Dancing around the families: A grounded theory of the role of neonatal nurses in child protection

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Abstract

The Ministry of Health objectives aim to protect the health and safety of children by reducing death rates, injury and disability from abuse. Family Violence is a significant health issue that impacts on children. Health professionals are key in the screening for Family Violence and assessment for child abuse. The philosophies of Family Centered Care and Developmental Care underpinning neonatal nursing practice are especially relevant for child protection. Nurses are in an ideal position to intervene before abuse perpetration. Increased awareness of child maltreatment and requirements for screening and reporting led to my research question, "What is happening for Neonatal Nurses in Child Protection?" Glaserian Grounded theory guided this study and the analysis of data. A total of ten semi-structured interviews was undertaken with nurses working in the participating neonatal units. Data were analysed and constructed into a substantive grounded theory, *Dancing Around the Families* and a Basic Social Psychological Process of *Knowing at Risk Families. Dancing Around the Families* explains nurses' coping and acting upon child protection issues. It is about the creative conversations and work required to help support or enhance the infant's safety. Difficulty with communication and transparency of information sharing between services, and differing perspectives creates this dance. *Knowing at Risk Families* captures how neonatal nurses construct child protection by acting on their personal and professional levels of knowledge. Nurses act on gut instincts, intuition or *Red Flags* to put supports in place for the protection of the infant. Child protection presents a state of conflict for nurses, where a sense of social justice prevails in their care, and their ideals and reality are often not congruent. Implications for practice require nurses to consider the way we look at families, as well as family capacities, capabilities and health literacy, and the importance of facilitating attachment.

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Chapter One

Introduction

The high level of child maltreatment of infants under one year of age (UNICEF, 2003) highlights the need to establish neonatal nurses' understanding of child abuse and neglect, and their contribution to child protection practices. The New Zealand (NZ) child abuse figures are overwhelming and provide a catalyst to a refocus on the protection of our children. New Zealand is among the top four countries in the world for the highest rates of child abuse for infants less than one year of age (UNICEF, 2003) and is currently ranked second lowest for rates of health and safety for children in the OECD and fourth highest for infant mortality (UNICEF, 2007). High profile media attention has increased society's awareness of this phenomenon. The targets for the abuse and violence are vulnerable children. Those beginning life vulnerable are the pre-term infant population. These infants are at risk of co-morbidities and attachment problems that increase stressors for families, and are thereby at increased risk of child maltreatment.

As a nurse I have been interested in the fundamentals of abuse perpetration and how innocent children could be harmed. Neonatal nursing presents complexities arising from social issues when trying to construct child protection. Challenges encompass the infant's prenatal history, the in-utero environment and the potential risk upon discharge to the home environment. The identification of children at-risk of child maltreatment but not yet harmed poses a different challenge from the identification of child abuse. This led me to ponder the different outcomes for each infant depending on their neonatal journey and home environment. I became part of the child protection and screening family violence training committee within my District Health Board (DHB), a family violence leader and trainer for our service. Awareness of these initiatives and directives from the Ministry of Health made me question the impact on neonatal nurses, and therefore how they perceived their role in child protection and how this was evident in their practice.

This chapter provides a background to this thesis and an introduction to the research. This research undertaken presents a grounded theory explaining what neonatal nurses working with premature or unwell newborn infants understand, know and believe about child maltreatment and protection issues, including how they perceive their role in child abuse

prevention and its relevance to their nursing practice. A background to this study and an overview of the research methodology is provided, followed by an outline of each chapter.

This study makes a contribution to the body of literature on child protection by providing insight into the child protection practices and issues in the neonatal nursing setting. It is also aligned to the government and Ministry of Health (MOH) objectives to improve and protect the health of children by reducing death rates, injury and disability from child abuse and the recent recognition of the significance of screening for family violence (Ministry of Health, 2002).

Operational Definitions

For the purpose of this study, the following terms used in this thesis are defined.

Child Maltreatment

Child maltreatment is the physical and or emotional harming, ill-treatment, abuse, neglect or deprivation of any child or young person, resulting in actual or potential harm to the child's health, survival, dignity or development within the context of a relationship of trust, power and responsibility (Ministry of Health, 2002).

Sexual abuse is also recognised as a form of child maltreatment. For the purpose of this study sexual abuse has been excluded, as literature indicates a higher incidence and relevance of physical and emotional harm, and neglect, shaken baby syndrome and the significant impact of family violence for the study phenomena.

Child Physical Abuse

Physical abuse is any act or acts resulting in an injury to a child or young person. This includes the deliberate use of physical force against a child resulting in, or increasing, the likelihood of harm for a child (Ministry of Health, 2002).

Child Emotional/Psychological Abuse

Emotional or psychological abuse is the persistent failure of a parent or caregiver to provide a developmentally appropriate and supportive environment over time. It includes any act or omission resulting in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person (Ministry of Health, 2002).

Child Neglect

Child neglect comprises any act or omission resulting in impaired physical functioning, injury and/or development of a child or young person. It may include physical, supervision and medical neglect, abandonment, or the refusal to assume parental responsibility (Ministry of Health, 2002).

Family Violence

Family violence involves a broad range of controlling behaviours including violence or abuse of any type (such as emotional, physical, verbal, sexual, or financial abuse) which is perpetrated by one family member against another family member. It includes child abuse, partner abuse and elder abuse, and generally incorporates aspects of fear, intimidation and emotional deprivation (Ministry of Social Development (MSD), 2002). It frequently involves a pattern of coercive or manipulative behaviours perpetrated by one intimate partner against another, or to maintain control, in the relationship (Carpenter & Stacks, 2009)

Routine screening

Effective identification of partner abuse requires asking everyone. Without self-disclosure or recognisable signs and symptoms indicative of abuse, routine screening of partner abuse is recommended. Best practice guidelines suggest all females 16 years of age and older should be screened routinely, using validated tools. The screening process includes identification, provision of emotional support, assessment of risk, referral and safety planning and comprehensive objective documentation. Best practice guidelines also support screening of any females aged between 12 and 15 years and males older than 16 years who present with signs and symptoms (Ministry of Health, 2002). The relationship of family violence and child maltreatment is further discussed, along with the affects of living amidst Family Violence in Chapter two.

Child Abuse and Neglect in New Zealand

New Zealand ranks among the top four countries in the OECD per head of population for the highest rates of child abuse, with infants aged less than one year at increased risk of death from physical abuse and neglect (UNICEF, 2003). The younger the age of the infant or child the more dependent they are on adults for care and protection and they are therefore considered the most vulnerable age group compared to children aged 1-4 years and those over five years (Duncanson, 2006). Statistically, infants are at three times greater risk than children aged one to four years, who are at double the risk of children aged five to fifteen years. Children

identified as Maori are also over-represented in the mortality and maltreatment figures (MSD, 2006). From 1999 to 2004, the rate of hospital admissions for children aged less than one year was four times higher than children in the one to four year old age group for intentional injury (MSD, 2006).

Actual rates of child abuse and neglect have been reported as continuing to rise, evident by increasing notifications to Child Youth and Family Service and subsequent increases in substantiated abuse cases (Cutler-Naroba, 2006). Although, when interpreting statistics, factors skewing results should be considered. For example, New Zealand's relatively small population compared to other OECD countries causes some cultures to be overrepresented in the data, as small changes in absolute numbers substantially alter the rates (MSD, 2006).

Infants are vulnerable to maltreatment due to their inability to verbalise or escape, their dependence on caregivers contributing to the stressors parents face in the care of their infant (Doolan, 2004; MSD, 2006). Maltreatment often occurs within the context of poverty, psychological stress and limited support, at an individual, family, community and societal level (UNICEF, 2003). Health care provider responses have been activated by policy guidelines and initiatives from the government.

The New Zealand Child Health Strategy prioritises the needs of children in health promotion, prevention, early intervention and coordination of services (English, 1998). Newborn infants are identified as a critical sector in health care provision, as this period has been highlighted as an opportunistic time for health promotion to maximise opportunities for the best possible start in life. Risk factors can also be identified during this period, allowing for education and necessary support to be put in place. Therefore a coordinated response is required for high-risk infants, which aims to target resources, build capacity in families, coordinate agencies, and monitor and respond to infants at risk. Services include Family Start, Strengthening Families, Well Child/Tamariki Ora, as well as child protection services and links with Maori providers for whānau well-being (MSD, 2006). There are many other community agencies providing specific support to families in need.

The New Zealand Health Strategy (King, 2000) articulated priority objectives to reduce inequalities through set goals with defined outcomes. Specific goals include healthy communities, families and individuals requiring steps to reduce the impact of interpersonal violence within families and child abuse. Other goals identified include a healthy lifestyle and better mental health for individuals, which influence health promotion and protection for

families and children. To support the objectives, development of protocols and training to recognise and respond to health priority goals including family violence and abuse, and also public health campaigns to raise awareness, have been implemented in both health care services and society.

To address issues of family violence the Domestic Violence Act was introduced in 1995. Since then there has been a global recognition of the need for collective action. The need for an intersectional approach was identified at the government level to provide leadership and enact changes. The Te Rito Family Violence Prevention Strategy was established in 2002 to achieve family violence reduction and to have families living free from violence. In 2002 the Family Violence Intervention Guidelines signified family violence was a health care issue and provided the impetus for DHBs to introduce screening in order to reduce interpersonal violence, a goal of the NZ Health Strategy (King, 2000). In 2005, both the Ministerial team and the Taskforce for Action were established in recognition of the need to support collaborative action and leadership.

District Health Boards, in response to the New Zealand Health Strategy, are also implementing family violence policies and screening practices (Fanslow, 2006; Fanslow & Robinson, 2004; Ministry of Health, 2000). Implementation of screening for family violence is imperative in the campaign against child abuse as it is now recognized that family violence is detrimental to children, with subsequent significant health risks. Nurses are in an ideal position for witnessing family dynamics, interactions, behaviour and communication.

Family Violence and Child Maltreatment

Child maltreatment co-occurs with family violence which impacts on children, directly or indirectly. Nationally, child maltreatment figures have increased in 2008; there were 72,482 police recorded incidences of family violence where 74,785 children under the age of 17 years were recorded as being involved and a total of 23 murders specifically related to Family Violence incidents (New Zealand Police Statistics, 2007/2008).   Furthermore, a significant proportion of family violence goes unreported or unrecognised (McKie, 2005; Snively, 1994).

Since the Domestic Violence Act was implemented, Robertson et al.'s (2007) study highlighted from 1995 to 2007 there were 212 deaths of women and children from homicide related to domestic violence. Of these deaths, 31 were children aged less than one year, and

34 were children aged between one and five years, together accounting for 30% of the total. This equates to an average of five deaths a year for children aged less than five years. Although death is the most measurable and significant outcome of child maltreatment, for every infant dying as a result of maltreatment there are many more who have been subjected to abuse and suffer subsequent morbidities, and more not identified or accounted for.   These statistics heighten the need for the priority on family violence prevention and awareness. Child maltreatment prevention and protection, however, should not be clouded as a family violence issue alone, as infants can be at risk of maltreatment due to other risk factors, where family violence is not disclosed or occurring. Child abuse prevention should therefore be considered as a separate entity from family violence as well as a significant consideration in family violence screening practices (Cutler-Naroba, 2006),

Rights of the Child

All children have the right to grow up in a safe environment that allows them the opportunities for optimal growth and development. Ideally, this should be an overriding aim and goal for all children. Children need the right to a safe environment to maintain this aim and for the protection of their safety. The provision of rights allows people to help advocate for children's safety and needs, especially when they are defenceless, vulnerable and or unable to speak out, particularly as most child abuse is perpetrated within the context of the family.

Children in New Zealand who are maltreated have had their rights violated. The United Nations Convention on the Rights of the Child provides guiding principles that fundamentally shape the way in which children should be viewed. It sets out the necessary environment to enable a child to survive and to reach its maximum developmental capabilities, and includes the right to be protected from abuse and neglect (United Nations, 1989). Countries and individuals adhering to this convention advocate for the child's right to life, optimum survival and development (Reading et al., 2009). This convention is also upheld by neonatal nurses working and advocating for the protection of children's rights.

The repeal of section 59 of the Crimes Act 2007, commonly referred to as the 'anti-smacking' legislation, aimed to remove discrimination against children, and encourage a safe and secure family environment free from all forms of violence (Kiro, 2008). It aimed to do this by removing the parental defence of "reasonable force" for the purpose of disciplinary correction. The attitudes of the New Zealand public toward children's rights became apparent

in 2005 with the 'anti-smacking' legislation. Many opposed to passing this Bill claimed it was an affront to democracy and parental rights, which mobilised the country into action and debate. This 'anti-smacking legislation' became topical, polarising individuals (Schluter, Sundborn, Abbort, & Paterson, 2007).

Parental rights regarding their child are not exclusive and exist only until they breech the best interests of the child. The repeal of Section 59 gives children the same status in law that adults have with regard to assault (Kiro, 2008). One of the primary objectives was to improve attitudes, with the ultimate aim being a reduction in violence against children. Changing adult attitudes toward physical discipline can contribute to decreasing the violence towards children, as much of this violence is perpetrated under the guise of discipline (Children's Commissioner, 2008). Care and protection agencies are charged with upholding children's rights to protection and to be free from harm. The irony or contradiction is that often the rights of the child are required to be implemented by their caregivers.

Implications of Child Maltreatment and Neglect

Maltreatment often occurs within relationships which are meant to be beneficial to the child, but instead are a cause of harm (Hilyard & Wolfe, 2002). Maltreatment, neglect and living amidst family violence have a significant impact on infant/child development (Anda et al., 2006). Further to this, infant vulnerability is increased by multiple risk factors including poverty, substance abuse and parent psychopathology (Hilyard & Wolfe, 2002). The implications of child maltreatment on development from in-utero and beyond will be discussed in greater detail in Chapter Two.

Practice Implications and Relevance to Neonatal Nurses

Family Centred Care and Developmental Care philosophies in the newborn unit underpin neonatal nursing practice and are especially relevant when examining child protection. Promotion of these philosophies by nurses aims to empower families, enhance attachment and optimise the infant's ability to reach their neurodevelopment potential. These philosophies of care are individualised to match the needs of each infant and family. By individualising the care for each family, nursing actions can have a positive influence on newborn infant health. Nurses can facilitate the quality of the maternal-infant relationship and help improve growth and development. They do this by carefully avoiding judgments and

biases that may negatively affect the maternal-infant relationship and by promoting collaboration with the family unit to enhance caregiver activities.

In addition to including the family and enhancing caregiver activities, developmental care aims to integrate the infant's developmental needs within the context of medical care. This recognises premature infants are at risk of neurodevelopment problems as a result of maturation of the infant's brain and systems outside the womb, which is now exposed to environmental stressors. This framework encompasses all care procedures as well as the social and physical aspects in the neonatal units. The goal is to support each individual infant to be as stable, well organised and competent as possible, and to recognise the importance of parental inclusion (Koch, 1999).

The infant's physiological and behavioural expression of current functioning is seen as a reliable guide to measure its strengths, vulnerabilities, and threshold for disorganization. This also aids identifying care practices to enhance an infant's stability and competence. Nurses' responsibilities involve maximising opportunities to enhance infant and caregiver strengths to reduce apparent stressors, and to aid in a confident discharge from the neonatal unit. Evidence supports the importance of infant-parent relationships to promote positive outcomes. Nurses who work with families are in an ideal situation to engage with individuals, and to witness family interactions (Records, 2007). They are also ideally positioned for early intervention practices, such as the identification of risk.

In Chapter Two, literature identifies risk factors for infants and children, including premature infants, for child maltreatment and neglect, although there is currently little evidence about neonatal nurses' role in child protection. Increasing evidence of the detrimental effects for children living amid family violence means child abuse is relevant to the neonatal arena and there is a need for increased focus and attention to be given to family violence issues. With increased awareness of the co-occurrence of family violence and child abuse, nurses can play a vital role in the early identification of child abuse risk factors and the prevention of potential child abuse.

Statistics for notifications of infant and child abuse to child protection services, hospital admissions and mortality data strengthen the need and importance for prevention of maltreatment through the early identification of risk factors and intervention before abuse occurs. Children less than one year are more likely to be killed by a parent (Doolan, 2004),

which supports the need to address child protection issues in the neonatal unit, particularly due to the increased stress families often report in the first year of their infant's life.

Premature infants can be born as early as 24 weeks, weighing as little as five hundred grams, which places them at risk for ongoing difficulties and challenges. While some pre-term infants do well throughout their neonatal course, many have ongoing developmental and medical problems post-discharge from a neonatal unit. They can display lower intellect, have learning difficulties, cognitive impairments, and speech and language delays. They are also at risk of vision and hearing impairments, cerebral palsy and multiple disabilities and behavioural problems. They may also display unsettled behaviours, and generally have higher needs than the normal term infant (Louch, 1999).

Psychosocial concerns include family disruption and increased financial stress for families, common with the separation from their infant at birth. This leads to increased stressors for the family, exacerbating an already unstable or unpredictable situation and placing the infant at greater risk of child abuse or neglect. Given this, an important aspect of the work for neonatal nurses is concerned with optimising outcomes to enhance child development, and promotion of parent interaction.   Nurses are also advocates for child rights and needs. The philosophies of practice, as well as participation in risk identification practices, can enhance infant opportunities.

Research Question and Study Aim

The research question was: "What is happening for neonatal nurses and child protection". Therefore, this study aimed to determine neonatal nurses' role in child protection. The following areas were explored with neonatal nurses to uncover their role in child protection:

- Their understanding, knowledge and experience of child abuse, pertaining to their practice.

- Their beliefs around child abuse and pre-term infants.

- How their attitudes influence their child protection activities.

- How nurses perceive their role in child abuse prevention

- How they perceive the relevance of child protection and child abuse prevention to neonatal nursing practice.

A qualitative research design was adopted, using Glaserian Grounded Theory to produce a substantive grounded theory inductively derived from the data. The underlying basic social psychological process neonatal nurses use to resolve child protection issues was discovered and enabled a theoretical explanation of their role in child protection to identify what is happening. Participants were recruited using purposeful and theoretical sampling, and data collected utilising face-to-face semi-structured audio-recorded interviews that were transcribed and coded.

Chapter Overviews

Chapter Two provides a justification for this study, and reviews and critiques the literature on aspects of child abuse and protection relevant to this study, including aspects of societal norms and values, and family violence.

In Chapter Three, the research design is explained. The grounded theory approach used in this study is discussed, along with its methodological underpinnings. The research methods used, including participant selection, data collection and analysis are also outlined. The process of ethics approval, consent and the establishment of rigour is also provided in this chapter.

The substantive grounded, *Dancing Around the Families,* is presented in Chapter Four. The Basic Social Psychological Process (BSPP) of *Knowing at Risk Families* is explained, along with the core concepts of *Belonging to Us*; *Belonging to the Family* and *Shaping the Infants Safety*.

Chapter Five discusses the implications of the grounded theory generated for nurses' practice. Further literature is used to support findings, including implications for Family Centred Care, attachment and building on family capabilities.

The thesis concludes with Chapter Six, which summarises and presents the key areas of the research. Recommendations for practice and further research are also made. In this chapter, the study has been outlined, including the research aims and method. Aspects and

significance of this research have also been introduced. Operational definitions are provided for the content referred to in this study. My personal interest and drive for the research was also acknowledged. The following chapter will provide a critique of the relevant literature to provide a justification of this study.

Chapter Two:

Justification for the Research

The risk of death from maltreatment is approximately three times higher for those less than one year of age compared to children aged between one and four years, who have double the risk of children age five to fifteen years. This illustrates the importance of child protection practices and interventions to begin at birth. Research and literature into child maltreatment and protection is extensive. Child maltreatment inflicts a significant toll on society. If not fatal it causes immense childhood suffering and leads to potential health problems and an inability to achieve full emotional or cognitive potential in adulthood (Krug, Mercy, Dahlberg, & Zwi, 2002). There is also potential for the cycle of violence to be perpetuated. Reducing rates of child death and morbidity from abuse is a priority for many countries. Chapter One provided an introduction to this research, while this chapter further critiques relevant literature pertaining to child maltreatment and protection issues, and outlines their relevance to neonatal nursing and the justification for this study.

Search Strategy

Although there is extensive literature on child maltreatment and protection, there is limited research specifically related to pre-term infants and neonatal nurses' contribution to child protection. The main databases and search engines used to search for literature included Medline, CINAHL, PsychINFO and Google Scholar. The following key search words were used to identify literature: child abuse, child maltreatment, child protection, neglect, effects of abuse, family violence, nurses, neonatal nurses, pre-term, infant, neonate, neonatal unit, and attachment. Textbooks were sourced and used where appropriate and useful websites included the Ministry of Health, Ministry of Social Development and Child Youth and Family. The inclusion criterion was literature focused on child maltreatment issues, which ideally focused on the neonatal area dealing with pre-term infants and extended to paediatric child protection nurses. Sexual abuse was specifically excluded from the study.

Societal Norms and Values

Reflecting societal values of the times over the last one and a half centuries, the definition and meaning of childhood has changed as have the recognition and definitions of child abuse and neglect (Corby, 2006). Historically, little attention has been given to the extent New Zealand children have been exposed to physical punishment in the forms of correction or control (Woodward, Fergusson, Chesney, & Horwood, 2007). Woodward et al. (2007) affirmed injury was likely to occur, regardless of the intent of using physical punishment and that smacking is widely employed as a form of discipline. In New Zealand this allows parents to use physical force to discipline their children. Physical chastisement by parents can be conceptualised as light smacks through to frequent harsh physical beating (Reading et al., 2009).

Physical punishment in the form of smacking is widely accepted as an appropriate form of punishment in New Zealand but can be frequent and severe enough to qualify as abuse. A study by Dobbs (2007) surveyed 80 New Zealand children aged between five and 14 years on their views of family discipline and found incidences of frequent severe physical punishment, which using any threshold, constituted child abuse. Discrepancies also exist between child and parental views on the use of physical discipline as an effective parenting tool (Dobbs). Public views on parental rights and beliefs that children are their property raise the threshold and tolerance for child maltreatment, and subsequently normalises what is considered abuse of children (MSD, 2008). Believing children need correction instead of guidance and protection justifies physical punishment as a method for correction (Debski cited in MSD, 2008).

For Māori, however, there are additional factors that have resulted in the change from a people who valued highly women and children to being over-represented in the family violence and child abuse statistics (Pihama, Jenkins & Middleton, 2003). Contributing factors include changes in Maori family and social structure, loss of land, language and cultural practices, the assimilation of the colonial cultural practices as a consequence of colonisation, and the socioeconomic deprivation and inequalities they experience (Kruger et al., 2004; Pihama et al., 2003). This will be explored in more depth later in this chapter.

World Policy Recommendations

The United Nations Convention on the Rights of the Child (UNCRC, 1989) was vitally important in recognising the position of children and in establishing recommendations for countries to act to safeguard all children. It outlines children's entitlement to be respected as

human beings, to be cared for and protected, afforded optimal development opportunities and to be considered in policy and programme development. Additionally, it outlines the way we should view children. Article 6, of The Rights of the Child, argues every child has a right to life, and governments need to ensure their survival and healthy development. Therefore governments should develop and provide services that safeguard children from harm. Article 3 stresses the primary importance of the best interests of the child, and when parents are unable to meet their children's needs, concludes the State must intervene.

Undoubtedly, children's rights can strengthen child protection practices (Reading et al., 2009), especially when focused on assessment and identification of abuse, and appropriate intervention. Irrespective of prevailing societal attitudes, child abuse is a violation of these rights. Furthermore, health inequalities and risk factors associated with child maltreatment are also a violation of children's rights to protection (Reading et al., 2009).

Current Political and Legal Influences in New Zealand

The Children, Young Persons and Family Act 1989 reflected the UNCRCs philosophy, and legally secured the safety of the child as paramount in New Zealand. This law provides the framework for civil protection of children and young people and allows children to be placed in secure placements when their parents are unable to provide for their needs, are causing harm, or where there is likelihood of significant harm. Parents who harm or kill their children are prosecuted under criminal law. Nevertheless, until 2007, section 59(1) of the Crimes Act 1961 legally provided parents with a defense for the use of 'force' when disciplining their children. It stated:

> Every parent of a child and … every person in the place of the parent of a child is justified in using force by way of correction towards the child if the force used is reasonable in the circumstances.

The repeal of section 59 of the Crimes Act 1961 prevented parents from using physical force such as smacking as a disciplinary measure. This was in line with the UNCRCs assertion that any physical action against children, under the guise of reasonable punishment or parental institutional authority, should not be allowed (Reading et al., 2009). However, many countries continue to allow physical chastisement as reasonable punishment. Notably, New Zealand citizens were divided in their opinions about the repeal of section 59 and it was generally unpopular with the majority of the New Zealand public, because it challenged societal norms, cultures and values.

Many parents were concerned they would risk facing prosecution for smacking their child and the removal of the parental defense of reasonable force was an affront to their democratic rights (Hassall, 2007). However, Woodward et al. (2007) argued the repeal would help to combat New Zealand's high incidence of child maltreatment and change individuals' mindsets about physical discipline. This is particularly important with a high incidence of abuse for children aged less than 1 year, and less than 5 years (Woodward et al., 2007). Debate continued on smacking and a referendum held in 2009, found many individuals still believed it was all right to smack children as a form of discipline (Wood, 2009).

As recently as October 2010, The Children's Commissioner implied there has been little collective will to address child protection issues in New Zealand and the public has deferred responsibility for action to the Child Youth and Family Services – the statutory agency for the care and protection of children. The Commissioner called for "... behaviour to change at parent, family and neighbourhood and community levels. We need change in our institutional arrangements including government services and we need changes at a society level about norms and expectations" (Angus, 2010, p. 7). Angus believed an ecological systems approach is needed to prevent child abuse and neglect, using a public health model and involving communities – a problem for all adults.

Prevalence of Child Abuse and Neglect

The average annual rates for child deaths by maltreatment in New Zealand from 1993 to 2003 for children less than one year are 4.6 deaths per 100,000. It was also identified that 30% of children who died were less than one year old, while 63% were under five years of age. These statistics are also in keeping with international studies (MSD, 2006).

Connolly, Wells and Field's (2007) study between July 2005 and June 2006 on notifications to Child Youth and Family found 6699 notifications were made to this service. Out of these notifications 74% required further action, 50% were infants less than one year of age, and 46% were aged between one and two years when first notified; only 7% required care placement. As part of this retrospective study Connolly et al. broadly reviewed 171 case files from the study sample. At the first identification initiated at age six months, 49% were Maori while 33% were New Zealand European. Neglect was the largest category of maltreatment and early identification, as particularly pre and post delivery of an infant, concerns centred on the mother (Connolly et al., 2007).

Maori children are over-represented in child abuse statistics and are reported to die from maltreatment at an average annual rate of 1.5 per 100,000 compared to 0.7 per 100,000 for NZ European children. Hospital admissions for Maori children with intentional injuries under five years of age between 1994 and 2004 were consistently twice the rate for children of other ethnic groups (MSD, 2006). When comparing Maori and non-Maori children the underlying differences in histories, socioeconomic status and risk factors for child abuse need to be recognised. International statistics also need to be viewed carefully as countries differ in their reporting systems. They also differ in how they define and categorise abuse and there is the potential to under-report child maltreatment.

Social Predictors of Child Maltreatment

Child maltreatment statistics are useful to highlight the severity of social situations and identify need but it is important to consider the circumstances leading to abuse in order to change practices and reduce the rate of abuse. Accumulation of risk factors increases the risk of abuse for children. Risk factors may be separated into those associated with social circumstance, or with the parent or child.

Social variables include poverty, unemployment, overcrowding, poor quality housing, lack of community connection (for example, difficulty accessing shops, transport, social groups and support, social isolation), and discriminatory environments. (Hunter, Kilstom, Kraybill, & Loda, 1978; Reder & Duncan, 1999.; Reder, Duncan, & Gray, 1993; UNICEF, 2003) Of these factors, poverty and isolation are most associated with abuse and neglect (UNICEF, 2003). Poverty is also associated with low birth weight infants (mothers are more likely to be less well nourished and to smoke), and they are at increased risk of entering a neonatal unit at birth (Neggers, Goldenberg, Clivers & Hauth, 2006; Rosen, Seng, Tolman, & Mallinger, 2007).

Parent Predictors of Child Maltreatment

Dale, Green and Fellows, (2005) collated material from Child Death Review Teams in Australia, USA, and from statutory inquiries and reviews in England and Wales, examined infants' risk (babies under one year of age). Family structure was important and the first baby or the youngest baby was more likely to be seriously or fatally abused. Step-parents were not associated with serious physical abuse to infants – but they were more likely to abuse older

children in the family. Parental age was not an indicator for harming infants, although younger parents are more likely to harm older children. Low educational attainment, low stress threshold or parents who had previously been abused themselves, all presented as risk factors for the perpetration of abuse. Dale et al. also found the level of risk was related to an individual's history, as violence, poor compliance with treatment, substance abuse, recent stress or unstable lifestyles were all indicators of the potential for abuse. However, the most significant risk is from parents who present with mental health concerns. Dale et al. defined mental health concerns broadly, and included post-natal depression, mood disorders, organic neurological disturbances, cognitive disorders, intellectual impairment, anxiety and psychotic disorders, substance dependence, personality and impulse-control disorders.

Falkov (1996) found 32% of 100 child deaths in England and Wales had at least one parent with mental illness and 75% of these were mothers. 40% of them had previous contact with psychiatric services in the month before the children were killed. Killings included use of asphyxia, poisoning, drowning and implements.

Mothers with maternal depression are often less responsive or interactive, and withdrawn, but can be hostile and intrusive with their infants. They may also exhibit despair and possess less knowledge of developmental norms (Hummel, 2003). Therefore, observation and assessment of a mother's mental health state should be considered where there are signs of alteration. Depressed mothers are commonly poorly attuned to their infants, and therefore are likely to be less affirming and they therefore neglect addressing their infant's needs (Veddovi, Gibson, Kenny, Bowen & Starte, 2004).

Parents are faced with a mixture of responsibilities and demands, including a demanding dependent infant, financial pressures, relationship problems, contending with feelings of possible inadequacy, exhaustion and depression. These factors can prove too much for parents who are ill-equipped, ill-prepared and unsupported (UNICEF, 2003). Young parents are also likely to be poor, have limited resources, limited knowledge about child behaviour and parenting practices, experience high levels of environmental stress, and have few coping mechanisms or support systems. For young or older parents there is also a discrepancy between having high expectations of parenting and the reality of caring for an infant (Shepherd & Sampson, 2000).

Family violence is linked with parent predictors for child maltreatment. Women overwhelmingly bear the burden of violence perpetrated by men, such as a husband, partner

or ex-partner, irrespective of their culture, religion, social or economic circumstance. Women report more intimate partner violence and are significantly more likely to be injured and killed than men. The more violence against a partner, the increased likelihood of the co-occurrence of child abuse and maltreatment, and its detrimental effects (Edleson, 1999; Fanslow, 2006; Little & Kantor, 2002; McKie, 2005; World Health Organization, 2002).

There is increasing evidence that perpetrators of child abuse and neglect differ in their psychological profile, many of which have been discussed previously in this chapter. This presents difficulties with trying to classify individuals for early intervention of abuse (Fanslow, 2006). However, globally some common prevailing risk factors have been identified, such as poverty, social isolation, poor educational attainment, unemployment and alcohol abuse. Biological and individual factors explain some of the predisposition to aggression but it is interlinking factors that can create a situation where violence is likely to occur. Any health, education, economic and social policies that maintain high levels of economic and social inequalities between groups in society also place individuals at risk. Family violence shares interlinking factors with child abuse and this places children at risk of maltreatment (Kyriacou et al., 1999; World Health Organization, 2002).

Children's exposure does not end when the violence ends, as they can also be unwilling participants amongst family violence and abuse. This may involve social services, police, alternative accommodation, witnessing their distressed mothers or hospitalisation. Early identification and screening for partner violence can improve identification of child abuse and health and well being outcomes for mothers and children (Fanslow, 2006; Little & Kantor, 2002; Ministry of Health, 2001).

The social and parental indicators outlined can also be attributed to parents in the Neonatal Unit. Many parents present with issues, identified following the birth and admission of their pre-term infant or sick full-term infant into the unit. Compounding existing risk factors are the difficulties pre-term labour presents. Pre-term infants are at risk of many development and health issues, as well as disruptions to attachment.

Cultural Perspectives and Attitudes Toward Children

Culture influences the meaning individuals hold about health, the expectations they may have, and influences their decisions and beliefs (Wilson & Grant, 2008). Social and cultural

traditions justifying intentional violence need to be considered (Krug et al., 2002), as attitudes and values entrenched in each individual's identity can influence parental behaviour and responses. Attitudes and behaviours of individuals and families should be considered, factoring beliefs on familism, machismo and the value placed on children (Ferrari, 2002), although caution is needed to avoid mistaken assumptions and stereotypes.

The cultural justification of violence usually follows traditional notions of roles of men and women, of wife beating for discipline and religious reasons, and the belief the wife is the property of the man (World Health Organization, 2002). Societal and cultural norms that accept violence as a conflict resolution strategy, physical punishment of children and that entrench male dominance place women and children at risk of maltreatment and family violence (Kyriacou et al., 1999; World Health Organization, 2002).

Within New Zealand the over-representation of Maori in family violence and child abuse statistics (MSD, 2006) is erroneously associated with it being a trait of Māori culture. Undeniably, rates of shaken baby syndrome and other forms of child abuse and neglect are high among Maori although this is confounded by other predictors, such as on average, increased pregnancy rates and decreased maternal age (MSD, 2006). Nevertheless, the incidence for Maori need to be viewed in the context of the many risk factors arising from historical traumas, contemporary socio-economic determinants and disadvantage, which places them at higher risk for family violence and maltreatment issues, rather than viewing family violence and child abuse as a cultural issue.

The current position of Maori must be considered within the historical context for Maori and the impact of colonisation on Maori family, tribal and social structure (Kruger et al., 2003; Pihama et al., 2004). For many, the whānau and hapū structure has changed due to urbanisation and isolation from marae, where child-rearing was a collective whānau responsibility that included men and women equally, to the contemporary high prevalence of single parent families with less male involvement (Kruger et al.). Settlers noted with some astonishment that women and children were held in high esteem and never chastised (Pihama, et al.). Furthermore, colonisation has detrimentally impacted cultural knowledge and practices that ensured the safety of women and children through whakapapa. Diminished whānau support, and the deterioration in lifestyle and economic conditions for many Maori whānau, means they are more likely to have multiple risk factors for ill-health, which is compounded by the risk arising from family violence (Ministry of Health, 1996).

Child Predictors of Child Maltreatment

In the addition to the adult risk factors outlined above, child characteristics have been identified as potential predictors for child abuse. Awareness of child-related risk factors can lead to recognising potential risks of harm and enable appropriate utilisation of supports and referrals. Child-related risk factors include, but are not limited to, a child aged less than one year, a history of pre-term birth, decreased birth weight, disabilities including pre-term morbidities, boys, twins, stepchildren, lower socio-economic conditions, conduct disorders, and infants displaying incessant crying that cannot be soothed (MSD, 2008).

Spencer, Wallace, Sundrum, Bacchus and Logan's (2006) study linked infants with pre-term birth or poor foetal growth to the risk of child abuse independent of maternal age and socio-economic status. They also reported premature infants have characteristics making them more vulnerable to all forms of abuse. These infants may provoke hostile parental feelings possibly due to initial separation at birth. This is more commonly experienced by parents of pre-term and small for gestational age infants, where increased length of hospitalisation may have interfered with parent-infant bonding. Alternatively, pre-term birth and poor foetal growth may share a common pathway for abuse, where maternal situations place the foetus at increased risk of poor pregnancy outcomes and the infant of child abuse, such as family violence or substance abuse and mental health problems.

Pre-term morbidities create a potential inability for the infant to participate in physical activities and can lead to difficulties with socialisation. These morbidities are usually inversely related to gestation age and birth weight. However, morbidities are also being identified in older pre-term infants (Adams-Chapman, 2009; Reuner, Hassenpflug, Pietz, & Philippi, 2009). Pre-term morbidities include a range of conditions such as cerebral palsy, disabilities in cognitive and or motor function, sensory and communication impairments, neurosensory impairment such as visual and hearing impairments, and functional limitations (delays in growth, mental and emotional development), as well as developmental lags without a defined impairment evident (Daily, Carter & Carter 2011; Louch, 1999).

Pre-term infants are at increased risk of disabilities or delays in normal development, and therefore meet developmental milestones at different stages from their term counterparts, leading to parental perceptions that their children are different or below average (Hunter et al., 1978; Jeffcoate, Humphrey, & Lloyd, 1979; Nagler, 2002). Children with disabilities may create higher physical, emotional and social demands on families, or pose behaviour

challenges placing them at risk. Parental frustration can arise when a child with a disability does not meet parental expectations of normal child development.

Factors for why pre-term infants are at greater risks of harm from physical abuse are varied and complex. Undoubtedly, infants aged less than one year have increased vulnerability as they cannot articulate specific hurts or ask for help, and are often dependent on the abusing caregivers (UNICEF, 2003). This dependence adds to the stresses families face (MSD, 2006). Young children can spend most of their time in stressed family environments, increasing the likelihood of newborns being maltreated by their mother, and young children by family members (MSD, 2006).

Shaken Baby Syndrome

Shaken baby syndrome is a significant child health issue in New Zealand and is the most common cause of death in infants less than one year. It needs to be addressed by health professionals due to the significant mortality and morbidity of these infants. Despite this knowledge, there is a risk significant numbers of infants with serious head trauma may not receive adequate assessment, nor be identified or reported as at-risk (Kelly & Farrant, 2008).

The main cause of mortality or morbidity related to shaken baby syndrome is subdural haemorrhage, arising from non-accidental physical abuse such as shaking. Trauma is caused by the sudden acceleration and deceleration of the head including all internal structures of the cranium (Goulet, Bell, Tribble, Paul & Lang, 2009). There is a poorer prognosis for infants suffering from shaken baby syndrome, compared to those with head injuries of a similar magnitude. This is attributed to the diffuse nature of injury from shaken baby syndrome (Showers, 1992). Infants' susceptibility is increased due to a complete dependence on caregivers (Davies & Garwood, 2001). Other risk attributes include a child's smallness and immaturity; they are easily lifted, dropped, thrown or shaken. The combination of heavy head, weak muscles, soft rapidly growing brain, thick skull wall and the lack of controlled head and neck mobility make infants particularly vulnerable to shaking (Showers, 1992). Little force is required to cause serious injury or fatal harm placing them at significant risk of cerebral trauma.

Potentially there is also a disruption to the attunement, attachment and bonding of the family and their infant, increasing family stress levels. It is thought that parents who are experiencing various forms of stress resulting from social, financial, biological or environmental factors may be vulnerable to impulsive and aggressive behaviour leading to shaken baby

syndrome, and they are more reactive to child-initiated stimuli than their non-abusing counterparts (Davies & Garwood, 2001). Other correlates for shaken baby syndrome include the psychopathology of the parent, how isolated the caregiver is from social supports, and the nature of the child and caregiver relationship. Expectations, perceptions, attitudes and attributions regarding child behaviours will also impact on the coping ability or frustration levels of caregivers as well as situational factors, and overwhelming stress.

In addition, crying is reported to be a common stimulus for shaken baby syndrome. Difficult to resolve or prolonged infant crying that is unpredictable and unexplained presents parents with challenges leading to parent-child interaction problems. Some correlation has been noted between the infant's normal crying curve and time of shaken baby syndrome occurring, with infants' crying measured to peak at around three months of age as a normal developmental phenomenon (Barr, Trent & Cross, 2006). Increases in infants' crying due to colic and other factors are also known to lead to increased stress and parental frustration (Showers, 1992).

Shaken Baby Syndrome warrants consideration from a neonatal perspective, as pre-term infants are often more unsettled and difficult to console than their full-term counterparts. Interactions with premature infants can also be more difficult. Parents may work hard to illicit an interaction as the infants tend to be less organised in their behaviour, less alert, and less able to communicate, which may be less rewarding then for parents of full-term infants,. The inability to give clear cues and signals leads to decreased gratification, and the cry of these infants has been described as aversive (Macey & Harmon, 1987).

Attachment Difficulties

Pre-term birth can be described as a violation of expectation (Macey & Harmon, 1987) and poses significant stress to families (Prentice & Stainton, 2004). Mothers who give birth to a pre-term infant begin their mothering in the public arena of the neonatal unit as opposed to the privacy of their own home (Prentice & Stainton, 2004). Pre-term birth is known to disrupt the bonding and attachment process and mothers report difficulty establishing motherhood in the neonatal unit. The length of hospitalisation for the neonate, along with other social factors, can lead to decreased visitation. Zeskind and Iacino (1984) recognised many years ago, and reported that decreased visitation led to decreased attachment.

Being the parent of a pre-term infant is an immensely complex process and contributes to the disruption or delay of motherhood (Veddovi et al., 2004). Loss of the expected or anticipated experience of birthing outcomes can induce feelings of grief, loss, fear, and account for severe levels of psychological stress during the neonatal period. This is more evident with pre-term than full-term infants (Hummel, 2003). With the increasing survival of pre-term infants, social factors and care giving processes are important considerations of later infant outcomes.

Acceptance of the pregnancy and psychological availability enables a favourable environment for attachment. Strong parent-infant attachment contributes to the prevention of abuse (Goulet et al., 1998). Separation of the mother from her infant leads to less contact, leaving parents feeling they are less involved in the care of their infant, and thus less able to tolerate the infant's behaviour once discharged (Prentice & Stainton, 2004). Attachment is significant for the protection of infants and has significant relevance for the pre-term infant population theoretically. In the absence of any adult risk factors for child abuse perpetration this lack of attachment places them individually at risk for maltreatment. In addition lack of attachment, decreased empathy and inadequate parenting skills are also potential risk factors for child maltreatment (MSD, 2008).

Quality of adjustment to the birth of an infant affects his or her development. The birth of a pre-term infant can make the process of accommodation and adaptation more difficult, and therefore, intensify stressors, particularly for families with decreased support.

Social risk factors can increase the risk of child maltreatment and be an indicator of parent-child interaction as socio-demographic disadvantage may decrease the mothers', caregivers' or families ability to provide an optimal environment and response to the needs of the infant. The association of socio-demographic factors and referrals to child protection services is more significant in predicting cognitive outcomes than neonatal conditions (Strathearn, Gray, O'Callaghan, & Wood, 2001). Many neonatal nurses are well versed on the subject of attachment, which has also been extensively researched by many.

Attachment is a profound and complex experience that is highly individualized. Defining whether a mother and infant or father and infant have definitely attached can pose problems, especially since attachment can happen at any stage in the continuum from conception to birth and beyond, including when an infant's survival was in doubt. Attributes for attachment include proximity being able to be close to the infant (Goulet et al 1998). Yet, many physical

and environment conditions make this difficult to achieve including the severity of the infant's condition. Parents need to have a commitment to their infant and this can be challenged due to prolonged hospitalisation, stress, guilt, fear and other socio-economic determinants. Attachment is not a one way process; it requires the process of reciprocity but due to the development capabilities of pre-term infants they can appear less responsive to their caregivers and their environment and display inconsistencies in social interaction (Johnson, 2008).

Outcomes of Infant Abuse and Neglect

Increasingly child maltreatment is being recognised as a significant health issue to society and the individual. Childhood exposure to maltreatment, including witnessing and living amidst family violence has significant effects on child wellbeing. Children's exposure to maltreatment places them at increased risk for adverse behaviours that subsequently influences their development and heath during adolescence and adulthood (Krug, Mercy, Dahlberg, & Zwi, 2002). The particular effects on infant development and cognitive functioning will also be reviewed.

Throughout the lifespan adverse childhood experiences lead to social, emotional and cognitive impairment with the potential for those affected to adopt high-risk, health-risk behaviours. Behaviours such as smoking, substance abuse, eating disorders and sexual promiscuity may consciously or unconsciously be adopted as a way of coping in adverse situations. Feelings of anxiety, anger and depression may also be alleviated with these behaviours. The adoption of these health-risk behaviours can lead to disease, disability, and social problems and, further in the continuum early death, (Felitti et al., 1998).

The consequences of maltreatment include morbidities such as blindness, permanent brain damage, hydrocephalus, developmental delay, deafness, mental retardation, disability and death. Survivors may experience a range of spectrums of disability and including morbidities such as, spastic quadriplegia, mental retardation, severe motors dysfunction, seizure disorders, and further child development issues including behavior, speech and language issues. This in turn further places them at risk of maltreatment and substantially limits their developmental potential (Karandikar, Coles, Jayawant, & Kemp, 2004). The morbidities associated with shaken baby syndrome only, increase family stress and worsen social situations.

Detrimental stress arises from abuse, neglect, witnessing domestic violence and or serious household dysfunction (Anda et al., 2006). Child abuse and neglect often occurs within relationships that should be nurturing, supportive and protecting. In such situations, environments are created that fail to provide the necessities for optimal development or positive outcomes, instead leading to physical and emotional harm which is inflicted on the child (Hildyard & Wolfe, 2002). Normal infant development is further impaired by a multitude of risk factors (as previously mentioned) that include poverty, substance abuse, parental psychopathology and poor prenatal and postnatal care, each independently increasing infant vulnerability (Hildyard & Wolfe, 2002). There is also evidence the social environment can either positively or negatively modulate the developing brain (Schore, 2001) and that maltreatment is pathogenic to immature brains because they are rapidly developing and therefore vulnerable to early adverse experiences including social trauma.

Abuse and exposure to violence have been linked to delayed cognitive development and poor academic functioning (Margolin & Gordis, 2000). Age appropriate developmental tasks may not be achieved and regressive behaviour, such as toileting issues may also be evident. Behavioural effects can include irritability, sleep disturbances, somatic complaints and emotional distress (Margolin & Gordis, 2000), anxiety, post traumatic stress disorder (PTSD), poor self esteem, physical health problems, poor school performance, under immunization (Sharps, Campbell, Baty, Walker, & Bair-Merritt, 2008)

Stress effects are intricately interlinked and the most concerning effects are on brain development as well as long-term health and developmental outcomes. Optimal developmental environments are important for the organisation, functional capacity and maturation of the developing brain as development is dependent upon a sequence of developmental and environmental influences or experiences. During periods of critical or circumscribed periods of brain development, extreme, repetitive or abnormal patterns of stress can have profound and lasting neurobehavioural consequences (Anda et al., 2006). Because of this, high levels of maternal stress can significantly affect the developing foetus as various maternal behaviours or environments may severely deregulate homeostasis (Schore, 2001) particularly during the third trimester where there is a significant increase in brain development.

The detrimental effects of stress and trauma result in increased levels of neuronal cell death and decreased cognitive function. At birth, infants have an increased number of neurons, although only neurons used will be retained. Survival depends on neurons being

stimulated by chemicals called neurotransmitters released in response to environmental and internal stimuli.   Early stress experience also shapes responses to stress in the future (Carpenter & Stacks, 2009).

The hypothalamus-pituitary-adrenal (HPA) axis, as well as the catecholamine system/sympathetic nervous system (SNS) are the body's major flight or fight response to stress and recovery after an event. The HPA axis reacts to stress by increasing production of maternal cortotropin-releasing hormone (CRH), affecting an infant's developing brain as it is unable to buffer stress effects. Subsequent exposure to chronic stress leads to changes in regulation, which can alter the infants HPA axis, creating ongoing neurophysiologic vulnerability. This is further affected when stress continues, for example, in the presence of maltreatment or family violence (Carpenter & Stacks, 2009).

Cortisol released in response to stress affects almost every organ in the body, particularly suppressing the immune response, as well as slowing digestion and growth that aids in increased energy and focused attention. Chronic exposure to stress with high or low levels of cortisol is attributed to neurological damage and other significant health issues (Carpenter & Stacks, 2009). Increased cortisol in response to stress may also be associated with low birth weight, prematurity, infant interactive capabilities, a decrease in head circumference measurements at birth, suggesting a decrease in brain growth, and future potential cognitive deficits. Links have also been found with behaviour and emotional problems in children (Margolin & Gordis, 2000)

Pre-term infants can be at risk of maltreatment due to the consequences and effects of being born premature and consequent possible disruptions to parent-infant attachment caused by difficulties that can be associated with mothering a pre-term infant. Infants who are born pre-term, and some infants with low apgar scores, are at a greater risk of health problems which is a key factor in maternal stress responses and decreased responsiveness of the infant (Bugental & Happaney, 2004), influencing maternal interaction. Limited social responses can lead to parental avoidance, rejection and abuse of premature infants (Hunter, Kilstom, Kraybill, & Loda, 1978), which could be a factor in the neglect of an infant.

Neglect is one of the most common forms of maltreatment affecting child development. Neglect is under-reported and difficult to substantiate (Mackner, Starr, & Black, 1997), involving chronic incidences not easily identified (Hildyard & Wolfe, 2002). Although the consequences of neglect are just as damaging as physical abuse, often it does not result in the

same high priority.   An example of the detrimental effects of neglect was provided by Carpenter and Stacks (2009), where scans comparing the brain of a three year old severely neglected showed a much smaller brain size compared to a non-abused child, particularly in the area of the neocortex.

Emotional neglect is particularly detrimental in infancy as shown on Bailey Scales of Infant Development, as infant's scores in performance decline as attachment problems worsen. This highlights the importance of emotional nurturing in the beginning stages of life in subsequent psychological development (Hildyard & Wolfe, 2002). Given the lack of parental care and nurturance neglect, is one of the greatest threats to growth and well-being of children, thus highlighting the importance of the neonatal environment post birth.

A secure attachment in infancy is associated with optimal infant development, higher levels of social competence, language and cognitive skills and advanced emotional understanding and behaviours. Babies who are securely attached display better tendencies or abilities to self-soothe in times of stress, attributed to a decreased amount of cortisol released in the brain (Carpenter & Stacks, 2009). A child's coping capacities, attachment abilities and behaviour modification are limited to the negative effects from trauma (Schore, 2001). Parents are meant to be the main source of protection but if they are in fact the main source of harm this leads to disorganised, insecure or anxious attachment. Consequently, social adaptation and withdrawal are noted in neglected children (Hildyard & Wolfe, 2002).

Neglect and attachment difficulties impact on an infant's emotional regulation ability. Emotional development begins at birth and includes the ability to express emotions and accurately interpret others' emotions to regulate and develop attachment, and it therefore strongly influences by the mother's response to her infant. Infants have a learned ability to adapt feeling states and physical arousal levels in response to stimuli but until regulation is learned, infants rely on external regulation provided by caregivers (Carpenter & Stacks, 2009).

Human behaviour and emotions are controlled by the limbic system and the neocortex. The limbic system undergoes a critical period of growth in infancy. Glucocorticoids produced due to increased stress selectively induce neuronal cell death in affective centres in the limbic system, which leads to functional emotional impairments (Schore, 2001). The two systems together primarily influence interactions with infants caregivers and ultimately social and emotional development (Carpenter & Stacks, 2009). The provision of care to infants shapes the brain and is therefore also linked with, and required for, brain development potential.

There are multiple effects of stress from neglect, abuse and family violence on the developing foetus in-utero and the infant post-birth. Accumulation of negative influences increases the risk for compromised cognitive development. Abuse and neglect is setting children up to be maladaptive adults, potentially having ongoing attachment, relationship and emotional issues. Child maltreatment is contributing to long-term health problems for these children as adults, such as cardiovascular disease, hypertension, hyperlipidemia, asthma, metabolic abnormalities, obesity and infection, and substance abuse (Anda et al., 2006). Therefore, the effects of their childhood environment are ongoing even when they can escape from the home situation.

Health Care Provider Responses

Neonatal nurses are strategically placed to promote positive outcomes for infants and their families. Therefore, this requires attention to be given to family dynamics, interactions and functioning (Prentice & Stainton, 2004), as most child maltreatment is set in the context of adverse family interactions and additional situational stressors which precipitate abuse (Naughton & Heath, 2001). Philosophies of care in the neonatal units recognise potential family stressors and implementation of family centred care policies and practices enhances outcomes and interactions. As identified previously, the potential for attachment disorders to develop and for the mother to feel inadequately prepared to care for their infant at discharge exists if they have had less involvement in the infant's management.

While neonatal nurses are rarely involved in the treatment of overt child abuse they have a vital role in recognition of risk factors, reporting and prevention. Neonatal nurses are ideally placed to have insight into family situations and to witness parent-infant interactions including interactions with other siblings when visiting in the unit. A significant portion of their work is focused on family centred care, family interaction and particularly the maternal infant relationship. Nurses can help in the identification of risk by assessing for caretaker stress, substance abuse, and response to crying (Nagler, 2002). The role of child protection, knowledge and awareness of predictive factors for abuse potential and vulnerabilities, future problems and checking visiting siblings and mothers for signs of abuse can be significant to protection. As a result of this, families at increased risk of abuse may be identified, leading to appropriate referrals being made and resources sought for support.

As part of this risk identification, clinicians must continue to screen families, recognize signs, symptoms of abuse and neglect. Prevention is the key to ending child abuse and neglect (Tenney-Soeiro & Wilson, 2004). Implementation of screening for family violence is imperative in the campaign against child abuse. The healthcare sector contributes to a multi-sector effort in the primary prevention of family violence. Early identification is imperative to reduce its consequences. Obstetric areas are viewed as prime environments for engaging in screening for family violence (Gracia-Morena, 2002) and prevention and the promotion of activities for good health.

Nurses need to remain non-judgmental and supportive. They may suspect and identify family violence, or potential maltreatment issues, but they need to be aware that mothers can also be stuck in their own psychological trap, limiting their ability to protect their child (Wilson, McBride-Henry, & Huntington, 2005). Health professionals dealing with the co-occurrence of child abuse in family violence situations should be mindful of the mother's own challenges and constraints on child protection practices, and focus supports on strengthening the maternal-infant relationship where possible rather than alienating the mother from the child (Wilson, McBride-Henry, & Huntington, 2004/05). This is of particular importance for first time mothers who may not be aware of the effects that living in a family violence situation have on children.

Society seems to judge mothers harshly as the sole protector of the child with little consideration for their own circumstances. If child exposure to partner violence is defined as neglect or maltreatment this can imply that the victims are neglectful parents or should have stopped the abuse (Dowd, Kennedy, Knapp, & Stallbaumer-Rouyer, 2002). Children may inadvertently suffer from neglect as the mother tries to deal with her own turmoil or over disciplines as a form of protection to avoid further abuse. Negative thoughts and low self esteem may also be projected onto the child (Little & Kantor, 2002).

To engage change a partnership requires a collaborative response, particularly focused on prevention and protection. This may help to reduce the consequences of child maltreatment. Societal responses are evident by policies focused on socio-economic conditions, by challenging cultural norms and mass media campaigns that broadly influence societal (Krug et al., 2002) thinking, attitudes and behaviours.

Summary

As has been discussed there are many contributing factors associated with child abuse, with child death occurring predominantly within the context of psychological stress, limited support and poverty (UNICEF, 2003). Many facets have to be taken into consideration for addressing child abuse and protection to highlight the difficulties with prevention and in identifying pre-term infants at potential risk of abuse. Recent attention on family violence and its correlating effects on children will increase the focus for prevention and appropriate supports. Anti-smacking legislation, despite controversy, will inevitably open more debate on children's rights.

Where several factors present together from any of the above sections, there is more likelihood of abuse occurring. Infants who present pre-term or with low birth weight and require neonatal unit care are particularly vulnerable. Stress on parents can increase the chance of attachment disorders and the combined risk heightens the relative rate of infant death for these children. Although all these risk factors are strongly linked with abuse, trying to identify abuse or its likelihood has been found to be difficult as there can be many false positives. Therefore it is better to work to try to reduce the significant risk factors for families and to increase family resilience.

Despite the vast array of child maltreatment literature, limited literature specifically targeting the neonatal areas for child protection practices demonstrates the need for research in this field. Literature on attachment issues and statistics on maltreatment for children under one year of age highlights the relevance of this study. The contributing factors and indicators for child maltreatment could be identified during the neonatal period as they are opportunities for nurses to identify issues, required supports, and to provide educational opportunities. Premature infants bring their own specific challenges to the family environment.   Despite difficulties, it is evident that child protection should be an important focus for neonatal nurses. The following chapter will describe the methodology used to construct the role of child protection for nurses working with pre-term infants in neonatal units.

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Chapter 3

Research Design

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In qualitative research, reality is constructed from a humanistic perspective of shared social and individual interactions and meaning derived from situations and phenomena (Cutliffe, 2000). Grounded theory seeks to construct theory from issues of importance and relevance in people's lives that account for patterns of behaviour. Grounded theory captures a social process in a given social context that explains human behaviour when little is known or there is limited understanding of a subject area (Glaser & Strauss, 1967; Munhall, 2007). To gain an understanding of the role of neonatal nurses in child protection, Glaserian Grounded Theory was selected as an appropriate research method to achieve the objectives of this research and to provide a framework for data collection and analysis. The methodology and methods used in this research are elaborated on in the following discussion.

Methodological Underpinning

Glaser and Strauss first developed grounded theory in 1967 (Glaser & Strauss, 1967). It is a qualitative research method for studying social phenomena based on symbolic interactionism. Symbolic interactionism evolved out of the social psychology and sociology spectrums and informs grounded theory to understand social life patterns. Understanding human meaning requires looking past the behavioural component to uncover the underlying meaning motivating overt and covert behaviours. Shared meanings are the foundation of interaction responses and understandings are somewhat similar within cultures, organisations, professions and socially. Behaviour is modified based on anticipated responses from others and meaning is constructed and influenced by the predictability of interactions following a process of perceiving, choosing and rejecting potential options for action (Milliken & Schreiber, 2001). Therefore one could say in nursing that an individual will assess options before acting based on past experience, knowledge, energy, response and potentially, the unit culture. These actions are created by their own actions and interactions with others.

Grounded theory methodology provides a framework that ensures the researcher seeks, listens to and values the participants' perspectives of the research area (Glaser & Strauss, 1967; Glaser, 1978). Discovering a human problem and the social psychological or social process to resolve it is the basis of grounded theory research. Individuals construct reality and

are active participants in creating meaning; therefore, reality is defined by social interactions (Cutliffe, 2000)

Grounded theory is useful to explore how basic social processes resolve problems or issues, and to uncover it's meaning in multiple interactions and variations in process (Munhall, 2007). It is discovered from data, is inductive in nature and is systematically obtained using constant comparative analysis of data for the generation of theory. Constantly comparing data allows relevant concepts to emerge, which are verified through further data collection and analysis to develop a deeper understanding of the research subject (Duchscher & Morgan, 2004). Data collection and analysis occurs simultaneously, enabling constant comparative analysis which means each facet of data is constantly compared with another facet of data until data saturation is reached. This process helps verify that all possibilities have been considered and that the theory is constructed from the participants' input rather than predetermined by the researcher (Glaser & Strauss, 1967; Glaser, 1978).

Since grounded theory was first developed, there has been a methodological split between the two researchers Barney Glaser and Anselm Strauss, who both continued to develop and evolve grounded theory separately as a methodology. Anselm Strauss developed a more prescriptive approach which Glaser (1992) criticised as blocking emergence of theory inducted from data. Strauss' approach being more deductive, Glaser believed was forcing the data by testing deductive hypotheses to prove or disprove the theory, rather than letting the data speak for itself. This form of verification is in conflict with the emergence of patterns in the data, and concepts and theories (Glaser, 1992).

Glaserian Grounded theory recognises the ontological and epistemological position of Glaser who has continued to develop the original approach to grounded theory methodology (Glaser, 1992; Mills, Chapman, Bonner & Francis, 2007). Glaser developed grounded theory based on the notion of emergence of theory from data; trusting theory would emerge out of the induction process of data analysis. I had limited preconceived ideas that could be substantiated or formulated or forced onto the data and that allowed induction. Prior understandings were based on general problem areas and Glaser (1978) acknowledges that a researcher will not enter the field free from ideas but wide reading and general understanding leaves research open to possibilities and induction. Although qualitative research methods create reality that is based on human perspectives, shared interactions and meaning restricting researchers from utilising their knowledge can stifle creativity. To avoid research bias and add to the credibility of the research by following Glaserian Grounded Theory principles, if the

concepts belong solely to the researcher they will not be valid or have meaning to the participants and will then be discarded (Cutliffe, 2000).

In order to find out what is happening for neonatal nurses and child protection information needed to come from the participants and be constructed from the neonatal area as there is little evidence in the literature on the role of neonatal nurses in child protection. Therefore, the aim of the research required a methodology that would allow the theory to be derived directly from the analysis of the participants' information. This enabled moving beyond a descriptive study, to conceptualise and explain what was happening for neonatal nurses and child protection. Therefore, grounded theory was used to explain the role of neonatal nurses in child protection and how it is constructed.

Research Aim and Question

The research question was, "What is happening for neonatal nurses and child protection?" The aim of this research was to determine neonatal nurses' understanding of their role in child protection issues. Thus the following areas were explored to uncover their role in child protection:

- Nurses understanding, knowledge and experience of child protection, in their practice;
- Beliefs around child abuse and preterm infants;
- How attitudes influence child protection activities;
- How nurses perceive their role in child protection, and
- The relevance of child protection and child abuse prevention to neonatal nursing practice.

Participant Recruitment

Initial recruitment involved accessing participants who were knowledgeable. Registered nurses were eligible to participate in this study if they had more than 6 months experience working in a neonatal unit. This ensured that nurses had some working knowledge and experience of the neonatal work environment to allow reflection on their practice. Those nurses who were involved in any child protection research projects, or who had a history of

working with other child protection agencies, were excluded so the data were not biased by experiences of nurses who also worked in other areas or in child protection.

Through the utilisation of grounded theory principles, purposive sampling is initially undertaken and then superseded by theoretical sampling. Purposive sampling is a form of non-probability sampling (Polit, Beck, & Hungler, 2001). Participants were recruited into this study using this method which allowed me to choose the study participants from the population of interest. After each interview the data gathered was analysed and concepts emerging highlighted the direction for further analysis (Cutliffe, 2000). Theoretical sampling is guided by demands of this theory development and seeking elaboration on findings as they arise from analysis (Munhall, 2007). Utilising principles of theoretical sampling allowed the researcher to build on each interview with subsequent participants based on emerging findings to achieve adequate representation of the concepts and reach theory saturation.

An initial contact was made with the manager from each neonatal unit in order to seek permission for inclusion of their staff in this study. A range of neonatal units was chosen with different demographics, to aid in credibility and transference of findings. Diversity among the participant areas also assisted the development of a grounded theory (Glaser & Strauss, 1967).

The managers of each unit who agreed to participate were sent information packs for each nurse within the unit. These included flyers to advertise the study, and participant information sheets and consent forms (see Appendices 1 & 2, respectively) and were placed in the nurses' mail slots. There was no direct contact with potential participants until they expressed an interest in the study. Some of the participants contacted me directly to glean more information or to introduce themselves and check their eligibility. Once each participant had returned the signed informed consent to participate in this research, I was able to contact them directly and plan an interview time.

Data Collection

To capture neonatal nurses' current knowledge and understanding of child protection issues, semi-structured audio-recorded interviews were undertaken with each participant. Field notes were utilised during the interview to document observations of expression and body language to enhance the essence or context of the participant's information. Field notes also enabled the documentation of reflections on each interview.

Due to the sensitive nature of child protection, participants were offered the opportunity to choose a time and venue of their convenience for their interviews. The participants either chose the hospital environment outside of scheduled work hours or their home. The only requirement from my point of view was that the environment had to be quiet for recording purposes and free from interruptions where possible so as to not disturb the flow of information sharing and to protect their privacy.

At the commencement of each interview, participants were reminded that the interview was audio recorded and informed that I may also be writing things down. Participants were also reminded that they did not need to answer all the questions and at any stage they could request the recording to be paused for a period during the interview or have the interview terminated. This process enabled consent to be obtained again and issues clarified. A high quality digital audio-recorder was used to record each interview. Field notes were either made unobtrusively during the interview or immediately following the interview. Additional notes or thoughts were recorded into the audio-recorder. This part was often performed in the privacy of my car.

Semi-structured interviews were chosen to capture the essence of the study phenomenon. Utilising open-ended questions allowed the flexibility to uncover issues and information as they arose during the interview and allowed me to keep the interview focused, while still allowing the participants to define the dimensions of the phenomena that are relevant to them (Polit, Beck & Hungler 2001). Examples of the questions and ideas explored included:

- What are your thoughts, feelings, and knowledge around child protection?
- What happens for child protection in your experience as a neonatal nurse?
- Tell me about the role if any that child protection plays in your nursing practice
- Beliefs about child abuse and preterm infants.

In response to participants' feedback and data analysis, other questions were formulated as the study developed and throughout each interview.

A person was employed specifically to transcribe the digital recordings of all the interviews verbatim. I received a signed confidentiality contract before any interviews were transcribed (see Appendix 3). After each interview was transcribed, I double-checked the typed data against the recording to ensure its accuracy. Throughout the process the participants' identities were protected by each choosing a pseudonym, and by limiting the use of names during the interview process. All other identifying features were removed from the transcripts.

Each interview was also coded by giving each participating hospital a code and each participant a number. For example, an interview would be coded 10-02. All collated data and information were securely locked away, and consent forms were kept separately from the data.

Data Analysis

Findings in grounded theory emerge out of the data collected. The emergence of theory from the data is a distinguishing feature of Glaser's approach to grounded theory (Duchscher & Morgan, 2004). The use of literature, interviews and field notes are all considered data and are analysed utilising comparative analysis. Data were simultaneously collected and analysed to discover the core categories and the underlying Basic Social Psychological Process (BSSP) of *Knowing at Risk Families* (Glaser & Strauss, 1967). See Chapter Five for discussion and implications for practice identified from the core categories and the basic social psychological process.

Data were initially subjected to a line-by-line analysis of the participants' responses to determine meaning. Open coding led to the initial discovery of categories and their properties, as data were examined for similarities and differences. This allowed for the verification of the concept as a category denoting a pattern in the data, and fit of the category. Properties of a category were generated until saturation of the category and its properties were achieved (Glaser, 1998). Figure 3.1 displays a diagram of this process used to analyze data to construct the basic social psychological process.

Figure 3.1. *The process of inductive analysis and emerging core categories and the basic social psychological process.*

Constant comparative analysis is fundamental to the analytic process. Commenced at the start of the research process, data is collected and analysed simultaneously and integrated into

the research (Sherman, 1988). The significant numbers of properties and concepts that develop a consistent pattern that are relevant to or similar in most areas, gives credibility to the core concept and basic social psychological process (Glaser & Strauss, 1967). Codes are constantly compared to form categories, which lead to the conceptualisation of the core categories and the development of the core process or BSSP (Sherman, 1988). A line-by-line constant comparative analysis helped to create a dense account of the phenomena under study and allowed for emergent fit (Duchscher & Morgan, 2004). A substantive grounded theory was generated by constantly comparing data to discover concepts and verify emerging issues from within the data in order to reach theoretical saturation (Glaser & Strauss, 1967). Emerging concepts were generated and refitted by comparing categories of data and the new data arising constantly. The weaving together of these categories or substantive codes forms the Basic Social Psychological Process (Walker & Myrick, 2006).

Core categories were labelled using social constructs inducted from the analysis of the data. In vivo codes, which are taken directly from the words of the participants, were given to some of the concepts such as '*Dodgy Families*', '*Red Flags*' and '*Protecting the Infant*'. Table 3.1 provides an example of the emergence of a core category after using the process of inductive analysis.

Table 3.1.

The Inductive Process and Development of the Core Category.

Data	Codes	Properties	Concept	Core Category
Parenting classes Supports in place community Room-in family togetherness, coping, learning Facilitation family growth, development and security Value of family unit Encourage family interaction Ask family and discuss how it will work for them Negotiation and discussions with family Nurses do care for family have understanding of stress Support baby and family to come out other end Building connections If we concentrate on support, resources, teaching making the right links query potential to improve outcomes	• Value of the family • Supports available • Care for families / understand stress • Acknowledge family difficulties and how it will work for them • Support family and baby through process to come out other end	Commitment to the family Parental supports Chatting	Having faith in the family	Belonging to the family *Hoping for positive outcomes*

Data were also generated through literature and a review was undertaken to support the emerging concepts at a time when the emerging theory or core variable were identified and sufficiently developed (Munhall, 2007).

The process of grounded theory stipulates the use of memos and interrupting coding and analysing data, where necessary, to memo (see Table 3.2). Memos record the thoughts and ideas about the process of coding and the emergence of the grounded theory. The theoretical writing up of ideas about the data gathered helped to highlight the relationship between codes and their properties as they developed (Duchscher, & Morgan 2004), and formed part of the comparative analysis (Heath & Cowley, 2004), with the emphasis on conceptualization (Sherman, 1988). Pertaining to this research, memos were sorted to help shape the categories and glean similarities through properties.

Table 3.*2.*

Example of a Memo

Neonatal Nurses want to ensure that these infants go to a good home. They have played a role in the survival of the infant and they don't want it to be harmed. There appears to be a contradiction created. Nurses are putting measures in to protect and enhance opportunities for the infant to reach its full potential versus the substandard environment and potential risk the infant is being perceived to be sent home to.

Ethics

Ethics approval for this study was granted by the Massey University Human Ethics Committee. (Appendix 4) The Health and Disability Ethics Committee (HDEC) was also contacted as District Health Board staff were being interviewed. A letter of exemption was received (Appendix 5), as the research occurred outside the nurses' work hours, and did not directly relate to patients or their personal information.

I was also guided by the following publications:

1. Code of ethical conduct for research, teaching and evaluations involving human participants (Massey University Health Ethics Committee)

2. The HDC Code of Health and Disability Services Consumer's Rights Regulation 1996 (Health and Disability Commissioner, 1996)

3. Guidelines on Ethics in Health Research (Health Research Council of New Zealand, 2002)

4. Guidelines for health researchers on health research involving Maori (Health Research Council of New Zealand, 1998).

Ethical issues were considered carefully for this research given the sensitive nature of the research phenomena. Particular attention was paid to the potential for psychological discomfort; this was anticipated with regard to psychosocial aspects of the study. I was aware that although the research was not directly related to the individual's personal situations, I was delving into the personal experience and history which for some individuals could impact on their interview. There was potential that stress would be created for the participants by their reflection and sharing of incidents that may not have gone well. This was addressed by allowing the participants a break if required and allowing the recording to be stopped upon request. Information was also offered for Employee Assistance Program (EAP) services for further support and debriefing.

Consent process

Each potential participant was given an information sheet (Appendix 1) inviting him or her to participate in the research study. The sheet contained information regarding the purpose of the study, eligibility criteria, their rights, treatment of data and storage, support process and involvement required. Contact details were provided for me and my supervisor so that the participants had the opportunity to ask further questions or details about the study prior to agreeing to participate in the study. Consent was given by the participant signing and returning the consent form to the researcher (Appendix 2).

Confidentiality and anonymity were protected by all identifying information being removed from the participant's transcripts and any publications of this research. Each hospital and participant used in this study was given a code, for researcher use. Participants were also given the option and advised to choose a pseudonym which would also be non-identifiable. Transcripts, consent forms, audio files were all kept separately and in a locked file. Copies of information were available only to the research supervisor.

The ethnicity of participants was not identified. Issues relating to Maori were reflected upon due to their being over-represented in the child abuse statistics (MSD, 2006), and many other socio-economic determinants linked with child protection issues, such as poverty, unemployment and educational levels (UNICEF, 2003). Maori cultural advice was sort in the planning stages of this study and a commitment was received from an identified Maori cultural advisor for ongoing supervision, if required. This also helped ensure that findings were presented in a way that avoided reinforcing negative stereotypes which are not beneficial.

Seeking cultural advice helped maintain cultural safety and also commenced the research with the acceptance of nurses as the dominant culture. Principles of respect, participation and partnership were encouraged with information and knowledge sharing, and protection was considered with regard to the protection of identity. These principles were upheld throughout the study for all participants.

Establishing Rigour

Establishing rigour or trustworthiness of qualitative research is a fundamental component of research validity or worthiness Establishing rigour in qualitative research relies on trustworthiness of the researcher and the process; systemic inductive guidelines aided collecting and analysing data. Theory works if it is useful in explaining, predicting and interpreting the substantive area of the study and is modifiable to change in response to new data (Glaser, 1978).

Fit is another word for validity and is the beginning functional requirement of relating theory to data. The researcher and readers should ask does the concept represent the pattern of data it claims to portray. Fit was achieved through the development of theoretical categories that were inducted from analysis of the data collection. A line by line analysis of data meant that data inducted out of the participants' responses were systematically checked and rechecked, constantly confirming fit or development of concepts. Constant comparative analysis enhanced flexibility and ensured fit and by identifying replication led to saturation of categories and helped verify the study (Morse, Barrett, Mayan, Olson, & Spiers, 2002). With development of concepts that fit, integration of categories accounted for most of the variation in behaviours and started to explain how the main area of concern and issues for the participants are resolved.   This creates a theory tightly related to data and therefore works (Glaser, 1998)

A grounded theory study should be immediately applicable to individuals and groups who share the same issue as this research study (Glaser's 1967). Relevance was confirmed by fit and by uncovering what is happening and important directly from the participants in the area of focus. This was supported through the process of memoing and constantly comparing new emerging data with previously collated data. This helped the study to have true meaning and impact by way of participants' voices (Glaser, 1998). This relevance comes from the analytic explanations of the emergence of the Basic Social Psychological Process in the research study.

Modification of emerging codes and concepts occurred along the process of constant comparative analysis. Modifications occurred with the analysis of data and emergence of ideas and further data collections. Data were not forced and therefore new data could be incorporated and concepts modified where required to fit, if appropriate. This also implies that no theory is wrong; it is modified by new and emerging data from future different areas.

Theory with fit and relevance that works that can easily be modified has 'grab' (Glaser, 1998). Grab was created by not forcing the data, and allowing the development of the core categories through induction. Trust will be given to the research if it has grab and can resonate with the substantive area from which it was inducted but also if other areas can relate to it (Glaser, 1998). Theory that is intimately linked and induced from the data should be highly applicable to the realities of this substantive area (Glaser & Strauss, 1967), and to groups and individuals who share this issue.

Theory will also have credibility if participants and other nurses can identify with it and if the findings fit the data and captures interest because they resonate or grab. I recently (2010) presented a preliminary presentation of this research at a neonatal conference. Following my presentation delegates from areas not used in my study confirmed that they could relate to the findings. The feedback and discussions that followed were evidence of 'grab' and credibility of this research.

Summary

Qualitative research methodology is fitting in order to gain an understanding of the role of neonatal nurses in child protection. The experiences and the construction of this phenomenon would be difficult to achieve by using a quantitative methodology as you may lose the impact of the dialogue using a statistical analysis. Grounded theory enabled me to use a methodology

that ensured the findings were induced directly from the data without being forced to capture the true essence of what is happening for the nurses in child protection. To gain this understanding one must question neonatal nurses working within the field. To achieve this, Glaserian Grounded Theory methodology was chosen and semi-structured interviews were utilised and the principles of theoretical sampling were incorporated. This allowed me to build on each interview with subsequent participants based on emerging findings to achieve adequate representation of the concepts and reach theory saturation.

A substantive grounded theory was generated by constantly comparing data to discover concepts and verify emerging issues from within the data in order to reach theoretical saturation. Constant comparative analysis helps to create a dense account of the phenomena under study and allows for emergent fit (Glaser & Strauss, 1967). Data were initially subjected to a line-by-line analysis of the participant's responses to determine meaning. Open coding led to the initial discovery of categories and their properties, as data were examined for similarities and differences. This allowed for the verification of the concept as a category denoting a pattern in the data, and fit of the category. Properties of a category were generated until saturation of the category and its properties were achieved (Glaser, 1998). Coding was interrupted when required to memo, which helped conceptualise ideas and formed part of the comparative analysis to reach the core categories. The following chapter presents the findings of this study and the Basic Social Psychological Process of neonatal nurses resolving child protection issues.

Chapter Four (Findings)

Dancing Around the Families

In this chapter I present the findings of the research. Ten registered nurses working in New Zealand neonatal units participated. *Dancing Around the Families* is a grounded theory explaining the role of neonatal nurses in child protection. *Knowing at Risk Families* is the Basic Social Psychological Process that explains nurses' coping with, and acting upon child protection issues. It is about the creative conversations and work required to help support or enhance the infant's safety (refer to Figure 4.1). The process is continuous, integrated, blurred and comprises backwards and forwards movements within the different core categories. It is possible to recognise elements of each category and move through the phases with the family at continuous or different times.
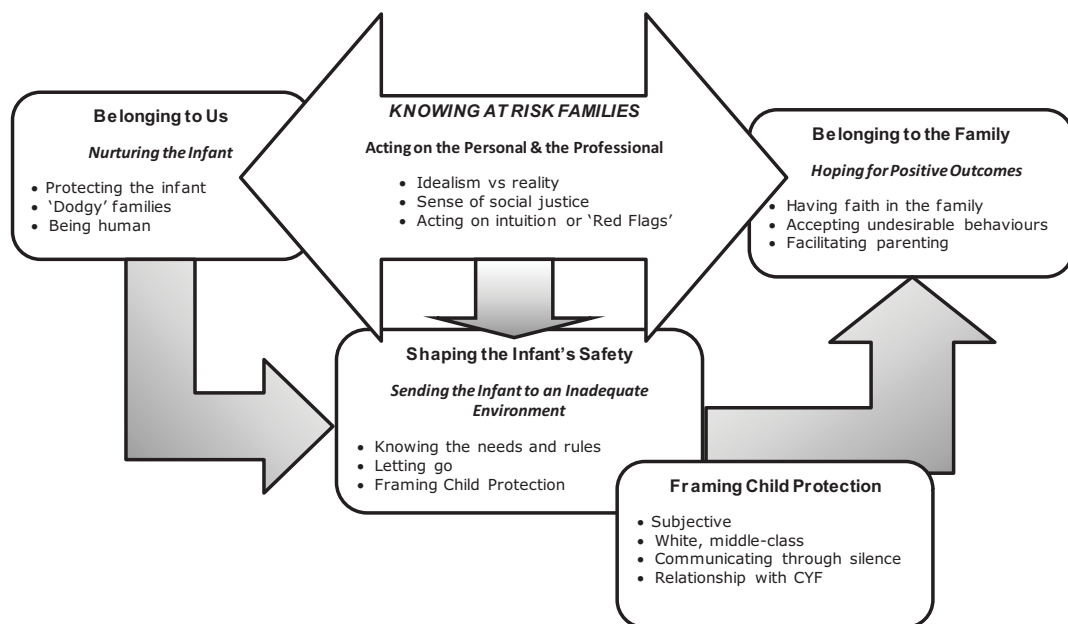

Figure 4.1. *Overview of Dancing Around the Families*

Nurses worked through the infant's journey from admission to discharge. The first core category of *Belonging to Us* focuses on the infant's journey with the nurses, usually during the initial period of admission to the neonatal unit. *Belonging to the Family*, the next

core category, occurs as the focus shifts from the infant's journey with the nurses when it is recognised that the responsibility and care for the infant ultimately belongs to the family. The nurses have to have trust in the family and the systems, particularly when sending an infant to what they perceive to be a substandard environment (their home). *Shaping the Infant's Safety* is the core category that depicts how neonatal nurses frame child protection practices. Neonatal nurses' role in child protection is constructed by the consequences and outcomes of working with families, whereby a dance is created when at-risk infants are identified and child protection practices initiated (see Table 4.1).

Knowing at Risk Families

The Basic Social Psychological Process, *Knowing at Risk Families,* involves identifying significant risk factors indicating a neonate's safety is at risk. The family-centred care philosophy heightens neonatal nurses' sensitivity to including the family in an infant's care and to identifying family issues. Neonatal nurses' experience and personal and professional knowledge assists them in the identification of issues compromising an infant's safety, although not all nurses have access to education or training in identification of child abuse and child protection issues. In addition to experience and knowledge, media hype and attention on high-profile cases of child maltreatment leading to death has raised nurses' awareness as well as the public's. In addition to this, national public health campaigns like "It's not okay" are raising awareness. Heightened awareness and sensitivity to child protection and safety issues not only makes abuse hard to hide, but it also means nurses also have to act as well.

I think the media coverage has made a huge difference. (Gerty)

Table 4.1

Dancing Around the Families: A Grounded Theory of Neonatal Nurses' Role of Child Protection

	Core Categories	Focus	Concepts	Properties	Theoretical Notions & Outcomes	
BSSP: Knowing at risk families	***Belonging to Us*** *Nurturing the infant*	The focus is on the infant's journey with the neonatal nurses	**Protecting the infant**	Saving the baby Best possible outcomes Unpredictable outcomes	Wanting the best possible outcomes for the infant	Producing a well healthy and safe infant that will reach its potential
			Lacking trust in the family	Sick babies Parents not visiting Anti-social behaviour		
			Allowing the mothers to mother **Being human**	Facilitating attachment Having Control Seeing and acting or not acting Being mad, sad, and angry Left wondering Construction of coping		
	Belonging to the family	The focus is on the infant and the family's journey	**Having faith in the family**	Commitment to the family system	Having to give over responsibility for the infant to the mother and family	Hoping for positive outcomes for the infant
			Accepting undesirable behaviours			
			Facilitating parenting	Empowering families Role modelling behavior Planning for discharge		

	Core Categories	Focus	Concepts	Properties	Theoretical Notions & Outcomes	
	Shaping the infant's safety Sending the infant to substandard environment	How neonatal nurses frame child protection and let go	**Knowing the needs & rules**	Creative conversations with families Passing the buck	Having done as much as possible	Having trust in the family and the system
			Letting go	Two faces of families		
			Framing child protection	Forming relationships Timeliness of interventions Not being heard Relationships with CYF		
			'Dodgy' families			

The concept, *Red Flags*, explains the cues neonatal nurses use to recognise there is a problem. *Red Flags* comprise known risk factors, signs or gut-feelings alerting nurses to something wrong, or a family needing support. Signs may include parental behaviours such as alcohol and drug abuse and not visiting. However intuition, often described as gut-feelings,

provides the impetus for nurses to build a bigger picture and validate their intuition by gathering information. Gathering information means nurses do not make value judgments in isolation; instead they discuss thoughts, observations and feelings with one another.

Nurses in this study illustrated how their experience and knowledge informed *Knowing at Risk Families*. Underpinned by a sense of social justice and their idealism, in reality there are barriers to construction of child protection and risk identification. Identifying risk factors is significant in child protection as is the ability to intervene before abuse occurs. The lack of physical signs of abuse on an infant was not a deterrent for nurses who believed they had a role to play protecting the infants in their care.

…Nurses pay attention. I mean that's our whole focus and sometimes the baby is the least of the problem. Sometimes it's the family that you end up spending most of the time with. Babies are easy – it's the parents that cause the most work. (Marie)

For me its risk . . . assessing risk to a baby . . . risk through drugs, alcohol leading to inability to care. Risk through witnessing or being around family violence and risk of direct violence itself . . . (Ruth)

Knowing was created by in-service education, focused readings and study days, which are standard methods for the transfer of knowledge. Knowledge is imparted to new staff nurses by experienced neonatal nurses as a way to disseminate and share not only knowledge but also experiences with colleagues. However, opportunities to attend study days and in-service education was compromised by shift work, staffing issues, and the busyness or acuity of the units. The unpredictable nature of neonatal units in relation to their busy periods throughout a shift makes it difficult to release nurses for education. Moreover, education opportunities are often restricted for nurses in specific roles.

We are chronically short staffed so just because it is advertised does not mean you can go to it …… I did say oh, I'd really like to go to that one but oh no, sorry, no can do....so when do we get these lovely in-services on child abuse and child protection and bonding? We just rely on nurses to be aware of those things. And I think we are, we are all aware of how important that is but sometimes I think you do need in your face in-service. (Marie)

Nurses also identified a lack of formal training and a lack of clarity around processes to ensure all nurses had child protection and screening family violence training. Available training

focused on the child and abuse identification, and did not specifically acknowledge the special needs of the neonatal population.

> *No. It just includes general criteria and anyone can make a referral and this is what you do and they showed us some slides of some really awful things of older children . . . But you know . . . there is no neonatal kind of pre-term thing going on (Katy).*

Relying on their intuition or gut instincts they are therefore more inclined to discuss issues with colleagues.

> *Learn by experience, by being here, by seeing, by chatting in the staff room. (Gerty)*

Recent media coverage has also contributed to increased awareness of violence issues; particularly the detailed coverage of specific abuse cases over the last five years.

> *I think also, probably with the publicity of all these dreadful cases, there have been some extreme ones, you just know that you just can't turn a blind eye and then find out that something like this has happened. (Bridget)*

> *Also too I think, there is a link with there being a bit more talk about what's really going on and a bit more awareness now as things are kind of coming out that babies in . . . New Zealand's terrible for looking after i's children and it's kind of a bit of a global thing as well. How many children under five die in the care of their caregivers and you hear about it all the time and these horrific cases (Katy)*

In contrast, increased media attention and stereotyping was cited as a contributing barrier to child protection, causing nurses in this study to question their intuition. Increased awareness meant nurses wondered if they focused on maltreatment issues too much and subsequently looked for problems.

> *I think it's huge the impact of the media and some of that I think makes me wonder if I'm focusing on it too much sometimes. Like I go out there with this awareness and I think am I looking for things that are not necessarily there. Is it my intuition? Or am I just overreacting? . . . I do not think people are hiding so much under the pillows anymore. (Garfield)*

Red Flags

Events or behaviours signifying warnings were referred to as "*Red Flags*". Experience and awareness influenced picking up the subtleties of family dynamics and interaction. Identifiers for risk around the family and potential environmental influences the infant would be discharged home to heightened anxiety for the nurse. Having a feeling that something was not quite right required nurses to act on and trust their intuition.

Taking note of my intuition and the feeling that I get that may or may not be right …Yeah my intuition is really – I don't know why it is but I suppose it is just life experience and you look, I don't know, you just get vibes don't you? (Garfield).

Not one thing, it's never one thing, it's a combination of all the things that you put together to build a picture. (Ruth)

Well, it is talking about it with everybody and trying to validate – I mean, it's really hard when you get those feelings and intuition and you don't know whether it's valid or not and you keep tumbling it over and over and thinking, is it just me? Is it real? And you talk it over with your friends. But it's like everything in nursing, you can see clinical things as well and you think, is that real or am I just imagining it? And you seek validation from people don't you, that what you're thinking and feeling is possibly right and you either do something about it or you just stop worrying about it. You've got to go through the processes, go through the steps and talk about it, refer on, document, make sure you've done all the channels you can do and then you just have to hope and pray that nothing else happens really (Garfield)

Sometimes you just get a gut feeling that there was something not right so you hand it over to the next nurse of, you know, I just got this feeling and this is kind of the body language or what was said and that, can you keep your eye out of, you know, what happens on your shift, type thing and they kind of just – think you're crazy, you're seeing things. But I mean, you kind of have to get some kind of evidence to go along. (Lucy).

Preterm infants are seen as being even more vulnerable with some of the risk-taking behaviours of the mother influencing the reason for admission of the neonate. The attitudes

and beliefs of some families, including the behaviours they display, encourage the nurse to protect the infant.

Belonging to Us

Belonging to Us is the core category depicting how the neonatal nurses focus on nurturing the infants during their stay in the neonatal unit to achieve the best possible outcomes. At this stage nurses see the baby belongs to them rather than the family. The focus is on the infant's journey with the nurses during this time. Driven by neonatal unit philosophies of care, producing a well, healthy and safe infant who will reach its full potential is the neonatal nurse's key focus. *Belonging to Us* comprises three concepts: *Protecting the Infant, Dodgy Families, and Being Human.*

Protecting the infant

The concept of *Protecting the Infant* involves the nurse's perception that the baby belonged to them while in the neonatal unit, as opposed to the family. Practice knowledge and experience means nurses often have a deeper understanding of the infant's physical wellness and potential neurodevelopment outcomes following discharge. Nurses ultimately believe in and value their role in being there for the baby, helping the infant survive, and *Protecting the Infant*. Doing whatever was best for the child was what they needed to try to achieve. An irony is created when nurses reflect on how hard they work with these infants by manipulating the neonatal unit environment and facilitating bonding and attachment, versus the environmental influences the infant may potentially be discharged home to.

> *Well some of those babies, you spend months saving their lives, millions of dollars and that is what I think is frustrating sometimes, when they go to an environment that you think might not turn out so well. You think, you've invested all this time and energy on keeping this baby well and trying to make it well and trying to protect its intellect and making it the best person it can possibly be and then it goes to an environment that you think may not treat it quite so well. Or something like that may happen. (Garfield)*

> *And then you cross your fingers and your toes and everything that it goes alright. (Katy)*

Yeah. While they're under our care, yeah – it is very, very hard though sometimes when you know that the nurses have put everything into these babies and got them so far and that they're going home to a family where it's not going to be fantastic for them. It is really, really hard. (Lucy)

The nurses in this study questioned the number of opportunities some families received to parent their infant despite an already extensive history with child protection services. In these situations parental rights appear to override the rights of the infant. In these circumstances, the nurse focuses on what is best for the child, while his/her accountability is constructed out of their own social consciousness and sense of social justice.

I think the bottom line is if you see something that you think is a breach of the child's human rights, and that is not acceptable in terms of their health or in terms of the law, you have to be upfront and say that's not acceptable, it's dangerous or I fear for that child's welfare. You have to otherwise you have no morals or credibility to bring to the job. Well, I wouldn't anyway. I'd have to say that's not acceptable and I have concerns and if the child is in danger or it's a law breaking thing, you have a duty for mandatory reporting so you have to do it. (Garfield).

That is probably the frustrating part really is that they're supported. I don't know whether I want to see them punished you know, and what sort of punishment are we dishing out. . . . I was just in a meeting that we have . . . heard – a mother's going to have another child which we've already had three go from here and the last one went out to a family in the … and that mother gets access every four weeks. Two and a half thousand to fly, accommodation to see her child and it's all on the taxpayers' money and I kind of think well, from my point of view, they've all done well haven't they. I mean, the child has gone to family and is being brought up in a safe family environment. Mum hasn't been able to cope, or the environment that they were in couldn't cope so she's not having to bring that child up but she's still getting contact and almost rewarded, not rewarded but there's a – I don't know, I don't understand that then they can get supported really isn't it, and then that they can get pregnant again and the next one will be automatically uplifted . . . You know, it's like we're encouraging you to carry on doing what you have always been doing (Amanda).

Dodgy Families

Dodgy Families are those families where the risk factors for child abuse and neglect are evident. These families appear to hide things, or display overt behaviours judged as not conducive to the NICU environment or to the future of the infant. Simply, '*Dodgy Families*' comprised people or families who were not very nice. Behaviours leading to the label of a 'dodgy family' included anti-social behaviours, the past histories of families, and intoxicated parents who led other vulnerable mothers astray. Common concerns related to alcohol and drug use, violence, criminal histories, gang involvement, poverty, and previous incidents where Child Youth and Family Services were involved or children had been removed. The presence of these factors led nurses to conclude individuals and families were unable to function effectively as parents. They come to lack trust in the family because of concerns over their behaviour, parenting capabilities, or past history, leading to conflict that impacts on the nurse's attitudes

> *And these are a dodgy family, you know, they're really dodgy. . . . Battering, abusive, horrible drug household. (Marie)*

> *. . . because this was a . . . weaker that wasn't going to live. And he lived through the skin of his teeth to go home with someone that would rather be in . . . feeding her aunt's dogs. (Katy)*

To combat the effects of forced separation on mothers, nurses promote attachment and bonding into the infant's care. Most parents seek opportunities to be involved in the care of their infant. Nevertheless, parents who are not visiting their infants are an instant red flag for the neonatal nurse, although their judgments can sometimes preclude parental involvement. This in turn can compound a lack of trust in the family if the family backs off because of the nurse's attitude. This gate keeping behaviour prohibits the empowering process that should be happening.

> *. . . that's one thing that really grates me about what nurses need to do, in my view, is get over the fact that it's not "their" baby and that – another one that gets to me, is the fact that they see parents as a hindrance to their shift. (Katie)*

The initial approach with families, and the nurses' appearance and attitude impacts on disclosure and interaction. Nurses' personal experiences increased awareness and the way they related to families in different contexts was used to elicit information. If the nurse looked

non-judgmental, not part of the establishment, and therefore non-threatening, there was an increased chance of families sharing information.

> *How our identity impacts on our profession and our interaction with clients and I think we need to be made more accountable of that interaction….and kind of getting a feel for people and sometimes it's to do with how you approach them at the beginning. (Katy)*

> *She actually expressed a great deal of anxiety over that, about how she was being treated on the unit, her partner said people treated him – they felt as if they had been ostracised by nurses on the unit, that they had been treated differently and more suspiciously than they felt this warranted. There was a lot of stuff that went on with that one. But, I think they did go home with a CYFS order. (Marie)*

To deal with *Dodgy Families*, nurses often viewed or judged based on white middle class ideologies. Within the context of child protection and family violence, the dominant knowledge informing nursing practice is perceived to be the white middle class western way. In contrast, nurses dealing with child protection issues require them to remain non-judgmental and consider the world of others. Being raised on what was perceived the right side of the street and individual ideals made different behaviours hard to accept.

> *Such different scales of people in society ….. Yeah, so if you've got like – say your units all full of middle income, middle class, can say white I guess – middle income, middle class, white nurses all well educated etc, then come and work in what I call the real world and can come across as quite harsh because they don't understand where a lot of other people are coming from. And I guess that's a lot to do with cultural safety and cultural sensitivities with just different people, whether they're in a different ethnicity or race or whatever. (Amanda).*

> *A lot of these families, unfortunately, they don't know the finesse of language and finesse of behaviour that we've had the fortune to be brought up with. Quite often things that we said we are really concerned about may just be the way they deal with it, within themselves (Bridget).*

Nurses used the subtle identifiers of risk factors to make judgments about potential family dynamics, such as the body language and general respect between the parents and the responses to each other within the family context, including the siblings and the infant. Using

these judgments nurses would observe families where the siblings appeared to be neglected, but in other respects appeared to be flourishing and receiving love. They would therefore appear to be protected in other ways by the family. By looking past these behaviours and taking the time to discuss issues with the family, and focusing on what the families are experiencing nurses may discover something other than child protection issues. For example, finding that the plans put in place for the family are not working, which allows opportunities to create new plans. This highlights the importance of the initial approach and interaction with the family, and being open and non-judgmental.

> So working with people can determine whether it is a stress situation or whether there is actually physical abuse there. (Bridget)

> But you know, it's about maximising the opportunities for the kids to me and sometimes what we deem is a not so suitable environment might really be okay. You know, just because the paint's not so good on the house or the fence is scruffy or whatever, it may be a fantastic place for kids to grow up so don't judge a book by its cover is the biggest factor isn't it really (Amanda).

> Dad, he's going to kick off, he's going to be really shitty, you know. Just keep out of his way or if he does, here's the number for security, you can ring them. So you go in half expecting a fight and you're sure that they can kind of sense that so they either puff out their chest and it's all on or they shut down and they don't talk to you and I think that's it. There's an element of that too when you hear, oh, that Mum, she just doesn't come in and when they do come in it's like, ah, so you've decided to show up kind of attitude, you know. But that doesn't help communication so we talk about things like that. Say it's all how you kind of approach it so, if you go in nicely, how you'd expect to be treated, that should be okay and then if you still feel unusual and it's not quite right, then you can kind of make a comment about it but until you make that first step in a non-judgmental way, you got to see how it goes. So, it's quite good. Still frustrating in the long term but we do try. (Katy)

Being Human

Nurses working in challenging circumstances are required to conduct themselves in a professional manner, despite frustrations. Their tone and language depicts the human element of child protection issues, while trying to remain non-judgmental. Feeling "mad, sad, and angry" was evidence of this and a key identifier of *Being Human*. *Being Human* contributed to nurses feeling powerless to change the course for the infant, resulting in them having to let go.

> *You hear about it all the time and these horrific cases that are just burnt in your brain . . . they never did anything about it and that baby went home with that family and it was just like, I want to cry. (Katy)*

> *. . . because I have had a run in with a family before and I've just gone to my educator and gone, and spouted it all off at her because I was just so mad and wound up by the situation that it almost brought me to tears because I just – and I – you just go to them and offload onto them and take a breath and then off you go again. (Lucy)*

Being Human creates an ambivalence about wanting feedback post-discharge regarding how the infant was, especially after trying to initiate strategies to support and protect the infant that were not actioned. Surviving the human element means nurses are required to construct a way of coping when dealing with the complexities of child protection and the recurrence of frustrations. Nurses are forced to cope with the turnover of infants in the neonatal unit, requiring them to let go of one family and delve in to sort another family. Choosing not to see any problems and attempts to avoid future situations is another coping strategy; others always look to make a difference. Sometimes coping is getting over-involved and not letting go.

Part of *Being Human* is the seeing and acting or not acting on identifiers and risk factors neonatal nurses are aware of, and actively observe for. The openness to become involved, and the professional responsibility to act, requires nurses to pay attention.

> *I guess a part of it is we have a big turnover anyway with our babies, it's not getting too attached, making sure we have supported the families whoever we feel is the victim, making sure we have supported them as much as we can, making sure they've got the information. (Gerty)*

You kind of have to – once the baby moves on, you kind of just have to distance yourself from that and kind of cut yourself off otherwise it would just totally consume you. (Lucy)

I think that depends on the nurse. Some ask how it's going. We don't tend to hear once the baby has gone home and that's – but then you see we've replaced it with another lot so often, it sounds terrible, out of sight out of mind. You know, and I think for all of us, as long as we know we've done our job in identifying those babies that could be at risk, then that's all we can really possibly do in the circumstances. (Gerty)

Eighteen months down the line, when you find out by chance that that person did know what was going on and did all the right things and suddenly now, because something else has happened, she's really worried and stressed out and doesn't want to look after that baby or really wants to look after that baby and give it heaps of attention and, you know, because that often happens too doesn't it? They don't want to, they either don't want to look after something, a situation because it's bad or they want to really always look after it because they know it's been bad before and they want to make this one better. (Katy)

Individual professional credibility was a reason for acting on child protection risk factors and identifiers, requiring nurses to be open and willing to be involved and view social issues as an extension of their job. Many of the nurses in this study held positions of responsibility and therefore had the experience or professional responsibility to act, otherwise they felt their credibility was in question. Furthermore, the opportunity to access child protection education came with this responsibility.

No, I believe it is our professional responsibility – the social factors . . . . yes, absolutely. That boils down to personality in a way because some people are action people, some people are sit and think people. But, if they see – if they see anything that would be worth documenting and acting on and not acting on it, then that is neglect in itself, or negligence on behalf of the practice. But proving that would be interesting. Proving that would be interesting bar the fact evidence later on, you know. If anything happened to a child or a family later on down the track, you'd go, oh damn, I wish I'd said something, I hope that never happens. It would be awful. (Amanda)

Supportive environments for nurses to make a decision so they feel they are not working in isolation, can lead people them to take action. In some incidences articulation of

risk factors and increasing awareness does not lead to action, therefore some barriers to child protection within the services exists. When some behaviours of the family are obvious, or risks have already been identified, the nurse is protected from having to identify risk factors, although some families could potentially fall through the cracks if the evidence was not so overt.

> *I think if there's major issues there, all the nurses would step up and say something and do something. Like everyone, you know, people see different things …. I mean, we do get to that stage that you're so busy and you just don't see things that are happening around you and we do have other nurses that have been there for donkeys years and are there to do their days work and they don't take on anything else. I mean, 99% of the team is excellent but you do get the odd person that, oh well it's not my problem, you know, that's the social worker's problem, I'll tell them and let them deal with it. "But a lot of our nurses are good and they will step up and notify people of things that have been happening and watch out for family dynamics (Lucy).*

> *And that's why you're looking for less intense things, the little flick of fear, the head hanging down all the time, all those little things. When talking further of a woman's partner . . . Real charmer, very nice . . . comes across really well, but you can see that the mother won't make any decisions when he is here, controls are so obviously there, when he's not here she can be totally different . . . . and the mother won't say a word against him either . . . something's not quite right and you need to look at this a bit more. (Bridget)*

The nurses in this study identified examples of other nurses who had accepted incidents at face value and were not willing or were unable to dig deeper. Because of this they were able to pick up things others had missed. For nurses to identify subtle indicators of child protection concerns required them to be open and aware. Nurses who really pay attention could give examples of the subtle nuances alerting them of concerns. Nevertheless, there is a large degree of subjectivity in instances without any substantiated abuse or definitive risk factors.

> *the more you open your eyes the more you see what's happening (Lucy).*

Often some families are already identified as being "dodgy", creating an element of fear or concern. Sometimes people see different things due to their own knowledge and personal judgment. The nature of dealing with social issues and the energy it takes can also

make it too hard to deal with the complexities. Nurses' own personal history was cited as a barrier. Issues maybe painful to deal with, or their own exposure can create a therapeutic tolerance level diminishing the nurse's ability to notice.

> *Personal barriers I think probably. I don't want to be the one to make that referral. I don't want to be the one to cause problems in that family. I feel threatened. I'm frightened that if they find out I'm the one who brought it up to start off with, they'll come and get me. That sort of thing is a sort of a personal barrier. (Bridget)*

Difficulties or constraints with systems, communication, documentation or nurses not listened to leads to complacency, especially if professional credibility or personal judgments and ideals are not dependent on or affected by the outcome.

> *Absolutely! I'm sure. Yeah. I think probably for nurses at the bedside, it would be very easy to turn a blind eye. I think the people higher up the chain who have got the responsibility for discharge planning would always report and act on, but I think for the less senior people it would be very easy to just say oh well, that's the way they are and not report verbal abuse, harassment or physical, that may place the child – the mother and then the child at potential risk or see some whacking the sibling and think oh well, that's just the way they are and that family are going to do that regardless. It would be very easy I would say. (Garfield)*

Trust in other health professionals is undermined by the times things have not gone right in the unit or how the nurse expected or wanted it to go. Sometimes systems and process also let nurses down forcing them to accept undesirable behaviours – like parents drinking and verbally abusing nurses, creating an element of fear and risk for the unit, nurses and infants.

> *Mmm. So it's not always – to be honest I just think, what's the point in referring them because they just go home with them anyway? And are we referring for the wrong reasons but you get a feeling and you know what the behaviour is like and you know the history and you think well, it's an alert, you have to act on that. (Katy)*

The preference is to get it wrong than be responsible for missing a child at risk.

> *I think, yes, sometimes we get it wrong but hopefully we won't miss the ones that we need, and that's what we explained to the mother. That okay, the nurse thought she was doing the best thing for you and your baby, and had it been different*

circumstances and she just didn't do anything then that woman could be bashed or her baby, in the end the mother came round and understood why that process started, but she still was quite uncomfortable that she thought that she was being beaten. So it has made for a difficult relationship with that nurse and that will happen. (Gerty)

Mmmm. Because there's been so many hideous cases. I think people really don't want to be involved in something like that, dragged through those sorts of things or feeling like they've missed something. (Garfield).

It would make you hesitate I guess. No it shouldn't do actually. I'm just trying to think about how I would feel if I was wrong about making – not making assumptions because you wouldn't be making assumptions, you'd be making referral on x – xyz that you've picked up, it would be black and white stuff. So it shouldn't really make any difference in future assessments. But it must make you err on the side of caution as well. I mean, just as human nature but at the end of the day the child safety and the family safety is what we're talking about so you can't step back. You've always got to put a step forward and if you're wrong then so be it. Then that's great, that families going home and that child will be safe. So that's good. (Amanda)

They also remind themselves that the baby belongs to the family. They continue to support the family to enhance outcomes and safety for the infant within the family context.

Belonging to the Family

Belonging to the Family is a core category about constructing the family unit. It comprises two concepts: *Having Faith in the Family* and *Facilitating Parenting.* Here the focus changes to the infant and family's journey. The nurses have to give over responsibility to the mother and the infant's family. Nurses actively work to facilitate this and hope for positive outcomes for the infant.

Nurses are required to be committed to the family as a whole and recognise the importance of the family in the infant's life. Empowerment of the mother is seen as a key to promoting neonatal outcomes. They employ strategies to enhance families, particularly vulnerable and at-risk ones, and put supports in place to assist family functioning. Challenging behaviours presented by families can make this difficult to achieve.

During this time potential risk factors can be masked by nurses unwittingly accepting undesirable behaviours regarded as a stress response. Neonatal nurses focus on facilitation and encouragement of parenting practices in an attempt to maintain or enhance infants' safety. They maximise opportunities for interaction to combat stress and the disruption to attachment and bonding compromised through the separation of the infant and family at birth.

Having Faith in the Family

Nurses recognise that a premature birth or an infant admitted to a neonatal unit creates immense stress for families. Increased time in a neonatal unit can lead to increased stressors and pressures for families, including increasing pressure from other socio-economic determinants, placing the child at further risk. Nurses recognise this stress influences families' abilities to function. Nurses who had their eyes open to potential areas of risk or problems used chatting as a tool to identify possible risk factors and place appropriate supports. Putting these supports and plans in place helped nurses to have faith in the family, and could be used for identifying what the real issue was, and hopefully decreasing any future risk to the infant.

> *Like, for instance if you have got a parent who hits his wife in the middle of NICU. You actually can say, well, if he does it here what does he do at home? But maybe at home he's not being under the pressure of his baby dying, his wife sick. And I'm not saying it's right, it doesn't make it right at all, but NICU is not the big picture. It's a small picture in the whole life of these people and I think in nursing in NICU, you get so into your little climate that we run into CYFS with this incident and that incident and they're taking our incidences too literally instead of doing the bigger investigation. (Ruth)*

> *If the families aren't connecting, aren't secure, have all those issues then they're not going to be able to care for their baby safely. Bonding and attachment is difficult when you've got all these other issues in your life – being physically separated from family, your support networks and things. A lot of women are very isolated in looking after prem* [premature] *babies…… That's very hard to deal with when you've got all the stress of a baby who is well one day, sick the next day, that sort of thing. Babies are very precious, families are very precious. Working in SCBU* [Special Care Baby Unit] *is more than working with babies, it's working with families. Families who are under*

huge stress . . . . We need to make sure that the babies are safe but we need to support the families too where we can. I think it's part of our role. (Bridget)

When you've got stresses you have people not coping, and when you've got people not coping you will have abnormal behaviour. Whether it comes out as violence or neglect or abuse or whatever, or they're left on their own, abandoned. So you know, there is a whole lot of a thing. (Gerty)

And I can sort of understand how it can happen, people stressed, tired. They react in the only way they know how and it's maybe like that. Or a shake or a hit or whatever and instantly that child was no longer. Stress is terrible. (Garfield)

The type of family or culture of an infant's family can influence the acceptance of undesirable behaviours due to a personal judgment on what is acceptable and what is not and our own construction of culture and accepted behaviours within that culture. Have we as a New Zealand culture also created an acceptance because we are also accustomed to it? The rights of the child were also mentioned, with one of the best examples being the 'anti smacking legislation' generally, society thinks it is okay to hit children. It is almost like an acceptance or tolerance of abuse, leaving a question mark over the social worth of children in New Zealand.

I'm speaking as a Kiwi and I think that we don't do enough, that whole mystique of the staunch, self-reliant New Zealander who takes care of themselves and does for themselves and has this autonomy, maybe isn't what it should be. I think as a culture we are a pretty violent culture and we revere violence in this culture and I think that we should do more to protect children from it . . . . What is the difference between your child and a woman? It's like okay to hit children? (Marie)

Nurses often shift responsibility to the social worker or others deemed to be in a better position to address the issues and provide support for the family. It can also be a unit expectation to shift the responsibility, seeing separate areas of expertise when it comes to social issues. Shifting responsibility, particularly in complicated social cases, creates opportunities for nurses to be excluded, leaving the nurses to handle the bedside care, but having no responsibility or input into social issues. Having passed information on, nurses are not always in a position to follow a referral up or actively take the opportunity to do so, due to shift work or other system barriers. This often leaves them feeling disengaged from the situation, especially if feedback or documentation is lacking. "Passing the buck" can be a form

of letting go, feeling that issues will be taken more seriously anyway if they come from a social worker. Therefore, social workers are seen as more appropriate supports and able to pass information on to enhance infants' protection and outcomes.

> *In this instance, making a referral to a social worker and allowing them to do their job, going through their processes with their systems instead of hanging on ad interfering and getting quite involved with the families. We do see that as quite difficult to work between ourselves in these social issues that we have here (Amanda).*

> *. . . because we don't, I think by and large, we don't feel as if our concerns go anywhere. Maybe I'm speaking generally but when you talk to people in the staffroom, we all have these concerns but we all say, what's being done about it? What happens next? What happened to so and so? We don't know. It would be nice also to get some feedback sometimes about what has happened. (Marie).*

Facilitating Parenting

Facilitating Parenting is providing opportunities and promotion of parental interaction to enhance the family unit and parents' knowledge. Long term neonatal outcomes and survival are influenced by and dependent on family interactions. A disruption to the attachment and bonding process is created through separating the mother, family and infant at birth. Neonatal nurses are working to counteract this by focusing on facilitation and encouragement of parenting practices attempting to maintain or enhance infants' safety. Neonatal nurses try to maximise opportunities for interaction promoting interventions such as skin-to-skin, encouraging handling and infant cares, touch and physical closeness.

> *It's because, historically I know that they have to be involved, they have to feel involved because if they don't feel involved then it can fall apart and – not from the baby's side, the babies don't, they just assume their parents love them. Well, you know, it's about their being there I think. And I think if the parents aren't there and they don't ask questions of us, the babies don't do as well. So children do better if the babies . . . [parents] are , and if I'm talking to parents in the very beginning that's often what I say too. They say, "they don't need me for anything" and actually they do, they need the parents to be there to watch us. (Tom)*

Yeah, but that's what I think we need to develop that contact with the mums and babies so we don't have abused children. (Marie)

Teaching mothering and parenting issues and people don't know what normal baby behaviour is - what to expect from this child and what its needs are. Development as well as just nurturing and feeding and warmth and clothing, it's more than that. Looking after one another, if you can. It mightn't be appropriate in some cultures to say well, husband you need to do this for your wife or wife you need to do this for your husband, to help them understand. Try and make them work as a team. It's a huge thing really. (Garfield)

Mothers themselves and empowering them and I think that is at the heart of – and what is so critical about the neonatal time period phase, is getting in there to make a difference with Mum and baby because I believe that there are only very few circumstances where there are truly at-risk babies that will die out in communities. I think that's only very, very rare. The majority of cases are at risk in terms of other extenuating factors that will influence chance occasions of death and that's the reality. (Katie)

I think we can sort of strengthen a lot of our women by empowering them too and that's where I think we can make a big change (Bridget).

Using language such as "my baby" by nurses looking after the infant can easily disempower mothers and reinforce the image that the babies belong to the nurses rather than the family, further disrupting the attachment and bonding process. To facilitate a process of empowerment, nurses need to ensure they don't disempower the mother as this conflicts with their attempts to promote child protection.

We've got to be so careful not to disempower people. Because they are disempowered automatically when they come into a foreign environment (Bridget)

I'm highly sensitive to subtleties, to the nuances of the clinical practice setting and there's so many things that can set Mum off or Dad off and make them feel disempowered. I work really hard to empower – I think that's my main role and the best thing that I can do for preventing child abuse problems, child protection, is to empower Mum and Dad throughout the whole encounter. There's one thing that gets to me in relation to that, that nurses can improve on, is how they describe as "their"

baby and it's the subtleties, the nuances of the genre of the unit and it relates to this power relationship. That baby belongs to them, whatever the kaupapa, whatever the risk factors. I believe our job is to empower Mum and the whānau [extended family] within this whole framework of their life, whatever the context and it's not for us to judge them. A lot of people – a lot of nurses get affected by that and that prohibits the empowering process that should be happening (Katie).

Facilitating Parenting is identified as a key component of *Shaping the Infant's Safety.*

Shaping the Infant's Safety

The core category, *Shaping the Infant's Safety,* explains how neonatal nurses frame child protection and let go, particularly when sending the infant to what nurses believe to be a substandard environment. Having done as much as possible, the nurses have to trust in the system and the family. The key focus is on how to shape the infant's safety within the complexities. It comprises three concepts, the *Two Faces of Families*, *Knowing the Rules,* and *Difficulties with Child Protection Services.*

Two Faces of Families is indicative of the many constraints factored into constructing safety. The ability to distinguish a family's reality, rather than the constructed reality of keeping up pretences along with the *Two Faces of Families* creates uncertainty in identification of at-risk families. Creative conversations often occur when engaging with families to help construct safety. *Knowing the Rules* and needs requires nurses to enact safety for the infant with a lot of the child protection work being done *ex-parti*. The concern is the possibility of parents removing their child from the unit before anything is even put in place, increasing the risk to the infant. For neonatal nurses to frame child protection they need to construct relationships with child protection services. These relationships are essential for an at risk neonate to be discharged home, and for the nurses to frame safety for the infant and have trust in the process.

Two Faces of Families

Nurses identified that reactions and behaviours families display in the neonatal unit are often unpredictable. A family keeping up appearances gives an impression of holding it together, appearing to function how they are expected to function, while struggling to manage

with the situation. Both approaches may be in conflict with how families conduct themselves in their own home environment.

> *Yes, very clever, because you know, people can put on a wonderful face in public and you don't know what they're like once they get out that door. (Gerty)*

> *I think, sometimes it's people are very good at keeping things hidden in hospital. They are not going to divulge, a lot of people. When we go out we see other things and families are so different in the home and I think that's what a lot of people in the hospital don't realise, that they might be holding it together in the hospital and then when the child comes home it's a completely different scenario. Whether it be stress of what's gone on before, taking a child home that may be very difficult to manage or compounding or just all the stress of being at home, be it monetary worries, be it space, crowding (Garfield).*

> *But if they are hiding dangerous behaviours, does that change? I don't know. I think people like that are usually quite skilled at hiding really. (Tom)*

> *…the bottom line is people will lie to you and deceive you. So you can only deal with as much as you have got at the time and I think you have got to accept that.*

Nurses recognise that they see a snap shot of someone's life at a time when they have more stressors placed on them than usual, so this is the small picture in the whole life of someone. But, depending on the length of time spent in the unit, nurses felt at some stage the families should adapt to their environment and therefore would expect adapted behaviours more in line with a perceived norm. Stress impacts on families in the unit and when the stress lessens a change in behaviour should occur. A window of opportunity appears when parents start to know the nurses and feel more comfortable and abnormal behaviours may become easier to detect in order for nurses to identify and do something before discharge. The window of opportunity is the time in the unit when the nurses have to try to enact change. Nurses' intuition and observation of many families means they can identify concerns if they are open to recognising when things they are not quite right

> *The way that a family would behave here under observation of staff, like, I don't know how you could accurately say that you have evaluated that a family walks in and is showing you what you need to see but for some reason you can tell that. You get that immediate feeling like okay, you're not actually doing what you normally do or talk*

how you normally talk etc and you're putting up a front and that would make me suspicious. Why are you putting on a front in front of health professionals? What are you hiding? It may not be anything. It may just be fear if they have had some previous associations with family members etc that may have been removed or uplifted. What are some other red flags? (Amanda)

You do get quite intuitive feelings, don't you, with certain families. You just don't – I mean, straight away we knew there was a problem with one of our families that were born here, we just knew straight away, you just think that's not kosher, we just found out today - they've been here seven weeks - that the dad's not supposed to be in cooee of the mother. He's up for visible abuse of older children and other stuff but they're not telling us what the other stuff is and he's here visiting with the wife. (Katy)

Knowing the needs and rules

Information is gathered and referred on, sometimes before a conversation is had with the woman or family. This lack of transparency places nurses at risk and creates an uncertain environment. But nurses, as moral practitioners with a social conscience, are also in disagreement about encouraging parents to parent, knowing they may not take the child home.

It's not good at times and I guess a lot of it is the fear that gosh, once Mum and Dad know perhaps they'll just run out, run out and that will be I guess you are covering up for the safety of the child. They're not sparing the parents in this instance, you're sparing the child because you don't want that child to be whisked off . . . (Amanda)

. . . I have knowledge that the parents don't. I don't want that system run any more….. the situation's not fair, it's inhumane to these people….You don't have to because you know that she knows that there's a chance she might not [take her baby home] *and you don't have to get into these silly double conversations (Ruth)*

that's another thing that nurses have a lot of issues – is when do the mothers and families get told the truth (Amanda)

Health professionals are expected to observe for social issues, child protection concerns and screen for family violence. Screening family violence is a way of *Shaping the*

Infant's Safety. Constraints were however identified by nurses. Discrepancies within the neonatal units about whether they screened or did not and whether it was a good thing or not were evident. Breakdowns of trust in relationships with families are a barrier to screening, as nurses fundamentally believe families need to trust them before they divulge their personal circumstances. Creating offence by screening and interfering in their private business was cited as another reason for difficulties in screening. Nurses are *Dancing Around the Families,* trying to elicit information which could lead to inaction, but not create offence – but not asking inhibits action and places the child further at risk.

> *we haven't quite yet got into – it's sort of been compulsory for us to do family violence as a formal assessment because there is debate about whether you – you know, were trying to develop this trusting relationship and like you say, if we ask certain questions then action is taken on it, where does that leave you and that family. Then again, and saying that out loud, it's not about you, it's about the family. (Amanda)*

> *It does worry me about the whole heightening of the family violence, the good thing is some women might think, look if they tell me all the time I don't have to deal with this, I don't have to – this is not what you have to put up with, you don't have to live like this. But what about these really twisted people? Does it make them more and more underground in knowing that when they come into the hospital this woman is going to be asked? Do they threaten her even more to make her be quiet and not confess? And then when she does confess, the first time she does it we all rush in and take the children. Well flip she's never going to! It's not that simple. It's not that – oh yes, I've got family violence; well dear, we'll help you now and it'll all go away and we'll make everything better. If it was only that simple. (Ruth)*

> *But you know, if she says yes, then maybe we can effect change so that that child doesn't grow up to hit or be hit. And I think trusting in the fact that he only hits me is slim, you know, that's maybe trusting an abuser a little too far, that he's not going to hit the child somewhere along the line. Look at the Kahui twins and little Nia Glassie. Are we going to forget them? (Marie)*

Difficulties with Child Protection Services

As nurses try to care for families and babies and do it all properly to construct safety, child protection services (Child Youth and Family Service (CYFS)) are often a constraint. Nurses believe they are not well co-ordinated and they are often left in the dark when they do notify a child protection concern. Immense frustration and feeling unsafe impacts on their work. The very service charged with protecting children was often seen as a major detriment to child protection facilitation.

> *I think CYFS themselves are half the problem myself – they make it very difficult I think (Garfield)*

A lack of trust is created through difficulties with communication and feedback between the units and CYFS. This creates tension, disengages action, affects nurses' ability to do their job and leads to assumptions that CYFS has no idea more often than not about what they are doing.

> *I don't know what they are supposed to be doing. I just know that I can't do my job in a holistic way for this baby and family if I don't know what they're doing and all I know is, you're blocking me, you're stopping me for this baby for protection for this unknown quantity reason of time and I've got a full unit and this baby needs to be safe – what's happening (Katy).*

Nurses are forced to accept the situation and feel they are not listened to and have a lack of control over the situation. This is interpreted as a lack of professional respect as nurses who are charged with identifying risk factors are not listened to or acknowledged - a contraindication to child protection and prevention of abuse and neglect.

> *It's like we don't really have voice – you can say and it's just invalidated really. (Katy)*

> *Or the parents haven't proved their ability to parent or not to parent so you haven't got proof that this parent can't parent but how – do you put the baby at risk? Well, take the baby and if you kill it then we know you couldn't and if you didn't, you were fine. And that's a hell of a shock as a nurse and I can think of five cases off the top of my head, one died, three brain damaged and one - I don't think she had a broken – these bones, what do you call them? Humeruses? From pressure. And these were all babies that left here and every one of them we had our suspicions where you could pick out something with each of them and the biggest indicator, I would say, is – I think not*

visiting and the attachment's not there and you take home a baby you're not attached
to and it screams at night time, you're just not attached. And it probably fits in with
the kind of stepfather abuse, you know. They're just not attached to that child (Ruth)

Neonatal units appear to be seen as safe havens for at-risk infants, compromising the neonatal unit staff's credibility and their safety. Delaying any intervention by CYFS unfortunately also means sometimes missing the very babies they were meant to be protecting, which is a contradiction to child protection

. . . incidences where CYFS are so overloaded that we've had to send the family home
and they've said they'll follow up at some stage and we don't hear back… that's
frustrating and you can never really get those situations out of your head and you're
always thinking.. to that baby and that family (Lucy)

We've struggled with CYFS, struggled dreadfully with CYFS. That around their belief
that a . . . weaker with severe child protection issues is safe therefore no work has to be
done . . . big run around at the end . . . (Ruth)

. . . Always left to the last minute. (Katy)

Shaping Safety

Neonatal nurses have a clear idea on their role given the total dependence of the infant in terms of survival and the fragility of their little lives. Collectively participants believed their role was primarily to enhance infant outcomes by way of family facilitation and promoting child protection. Safety of the neonate is paramount, precipitated by the small window of opportunity nurses have to identify issues and put safety measures and supports in place before the infant is discharged.

It's one of my major things – that's why it was like . . . I'll be interviewed and things
because we do have such a lot of violence and stuff with families that we do see and it
is heartbreaking for these babies and having to be the voice for these babies is huge
and I see that as my role. I'll do everything I can to make sure that this baby at the end
goes into a loving home, that they're not going to be harmed . . . I see my role as an
advocate for the baby and they don't have a voice and they can't project their

emotions or put words to what's happening for them so I see it as my role to have a voice for that baby and to step up and say if there's things happening. (Lucy)

A bit of a gatekeeper I think. An observer, gatekeeper, enabler, educator, supporter, trying to put in good parenting education, how to care, what the expectations are, what normal baby behaviour is, trying to give them strategies and skills to cope with a life changing event. Putting them in touch with resources that they can call upon and sharing information with other community agencies. (Garfield)

I am protecting the child now while it is hospitalised and hopefully protecting the child when it goes home, that I have thought about that child's welfare now and in the future . . . I have accessed every possible thing or made sure that everything that could be done for that child was done – physically, mentally, safety, everything. That's my ideal. (Marie)

Watch, watch everything. (Gerty)

Being an observer in my role, observer of family dynamics. (Garfield)

As providing caring, support for baby and family, but all eyes and ears wide open and alert for things that aren't quite right, and being prepared to document and refer as necessary in order to protect that child. (Bridget).

Child protection is about chatting, observing and catching vulnerabilities. There is a subjective element where nurses' own attitudes, experience and beliefs may impinge upon what they view as a care and protection concern and what they do not. Sometimes ideals and reality are not congruent as there are elements of risk in all families, but their coping capacities will influence future outcomes or circumstances for the child in their care.

If you don't have an expectation they will never meet it. (Gerty)

Summary

A delicate balance is required between meeting the needs of the infants, families, service and society as a whole. In *Dancing Around the Families* nurses working to shape the infants' safety is about capitalising on the advantage of having a window of opportunity to promote infant outcomes and recognising maltreatment risk factors which leads nurses' to

instigate supports.   This is all in the hope of minimising the potential risk of child maltreatment, which is a contributing factor to prevention and protection of the child. To do this the nurse appeared to focus on the infant first then the family and enhancing this connection. Depending on the response and the behaviour of the families and the gut feeling of the nurse, the process to shape safety is adapted. There are inherent constraints in shaping child protection but it is clear the nurses believe they have a role to play and are active participants in the identification of at-risk or vulnerable families. The following chapter will discuss the implications of these findings for nursing practice.

Chapter Five

Implications from Practice

Dancing Around the Family explains nurses coping with, and acting upon, child protection issues. It is about the creative conversations and the work required helping support or enhancing the infant's safety. However, difficulty with communication and transparency of information shared between services and families exists. Individual nursing assessments and tolerance levels of situations and behaviours leads neonatal nurses to see and either act or not act, which in turn creates the dance. In this chapter the implications for nursing practice are explored.

Knowing At Risk Families

The Basic Social Psychological Process neonatal nurses use to identify the at-risk families is *Knowing at Risk Families* by working through the process of *Belonging to Us, Belonging to the Family* and *Shaping the Infants Safety*. The lack of a linear process as depicted in chapter four implies nurses can relate and respond to families at any phase within the core category process; yet this depends on their findings, interactions, information received and shared, and the behaviours displayed by the families. Nurses constantly need to adapt their interactions based on these factors, and families will potentially adapt their interaction in response.

Knowing at Risk Families captures the way neonatal nurses construct child protection by acting on the personal and their professional levels of knowledge. Participants acted on intuition or what many of them referred to as gut instincts.   They often used risk factors identified as "*Red Flags*" to put supports in place for the protection of the infant upon discharge. The difficulty lies in the classification or substantiation of potential abuse and associated risk factors for abuse, including discrepancies between individual nurses or services in risk identification. Child protection presents a state of conflict for neonatal nurses where a sense of social justice prevails and their ideals and reality are often not congruent.

Social Justice

The social mandate of nursing suggests that nurses have strong professional, legal, and moral responsibilities to advocate for infants in their care, and are therefore obliged to take

appropriate actions to protect children (Johnstone, 1999). This behaviour also encompasses aspects of social justice evident in the beliefs and ideas expressed in some participants' comments; and the desire for the infant's well-being. Powers and Faden (2006) claim:

> Justice, then, is not a matter of conforming society to an antecedently identifiable set of distributive principles, but rather it is a task requiring vigilance and attentiveness to changing impediments to the achievement of enduring dimensions of well-being that are essential guides to the aspiration of justice (p.5).

Nurses demonstrated 'vigilance and attentiveness' by wanting the best outcomes for infants and families and also in their desire to have families held accountable. Professional accountability, credibility and willingness to be involved are a human element in child protection practices. The notion of social justice is incorporated with regard to infants' wellbeing and potential outcomes. Neonatal nurses subconsciously or consciously fight for infants at risk of potential maltreatment and adverse outcomes and for them to have equal opportunities for individual development and for their rights to protection and to be free from harm.

Constructs of social justice and fairness for children exist when risk, significant harm, welfare, individual needs, best interests and the rights of the child are discussed in relation to protecting the child. Achieving social justice for children includes the protection of their safety and promotion of their welfare (Sharland, 1999), an aspect the nurses in this study were acutely aware of. The prevailing social-cultural ambivalence about violence towards children is evident in physical discipline being a widely accepted practice by parents and caregivers (previously discussed in Chapters One and Two).

Children are extremely vulnerable and unable to protect themselves from the harm imposed on them by those more powerful (Johnstone, 1999). Therefore, while neonatal nurses try to respect and tolerate people's differences, they are also aware of the criminal justice system as society's way of preventing indecent behaviour and promoting virtuous behaviour. Nurses want to see individuals held accountable for their behaviour and to accept consequences of their actions. They wondered how many opportunities some families received, particularly where concerns had already been identified and where children had previously been removed from a family's care.

Ideally children's rights should be activated by their caregivers or parents. Parents are mandated to protect children and are therefore expected to uphold their rights. However,

they can act as a barrier to children's rights being met. The rights of the child end up being viewed within a family centred framework. The child's rights are therefore marginalised when they are placed as part of a whole, seen as one with their family, rather than as an individual who deserves the respect of the family and society. Children need to be seen as people, rather than as appendages to their caregivers (Brown, 2000). The government has responded to this by initiatives and policies implemented that seek improvements in child outcomes as discussed in Chapters one and two.

Nurses working in neonatal units face a range of moral issues in dealing with child protection. The reality is that not all neonatal nurses are as specifically prepared or equipped to deal with child protection issues as they are for other clinical areas, aspects or skills. Despite the lack of formal, focused neonatal training in this area, the nurses in this study had years of experience and all reported an increased awareness of child protection issues and of risk factors. All units had some form of child protection education, although there was inconsistency in the uptake of these opportunities. In some cases the opportunities were more available for senior nursing staff because of the roles and responsibilities they held within the unit. The difficulty about education for senior nurses is possible absence from the bedside, and although they are in a great position to support the nurses they are generally not the ones interacting 24/7 with the families. It is bedside nurses who are generally in the position to witness family dynamics on a day-to-day basis, and they are the ones in need of education.

If nurses are unprepared, this can lead to ineffectual or inadequate assessments of child protection situations or action concerns. Not all nurses were clear about the practices for family violence screening, neither had all nurses within the units had specific training for child protection or screening for family violence. Nurses who are not screening for family violence, or identifying any child protection concerns, could be displaying what Johnstone (1999) refers to as moral blindness or indifference to a situation. If nurses are not sufficiently prepared to deal with the moral complexities of a given situation, they are unprepared to deal with these situations appropriately and effectively (Johnstone, 1999).

Moral stress, distress and perplexity may cause nurses to be morally indifferent to child protection issues or to defer to institutional or individual norms, instead of acting on concerns. Distress and perplexity occur when nurses know the right thing to do but institutional constraints or confusion about the right processes make pursuing a course of action nearly impossible (Johnstone, 1999). This was evident in this study, as nurses expressed frustration at not being heard or respected when they did deal with issues of child protection.

Consequently, the absence of a supportive environment, or a culture of looking the other way can eventuate. Commitment and education may not be enough, as a supportive social environment and an institutional commitment need to exist to prevent the harms associated with child maltreatment (Johnstone, 1999).

Wills, Ritchie and Wilson (2008), implemented a formal organizational change approach to implement New Zealand's Family Violence Intervention Guidelines aiming to improve detection and assessment of child and partner abuse. Seven hundred staff undertook a full day training reporting increased confidence in identification, assessment and referral; a particular increase in success of screening was seen in the Special Care Baby Unit where the screening was incorporated into a social assessment tool.

Practice Philosophy

The normal experience for most mothers is that they get to practise motherhood in the private setting of their home. Conversely, mothers of newborn infants who are hospitalised at birth for a period of days, weeks or months have to construct and practise motherhood in the public arena and under the surveillance of nursing staff (Lupton & Fenwick, 2001). The birth of a preterm infant or infant requiring a neonatal unit admission can overwhelm, shock and disappoint the mother, father, family/whānau (Siegel, Gardner, & Merenstein, 2006). Parents face barriers posed by the physically intimidating and potentially threatening environment of the neonatal intensive care unit (Johnson, 2008). Parenting is subsequently inhibited by the unknown and unfamiliar (Cleveland, 2008), within an area of high stress and turbulent emotions (Saunders, Abraham, Crosby, Thomas, & Edwards, 2003).

Current technological advances for preterm and critically ill infants isolate infants from their mothers. Parents' focus may shift from the infant to the equipment and technology that supports their infant (Johnson, 2008). Neonatal unit culture and environments can unintentionally place significant constraints upon how parents interact with their infant and begin their experience of parenthood (Heermann, Wilson, & Wilhelm, 2005). Parents may feel like they need to gain permission to handle their infant, are always supervised, and have no choice. Subsequently, they give responsibility to health professionals, trust being a fundamental aspect of this action (Fegran, Helseth & Slettebo, 2006). Nurses can act as 'gate keepers', place constraints on parents, and their need to supervise adds to the mother's

feelings of 'not being a normal mum'. This may make parents feel as if they have to leave some of the parenting to staff, who unconsciously adopt the infant (Jackson, Ternestedt, & Schollin, 2003). Mothers struggle with their limited role in being a mother, especially as nurses and other health professionals provide care for their infants (Johnson, 2008) in the technological environment.

Wilkinson's (2007) comparative descriptive study research of the 'changing rooms in NICU' provided a parental perception of the Neonatal Intensive Care Units physical environment. Positive changes in the NICU environment for parents included the provision of increased space, quieter cot spaces, less intrusive equipment, and comfortable lighting. Improvements in neonatal unit designs can potentially lessen stress and increased space can increase opportunities for uninterrupted times with infants that optimise parenting.

Neonatal nurses recognised that difficulties encountered in the neonatal unit can camouflage normal parenting behaviour and adaptations. Some parental reactions when there are apparent care and protection issues reinforced the concept identified of the infant *Belonging to Us* (that is, the nurse). Nurses use a range of skills to help change this perception. Current neonatal philosophies centre on interventions that support the physical developmental needs of infants and ways to support and enhance the mother-infant attachment (Johnson, 2008). The provision of family centred care practices and developmental care are the components of best practice models in neonatal care (Fegran et al., 2008; Higgins & Dullow, 2003).

The inclusion of families as partners in neonatal units has become a central philosophy of care. Four basic concepts of family centred care in the neonatal units described by Griffin (2006) are: dignity and respect, information sharing, family participation in care, and family collaboration. Information sharing and collaboration are cornerstones of family centred care. The focus of NICUs has become increasingly family centred (Cone, 2007) where parents are empowered – no longer visitors but involved as partners in their infant's care (Cone, 2007). This philosophy of care helps practitioners, like nurses, to recognise that parents and other family members are a constant in a child's life. Nurses have a great influence on an infant's health and wellbeing (Thomas, 2007) while facilitating parent-infant interaction, and integrating care that merges the technical aspects with developmental care.

Attachment is crucial to the infant's survival including psychological and physical health, and cognitive, emotional and behavioural development (Gardener & Goldson, 2006;

Talmi & Harmon, 2003; Wigert, Johanson, Berg & Hellstram, 2006). Nurses recognised in this study that empowerment of the family, but particularly the mother, was vital for promoting positive neonatal outcomes. Family centred care helps construct the family unit, encourages parenting and moves practice from the infant *Belonging to Us*, to the infant *Belonging to the Family*. Nurses recognise the value and importance of the family in an infant's care for positive outcomes. Encouraging parental practices helps them to assess a family's adaption based on observations of participation and interaction, which enables the nurse to have faith in the family.

Barriers to working collaboratively with families include organisational constraints and inconsistencies. Difficulties arise for nurses working with certain families due to their personal values, beliefs and attitudes; this can also create barriers to collaboration and establishing relationships (Saunders et al., 2003). Crisp and Lister (2004) found child abuse surveillance created a role conflict for community nurses with the traditional values of family support. Throughout the surveillance process, neonatal nurses in this study made judgments on parental behaviour, while also recognising the constraints inherent in the NICU environment. However, neonatal nurses have a relatively small window of opportunity to identify at-risk families. The window of opportunity participants referred to in this study and the expectation for parents to start to normalise behaviour in the neonatal unit, is supported by the findings of Fegran, Fagermoen and Helseth (2008). They found a 'stabilisation' phase occurred where parents adapt to life in the unit and their new parenting role. For this to happen, the nurses needed to feel comfortable with the parents, while the parents needed nurses to confirm their ability. This also suggests nurses need to trust families.

The philosophy of family centred care becomes compromised when issues of family violence or a suspected risk of child maltreatment become evident for the infant post-discharge, especially for 'dodgy' people or families. Nurses come to lack trust in the family due to judgments about parental behaviours and possible past history, which impacts on the nurses' attitude and the potential gate-keeping behaviour of the nurses inhibits empowerment of the family. Wilson et al. (2004/05) discussed the complexities of family centred care within the context of family violence, which may compromise the status of the parents or family being constant in a child's life, as the focus shifts to the best interests of the child rather than the family as a whole. When a mother is the recipient of abuse this can further disrupt the mother-infant attachment. As nurses are motivated by the protection of the child, family centred philosophy in reality is more a child-centred philosophy (Wilson et al., 2004/05). This

is particularly evident when neonatal nurses wanting the best possible outcomes for an infant, suspect it may be at risk of potential abuse or neglect. Practice then moves to the infant belonging to the nurse.

Red flags and Intuition

Neonatal nurses working with child protection issues, at-risk families and at-risk infants, talked of subjective judgments based on feelings, not always verified by objective data. This information is derived from observations in their practice. Relying on nurses' intuitive knowledge contributed to judgments being made, such as *Red Flags*. *Red Flags* are risk factors or behaviours that families present with and indicate a warning an infant's safety may be compromised. Some families are referred to in Chapter Four as *Dodgy Families*. The nurse's response to intuition is also influenced by the nature of the engagement with the family and is based on social interactions, knowledge of child protection, the context within which it occurs, and knowledge of its patterns and presentation.

Intuition has been identified as a key component of nursing practice, a sophisticated form of reasoning acquired through years of nursing practice and involving a significant component of reflective practice (King & Appleton, 1007). Carper (1978) recognised that intuition was a way of knowing and informing nursing practice. It has also been described as subjective, immeasurable, non-scientific and mystical and consequently, part of the 'art' of nursing, as opposed to the 'science' of nursing (Cash, 2001; Effken, 2001).

Direct observation of a situation in the clinical setting is thought to be information based and can therefore have a role in evidence based practice (Effken, 2007). Intuition in practice evolves from the acquisition of knowledge, skill and practice (Rovithis & Parissopoulos, 2005) and therefore the direct observation of environmental information, and complex relationships and patterns are inherently meaningful (Effken, 2001). This requires the nurse to be open, receptive and tuned in to a situation (Young, 1987). Information for direct perception comes from the belief that certain events or behaviours occur within a context or in response to other events or behaviours, leading to some form of predictable behaviour or outcome. Therefore, some events will precede others while other events may follow (Effken, 2007).

Nurses' actions as a consequence of intuitive experiences include gathering additional data, validation and corroboration with another nurse and reporting findings of specific interventions. This period of reflection involves being open to incomplete or unclear data and trying to validate intuitive feelings against objective data (Hams, 2000; L. King & Appleton, 1997). The subjective nature of nursing intuition is often at odds with objective practice, but is an important facet of knowledge during times of uncertainty. It allows the nurse to start asking questions and to observe a little more closely, make referrals, and identify supports for or needs of the family (Hams, 2000; King & Appleton, 1997).

McCutcheon and Pincombe (2001) talked about 'synergy' approach for intuition that occurs through the interaction of knowledge, experience and expertise. This linking together of knowledge, past experience, patient cues and gut feelings has also been defined as knowledge received as a whole (or gestalt) (Pyles & Sterns, 1983; Benner, 1984), and allows the immediate grasp of ambiguous patterns of data (Brenner & Tanner, 1987). This produces an emotion or feeling about a situation and engages a quicker response from an individual and the possible explanation for the 'gut feelings' that are associated with intuition. As a nurse's physical sensation or emotion rather than rational thinking may be the first response to be acknowledged, it can be difficult to verbalise due to the inability to support initial feelings with objective fact (Smith, 2009).

In turn, gut feelings nurses experience are the discrepancy between the responses they expect to see in the family and the actual behaviour displayed. Neonatal nurses working daily with families observe expected normal behaviour of parents – that is, the expected interaction, behaviour and conduct in the neonatal unit. Due to limited privacy, nurses develop an expected response from families amongst the stress and constraints of the unit. This is based on previous knowledge and experience gained from interacting with other families. The developed background knowledge of the patient and family would provide the basis for judgments of infants and families. The better the nurse knows the family, the greater the possibility of a comprehensive and appropriate sense of the family situation.

The use of intuition when working with vulnerable families and child protection concerns has inherent difficulties when people are required to rationalise and articulate protection issues given the legal implications in the judicial aspect of the child welfare system (King & Appleton, 1997). This may explain one of the difficulties for neonatal nurses interacting with Child Youth and Family Services (CYFS). Where child protection services don't listen to or value nurses' intuition, this may partially explain some of the communication difficulties and

frustrations nurses' experience when trying to deal with these issues, particularly in light of the increase in abuse cases and the need for substantiated evidence.

Building on Family Abilities

Families exist within a social context and therefore react to social and economic pressures and can reflect general societal attitudes. Families all function in different ways so need different approaches (see Table 5.1). In order for a family to work effectively or to be safe it must function with the capacity to care, to support, protect one another, and show love, tenderness and compassion. The capacity to care is a crucial role for whānau particularly with respect to children (Durie, 2003). Durie (1994) identified five types of families and functioning capabilities for each, necessary to promote and maintain the health and safety of family members. The capacity of whakamana (empowerment) must also be present to situate the child's safety and optimal development potential within the family context. Whānau functioning impacts on the health and safety of family members - an ideal family or whānau will provide an optimal environment (Durie, 1994).

Health enhancing families are resourced with capable functioning to invest in the well-being of themselves and others. Laissez-faire families can be well meaning but lack direction or guidance while restricted families lack resources. Overwhelmed families function at a day-to-day level and cannot cope with the unexpected, such as a premature birth. Their reserves may have been over-reached with socio-economic factors influencing health outcomes. Unsafe families have a basic lack of respect for others, often resorting to violence, and have a high risk of socially adverse behaviours. Table 5.1 describes these families and aspects of characteristics that may be able to be identified, or may be displayed, in the neonatal unit and the potential perspective of risk for the infant.

Differentiating families and modifying interventions to match links well with nursing philosophies, such as family centred care and the principles of individualised care planning. Durie's synopsis of different families could help nurses to start to differentiate the different types of families as opposed to lumping at-risk families into one category. Providing a guide to tailor responses and interventions for health professionals may help alleviate frustration for staff, and importantly, better meet the needs of families by providing and offering resources and supports appropriate to the family type.

Table 5.1

Family/Whānau Type, Characteristics and Child Protection Risks

Family/Whānau Type	Characteristics Displayed/Identified	Perspective
Positive families *Positive functioning. Caring, consider safety of children*	High level of connectedness and functioning.	Low risk for child protection concerns. Positive environment for optimal development.
Unsafe families/ whānau *Inability to reach maximum potentials. High risk of socially adverse behaviours*	Control issues. Complete disregard for rights and respect of others. Violence, including history of violence and previous child protection issues.	High risk for abuse perpetration, including neglect.
Laissez faire families/whānau *Potentially due to limited knowledge and skills and lack of routine and organisation*	Ad hoc lifestyle with limited guidance. Limited guidelines, standards or interference, or engagement in relationships. Learning via observations, rather than knowledge and guidance. Unhealthy lifestyles, including smoking, poor nutrition, lack of discipline. Unexplained injuries or mismatch between explanation and injury.	Abuse issues perceived by some due to lack of choice and minimised best outcomes for neonates around lifestyle options and role modelling. Potential for neglect and abuse.
Restricted families/whānau *Good intentions but lack skills, knowledge and resources*	Passive attitude to healthcare and to children. Late interventions. Cost issues. Social determinants evident.	Potential for neglect, and need for education.
Overwhelmed families/ whānau *Reserves reached Unable to access or depleted*	Cannot cope with the unexpected, such as premature birth. Day to day functioning, no long-term goals.	Limited or impaired ability to function. Potential for neglect and abuse. Potential for disruption of attachment.

Note: Adapted from Whānau, family and the promotion of health. M Durie, 1994

Durie's cultural perspective is Māori-centred, intended to encapsulate the health, well-being and safety, it also makes recommendations for improving outcomes for Māori (Burrell, Thompson, & Sexton, 1994). Reviewing the literature for child maltreatment highlights that risk factors for abuse are not only present in Maori society, but other cultures as well and therefore these similarities in risk factors are present irrespective of culture. Interestingly, the focus of the neonatal nurses in this study is on risk factors, rather than consistently appearing to identify one cultural group. Considering this, Durie's framework fits well with this research. Maltreatment of children is the collective impact of community, family and individual and cultural factors; where stress, family resources, social supports and the resilience of families, appears to impact on potential for child maltreatment to occur (Burrell et al., 1994). Family

capacities are evident cross-culturally, including the recognition of, and implication of, health literacy skills.

In my experience, when trying to engage families in health promotion, comments are often passed on how families who need the education or supports available do not take up these opportunities. Instead it is the families that nurses' are least concerned about that willingly accept all information available. Families who display evidence of continual patterns of 'dodgy' behaviour and not accepting support add complications to child protection. Information sharing needs to be viewed in terms of health literacy and as a social determinant (Nutbeam, 2000). Social, economic and environmental factors determine increased risk of adverse outcomes.

Health literacy refers to the personal, cognitive and social skills that determine the ability of an individual to understand, gain access to and use information to promote outcomes, together with their motivation and ability to use information effectively (Nutbeam, 2000). The interaction of differing levels of literacy, people's social and personal skills and exposure to information enhances people's autonomy and empowerment (Nutbeam, 1998; Nutbeam, 2000). This enables health-seeking and safety-promoting activities, and importantly, the capacity to use information effectively (Nutbeam, 2000). Low literacy is associated directly and indirectly with poor health outcomes and is observable in responsiveness to health education (Nutbeam, 2008). It is the central factor in inequalities in health (Nutbeam, 2000). If health literacy is viewed as an asset, there is the opportunity to empower others to have greater control over their personal, social and environmental effects on health. Health literacy can also be viewed as a risk if individuals are unable to understand or assimilate the information provided, and therefore interventions should then be aimed at empowerment (Nutbeam, 2000) of the parents.

By considering health literacy, nurses could engage change by trying to determine the best approach for the family. Thinking about health literacy could lead them to ask: "Are we getting the message across effectively?" "Is it being delivered in the right forum or right way so that it is understood?" This is about providing the family with health-promoting education. The health sector can mitigate effects by recognising the impact of health literacy on individuals, by professionals showing sensitivity to families and by adopting appropriate language and communication and teaching strategies to meet their needs (Nutbeam, 2008).

Overcoming Barriers

Child protection practice in neonates is potentially based on unsubstantiated assumptions. In part this is due to different acceptance levels and the knowledge base of the nurses but is also in part due to the difficulties in determining exactly which infants may potentially be abused, the accuracy of information shared and collaboration with other services. This leads to difficulties in addressing concerns with child protection agencies as well.

Much of the child protection training for nurses focuses on identification and observation for physical signs of injuries or neglect. Nurses who work in areas where infants and children are admitted may have the objective physical evidence to substantiate their intuition. Nurses working in the neonatal units are detecting and intervening pre-abuse, which is ideal for protection and prevention but it is difficult to substantiate whether a child is definitively at risk. Objective evidence of maltreatment relating to other siblings or the mother could be identified if the nurse is attentive.

The use of emotive language by the nurses reflects the depth of feeling about wanting the best possible outcomes for the infants in their care. Although labelling types of families may be viewed as negative and counterproductive, it does highlight the potential for the nurses to better identify at-risk families, by enabling the identification of the type of parent, including the risk that the child will be removed from the unit by the family (placing the child at further risk) including the risk to the nurses and service. Throughout the infant's admission, nurses try to shape safety for discharge. In order to discharge an infant they have to trust the family or the system. Trust is described by Johns (1996), as an important aspect in the nurse-patient relationship, requiring belief, hope and confidence. This often results in a realisation that they have done as much as they can do to protect the infant.

Issues about the quality of social work interventions in child protection services can impact on outcomes for the neonate and frustration for nurses. Social workers themselves acknowledge the difficulties and ambiguity.

The work is complex and there are few absolutes. Staff members deal with ambiguous information, grey areas and find solutions among options that are less than ideal. The work is high risk and mistakes are dangerous and costly in both human and financial terms (Brown, 2000 p.9).

Difficulties arise in assessing risk and making safe decisions, due to lack of training, difficulties with retention, and high case loads (Brown, 2000).

Barriers to child protection identified in this study have also been supported by other studies. Land and Barclay (2008) used the term 'mushrooms in the dark' to explain communication barriers to interdisciplinary collaborative practice, compounded by child protection workers being unnecessarily secretive. Communication problems can lead nurses to feel inadequate (Nayda, 2002) and in an unequal position with child protection services, identifying the need for equal status and respect when dealing with child protection services and workers (Lagerberg, 2001; Land & Barclay, 2008; Piltz & Wachtel, 2009). Nurses making referrals to child protection services expressed a lack of feedback, which was also identified in this study. Any difficulties with referrals, such as getting concerns across, perceived ineffective interventions where there are either delays in response or no response, causes a lack of trust in the child protection services, despite acknowledging an overburdened system and workload (Lagerberg, 2001; Land & Barclay, 2008; Mummery, 2002; Nayda, 2002; Piltz & Wachtel 2009).

Possibly the burden of risk that lies with social workers contribute to the perception by nurses that they are not being heard. This burden leads also to a lack of support provided by social workers from care and protection services. The statutory investigation by child protection services into a report of child abuse or neglect carries enormous responsibilities, and the quality of investigation and assessment work lies with the ability of the social workers, who themselves have individual thresholds, and varying case load volumes. Complex, ambiguous or unreliable information leads to grey areas and therefore social workers can become hesitant in their decision making, subsequently leading to errors occurring (Brown, 2000). Naturally a barrier to referrals can occur in these situations, particularly when nurses are used to managing clinical situations and relinquish responsibility of care only when they have assessed the person taking over as competent (Mummery, 2002), almost as they do when building trusting relations with parents: though in this case it is working with child protection services, which they sometimes do not consider competent.

Interagency collaboration is also difficult due to differing philosophies and other structural, cultural and financial blocks, as well as the uncertain environment of child protection work leading to heightened anxiety. Neonatal units, when notifying child protection agencies, experience frustration, especially at not being communicated with about what action is being taken and if the plan is not communicated in an appropriate timeframe

for the neonatal service. Notification response time can also have an impact on the notifying service with discrepancies between response time and timeliness required prior to infant discharge from the neonatal unit (Brown, 2000).

Some infants classified as non-urgent have a child protection agency response time of 28 days (Brown, 2000), meaning they are likely to be discharged prior to their risk being assessed. There is a then a possibility that children remain in situations detrimental to their welfare. A decrease in reporting, with external perception that low urgency cases will not be responded to also potentially impacts on infants' safety. Unfortunately children at the low-risk end of the continuum, who are not responded to, could potentially have their risk escalated requiring a high level of intervention at a later point.

Child Youth and Family Services are charged with the care and protection of children. Ultimately their success depends on the amount of resources available and accurate identification and targeting of resources for children in immediate danger or with the highest need (Heatherington, 1998). Family links need to be maintained but the safety of the child should be paramount. Children are only removed from the family as a last resort and only if serious risk can be found (Brown, 2000). To balance this, Children Young Persons and Their Families Act 1998 governs child protection practice with the aim to keep children free from abuse and neglect.

The primary role in care and protection of a child lies with the family. Maintenance of the family requires assisting and promoting care and responsibility within the family unit, while providing protection for children from maltreatment. The family should be supported, protected and assisted as much as possible and therefore any intervention into the family should be minimal to ensure a child's safety and protection (Brown, 2000). This highlights the reason for possible conflicts between neonatal nurses and child protection services, as there is a discrepancy between nurses wanting to see maximum input into the family from Child Youth and Family, who come from a minimal intervention framework. In addition to this, Munro (1999) found care and protection workers based assessments of risk on a narrow range of evidence, biased towards information readily available, overlooking significant data from other professionals.

Risk assessment involves the systematic collection of information to establish care and protection practices related to the potential abuse or neglect of a child. Risk assessment appears to be primarily concerned with families already identified and the goal shifts from

substantiation to determining probability of further abuse or maltreatment (Munro, 1999). It is an estimate of the probability that a child will be maltreated in the future, assessing for the type of intervention required. Risk conveys there is the possibility that a given course of action will not achieve its desired outcome and that some other undesirable situation will occur. Objectively, any given environment may contain behaviours or conditions associated with adverse outcomes. Subjective perceptions of risk vary between individual and social groups leading to different levels of risk or adverse outcomes (Alaszewski & Manthorpe, 1991).

Nurses in this study created ways of knowing, so *Knowing at Risk Families* is achieved despite the availability of formal focused neonatal child protection training and previously mentioned constraints on attendance at education sessions. Nurses' awareness and knowledge is shaped by their personal and professional experiences, and previous interactions with at-risk families. Reflection on experiences of themselves and others also serves to increase their knowledge base for dealing with future child protection concerns. The subjectiveness, discrepancies, opinions and judgments involved in dealing with child protection concerns was highlighted in *Knowing at Risk Families.*

How to gain the best possible outcomes and protection for at-risk infants is reflected in the work nurses do to promote parenting and opportunities to enhance attachment and bonding by providing skin-to-skin contact as one example, as well as seeking appropriate supports for families and making referrals. However, in doing so nurses could unintentionally impose judgments on parental behaviour and must navigate the minefield to ascertain whether it is a child protection issue, or issues brought about by the NICU arena, and the pre-term birth.

Family centred care practices become challenged when trying to navigate between the family, child protection services and the desire for the best possible outcome for the infant, especially since the change from a safe to an unsafe family or unhealthy environment is seldom sudden (Durie, 1994). The impact of increased stress from the birth of a preterm infant could potentially exacerbate this already unsafe environment. Neonatal nurses, who have a grasp of risk factors, intervening with resources or education to help at this level are helping to resource families and could equip the family with functional capabilities.

Summary

In this chapter implications for nursing practice have been discussed and it has been concluded that despite the difficulties, nurses help create solutions to enhance outcomes. Child protection is now a significant focus of neonatal nursing encompassing the social and moral mandates of nursing practice. The following chapter will summarise the study and present the key areas of this research study.

Chapter Six

Conclusion

This thesis explored the research question, "What is happening for neonatal nurses in child protection?" In the process a grounded theory emerged, which provided an understanding of their role. Personal interest and knowledge, increased awareness arising from media campaigns and the reporting of child maltreatment, along with Ministry of Health objectives and initiatives inspired the initial conception of this research study. Neonatal nurses are in an ideal position to interact with, observe and empower families, and to intervene where child protection is needed. This is especially important as infants less than one year of age are at increased risk of maltreatment.

Literature identified risk factors at the social, parental and child levels that can collectively and independently place infants at risk of maltreatment. Infants aged less than one year are particularly vulnerable due to their complete dependence on caregivers (MSD 2006; UNICEF, 2003). In addition to this, the disruption to parenting and attachment occurs from the mother-infant separation and increased stressors at birth (Bugental & Happaney, 2004; Prentice & Stainton, 2004). Furthermore, the significance of screening for family violence for its co-occurrence with child maltreatment is recognised, along with its association with detrimental effects for both mothers and infants (Fanslow, 2006; Fanslow & Robinson, 2004; Ministry of Health, 2000).

To determine neonatal nurses' understanding of their role in child protection and uncover what was happening, a qualitative research design using Glaserian Grounded Theory as a methodology and semi-structured face-to-face interviews was implemented. Areas explored in the interviews covered participants' knowledge, understanding and experience of child abuse relative to their practice; their beliefs around child abuse and preterm infants; how they perceived their role; how their attitudes influenced child protection practices; and how they perceive the relevance of child protection and maltreatment prevention to neonatal nursing practice. Grounded theory guided the inductive analysis and construction of the findings into a substantive theory about neonatal nurses and their role in child protection. The findings were derived directly from the participants themselves and constructed from the substantive area relevant to the study phenomenon to identify the Basic Social Psychological

Process of *Knowing at Risk Families*, and the substantive theory *Dancing Around the Families*, conceptualising and explaining the behaviours and understandings of neonatal nurses.

The grounded theory produced as a result of this study is a reflection of current neonatal nursing practice regarding child protection. However, there were limitations to this study. There was a small number of participants in this study compared to how many nurses work in the neonatal field, and recruitment was limited to those who consented to participate, limiting more extensive theoretical sampling. This was overcome though by exploring new concepts with each new participant. Interestingly, theory saturation was still achieved as the data was similar from each participant. Glaser and Strauss (1967) support the successful development of consistency among the concepts uncovered, which gives credibility to the Basic Social Psychological Process and the core concept discovered.

The nurses interviewed were passionate about child protection issues, articulate and actively working to maintain the protection of the infants they believed to be at risk. The participants interviewed were experienced nurses whom colleagues often referred to, given their expertise, and who therefore felt obliged to deal with care and protection issues – evidence of their credibility among colleagues. Due to the experience of the participants, I potentially missed a group of nurses who were limited in their child protection activities, and I can only speculate as to why this may occur. To try to engage changes in practice, there is also a need to uncover what is happening for these nurses. The participants interviewed gave in-depth accounts of what was happening and what they perceived to be happening in all aspects related to their area.

The Basic Social Psychological Process of *Knowing at Risk Families* was constructed out of the core categories identified as *Belonging to Us*, which related to the nurses' journeys with the infant; *Belonging to the Family* which related to nurses recognising that responsibility and care belongs to the family; and *Shaping the Infant's Safety* which involved how nurses construct child protection for infants they believe to be at-risk.

Dancing Around the Families incorporates aspects and practices of nurses that explain their coping with, and acting upon child protection issues. It is about the creative conversations and work required to help support or enhance an infant's safety. Nurses' individual tolerance levels and assessments of situations influence whether or not they will act on child protection concerns. Their decision is also affected by difficulties in communication and transparency of information sharing between services and families.

Belonging to Us depicts how nurses nurture the infants during their hospital stay to enhance outcomes. During this period the focus is on the infant's journey with the neonatal nurse. Neonatal unit philosophies of care underpin practice to enable each infant to reach its full developmental potential, and to be discharged to a safe environment conducive to positive health outcomes. Reflection on these practices creates an contradictions for neonatal nurses constructing child protection by manipulating the neonatal unit environment, facilitating bonding and attachment, while having regard for the environmental influences the infant will be exposed to when discharged home.

Nurses' knowledge allows them to have a deeper understanding of the infants' physical wellness and potential neuro-developmental outcomes. It also means that they are aware of the need for health enhancing behaviours if infants are to reach their full development potential. When faced with a family perceived to be dodgy, nurses are able to take a stance of ultimately being there to save and protect the infant, adopting a stance that the infant belongs to them. These '*Dodgy Families'* ticked all the risk factors for child abuse and neglect or appeared to hide things, while some overtly displayed behaviours considered not conducive to the neonatal unit environment or to the future of this infant.

In spite of the emotional context when dealing with child protection issues, nurses are required to deal with *Dodgy Families* and situations in a professional manner, despite expressions of frustration and being 'mad, sad, angry'. Engaging with infants and families requires having (to have) faith in the family. *Belonging to the Family* identifies practices for constructing the family unit, such as facilitation of parenting, attachment and bonding, family responses to interventions and their infants, all helping the nurses to have faith in the family. N*u*rses having to give over responsibility for the infants to the family changes the focus from the nurse to the infant and the family's journey. The hope is for positive outcomes for the infant and this is actively facilitated by the nurses being committed to the family as a whole. Empowerment of the mother and family is identified as the key to promoting neonatal outcomes.

Knowing at Risk Families captures how acting on both personal and professional levels of knowledge, neonatal nurses construct child protection. Nurses put supports in place to protect an infant in response to intuition, gut instinct and *Red Flag*s. In constructing child protection a state of conflict is created where the nurses' sense of social justice and ideals are not always congruent with achievable outcomes and the reality of the situation.

Knowing the needs of the system and rules leads to creative conversations with families. To create safety for an infant a lot of work is done *ex-parti*, meaning information gathered is potentially referred on to social workers, other health professionals and child protection services before conversations are even had with the family. A concern is the possibility that parents will uplift their child, before supports and plans are put in place, increasing the risk to the child. A lack of transparency places nurses at risk of abusive behaviours from families, although it can lead to creative conversations with families. This makes nurses feel uncomfortable as they disagree with encouraging parents to parent, knowing they may not take the infant home. Framing child protection and letting go requires the neonatal nurses to shape the infant's safety. The many difficulties arising in the construction of safety leads to nurses feeling powerless to change the course of events for some infants, and eventually a situation is created where they just have to let go.

Relationships need to be constructed between neonatal units and child protection services, such as Child Youth and Family in shaping child protection. These relationships are essential for an at-risk infant to be discharged home, and for the unit to trust the process and systems in place. When these relationships break down, acceptance is forced upon nurses who feel that they are not listened to, and that they have a lack of control over the situation. This also creates distrust and conflict between neonatal units and child protection services.

Neonatal nurses shaping child protection are constrained by a process that is not well coordinated and by their being left in the dark. Nurses often feel frustrated and that their efforts in child protection are compromised by a lack of communication from Child Youth and Family and the timing of their interventions and plans of safety being implemented, which leads to difficulties working with families. Delays in interventions by Child Youth and Family Services, create the perception neonatal units are viewed as safe havens, although this compromises the credibility of the unit. Unfortunately delays in interventions sometimes mean infants end up being discharged home, and consequently the very babies they were meant to be protecting can be missed – a contradiction to child protection. Unfortunately the service charged with child protection was often cited as detrimental to the facilitation of child protection.

Another constraint on identification of at-risk families is the potential to accept undesirable behaviours of families. This is attributed to a stress response created by separation from the infant, and the impact of the neonatal unit environment, placing pressure on other socio-economic determinants that impact on the family. Culture also impacts on the

acceptance of undesirable behaviours measured by the nurse's own beliefs and accepted norms within his/her culture, along with personal judgments about acceptable behaviours. It was also apparent that neonatal nurses tend to look at child protection issues based on a western, white middle-class ideology. In the context of child protection and family violence this dominant knowledge-form informs the practice of neonatal nurses.

Neonatal nurses applying their own judgments of good parenting behaviours to other cultural groups potentiates the risk of labelling parental behaviours as abusive or benign (Ferrari, 2002). Therefore, neonatal nurses need to be aware of their own beliefs about, and acceptance of, child maltreatment. Reflection is required to determine whether their beliefs fit with hospital standards and policies and government strategies.

The ability to distinguish the reality for a family, as opposed to the constructed reality of keeping-up pretences is a constraint in accurately identifying at-risk families. The subjectivity of assessing the *Two Faces of Families* is compounded by individual and sometimes unpredictable responses displayed in the unit. These behaviours may be in conflict with how a family functions in their own home environment. Vulnerable and at-risk families are assisted by nurses who have their eyes open to potential areas of risk or problems and use chatting as a tool to help identify issues. These issues or risk factors are used to place appropriate supports in place, helping nurses to have faith in the family. Identification of vulnerable families may subsequently decrease the future risk to the infant, and it makes the nurses feel that they have contributed to the protection of an infant and enhanced its outcomes.

Nurses subconsciously or consciously fight for infants at risk to have equal opportunity for personal development and equal rights in terms of their protection to be free from harm. The social mandate of nursing implies nurses have a moral responsibility to respond effectively to moral issues encountered. Nurses have strong professional and legal responsibilities and are obliged to take appropriate action to protect children. Concepts of social justice are incorporated where nurses express a wish to see families held accountable for their actions and in efforts to support infants' wellbeing and potential outcomes

Incorporating the application of Durie's (1994) (see table 5.1) family types, family function and required capacities into assessment and care, could enable targeted interventions to support families and to respond to the differing needs of each, rather than treating them all the same. Families' and individual's opportunities could be further enhanced by the consideration of family capacities, capabilities and health literacy ability. Individualising

approaches to care links well with neonatal philosophies of practice, and differentiating family interventions may alleviate frustrations for nurses and improve child protection practices.

In addition whānau ora is a new policy for working with families that requires identifying their strengths and capabilities along with putting in place support systems. It is about engaging with families actively and positively, while recognising the distinctiveness of whānau-centred practices for the promotion of whānau well-being. The framework sets out a range of recommendations for achieving outcome goals, paying particular attention to social, economic and cultural benefits for individuals, as well as the collective whānau, and at a population level. The focus is on whānau as a whole, building on strengths to increase their capacity for overall well-being (Durie et al., 2010). As a model of practice whānau ora is not new to health or social services but provides a distinctive approach, recognising the collective entity, and endorsement of group capacity for self determination. It is built on a Māori cultural foundation to assert a positive role for whānau within society and can be applied across a range of social and economic sectors (Durie, Cooper, Grennell, Snively, Tuaine, 2010).

Nurses are actively working towards ensuring the best outcomes for infants and families. There are constraints and limitation on constructing child protection which are created by the differing philosophies, objectives and realities of families, health professionals, social workers and Child Youth and Family Services. No judgments or plans should be made without collaborative practice but for positive and effective interactions nurses require a more open approach from Child Youth and Family Services and subsequent improvements need to occur in collaboration and team work. Individual approaches, assessments, attitudes and willingness to share can potentially be accounted for by ensuring training for all front line staff and advances in communication and information sharing between neonatal units and child protection services.

I believe this study to be a true reflection of what is currently happening for neonatal nurses in child protection and this is evident within the study content but there are still a few limitations to this study. This grounded theory provides an explanation of the practice of nurses in a small number of neonatal units, although the units were chosen based on trying to cover a range of social demographics.

There were a small number of participants in this study compared to how many nurses work in the neonatal field and recruitment was limited to those who consented to participate, limiting theoretical sampling. This was overcome though by exploring new concepts with each

new participant. Interestingly, theory saturation was still achieved, as the data were similar in each area.

The nurses interviewed were passionate about child protection issues, they were very articulate and actively worked to maintain the protection of the infants believed to be at risk. They were also very experienced nurses, which meant that they often held positions where engaging in child protection activities was expected of them and a reflection of their professional credibility. This does mean though that I potentially missed a group of nurses who were limited in their child protection activities and we can only speculate as to why this may occur. To try and engage change we would also need to uncover what is happening for these nurses. The participants interviewed however, could give in-depth accounts of what was happening for them.

Information regarding child maltreatment and protection is vast but literature specific to child protection and neonatal nursing practice was limited, however due to the amount of literature, there is the potential to have missed some relevant articles and information. During the timeframe in which this research was undertaken new initiatives or advancements in child protection have been commenced. These may have been missed or not included as a focus. For example during the data collection the Never Ever Shake a Baby campaign, which will have significant relevance for parental education within the neonatal units pre-discharge, had not started.

Recommendations

To conclude this study the following recommendations are put forward for nursing practice and education, and a suggestion for future research to follow up further in this field:

- Meetings should be held between neonatal units and child protection services separately from child protection cases, with the aim to improve communication and to encourage a partnership and collaborative practice at all levels. This should include nurses, not just social workers.
- Implementation of joint case reviews and feedback from child protection services regarding the infants under Child Youth and Family Services.
- Changes need to be implemented to improve documentation from child protection services.
- Safety plans need to be formalised in a more timely fashion. A timeframe should be agreed upon when a case is first referred to child protection services.

- Education for neonatal nurses on the documentation required and how to articulate concerns to engage action from child protection services.
- An education package needs to be developed and provided to child protection services. This could include information around general practices, principles in the neonatal unit, and neonatal conditions. It could also incorporate service requirements for admission discharge and regional commitments.
- Education for nurses about intervening with the different types of family functioning including family capabilities, health literacy and the determinants of health that contributes to being vulnerable.
- Incorporation of the Whānau Ora framework into practice
- Neonatal nurses should be aware of the range of community services to which parents could be referred, and how to refer.
- Education to parents on the safe care of distressed infants post-discharge.
- All nurses should receive child protection and screening for family violence education.
- A specific neonatal group be established to advise in neonatal/preterm infant child protection issues.

Future Research

- Future research should critique the different approaches to protecting neonates and the specific difficulties with protection for this vulnerable group.
- Research could also include examination of the actual relationship between premature infants or unwell infants admitted to a neonatal unit and maltreatment, which includes incidences and statistical analysis, Child Youth and Family Service involvement and outcomes.
- Additionally for each case of child maltreatment, parental perception on why maltreatment occurred and what could have prevented the abuse from a perpetrators viewpoint should be recorded.

A Final Word

Finally, neonatal nurses should think about their interactions with families in practice at all levels, and ask themselves the following questions:

- Are you giving the best you can, or is there room for improvement?
- Are you role modelling safe practice and taking opportunities to have conversations around health outcomes?
- Do you need more knowledge support and processes in place?
- Are you acting on assumptions not validated, or have you validated them?
- Are your eyes open to all possibilities with a non-judgmental attitude and heart?

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Appendices

Appendix 1: Information Sheet

The role of Neonatal Nurses in Child Protection

INFORMATION SHEET

My name is Tina Saltmarsh, and I am a postgraduate student of the School of Health and Social Services at Massey University. I am currently enrolled in the Masters of Philosophy in Nursing and undertaking the above research project as part of my thesis for completion of this degree. I am currently employed as the nurse educator for Special Care Baby Unit Waitakere Hospital.

Throughout my nursing career, I have had a particular interest in child protection issues. Currently there are expectations placed on nurses to screen for family violence and identify child protection issues. I am interested in nurses' views of how they construct child protection in their nursing practice in order to understand what the current perceptions of child maltreatment and protection issues is for neonatal nurses. I would like to invite you to participate in this qualitative research study. This research may be used to inform future planning and development of child protection practices, and will add to the body of literature on child abuse. Currently there is little literature in NZ pertaining specifically to neonatal nurses.

I am aiming to recruit up to 20 neonatal nurses. If you are interested in participating in this study, you will be eligible to participate if you meet the following criteria

Eligible to participate in this study if:

- You are a registered nurse working permanently within a neonatal unit.
- If you have been employed in your current unit for more than 6 months

You will not be eligible to participate in this study if you are:

- Employed by the unit on the casual bureau, or a bureau nurse working in a neonatal unit
- Currently employed in another service.
- Undertaking any child protection research projects.
- Have a history of working with child protection agencies.

Your involvement

You will be invited to participate in one interview of approximately one-hour duration. The interview will involve a series of questions related to the study that allow you to share your experiences and thoughts. The interview will be audio-recorded to allow for later transcription and analysis of the data. I may also take notes during the interview. The interview will take place at a venue of your choice and at a negotiated time outside of your work hours and commitments.

To ensure confidentiality you will be asked to choose your own pseudonym for this study. Any identifying information will only be accessible to me and Dr Denise

Wilson (research supervisor). The interviews will be transcribed by me or Massey University recommended transcriber who will sign a confidentiality agreement. The recorded information will be erased once the transcripts have been checked for accuracy, and any information used in my thesis or any publications will contain no identifying information.

The interview information will be kept in a securely locked filing cabinet, on a computer and USB Flashdrive that will be password protected. I will have access only to this during the study. All consent forms will be kept separately in a secure filing cabinet in a sealed envelope, and following the research all data will also be stored at Massey University in a secure location and disposed of as per the School of Health & Social Services protocol.

Your rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Contact me at any stage before signing consent or during the research if you have any further questions.
- Decline to answer any question.
- Stop the interview at any time and ask for the recording to be stopped.
- You have the right to withdrawn from the study up to one week following your interview.
- Provide information on the understanding that your name will not be used.
- Request a copy of your transcript and a summary of the findings.

Support processes

I will have available information on EAP services for your area of employment should you feel distressed and need to talk to someone.

Please feel free to contact the researcher, and or the research supervisor, if you have any questions about this project:

Tina Saltmarsh:	Dr Denise Wilson:
Researcher	Supervisor
Nurse Educator	Senior Lecturer
Special Care Baby Unit	School of Health and Social
Waitakere Hospital	Sciences
(09) 4868920 ext. 7895	Massey University
tina.saltmarsh@waitem atadhb.govt.nz	(09) 4140800 ext. 9070
	D.L.Wilson@massey.ac.nz

Thank you for your time in reading this information sheet. If you would like to participate in this study and are happy with the information you have been supplied, please sign the consent form and return to the researcher in the supplied freepost envelope.

Regards, Tina Saltmarsh

Appendix 2: Consent Form
A

The role of Neonatal Nurses in Child Protection

Participant Consent Form.

I have read the information sheet and this has explained the details of the study to me.

I have been given the opportunity to ask questions.

The questions I have asked have been answered.

I am aware that I may ask questions anytime throughout the study and I can contact the researcher and / or the research supervisor.

I am aware the interview will be audio recorded and I agree to this.

I am aware that my participation in this study is confidential and no identifying information will be published, including any information pertaining to my area of employment.

I may withdraw from the study anytime up to one week following the interview.

My participation in this study is voluntary.

I agree to participate in this study under the conditions set out in the information sheet.

Signature _____ Date _____

Full name printed _____

Contacts details   _____

                    _____

                    _____

Preferred method of contact _____

Appendix 3: Transcriber Confidentiality Form

Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
Te Kura Pūkenga Tangata

SCHOOLOF HEALTH AND SOCIAL SERVICES
Private Bag 102 904
North Shore Mail Centre
North Shore City 0745
Auckland
New Zealand
www.massey.ac.nz

Health Enquiries	Social Work/Policy Enquirie
T 64 9 441 8166	T 64 9 441 8164
F 64 9 441 8165	F 64 9 441 8165

The Role of Neonatal Nurses in Child Protection

Transcribers Confidentiality Agreement:

I _Viv McGuire_ agree to transcribe the recordings provided to me in full and without changing any of the information.

I understand the information provided to me is private, and I agree to keep this information confidential.

I will not make any copies of the transcripts, or keep any record of them other than those required for the project.

I agree to keep the tapes and transcripts secure while in my possession.

Name: _Viv McGuire_

Signature: _V. McG_ Date: _27-02-09_

Appendix 4: Ethical Approval

Appendix

Massey University
AUCKLAND

OFFICE OF THE ASSISTANT
TO THE VICE-CHANCELLOR
(Research Ethics)
Private Bag 102 904
North Shore 0745
Auckland
New Zealand
T 64 9 414 0800 extension 9539
F 64 9 414 0814
humanethics@massey.ac.nz
www.massey.ac.nz

2 October 2008

Tina Saltmarsh
c/- Dr D Wilson
College of Humanities and Social Sciences
Massey University
Albany

Dear Tina

HUMAN ETHICS APPROVAL APPLICATION – MUHECN 08/057
"The Role of Neonatal Nurses in Child Protection"

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Mark Henrickson
Acting Chair
Human Ethics Committee: Northern

cc: Dr D Wilson
College of Humanities and Social Sciences

Appendix 5: HDEC Letter of Exemption

**Health
and
Disability
Ethics
Committees**
email: cheh_chua@moh.govt.nz

Northern X Regional Ethics Committee
Ministry of Health
3rd Floor, Unisys Building
650 Great South Road, Penrose
Private Bag 92 522
Wellesley Street, Auckland
Phone (09) 580 9105
Fax (09) 580 9001

13 August 2008

Dr Denise Wilson
Nursing (Maori Health)
School of Health & Social Services
Massey University
PB 102 904 North Shore Mail Centre
Auckland

Dear Dr Wilson

Thank you for your enquiry on 8 August concerning the ethical review of research by your student Tina Saltmarsh.

The Guidelines for an Accredited Institutional Ethics Committee to refer Studies to an Accredited Health and Disability Ethics Committee, sections 2.3 and 2.4, allow for research which involves staff of a District Health Board to be reviewed by the appropriate Institutional Ethics Committee when:

1. There is mutual agreement between the HDEC and the IEC
2. There is appropriate expertise on the IEC
3. The study does not involve participants who are patients/clients of any organisation providing health services or involves the use of health information about any identifiable individual.

I confirm from my telephone conversation with you that these conditions are all fulfilled.
You are chair of that committee, and we have agreed that the application may go to the Massey IEC for review. Your committee has members with expertise in nursing, psychology, social work and law. The study does not involve patients, or use of the health information of any identifiable individual.

I understand that you will not be involved in the review, as you are the supervisor of the student undertaking the research, but that there will still be expertise in nursing available within the committee.

Yours sincerely

Dr Vanya Kovach
Philosophy Department
University of Auckland
Private Bag 92019
Auckland
ph: 09 3737599 ext 87678

National Co-ordinator, Philosophy for Children New Zealand (P4CNZ)
www.p4c.org.nz