## Inquiry Into the Child Protection System in the Northern Territory 2010

Overarching issue

**4. Child protection roles and responsibilities of all government and non-government organisations and individuals.** The roles and responsibilities of other government agencies and non-governmental organisations, members of professional groups and the public at large in the protection of children in the Northern Territory. This includes issues of coordination, collaboration, resourcing, training and mandatory reporting. Also of interest are roles and responsibilities of inter-disciplinary and inter-agency teams and committees.

**Submission**

This submission relates to the role that child health nurses employed by the Department of Health and Families can offer in identifying vulnerable families and safeguarding the children in those families. This professional group is an untapped resource for supporting parents to provide a nurturing and safe environment for their children. The exponential increase in the numbers of children reported to be at risk of, or having suffered abuse has created a seriously overburdened workforce in NT Families and Children. Child health nurses have the expertise to assist parents with challenges that limit their parenting skills and abilities. Those nurses, working in collaboration with child protection workers, particularly focusing on those families that have not reached the statutory threshold, would provide much needed assistance to the NT Families and Children workforce. This has the potential to lessen the burden on child protection workers and give them scope for more thorough investigation of those children at serious risk. The Care and Protection of Children Act allows for such coordination of services for the protection and well-being of children. For example:

> **Division 2 Minister's powers**
>
> **25 Minister's powers**
>
> (1) The Minister may do anything for the adoption of a cooperative approach between the following in relation to the care and protection of children:
>
> (a) families;
>
> (b) Agencies and any other public authorities;
>
> (c) any other individuals or organisations (including, for example, community groups, business entities and any other bodies).

Within the Act there is also recognition of the need for interagency and interdisciplinary case planning when a child leaves the care of the CEO:

**Division 4 Powers to inquire or investigate**

**45 Coordination assistance**

(1) The CEO may provide assistance to persons or bodies in coordinating their effort to provide services (including child-related services) for a child or young person who has left the CEO's care, including assistance in:

(a) convening a meeting of the persons or bodies; and

(b) drawing up a plan for the provision of the services.

I am currently writing a PhD thesis that will detail a pilot project (Land and Barclay 2008) that investigated NT nurses' perceptions of their role in protecting children and the subsequent attempt to undertake action research cycles to address some of the recommendations from the pilot project. The study was authorised in 2005 by the (then) CEO of the Department of Health and Community Services (now Department of Health and Families) and was given ethical approval by the Charles Darwin University Ethics Committee. His successor to the role of CEO, however, did not appear to explicitly support the research, although the Care and Protection of Children Act gives legitimacy to research surrounding the Objects of the Act, that is promoting the well-being and protection of children in order for them to reach their potential:

**44 Child-related services**

(1) The CEO may enter into an arrangement for:

(a) the provision of child-related services; and

(b) research and development to be carried out for child-related services; and

(c) the funding (in whole or part) of the services or the research and development.

The lack of support for the continuation of the action research study occurred at the levels of CEO, executive and middle management. The thesis, therefore, is about a 'failed' action research study, but more importantly about a missed opportunity for more effective services for vulnerable families and their children.

**Underlying assumptions of the study**

- Child health nurses are an untapped resource in safeguarding children and minimizing child abuse and neglect
- Child health nurses have professional expertise in providing parenting support and education so that children are raised in a nurturing and safe environment
- Identification of family vulnerability by child health nurses is possible through the use of evidence-informed psychosocial tools and the Edinburgh Postnatal Depression Scale

- Sharing of health information across the range of Department of Health and Families program areas that provide services to families and their children will minimize the potential for harm to children
- Interdisciplinary and interagency collaboration is the most effective model of service delivery for early intervention in identified vulnerable families
- The development of interdisciplinary and interagency collaboration is supported by interdisciplinary education, a shared understanding of professional roles and expertise, and pooled funding across service delivery agencies

Aims of the Research

- Facilitate, through participatory action research (PAR), organizational change that provides child health nurses with the ability to identify vulnerable families and provide early intervention and preventive strategies to safeguard children in those families
- Facilitate through PAR the development of interdisciplinary and interagency collaboration to safeguard children in vulnerable families

A Reference Group of middle managers from acute maternity services, NT Families and Children, Community Health and Systems Performance and Aboriginal Policy was formed to discuss recommendations from the pilot study and identify problems that could be addressed by action research cycles. There was consensus among this group that there was a need to:

- develop an evidence-informed family psychosocial tool to identify vulnerable families
- develop mechanisms for sharing of health information
- deliver services in collaboration with other agencies/branches of the Department
- create opportunities for interdisciplinary education

One of the recommendations from the pilot project was to develop a mechanism for sharing of relevant health information across program areas including the acute maternity service, child health service and child protection service. I facilitated a 'Sharing of health information' workshop with presenters from the legal branch of the Department for the Reference Group of managers. While it was made clear that there

is a legislative framework through the Information Act to allow for sharing of health information for the purpose of minimising harm, there was no uptake by the managers present to progress or support this concept. Following this in 2007 Dr. Howard Bath conducted an audit of high risk clients as a result of some disastrous events that had occurred (Bath 2007). One of his recommendations was concerned with sharing of health information across the Community Services branches. Unfortunately it appears that the concept of child health nurses as professionals involved in the well-being of children and their families was not considered. Practitioners who work in NT Families and Children, Mental Health, Alcohol and Other Drugs and most areas of Aged & Disability have the ability now to see if their clients (and their parents if registered in their electronic record) also have involvement in any of these services. This information allows for the development of a collaborative approach to service delivery within a 'shared care' framework.

Child health nurses provide universal services to all families with infants and pre-school aged children in urban settings in the NT. These services include psychosocial assessment, developmental assessment and parenting education. This professional group has the most (and usually first) contact with these families but their potential for delivering services in collaboration with professionals in other service areas is limited partly due to a lack of knowledge of families' involvement with those other areas. A finding from the pilot study was that nurses understand their responsibility concerning mandatory reporting where there is suspected child abuse, however they were disconcerted by the lack of feedback from child protection workers. The participants also commented that many cases referred to the child protection agency were not investigated, but no information was given as to the reason for this.

Effective interdisciplinary and interagency collaboration is more likely to occur where there is a shared understanding of the roles and expertise of the professional groups involved. Personal communication with various child protection workers during the course of this study has revealed that many of them view the role of child health nurses as simply weighing and immunising children. There appeared to be no knowledge of child health nurses' role and expertise in undertaking family psychosocial assessment and providing parenting education and support. This perception may change if interdisciplinary educational opportunities within tertiary courses and also Departmental professional development courses were created.

**Recommendations to the Inquiry**

- Develop mechanisms for the inclusion of child health services in the sharing of health information framework
- Formulate processes for collaborative practices between child health nurses and child protection workers
- Create opportunities for inter-departmental interdisciplinary education

**Attachment A**

"Nurses' Contribution to Child Protection" – Executive Summary

## EXECUTIVE SUMMARY

This qualitative study aimed to explore nurses' perceptions of their contribution to child protection and any perceived barriers to that role. Nurses, like others, are mandated reporters of suspected or actual child abuse. Ten nurses whose work involved the care of children and their families were interviewed using a semi-structured, open-ended interview technique. Participants were from acute care, community health and school nursing and they were employed in a range of settings across the Northern Territory.

Interpretive interactionism underpinned the thematic analysis of the interviews. Results of analysis identified three broad areas that impact on the ability of nurses to have an effective role in the protection of children:

- Organizational structures
- Institutional practices; and
- Legislative frameworks

In brief, organizational structures impeded interdisciplinary and inter-agency collaboration thereby limiting the opportunity for safe, effective and evidence-based continuity of care and support for families. Structures that are based on cost centre driven budget imperatives create challenges for professionals who need to take collaborative action to protect children and families.

Institutional practices that impede nurses in their role of child protection were seen to arise through organizational hierarchies and a lack of departmental guidelines and protocols for these nurses. Constraints in this area also include the lack of appropriate educational preparation and continuing professional development for nurses in the field of child protection. Many nurses feel constrained in their ability to function adequately in a role of protecting children because of lines of authority employed in the workplace. Doctors and nurse managers, particularly in tertiary hospital institutions, appear to disempower nurses. The revolving door syndrome in the tertiary setting that sees Indigenous children re-presenting frequently for avoidable conditions such as infected scabies lesions and failure to thrive has the effect of desensitizing nurses' concerns for the protection of this marginalized and disadvantaged section of our community.

Legislative frameworks within the Northern Territory have an influence on information sharing between health professionals. While it is thought by some nurses that the Information Act 2002 presents obstacles to the sharing of information relating to the potential for abuse, or actual abuse of children, it would seem that an inadequate knowledge of the Community Welfare Act 1983 presents the major obstacle to the sharing of information between Family and Children's Services and nurses who are caring for children.

Recommendations arising from this study include collaborative interdisciplinary and inter-agency practices, the development of departmental protocols to support such practice, and nurse-led models of care that aim for early identification of risk factors for child abuse and early primary intervention to improve family functioning.

### References

Bath, H. (2007). "Independent Audit of Clients at Risk". Department of Health and Community Services, NT

Land, M. and Barclay, L. (2008). "Nurses' contribution to child protection". Neonatal, Paediatric and Child Health Nursing 11(1): 18 – 24

# The Value of Nurses' Contribution to Child Protection – a Qualitative Study

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# 2. EXECUTIVE SUMMARY

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# 3. OVERVIEW

The Australian Institute of Health and Welfare (AIHW) reports that the incidence of child abuse reports, and substantiation of such reports, is rising (Foster, 2004). Legislation in the Northern Territory requires that nurses, like all other residents, are mandated reporters of child abuse. It is not clear however that nurses have a sufficient understanding of the provisions of the Community Welfare Act 1983 and what processes should be followed to report child abuse appropriately. It is also unclear whether nurses perceive any barriers to their role and involvement in child protection. Of particular importance at this time is the possible replacement of the Community Welfare Act with the draft Care and Protection of Children and Young People Act 2005 (draft) and the implications this may have for nurses.

While "***Child Protection Is Everyone's Business***" (NAPCAN, 2004), nurses are ideally placed to recognise risk factors that may lead to child abuse as well as identifying signs of suspected abuse in children. The '*caring*' nature of nursing work, however, is, perceived as a barrier to the act of making a report to Family and Children's Services (FACS) regarding a suspicion of child abuse. Nurses whose work involves children and their families are concerned with socio-economic, psycho-social, emotional and cultural issues that relate to the health and well-being of their clients and, therefore, focus their attention towards therapeutic means of remediation of problems that may have an adverse impact on their clients.

This research study aimed to explore nurses' understanding of child abuse, involvement in child protection and any perceived barriers to their professional contribution to child protection. Ten nurses whose professional roles bring them into close contact with children and their families were interviewed to gain an insight into their perceptions of their role and involvement in child protection. The interviews were audiotaped with the consent of the participants. Most of the participants were interviewed in person, while two participants, one from a regional Northern Territory centre and the other from a remote location in the Northern Territory, were interviewed via teleconference. Verbatim transcripts of the interviews were thematically analysed with three major

marginalised groups of children due to individuals' perceptions of cultural practices.

This study aimed to elicit the experiences and perceptions of the participants' involvement in child protection and any perceived barriers to that role. Nurses whose role specifically involved the care of children and their families were recruited as participants in this study. All participants had a minimum of two years' experience in a practice setting that was focused on children and their families. A critical methodology was used to analyse the data gathered through open-ended, semi-structured audiotaped interviews of ten nurses. This approach challenges the social, political and cultural status quo and has the intention of uncovering the inequities and power relations that underpin the social reality (Kincheloe and McLaren, 1994).

## 5. SIGNIFICANCE OF THE STUDY

Since the 1990s the AIHW has published annual statistics concerning the number of reports of child abuse in Australia and the number of substantiated reports. These statistics demonstrate that the numbers of both reports and substantiations are increasing (Foster, 2004). It is unclear 1) whether these figures are increasing due to the effect of mandatory reporting legislation that is required in all jurisdictions of Australia except Western Australia, 2) if the community is more conscious of this phenomenon, or 3) if there has been an actual increase in the incidence of child abuse. Kovacs and Richardson (2004) state that mandatory reporting has the dual effect of increasing community awareness of the phenomenon as well as increasing the number of reports.

Most children in the Northern Territory come into contact with nurses on many occasions throughout their early years and school years. Encounters with Child and Family Health Nurses (CFHN) occur for such regular services as developmental assessments and immunisations in the first two years of life. Once at school, children may seek consultation with, or be referred to, the Health Promoting School Nurse (HPSN) or may be involved in education sessions delivered by the HPSN. Prior to any suspected maltreatment, both the CFHN and the HPSN are in a privileged situation with

There is limited literature available that explores Australian nurses' perceptions of their role and involvement in child protection. There is none in the Northern Territory context. This gap in research is of significance considering the large Indigenous population in the Northern Territory and the over-representation of Indigenous children in child abuse reports as shown by statistics published by the AIHW (2005). These figures indicate that the rate of substantiated child protection reports for Indigenous children in the Northern Territory is 16.2 per 1000 while it is 3.5 per 1000 for non-Indigenous children. This disproportionate and alarming statistic warrants investigation.

While journal articles and books abound on child protection and child abuse, few references to the role of Australian nurses in this tragedy for children were found in a search undertaken for this study. This search of the EBCSOhost and Informit databases from 2000 to 2005 using the keywords of *child abuse* or *child protection* and *nurs** revealed only eight articles that had an Australian nursing perspective. Sherman (2000), in a very short letter to the Australian Nurses Journal (ANJ), specifically addressed the legislative requirement in the Northern Territory for nurses to report suspected child abuse. The point of his letter was to correct an AAP article published in the March 2000 Australian Nursing Journal that stated Victoria, Tasmania, South Australia and the ACT were the only jurisdictions where nurses had a legislative requirement to notify suspected child abuse.

Robyn Nayda, a nurse academic from South Australia, has conducted research and published several papers regarding nurses' role in child protection. In 2002, a paper by Nayda outlined the decision-making processes of South Australian Community Health nurses in reporting of child abuse. Her study concluded that nurses are constrained by a number of factors including their perception of the services that may be offered to a family following a report of child abuse. The nurses were also concerned about the potential damage to their therapeutic relationship with the family and preferred to offer support and strategies to the family as a first step. A further article by Nayda (2004), confirms the limited research conducted in the area of nurses' involvement in child protection in Australia. It informs nurses of the varying State and Territory legislation,

f) Influence the active involvement of nurses in child protection.

g) Disseminate the findings of the research to appropriate professional groups locally.

## 9. ETHICAL CONSIDERATIONS

Ethical approval for this study was gained from the Human Research Ethics Committee, Menzies School of Health Research and the Department of Health and Community Services. The length of time in gaining approval was several months due to concerns from the ethics committee about the sensitivity of the subject area, the potential to cause previously undisclosed distress to participants, and the possibility of identifying actual clients or communities. Following detailed amendments to the original application, approval was granted. The following paragraph formed part of the amended submission for ethics approval and outlines attention to the issues of concern to the Ethics Committee.

*"The guideline questions set are non-threatening and it would be highly unlikely that there would be any risk to participants. Exploration, however, through questions prompted on the basis of verbal and non-verbal cues of participants have the very slight potential to cause some difficulty if the particular participant felt any previously undisclosed emotional distress because of past professional or personal experiences. If participant distress became evident during an interview, the interview would be stopped and the data gathered to that stage would not be included except with the consent of the participant. The participant would be given professional guidance about options for counseling, for example referral to the Employment Assistance Scheme (EAS) or to the Social Worker at Casuarina Community Care Centre and all endeavours would be taken to ensure the emotional well being of the participant. Participants will be asked to talk in general terms about past experiences and not to disclose clients' names or any identifying references about clients. If it became clear that participants were unaware of their legislated responsibilities concerning mandatory reporting, this information would be provided to them by the researcher."* (Addition to original submission for ethics approval)

*subjectivity, and value humans and their experiences ...* " (1998, p.15)

## 10.2. METHOD

Interpretive interactionism (Denzin, 1994) was the framework used for the collection and analysis of data. According to Schwandt (1994), with reference to the work of Denzin, this approach is useful in critically analysing the way people make sense of, and interpret, their lived experiences. Interpretive interactionism as a methodology is appropriate for studying human behaviour as it relies on the ability to gain an understanding of how people make sense of their social worlds, that is, "see[ing] social action from the actor's point of view to understand what is happening." (Lindlof and Taylor, 2002, p. 31). According to Denzin (1994), researchers bring their own personal experiences to the fore when making sense of, or interpreting, the data – "[t]he events and troubles that are written about are ones that the writer has already experienced and witnessed firsthand" (1994, p.510). Having had a career in nursing spanning several decades, most of which has been in the areas of paediatric, neonatal and child health nursing, I have experienced many of the contexts of the participants' working worlds. Knowledge of the sub-culture of these environments, as well as many of the day to day experiences for nurses working with children, enabled me to understand and critically interpret the meaning inherent in their responses.

## 10.3. SETTING

Issues surrounding privacy as well as providing a non-threatening environment were considered for the interview setting. Participants were given the opportunity to identify their preferred choice of location and time of interview. Most of the participants chose to be interviewed at my home, one participant who lived alone requested that the interview be conducted at her own home, and two participants requested the interview to be conducted in an office at their workplace. The remaining two participants were interviewed by

## 10.5. DATA COLLECTION

While there were some guideline questions (see below) used for the interviews, these served mainly to ensure that each participant had an opportunity to address all the areas of interest. The questions were semi-structured and open-ended to allow for a full exploration of experiences. Questions were not asked in a set order or word-for-word, however attention was paid to gaining information and perceptions surrounding the concepts contained in each of the guideline questions. Further questions, prompted by cues from participants, were asked to explore perceptions and clarify meanings. Interviews lasted from a minimum of thirty minutes up to one hour. The interviews were audiotaped and then transcribed verbatim by the researcher. The transcriptions included comments in brackets to indicate the perceived emotions during the responses, e.g. (nervous laugh). The transcriptions also include substitutes for identifying data by the use of square brackets, e.g. [in the other State]. Attention was paid to verbal and non-verbal nuances, but field notes were not taken during interviews as this would have distracted from "active listening" (Lindlof and Taylor, 2002, p.193 – 194). Some notes were, however, added at the conclusion of the interviews so that analysis of the context of the words was considered. Accounts by participants of their experiences and feelings triggered further questions for a fuller description of perceptions. A conversational interviewing technique was used for the purpose of allaying any fears that participants may have felt regarding the sensitive nature of the topics being explored.

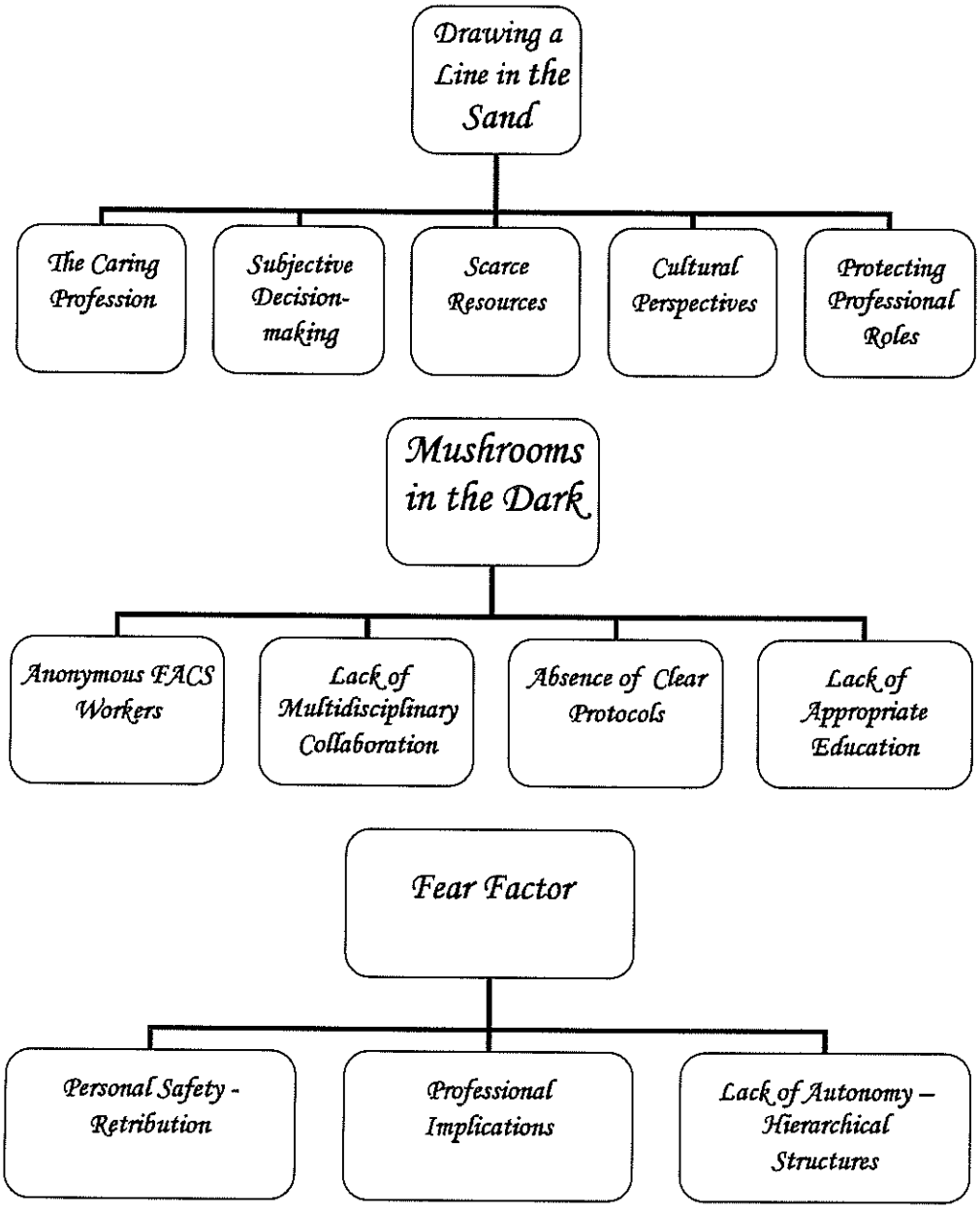
### *GUIDELINE QUESTIONS*

- Tell me about your role as a nurse in ED/Paediatrics/Child Health/School nursing

- What have been your experiences in relation to child protection or child abuse?

## 10.7. THEMATIC ANALYSIS

The practice setting, seniority and previous professional experiences of the participants influenced to some degree their priorities and the barriers they perceived in a child protection role. Three major themes were identified as overarching the sub-themes that were drawn from the analysis of the interview data as shown below.



immediate danger to the child. *"We have to follow her up the whole time", "If we're concerned we'll go in and do a few other visits to just see that everything's going alright".*

This was equally so for the HPSNs in the study "we are ideally placed to build up that trusting relationship with families so, and provide that early intervention sort of stuff". It was less evident in the responses of the acute care nurses. Nurses within the hospital setting demonstrated the caring component of nursing work, but their focus of care appeared more task driven and medically orientated. Given the nature of tertiary hospital institutions and the acuity of the patients, this is not surprising; but this workplace environment did not prevent the nurses from demonstrating concern for the well being of their patients and their families. As one nurse put it: "... you also have to make yourself available to, if there are greater needs for these people, and put it out as best you can that you're here, and try to provide the safest and most comfortable environment, and there are more people involved than just one patient – it's the mother, it's the father and maybe other children.". There were difficulties faced by these nurses in following through processes for thorough assessments and planning of appropriate psychosocial and emotional care. This is likely to be based in the lack of a Primary Nursing model of care. Such a model of care would give responsibility to a nurse to assess the patient's needs, plan care based on that assessment, and continue to evaluate the effectiveness of that care throughout the course of the patient's hospital admission. A paediatric nurse, discussing the care of a particular child who was being investigated by FACS commented "this kid stayed in hospital for the next couple of days 'til things were sorted out because no one was really familiar". Nurses on duty at the time were not aware of the protective needs and plans for this child and the situation was further complicated by the fact that the child protection worker had gone on holidays. Administrative practices in patient allocation appear to pay more attention to a pre-determined roster of rotating shifts and skill mix of available nurses on any particular shift than to the needs of individual patients and

### 11.1.2. SUBJECTIVE DECISION-MAKING

Clear, prescriptive definitions are not available in either the current Community Welfare Act 1983 or the draft legislation. This leaves nurses in the position of making subjective judgments about their clients' well being – *"... psychological stuff is hard, really, really hard"*. Many of the participants stated that obvious signs of physical abuse did not present them with a dilemma in their responsibility for mandatory reporting. However, they expressed concern about reporting suspicion of other types of abuse and neglect – *"how emotionally tied up in a knot we get about some of the fine line ones"*, *"you think everything's cut and dry and it's going to be obvious"*, *"so not just black and white that I thought things would be"*, *"it's that grey stuff that's hard, yeah; I don't think any Act's going to change that"*. Subjectivity is based on a person's life experiences, including their own up bringing, values and beliefs and orientation to parenting. While nurses base their professional roles on being non-judgmental, it is not necessarily easy to completely separate themselves from their long held values – *"everyone brings a lot of their own socialisation to their job"*.

While recognition was given to responsibility for reporting being with the individual who suspects abuse, some of the participants expressed a preference for confirmation of their assessment from others prior to making a report. This perspective was particularly evident in the accounts of hospital-based nurses and HPSN, all of whom work in interdisciplinary and multi-professional environments. It was less often mentioned by CFHN who mostly work in a comparatively independent way. Accounting for decision-making in mandatory reporting, a HPSN expressed the view that *"... it's never one professional's unilateral decision. It is a team decision because obviously if you start having unilateral decisions it becomes quite a subjective issue ... the more professionals you can get to talk about an issue, the better the understanding of all the dynamics you can get."* This view was supported by a paediatric nurse

*extended visiting that we could, probably should do".* The need for home visiting was based, in part, on the premise that vulnerable families do not regularly attend child health clinics – *"a lot of people don't go to clinic, never will ...not their way of working through their problems ... respond day by day to emergencies because that's how their lives go around".*

It can be seen that some participants felt that there are budgetary constraints limiting the effectiveness of a primary and early intervention approach to child protection by CFHN. As well as this, several participants raised concern that FACS also faced the pressure of less than adequate financial and human resources and believed that this limited its ability to respond to reports made – *"half the time they are not investigated", "people aged 15 are ... often put to the bottom of the pile".* This last quote was later explained by *"there's not enough people in FACS".* Another participant described FACS as *"a little area that just runs on stress and crisis all the time...[s]ometimes, you know, they are out of their depth with the workload".* Another commented about the limited services and limited experience of the FACS workers in her region – *"... the reality of limited services, and limited effective services"* and *"...and the follow up isn't as good as it could be and that's really letting the families and children down".* These comments were from a participant outside of the Darwin region where recruitment of staff in all areas is possibly problematic at the best of times, but even more so in rural and remote regions. But comments were made by other nurses as well to indicate reservations in the skill of the FACS staff – *"I think there is a high transient staff in there just as there is everywhere else in the NT"*, and *"I've found some of their service provision inappropriate at times".* The explanation for this comment was that FACS had sent a male taxi driver to take a girl who had been sexually abused to the Sexual Assault Referral Centre.

With perceptions of a poorly resourced agency perceived to be unable to cope with reports of child abuse, nurses felt that there would be no action taken

*every day and done this and this and this because they just don't have the ability to do that".*

Delineation was made by some participants between deliberate and unintentional neglect or abuse on the basis of a lack of facilities and resources – *"I don't know whether the neglect is deliberate neglect or just circumstantial neglect really. You know, that sort of thing where there's just not facilities for people to access, so their kids end up skinny and stuff like that. Or ignorance or lack of education or something".* Recognition was also given to the need to break the cycle of dysfunction within some remote communities and one participant said *"I'd like to see more services reallocated, rather than focusing on an organisation like FACS, why aren't we focusing on organisations that support families".*

There was, however, recognition that evidence of, for example, repeated skin infections, failure to thrive or exposure to a violent or substance abusing community constituted a threat to the future well being of the child. One participant was of the view that, for some nurses, the constancy and alarmingly high rates of situations such as these in Indigenous families had a desensitizing effect. They have become the 'norm', and therefore nurses saw it as acceptable for this population – *"It's a normal type thing for people to have scabies or for parents to come in intoxicated or for, you know, parents to yell and swear and scream at their children ... and I think what we do now is we say, that is culturally acceptable*". But another participant was quite clear in her view that such behaviours were not part of the Aboriginal culture and were not acceptable - *"Aboriginal children are left exposed to dangers that they should not be"* and *"... in particular I talk about children in the long grass and I say that is not culture".* Recognition of the difficulties faced by Indigenous families residing in urban areas was noted by a HPSN. She expressed the view that supportive community environments in remote locations assisted families to establish healthy family dynamics – *"we can learn a few lessons from Indigenous*

of Anonymous FACS Workers, One-Way Communication, Lack of Multidisciplinary Collaboration, Absence of Clear Protocols, and Lack of Appropriate Education. Following is a discussion of each of these sub-themes.

### 11.2.1. ANONYMOUS FACS WORKERS

Of great concern to many of the participants was their lack of knowledge of the members of the child protection units and the service delivered by them – *"that's an emotional part for you, for revealing that over the phone to someone else"*. This participant thought it would be very helpful if nurses could meet with the child protection team members so that they knew to whom they were talking if they needed to ring FACS – *"I think I would like to meet them, who they are, face to face, it would be good"*. Another participant, when talking about her inability to access relevant professional development, expressed a desire to at least meet with members of the child protection team – *"it would be good if Family and Children's would just come and tell us what they do, and not feel as if they were being checked up on or anything, just the information"*. In relation to particular instructions from child protection workers, a participant stated *"I feel like more of it is done over the phone"*. Like some other participants, this nurse was particularly concerned about the lack of documentation of such things as Holding Orders and plans – *"if things aren't put in writing really no one's got a leg to stand on"*. Even when child protection workers were in the workplace, the experience of one participant was that they did not readily identify themselves to the nurses present – *"they'll ask about five questions about the patient before they would identify who they are"*.

Participants from regional areas of the NT were more likely to know who their child protection workers are –*"that comes with a small place too and you're more interconnected with the staff all around than with a bigger place*". The feeling was that this helped in many ways, for example creating supportive, educational and collegial relationships. This was evident in the quote "... *sometimes I don't feel I want to report it as a mandatory reporting, but I just*

*as far as information goes. I find that really frustrating".* Another participant was concerned about the lack of documentation by FACS workers. She commented : *"I feel like most of it is done over the phone and a lot of it, when they come in, is not documented. Like I think things should be put in writing".* This participant was particularly concerned about the lack of professional communication through the accepted method of documentation rather than word of mouth. She continued with *"I feel like it's been prompted but it's not reciprocated and they should see that documentation is really, really the most important thing that we've got; documentation, communication sort of thing".*

### 11.2.3. LACK OF MULTIDISCIPLINARY COLLABORATION

This sub-theme is a closely related to the previous *One-Way Communication*, but contains broader elements for consideration. Some of the participants expressed the view that working with FACS prior to making a report of child abuse may be of some assistance to them in delivering care to families – *"... we've now got another good case worker and I know that sounds terrible, but when you get someone good that you can go to and you can bounce off and feel comfortable with and you know they are giving you good solid information, you hang on to them and you keep going to them".* For CFHNs the lack of collaboration also extended to professional relationships with referring hospitals. One participant spoke of a case of a woman who had previously had children removed from her care but was discharged from a Northern Territory hospital with twins and seemingly no strategies in place to monitor her ability to care for those babies – *"It was just that I felt uneasy, unhappy about the situation and I went back again ... there was nothing in the referral from the hospital would make you keep going back ... not on the information you got from the hospital".* This senior CFHN demonstrated her intuitive expert practice, developed through many years of clinical experience, by her persistence in seeking to gain access to this client. She also sought more

There is limited association between child protection workers and the nurses who are working with children and their families in Darwin, and limited recognition by FACS of the role of paediatric, CFHNs and HPSNs. As one participant said of child protection workers – *"... they have no idea what our roles, as in Registered nurse, Registered midwife, Maternal and Child Health, they have no idea the skills that are involved in all that. They have no idea"*. Another participant commented *"The Child and Family Nurses are often left out of the case conference ... like we don't logically go with child protection as a community view. But, yeah, if we worked that way you would be able to do a lot more of that early intervention"*. The lack of empirical literature within Australia that includes nurses in research about child protection or abuse supports the participants' view that they are not explicitly recognised as involved providers of care in this situation.

### 11.2.4. ABSENCE OF CLEAR PROTOCOLS

While some participants spoke of departmental protocols surrounding child protection, it appeared to participants that these are mostly unwritten and nurses would only become aware of them by 'making mistakes', that is experientially – *"I think you only find out the hard way, by doing the wrong thing."*. On the issue of making a report to FACS, one participant had an understanding that *"the hospital protocol sets down that it's only if doctors consider it's necessary"*. There had been no verification made of this opinion by any nurse. Some participants felt that there were protocols or guidelines, but they seemed to have been referring to simply the legislative requirement of mandatory reporting – *"Well, yeah, there is a mandatory reporting protocol that's there ..."*- rather than any particular departmental directions for provision of services to clients who may be considered on 'the cusp' of needing a formal child abuse report – *"So there's no, there is no standardisation, it's hard to do that ... it will take a decision by the department on what they want and then to train people"*. The Community Welfare Act 1983 presently in force in the NT is

## 11.3. FEAR FACTOR

Interview data led to the identification of a number of sub-themes that, grouped together, made up the major theme of Fear Factor. The sub-themes related to issues of personal safety, professional integrity and subjugation of professional roles to higher authorities.

### 11.3.1. PERSONAL SAFETY – RETRIBUTION

Some nurses, particularly CFHN, in this study were mindful of the fact that they would be the suspected reporters of child abuse and were apprehensive of the subsequent potential for personal recrimination. Some had experienced verbal attacks while there was one account of a serious threat to the personal safety of a colleague – *"the father of the child ... told FACS it was that nurse and I'll track her down"* and *"there was always that fear that they were going to be coming in"*. Some participants spoke about the increased likelihood of recognition of reporter identity in smaller communities *"being a small town, one shopping center, you're bound to see them in there as well ... it was very disturbing for the nurse, extremely disturbing"*. Maintaining the anonymity of a reporter of child abuse is accommodated in the Community Welfare Act, however many nurses preferred to inform parents of their intention to make a report to child protection services – *"I tend to sit down and talk through with the parents what's going on. I've made reports to child welfare, I've always told the people associated"*. At the same time there was a realisation that it may leave them open to some retribution – *"I don't know how this is going to go, his moods, anything could trigger the mood to escalating"* and *"I didn't want to go to the house for my own safety ... I was feeling a bit vulnerable"*. Another participant who had not been the reporter of a particular client made the point that often it is the CFHN who would be suspected of making the report due to their close, and often continuing, association with clients – *"I thought, gosh, how is she going to be with me because she thinks I dobbed her in"*.

*ward nurses aren't involved in* [ward meeting], *I don't feel like we're included in that ... you'd have to like force yourself into it ... we'd have to push the issue"*. It was almost as if they thought it would not be acceptable if they actively sought involvement in the case. They were, therefore, not willing to risk a perceived lowering of professional standing through 'rocking the boat'.

# 12. DISCUSSION

While nurses, whose work brings them into close and frequent contact with children, would appear to be the health professionals most likely to identify issues regarding the safety of those children (Nayda, 2004, Joughin, 2003), it seems that there are some constraints for those nurses in exercising a child protection role. It is timely to examine the nature of the apparent constraints, particularly in light of the draft legislation before Parliament that is intended to replace the current Community Welfare Act 1983. The Care and Protection of Children and Young People Act 2005 (draft) contains some pertinent departures from the current Act that could, arguably, require a more stringent and broader application of mandatory reporting.

There were many concerns raised by the participants of this study that indicated that there may be some barriers surrounding their professional involvement in child protection. Participants, generally, expressed their understanding of factors that placed families at risk and were of the view that they were professionally well prepared to support those families to achieve a safe level of family functioning. However they expressed concerns and frustrations about the perceived impediments that restricted their ability to practise in this role. These frustrations mainly arose due to:

- limited human and financial resources,
- the absence of clear departmental protocols to guide and assist them in their child protection and family support role,
- the inadequate level of knowledge they had about the services delivered by FACS and the professionals delivering those child protection services,

this, professional acquaintances are often non-existent except in smaller regions of the Northern Territory.

Neither the current Act nor the draft legislation is totally prescriptive and definitions of child abuse and neglect could be said to be open to interpretation. It is recognised in the literature that it is particularly hard to determine when neglect of a child becomes a reportable matter (Truman, 2004). The current Act requires any person, other than a member of the Police Force, to report to the Minister a belief that "a child has suffered, or is suffering, maltreatment". There is also a clause referring to potential for harm but uses terms such as "substantial risk" of "serious" harm. However the draft legislation mandates reporting if it is believed that "a child is in need of protection." This is a significant, while at the same time, subtle departure from the current Act in that it includes the recognition and reporting of potential for harm or maltreatment without attempting to quantify an extent of the harm or maltreatment. In its Overview, Section 5 (a) states "... for the protection of children **at risk of harm** ..." and again in Section 19 (d) "the child has suffered or **is likely to suffer harm** as a result of an act or omission of a parent of the child". Participants in the study made frequent comments about recognising potential for abuse and were quite clear about the risk factors that could lead to child abuse. If the draft legislation is passed by Parliament, the floodgates could be wide open for an exponential rise in reports.

This raises the issue of the available resources to deal with the increase in reports. Some participants were cynical about the ability of FACS to deal with the current significant number of reports received and described their view of the service as reactive and at times in crisis. There is abundant literature from United States of America that recognises the relative limits of child protection services to act on child abuse and neglect reports - see, for example, Straus and Kantor (2004) who discuss the probable inability to deal with reports of potential harm through neglect in light of the already apparent resource limitations of those services. Melton (2004), in a discussion paper prepared for the International Society for the Prevention of Child Abuse and Neglect, is critical of the concept of mandatory reporting for this very reason. He believes that it can

An issue of concern that emerged from this study was the apparent attitude that some nurses hold regarding indicators of abuse, mainly neglect, in Indigenous children. It would appear that this may be overlooked in the case of Indigenous children but would possibly be reported if the same evidence were to be seen in a non-Indigenous child. This appeared to be particularly so in the acute care sector where nurses are dealing with a disproportionate number of Indigenous children attending, sometimes according to participants, with intoxicated caregivers, and admitted for conditions such as failure to thrive and severe skin infections from scabies infestation. Nurses, with such conditioning over time, can form the view that these problems are the 'norm' rather than cause for great alarm. Considering Truman's view that definitions of child abuse are determined by "cultural, community and societal values" (2004, p. 33), it would be timely to investigate the indifference of nurses to the plight of those Indigenous children and families. Mark Sheldon, a psychiatric registrar, spent his dissertation year exploring psychiatric care to Aboriginal people in Central Australia. He developed useful interviewing techniques, understanding of the cultural imperatives of this group and an appreciation of the need for assistance from Aboriginal Health Workers in this field. Tragically he died of natural causes before his dissertation paper was complete, however his records were used to complete the paper after his death. Of interest in this paper is his recognition that "[I]t was possible to become totally desensitised such that any degree of poor hygiene or neglect was dismissed as being non-pathological" (2001, p.441). In a discussion of the referral process to mental health services, Sheldon also commented on the lack of referrals of children to the service as being due to the fact that "behavioural problems [in children] seemed to be well tolerated" (p.437). Korbin (2002) undertook a literature review of the relationship between culture and child abuse. She outlines the need to appreciate differences within cultures and also talks about the socio-economic disadvantage of some cultural groups. She discusses issues such as the need for cultural competence in service delivery.

Russell-Johnson (2003), in a paper which outlines the effect of domestic violence on the children in this environment, comments about the difficulty in determining when such exposure to this type of aggression warrants a child abuse report. She emphasises that

timely for some clear departmental protocols to be developed with a view to interdisciplinary and interagency collaboration in providing services for 'at risk' families. Such a move may see benefits to all involved in the protection of our children and youth.

A degree of discomfort, even fear, was expressed by many of the participants concerning making a child abuse report. Personal retribution, legal consequences and questionable professional conduct within a hierarchical institutional structure were identified as potential barriers. It appears that some nurses are influenced by the perception that mandatory reporting may expose them to both personal and professional disadvantage. This perception may, in deed, be based on personal experience or it may be as the result of hearsay. A News article in Practice Nurse (2004) reported on research conducted by a UK nurse, Mary Russell, who investigated child abuse reporting by primary care professionals in Northern Ireland. She found that many of these professionals, including nurses, were fearful of facing litigation through a misdiagnosis of child abuse.

The current Act and the draft legislation both contain clauses that protect people who make a genuine mandatory report of child abuse from civil or criminal liability. Legislation per se, though, cannot protect people from personal retribution from those parents who may be the centre of a child protection investigation. No participants, however, recognised the liability for a legal penalty if they did not make a mandatory report where they had formed the view that there was clear evidence of child abuse or neglect. In the case of the Community Welfare Act, this amounts to a hefty fine. The draft legislation includes a term of imprisonment as well as a fine, but more importantly, these punitive outcomes could arguably also result from the failure to report the potential for harm to a child. Joughin (2003) examines the role of UK A&E staff in child protection. She warns nurses about their legal duty of care to protect children through mandatory reporting and the possibility of a negligence charge against them if they failed to make a report. Both the current Act and the draft legislation also contain clauses that protect mandated reporters from any loss of professional integrity through the making of a genuine report.

Nursing is seen as a mobile workforce, so problems present immediately within the area of knowledge of child protection legislation because there is no uniform legislation throughout Australia. In the UK, the Royal College of Nursing has called for mandatory education for all nurses in child protection on induction to the workplace and then periodically thereafter (Smith, 2003). Nayda, drawing on results of an ethnographic study into Registered nurses' communication about child abuse (2002) comments that "... a department or organisation may adhere to protocol that does not reflect state legislation and discourages reporting" (2005, p.27). While not suggesting that the DHCS would operate either covertly or overtly in this way, it is important for nurses to be quite clear about their jurisdictional legislative requirements and assess any purported protocols against them.

Suggestions of interdisciplinary collaboration, sharing of information and appropriate access to education are noble aims, but a very important piece of the jigsaw puzzle is clear departmental guidelines. Currently it does not appear that DHCS has any specific protocols that would help frame interdisciplinary and interagency service delivery in the area of child protection. It appears to those in this study that budgetary imperatives, rather than policies and protocols developed on the basis of legal requirements and best practice, drives service delivery.

# 13. CONCLUSION

This study has provided some preliminary data from which to build a body of knowledge about the current status of Northern Territory nurses' perceptions of their role and involvement in child protection and any perceived barriers to their active involvement in child protection.

Although the study has drawn on the experiences and perceptions of a small number of nurses, the data collected have shown that these nurses, across the acute care sector and the community setting, share some important perceptions and concerns about their role in child protection. The study has highlighted that nurses are constrained in their role through organisational structures, institutional practices and legislative frameworks.

benefits to the individuals, families, communities, and indeed the State coffers as well as minimising child harm. This model has shown that suitably trained nurses can make the difference between a continued cycle of deprivation, poverty and child abuse, and the development of functional families and communities. For the Northern Territory, there are obvious obstacles in the poorly resourced remote areas to the smooth pathway to a better future for the children in those communities. But to accept this as a given would represent a travesty of justice to the most marginalised groups in our society.

This study has identified some alarming professional barriers to collaborative practices –

- The inadequate knowledge between professional groups regarding their skills, roles and services delivered. This needs to be addressed as a first step.
- The lack of trusting relationships between all professionals whose focus is on the welfare of children. A change can only be achieved when the siege mentality of program areas is broken and open communication between program areas is the norm rather than the exception.
- Limited availability of child protection education to all nurses who work with children and their families. This could be addressed through existing educational supports available to Public Sector nurses.

Nurses are particularly vulnerable to hierarchical structures and task driven practices that limit their ability to function in accordance with their stated professional roles. In the hospital setting this equates to subjugation of their role to that of doctor's handmaiden, while in the community setting it is through the budget constraints imposed on them. A review of nursing practice in relation to these mitigating elements may address, in part, some of the issues highlighted.

A review and redesign of the way in which services are delivered by nurses and FACS workers is required to reduce the abuse within some families in our community. A whole of government, intersectoral approach that has community capacity building as one of its major aims can be achieved.

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