and evaluating frameworks that are inclusive, culturally safe and accessible to help address adversities experienced by diverse populations.

All communication frameworks were embedded within health services so it is unknown how or if communication frameworks may be used in other child and family settings. Communication frameworks for healthcare settings were

most frequently aligned with a biomedical focus on screening for risk during one-on-one consultations. As such, communication frameworks developed within biomedical health contexts and individual consultations may not easily translate to the service models of other settings. Interprofessional collaboration is necessary to effectively respond to the diversity of families' needs (Lines, Kakyo, Anderson, Sivertsen, & Hunter, 2025), yet communication frameworks developed exclusively for health settings represent another example of siloed working that perpetuates barriers for families experiencing adversities.

The lack of communication frameworks shaped by non-health services represents an untapped opportunity to reach families experiencing adversities. For example, early childhood education and care (ECEC) provides a universally accessed, non-stigmatising environment, offering an under-utilised opportunity to identify children and families experiencing adversity (Organisation for Economic Co-Operation and Development, 2021). Communication frameworks developed for ECEC contexts could provide guidance and help staff initiate conversations about support needs (Fordham & Kennedy, 2017; Murphy et al., 2021); especially given systemic challenges like poor intersectoral collaboration and retention of high-quality workers (Nielsen-Hewett et al., 2023). As such, this review highlights the need for communication frameworks to be co-designed with professionals in a broader range of child and family services to increase opportunities to identify ACEs and support families' needs through non-stigmatising, universally accessed environments.

Finally, implementation of some frameworks appeared to be ad hoc, or at least full details were not reported. Among the identified frameworks, these were most often not designed with wraparound support to ensure sustainable implementation, nor were the majority piloted or evaluated through an implementation science lens to improve the chances of uptake and maintenance. Future work needs to consider the comprehensive use of implementation science to support the co-design of frameworks that are both sensitive to the relational dynamics of care and adapted to the specific context in which they are applied (Hunter et al., 2024, 2025). The co-design of frameworks is essential as conversations around ACEs require a balance of

Table 4. Summary of Implications for Practice, Policy and Research.

Communication frameworks that guide professionals' communication and early support for family adversities typically address only one or a small number of adversities that harm children.
Additional research is needed to develop, tailor and implement communication frameworks that are feasible and acceptable for diverse populations, especially those most impacted by family adversities.
Further research is also needed to robustly evaluate the impact of communication frameworks on outcomes for children and families.
Findings can be used to inform upscaling of these communication frameworks into a range of early childhood settings to maximise opportunities for effective engagement and early support.
Polymakers aiming to promote healthy childhoods may want to prioritise the development and implementation of communication frameworks in real-world settings.

core elements that ensure fidelity to evidence-based guidance whilst also being flexible to meet the needs of diverse populations and settings. Implementation science frameworks also emphasise the importance of involving diverse stakeholders, iterative adaptation and continuous evaluation (Hunter et al., 2020, 2024), which will be critical to mitigate unintended harms and promote sustainability of future communication frameworks.

Limitations

One limitation encountered during full-text screening was scant or missing information about core components of the intervention – such as which adversities were addressed or what guidance was provided for practitioners. In selecting the studies for inclusion in this scoping review, an inclusive approach was taken when considering what constituted communication guidance. In taking this approach, while technically each framework had communication guidance for professionals, for many frameworks, this was very minimal. Given that a key barrier to providing early support to families experiencing adversities is professionals' skills and confidence (Lines et al., 2017; Loveday, Balgovind, Hall, Sanci, et al., 2023), more guidance is needed for professionals to engage in non-judgemental conversations early in the care pathway.

When synthesising studies, we used DFV to include related concepts of IPV, DV and FV. These concepts are often used interchangeably without standardisation (Warren et al., 2024), meaning there may be some ambiguity in how data were collected, reported and synthesised. Furthermore, all frameworks were implemented in health settings, despite aiming to also include frameworks in child education and welfare. The broad, complex and novel nature of communication frameworks spanning across child and family services presented design challenges. Some potentially relevant manuscripts implemented in education settings were screened out as these frameworks were focused on referring to child protection services rather than early communication before child protection involvement. It is possible that employing different inclusion criteria would have led to the inclusion of key frameworks for other child-focused settings. Similarly, differences in terminology across disciplines, sectors and countries may also have limited inclusion, as noted by the

sample representing only the Global North. Although the search strategy was planned carefully, the generalisability of results may be limited, and further research should use broader strategies to identify communication frameworks in more diverse settings – if they exist (Table 4).

Conclusion

This scoping review synthesised published research about communication frameworks that guide health and social care professionals to have supportive conversations about family adversities in pregnancy or early childhood. Fifteen communication frameworks embedded within healthcare settings provided guidance for (1) screening and responses to family adversities or (2) opportunistic discussions and responses to family adversities. A synthesis of these communication frameworks makes an important contribution to future work to implement, tailor and/or develop evidence-informed resources to equip health, education and social care professionals to effectively support families experiencing adversities. Most communication frameworks were in the global north and were small scale evaluations with limited application of implementation science to facilitate practice change. Consequently, this review has highlighted the need for further research to develop, implement and evaluate communication frameworks that enable professionals to effectively communicate with and support families experiencing adversities that impact children. Importantly, this future research should engage with populations most impacted by family adversities but were least represented, including First Nations peoples and stakeholders in the Global South.

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Data Availability Statement

The data that support the findings of the literature review are from publicly available sources, which are cited in-text.

Notes

1. We use the term First Nations throughout to refer to Indigenous peoples globally, inclusive of the Aboriginal and Torres Strait Islanders Peoples of Australia where most of the authors are located.

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Author Biographies

Lauren Elizabeth Lines, PhD, is a senior lecturer in nursing in the College of Nursing and Health Sciences, Flinders University. Lauren is a registered nurse and Credentialed Children and Young People's Nurse. Her research focuses on building interprofessional workforce capacity for public health responses that prevent and respond to child maltreatment.

Amelia Winter, PhD, is a postdoctoral researcher in the College of Nursing and Health Sciences, Flinders University, and the Adelaide Rural Clinical School, University of Adelaide. Her research focuses on development, implementation, and evaluation of interventions to improve health service delivery, particularly for people who experience additional barriers to engaging with health services.

Susan Platt, DHSc, is a senior lecturer in the School of Nursing at Auckland University of Technology. A registered nurse, her research focuses on child protection, with previous work focusing on nurses' suspicion of child abuse, their responses, and the barriers they encounter. Current research focuses on registered professionals' responses to child abuse.

Sarah Seekamp, PhD, is the lead occupational therapist at Catholic Education, South Australia. Sarah's research and practice experience are underpinned by a commitment to equitable outcomes for all children and their families through strengthening interprofessional collaboration with and for families.

Sarah Hunter, PhD, is a senior research fellow in the Caring Futures Institute, Flinders University, South Australia. Dr Hunter is a social psychologist and implementation scientist and applies her knowledge translation and implementation skills to shape an evidence-informed Early Years System in Australia that engages and supports parents and caregivers.

Appendix I: Full Search Strategy

DATABASE: Medline

Database(s): Ovid MEDLINE(R) and Epub Ahead of Print, In-Process, In-Data-Review & Other Non-Indexed Citations, Daily and Versions 1946 to January 17, 2025 Search Strategy:

#	Searches	Results
1	"adverse childhood experience*".tw,kf.	5,775
2	Child Abuse/ or Child Abuse, Sexual/	36,235
3	((child* or "Intimate partner" or family or domestic) adj3 (maltreatment or abuse or abusive or neglect or violence or safety or safe or "protective service*")).tw,kf.	63,453
4	((Intimate Partner Violence or Spouse Abuse or Domestic Violence) and (pregnan* or antenatal or child* or infant* or babies or baby)).tw,kf.	7,869
5	(Pregnancy/ or Infant/ or Postnatal Care/) and (Spouse Abuse/ or Domestic Violence/ or Intimate Partner Violence/)	2,868
6	or/1-5	82,527
7	((communication or questionnaire or engagement or dialogue or support or training or education or conversation*) adj5 (model* or protocol* or framework or feasibility or tool* or resource* or program* or implement* or protocol* or guide* or evaluat* or integrat* or validation or usability or exploration)).tw,kf.	354,193
8	Feasibility Studies/ or Program Development/ or Program Evaluation/ or Health Plan Implementation/ or Implementation Science/ or Guideline/ or Evaluation Study/ or Nurse-Patient Relations/ or Professional-Patient Relations/ or Professional-Family Relations/ or Interprofessional Relations/	574,647
9	(Psychosocial adj2 (vulnerab* or assessment* or tool*)).tw,kf.	2,775
10	or/7-9	905,670
11	exp Health Care Services/ or Child Health Services/ or Health Personnel/ or Nurses/ or Primary Health Care/ or Pediatrics/ or Social Work/ or Family Practice/ or exp Child Welfare/ or Child Protective Services/	390,389
12	("Primary care" or "Health care" or nursing or nurse* or pediatrician* or "Family medicine" or "social work*" or Health Personnel or Interprofessional or professional).tw,kf.	1,346,189
13	(Pre-school or preschool or daycare or day care or childcare or child care or kindergarten or nurseries or nursery).tw,kf.	78,456
14	Child Care/ or Child Day Care/ or Preschool Education/ or Preschool Teachers/ or Nursery Schools/	7,698
15	or/11-14	1,598,282
16	6 and 10 and 15	2,219

Database(s): **Ovid Emcare** 1995 to 2025 Week 02 Search Strategy:

#	Searches	Results
1	exp childhood adversity/ or exp child abuse/ or exp childhood trauma/ or child welfare/ or child protection/	48,777
2	((child* or "Intimate partner" or family or domestic) adj3 (maltreatment or abuse or abusive or neglect or violence or safety or safe or "protective service*")).tw,kf.	52,137
3	((Intimate Partner Violence or Spouse Abuse or Domestic Violence) and (pregnan* or antenatal or child* or infant* or babies or baby)).tw,kf.	7,850
4	"adverse childhood experience*".tw,kf.	4,397
5	or/1-4	79,983
6	((communication or questionnaire or engagement or dialogue or support or training or education or conversation*) adj5 (model* or protocol* or framework or feasibility or tool* or resource* or program* or implement* or protocol* or guide* or evaluat* or integrat* or validation or usability or exploration)).tw,kf.	198,609
7	feasibility study/ or program development/ or program effectiveness/ or program evaluation/ or implementation science/ or evaluation study/ or nurse patient relationship/ or professional-patient relationship/	114,463
8	(Psychosocial adj2 (vulnerab* or assessment* or tool*)).tw,kf.	1,715
9	or/6-8	303,943
10	health service/ or child health care/ or health care personnel/ or nurse/ or primary health care/ or pediatrics/ or social work/ or primary health care/ or primary health care/ or exp child welfare/ or child care/ or child day care/ or kindergarten/ or nursery school/	506,798
11	("Primary care" or "Health care" or nursing or nurse* or pediatrician* or "Family medicine" or "social work*" or Health Personnel or Interprofessional or professional).tw,kf.	834,182
12	(Pre-school or preschool or daycare or day care or childcare or child care or kindergarten or nurseries or nursery).tw,kf.	43,829
13	or/10-12	1,077,735
14	5 and 9 and 13	1,947

Database(s): **APA PsycInfo** 1806 to January 2025 Week 2 Search Strategy:

#	Searches	Results
1	Child Abuse/ or Child Neglect/	37,585
2	((child* or "Intimate partner" or family or domestic) adj3 (maltreatment or abuse or abusive or neglect or violence or safety or safe or "protective service*")).ti,ab,id.	76,648
3	((Intimate Partner Violence or Spouse Abuse or Domestic Violence) and (pregnan* or antenatal or child* or infant* or babies or baby)).ti,ab,id.	9,245
4	"adverse childhood experience*".ti,ab,id.	5,424
5	1 or 2 or 3 or 4	86,614
6	((communication or questionnaire or engagement or dialogue or support or training or education or conversation*) adj5 (model* or protocol* or framework or feasibility or tool* or resource* or program* or implement* or protocol* or guide* or evaluat* or integrat* or validation or usability or exploration)).ti,ab,id.	180,242
7	Program Development/ or Program Evaluation/ or Treatment Guidelines/ or Professional Standards/ or Evaluation/ or Interpersonal Interaction/ or Collaboration/	110,088
8	(Psychosocial adj2 (vulnerab* or assessment* or tool*)).ti,ab,id.	2,067
9	Psychosocial Assessment/ or Test Validity/	96,511
10	6 or 7 or 8 or 9	371,078
11	Health Care Services/ or Health Personnel/ or Nurses/ or Primary Health Care/ or Pediatrics/ or Social Workers/ or Family Physicians/ or Family Medicine/ or Protective Services/ or Child Welfare/ or Foster Care/	192,539
12	("Primary care" or "Health care" or nursing or nurse* or pediatrician* or "Family medicine" or "social work*" or Health Personnel or Interprofessional or professional).ti,ab,id.	488,118
13	(Pre-school or preschool or daycare or day care or childcare or child care or kindergarten or nurseries or nursery).ti,ab,id.	85,009
14	Child Care/ or Child Day Care/ or Preschool Education/ or Preschool Teachers/ or Nursery Schools/	19,560
15	11 or 12 or 13 or 14	633,332
16	5 and 10 and 15	1,716

CINAHL (EBSCO)

Search ID#	Search terms	Search options	Actions
S16	S6 AND S10 AND S15	Expanders—Apply equivalent subjects Search modes—Proximity	View Results (5,069) View Details Edit
S15	S11 OR S12 OR S13 OR S14	Expanders—Apply equivalent subjects Search modes—Proximity	View Results (1,640,115) View Details Edit
S14	(MH "Child Care") OR (MH "Child Day Care") OR (MH "Child Care Providers") OR (MH "Child, Preschool") OR (MH "Schools, Nursery") OR (MH "Teachers")	Expanders—Apply equivalent subjects Search modes—Proximity	View Results (251,823) View Details Edit
S13	TI ((Pre-school or preschool or daycare or day care or childcare or child care or kindergarten or nurseries or nursery)) OR AB ((Pre-school or preschool or daycare or day care or childcare or child care or kindergarten or nurseries or nursery))	Expanders—Apply equivalent subjects Search modes—Proximity	View Results (47,599) View Details Edit
S12	TI (("Primary care" or "Health care" or nursing or nurse* or pediatrician* or "Family medicine" or "social work*" or Health Personnel or Interprofessional or professional)) OR AB (("Primary care" or "Health care" or nursing or nurse* or pediatrician* or "Family medicine" or "social work*" or Health Personnel or Interprofessional or professional))	Expanders—Apply equivalent subjects Search modes—Proximity	View Results (1,017,091) View Details Edit

(continued)

(continued)

Search ID#	Search terms	Search options	Actions
S11	(MH "Health Care Delivery+") OR (MH "Child Health Services") OR (MH "Health Personnel") OR (MH "Nurses") OR (MH "Primary Health Care") OR (MH "Pediatrics") OR (MH "Social Work") OR (MH "Social Work Service") OR (MH "Family Practice") OR (MH "Family Nurses") OR (MH "Child Welfare+") OR (MH "Child Safety")	Expanders–Apply equivalent subjects Search modes–Proximity	View Results (644,054) View Details Edit
S10	S7 OR S8 OR S9	Expanders–Apply equivalent subjects Search modes–Proximity	View Results (882,878) View Details Edit
S9	TI ((Psychosocial N2 (vulnerab* or assessment* or tool*))) OR AB ((Psychosocial N2 (vulnerab* or assessment* or tool*)))	Expanders–Apply equivalent subjects Search modes–Proximity	View Results (1,765) View Details Edit
S8	(MH "Pilot Studies") OR (MH "Validation Studies") OR (MH "Program Development") OR (MH "Program Evaluation") OR (MH "Evaluation and Quality Improvement Program") OR (MH "Program Implementation") OR (MH "Implementation Science") OR (MH "Practice Guidelines") OR (MH "Evaluation") OR (MH "Nurse-Patient Relations") OR (MH "Professional-Patient Relations") OR (MH "Physician-Patient Relations") OR (MH "Patient-Family Relations") OR (MH "Interprofessional Relations")	Expanders–Apply equivalent subjects Search modes–Proximity	View Results (749,456) View Details Edit
S7	TI (((communication or questionnaire or engagement or dialogue or support or training or education or conversation*) N5 (model* or protocol* or framework or feasibility or tool* or resource* or program* or implement* or protocol* or guide* or evaluat* or integrat* or validation or usability or exploration))) OR AB (((communication or questionnaire or engagement or dialogue or support or training or education or conversation*) N5 (model* or protocol* or framework or feasibility or tool* or reso ...	Expanders–Apply equivalent subjects Search modes–Proximity	View Results (175,363) View Details Edit
S6	S1 OR S2 OR S3 OR S4 OR S5	Expanders–Apply equivalent subjects Search modes–Proximity	View Results (57,282) View Details Edit
S5	TI (((Intimate Partner Violence or Spouse Abuse or Domestic Violence) and (pregnan* or antenatal or child* or infant* or babies or baby))) OR AB (((Intimate Partner Violence or Spouse Abuse or Domestic Violence) and (pregnan* or antenatal or child* or infant* or babies or baby)))	Expanders–Apply equivalent subjects Search modes–Proximity	View Results (5,653) View Details Edit
S4	TI (((child* or "Intimate partner" or family or domestic) N3 (maltreatment or abuse or abusive or neglect or violence or safety or safe or "protective service*"))) OR AB (((child* or "Intimate partner" or family or domestic) N3 (maltreatment or abuse or abusive or neglect or violence or safety or safe or "protective service*")))	Expanders–Apply equivalent subjects Search modes–Proximity	View Results (43,059) View Details Edit
S3	((MH "Pregnancy+") OR (MH "Infant+") OR (MH "Postnatal Care")) AND ((MH "Intimate Partner Violence") OR (MH "Domestic Violence"))	Expanders–Apply equivalent subjects Search modes–Proximity	View Results (2,323) View Details Edit
S2	(MH "Child Abuse") OR (MH "Child Abuse, Sexual")	Expanders–Apply equivalent subjects Search modes–Proximity	View Results (24,934) View Details Edit
S1	TI "adverse childhood experience*" OR AB "adverse childhood experience*"	Expanders–Apply equivalent subjects Search modes–Proximity	