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A qualitative study of public health nurses' experiences detecting and preventing child maltreatment in primary care settings

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Abstract

Aim: To explore how public health nurses in child and family health centres experience detecting and preventing child maltreatment.

Design: Qualitative study.

Methods: Fourteen semi-structured individual interviews with public health nurses who worked in 11 different child and family health centres were conducted. The interviews were analysed using thematic analysis.

Results: Three themes were identified: (i) integrating knowledge to prevent child maltreatment as part of their everyday job, (ii) striving hard to detect child maltreatment and (iii) experiencing the assignment to be complex and demanding.

Conclusion: Despite extensive experience, knowledge and following the guidelines, public health nurses in this study had difficulties finding children exposed to child maltreatment in child and family health centres. Public health nurses called for mutual multidisciplinary cooperation with other services and organizational facilitation, such as enough time and clear guidelines to effectively address this issue.

Implications for Practice: This study provides knowledge about how public health nurses work with child maltreatment at the Child and Family Health Center, which can serve as valuable foundation for further research as well for collaborating services.

Reporting Method: EQUATOR guidelines were followed, using the COREQ checklist.

Patient or Public Contribution: No patient or public contribution.

KEYWORDS
child abuse, child nursing, child protection, family care, health promotion, nurse roles, primary care, public health nursing

1 | INTRODUCTION

Child maltreatment is increasingly recognized as an ongoing global phenomenon and public health problem, causing pervasive consequences for children, their families, and society (Gilbert et al., 2009; Graves & Gay, 2022; Segal et al., 2021; WHO, 2020). Child maltreatment is broadly defined as abuse or neglect of children under 18 years of age. As described by the World Health Organization (2020),

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it includes 'all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power'. According to the WHO Global Report on Child Maltreatment, nearly 300 million children, aged 2–4 years, regularly suffer from physical punishment and/or psychological maltreatment from their parents or caregivers (WHO, 2020).

Child maltreatment can have long-term negative effects on a child's physical, emotional and cognitive development (Gilbert et al., 2009; Irigaray et al., 2013). This includes death, illness, negative impacts on social ability and emotional trauma. The risk of being exposed to sexual abuse, physical abuse or neglect depends on a child's age. For instance, rates of sexual abuse tend to rise after the onset of puberty, with the highest occurrence being during adolescence. Infants, on the other hand, are more at risk for fatal physical abuse (U.S. Department of Health and Human Services [HHS], 2022; Gilbert et al., 2009). Further, although brain development may be harmed throughout childhood, children are the most vulnerable, both physically and psychologically, in the first 3 years of life (U.S. Department of Health and Human Services, 2022; WHO, 2015). During this time a child's brain undergoes rapid development, acquiring remarkable abilities such as recognizing faces, expanding vocabulary and strengthening cognitive skills, while early experiences play a crucial role in shaping their future adaptability, resilience and overall well-being (Bunge & Zelazo, 2006; Dehaene-Lambertz et al., 2010).

Child maltreatment is a highly prevalent societal and health threat in European and high-income countries (WHO, 2014). In a cohort study among Norwegian adolescents (age 12–16 years), 19% of respondents reported being exposed to any form of physical abuse, and 4% of respondents described being exposed to serious physical abuse (i.e. being kicked, hit with an object or beaten with a fist) (Hafstad et al., 2020). One in five had experienced psychological abuse from their parents, and 27% reported sexual abuse from an adult (Hafstad et al., 2020).

In many countries, there are laws that require individuals to report any concerns of abuse (Mathews, 2015). Healthcare professionals, in particular, play an important role in stopping child abuse by assessing children, detecting risk factors and reporting suspected child maltreatment to authorities (WHO, 2015). However, previous studies indicate that detecting and measuring childhood maltreatment is not easy (Naughton et al., 2018; Vollmer-Sandholm et al., 2021). Responses to child maltreatment tend to focus on dealing with its consequences, and little attention has been paid to its prevention. In the European Report on Preventing Child Maltreatment, the WHO (2015) asserted that if society is to demonstrate a real commitment to protecting children from abuse and neglect, prevention must be prioritized (WHO, 2015).

2 | BACKGROUND

In Norway, children have the right to essential medical care and check-ups free of charge in their municipality (Norwegian Directorate of Health, 2019). Norwegian child and family health centers (CFHC) provide universal health services following a standardized program with regular check-ups. Health and Care Services Act requires health care professionals such as public health nurses (PHNs) doctors and physiotherapists to be included in the staff. Midwives are also required to provide antenatal and postnatal care. Other specialists, such as psychologists, may also be included in the CFHC staff. Norwegian public health nurses (PHNs) are registered nurses who are further educated in health promotion and preventive care, specializing in children's psychological, physical, and emotional development. PHNs are primary caregivers at CFHCs, providing universal childcare services and following children and families from birth to school age, with a minimum of 14 check-ups before school age, mostly in the first year of life (Norwegian Directorate of Health, 2019). They perform home visits, immunizations, and developmental screenings and provide individual and group counselling and guidance. They regularly meet with the families and children they serve, beginning a few days after birth and continuing multiple times in the first year.

The guidelines recommend that PHNs observe children systematically while being particularly aware of conditions that may indicate child maltreatment (Norwegian Directorate of Health, 2019). The guidelines also provide a thorough description of how the task of the prevention and detection of child maltreatment can be resolved and maintained but do not present any description of routine questions to ask about child maltreatment (Norwegian Directorate of Health, 2019). The guidelines suggest that PHNs keep child maltreatment in mind during all visits, stating that 'child maltreatment should be treated as a syndrome' and 'the combination of symptoms defines the diagnoses' (Norwegian Directorate of Health, 2019). The guidelines also state that the PHNs are obliged to report to Child Protective Services (CPS). Nearly all children and their families (99%) follow the recommended programme and visits at their CFHC; thus, the PHN is in a unique position to contribute to preventing and detecting child maltreatment, as they may be the only person to meet a child, except the family, at the beginning of a child's life.

However, a white paper from 2017 (NOU, 2017, p. 12) that examined severe cases of abuse against children in Norway stated that children were overlooked in many cases where abuse should have been stopped earlier. In 2019, the National Criminal Investigation Service in Norway (KRIPOS) published a report of cases of severe maltreatment in children (aged 0–4 years). More than 70% of the cases investigated were in children under 1 year of age, and 50% were in children under 5 months old (KRIPOS, 2019). These children are too young to attend day care, kindergarten or school, and therefore meet few people outside their own families. Children under 4 years of age are the most vulnerable for many reasons, including dependency, small size and inability to defend themselves. Prevention programmes that are supported by evidence of their effectiveness include early interventions for at-risk families, home visits by nurses and providing parental support, especially when the children are young (Mikton & Butchart, 2009).

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International studies among nurses working in primary care have found the detection of child maltreatment both important and challenging (Dahlbo et al., 2017; Lines et al., 2021). A recent study among nurses in Sweden found gaps between their attitudes regarding the importance of helping families and their ability to do so (Engström et al., 2021). Several studies have described barriers to communicating about abuse and neglect (Anderzen-Carlsson et al., 2018; Lines et al., 2021).

Moreover, a meta-synthesis of qualitative studies found that health professionals struggle to identify and respond to less obvious forms of maltreatment (e.g. when there are no visible bruises or injuries) where the symptoms are vague and difficult to define (McTavish et al., 2017). A systematic review of how child care professionals work with child maltreatment identified several barriers to reporting, including system and structure (e.g. reporting system), resources and support (e.g. lack of time, inadequate assessment tools), sociocultural context (e.g. cultural norms, upbringing), reporters' traits (e.g. profession, gender) and psychological characteristics (e.g. lack of confidence, attitude) (Wilson & Lee, 2021).

The role of PHNs in detecting and preventing child maltreatment has had a limited focus, and to our knowledge, there is no clear data on how PHNs in Norway interpret or follow the guidelines for child maltreatment.

3 | AIM

This study aimed to explore how PHNs in CFHCs detect and prevent child maltreatment.

4 | METHODS

4.1 | Design

This study aimed to gain a better understanding of PHNs' experiences in preventing and working with child maltreatment. We used a qualitative and exploratory design, with in-depth individual interviews to investigate this topic. The interviews were analysed using thematic analysis with a contextual approach, which is considered appropriate when the aim of a study is to describe how participants understand their experiences (Braun & Clarke, 2022). The Norwegian Social Science Data Service (SIKT) approved this study before it was conducted (Reg. No. 510861). The study was conducted in line with the consolidated criteria for reporting qualitative research (COREQ) checklist in order to promote transparency.

4.2 | Sample and recruitment

Participants were recruited by purposive sampling and were chosen based on certain characteristics in order to ensure information power (Malterud et al., 2021). We wanted to interview PHNs who had consultations with children aged 0–5 years at CFHCs. Permission for recruitment was sought by team managers in the CFHCs by email from the first author. The team manager distributed the request, including the study information sheet and the invitation. PHNs were asked to directly contact the research team if they wanted to be involved in the study.

Initially, 15 CFHCs throughout Norway received the invitation, asking for one or two PHNs to participate from each CFHC. To obtain variation in sample, we wanted to select PHNs with varied years of experience from CFHCs of different sizes and with varied clientele demographics. We wanted to include PHNs from areas with low socio-economic status within the large cities, assuming that the PHNs in these CFHCs had more experience with child maltreatment. Thirteen managers responded positively and forwarded invitations to the PHNs in the CFHC. Twelve PHNs replied to the first author via email or phone and registered their interest in contributing to the study. Information power was evaluated continuously throughout the study and determined by considering the specificity of the sample, applied theory, quality of the dialogue and variation in the data in relation to the study's aim (Malterud et al., 2021). After the initial 12 interviews were completed, participants from rural areas in northern Norway were included. The authors sent an additional invitation to the leader of the Nurses Association in Norway, who distributed the invitation to all its members in the northern county. This invitation resulted in the inclusion of two additional PHNs. After 14 interviews were conducted with PHNs from 11 different CFHCs and five different counties, the research group determined that the data set was rich; this is because new informants did not provide any additional information but repeated the experiences or expressions that had already been reported by previous informants in their interviews.

4.3 | Ethical considerations

This study was conducted in accordance with the recommendations of the Declaration of Helsinki, 2019. Oral and written consent were obtained from the PHNs prior to commencement of the interviews, and the participants were informed about their right to withdraw from the study at any time. All data were confidential and anonymized. Child maltreatment is a sensitive topic that may trigger reactions, thus, the research group was available to the PHNs participating in the project by phone and mail.

4.4 | Data collection

The objective of this study was to explore how PHNs in CFHCs work to prevent and detect child maltreatment, as well as their related experiences. We developed a semi-structured interview guide using open-ended questions. Additional follow-up questions including, 'can you tell me more?' or 'what do you mean by…?' were

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asked during the interviews to elicit participants' views. The interview guide was pilot tested with one PHN working in a CFHC and was subsequently used in the study because it provided a satisfactory amount of data. An additional final question was added to the interview guide. The participants chose where to be interviewed: four at the CFHC, three in their private homes and three by zoom. All interviews were conducted by the first author over a 4-month period between August and November 2021 and lasted between 40 min and 1.5 h. The first author had previous experience working as a PHN at a CFHC.

The interviews were audiotaped and transcribed verbatim shortly after their completion. Comments about observations and situations during the interview were in parenthesis within the text to explain the surroundings (e.g. PHNs' facial expressions and gesticulations). Additional notes were written about the conversation after the interview had finished, as several participants spoke more freely and openly. These notes were read to the informant for consent to be added to the interview, and to check whether what was noted was correctly understood. The first author kept a journal that included immediate thoughts after the interviews and additional notes after transcribing, which helped the author to be conscious and critical about their preunderstanding and assumptions.

4.5 | Analysis

This study used the thematic analysis method described by Braun and Clarke (2022). The analysis included the following steps: (1) Familiarizing oneself with the data by reading each interview several times to obtain a sense of the whole. (2) Generating initial codes that are relevant to the objective across the entire dataset. In this phase, the initial codes were developed by identifying and grouping meaningful units of text based on their relevance to the research question. The transcripts were exported to NVivo (version 1.5.1 [940]) to aid analysis. (3) Organizing initial codes into subthemes and then potential themes in relation to the coded extracts and the entire data set. We then generated a thematic 'map' of the analysis. (4) Arranging the subthemes into overarching themes. In this stage, we revised our potential themes and read the entire dataset again, realizing that some themes could be merged from five to three themes. (5) Defining and naming themes. The aim was to obtain a systematic and trustworthy description of the interview. All five authors contributed to the analytical process to ensure the trustworthiness of the analysis. First, all the authors read the first interviews independently; second, the entire analysis process was conducted, discussed, and reflected upon as a group.

5 | RESULTS

The results are presented as three main themes and 14 subthemes (Table 1). Table 2 presents the characteristics of the participants.

TABLE 1 Themes and subthemes.

Main themes	Sub-themes
Integrating knowledge to prevent violence against children as part of their everyday job	Establishing a secure relationship
	Mapping and assessing for risk factors as a continuous process
	Educating parents about violence using a developmental perspective
	Individualizing follow-up
Striving hard to detect child maltreatment in the CFHC	Continously aware and searching for explanations if concerned
	Adjusting actions to the degree of concern
	Emphasizing the need for reciprocal cooperation
	Difficult to detect
A complex and demanding task	Balancing support and suspicion
	A solitary responsibility
	Characterized by uncertainty
	Requiring support, facilitation, and sufficient time

Abbreviation: CFHC, child and family health centers.

5.1 | Integrating knowledge to prevent violence against children as part of their everyday job

5.1.1 | Establishing a secure relationship

Several of the PHNs emphasized that establishing a secure relationship with parents was necessary to prevent violence. Some PHNs emphasized being available to the family when needed. One PHN said:

> I want them to be prepared just in case. To ensure that they can always call me.
>
> (PHN 6)

Most PHNs initiated a conversation about violence at their first meeting with the family after the baby was born. They highlighted the benefit of starting the conversation early because it gave them the opportunity to talk about the topic several times in different ways. An experienced PHN with a long history of working at a CFHC in a rural community explained:

> By addressing it [child maltreatment] early, preventively…when it is presented as a natural part of the conversation…and talked about in a natural way… several times… Then it might be easier for a mother, or a father maybe…to tell me 'I was exposed to physical violence by my partner'…or 'psychological violence'…or…yes, 'that the child isn't doing so well' and so on.
>
> (PHN 13)

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TABLE 2 Characteristics of the participants.

Interview No.	Age	Experience as PHN (in years)	Previous experience in children hospital	Population	The CFHC i located in an area of
1	>50	>15	Yes	>600,000	Large City W[a]
2	30–40	<2	No	>600,000	Large City W
3	>50	5–10	Yes	>600,000	Large City E[b]
4	30–40	2–5	Yes	>600,000	Large City W
5	40–50	5–10	Yes	>600,000	Large City E
6	30–40	5–10	Yes	>600,000	Large City E
7	40–50	10–15	Yes	>600,000	Large City W
8	<30	<2	Yes	40–45,000	City
9	30–40	5–10	Yes	>600,000	Large City E
10	30–40	10–15	Yes	40–45,000	City
11	>50	10–15	Yes	2–5000	Town
12	40–50	>15	No	<2000	Town
13	>50	10–15	No	5–10,000	Town
14	30–40	5–10	Yes	10–15,000	City

Abbreviations: CFHC, child and family health centers; PHN, public health nurse.
[a]W, West, population with a higher proportion of high socio-economic status.
[b]E, East, a population with a higher proportion of lower socio-economic status.

Many of the PHNs expressed that talking about child maltreatment from a preventive perspective is an uncomplicated task. At the same time, they often perceived parents to be uncomfortable when the topic was broached. PHNs were therefore concerned that the topic should be communicated in a natural but sensitive way.

5.1.2 | Mapping and assessing for risk factors as a continuous process

Several of the PHNs explained how they started to assess risk factors when they first met their families and continued to do so at every appointment. The PHNs stated that they initiated the first meeting by asking about the parents' backgrounds and histories, trying to paint a picture of the parents while searching for red flags.

Some PHNs offered a home visit during pregnancy as part of their general CFHC program, where they asked their parents about their expectations, worries, and childhood. PHN's who did not have home visits before the baby's arrival emphasized and valued interdisciplinary cooperation with midwives as part of early intervention.

5.1.3 | Educating parents about violence using a developmental perspective

PHNs educated parents about child maltreatment. They encouraged parents to reflect on their own thoughts and feelings in different situations. PHN 2 explained: 'At the first home visit where we talk about, especially in relation to babies crying and how to be a parent when the baby screams, what prior experience do they have in handling stress? What strategies do they use?'

Many PHNs use diverse educational tools, such as brochures, booklets and films, complemented by exploratory and reflective questions. The majority had their own strategy for approaching the topic, whereas a few explained that their approach was random and based on the situation. All the interviewed PHNs provided information about Shaken Baby Syndrome during their home visit or the first visit after the baby was born. Several PHNs asked the parents reflective questions in what to do in stressful situations: 'where you…want to hurt your child…Talk about that, and how this is something anyone may experience…talk about that…if you get tired and become desperate…and preventing violence by making a plan of what to do. (PHN 1).

In addition to discussing child maltreatment/violence during home visits, PHNs also brought up the topic at mandatory checkups. Many said that they discussed it during the 15-month appointment as a natural part of toddlers' developmental needs and the challenges parents face in setting boundaries. A few highlighted the 2-year appointment as a useful time to talk about sexual abuse in relation to sexual development.

Several PHNs used a verbal screening tool in the 4-year appointment to talk about violence directly with the child. Some found it difficult, while others found it to be successful. Some children were uncomfortable while others were open and honest. The PHNs mapped and assessed developmental challenges during all visits to the CFHC, explored the impact on parents, and used the challenges as an approach to educate parents about child maltreatment.

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5.1.4 | Individualizing follow-up

When parents experienced difficulties such as feeling blue or having a baby with persistent crying or sleeping problems, the PHN tailored their follow-up. They also suggested activities offered by the CFHC or in their municipality. A PHN explained:

> First, I try to follow up by offering extra appointments, to support and help to solve their situation. But if they need more guidance, I try to refer them to the COS (circle of security) course or to the community psychologist and sometimes to a doctor. It depends on the challenge and situation.
>
> (PHN 4)

All the interviewed PHNs offered additional appointments when a family experienced challenges, such as infant colic, sleep and setting boundaries. Sometimes, the PHNs determined that these challenges demanded more extensive help than what the CFHC or primary care could provide, so they engaged the CFHC doctor for referral to a specialized health professional. However, PHNs sometimes experienced parents declining referral and preferring to be followed up exclusively by their primary PHN. In this case the PHN followed up themselves.

5.2 | Striving hard to detect violence against children in the CFHC

All PHNs in this study reported that they considered the detection of child maltreatment as an important part of their assignment as PHNs.

5.2.1 | Continuously aware and searching for explanations if concerned

During every consultation at the CFHC, the PHNs said they always checked children for bruises or marks, looking for any signs or symptoms of concern. Many PHNs examined children during their weight, length and head measurements, while they were naked. Physical examination is part of the routine and is not necessarily communicated loudly.

They also observed and assessed the interactions between the children and their parents, the parents with each other, and the parents with the PHN. One PHN explained, I first and foremost look at the child. How the baby…what expectations it has of the parents, right?…When they grow older, how do they react to me? What do they do…do they seek support and security from their parents? Do they go careless out and play, do they look stressed…or like, do strange things? (PHN 10).

One PHN kept her office door open so that she could listen to the parent–child interaction as they entered the CFHC. Several PHNs noted that the waiting area was a good spot to observe parent–child interactions unobtrusively, often revealing important information on how the parent responds when the child is uneasy.

All PHNs explained that they asked parents about bruises or marks and used the child's medical history and journal for additional information and to complement their assessments. PHN 13 explained:

> I always ask why…'What happened here, I see there's a bruise mark on the child's thigh…or back…or forehead. What happened?'…In addition, I would scroll backward in the journal history to see if there have been similar or other episodes.
>
> (PHN 13)

Some PHNs asked direct questions about concerns, whereas others used other reasons to schedule follow-up visits. A PHN who had worked at CFHC for several years said: 'Well then, for example, you can explain that you wish to see them again to follow up the baby's weight… I mean, you come up with an excuse… I know I do, anyway' (PHN 1).

Some PHNs had negative experiences of asking direct questions as they caused parents to be offended or angry. One participant had positive experiences of being honest, asking direct questions, and being warm, generous, and listening. They all emphasized the importance of being sensitive, open-minded and respectful when discussing concerns.

5.2.2 | Adjusting actions to the degree of concern

When concerns arose, PHNs scheduled additional appointments beyond the CFHC program to gather more information. Many have evaluated concerns and risk factors as part of the overall assessment before deciding on the next steps. PHN 6 explained: 'When worried, you follow up, right. If you see a completely detached mother, then I start to follow up right away' (PHN 6). Many discussed their worries with their colleagues.

Some PHNs sought permission from parents to talk to the child's daycare and gather more information, but noted confidentiality as a potential obstacle. PHNs contacted the Children's House (an interdisciplinary resource centre that provides guidance when maltreatment is suspected) or paediatric hospital for advice and/or discussed situations anonymously with CPS before deciding on their next steps.

Many PHNs discussed with or reported the family to CPS when they were concerned about child maltreatment. Many explained how they tried to do this in cooperation with their parents, trying to make the parents positive and accepting of getting help. If the PHNs witnessed violence while the family visited the CFHC or perceived clear signs of concern, several said that they would have contacted CPS or the police directly, without consulting the parents.

5.2.3 | Emphasizing the need for reciprocal cooperation

All interviewees emphasized the importance of interdisciplinary and multidisciplinary cooperation in detecting child maltreatment. The PHNs worked with various collaborating partners, such as daycare centres, medical specialists, CPS, and police, to gather information,

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advice and support. However, many PHNs said that they rarely contacted them. PHNs also called for better cooperation with children's hospitals, stating that they rarely receive medical reports after admission. One PHN working in a small city said that the children's hospital in her city routinely sent medical reports when a child had been hospitalized, explaining how the information facilitated a better scope in assessing the child and concerns.

PHNs sought better cooperation with CPS in relation to their reports of concern and children who had already received assistance. Some PHNs felt that the cases were dismissed without notice or explanation, leading to them feeling unsecure. One PHN explained that she felt unsafe after reporting concerns about severe violence to CPS and not receiving feedback. She said,

> After reporting this case, I was scared, because I had never received feedback from CPS. I began to realize that this father was a man who could be very angry. One day, he just burst into my office, black as a cloud, and I did not know what was going on. I do not remember what he or I said.
>
> (PHN 12)

Many PHNs reported not receiving feedback or being invited by CPS to participate in meetings. Several said families sometimes switched PHNs after they were sent reports of concerns, resulting in a lack of continuity and follow-up. The PHNs questioned CPS's assessments and decisions. One PHN said:

> I have had children I have reported and do not understand anything when it's dismissed, right. I have conducted a thorough assessment, right? Do they [CPS] know what a little baby needs? Do they not realize that this child needs care and family help? You get a little disillusioned, right?
>
> (PHN 9)

Several PHNs expressed similar statements.

On the other hand, some PHNs had positive experiences working with CPS, day care centres, and other services. This was particularly the case in rural areas or small CFHCs where meetings were organized, and the collaborating partners were located close to the CFHC and knew each other. One PHN said:

> I think the collaboration works very well. I know it is not always easy to get ahold of people working in CPS. However, I know one person there that I…who I can depend on will call back. So, I often choose to call him if I am going to discuss something.
>
> (PHN 4)

5.2.4 | Difficult to detect

Several PHNs reported having rarely or never detected physical maltreatment at the CFHC; however, the majority of interviewed PHNs reported that they had detected children who were exposed to psychological or emotional maltreatment or neglect. They expressed despair and said it was frustrating to fail this assignment when statistics showed how many children are exposed to child maltreatment. One of the PHN said:

> I find it very frustrating. Because you like, you are really trying! […] But you look, and you search, and you ask. And you hope that the information you provide will help and prevent. But oh, it is extremely frustrating.
>
> (PHN 5)

Many PHNs believed that child maltreatment is a taboo topic in society, and that parents hide truth due to shame and fear of what will happen. Some PHNs had experiences of parents hiding injuries and cancelling appointments. One PHN who often asked direct questions about violence said:

> I think they're ashamed…the parents…to admit it. I think that…even if you ask. It's so taboo. I am sure they are so afraid. They believe that someone will take my baby or they will be sent away. Instead of thinking 'now I can get help, if I tell her, she will surely help me.'
>
> (PHN 5)

5.3 | A complex and demanding task

5.3.1 | Balancing support and suspicion

The PHNs stated that supporting parents to become good parents was one of their most important tasks. Many problematized the challenge of trying to build trust, as well as help and support parents and children while also talking about or suspecting violence. Many interviewees found this to be difficult and noted that it often created dilemmas. An experienced PHN said: 'You're supposed to be so cheerful and enthusiastic, and then suddenly…then you start asking about something they obviously find uncomfortable and difficult to talk about' (PHN 10).

Several PHNs were concerned about how the parents felt and did not want them to feel like suspects. A PHN explained how she presented the topic as part of the routine of the CFHC program. She started the conversation by saying:

'This is something we bring up with everybody… and that's because we know that violence… that children may be subjected to violence. It is something we talk about with everyone'. Then I believe that …they might not feel attacked by the questions. Because I don't want them to feel made into suspects. I am very concerned about wanting them to like and trust me, and to create a good relation between us. (PHN 2).

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PHNs wanted to discuss violence with parents while ensuring that the parents did not feel violated or distrusted. They acknowledged that it was their responsibility to bring this up. Many participants described how they had to approach the subject to make it acceptable to their parents. One PHN explained:

> I'll try to explain how I angle it in…because…one cannot just jump from … growth and food, and then straight away say something like: 'do you hit your child?' But maybe start talking about challenges the parents experience, depending on the child's age.
>
> (PHN 1)

5.3.2 | A solitary responsibility

All interviewed PHNs acknowledged their responsibility to address child maltreatment and showed strong commitment to children. They used terms like 'my children' and mentioned being dedicated to keeping them in mind at all times. Many of the PHNs who were interviewed were available for the families outside of the regular hours at the CFHC. Several PHNs said that they felt alone in assessing the cases, but also felt it was their responsibility to follow up. One PHN said:

> You are very much alone…I sometimes wish…'Oh, I just want someone else to take that family and assess the child'…but at the same time it feels strange to say something like: 'you know what, next time you come to the CFHC, you will meet one of my colleagues.'
>
> (PHN 9)

Another expressed relief when CPS and police were involved in the case. She said: "Because, in a way…when you get CPS in, and you know the police are in, right? Then you think (sighs): 'Finally! It's not just me anymore', right? Because most of the time, it is just you" (PHN 6).

Several PHNs emphasized the importance of supportive managers at their CFHC. Many commented that the CFHC manager wanted to co-sign a notice of concern before it was sent to CPS.

5.3.3 | Characterized by uncertainty

PHNs talked about uncertainty in relation to the work of child maltreatment prevention and detection. They felt unsure about how to address their concerns and what steps to take if abuse was confirmed.

I think you are afraid of the answer, or you don't know how to ask […] So, it is…very complex …but I believe it has to do with the uncertainty of what to do… and then, you do not want to offend anyone. (PHN 3).

Several PHNs explained that it is hard to tell if the signs they observe are from child maltreatment or other causes such as medical issues, which makes their work difficult.

PHNs expressed their uncertainty if and when they reported to CPS about what would happen, which also resulted in postponement in reporting families. Several talked about uncertainty about whether the family would be offered help from CPS and worried that their relationship with the parents could be destroyed. Many PHNs also questioned whether reporting could worsen the situation of the child. A PHN with a lot of experience reporting to CPS said:

> Sometimes you can get the feeling, after reporting to CPS…you start thinking and questioning, was this the right decision? Will this make it fuss more than good? Perhaps it was not as severe as it seemed. Maybe I am exaggerating? Things like that.
>
> (PHN 4)

5.3.4 | Requiring support, facilitation and sufficient time

The PHNs said their job was busy with many mandatory tasks and identifying child maltreatment led to extra work, sometimes over a long period of time. One PHN explained: 'It is very demanding for me, as a helper to get on that rollercoaster. It adds so much more work…for several weeks, months, or maybe years…in just one single case, you know' (PHN 3).

Many PHNs mentioned lack of time as a barrier to their work on child maltreatment. Several PHNs described work as being mentally stressful and demanding: 'Well, sometimes it's very stressful. It's eating you 24/7…about what to do next, what the child is experiencing right now, what will happen if CPS closes the case without offering any help and so on' (PHN 13).

Many PHNs wanted clear guidelines and tools to use when discussing child maltreatment and highlighted the importance of maintaining awareness among employees through workshops and discussions. Several PHNs underlined the importance of setting up appropriate office spaces and waiting areas where families' interactions can be observed. Many also emphasized the need for knowledge in the general assignment of preventing and detecting violence at CFHCs.

6 | DISCUSSION

This study aimed to explore the experiences of PHNs in CFHCs in preventing and detecting child maltreatment. The main findings were that the PHNs integrated knowledge to prevent child maltreatment as part of their everyday job, they strived hard to detect child maltreatment, and they found this task to be complex and demanding.

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All the participating PHNs reported that they integrated knowledge, such as establishing a secure relationship, mapping and assessing risk factors, and educating parents about child maltreatment, in order to prevent child maltreatment. They used their knowledge to customize and provide individualized follow-up. In their care, PHNs combined the developmental needs of children, the parental skills required to meet the child's needs, and the family and environmental conditions that influence both developmental needs and parental skills in their assessments. The way in which the PHNs described their work indicates that they use a child-centred and holistic approach to prevent child maltreatment; that is, they consider the child, family and environment. These findings are in line with the key principles of the Ottawa Charter for health promotion, which promotes tailor-made care for the 'whole person', states that social, environmental and cultural factors must be addressed, and emphasizes that close nurse–patient collaboration must be established in order to identify the latter's need (WHO, 1986).

There is scant research on the work of PHNs in Norwegian healthcare settings. However, our findings are similar to those described in a study regarding how PHNs in the nurse-family partnership (NFP) programme (which helps families learn and improve their parenting skills) describe their work (Jack et al., 2021). The NFP programme is specialized for high-risk families and is not provided for the whole population, in contrast to the work of PHNs in CFHCs in Norway.

Our findings indicate that PHNs distinguished between preventing and detecting child maltreatment. All of the participants found that detecting child maltreatment was more challenging and demanding than preventing it. Even though they tried to detect maltreatment each time they met a child by being aware of concerns, they rarely experienced anyone admitting that they had been exposed to violence or succeeded in uncovering obvious signs. They would try to gather more information when they sensed 'something was off' or had a 'gut feeling'. This is consistent with a recent study of healthcare providers in primary care in the Netherlands (Erisman et al., 2020). Erisman et al. (2020) describe how Dutch health professionals used their intuition (i.e. practitioners' sensations or gut feelings) in their practice to manage and navigate the complexity of differentiating between 'normal' and 'abnormal', especially in cases where evidence of child maltreatment was subtle or hard to prove.

The PHNs in this study requested better reciprocal cooperation with collaborating partners in their efforts to identify maltreated children. Visits at the CFHC are voluntary and based on appointments in an established programme, thus cancellations were common (Norwegian Directorate of Health, 2019). The PHNs argued that it would be useful to be informed about injuries and incidents that could confirm an already existing concern or gut feeling. However, few health personnel in hospitals had experience reaching out to the CFHC to discuss concerns or provide discharge reports when children were admitted. This is supported by a Norwegian study among paediatricians, who did not mention or discuss CFHCs as collaborating partners when children were admitted due to injury (Vollmer-Sandholm et al., 2021). This supports the PHNs' request for more multidisciplinary cooperation between services. This also suggests a gap in communication and collaboration between hospitals and PHNs when it comes to detecting and addressing child maltreatment. Improving this cooperation could help to identify and address cases of child maltreatment more effectively.

In general, all PHNs in this study highlighted that work against child maltreatment was demanding and created many dilemmas. They had to prioritize their time, felt alone in their work, and were burdened by their responsibility. This is consistent with several previous studies, where lack of time, the balance of risk and support and loneliness were highlighted (Adams et al., 2022; Dahlbo et al., 2017). Dahlbo et al. (2017) studied paediatric nurses and found that their work to prevent child maltreatment often led to feelings of powerlessness and thoughts about children that persisted even after working hours.

The PHNs in our study were burdened by the responsibilities of having to juggle between mandatory examinations and their need to explore concerns within a limited timetable. A recent report showed that the staff figures for CFHCs remained unchanged, although they had been given more mandatory tasks and greater responsibility in fighting child maltreatment in their revised guidelines (Lassemo & Melby, 2020). This underpins the PHNs' experiences of the complex and demanding work in the CFHCs in this study. Given the findings of our study and previous research, this highlights the emotional toll that this work can have on healthcare professionals and the importance of providing support and resources to help them cope with the emotional strain.

Further, the PHNs experienced insecurity when reporting maltreatment to CPS. They emphasized that they were uncertain about whether their assessments were serious enough and that they had concerns about what would happen to the child if they filed a report. Several PHNs also reported negative experiences reporting to CPS, such as CPS dismissing cases where the PHN had serious concerns, as well as instances where they did not receive any feedback when they reported a case, which led to more questions and insecurity.

Studies have shown that many healthcare professionals feel insecure and have negative experiences when reporting child maltreatment to CPS (Dahlbo et al., 2017; McTavish et al., 2017; Sigad et al., 2019). A meta-synthesis of mandatory reporters found that many of them were frustrated by a lack of feedback from CPS and had less trust in CPS (McTavish et al., 2017). Other studies found that healthcare professionals were uncertain about identifying child abuse, reporting it, and understanding the outcomes for the child and family (Cleek et al., 2019). Moreover, some research has highlighted that there is a lack of cooperation with other services that work to prevent child maltreatment (Lines et al., 2021). A recent Norwegian study also found that healthcare professionals had challenges collaborating with CPS, and they also complained of not being invited to meetings or not receiving any information about the actions taken by CPS (Vollmer-Sandholm et al., 2021).

However, in our study, there were a few PHNs who experienced good cooperation between hospitals and CPS. The common

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denominator for these PHNs was that they worked in smaller places or personally knew people who worked in the collaborating services. Having a contact person in partnering organizations is essential for effective collaboration among home-visit nurses in public health prevention programmes (Williams et al., 2022). Collaboration with other professions has been emphasized as important and beneficial for detecting vulnerable children and supporting families (Tung et al., 2019).

Our findings have important implications for practice. It can be argued that PHNs can provide considerable information about families to collaborating partners in regard to detecting and preventing child maltreatment. First, they met (nearly) all their families and children several times. Second, they have the privilege of meeting the families in their private homes, which gives them the opportunity to identify potential risks. Third, they hold expertise in children's development and are working within a structured programme that facilitates individual follow-up when needed.

The study's findings have important implications for supporting PHNs in their role of preventing child maltreatment. It is important to consider the availability of appropriate resources that can aid PHNs in effectively carrying out their responsibilities. Further research should be conducted to explore potential relationships between resource adequacy and PHNs' perceptions of preventing child maltreatment. Given the negative experiences with reporting that were discussed, the interface between PHNs and CPS agencies requires attention in terms of more research, organizational structure changes, such as enough time and the creation of clear guidelines and tools to use when discussing child maltreatment.

6.1 | Strengths and limitations

This study has several limitations. Our aim was to understand how PHNs experience their role in preventing child maltreatment in CFHCs; however, the results come from a small group of participants and their answers reflect the specific questions asked during the interviews. Although the participants had different levels of experience working in CFHCs, they were all experienced nurses. It is possible that different questions and more participants would have provided different perspectives. However, all PHNs that participated in the study volunteered to be interviewed and were open to their responses, which can be considered a strength of the study. Additionally, the researchers were from different fields and included experienced PHNs, which can be considered a strength of this study. The researchers were also aware of their prior knowledge and understanding of PHNs and tried to avoid bias through continuous discussion and reflection during the research process.

7 | CONCLUSION

In this study, we found that PHNs integrated knowledge to prevent child maltreatment as part of their everyday job. PHNs made a concerted effort to detect child maltreatment but found it to be a complex and demanding task. The PHNs reported that they used a holistic, child-centred approach to prevent child maltreatment, taking into account the child, family, and environment. The challenge faced by PHNs in balancing their time and responsibilities highlights the need for organizational structural modifications, including the allocation of adequate time and the establishment of clear guidelines and tools for addressing child maltreatment in healthcare settings. Additionally, the study found that PHNs requested better collaboration and communication with other healthcare providers to identify and address cases of child maltreatment more effectively. This study highlights the importance of addressing the communication and collaboration gaps between healthcare providers, as well as the need for more research in this field.

AUTHOR CONTRIBUTIONS

Study design: ADM, LH, LG-H, LV, ML; data-collection: ADM; data-analysis: ADM, LH, LG-H, LV, ML; and manuscript preparation: ADM, LH, LG-H, LV, ML.

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Data available on request from the authors.

ETHICS STATEMENT

The Norwegian Social Science Data Service (TISK) approved this study (Reg. No. 510861).

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REFERENCES

Adams, C., Hooker, L., & Taft, A. (2022). The characteristics of Australian Maternal and Child Health home visiting nurses undertaking family violence work: An interpretive description study. *Journal of Advanced Nursing*, *79*, 1314–1328. https://doi.org/10.1111/jan.15160

Anderzen-Carlsson, A., Gillå, C., Lind, M., Almqvist, K., Lindgren Fändriks, A., & Källström, Å. (2018). Child healthcare nurses' experiences of asking new mothers about intimate partner violence. *Journal of Clinical Nursing*, *27*(13–14), 2752–2762. https://doi.org/10.1111/jocn.14242

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.

Bunge, S. A., & Zelazo, P. D. (2006). A brain-based account of the development of rule use in childhood. *Current Directions in Psychological Science*, *15*(3), 118–121.

Cleek, E. A., Johnson, N. L., & Sheets, L. K. (2019). Interdisciplinary collaboration needed in obtaining high-quality medical information in child abuse investigations. *Child Abuse & Neglect*, *92*, 167–178.

Dahlbo, M., Jakobsson, L., & Lundqvist, P. (2017). Keeping the child in focus while supporting the family: Swedish child healthcare nurses experiences of encountering families where child maltreatment is present or suspected. *Journal of Child Health Care: For Professionals Working with Children in the Hospital and Community*, *21*(1), 103–111. https://doi.org/10.1177/1367493516686200

Dehaene-Lambertz, G., Montavont, A., Jobert, A., Allirol, L., Dubois, J., Hertz-Pannier, L., & Dehaene, S. (2010). Language or music, mother or Mozart? Structural and environmental influences on infants' language networks. *Brain and Language*, *114*(2), 53–65.

Engström, M., Hiltunen, J., Wallby, T., & Lucas, S. (2021). Child Health Nurses' experiences of addressing psychosocial risk factors with the families they meet. *Acta Paediatrica*, *110*(2), 574–583. https://doi.org/10.1111/apa.15492

Erisman, J. C., de Sabbata, K., Zuiderent-Jerak, T., & Syurina, E. V. (2020). Navigating complexity of child abuse through intuition and evidence-based guidelines: A mix-methods study among child and youth healthcare practitioners. *BMC Family Practice*, *21*(1), 157. https://doi.org/10.1186/s12875-020-01226-6

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet*, *373*(9657), 68–81. https://doi.org/10.1016/S0140-6736(08)61706-7

Graves, K., & Gay, Y. (2022). Examining interpersonal violence from a trauma–informed and human rights perspective. In *Handbook of interpersonal violence and abuse across the lifespan: A project of the national partnership to end interpersonal violence across the lifespan (NPEIV)*, pp. 81–95.

Hafstad, G. S., Sætren, S. S., Myhre, M. C., Bergerud-Wichstrøm, M., & Augusti, E.-M. (2020). Cohort profile: Norwegian youth study on child maltreatment (the UEVO study). *BMJ Open*, *10*(8), e038655. https://doi.org/10.1136/bmjopen-2020-038655

Irigaray, T. Q., Pacheco, J. B., Grassi-Oliveira, R., Fonseca, R. P., Leite, J. C., & Kristensen, C. H. (2013). Child maltreatment and later cognitive functioning: A systematic review. *Psicologia: Reflexão e Crítica*, *26*, 376–387.

Jack, S. M., Gonzalez, A., Marcellus, L., Tonmyr, L., Varcoe, C., van Borek, N., Sheehan, D., MacKinnon, K., Campbell, K., & Catherine, N. (2021). Public health nurses' professional practices to prevent, recognize, and respond to suspected child maltreatment in home visiting: An interpretive descriptive study. *Global Qualitative Nursing Research*, *8*, 2333393621993450.

KRIPOS [The National Criminal Investigation Service]. (2019). *Alvorlig vold mot små barn (1). Politiet* [Serious violence against young children (1). The police]. https://www.politiet.no/globalassets/04-aktuelt-tall-og-fakta/vold-mot-barn/alvorlig-vold-mot-barn.pdf

Lassemo, E., & Melby, L. (2020). *Helsesykepleiere i helsestasjons-og skolehelsetjenesten [Public health nurses in the child and youth health centres and school health service]*. SINTEF AS (ISBN 978-82-14-06425-4).

Lines, L. E., Hutton, A., & Grant, J. M. (2021). Constructing a compelling case: Nurses' experiences of communicating abuse and neglect. *Child Abuse Review*, *30*(4), 332–346. https://doi.org/10.1002/car.2697

Malterud, K., Siersma, V., & Guassora, A. D. (2021). Information power: Sample content and size in qualitative studies. In P. M. Camic (Ed.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 67–81). American Psychological Association. https://doi.org/10.1037/0000252-004

Mathews, B. (2015). Mandatory reporting laws: Their origin, nature, and development over time. In *Mandatory reporting laws and the identification of severe child abuse and neglect* (pp. 3–25). Springer Netherlands. https://doi.org/10.1007/978-94-017-9685-9_1

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*(10), e013942. https://doi.org/10.1136/bmjopen-2016-013942

Mikton, C., & Butchart, A. (2009). Child maltreatment prevention: A systematic review of reviews. *Bulletin of the World Health Organization*, *87*(5), 353–361. https://doi.org/10.2471/BLT.08.057075

Naughton, A., Nurmatov, U., Hoytema van Konijnenburg, E., Watkins, W. J., Otterman, G., Nelson, J., & Kemp, A. (2018). Variability in child protection medical evaluations of suspected physical abuse in four European countries: A vignette study. *Child Abuse Review (Chichester, England)*, *27*(5), 404–418. https://doi.org/10.1002/car.2515

Norwegian Directorate of Health. (2019). *Nasjonal faglig retningslinje for helsestasjons-og skolehelsetjenesten* [National guideline for health promotion and preventive work in the child and youth health centres and school health service]. https://www.helsedirektoratet.no/retningslinjer/helsestasjons-og-skolehelsetjenesten/helsestasjon-05-ar

NOU. (2017). *Svikt og svik. Gjennomgang av saker hvor barn har vært utsatt for vold, seksuelle overgrep og omsorgssvikt* [Failure and betrayal. Review of cases where children have been exposed to violence, sexual abuse and neglect] *Barne og Familiedepartementet*. https://www.regjeringen.no/no/dokumenter/nou-2017-12/id2558211/

Segal, L., Armfield, J. M., Gnanamanickam, E. S., Preen, D. B., Brown, D. S., Doidge, J., & Nguyen, H. (2021). Child maltreatment and mortality in young adults. *Pediatrics*, *147*(1), e2020023416. https://doi.org/10.1542/peds.2020-023416

Sigad, L. I., Beker, G., Lev-Wiesel, R., & Eisikovits, Z. (2019). "Alone with our interpretations": Uncertainty in child abuse intervention among healthcare professionals. *Children and Youth Services Review*, *100*, 206–213.

Tung, G. J., Williams, V. N., Ayele, R., Shimasaki, S., & Olds, D. (2019). Characteristics of effective collaboration: A study of Nurse-Family Partnership and child welfare. *Child Abuse and Neglect*, *95*, 104028. https://doi.org/10.1016/j.chiabu.2019.104028

U.S. Department of Health and Human Services, Administration for Children and Families, Adminsitration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment. 2020. Retrieved from https://www.acf.hhs.gov/cb/data-research/child-maltreatment

Vollmer-Sandholm, M. J., Myhre, A. K., Otterman, G., Lydersen, S., & Stray-Pedersen, A. (2021). Amongst Norwegian paediatricians there is little agreement in management of cases of suspected child

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maltreatment. *Acta Paediatrica*, *110*(10), 2865–2872. https://doi.org/10.1111/apa.16017

Williams, V. N., McManus, B. M., Brooks-Russell, A., Yost, E., Allison, M. A., Olds, D. L., & Tung, G. J. (2022). A qualitative study of effective collaboration among nurse home visitors, healthcare providers and community support services in the United States. *Health and Social Care in the Community*, *30*(5), 1881–1893. https://doi.org/10.1111/hsc.13567

Wilson, I. A., & Lee, J. (2021). Barriers and facilitators associated with child abuse and neglect reporting among child care professionals: A systematic review. *Journal of Psychosocial Nursing and Mental Health Services*, *59*(6), 14–22. https://doi.org/10.3928/02793695-20210324-01

World Health Organization. (1986). *Ottawa charter for health promotion* (Vol. *0957–4824*). Oxford University Press.

World Health Organization. (2014). *World Health Organization: Investing in children: The European child and adolescent health strategy 2015–2020*. World Health Organization https://apps.who.int/iris/handle/10665/337284

World Health Organization. (2015). *World Health Organization: Investing in children: The European child maltreatment prevention action plan 2015–2020*. World Health Organization https://apps.who.int/iris/handle/10665/350142

World Health Organization. (2020). *Child maltreatment*. https://www.who.int/news-room/fact-sheets/detail/child-maltreatment. World Health Organization.

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