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Public Health Nurses' Professional Practices to Prevent, Recognize, and Respond to Suspected Child Maltreatment in Home Visiting: An Interpretive Descriptive Study

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Abstract

The purpose of this analysis was to understand public health nurses' experiences in preventing and addressing suspected child maltreatment within the context of home visiting. The principles of interpretive description guided study decisions and data were generated from interviews with 47 public health nurses. Data were analyzed using reflexive thematic analysis. The findings highlighted that public health nurses have an important role in the primary prevention of child maltreatment. These nurses described a six-step process for managing their duty to report suspected child maltreatment within the context of nurse-client relationships. When indicators of suspected child maltreatment were present, examination of experiential practice revealed that nurses developed reporting processes that maximized child safety, highlighted maternal strengths, and created opportunities to maintain the nurse-client relationship. Even with child protection involvement, public health nurses have a central role in continuing to work with families to develop safe and competent parenting skills.

Keywords

child maltreatment, mandatory reporting, prevention, public health nursing, home visitation, interpretive description, Canada

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Introduction

The process of supporting and protecting children in Canada continues to evolve to reflect changing societal perceptions of appropriate care and what constitutes maltreatment (Dubowitz et al., 2018). In Canada, definitions of child maltreatment include neglect, physical abuse, sexual abuse, emotional maltreatment, and exposure to intimate partner violence (Public Health Agency of Canada, 2010). Public health nurses have historically addressed the health and social needs of children, women, and families in multiple settings including home visiting programs. Nurse home visitation interventions include universal programs offered to all families, generally in the postpartum period, as well as targeted home visitation programs for populations experiencing higher levels of disadvantage and who are at-risk for poorer health outcomes across the lifespan (Aston et al., 2014).

Many families enrolled in universal or targeted nurse home visitation programs parent within social and economic conditions that may influence parenting capacity and put infants at risk for maltreatment (Moules et al., 2010). Identified risks associated with child maltreatment include single parenthood, young maternal age, presence of a non-biological caregiver,

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and indicators of family socioeconomic disadvantage such as low income and receipt of welfare assistance (Gonzalez & MacMillan, 2008). Community-level risk factors include social isolation, low levels of social support, and neighborhood poverty and high mobility (Dong et al., 2005; Freisthler et al., 2006; Molnar et al., 2016). Ultimately, there is no single factor, or constellation of factors, that predict child maltreatment, but instead, multiple factors may interact and interdependently contribute to the increased likelihood of child abuse and neglect (Violence Prevention Alliance, 2020).

Given their knowledge and skills in assessing child development and parenting, public health nurses are in a strategic position to identify families experiencing challenges with parenting and are often among the first professionals to recognize when infants and young children are at risk of maltreatment (Crisp & Green Lister, 2004; Lines et al., 2017; Marcellus, 2005; Phelan & Davis, 2015; Tonmyr & Hovdestad, 2013). In Canada, the development and regulation of child welfare legislation is the responsibility of provincial and territorial jurisdictions. Within this legislation, there are statutes or acts that outline healthcare providers' legal requirements to immediately and directly report suspected or observed child maltreatment to the appropriate child protection services.

Nurse-Family Partnership

Nurse-Family Partnership® (NFP) is a nurse home visitation program for adolescent girls and young women who are preparing to parent for the first time while also experiencing social and economic disadvantage. Nurse home visits start early in pregnancy (by the 28th week of gestation) and continue regularly until the child's second birthday. Through the development and maintenance of a therapeutic nurse-client relationship, the program seeks to improve: (1) pregnancy outcomes by promoting healthy lifestyle behaviors; (2) child health outcomes through the promotion of competent and responsible parenting; and (3) maternal economic self-sufficiency (Olds et al., 2007).

NFP has been identified as an intervention with strong evidence of effectiveness for preventing child maltreatment among young, first-time mothers with who received home visits prenatally and during the first 2 years of the child's life (MacMillan et al., 2009). In the first randomized controlled trial to evaluate NFP in the United States, a 48% reduction in state-verified rates of child abuse and neglect was measured among nurse-home visited families during the first 2 years of the child's life (Olds et al., 1986). As child maltreatment is associated with childhood injury, it is important to note that in this same trial, there was also a 56% relative reduction in emergency department visits for ingestions and injuries for children of nurse-visited mothers. Similar reductions in childhood injury outcomes were also measured in a second trial conducted in the United States where a 28% relative reduction across all types of health care encounters for ingestions and injuries was measured (Kitzman et al., 1997). In Australia where the NFP program has been adapted for implementation with Aboriginal and Torres Strait Islander communities, a cohort study that used linked administrative data was conducted to measure and compare child involvement with child protection services (as a measure of child maltreatment) among two groups: (1) children born to women enrolled in the Australian NFP program; and a control group of (2) children of eligible women who were not referred to and who did not participate in NFP (Segal et al, 2018). The results suggested that maternal engagement in the adapted NFP program resulted in statistically significant reductions in child protection services' involvement and that these benefits were most pronounced amongst first-time and young (≤20 years) mothers (Segal et al., 2018).

Within NFP, a strengths-based, solution-focused, client-led approach to care is provided by nurse home visitors to support pregnant and parenting girls and women to develop safe and sensitive parenting practices and strong emotional connections with their children. However, nurses are aware that given the challenges present in the lives of many girls and young women enrolled in NFP, their children may be at greater risk of child maltreatment. Early identification of families at risk for having a child experience maltreatment is important as it allows nurse home visitors to provide additional support and prevent the development of risk situations or possible child protection concerns (Mulcahy & McCarthy, 2008). In British Columbia Canada, NFP is delivered by public health nurses, who as mandated reporters are required through provincial legislation to report suspicions of child maltreatment to the designated child protection service. This includes children in need of protection or considered at risk of harm. In British Columbia, the *Child, Family and Community Service Act* is the legislative authority for child welfare (Ministry of Children and Family Development, 2019b).

Purpose Statement

The British Columbia Healthy Connection Project comprises a randomized controlled trial evaluating the effectiveness of NFP compared with existing services in a sample of 739 mothers and 737 children in four of five British Columbia regional health authorities (2011–2022). Main trial outcome aims include: (1) reducing prenatal substance use; (2) improving children's mental health outcomes by age 2 years; (3) improving children's cognitive and language development by age 2 years; (4) reducing subsequent pregnancies by 24 months post-partum; and (5) reducing child injuries by age 2 years, the primary outcome indicator (Catherine et al., 2016, 2019, 2020). Additional measures will be used to assess the impact of NFP on reducing intimate partner violence and on improving other aspects of child and maternal wellness. There are also two adjunct studies associated with

the British Columbia Healthy Connections Project: (1) the Healthy Foundations Study, which is being conducted to examine the impact of NFP on biological outcomes (stress reactivity and DNA methylation) in infants across the first 2 years of life (Gonzalez et al., 2018); and (2) a process evaluation to describe how NFP is implemented and delivered across five unique regional health authorities (Jack et al., 2015). The purpose of the analysis presented in this paper was to use a sub-set of data extracted from the British Columbia Healthy Connections Project process evaluation to understand and describe NFP public health nurses' professional practice patterns in preventing, recognizing, or responding to suspected child maltreatment within the context of home visiting.

Methods

The overarching British Columbia Healthy Connections Project process evaluation is a convergent mixed methods study that included both qualitative and quantitative components (Creswell & Plano Clark, 2018). This longitudinal process evaluation included the collection and analysis of quantitative program implementation data and qualitative interviews with NFP public health nurses and supervisors, and senior managers from the five participating regional health authorities; the study protocol details have been described previously (Jack et al., 2015). The findings presented in this paper emerge from the embedded qualitative component that has been informed by the methodological principles of interpretive description (Thorne, 2016). Interpretive description is commonly used within applied health research as a method to explore issues that arise within clinical practice, through a disciplinary lens, and then to produce practice-oriented outcomes through the research process (Thorne, 2016). In this analysis, we sought to understand how public health nurses working with pregnant and parenting clients, within the context of a long-term home visitation program, implemented practice strategies to prevent child maltreatment as well as fulfilling their professional responsibilities to safely recognize and respond to suspected child maltreatment. This study was reviewed and approved by 10 Research Ethics Boards: at the five participating regional health authorities, at the four universities where members of the research team held appointments, and at the Public Health Agency of Canada (full list of names included in a Supplemental File). Written informed consent to participate in the study was obtained from all participating public health nurses.

Setting and Sample

In British Columbia, five regional health authorities are responsible for delivering all health services to meet the health needs of individuals and populations living within their respective geographic boundaries. There is also a First Nations Health Authority responsible for funding, managing, and delivering health services for First Nations and Indigenous populations across the province (First Nations Health Authority, n,d.). The five regional health authorities participated in the British Columbia Healthy Connections Project process evaluation and the NFP program was implemented through regional public health services and delivered by public health nurses who had received NFP education. Within British Columbia, it is also common for NFP public health nurses and supervisors to communicate, collaborate, or coordinate client care in partnership with social service programs responsible for ensuring the safety and protection of children. The British Columbia Ministry of Children and Family Development provides oversight of the Child and Family Services Offices located throughout the province. To support the healthy development of children, youth, and families, these offices provide a range of programs and services covering: early childhood development and childcare, children and youth with disabilities, children and youth mental health, youth justice, adoptions, and child protection services (Ministry of Children and Family Development, 2019a). Under the British Columbia *Child, Family and Community Services Act*, 1996, the Ministry of Children and Family Development is also responsible for designating a Director of Child Protection, who delegates all services related to child protection to child protection social workers (Ministry of Children and Family Development, 2019b). This same act also outlines the conditions under which any individual who suspects that a child is in need of protection has a duty to report.

The full population of NFP public health nurses in the five regional health authorities was invited to participate in the process evaluation. These nurses were eligible to participate in the process evaluation if they: (1) had completed, or were in the process of completing, the NFP nurse education; (2) were delivering the NFP intervention to eligible girls or young women enrolled in either the British Columbia Healthy Connections project randomized controlled trial (intervention arm) or process evaluation; and (3) speak English. The findings reported in this article reflect the experiences of 47 out of 49 (96%) public health nurses employed in NFP at the time of these interviews. Two nurses were on leave and were not available to complete the interviews.

Data Collection

In the process evaluation, qualitative data were collected from these nurses at eight different points in time, with each data collection wave spaced approximately 6 months apart over a 4-year period. The data extracted for this analysis were collected in the third wave of interviews where questions specific to types of violence experienced by families, public health nurses' recognition and response to family violence, and their intersections with child protection services were asked. These nurses' experiences of implementing and

Table 1. Summary of Questions in Semi-Structured Interview Guide (Wave 3).

Concept	Questions
Process of recognizing and reporting suspected child maltreatment	1. Can you describe at least one situation, based on a client on your NFP caseload, where you had to determine if this was a child protection issue? 2. Can you describe the nursing process related to making a decision to report a family, or not, to child protective services? 3. What factors influenced your decision to report (or not report)?
Impact of reporting suspected child maltreatment to child protection services	4. What impact does the decision to make a report to child protection services have on: (i) the family; (ii) the nurse-client relationship? 5. What is the nature of the response from the child protection system?

delivering NFP were captured through two forms of interviewing: focus groups and one-on-one in-depth semi-structured interviews. The majority of public health nurses interviewed ($n = 37/47$; 78%) participated in one of five focus groups conducted between October and November 2015. Focus groups were held in medium or large urban centers, located in four of the five participating regional health authorities (Fraser, Interior, Island, and Vancouver Coastal). Given the larger team size in one regional health authority, two focus groups were conducted. Focus groups were facilitated by either the study lead (SMJ) or research coordinator (NVB). Overall, focus group lengths ranged from 116 to 153 minutes. In-depth, one-to-one, telephone interviews were conducted by the research coordinator (NVB) with nurses working in smaller rural or suburban communities ($n = 10/47$; 22%) where their geographic distance from a medium to large urban center decreased the feasibility of focus group participation. All NFP public health nurses in Northern Health completed one-to-one telephone interviews. These telephone interviews were completed in April 2015 and ranged in length from 45 to 137 minutes. Questions for both the one-to-one interviews and the focus groups were the same and are summarized in Table 1. All participating nurses were asked to reflect on at least one practice experience in the NFP program related to recognizing and responding to suspected or observed child maltreatment. All interviews were digitally recorded and transcribed verbatim with identifying information removed. All participants completed a short demographic questionnaire.

Data Analysis

To promote overall dependability of the coding, three members of the research team participated in early open coding and categorization of the raw data (SMJ, AG, NVB). The principles of reflexive thematic analysis (Braun & Clarke, 2006, 2019) were then applied to guide the overall process for analysis and synthesis of the raw data. Each transcript was revisited and narratives of specific "scenarios" describing nurses' actions of recognizing, considering, or reporting suspected child maltreatment to child protection services were extracted. In this analysis, matrices were used to display, order, and compare concepts extracted from each unique identified scenario (Miles et al., 2014). The benefits of using matrices as a visual display during analysis is that it allowed for mapping out processes, identifying patterns and variations, and allowing for cross-case analysis (Miles et al.). Two team members (SMJ, AG) double-coded a sample of five transcripts and independently identified steps of the reporting process, which were subsequently used to inform the development of two matrices. Using this template, the lead researcher (SMJ) coded the remaining transcripts and completed the matrices.

Findings

A total of 47 public health nurses described their roles in supporting NFP clients to create safe environments for infants and shared their experiences as mandated reporters within the context of their home visitation practice. The highest degree held for the majority of nurses interviewed was a Bachelor degree in nursing (92%), while 8% of participants also held a Master's degree. All participants were female, and the mean age of the sample was 49 years (range 26–62 years). This purposeful sample of nurses was well equipped to speak to these nursing practice issues given that the participants reported having an average of 23 years nursing experience (range 2–40 years), with a mean of 14 years (range 2–28 years) spent in public health.

Extracted from all interview types, a total of 49 scenarios were identified and mapped within the matrices. Among the 49 scenarios narratives, 39 consisted of nurses' descriptions of specific actions or distinct events from their home visiting practice and the remaining 10 scenarios were composite or generalized descriptions. In these latter scenarios, the public health nurse did not discuss one specific experience but summarized a general process of working with multiple families at risk for maltreatment (across her career trajectory) and the decisions involved in mandated reporting that she had made or would follow if required (e.g., in the situations where the interviewed nurse had not previously made a report).

Primary Prevention of Child Maltreatment

Eligible girls and young women are offered NFP and enroll in the program early in pregnancy or less than 28 weeks gestation, with many enrolling earlier (e.g., <16 weeks gestation). During this period, public health nurses establish therapeutic relationships and work to support clients in making healthy lifestyle choices to improve their overall health and well-being during pregnancy, support healthy maternal role development, and to prepare them for parenting their infant. In keeping with NFP's goals, the nurses identified that many clients enrolled in NFP experienced: (1) individual issues (e.g., mental health concerns, past experiences of maltreatment in in their own childhood); or (2) relationship issues (e.g., exposure to intimate partner violence); and/or (3) exposure to challenging social conditions (e.g., poverty, unstable housing). Recognizing that these issues or conditions are risk indicators for child maltreatment, the public health nurses identified that they have an essential role in focusing on primary prevention. As one nurse described it, "[we are] setting the stage. . .setting them [the pregnant client] up in a positive way, so that this can be a good outcome for them."

Within the context of NFP delivery, the nursing strategies applied during home visits in pregnancy to prevent child maltreatment included: (1) demonstrating and role modeling healthy relationships; (2) increasing clients' knowledge, awareness, and skills in providing safe and sensitive parenting practices; (3) discussing safety planning for girls and young women experiencing abuse, including intimate partner violence; (4) teaching strategies for stress management; (5) connecting clients to services and supports such as mental health or substance use counselling or income supports, to address known risks for child maltreatment and to improve overall maternal well-being; and (6) promoting clients' early engagement and involvement with social services and supports as needed. Within some scenarios, it was noted that public health nurses had very open and direct discussions with their clients about the potential risks and unsafe situations they were observing in the home. This sometimes led to a discussion about the caregivers' responsibilities related to competent infant care. In these discussions, some nurses raised the issue of potential consequences for the family should child protection service workers' expectations regarding safe parenting not subsequently be met. As one nurse explained, "There's that conversation around, 'what are your roles and responsibilities as a parent?' You know, 'what's going to happen if this isn't met?' These conversations happen quite a bit."

These nurses invested significant time in referring and actively supporting the young pregnant clients on their caseloads to access a range of health and social services, to mitigate risks and create a safe, healthy environment for the mother and her future child. For public health nurses, this provided opportunities for them to meet, engage, and build new relationships with other health and social care providers in the community, which supported a secondary aim of increasing community awareness of NFP. The benefits of active system navigation are evident in this nurse's description of a positive outcome for one of her clients who had experienced multiple health crises, food insecurity and unstable housing during her pregnancy and where the nurse connected the young woman to counselling, a community-based program for young mothers, and attended multiple case conferences with the client and other service providers:

> I got to know the social worker quite well. Because all the supports were in place for her to be able to parent, [the social worker] was saying, "you know, we don't need to open anything with [child protective services] because she's got your support and various other care providers.

The nurses shared that some of their young, pregnant clients (who may have been minors themselves) had histories of child protective services involvement and already "have files open" with social services and, subsequently, feared apprehension of their first child at birth. Within this context, the nurses identified themselves as strong advocates for their clients and worked to establish frequent and open communication, as well as genuine collaborations, with the clients' social workers. In this advocacy role, nurses shared with the social workers summaries of clients' strengths, accomplishments, and pro-active steps clients were taking to become safe and competent parents. Public health nurses also talked about the importance of transparency, and that in conditions when it was safe to do so, they indicated that they informed the client about the nature of the information shared with their social workers. One NFP nurse described the process and impact of this strategy as such:

> I have a relationship with the social worker and I'm going to share some information about how great she [the client] is doing or good things and all that. . .Then I also photocopied the email and I showed it to my client, so she would know what I wrote. She actually liked it because it was so positive and she put it in her purse, she kept it.

Nurses generally spoke positively about the nature of supports offered and provided to their clients during pregnancy from child protective services, particularly when the nurse was able to establish two-way communication with the social worker and be present with the client during initial visits with the social worker. Within this context, one nurse described the supports provided to her client and the outcome:

> It's been a very positive relationship [with the social worker]. She offered doula services for prenatal on top of our services and got a youth agreement in place so [the NFP client] had money. Doing a background check on her partner to ensure there is no history of intimate partner violence. And just connecting

> with me and really encouraging me to call if there's any other supports that we see are needed.

Negative referral experiences to child protective services in pregnancy were related to: (1) a lack of available supports or services in a particular community and; (2) some nurses' perceptions that social services within that community prioritized surveillance and identification of maternal risks, to build a case for apprehension at birth, rather than a focus on prevention. This perception left some public health nurses ambivalent about connecting with child protective services during pregnancy:

> I know that the earlier I bring [social services] in the better. But similar situations [in the past] have shown me that [social services] does not always act in a supportive way. They don't offer supportive support in a preventive way. They just don't do it. They would offer nothing. They would open a file for her and red flag her. . .They're going to be pigeonholing her [the client] into how, when and where they're going to remove the baby rather than offering her support.

Opportunities to engage in primary prevention were also present as nurses continued to visit in the postpartum phase until the child's second birthday. Many nurses shared that when they identified and assessed situations of potential risk (e.g., limited infant stimulation, lack of sensitivity to infant cues, plans for an abusive partner to move in with the client and her child), or as what one nurse described as "little alarm bells going off," they would find opportunities to intervene by: (1) providing information; (2) reviewing risks to infant safety; (3) discussing the potential consequences of not changing one's behaviors; (4) identifying parenting strengths and implementing interventions to build on them; and if appropriate, (5) referring to other services (e.g., mental health supports). However, given the complexity of their clients' lives, situations arose where prevention efforts were not sufficient as nurses recognized indicators of suspected maltreatment.

Process of Recognizing and Responding to Suspected Child Maltreatment

Within the NFP program context of initiating, developing, and maintaining therapeutic relationships with clients, public health nurses discussed the process, strategies, and challenges they experienced in practice related to recognizing and responding to suspected child maltreatment. The overarching process included: (1) "laying the groundwork" and providing anticipatory guidance; (2) "walking the line" through assessment and considering child maltreatment; (3) confirming consideration of child maltreatment by "consulting" other professionals; (4) "making the call"—the actions associated with mandatory reporting (duty to report) while; (5) "treading carefully" to maintain the integrity of the nurse-client relationship and finally; (6) "hoping to stay connected" as a source of support following child protection involvement.

"Laying the Groundwork" by Providing Anticipatory Guidance

At the time of, or shortly following, client enrolment in NFP, public health nurses identified that two of their responsibilities were to: (1) provide information about the role of the public health nurse as it relates to infant safety and the prevention of child maltreatment; and (2) inform the client that the public health nurse is a mandated reporter. Nurses emphasized to clients the importance of focusing on prevention in pregnancy and the value of early engagement with services and supports once the infant was born. As one nurse explained:

> I lay the groundwork with my clients beforehand, even in the initial consent when we talk about it [the duty to report child maltreatment] but also as we are getting to know each other. If I feel that there are things that might be leading to that [a child protection issue] in the future, then I start talking about it right away, so that it's more of a prevention of what might happen versus dealing with a crisis.

Disclosure that the public health nurse is legally mandated to report suspected or observed child maltreatment to child protective services occurred early in the home visiting process. This was demonstrated by this nurse's description that, "Right when I'm signing a client up, I tell them, 'if I see something that I am concerned about, I'm going to tell you first. Then I have the obligation legally to report anything to [child protective services].'" Nurses also discussed situations and conditions where they would need to share information with the client's social worker. Within these early discussions with pregnant clients, some nurses also discussed the clients' responsibilities as future mothers to promote healthy infant growth and development, including a focus on infant safety, then clearly identified potential situations where the public health nurse would have an obligation to contact child protective services if concerns arise. During this period, public health nurses also typically provided information about supports and services available through local community-based agencies. NFP nurses also explained their role as a client advocate and that they were available as an additional source of support if engagement with a child protective service agency was required.

"Walking the Line" Through Assessment and Considering Potential Child Maltreatment

Within NFP, nurses have the flexibility to visit families regularly and frequently, based on client needs. The intensity of this intervention provides nurses with opportunities to continually assess the home environment, the quality and safety of relationships within the home, and changes to

maternal-infant health or well-being. In this sample of nurses, there was a high level of knowledge about risk indicators for child maltreatment, signs and symptoms potentially associated with child maltreatment, and parent/caregiver behaviors that may result in physical or emotional harm to the child. These nurses were also aware of their legal responsibilities as mandated reporters and knowledgeable about different types of child maltreatment.

What was clinically challenging though for many public health nurses was the process of considering if the presenting situation was one of suspected maltreatment. In this stage of "considering," these nurses spoke about the need to carefully assess the situation and risks, and the need to "see [the family situation] clearly and you want to have enough evidence." The dilemma for many nurses was that when working with young families with infants, "obvious" or common indicators of suspected maltreatment were not always present. As one nurse described it, they worked with families in a context where, "the red flag is at half-mast all the time." Meaning that there may be evidence of historical risks (e.g., maternal history of child maltreatment), potential current risks (e.g., inconsistent presence of a male partner who demonstrates abusive or controlling behaviors, caregiver mental health concerns including substance use), or observations of a single incident, but no clear pattern of unsafe parenting (e.g., caregiver leaves infant unattended for short period of time on couch, father pulls infant closer by grabbing foot). The NFP nurses were also sensitive that the mothers' experiences of poverty created conditions such as inadequate housing or food that may be judged as maternal "neglect" by society or a child protection worker, whereas through the relationship developed with the mother, the nurses observed young women who cared for their infants and were working under difficult circumstances to create safety.

A particularly "gray" area for public health nurses was when the mother was providing safe and competent care for the infant while also engaged in a relationship with a violent or emotionally abusive partner (who may or may not live in the same residence). These nurses understood that infant exposure to intimate partner violence is a form of maltreatment and yet there are many factors that limit a mother's ability to safely leave the relationship. When it became evident that a call to the child protection agency was warranted, many nurses expressed concerns about reporting maternal and infant exposure to intimate partner violence as a form of suspected maltreatment. Their concerns were grounded in past experiences where child protection services either did not respond or were unable to provide additional supports to increase both mother and child safety (consequences related to an overburdened system), or that a child protection service worker contacted the perpetrator and created a situation that escalated the potential risk of more violence for the mother.

Public health nurses recognized this period of time as a critical juncture when a decision would be required to guide their subsequent nursing actions. As one nurse shared, "I found it extremely challenging. I just struggle with knowing, 'when is the right time?' And 'what is something that is considered neglect and what is something that is considered a risk?'" In many situations, actual or perceived risks were often balanced by the observation of maternal strengths, including appropriate maternal-infant interactions and responses to infant communication cues, and implementation of strategies by the mother to protect the infant or increase safety. Some nurses also expressed awareness that many clients were quite vigilant during this stage and were cautious about the type of information they shared with their nurse, particularly if the client had past or current involvement with child protection services. During this phase, which one nurse termed "walking the line," feelings of ambivalence existed among some nurses about if, and then when, to contact the child protection agency. As one nurse shared, "[I have] [child protection services] on speed dial but I don't want to push the button yet." During this phase, public health nurses purposefully strategized to put more supports in place, engaging other professionals to observe and work with the client, and increasing maternal understanding of sensitive parenting strategies—while also remaining cognizant of protection issues and their legal obligations.

Confirming Clinical Judgment of Suspected Maltreatment by Consulting with Other Professionals

The nurses discussed situations where their assessment brought them to a decision point where they needed to consider if this was a situation of suspected maltreatment that would require a report to the child protection agency. In these situations, it was a consistent practice for public health nurses to consult with other professionals. Nurses provided examples of consulting internally with their NFP nurse colleagues and their supervisor, or externally with other health care and social service providers working with their client. In one-on-one conversations with their colleagues, or during case consultations, NFP nurses sought their colleagues' validation of their observations and decision to report (or not) to the child protection agency. These peer consultations increased their level of confidence in their decision. For some, learning from other nurses' past experiences provided them with insight and strategies for supporting clients to navigate the mandatory reporting process. In summarizing this process, one nurse shared:

> You talk to your hub mate [another NFP nurse]. You talk to your supervisor prior to making the call. Because you want to make sure, "am I seeing this right?" You need to get a few different eyes on it and then make up the script as to what you are going to say in this situation.

Consultations with the NFP supervisor were regularly completed around mandatory reporting decisions, and the

consultation included a review of the nursing documentation and the local process for contacting the child protection agency. In these discussions, it was shared that the supervisors further validated the nurses' decisions, and also supported them during this difficult process. As one nurse explained, "If [a client] meets the criteria [for mandatory reporting], then I feel like I have a responsibility to talk it over with my supervisor . . . to look [to see], 'Does it meet the criteria?'"

Social workers working in child protection were the most common professionals external to the NFP program with whom nurses consulted. Nurses spoke about making calls to the child protection agency to discuss a "hypothetical" case and ask for guidance on whether the situation met the threshold for reporting. When nurses had well established relationships with social workers, particularly when clients already had open files, the nurses described consulting for the purpose of exploring additional supports or services for the client. One nurse validated this process in the following description:

> With regards to some issues, I've called [the child protection agency], sometimes on a hypothetical situation. I'll call and say, 'you know, hypothetically this is what might be happening and do you guys feel that this is a safety issue?' I just sort of troubleshoot a little bit with regards to next steps to get some support.

"Making the Call"—Process and Outcomes of Mandatory Reporting

Across cases, the decision to report suspected child maltreatment to child protective services was based on observations or awareness of: (1) overt signs of infant physical abuse; (2) multiple parent or environmental risk factors combined with unsafe parenting behaviors; or (3) maternal and infant safety at risk due to intimate partner violence. Nurses' perceptions of the challenges related to mandatory reporting within their role related to: (1) who makes the report; (2) how and when to report; (3) managing inconsistent responses from an often-overburdened child welfare system; (4) being aware of, in the context of child protection, the potential negative consequences to the mother and having to balance care for the mother with care for the child; and (5) the potential that the nurse-client relationship would be fractured and the client might leave the program.

Identification of "who" should initiate the call to the child protection agency was a secondary decision nurses were required to make. Only one case was shared where the client took the initiative to independently self-report to a child protection agency. Under ideal circumstances, when physical harm to the infant, mother or nurse was not imminent, public health nurses discussed a preference for transparency and informing the mother about the need to call child protection. Nurses framed this requirement to call child protective services as a positive strategy to garner additional supports for the mother and to increase the safety and well-being of the infant. One nurse emphasized with her client, that it is the responsibility of adults to protect children:

> This young girl [the toddler] is not able to protect herself. Me, as an adult, I have to say something, to see what we could do to protect her. And that's your [the mother's] responsibility as well. So, after a lot of crying, she [the mother] said, 'okay, you know, I understand.' So that was really a challenge. So, then I made the call.

Under these conditions, public health nurses provided the option to the mother to call the child protection agency. Most often, the client would decline but understood that the nurse then had a responsibility to call. Several nurses described being able to find an opportunity to make the call in the presence of the mother. As one nurse shared:

> If it works out, the best thing to do is to report with the parent present. Make the phone call together. Do the report together. Be very open with them. Because that's how you're going to maintain that relationship way better than if you try and do it behind somebody's back.

Nurses expressed dismay when they had to make a mandated report without the mother's knowledge, as one nurse further explained:

> My client was involved with a man who was violent. One day he's there and I'm like, 'I have to contact [child protective services].' I couldn't even tell her I had to, but you know, he's there, I had no choice. I'm not going to tell her I'm going to report you, because he's here. So, I had to do it behind her back, and I felt really awful. I didn't want to do it that way, but the baby was at-risk.

Across the nurses' narratives, what emerged was an important value of providing detailed assessment information and highlighting maternal strengths, balanced with child protection concerns, when speaking with a child protection worker. There was a deep recognition of the anxiety experienced by mothers during this period and their fears of having their child apprehended. Nurses regularly emphasized that within NFP their work is preventative and focused on strengths, an approach that many felt was contrary to what they perceived as a child protective services' culture of surveillance. One nurse shared, "We're so focused on the strengths, which is a wonderful way of being. It gives parents hope and confidence. I think sometimes [child protection workers] see more of what they're not doing right."

Some nurses expressed a sense of relief when another professional working simultaneously with the family took on the responsibility to call the child protection agency. Nurses perceived that this action would reduce the risk of disrupting the nurse-client therapeutic relationship and provide an

opportunity to work with the mother in the interim to develop a safety plan.

"Treading Carefully": Managing the Nurse-Client Relationship

Nurses provided detailed depictions of the nature of problems related to mandatory reporting within the context of a long-term home visitation program. The primacy of the therapeutic relationship is highly valued in NFP and nurses invested significantly in establishing, maintaining, and evaluating this therapeutic alliance,—the platform through which health promotion and behavior change interventions are discussed and supported. They described working with clients who had experienced trauma across the lifespan, few healthy relationships, and negative past encounters with social services. For many of these public health nurses, making a mandated report of suspected child maltreatment to an often stressed and under-resourced child welfare system created feelings that their required action potentially could lead to more harm than benefits for a family, if adequate supports were not put in place. This perceived harm was believed to be greatly exacerbated in those situations where an outcome of the reporting process included the client also leaving the NFP program.

While nurses shared many positive examples of child protection responses that they perceived were supportive of their clients, nurses' reports of inconsistent responses by child protective services to their child protection concerns were frequent. Inconsistencies in the types and levels of responses, compared across similar client cases, were reported to vary at all levels, including between social workers from the same agency, or different offices within a region, or across health authorities. Nurses also described the child protection system responses to clients with infants as often "heavy-handed," "punitive," or like a "heavy hammer." Most distressing to nurses were the scenarios when they made a report, the family was subsequently assessed by a child protection worker and then few or no supports were provided. Consequently, nurses experienced that the family then had decreased trust in the nurse, participation in NFP decreased or stopped, and the mother and infant were subsequently left with fewer resources or supports than prior to the report.

In the clinical scenario, where child maltreatment was substantiated and the client knew or suspected that the nurse was the reporter, it was common for the therapeutic nurse-client relationship to be fractured. One nurse explained, "the relationship was destroyed, even though in this situation, it had to be reported because there were too many red flags and concerns about this child being safe." Similarly, another nurse shared, "I lost this relationship and it was gone. We had a good relationship and it ended quite suddenly. I got to be known as the nurse that had her baby removed." In cases where the client remained in NFP post-report, mothers were described as "guarded" and the nurses "treaded carefully" in the continuing home visits. As a nurse described:

> The visits are just different. Whether it's because [the visits] had been consistent and now they're more spaced out, or trust issues, or both. I'm not sure. But there is a change. But, there's still a connection, so that's good.

Despite finding it often difficult to make a report to child protection services and recognizing that doing so had the potential to increase maternal stress, threaten the nurse-client relationship, and decrease client retention in NFP, the nurses continually acknowledged that they had a legal obligation to report and that the protection of the infant was their ultimate responsibility. Awareness of these complex situations was expressed by this public health nurse:

> I've worked in nursing for [over three decades]. I have made lots of calls to [the child protection agency]. For me, it's always the most important thing, which is difficult when we're making these amazing relationships with these women, is to always remember that the child is the most important [person] we need to remember. Unfortunately, sometimes in situations you end up with relationships with moms that don't go okay because of that, but it's something.

"Hoping to Stay Connected" as a Source of Support Following Child Protection Involvement

For girls and women who remained in the NFP program following a mandated report, the public health nurses identified that this created an opportunity for them to work with the mothers on strategies to prevent further child maltreatment. The nursing interventions reflected an extension of the activities undertaken to promote primary prevention and focused on: (1) increasing maternal awareness of reading infant cues; (2) engaging the client in activities focused on maternal-infant attachment and communication; (3) developing general parenting skills; (4) addressing safety risks within the home environment, including exposure to intimate partner violence; and (5) facilitating ongoing referrals and engagement with other community health and social services. In two sites, some nurses discussed that in their work with mothers involved with child protection services, they also actively encouraged the girls or young women to develop the skills to become their own advocates. This work involved supporting clients to take the initiative to set up meetings with their social workers, create and circulate an agenda for a case conference, and to be prepared with a list of questions they had for their social workers.

Discussion

In this component of the British Columbia Healthy Connections Project process evaluation we sought to explore

and understand how public health nurses, working with pregnant and parenting girls and young women, prevent, recognize, and respond to suspected child maltreatment. The use of interpretive description (Thorne, 2016) provided us with a pragmatic approach to qualitative research, allowing us to deepen our understanding of expert nursing practice applied to respond to the challenges that public health nurses who conduct home visits experience in working alongside families with children at-risk for maltreatment. Use of this methodology also facilitated the identification and documentation of tacit nursing knowledge related to how nurse home visitors specifically respond to these complex situations in ways that increase the safety of the child while minimizing potential harms associated with mandatory reporting, and value the development of strong professional collaborations between home visitors and child protection workers. The findings from this study contribute to the disciplinary knowledge about how home visiting nurses can safely recognize and respond to child maltreatment.

Nurse home visitors have an important role in the prevention of child maltreatment; and starting this work during pregnancy is critical. Initiating home visits prenatally provides a substantive period of time in which a therapeutic relationship can be established; historical and current risks for maltreatment can be identified; and multifaceted nursing interventions focused on sensitive and responsive maternal caregiving can be implemented. As the NFP program is theoretically grounded within an ecological framework (Olds & Henderson, 1997), when nurses work to engage supportive services early in pregnancy, this may help to mitigate or reduce the likelihood of an infant being apprehended at birth or maltreatment during the first 2 years of life. Home visiting beginning in pregnancy also ensures that the focus remains on primary prevention, as there is no evidence for the effectiveness of parenting programs of nurse home visiting in preventing the recurrence of child maltreatment (MacMillan et al., 2005).

The initiation of home visits in pregnancy also provided time for public health nurses to carefully assess clients' needs for additional supports, and then to provide clients with warm referrals to other service providers and organizations focused on addressing conditions such as substance use, lack of safe or secure housing, or extreme poverty that are known risk indicators for child maltreatment. Warm referral processes involve carefully assessing the fit of the agency to meet client needs, facilitating client introductions to new providers, setting up joint meetings as needed, and following up to assess if the new service is meeting client needs (Miller, 2019). To support clients in feeling confident and safe to contact and engage with a new service provider, it is critical that public health nurses are competent in providing active, rather than passive, system navigation. Competency in a system navigator role requires the acquisition of knowledge related to how local agencies operate and provide services to pregnant women and parents with young children as well as the development of skills such as communication, motivational interviewing, overcoming barriers to accessing care, and care coordination (Carter et al., 2018). What was further revealed in this analysis was that as system navigators, NFP nurses' practice reflects and embodies the principles of trauma-and-violence informed care (Ponic et al., 2016). These public health nurses prioritized establishing emotionally safe referral processes by providing anticipatory guidance on what a client could expect on their engagement with another system. Warm referral processes (Miller, 2019) that actively engaged the client in the process and communicated information about client strengths to the other professionals was also identified as a critical component of the public health nurses' practices. To be able to focus on prevention efforts using these types of strategies requires agencies with home visiting programs to allocate sufficient time and flexibility for nurses to: (1) visit clients regularly and frequently during the period of pregnancy; (2) locate, meet with, and build strong professional collaborations with other community-based agencies and professionals; and (3) when requested, attend meetings or appointments with clients.

This analysis also elucidates that compared to the single or infrequent patient-provider encounters common to primary or acute care settings, home visiting is a unique practice setting. In the NFP program, frequent and regular home visits over an extended period of time provide nurses with the opportunity to develop long-term therapeutic relationships with families (Landy et al., 2012), which then become the mechanism through which the nursing process of assessment, diagnosis, planning, intervention, and evaluation is applied. The concepts of therapeutic relationship and relational practice are central to public health nursing (Browne et al., 2010). Establishing and maintaining therapeutic relationships with clients is essential for promoting program engagement; yet nurse home visitors' duty to report can create role conflict and ethical tensions and interfere with the ability to gain trust when working with families experiencing significant levels of social and economic disadvantage (Marcellus, 2005). This results in a clinical practice that can place nurses in the position of perceiving that they are simultaneously supporting and policing families. Over the past 20 years, accumulating evidence suggests that there is increasing concern that these hard-won trusting relationships may be at risk for irrevocable damage, in particular from involvement in child protection issues (Browne et al., 2010; Crisp & Green Lister, 2004; Davidov et al., 2012; Einboden et al., 2019; Lines et al., 2017; Mulcahy & McCarthy, 2008; Peckover, 2002).

Therefore, it was not surprising to learn that the NFP public health nurses found mandated child protection reporting a challenging problem that they sought to manage in practice. The NFP nurses' actions clearly reflected their priorities on promoting infant safety and a deep awareness and understanding of their legal responsibilities to report suspected or observed child maltreatment. However, for many, their

professional practice experiences have taught them that the act of mandated reporting creates stress for young mothers while they simultaneously seek to protect the rights and interests of the children. Furthermore, that this action (reporting) intended to increase the safety of the child may conversely create a situation where a family is left increasingly vulnerable and isolated if no additional supports are put in place following the child welfare investigation. As well, the family, having lost trust in the NFP public health nurse, may no longer accept the supportive services of the home visiting program. It is important to note that these interviews were conducted prior to the introduction of amendments to the British Columbia Child, Family, and Community Service Act in 2019 and critical changes to child welfare practices. Changes, including an end to birth alerts which disproportionately targeted Indigenous and marginalized women, and an increased focus on providing more supports and preventative services, will hopefully lead to more families voluntarily seeking services to promote the safety and well-being of their children (Ministry of Children and Family Development, 2019c, 2020)

However, beyond problem identification, our analysis provides novel insights about how NFP public health nurses managed this persistent and complex practice challenge in a manner that prioritizes infant safety, promotes transparency, recognizes maternal strengths, and creates conditions for maintaining the therapeutic relationship. For public health nurses, mandatory reporting is more than just a linear, two-step process of (1) observing or suspecting maltreatment and then (2) making a report to the local child protection agency. Instead, they described a complex, multi-faceted, reflective process of "considering" suspected maltreatment where in-depth nursing assessment data about potential risk indicators were collected, often over a series of home visits. Within this process, the NFP public health nurses demonstrated incredibly skilled and nuanced critical thinking to reach a clinical judgement on whether suspected maltreatment was present or not. Through repeated client encounters, NFP nurses attain a deep understanding of the complex lives of their clients and that these are often particularly ambiguous cases where evidence of suspected maltreatment is not always immediately evident. While the public health nurses demonstrated a high level of knowledge about the types of reportable child maltreatment and risk factors for maltreatment, some nurses expressed uncertainty related to the need to make a report to a child protection agency. The National Institute for Health and Care Excellence (NICE) evidence-based clinical guidelines substantiate that a process of considering maltreatment exists; and that decisions made during this consideration stage may lead a healthcare provider to exclude or suspect maltreatment (NICE, 2009). The findings in our study validate that "considering" maltreatment is an important part of nursing practice. The process the nurses used to navigate mandatory reporting requirements also maps onto the guidance provided by NICE to: (1) continue looking for other alerting features of maltreatment; (2) discuss assessment data, concerns and options with other colleagues; and (3) gather additional information from other professionals involved in the care of the child.

Simultaneously, while always being vigilant about the need to "consider" suspected child maltreatment, the NFP public health nurses were consistently engaged in transparent actions that served to strengthen the nurse-client relationship, promote the development of sensitive parenting practices, highlighting and validating mothers' parenting strengths, and linking families to multiple services. Consistent across this process, in addition to advocating for the safety of the child, nurses also positioned themselves as the clients' advocates in that they were uniquely able to provide constructive information to an investigating child protection worker about the mother's caregiving strengths, goal accomplishments, and steps being taken to increase safety for the child. In the United States, NFP nurse home visitors' purposeful inclusion of maternal strengths, particularly related to parenting capacity, in their risk assessments has also been identified as an essential component of practice, and a strategy that facilitates the discussion of risks with the parent (Williams et al., 2019). Recognizing and sharing a mother's parenting strengths and competencies help to also assure the NFP client that a balanced account of her ability to care for her child is shared in this reporting process (Davidov et al., 2012). Public health nursing's focus on prevention, combined with providing anticipatory guidance and being an advocate for both children and their mothers, may also help to reduce some of the common negative experiences often associated with mandatory reporting.

In a comprehensive meta-synthesis which examined mandated reporters' experiences with reporting child maltreatment to child welfare, 73% of 44 articles described negative experiences with the reporting process. No evidence was identified that examined whether mandatory reporting does more good than harm (McTavish et al., 2017). However, one might consider that as a child and client advocate working within an established nurse-client relationship, an opportunity for the nurse to encourage the mother to participate in the reporting process or empower her to connect directly with child protective services may also decrease fear related to the process and create a collaborative rather than contentious relationship between caregivers and child protection workers (Pietrantonio et al, 2013). It is also important to note, that the NFP public health nurses in this study were acutely aware that they were often referring to a child protection system that was under-resourced and over-burdened.

With the decision to report suspected child maltreatment to a child protection agency, different strategies were revealed on how to accomplish this required action while also preserving the unique therapeutic relationship with the parent. These strategies included exploring options for other health care professionals involved with the client to make the report, collaborating with the client to make the report (e.g., supporting

the client to initiate the call or having the client present while the nurse made the call), or being transparent about the type of information to be shared. Even when a report was made to a child protection agency, the nurses felt responsible and made efforts to provide ongoing care and support to the family during the process. Unfortunately, following a report to child protective services, nurses shared that some of their clients left the home visitation program, leaving them with fewer supports than prior to the report. This loss of a client is difficult for many nurses and left them concerned about the ongoing safety of both the mother and child. Given similar findings among NFP nurse home visitors in Colorado (United States), it was recommended that the core NFP nurse education include training to develop skills on maintaining the nurse-client relationship before and after a report to child protective services is made (Williams et al., 2019).

The analysis of these data informed by the experiences of NFP public health nurses home visiting within one Canadian province may limit the transferability of findings to reflect the experiences of nurses working in other home visitation programs or contexts. Yet, our findings suggest, that in nurse home visitation programs, where professionals have a duty to report, that nurses have a unique and important role in prioritizing the prevention of child maltreatment. This includes navigating a complex process of applying clinical judgment when considering if a child is at risk of maltreatment. We suggest that clear policies and processes should be in place to ensure that public health nurses have access to supervisors as well as child protection workers to consult with during this process and that there should be interagency processes to develop and strengthen collaboration, case management, and referral processes between home visiting programs and child protection agencies. At the practice level, orientation to this role could include education on local reporting legislation, risk indicators for child maltreatment, communication skills for managing a report, and processes for making warm referals to community resources and supports. Clinically, nurses should be adept at providing anticipatory guidance to clients about under what circumstances, when and how a report to a child protection agency may be made. Then also ensuring that their practice is informed by the principles of trauma-and-violence informed care to ensure that emotional and physical safety is prioritized for clients and their children (Ponic et al., 2016). More broadly, consistent with repeated calls in Canada the wider social responsibility for preventing and responding to child maltreatment needs to be more effectively developed and resourced (Taylor, 2016; Trocmé et al., 2019).

Conclusion

Public health nurses working in targeted, long-term home visitation programs have a unique role and responsibility with respect to preventing, considering, and then safely recognizing and responding to suspected child maltreatment. Across all health care contexts, there are few clinicians who work in such a context where: (1) they are working extensively with families with significant histories of trauma, risk, and experiences of violence; (2) they have the privilege to spend a significant amount of time in families' homes, giving the opportunity to identify potential risks; and (3) they are working within a program structure that provides the elements necessary to establish trusting, therapeutic relationships with families experiencing significant levels of social and economic disadvantage. Being in such close contact with families highlights that public health nurses have an essential role in preventing child maltreatment, can be engaged in early identification of situations of potential risk, and also collaborate with the family to mitigate risks and focus on prevention. Our goal was to further understand the professional nursing practices inherent in this work; we found that in their relational work with families with young children public health nurses use their assessment skills and apply clinical judgment while considering if presenting risk indicators are indicative of suspected maltreatment—yet striving to preserve their relationships with the mothers even when reporting is indicated. Further, they work to navigate challenging systems and the socioeconomic circumstances that place disadvantaged young mothers and their children at risk. Finally, given their expertise and experiences, this work highlights the importance of situating public health nurses in positions of leadership where they can make substantive contributions to larger population and public health conversations about the importance of addressing the underlying social determinants of health. This would also include promoting the wellbeing of all children through increased public investments in health promotion and child maltreatment prevention programs such as NFP.

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Supplemental Material

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References

Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., MacLeod, E., & Randel, P. (2014). Universal and targeted early home visiting: Perspectives of public health nurses, managers and mothers. *Nursing Reports*, *4*, 3290. https://doi.org/10.4081/nursrep/2014.3290

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. https://doi.org/10.1191.1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Browne, A., Hartrick Doane, G., Reimer, J., MacLeod, M., & McLellan, E. (2010). Public health nursing practice with 'high priority' families: The significance of contextualizing 'risk'. *Nursing Inquiry*, *17*(1), 27–38. https://doi.org/10.1111/j.1440-1800.2009.00478.x

Carter, N., Valaitis, R.K., Lam, A., Feather, J., Nicholl, J., & Cleghorn, L. (2018). Navigation delivery models and roles of navigators in primary care: A scoping review. *BMC Health Services Research*, *18*, 96.

Catherine, N. L. A., Gonzalez, A., Boyle, M., Sheehan, D., Jack, S. M., Hougham, K. A., McCandless, L., MacMillan, H. L., & Waddell, C. for the British Columbia Healthy Connections Project Scientific Team. (2016). Improving children's health and development in British Columbia through nurse home visiting: A randomized controlled trial protocol. *BMC Health Services Research*, *16*, 349. https://doi.org/10.1186/s12889-01907479-5

Catherine, N. L. A., Level, R., Sheehan, D., Zheng, Y., Boyle, M. H., McCandless, L., Gafni, A., Gonzalez, A., Jack, S. M., Tonmyr, L., Varcoe, C., MacMillan, H. L., & Waddell, C. & Members of the British Columbia Healthy Connections Project Scientific Team. (2019). The British Columbia Healthy Connections Project: Findings on socioeconomic disadvantage in early pregnancy. *BMC Public Health*, *19*(1), 1161. https://doi.org/10.1186/s12889-019-7479-5

Catherine, N. L. A., Boyle, M., Zheng, Y., McCandless, L., Xie, H., Lever, R., Sheehan, D., Gonzalez, A., Jack, S. M., Gafni, A., Tonmyr, L., Marcellus, L., Varcoe, C., Cullen, A., Hjertaas, K., Riebe, C., Rikert, N., Sunthoram, A., Barr, R.G., . . . Waddell, C. (2020). Nurse home visiting and prenatal substance use in a socioeconomically disadvantaged population in British Columbia: Analysis of a prenatal secondary outcomes in an ongoing randomized controlled trial. *Canadian Medical Association Journal Open*, *8*, E667–E675.

Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). Sage.

Crisp, B., & Green Lister, P. (2004). Child protection and public health: Nurses' responsibilities. *Journal of Advanced Nursing*, *47*(6), 656–663. https://doi.org/10.1111/j.1365-2648.2004.03154.x

Davidov, D., Nadorff, M., Jack, S., Coben, J., & NFP IPV Research Team. (2012). Home visitors' perspectives of mandatory reporting of children's exposure to intimate partner violence to child protection agencies. *Public Health Nursing*, *29*(5), 412–423. https://doi.org/10.1111/j.1525-1446.2011.01003.x

Dong, M., Anda, R. F., Felitti, V. J., Williamson, D. F., Dube, S. R., Brown, D. W., & Giles, W. H. (2005). Childhood residential mobility and multiple health risks during adolescence and adulthood: The hidden role of adverse childhood experiences. *Archives of Pediatric Adolescent Medicine*, *159*(12), 1104–1110. https://doi.org/10.1001/archpedi.159.12.1104

Dubowitz, H., Hein, H., & Tummala, P. (2018). *World perspectives on child abuse* (13th ed.). International Society for the Prevention of Child Abuse and Neglect.

Einboden, R., Rudge, T., & Varcoe, C. (2019). Beyond and around mandatory reporting in nursing practice: Interrupting a series of deferrals. *Nursing Inquiry*, *26*(2), e12285. https://doi.org/10.1111/nin.12285

First Nations Health Authority (n.d). Accessed online [2020, April 1] https://www.fnha.ca

Freisthler, B., Merritt, D. H., & LaScala, E. A. (2006). Understanding the ecology of child maltreatment: A review of the literature and directions for future research. *Child Maltreatment*, *11*(3), 263–280. https://doi.org/10.1177/1077559506289524

Gonzalez, A., Catherine, N., Boyle, M., Jack, S.M., Atkinson, L., Kobor, M., Sheehan, D., Tonmyr, L., Waddell, C., & MacMillan, H.L. (2018). Healthy Foundations Study: A randomized controlled trial to evaluate biological embedding of early life experiences. *BMJ Open*, *8*, e018915. https://doi.org/10.1136/bmjopen-2017-018915

Gonzalez, A., & MacMillan, H. (2008). Preventing child maltreatment: An evidence-based update. *Journal of Postgraduate Medicine*, *54*, 280–286. https://doi.org/10.4103/0022-3859.43512

Jack, S.M., Sheehan, D., Gonzalez, A., MacMillan, H.L., Catherine, N., & Waddell, C., & The Members of the BCHCP Process Evaluation Research Team (2015). British Columbia Healthy Connections Project process evaluation: A mixed methods protocol to describe the implementation and delivery of the Nurse–Family Partnership in Canada. *BMC Nursing*, *14*, 47. https://doi.org/10.1186/s12912-015-0097

Kitzman, H., Olds, D. L., Henderson, C.R. Jr., Hanks, C., Cole, R., Tatelbaum, R., McConnochie, K. M., Sidora, K., Luckey, D.W., Shaver, D., Engelhardt, K., James, D., & Barnard, K. (1997). Effect of prenatal and infancy home visitation

by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. A randomized controlled trial. *Journal of American Medical Association*, *278*(8), 644–652.

Landy, C. K., Jack, S. M., Wahoush, O., Sheehan, D., & MacMillan, H. for the NFP Hamilton Research Team. (2012). Mothers' experiences in the Nurse–Family Partnership Program: A qualitative case study. *BMC Nursing*, *11*, 15. https://doi.org/10.1186/1472-6955-11-15

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

MacMillan, H. L., Thomas, B. H., Jamieson, E., Walsh, C. A., Boyle, M. H., Shannon, H. S., & Gafni, A. (2005). Effectiveness of home visitation by public health nurses in prevention of the recurrence of child physical abuse and neglect: A randomized controlled trial. *Lancet*, *365*(9473), 1786–1793. https://doi.org/10.1016/S0140-6736(05)66388-X

MacMillan, H. L., Wathen, C. N., Barlow, J., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. (2009). Interventions to prevent child maltreatment and associated impairment. *The Lancet*, *373*, P250–266. https://doi.org/10.1016/S0140-6736(08)61708-0

Marcellus, L. (2005). The ethics of relation: Public health nurses and child protection clients. *Journal of Advanced Nursing*, *51*(4), 414–420. https://doi.org/10.1111/j.1365-2648.2005.03512.x

McTavish, J. R., Kimber, M., Devries, K., Colombini, M., MacGregor, J. C. D., Wathen, C. N., Agarwal, A., & MacMillan, H. L. (2017). Mandated reporters' experiences with reporting child maltreatment: A meta-synthesis of qualitative studies. *BMJ Open*, *7*, e013942. https://doi.org/10.1136/bmjopen-2016-013942

Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Sage.

Miller, E. (2019). Trauma-informed approaches to adolescent relationship abuse and sexual violence prevention. *Pediatric Annals*, *48*(7), e274–e279.

Ministry of Children and Family Development (2019a). 2019/20-2021/22 Service plan. https://www.bcbudget.gov.bc.ca/2019/sp/pdf/ministry/cfd.pdf

Ministry of Children and Family Development (2019b). Child protection services in BC. https://www2.gov.bc.ca/gov/content/safety/public-safety/protecting-children

Ministry of Children and Family Development (2019c). Minister's statement on ending birth alerts. https://news.gov.bc.ca/releases/2019CFD0090-001775

Ministry of Children and Family Development (2020). Child protection response policies: Chapter 3. https://www2.gov.bc.ca/assets/gov/family-and-social-supports/policies/cf_3_child_protection_reponse.pdf

Molnar, B. E., George, R. M., Gilsanz, P., Subramanian, S. V., Holton, J. K., Duncan, D. T., Beatriz, E. D., & Beardslee, W. R. (2016). Neighborhood-level social processes and substantiated cases of child maltreatment. *Child Abuse & Neglect*, *51*, 41–53. https://doi.org/10.1016/j.chiabu.2015.11.007

Moules, N., MacLeod, M., Thirsk, L., & Hanlon, N. (2010). "And then you'll see her in the grocery store": The working relationships of public health nurses and high-priority families in northern Canadian communities. *Journal of Pediatric Nursing*, *25*, 327–334. https://doi.org/10.1016/j.pedn.2008.12.003

Mulcahy, H., & McCarthy, G. (2008). Participatory nurse/client relationships: Perceptions of public health nurses and mothers of vulnerable families. *Applied Nursing Research*, *21*, 169–172. https://doi.org/10.1016/j.apnr.2006.06.004

National Institute for Health and Care Excellence (2009). *Child maltreatment: When to suspect maltreatment in under 18s: Clinical guideline*. https://www.nice.org.uk/guidance/cg89

Olds, D. L., Henderson, C. R. Jr., Chamberlin, R., & Tatelbaum, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics*, *78*, 65–78.

Olds, D. L., & Henderson, C. R. Jr. (1997). The prevention of maltreatment. In D. Cicchetti & V. Carlson (Eds.) *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 722–763). Cambridge University Press.

Olds, D. L., Sadler, L., & Kitzman, H. (2007). Programs for parents of infants and toddlers: Recent evidence from randomized trials. *Journal of Child Psychology and Psychiatry*, *48*(3/4), 355–391. https://doi.org/10.1111/j.1469-7610.2006.01702.x

Peckover, S. (2002). Supporting and policing mothers: an analysis of the disciplinary practices of health visiting. *Journal of Advanced Nursing*, *38*, 369–377. https://doi.org/10.1046/j.1365-2648.2002.02197.x

Phelan, A., & Davis, M. (2015). Lessons learned: Public health nurses practice in safeguarding children in the Republic of Ireland. *Global Pediatric Health*, *2*, 1–9. https://doi.org/10.1046/j.1365-2648.2002.02197.x

Pietrantonio, A. M., Wright, E., Gibson, K. N., Alldred, T., Jacobson, D., & Niec, A. (2013). Mandatory reporting of child abuse and neglect: Crafting a positive process for health professionals and caregivers. *Child Abuse & Neglect*, *37*, 102–109. https://doi.org/10.1016/j.chiabu.2012.12.007

Ponic, P., Varcoe, C., & Smutylo, T. (2016). Trauma-(and violence-) informed approaches to supporting victims of violence: Policy and practice considerations. *Victims of Crime Research Digest*, *9*, 3–15.

Public Health Agency of Canada (2010). *Canadian incidence study of reported child abuse and neglect – 2008: Major findings*. https://cwrp.ca/sites/default/files/publications/en/CIS-2008-rprt-eng.pdf

Segal, L., Nguyen, H., Gent, D., Hampton, C., & Boffa, J. (2018). Child protection outcomes of the Australian Nurse Family Partnership Program for Aboriginal infants and their mothers in Central Australia. *PLoS One*, *13*(2), e0208764. https://doi.org/10.1371/journal.pone.0208764

Taylor, G. (2016). *The chief public health officer's report on the state of public health in Canada 2016: A focus on family violence in Canada*. Public Health Agency of Canada. https://www.canada.ca/en/public-health/services/publications/chief-public-health-officer-reports-state-public-health-canada/2016-focus-family-violence-canada.html

Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice* (2nd ed.). Routledge.

Tonmyr, L., & Hovdestad, W. (2013). Public health approach to child maltreatment. *Paediatrics & Child Health*, *18*(8), 411–413.

Trocmé, N., Esposito, T., Nutton, J., Rosser, V., & Fallon, B. (2019). Child welfare services in Canada: Contemporary issues in research and policy. In L. Merkel-Holguin, J. Fluke,

& R. Krugman (Eds.). *National systems of child protection. Child maltreatment* (Vol. 8, pp. 27–50). Springer. https://doi.org/10.1007/978-3-319-93348-1_3

Violence Prevention Alliance (2020). *The ecological framework*. World Health Organization. https://www.who.int/violenceprevention/approach/ecology/en/

Williams, V. N., Ayele, R., Shimasaki, S., Tung, G. J., & Olds, D. (2019). Risk assessment practices among home visiting nurses and child protection case workers in Colorado, United States: A qualitative investigation. *Health and Social Care in the Community*, *27*(5), 1344–1352.

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