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Child Health Nurses' experiences of addressing psychosocial risk factors with the families they meet

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Abstract

Aim: To examine how child health nurses perceive the routine assessment of psychosocial risk factors in the family environment as well as their self-reported competence and the present organisational conditions in this context.

Method: A mixed-methods design was used, including three focus group interviews and a web-based survey. Qualitative data were analysed using systematic text condensation. Quantitative data were analysed at the descriptive level.

Results: Nurses expressed that identifying psychosocial risk factors was both important and relevant to their work. They had little formal training and education on most psychosocial risk factors, and they lacked structured methods to address them. In areas where nurses reported more formal education and a structured methodology (depression, parental stress), they rated to a higher degree that they possessed sufficient skills and sense of security. The nurses perceived that they seldom came into contact with families with financial problems, hazardous alcohol use or intimate partner violence.

Conclusions: There is a gap between the nurses' attitudes regarding the importance of helping families in need and their ability to do so with the current level of training and methodological support. The results suggest that, in many cases, psychosocial problems remain undetected.

KEYWORDS
child health care, child maltreatment, health promotion, prevention, psychosocial risk factors

1 | BACKGROUND

Child maltreatment through abuse or neglect is a widespread public health problem throughout the world.[1,2] The youngest and most vulnerable children are often those most exposed, with a risk of maltreatment among children 0-4 years double that of children 5-14 years,[3] and seventy per cent occurs before the age of three.[4] Despite its high prevalence, child maltreatment is often hidden, unseen and under-reported.[5] Much of child maltreatment is predictable and preventable through programs that address its causes and risk factors.[6] Multiple factors in the child, parent, family, and community/society as well as interactions between them may all increase the likelihood of maltreatment.[7] Family-related risk factors commonly reported in the literature include alcohol and drug abuse, poverty, intimate partner violence (IPV), mental health problems and extreme parenting stress.[8] Studies have shown that identification of

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Abbreviations: CHS, child health services; IPV, intimate partner violence.

these problems among parents and provision of services to alleviate them, especially in combination with parenting support programs, can reduce the risk of child maltreatment. In addition, the influence of risk factors can be buffered by protective factors that may be internal characteristics (eg parental sense of competence) or external (eg social support).[9] When risk factors have been identified, preventive efforts that focus on the parents seem to be most promising.[10]

Few primary preventive strategies have been evaluated in the paediatric healthcare context.[8,11] Universal screening for risk factors (ie screening all families in a primary care practice) can eliminate the stigma of screening selected families and reduces the likelihood of missing at-risk families, and brief psychosocial tools are available to facilitate the early identification of patient needs.[12] In many countries, regular child health visits reach most infants and preschool children and their parents, and thereby provide multiple opportunities to screen for psychosocial risk factors. However, surveys suggest there are gaps in health professionals' knowledge and skills, as well as discomfort with addressing these issues.[13-15]

The aim of the Swedish Child Health Services (CHS) is to promote child health, prevent ill health among children and detect problems in the child's health or risks in the child's environment and facilitate the provision of appropriate interventions.[16] The CHS offers infants and preschool children (0-5 years) regular health visits including promotion of a healthy lifestyle, monitoring of the child's physical and mental health and providing vaccinations. Advice and support are given through home visits and visits to child health centres. The services are free of charge and reach nearly all children and their parents.[17] The child health program is staffed by district or paediatric nurses and general practitioners, with a high degree of continuity and frequent visits throughout the child's first years of life.

At present, the Swedish CHS lacks a systematic approach to identify most of the psychosocial risk factors in the child's home environment that are associated with an increased risk of child maltreatment.

The aim of this study was to investigate and describe how nurses in the Swedish CHS perceive their current practice with regard to routine assessment for psychosocial risk factors in young children's family environment (financial problems, depression, extreme parenting stress, alcohol misuse/abuse and IPV) as well as their self-reported knowledge, competence and confidence and the present organisational conditions in this context.

2 | METHOD

In order to gain breadth and depth in the description in the nurses' experiences of working with psychosocial risk factors, a mixed method approach was used, employing focus group interviews and a web-based survey. The qualitative part aimed to examine the nurses' experiences. The purpose of the quantitative part was to supplement the qualitative data with information on the scope and distribution of specific results. The qualitative and quantitative parts of the study were conducted in parallel.

Key Notes

- Child health nurses in Sweden expressed that identifying psychosocial risk factors was both important and relevant to their work
- The nurses felt that they possessed sufficient skills and sense of security in responding to depression and parental stress, but not for other psychosocial risk factors
- Child health nurses perceived that they seldom came into contact with families with financial problems, hazardous alcohol use or intimate partner violence

2.1 | Participants

All nurses currently working within the CHS in the county of Dalarna, Sweden (n = 79), were invited to participate both in the three group interviews and in a web-based survey.

Twelve nurses agreed to participate in the focus group interviews. Their work experience in the CHS ranged from 1 month to 32 years (median 13.5 years), and their working hours within the CHS ranged from 20 to 40 hours (median 40 hours) per week. Four of the nurses worked in rural areas and eight in urban areas.

The survey was answered by 64 nurses, giving a response rate of 81%. The survey responses of five nurses were later excluded as they had participated in a pilot study regarding identification of psychosocial risk factors and were therefore not considered to be representative of the CHS nurses in general. The background characteristics of the included nurses are presented in Table 1.

2.2 | Data collection

An interview guide was developed specifically to answer the research questions of this study (Table 2). Three main questions were prepared in Swedish with follow-up questions that could be used to gain further depth and detail if necessary.

The survey consisted of 44 questions and was developed specifically for this study. Question areas included the respondents' background characteristics, the socio-demographic profile of the families they meet and their experiences of working with families who have financial problems, parental depression, major parental stress, hazardous alcohol use or IPV. Questions regarding whether the respondents had sufficient knowledge, competence and confidence to address these problems were asked using a six-point Likert scale from one = 'strongly disagree' to six = 'strongly agree'. Questions were also posed about how often they meet these families, how much formal education they had within each risk area, whether or not they used a standardised method to assess each risk area and the number of cases of suspected child maltreatment that they had reported to the social services. Finally, a question was asked about whether it is appropriate within the CHS to ask all parents about

TABLE 1 Nurses' background characteristics (n = 59)

Nursing specialty	%
Paediatric nurse	17
District nurse	71
Both district and paediatric nurse	10
Registered nurse without specialty	2

Years of experience within the CHS	%
≤5	48
6-10	20
11-20	17
>20	15

Hours per week in the CHS	%
≤10	0
11-20	14
21-30	17
>30	69

psychosocial risk factors, with response options ranging from 'not at all appropriate' to 'very appropriate' on a six-point Likert scale.

2.3 | Procedure

In the spring of 2017, the child health nurses received personal invitations by e-mail to participate in the survey and focus group interviews, respectively, with information explaining the purpose of the investigation, that participation was voluntary and that the information collected would be kept confidential. A web-link to the survey was included in the e-mail. Two reminders were sent to those who had not responded.

Three focus group interviews, with four participates in each group, were held in April 2017. All interviews were held in Swedish with durations of 54, 42 and 47 minutes, respectively. A brief presentation of the study was given at the start of each interview, and the participants answered a short survey to provide their demographic information anonymously. The first author acted as moderator in the interviews, and the second author was present to take notes on the flow of discussion and individual participants' contributions. The moderator began the interviews by providing the participants with a description of the psychosocial risk factors targeted by this study. When the risk factors had been established, the main questions were presented in the same order to all of the groups, with follow-up questions if the topics had not been covered spontaneously. Primary data were collected as audio files from recordings during the three interviews. The audio files were transcribed verbatim, and no identifying data from the participants were processed.

2.4 | Qualitative analysis

Data were analysed using systematic text condensation[18] in a collaborative process between authors ME, JH and SL. The

TABLE 2 Interview guide for focus group interviews

Main questions	Follow-up questions
What is your opinion of asking about psychosocial risk factors in your work at the child health centre?	• Positive and negative experiences? • Ethical aspects? Thoughts on integrity? • Expectations? What effects will it have?
How do you perceive your competence in working with psychosocial risk factors at the child health centre?	• How do you experience your knowledge? • How comfortable do you feel addressing such issues?
What conditions would increase the ability to identify and work with psychosocial risk factors in the Child Health Services?	

transcriptions were read through several times to obtain familiarity with the material. Preliminary themes were created by ME and JH individually, and the final themes were agreed upon in discussions with SL. Meaning units highlighting aspects consistent with the study questions were identified and coded into different groups based on their connection to themes from the first stage. The code groups were divided into relevant subgroups, with respect to the content and the research questions. Each subgroup was then summarised into a condensate, which reflected the meaning units of that subgroup. Quotes from the interviews were selected to illustrate important aspects of the findings. An analytical text for each code group was created based on its condensates, and a heading was chosen to represent the main results. Finally, the analytical texts and corresponding headings were validated by comparing them to the original transcript and assuring their agreement as well as their relevance to the study questions. To preserve the participants' implications and expressions, the analysis was performed entirely in Swedish and the final results were then translated into English.

2.5 | Quantitative analysis

Frequencies for each variable were calculated using the Statistical Package for Social Sciences, SPSS version 26 (IBM Corp., 2019). Exploratory factor analysis indicated that the questions concerning knowledge, competence and confidence were closely related (data not shown). For simplicity of presentation, we therefore created an index using the average of the Likert scores on these three items for each participant.

2.6 | Final data synthesis

When all qualitative and quantitative data had been analysed separately, the findings of the two methodologies were compared and synthesised by authors ME and SL.

TABLE 3 Overview of themes and code groups

Themes				
The information parents offer depends on how we ask	Building rapport is especially important for discussing sensitive issues	All parts of the organisation must be in place for this to work	It is part of our job but it's not always easy	My work can make a difference for the child
Code group headings				
General questions or specific ones? Following up on unclear situations Screening tools available to us	Establishing contact Open conversation climate Handling sensitive issues with care Identifying strengths	What to do when parents disclose Team expertise is not always available Collaboration with maternal health and the social services	The CHS nurse's role has changed Learning by doing Feeling secure is important Priorities when time is short	The child's best interest Early identification On the child's side Going on for generations Guilt about missed cases

2.7 | Ethics approval

The study procedure was reviewed and approved by the Regional Ethical Review Board in Uppsala (dnr 2017/009).

3 | RESULTS

The qualitative analysis gave rise to five themes with three to five code groups each (Table 3).

The themes and code groups are presented below with their respective analytical texts together with illustrative quotes. Where relevant, quantitative results are reported at the end of each theme.

3.1 | The information parents offer depends on how we ask

3.1.1 | General questions or specific ones?

Many participants declared that they identify psychosocial risk factors by asking general questions about the family's situation, sometimes complemented by more specific questions, and being very perceptive to the answers: 'Because you ask generally, how are you doing at home? How are things working at home? How is it when it comes to money, or things like that. You have to package it'. IPV was viewed as especially difficult to address, and not all participants had done so when meeting parents. They found it important to speak with both parents, but mentioned that it was difficult because commonly the mother alone attended visits to the child health centre.

3.1.2 | Following up on unclear situations

The nurses experienced that they often could sense if there was a risk factor, and if so they felt obliged to ask about it. A couple of participants described that they scheduled more frequent visits in unclear situations to follow the family's progress, as long as they did not feel concerned

about the child: 'You could offer a little more frequent contact, too. If you don't get a proper response, so that you don't let them go'.

3.1.3 | Screening tools available to us

Screening tools for depression and alcohol use disorders were mentioned as useful, because they were generally well received by parents and provided an opening to bring up the subject and discuss the answers. The participants had the impression that parents answer truthfully if they know that help is available when potential problems emerge. It was viewed as a shortcoming that only screening tools for depression and sometimes alcohol use disorders were available at the CHS, which could imply that other risk factors were missed: 'Sometimes you waver, and then it is easier to have a number. I mean, if you see a number that says that this person, or this mother is unwell, then you know that you have to do something here. But sometimes you find yourself at this crossroads. It makes it easier for you to deal with it'.

3.1.4 | Survey results

In the survey, 76% of the nurses stated that they use a structured method to assess depression among parents. The rates were much lower for the other risk factors: only 2% for financial problems, 22% for extreme parenting stress, 19% for alcohol misuse/abuse and 14% for IPV.

3.2 | Building rapport is especially important for discussing sensitive issues

3.2.1 | Establishing contact

Many participants described that they endeavoured to promote an open conversational climate and a positive attitude towards the CHS early in their contact with families. They delayed addressing difficult matters until they felt that they had an alliance with the parents, and then felt it was reasonable to ask questions if they did it with respect

and explained the purpose: 'You feel that they need to get to know us, you would like to get to know them better, before you start, because there are quite complicated matters you can get yourself into'. The participants had experiences of parents bringing up separations and other relationship problems during visits, and in these cases, they had tried to remain neutral in order to maintain a positive relationship.

3.2.2 | Open conversation climate

They experienced that parents often, but not always, spontaneously told them about risk factors. If a parent became quiet and seemed bothered during a conversation, the nurse left the topic and returned later. The participants endeavoured to act professionally, respectfully and not to question the parents, to avoid damaging their trust in the CHS: 'I felt questioned myself as a mother. "Why are they standing there trying to tell me how to be a good mother?" And I try to remember that feeling sometimes, to avoid approaching them as if I knew better'.

3.2.3 | Handling sensitive issues with care

A few participants emphasised that they believe that parents are not forthcoming when asked questions about substance abuse and psychiatric disorders, while others had the impression that if they approached the subject carefully and with respect and made a point that help and treatment are available, most parents answered truthfully. Many perceived that there was a great fear among parents of losing custody of their child if they disclosed some kind of issue, and they could avoid seeking care for themselves out of fear of being identified: 'Because I immediately think the parents don't feel threatened when all this becomes a little less dramatic, that they don't think you will come and take away the child as soon as they say something'.

3.2.4 | Identifying strengths

Some shared that in their work they met many parents with social vulnerability, who were insecure in their parenting role. They described how they made an extra effort to point out these parents' strengths in relation to the child, to strengthen their confidence in their parenthood: 'To find what it is that is healthy here and what their strengths are and encourage them and support them so that they walk out of here upright and feel like "Yes, I can take on the world. I can do this".'

3.3 | All parts of the organisation must be in place for this to work

3.3.1 | What to do when parents disclose

All participants expressed the importance of knowing what to do if a parent discloses a psychosocial risk factor and that it was

unethical to inquire otherwise. They requested clear guidelines regarding what they as CHS nurses were expected to manage themselves, where the limit for referral is drawn, and where to refer depending on the risk factor identified. They also expressed concern that the receiving agency would deny the family help, but suggested that a clearer distribution of responsibility among caregivers could settle this: 'Sometimes you're almost a little worried that you will pick something up, because then you think, what should I do now? Because then there is no one next in line to give support'.

3.3.2 | Team expertise is not always available

The participants' experiences of the availability of team competence were highly variable, and they reasoned that this was related to the size and location of the workplace. Those working in rural areas had experienced periods when, for example, doctors and psychologists were unavailable, and they then had to accept temporary solutions. 'Every unique situation has to be handled ad hoc'. The impression was nevertheless that the chain of referral worked in acute situations, for example if a parent expressed suicidality.

3.3.3 | Collaboration with maternal health and the social services

Several of the participants described a model of work where the midwife reported information to the CHS regarding new mothers, including psychosocial risk that had been identified. When necessary, the midwife could also convene a structured meeting with appropriate agencies and care givers to establish an individual care plan.

The participants expressed a desire for improved cooperation with the social services. They described that the social services sometimes had information concerning a family that was not passed on to the CHS, on account of confidentiality. Their experience was that the families rarely were opposed to a dialogue between the agencies; on the contrary, the parents often were under the impression that they already shared information. The participants felt that if they had knowledge of the family's situation early on, they could adjust their work and offer suitable supportive actions. Cooperation would be facilitated if the social services was a natural part of the team, to enable uncomplicated referral, for example following positive responses on screening forms. 'Some families already have contact with the social services. And there you wish that the social services, when they know there is a new child on the way, or a family that recently moved in, would ask the family; "Is it okay if we talk with your new child health centre, so that we can meet and speak openly?", so it doesn't take 6 months before I have put all the pieces together, then you have lost so much time'.

3.4 | It's part of our job, but it's not always easy

3.4.1 | The CHS nurse's role has changed

Reflections that the professional assignment had changed over time were put forward. From having focused on physical problems in the child, the CHS nurse's assignment had become more extensive and involved closer cooperation with the parents. 'Our job has changed over time. Before we spent more time on the child, now there is more focus on the parents'.

3.4.2 | Learning by doing

Most participants expressed that psychosocial risk factors had been addressed briefly or not at all in their basic education, but that through working in the CHS they had received education on the screening tools used at the clinic and often taken a short local course.

The need for an overall education on psychosocial risk factors was expressed, and it was suggested that it could be centralised to ensure the same content for everyone. They experienced that education contributed to ease in formulating questions and confidence in addressing sensitive subjects. Many sought information on their own as they encountered different issues in their work. A large part of their knowledge was derived from personal experiences, and they relied extensively on this in their daily work: 'Then of course it's a lot of personal experience and common sense'.

3.4.3 | Feeling secure is important

There was great variation in how comfortable the participants felt in working with psychosocial risk factors. 'I don't feel comfortable asking questions like this, I haven't ever worked with them before. Do I have the competence to do this?' Even if they did not feel comfortable they endeavoured to appear calm and confident towards the parent. Having a clear action plan for how to respond to a particular risk factor they had identified contributed to the feeling of confidence, and they described that their self-confidence increased the longer they had worked as a nurse.

However, in one of the interviews, a deep uncertainty regarding documentation and a fear of conflicts and misunderstandings related to this was expressed, and the participants described an impression that they themselves and their colleagues consequently do not document everything they have knowledge of.

3.4.4 | Priorities when time is short

Some of the participants recounted that they avoided asking about psychosocial risk factors if they were short of time. It was not the conversation with the parents that was considered time consuming,

but the administrative tasks afterwards of making phone calls to find the right agency to provide the help the parents need. They expressed that it felt terrible to avoid the subject, but they determined that it would be worse if they started to inquire but were unable to manage the outcome: 'If you don't have time, then you avoid asking certain things'. Those who worked in smaller communities experienced that they had fewer resources to refer to, and thus had to manage a lot outside their professional assignment to provide the family with an acceptable solution. They were also under the impression that an increasing burden of routine tasks had been assigned to CHS nurses and expressed a desire to redistribute them to other professions, such as secretaries or assistant nurses, in order to free up time for work with the families.

On the other hand, some nurses expressed that they found it important to finish a conversation about vulnerability when a parent confided in them, and that their other obligations would have to wait: 'You can meet somebody who answers yes to this question on suicide and if you don't have the psychologist there, then you have to get along anyway. You have to just let everything else go and just stay there'.

3.4.5 | Survey results

In the survey, most (88%) of the nurses reported that they had more than 10 hours of formal education regarding depression. This was true for 9% regarding financial problems, 46% for extreme parenting stress, 42% for alcohol misuse/abuse and 29% for IPV. Marked differences were also found regarding how the nurses perceived their knowledge, competence and confidence regarding the different risk factors (Table 4).

3.5 | My work can make a difference for the child

3.5.1 | The child's best interest

The participants experienced that awareness of children's rights had increased. They wanted the parents to accept arrangements willingly, but if they were uncooperative, the well-being of the child should take priority. They thought it was important to be knowledgeable about how children are affected by growing up under difficult circumstances, and to maintain the child's perspective in complex family situations or when parents had greater needs due to social vulnerability. 'How does it affect the child to have a mother who doesn't have money, is extremely stressed and can't handle her daily life?'

3.5.2 | Early identification

In all interviews, the importance of early identification of psychosocial risk factors was brought up as being very important. They

expressed that this was a way to prevent or correct problems before they had grown in severity, to minimise any negative consequences for the child, and even to avoid a placement further on: 'I mean, we have a little child there who will grow up in all this. So, if you catch it early you could also help them early'. Most of the participants had the opinion that the number of parents with social vulnerability was on the rise.

3.5.3 | On the child's side

The participants commented that they see themselves as representatives of the child. They considered it to be their task to identify parents with psychosocial risk factors and to some extent provide counselling, but not to provide treatment of the parents' issues. They expressed the necessity of filing a report to the social services for more serious psychosocial risk factors. Some participants had confronted parents who threatened or used violence against their child during CHS visits: 'We also need to be straightforward, have the courage to act'.

3.5.4 | Going on for generations

Some participants with many years of experience shared the impression that psychosocial problems are passed down through generations, in the sense that children who have grown up in a psychosocially burdened environment to a greater extent risk having the same type of problems as adults, and that this in turn affects their own children. They described that they want to break the vicious circle by trying to motivate towards change, and they expressed the belief that this provides a great opportunity because parents of small children are more prone to change: 'There are generations of alcohol and addiction, the children we see now have also grown up with parents who have substance abuse or economic hardship. And then you want to help make a change somehow'.

TABLE 4 Index of how strongly the nurses agreed that they had sufficient knowledge, competence and confidence regarding psychosocial risk factors (n = 59)

	1	2	3	4	5	6
Score[a]	%	%	%	%	%	%
Financial problems	15	27	25	22	9	2
Depression	3	7	25	27	25	12
Extreme parenting stress	3	14	24	34	20	5
Alcohol misuse/ abuse	17	32	20	19	12	0
IPV	19	31	27	15	8	0

[a]Averages of scores for responses regarding knowledge, competence and confidence combined. Ratings were given on a six-point Likert scale, where 1 = strongly disagree and 6 = strongly agree.

3.5.5 | Guilt about missed cases

Many participants had experiences of hearing afterwards that a serious psychosocial risk factor had been present in a family, but that they had not discovered it at the time. They described how they questioned themselves in such cases, even though they had the opinion that sometimes nothing can be done and psychosocial risk factors are not always possible to detect: 'It is not as natural to bring up these thoughts when the child is 3 or 4 years old. Because then you think that you have worked with this family, that this is a safe and trusting family. A lot could have happened during that time'.

3.5.6 | Survey results

A majority of the nurses estimated that they seldom meet families with hazardous alcohol or IPV, while they more often encountered the other psychosocial risk factors (Table 5).

Most nurses reported that it is very suitable to ask about all the psychosocial risk factors inquired about except financial problems (Table 6); however, a small percentage responded that it was not suitable to address these issues within the CH.

4 | DISCUSSION

We used a mixed-methods approach to gain a thorough understanding of child health nurses' current attitudes and practices for identifying and addressing psychosocial risk factors in their daily work. The interview data indicated a number of shortcomings with regard to education, training and structured methodology that were corroborated by the survey data. In addition, the combination of methods brought forth that the nurses find it both suitable and important to ask about whether these factors are present in the child's environment and to act in the child's best interest.

A great deal is known about the prevalence of psychosocial risk factors among families with young children and their association to child maltreatment.[1,12] Even in countries where much is known, it has not become common practice to apply structured methods to identify such factors in an effort to prevent maltreatment, although efforts are underway to do so[8] This is the case in the Swedish CHS today. The only structured method of identification currently in general use is for post-partum depression, which is used once and only for the birthing mother.[19] A single consultation with the non-birthing parent has recently been incorporated into the Swedish CHS programme, but has not been fully implemented and no studies have yet been published regarding qualitative or quantitative outcomes.

The nurses felt that good rapport and a strong alliance with the family are essential for their ability to discuss sensitive issues with parents. This is in line with the general principles for the CHS outlined by the Swedish Board of Health and Welfare,[16] which describe the importance of partnership between professionals and parents to aid in strengthening parents' sense of empowerment.

TABLE 5 Nurses' responses in per cent to the question 'How often do you encounter families with the following risk factors in your practice?' (n = 59)

	Daily %	Weekly %	Monthly %	Quarterly %	More rarely %
Financial problems	3	24	32	14	27
Depression	3	22	46	22	7
Extreme parenting stress	12	37	34	10	7
Alcohol misuse/abuse	0	3	7	34	56
IPV	0	2	3	19	76

However, this is not altogether straightforward, as the nurses explained. On the one hand, they need to tread softly so as not to upset parents when problems are apparent, while on the other hand, they must act decisively to protect the child when there is a risk of maltreatment or other detrimental effects. The strategies described by the nurses, such as following up when situations are unclear and collaborating with other professionals when they suspect families need extra support, attest to their insight into the sometimes-precarious balance needed to address sensitive issues. This approach has also been identified in previous research that describes the complexity of how healthcare professionals relate to patients in order to provide high-quality care. The creation of meaningful and reliable relationships between the patient and healthcare professionals is described as the core of effective patient management and care as well as patient outcomes.[20]

In general, the nurses had very little formal education or training about most of the psychosocial problems we inquired about. Instead, they rely mainly on the experience they gain through their everyday work in the CHS. This may be reflected in the sense of knowledge, competence and confidence they report in dealing with each of the psychosocial issues, which is relatively low for those areas where the nurses had particularly little formal training. Similar findings have been reported previously in paediatric primary care professionals.[10-12] With respect to screening for depression, for which they have both training and well-defined methodology, the nurses expressed that they feel more competent and this appears to have diffused to their attitudes about dealing with parenting stress as well.

All of the risk factors discussed here are relatively common according to international studies. A report from the United States found that about 17% of children aged 17 or younger lived with a parent who had substance abuse during the past year.[21] In comparison, the Public Health Agency of Sweden reported that 17% of men and 11% of the women aged 30-44 years had a hazardous consumption of alcohol.[22] In a comparative study, 7% of children in Sweden live in poverty, compared to 22% in the United States, while the UK, Canada, Western Australia and New Zealand showed levels between these two extremes.[23] In the United States, 12% of mothers answered 'yes' to at least one screening question regarding IPV in a paediatric primary healthcare setting,[24] and in a Swedish survey study, 20% of women and 8% of men

TABLE 6 Nurses' responses in per cent to the question 'How suitable is it to ask about the following risk factors in the child health services?' (n = 59)

Score[a,a]	1 %	2 %	3 %	4 %	5 %	6 %
Financial problems	9	10	15	17	12	37
Depression	3	0	2	8	7	80
Extreme parenting stress	3	0	7	12	15	63
Alcohol misuse/abuse	5	0	3	10	14	68
IPV	5	2	3	10	15	64

[a] Ratings were given on a six-point Likert scale, where 1 = not at all suitable and 6 = very suitable.

reported previous exposure to psychological violence and 14% of women and 5% of men physical violence from a partner.[25] An Australian study found that 15.9% of men and 22.1% of men aged 18-34 years reported some form of domestic violence by a current or an ex-partner.[26] A Swedish study showed that 16% of children aged 25 months lived with at least one parent who had depressive symptoms. In the same study, 9.8% of the mothers and 10.4% of the fathers reported symptoms of parental stress.[27] A systematic review of studies from developed countries found a period prevalence of major or minor depression of 19.2% among mothers in the first 3 months after delivery.[28]

In the present study, most nurses reported that they meet families with depression or extreme parenting stress at least once per week, while they reported that they seldom encounter financial problems, alcohol abuse and IPV in their regular practice. Given the above-mentioned prevalence rates, this suggests that in many cases these problems remain undetected.

In the interviews, it emerged that the nurses see themselves as representatives and protectors of the child, and that it is important for them to identify children at risk in order to prevent the negative consequences associated with maltreatment. This is at odds with their ability to do so under the current circumstances in the CHS with respect to the above-mentioned lack of training and tools and guidelines, as well as weaknesses in many organisational

prerequisites including universal access to mental health professionals and collaboration with the social services.

The quantitative analysis showed that a predominant proportion of nurses think it is suitable to ask about the various risk factors. However, a small proportion reported that they did not think it was appropriate to address these psychosocial risk factors in the CHS, mainly with regard to financial problems. This is a striking finding that did not arise in the interviews. One factor that may have contributed to these responses is that some nurses were concerned that situations would come to light that they were not prepared to handle, either because of a lack of competence or lack of appropriate resources to refer to, which came up in the interviews. In general, the nurses considered that identifying psychosocial risk factors was part of their responsibility and that early identification is important for the child's health.

4.1 | Methodological considerations

The number of nurses in each focus group was relatively small, which may have been a limiting factor with regard to the completeness of the interviews. However, the wealth and saturation of the material collected suggest that this did not detract from the depth and breadth of their discussions. We chose systematic text condensation according to Malterud to analyse the qualitative data as it is easily applicable in healthcare settings and provides a clear and logical structure.[18]

To ensure diversity of the material and thereby increase the credibility of the results, participants in the focus group interviews were recruited from Child Health Centres with different socio-demographic characteristics. As the nurses in this study were all employed in the same county, the results may not be representative of all CHS nurses in Sweden. Authors ME and SL were well acquainted with CHS working methods while JH had less experience in this area. One potential risk was that ME and SL, through their pre-understanding of the subject, may have influenced the qualitative results by toning down or over-emphasising parts of the material.[29] To minimise this risk, the authors repeatedly reflected together on the data and analysis process to avoid or identify possible bias. This reflexivity together with the triangulation afforded by the authors' different professional backgrounds and comparisons to the quantitative results may have contributed to the study's credibility. The survey used here was created specifically to answer the research questions of this study and has not previously been validated in other studies. However, the qualitative and quantitative data were in close agreement, suggesting that the nurses understood the questions asked and that their responses to the survey questions were representative of their opinions.

A strength of the chosen design was that it allowed for comparisons between the results from the two methods. The extensive qualitative material gave a descriptive picture of the nurses' experiences of dealing with psychosocial risk factors in their daily work, which was confirmed by results from the quantitative data, and vice versa. This provided a more nuanced view of the material than if only one of the methods had been used.

5 | CONCLUSIONS

The nurses expressed that identifying psychosocial risk factors was both important and relevant to their work in the CHS. They had little formal training and education on most of the risk factors discussed, and they lacked structured methods to address them. They also described a lack of clarity regarding where to refer parents for help and which resources were available. In the areas where nurses expressed that they had formal education and a structured methodology (depression and parenting stress), they felt more confident. The quantitative analysis showed that the CHS nurses perceived that they seldom came into contact with families with financial problems, hazardous alcohol use or IPV. The results point out a gap between the nurses' attitudes regarding the importance of helping families in need and their ability to do so with the current level of training and methodological support.

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