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Research paper

Are we educating the future workforce for interprofessional responses to child maltreatment? An exploratory study

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ABSTRACT

Background: Public health responses to child maltreatment enable prevention and early support. Little is known about what education, health, and welfare professionals receive in preparation for collaborative interprofessional responses to preventing and responding to child maltreatment.
Aim: This study explored university educators' perspectives on curriculum for three frontline professions (nursing, midwifery, and social work) in Australia to identify where curriculum incorporated interprofessional public health responses to child maltreatment.
Methods: Two-phase interpretive descriptive design; Phase One was a cross-sectional survey and Phase Two involved qualitative interviews. In Phase One, 35 nursing, midwifery, and social work educators participated in an online survey via Qualtrics, and data were analysed using Statistical Product and Service Solutions (SPSS) version 27. In Phase Two, semistructured interviews were conducted with five educators, and data were analysed thematically.
Findings: Less than half (44.1%) of respondents indicated a dedicated topic about child protection within curriculum for nurses, midwives, or social workers, and none incorporated interprofessional prevention and early support. Perceived barriers included over-emphasis on statutory responses and inconsistent disciplinary perspectives.
Discussion: Without foundational skills for interprofessional practice, health and welfare professionals cannot effectively respond to child maltreatment, perpetuating its severe and lasting impacts. Further research is needed to explore opportunities for developing and implementing interprofessional education about child maltreatment into preservice curriculum.
Conclusion: Further work must identify core knowledge, skills, and values for health and welfare professionals, and how they can be equipped for collaborative prevention and early support for child maltreatment.

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Summary of relevance

Problem or Issue

Collaborative responses to child maltreatment are essential to mitigate its impacts on children, families, and communities.

What is already known

Collaborative responses to child maltreatment require professionals who are skilled in interprofessional practice. Little is known about what preservice education Australian nurses, midwives, and social workers receive to prepare them to collaboratively respond to child maltreatment.

What this paper adds

Findings identified no examples of Australian nursing, midwifery, and social work preservice education that comprehensively equipped them for collaborative responses to child maltreatment. Barriers included conflicting perspectives and definitions across disciplines.

1. Introduction

Child maltreatment is a growing international public health issue; the World Health Organization (2022a) estimates that, within the past 12 months, one billion children experienced physical, sexual, emotional violence, and/or neglect. Maltreatment during childhood has lifelong consequences (Widom, 2022), with survivors experiencing poorer physical and mental health, educational attainment, income, and interpersonal relationships — often with intergenerational transmission of trauma, disadvantage, and marginalisation (Conti, Pizzo, Morris, & Melnychuk, 2021; Toikko et al., 2024; World Health Organization, 2022b). Factors that increase children's likelihood of experiencing maltreatment include modifiable factors such as social exclusion, housing insecurity, discrimination, inadequate access to support, and lack of culturally safe services (Featherstone et al., 2017; Higgins, Lonne, Herrenkohl, & Scott, 2019). Addressing these factors requires a collaborative, coordinated public health approach emphasising prevention and early support to comprehensively meet the needs of children and families (Merkel-Holguin, Fuller, Winokur, Drury, & Lonne, 2019; Munro, 2019).

Health and welfare professionals across both child and adult-focussed services are well-placed to respond to families experiencing adversities that place children at risk of poorer outcomes (Lonne, Higgins, Herrenkohl, & Scott, 2020; Walsh et al., 2022). Health and welfare professionals are integral to public health responses to child maltreatment because they have many opportunities to identify and respond to family adversities (World Health Organization, 2021). Children and families experiencing adversities have multiple needs that require coordinated interprofessional responses to ensure comprehensive continuity of care (Herrenkohl, Lonne, Scott, & Higgins, 2019; Higgins, Lonne, Herrenkohl, Klika, & Scott, 2022). However, service responses are often fragmented; there are duplications and missed opportunities where children fall through the gaps of services with tragic consequences (Domestic Abuse Commissioner, 2025; Higgins et al., 2019).

Internationally, one barrier to collaborative early support for children is professionals who are inadequately equipped for interprofessional practice (Bogossian & Craven, 2021; Grant, Gregoric, Jovanovic, Parry, & Walsh, 2021; Parton, 2004). Effective interprofessional practice is core to high-quality care (Reeves et al., 2016), yet health and welfare professionals typically learn within the siloes of their own disciplines with variable access to interprofessional education (IPE) (Grant, Gregoric, Jovanovic, Parry, & Walsh, 2021; Khalili et al., 2022). The World Health Organization (2010, p. 7) defines IPE as '*students from two or more professions learn[ing] about, from and with each other to enable effective collaboration and improve health outcomes*'. Despite the need for effective IPE that equips health and welfare professionals for collaborative responses to child maltreatment, it is unknown how or if this education is occurring, or whether it is supported by robust evaluation. Australia has a national vision that all services and sectors work to reduce child maltreatment with the *National Framework for Protecting Australia's Children 2021–2031* (hereon the *National Framework)* (Commonwealth of Australia, 2021). The *National Framework* (2021) highlights the need for 'strengthening the child and family sector and workforce capability' (p. 7) and collaborative priorities such as 'better integration of government services', 'multidisciplinary models… for families with multiple and complex needs' (p. 21). Other priorities of the *National Framework* are also underpinned by comprehensive interprofessional responses, including prevention and early support to prevent harm to children, and reducing the overrepresentation of First Nations children.

Collaborative responses to prevent and respond to child maltreatment require professionals who are educated and prepared for interprofessional practice. A recent international scoping review (Lines et al., 2024) highlighted 12 examples of IPE in child maltreatment for preservice health and welfare professionals. However, none offered a comprehensive curriculum covering prevention, early intervention, and responses to child maltreatment, nor were they robustly evaluated or replicated beyond their initial context (Lines et al., 2024). Furthermore, existing education in related areas — such as mandatory reporting — has limited evidence demonstrating its impact on outcomes for children (Kenny, 2015; Walsh, 2019; Walsh et al., 2022). Given the lack of published evidence, research is needed to explore the nature and scope of IPE for preservice health and welfare professionals in child maltreatment.

Three professions that regularly collaborate to provide frontline services to children, families, and parents in a broad range of contexts are nurses, midwives, and social workers (Domestic Abuse Commissioner, 2025; Isham, Scott, & Taylor, 2021). Nurses and midwives are regulated by the Australian Health Practitioner Regulation Agency and the Nursing and Midwifery Board of Australia, which recognise 77 programs of study for a registered nurse and 33 for a midwife (Nursing and Midwifery Board of Australia, 2023). Preservice nursing and midwifery programs are typically offered as three-year bachelor's degrees or two years for individuals with a bachelor's degree in another field. Some universities offer qualifying graduate diplomas or master's degrees. All nursing and midwifery programs are externally accredited by the Australian Nursing & Midwifery Accreditation Council (2023). In social work, the Australian Association of Social Workers is responsible for accrediting social work preservice degrees leading to the Bachelor of Social Work (4 years) and Master of Social Work (2 years). At the time of this study, this was guided by the Australian Social Work Education and Accreditation Standards (ASWEAS) (Australian Association of Social Workers, 2021), which was curriculum content-focussed and has since been superseded by a new ASWEAS (Australian Association of Social Workers, 2024), which is outcomes-focussed. There were 37 Australian higher education providers with accredited preservice social work courses (Australian Association of Social Workers, 2023). All three professions require collaborative skills for working with diverse populations, including people experiencing vulnerabilities (Australian Association of Social Workers, 2024; Nursing and Midwifery Board of Australia, 2016, 2018).

Although Australian nurses, midwives, and social workers do work interprofessionally, little is known about how preservice education prepares them for interprofessional practice for a public health response to child maltreatment aligned with the *National Framework*. Consequently, this study aimed to explore educators' perspectives on curriculum content in nursing, midwifery, and social work preservice education to identify whether it incorporates interprofessional practice for public health responses to child maltreatment.

2. Methods

2.1. Methodology

This study was informed by an interpretive descriptive approach where data collection and knowledge generation occurred concurrently and iteratively, whereby the whole dataset collectively contributes to new insights and knowledge (Thorne, 2013). Knowledge produced through interpretive descriptive approaches captures the complexity of social phenomena, meaning that findings often prompt more questions that generate more nuanced understandings (Thorne, 2013). An interpretive descriptive approach facilitates iterative synthesis of data from multiple qualitative sources — such as written text (Phase One) and interview responses (Phase Two).

Data were collected in two phases to address the research question. Phase One (cross-sectional survey) gathered broad descriptive data about the Australian child protection curriculum, and Phase Two (qualitative interviews) aimed to explore the perspectives of survey respondents in greater depth. Data from both phases were analysed concurrently to enable researchers to 'ponder, challenge, chew on, wrestle with and massage' data and link meanings across the dataset (Thorne, 2013). Aligned with this interpretive descriptive approach, a six-phase thematic analysis was used as a structured method to integrate qualitative survey and interview data by 'telling an interpretative story' (Braun & Clarke, 2023).

The COnsolidated criteria for Reporting Qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007) was used to guide preparation of this manuscript (see Supplementary Online).

2.2. Ethical considerations

Ethical approval was provided by Flinders University Human Research Ethics Committee (Project number 5930), and all aspects of the research adhered to the National Health and Medical Research Council (2018) National Statement on ethical conduct in human research (2018).

2.3. Recruitment

Our study aimed to recruit educators who were responsible for developing or delivering university preservice education for Australian nurses, midwives, and/or social workers. Advertisements were shared via a flyer on social media (Twitter, Facebook), disseminated by professional organisations via email, social media and websites (nursing, midwifery, and social work), direct emails to university educators (identified via university websites), and snowball sampling. Interview recruitment occurred through survey responses, whereby respondents left contact details to enable invitation to interviews.

2.4. Data collection

Data were collected through a cross-sectional online survey (Qualtrics) (March to August 2023) and semistructured interviews (June to July 2023). The survey was developed and rigorously reviewed by the team and then pilot tested before data collection. Pilot testing involved 10 experienced researchers in nursing, social work, and midwifery who independently assessed face validity and content validity. Amendments following pilot testing feedback included updating the question flow, removing repetition, and adding extra choices to incorporate clinical and educational nuances across disciplines.

Survey questions included both closed- and open-ended questions. Closed-ended questions collected demographic information about participants' role, discipline, knowledge, and experience in child protection (Questions 1–10) and details of the curriculum (Questions 12, 14, 15, 17, 18, 21). Open-ended questions asked for participants' experiences in child protection (Q11), focus and learning objectives of curriculum (Q12, 13), descriptions of specific aspects of curriculum (Questions 14, 16, 18, 20, 22–24), and to leave their email (optional) to be invited to a semistructured interview. The full version of the survey is available in Supplementary Online One.

Semi-structured interviews were based upon an interview guide (Supplementary Online Two) developed by the research team and aligned with research objectives and key literature. The interview guide was reviewed by research team members with expertise in qualitative research, but was not pilot tested. Interviews aimed to gather in-depth information that expanded on the open-ended survey questions, with a focus on understanding complexity (Thorne, 2013), such as descriptions of learning activities, disciplinary philosophies/approaches, and strengths/challenges of the curriculum (Questions 14, 16, 18, 20, 22–24). Semistructured interviews (approximately 30 minutes) were conducted by the lead researcher (LL) via Microsoft Teams and were recorded and auto-transcribed. Semistructured interviews enabled the researchers to construct further understandings of the nuances of educators' perspectives (Thorne, 2013). Transcriptions were checked for accuracy prior to analysis (TK). Participants were emailed copies of their transcripts, but none requested changes.

2.5. Data analysis

Quantitative survey data were analysed via descriptive statistics (demographic and closed-ended questions) in SPSS version 27. Qualitative responses to open-ended questions were analysed guided by a six-phase thematic analysis (Braun & Clarke, 2023; Braun, Clarke, Hayfield, & Terry, 2019). The six phases were (i) familiarisation; (ii) coding; (iii) generating initial themes; (iv) reviewing themes; (v) refining, defining, and naming themes; and (vi) writing up (Braun & Clarke, 2023). Data were independently read and re-read (familiarisation) by two researchers (LL & TK), followed by independent coding. Researchers met regularly (weekly) to discuss independent coding and resolved discrepancies through mutual discussion to form a consensus on emerging themes (generating initial themes and reviewing themes). Data were coded in Microsoft Word by using different highlighting and font colours to signify different codes and themes.

Interview data were also analysed via the same six-phase approach to thematic analysis (Braun & Clarke, 2023; Braun et al., 2019), supported by NVivo Software (Version 12). The researchers followed the same process of independent data familiarisation and coding as for the survey data, achieving final consensus on themes first through discussion with coders (LL & TK) (reviewing themes) and then the research team (refining, defining and naming themes). Trustworthiness of findings was achieved through ongoing consultations and peer-review within the team, rigorous note keeping and documentation, and using quotes or 'thick description' to support themes (Nowell, Norris, White, & Moules, 2017). Data saturation was not achieved in Phase Two (interviews) due to the sample size and participant heterogeneity; however, saturation was not the objective of this exploratory study (Braun & Clarke, 2021).

3. Results

Survey and interviews are presented thematically in accordance with the research questions and themes developed inductively from the qualitative survey and interview data (writing up). Firstly, we present an overview of respondent demographics and curriculum details and then present the three key themes: (i) overview of child protection education in nursing, midwifery, and social work; (ii) challenges to child protection education; and (iii) interprofessional

principles in child protection education. Where quotes are used to illustrate findings, the context is provided by indicating the discipline of the respondent (nurse, midwife, or social work (SW) and survey question number (QX), or the interview number (chronological). An overview of qualitative findings from Phase One and Phase Two is presented in Tables 1 and 2, respectively.

3.1. Demographics

A total of 98 educators responded to the survey, but only 35 responses were retained for analysis because the remainder (n = 63) did not provide responses past the descriptive demographics (after Q11). Five respondents additionally participated in a semistructured interview (n = 1 midwife, n = 1 nurse, n = 3 SW). Only 18 of the 35 respondents indicated their university (Q1), which represented 14 discrete universities (not named for confidentiality). Just under half (n = 16) of survey respondents taught nursing, and most (n = 28) were at Academic levels A, B, or C, which reflects earlier career stages (see Table 3). Many (n = 21) participants further elaborated on their role in child protection education (Q8) and included lecturers/educators (n = 9), subject/course coordinators (n = 6), discipline lead (n = 1), practitioners (n = 1) and researchers (n = 1).

Participants ranked their knowledge (Q9) and experience (Q10) in different elements of child protection (see Figs. 1 and 2) on a Likert scale (1–4; none, low, moderate, high). Most respondents ranked their knowledge as moderate or high in each domain of practice, but a high proportion of participants ranked their experience as none or low (Figs. 1 and 2). Domains with the lowest levels of knowledge and experience (ranked none or low) were research (n = 16 none or low knowledge, n = 21 none or low experience) and practitioner/professional education (n = 13 none or low knowledge, n = 17 none or low experience). In contrast, the domains with the highest levels of knowledge and experience (ranked moderate or high) were mandatory reporting (n = 34 moderate or high knowledge, n = 25 moderate or high experience) and culturally inclusive, respectful, and safe practice (n = 32 moderate or high knowledge, n = 23 moderate or high experience).

Participants' (n = 28 responses) experiences in preservice child protection education (Q11) varied in detail, ranging from a couple of words to a paragraph. Where specific descriptions were provided (n = 22), responses most often related to statutory child protection, inclusive of employment within child protection agencies (n = 8) or associated settings such as domestic and family violence, sexual assault, or youth justice (n = 8). Other examples included experiences of reporting suspected abuse and neglect (n = 10), working with at-risk children/families in nonstatutory contexts and/or employment in an emergency department (n = 4).

3.2. Child protection education across the three professions

This section presents a descriptive overview of child protection education content across the three disciplines, including when it

Table 1
Themes from Phase One (survey).

Survey Question and Key Themes (Qualitative Questions 12, 13, 14, 16, 20 & 23)	Participants (n)	
Q12 - Please summarise the key focus areas of the child protection education	n=28 (Q12)	n=18 (Q13)
Q13 - What, if any, learning objectives relate to child protection?		
• Wellbeing, prevention and early intervention	n=4 (Q12)	n=5 (Q13)
• Screening, assessment and interventions	n=9	n=1
• Legal frameworks	n=20	n=10
• Theoretical concepts and historical, global and local context	n=8	n=6
• Professional skills	n=3	n=4
• Understanding child abuse (definitions, types, signs)	n=5	n=2
• Collaborations and interagency practice	n=4	n=2
• Not covered or unsure	n=6	n=4
• First Nations Peoples and Cultural Safety	n=3	n=2
Q14 - If Yes, please elaborate, including topic name, content and learning outcomes. If No, why do you think this is the case?	n=21	
There is a specific subject/topic dedicated to child protection.	n=6	
Child protection content is embedded within other subject/topics.	n=8	
No content about child protection	n=7	
Unsure if there is content about child protection	n=2	
Challenges to incorporating child protection content were:		
• Curriculum does not reflect clinical practice.	n=1	
• Curriculum is already crowded.	n=2	
• Lack of interest in child protection from staff and/or students.	n=2	
• Industry hesitant to share their expertise.	n=1	
Q16 What professional frameworks, guidelines or philosophies inform the child protection curriculum?	n=18	
• Family centred	n=2	
• Child centred	n=5	
• National and state frameworks	n=3	
• Professional standards	n=4	
• Culturally sensitive and First Nations Perspectives	n=3	
• Trauma informed	n=7	
• Person centred	n=2	
• Woman centred	n=3	
• Unsure	n=2	
Q20 - Please give an example of the interprofessional content	n=10	
• Guest lectures	n=2	
• Teaching multi-disciplinary approaches	n=4	
• Interprofessional experiences during placement	n=1	
• One-day intensive	n=1	
• Unsure	n=2	
Q23 - Do you have any further comments or information about the child protection education?	n=15	
• Agree that content is important.	n=3	
• Difficult to fit the content within the current pedagogies	n=2	
• Challenging and complex area of practice to adequately cover	n=2	
• Unsure of child protection coverage in curriculum	n=3	

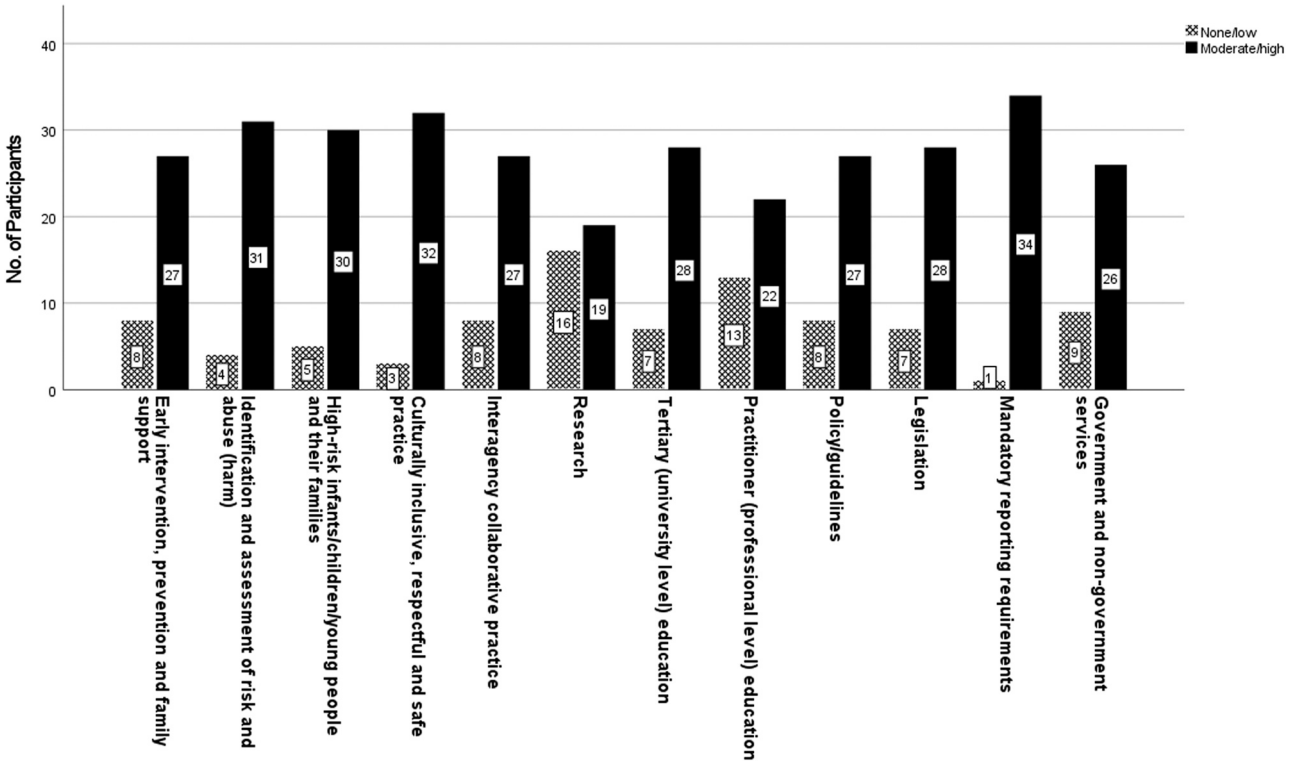

Fig. 1. The figure shows the level of knowledge in the following areas of child protection (Q9).

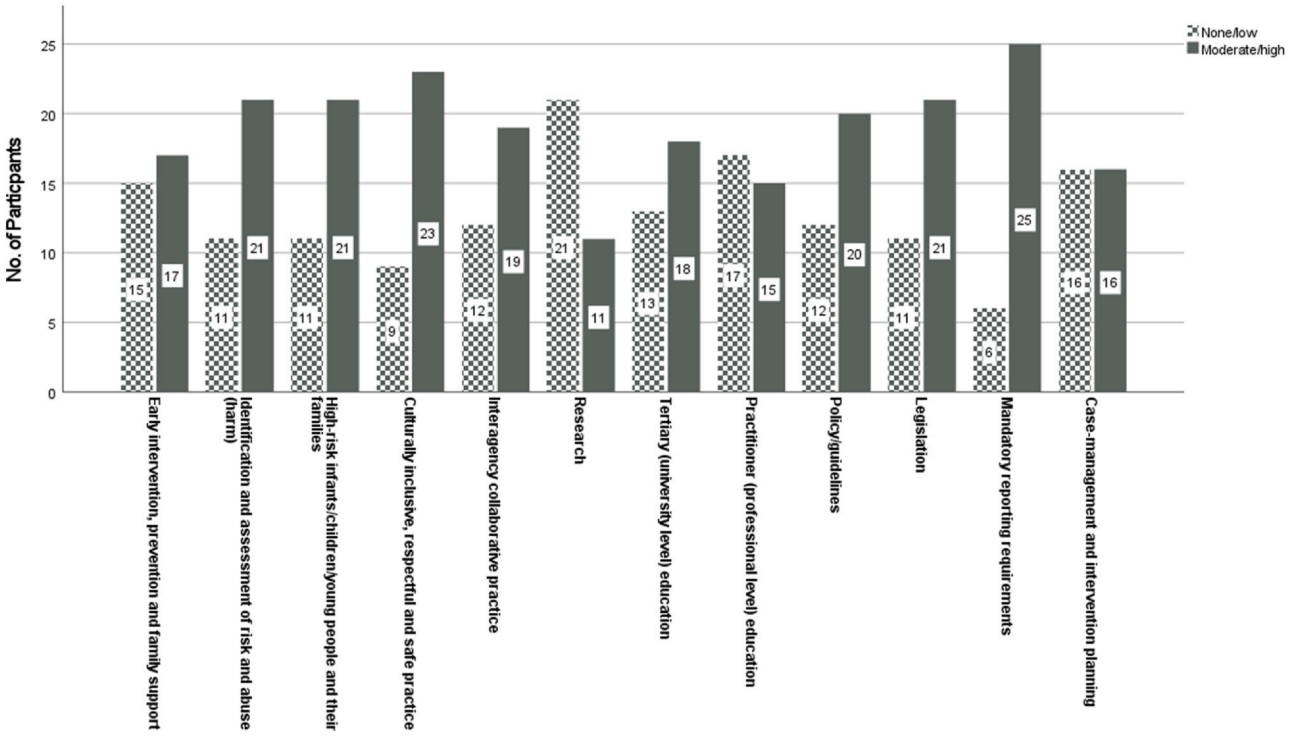

Fig. 2. The figure shows the level of experience in the following areas of child protection (Q10).

was delivered during the degree (Q11), key focus areas and learning objectives relating to child protection (Q12, 13), and the type of learning resources used to support student learning (Q15). Further questions about specific areas of child protection content were the presence of a dedicated child protection module (Q14), underpinning professional frameworks or philosophies (Q16), cultural safety (Q17, 18), interprofessional content (Q19, 20), and whether participants had any further comments (Q23, 24). Participants were able to enter free-text responses to the questions and, in some questions, upload further information such as learning objectives

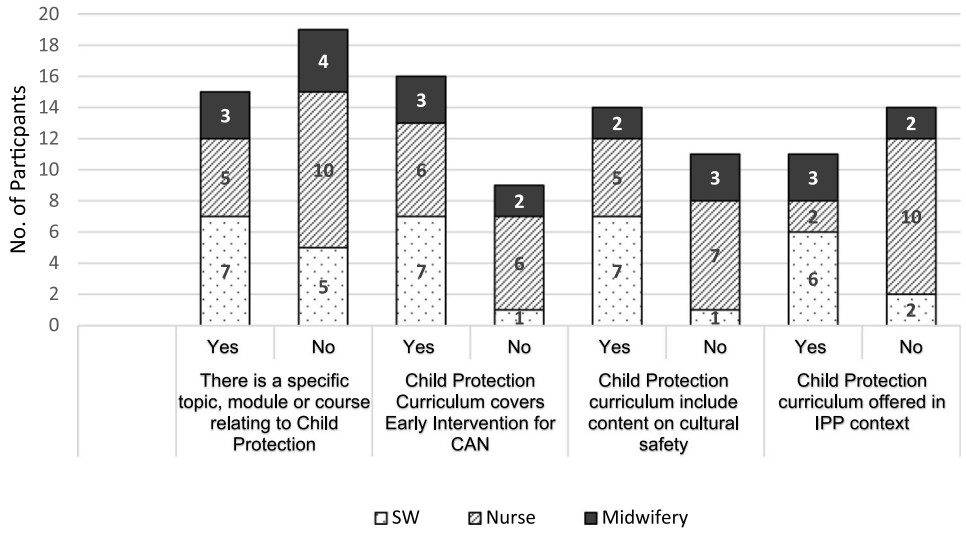

Fig. 3. The figure shows child protection education across the three professions. SW, Social Work; CAN, Child Abuse and Neglect; IPP, Interprofessional Practice.

(Q15), supporting resources (Q16), and/or further details (Q24). Only two respondents uploaded supporting information (Q15), which related to resources that 'are used to inform and support students' learning'; uploaded content was copied and pasted into Microsoft Word and analysed with the other qualitative survey data.

Delivery of child protection education was evenly spread across the first, second, and third/final years of students' education (Table 4) for each of the three professions, and in some instances occurred at multiple time points over the student's learning.

In contrast to the timing of child protection content, the structure and content varied considerably according to profession (Q12, 14, 16, 18–24). Only 44.1% (n = 15, Q14) indicated that there was a dedicated topic relating to child protection within their curriculum (Fig. 3) while open-ended responses (Q14) suggested that for many (n = 8), child protection content was integrated throughout the curriculum. Qualitative analysis of specific foci within child protection education (Q 12, 16, 18 & 24) for nursing, midwifery, and social work preservice curriculum demonstrated nine key themes (see Table 1). Themes relating to key focus areas (Q12) (n = 28 respondents) were (i) wellbeing, prevention, and early intervention (n = 4); (ii) screening assessment and intervention (n = 9); (iii) legal frameworks (n = 20); (iv) theoretical concepts and historical, global, and local contexts (n = 8); (v) professional skills (n = 3); (vi) understanding child abuse (definitions, types, signs) (n = 5); (vii) collaboration and interagency practice (n = 4); (viii) First Nations Peoples and cultural safety (n = 3); and (ix) not covered/unsure (n = 6). Notably, the most common content area was legal frameworks — a reflection that all three professions are mandated reporters of child abuse in Australia. In contrast, relatively few respondents described curriculum aimed at other response levels, such as prevention and early support or priority populations, such as First Nations Peoples. A small number (n = 6) stated that child protection content was not present or were unsure.

When approaches to child protection were explored in Question 16 and the interviews, it was clear that there was no consistent language relating to child protection across disciplines. See Tables 1,2,5 for a summary of approaches and frameworks reported as underpinning child protection curriculum. The most frequently mentioned concept (n = 7 survey, n = 5 interview) was trauma-informed practice (n = 8 SW, n = 3 nurses), which one participant described as: "*understanding that families… may respond to…workers in a range of different ways because of the historical intergenerational trauma…*" (SW, Interview 1). Another frequently described approach (n = 3) was strengths-based, mentioned by one nurse and two social

Table 2
Themes and subthemes from Phase Two – Interviews.

Themes and Subthemes	Participants (n)
Theme One: Challenges and future directions in child protection and interprofessional education	
Continuous improvement and ensuring curriculum incorporates rapid change	3
Managing complexity and linking theory to practice	4
Post-qualification courses necessary to extend preservice education	4
Variable clinical placements; not all students experience child protection	3
Theme Two: Diversity of approaches and content in interprofessional child protection and education	
Approaches which are unique to program or discipline (only coded once)	2
Child centred approaches	3
Addressing complexities and multiple layers in child protection	5
Current practices in child protection	4
First Nations Perspectives and Cultural Safety	2
Historical perspectives and changes in approaches to child protection	3
Interagency or multidisciplinary collaborative approach	3
Policy and legal framework for child protection	3
Strengths based approaches	3
Trauma Informed approaches	4
Theme Three: Intentional efforts to provide engaging and relevant interprofessional and child protection content	
Co-design and delivery of curriculum with stakeholders	5
Student learning through critical reflection	3
Using case studies, scenarios and simulation	5

Table 3
Participant demographic characteristics.

University role	Frequency N=35	Percentage
Discipline responses relate to		
Social Work	12	34.3
Nursing	16	45.7
Midwifery	7	20
Educators' university role		
Academic A (Associate Lecturer)	5	14.3
Academic B (Lecturer)	13	37.1
Academic C (Senior Lecturer)	10	28.6
Academic D (Associate Professor)	4	11.4
Academic E (Professor)	1	2.9
Other[a]	2	5.7

[a] Graduate student and casual academic.

Table 4
Time point(s) where child protection content is delivered in curriculum.

Curriculum year levels with child protection content	Profession			Total responses
	Nursing (n=15) (n=1 missing)	Midwifery (n=7)	Social work (n=12)	
First Year	9	4	5	18
Second Year	5	7	8	20
Third or Final Year	9	3	11	23
Other[a]	3	1	4	8

[a] Other (all the time n = 2, unknown n = 2, none n = 2, postgraduate n = 2.

Table 5
Approaches and frameworks that underpinned child protection curriculum.

Approach or framework[a]	Overall frequency (n)	Frequency by discipline (n)		
		SW	Nurse	Midwife
Trauma informed	11	8	3	-
Child centred	8	6	1	1
Professional standards	4	1	3	-
Cultural sensitivity or safety	3	-	2	1
National and local frameworks or policies	3	2	1	-
Family centred	3	-	3	-
Woman centred	4	1	1	2
Person centred	2	-	2	-
Strengths based approach	3	2	1	-
Multidisciplinary approach	2	-	1	1
Unsure	2	-	2	-

[a] Only includes items present in more than one response.

work participants, described as "*looking for capacity and resilience in families, children and young people*' (SW, Interview 1).

Some approaches were discipline-specific, with only nurses mentioning *family-centred* or *person-centred* approaches. Other approaches were named differently across professions but appeared to have the same meaning, such as working together with other professionals through *collaborative* (SW, Interview 3) or *multidisciplinary approaches* (nurse & midwife). Similarly, some participants mentioned approaches that shared elements of *strengths-based approaches,* such as *mental health recovery* (Nurse, Interview 2) or *solution-focused* (SW, Interview 3). The mental health recovery approach focussed on parental recovery to support change for children, explaining: *'even though a person is experiencing an acute or chronic mental health condition… there was always something [that] can be done to optimise that condition, so recovery is possible…'* (Nurse, Interview 2). In the same way, the *solution-focused approach* 'coincides with a strength-based approach' (SW, Interview 3). Thus, there are many different approaches, albeit with shared elements, that underpin child protection education in nursing, midwifery, and social work preservice education.

3.3. Challenges to child protection education

Participants acknowledged many challenges to incorporating child protection education, with more than half (n = 19, 55.9%) indicating that their courses did not have a dedicated child protection module. Some survey respondents (Q14) further elaborated that they were unsure if child protection was covered (nurse n = 2; midwife n = 1). One challenge to incorporating child protection education (n = 3) was the regulatory requirements of nursing and midwifery education, whereby '*the course is already crammed with many topics and requirements*' (Midwife, Q14). In the nursing context, child protection was not always prioritised because the '*majority of nursing is working with elderly*' (Nurse, Q14) or there had been no one to "*champion' this content*' (Nurse, Q14). For social workers, child protection content was a requirement for degree accreditation (Australian Association of Social Workers, 2021)[1] where learning may be further complemented by practical experience. However, not all students undertake child-related placements '*there are hundreds of students, so not everyone would get a placement in child protection.*' (SW, Interview 3). When students studied a dedicated child protection subject, it may be insufficient preparation for practice '*there's so much content… there's so much reading. It's so dynamic. I feel that there probably needs to be more time*' (SW, Interview 1).

Other challenges for interprofessional child protection education included authenticity and the ability to achieve transformative learning that challenges students' existing beliefs for practice change. Some respondents expressed concern that the content did not reflect actual practice in child protection or provide adequate opportunities for deeper learning. For example, although core principles such as cultural safety for First Nations Peoples are covered, there was '*no opportunity to discuss and generate deeper [meaning]*' (SW, Q18) and '*students have been shocked on placement*' (SW, Q18) when faced with the complex challenges faced by First Nations communities. In addition to building students' knowledge and competence, curriculum also needs to respond to students' existing attitudes and beliefs as explained by one nurse (Interview 2) *'people often think of child abuse as something that happens in some mythical land far, far away. They don't realise it could be happening [now]'.*

Barriers to comprehensive child protection education included the dynamic and complex nature of child protection practice. For example, practice is influenced by legislation and policies that vary across jurisdictions, changing government priorities, population characteristics and media criticisms (Q23 SW; SW, Nurse, Midwife, Interviews 1, 2, & 5). Strategies to respond to these challenges included continual improvement (SW, Interview 1 & 4), and co-designing and/or co-delivering curriculum with key stakeholders (Q18, SW; SW, Interviews 1 & 3, Nurse, Interview 2). For example, one social worker (Interview 3) outlined the process of updating child protection content to align with industry expectations, where university educators '*met with [child protection agency] and a range of non-government sector partners in a kind of roundtable workshop to provide them with their topic information booklets and the scaffold of their entire curriculum… [to look] at inclusion of any changes, any feedback and modification*' (SW, Interview 3).

Given the complexities of child protection practice and difficulties comprehensively covering content in preservice education, educators emphasised the need for scaffolding content into ongoing professional development and postgraduate courses (Interviews). This post-qualification training could provide an extension to the foundation education in child protection received during preservice education: '*I think that's something that's lacking. I mean, we have a great programme, but to enhance it in value or even as a micro credential or as possibly a postgrad [sic]… level*' (Nurse, Interview 2).

[1] The superseded ASWEAS (2024) does not specify child protection content.

3.4. Interprofessional principles in child protection education

Less than half of respondents (Q19, n = 11) indicated that some of their child protection education was delivered in an interprofessional context. Respondents provided examples of interprofessional content via an open-ended question (Q20, n = 10), but examples did not represent learning experiences where students from different disciplines learned with and from each other (World Health Organization, 2010). Common examples inaccurately provided for IPE (Q20) were guest lecturers from different disciplines (Midwife n = 2), theoretical content about interprofessional approaches (SW n = 2, Nurse n = 1, Midwife n = 1) or students' placement experiences (SW, n = 1). One example of IPE in child protection might meet the World Health Organization (2010) definition of students learning with and from each other, but insufficient detail was provided. For example, how IPE was embedded into the activity and/or the specific learning outcomes of the activity. This example was an '*interprofessional education day annually*' incorporating social work and multiple health disciplines (nursing, medicine, psychology, allied health) and educational content included '*some content/case studies on [child protection]*' (Nurse, Interview 2).

Participants acknowledged both the value and challenges of incorporating interprofessional perspectives in child protection education (Q20, 24) and described examples. In midwifery, interprofessional perspectives included teaching *'how to collaborate with hospital-based social work staff and child protection staff'* (Midwife, Q20). Like participants' strategies for providing education tailored to the complexities of child protection practice, some participants (Q18, n = 1 Midwife, n = 1 SW; SW, Nurse, Midwife, Interviews 1, 2, 4, & 5) outlined how they incorporated interprofessional perspectives by co-designing or delivering child protection content with industry partners, colleagues, First Nations Peoples and other community stakeholders. Similarly, another participant drew upon students' experiences of interprofessional practice on placement as a basis for reflection and learning: "*often they've [students] had experiences with well-being and working with multidisciplinary teams, so that's also a real value. And they can leverage their experience*" (SW, Interview 1).

4. Discussion

The purpose of this study was to explore curriculum content across nursing, midwifery, and social work preservice education to identify whether it incorporates interprofessional practice for public health responses to child maltreatment aligned with the *National Framework for Protecting Australia's Children 2021–2031* (hereon the *National Framework)* (Commonwealth of Australia, 2021). Our findings demonstrated that preservice curriculum in Australia does not incorporate IPE in child protection for future nurses, midwives, and social workers to prepare them for coordinated interprofessional responses to child abuse and neglect. Furthermore, other key elements of the *National Framework* — such as cultural safety for First Nations families and prevention and early support are minimally present within curriculum. There is extensive international evidence of increasing prevalence, lasting harms and socioeconomic costs of child maltreatment and the need for coordinated interprofessional responses (Conti et al., 2021; World Health Organization, 2022a). Therefore, it is highly concerning that there is no evidence of preservice education to equip nurses, midwives, and social workers for effective prevention, early support, and responses to child maltreatment in Australia.

Our findings about the absence of IPE in preservice education align with other recent studies. For example, Khalili et al. (2022) conducted a global scan of IPE in academic settings and identified only nine Australian institutions with established or developing IPE programs. Of these nine Australian programs, IPE engaged many health disciplines, including nursing (n = 4) and social work (n = 1), but not midwifery (Khalili et al., 2022). Similar findings are reflected in two other scoping reviews (Bogossian et al., 2023; Shakhovskoy et al., 2022), which identified a single Australian study using IPE in health professional education for promoting medication safety (Lapkin, Levett-Jones, & Gilligan, 2012). More specifically, around IPE for child maltreatment, a recent scoping review further highlighted a global paucity of preservice IPE in child maltreatment for health and allied health professionals (Lines et al., 2024). This scoping review identified only 12 examples of IPE in preservice education for child maltreatment internationally, with just two Australian studies — both single-site, short-term studies without replication (Kuliukas, Oehlers, & Berlingeri, 2017; Smith, Thornberry, Lyons, & Jones, 2005). Consequently, it seems likely that our study demonstrating an absence of IPE for child maltreatment in Australian nursing, midwifery, and social work education is an accurate representation of preservice education. This gap underscores the need for innovation and leadership to strengthen the evidence base and develop the infrastructure necessary for effective preservice IPE for health and allied health professionals. Interprofessional leadership will be essential in bridging disciplinary divides and establishing shared goals to promote children's health, safety, and well-being (Bogossian et al., 2023; Grant, Gregoric, Jovanovic, Parry, & Walsh, 2021).

Internationally, IPE in tertiary education is variable, with only half of institutions across six regions reporting established IPE programs (Khalili et al., 2022). Australia, like South America, Mexico, and African regions, lack consistent interprofessional standards across disciplines. When IPE does occur, it is only voluntary (Khalili et al., 2022). Although Australia has a national body to lead health professionals' IPE (Australasian Interprofessional Practice & Education Network – AIPPEN), there is no established framework, although a draft is undergoing consultation (Australian Health Practitioner Regulation Agency, 2023). In contrast, some countries have established national IPP frameworks, with Canada and the USA since 2010 and 2016, respectively (Canadian Interprofessional Health Collaborative, 2010; Interprofessional Education Collaborative, 2016). Implementation of a consistent approach to IPE in preservice health and allied health education that supports a public health response to child maltreatment could be underpinned by Australia's new IPE framework. However, the proposing body — the Australian Health Practitioner Regulation Agency — regulates only certain health disciplines under the *Health Practitioner Regulation National Law Act 2009*. Therefore, it is unclear how an IPE framework might translate to other key professions within the child and family workforce, such as social workers, family law professionals, or early childhood educators.

In addition to a lack of IPE, this study also identified gaps in curricula related to other core areas of the *National Framework,* including prevention and early support and engaging First Nations populations. Skills for prevention and early intervention are core to reducing harm from child maltreatment internationally, especially for priority populations like First Nations peoples who are disproportionately represented and harmed by Western child protection systems (Commonwealth of Australia, 2021; Duthie, Steinhauer, Twinn, Steinhauer, & Lonne, 2019). Few respondents indicated that child protection education included prevention, early support, or cultural safety for First Nations families, in contrast to the high proportion with mandatory reporting and statutory child protection. Historically, mandatory reporting has been emphasised as the solution to child abuse and is therefore prioritised in health and welfare preservice and continuing education (see, for example, Kenny, 2015; Walsh et al., 2022). Awareness of social, political, economic and intergenerational influences on children's wellbeing highlights the need for contemporary international workforces equipped for a public health response extending beyond mandatory reporting (Klevens & Metzler, 2019; Mathews, 2015). If we are to provide

comprehensive preservice education that equips health and welfare professionals for a public health response, we first need to understand the nature of the current child welfare workforce and specifically what knowledge, skills, and values are necessary (Lonne et al., 2021; Lonne et al., 2020; Russ et al., 2022). This would require further research to develop an international consensus across different disciplines about core interprofessional competencies for this interprofessional public health response.

5. Strengths and limitations

This study had strengths and limitations. Strengths included the focus on IPE for addressing child maltreatment within preservice health and welfare training, which is a previously under-researched area, therefore offering strong foundations for future research. The two-phase interpretive descriptive approach is methodologically robust, providing a comprehensive perspective through quantitative and qualitative analyses. Furthermore, the study aligns with national and international policy frameworks and has the potential to inform global curriculum development in nursing, midwifery, and social work.

Some limitations must be considered when interpreting study findings. Firstly, the heterogeneous sample and low response rates mean data saturation may not have been achieved. However, the proportion of respondents from nursing, midwifery, and social work was relative to the number of study programs and academics teaching these disciplines. Furthermore, findings were supported by several international scoping reviews with results similarly highlighting a paucity of health professional IPE. Another limitation is selection bias because educators interested in IPE and/or child maltreatment were more likely to participate. Similarly, as survey respondents reported their own perspectives on the curriculum, responses may be limited by the extent of their individual knowledge and may not provide a comprehensive overview. Future research should objectively identify and map curriculum for nurses, midwives, and social workers at universities to more comprehensively scope the presence and nature of any IPE for child maltreatment.

6. Conclusions

Interprofessional practice amongst health and welfare professionals is essential for an effective public health response that reduces the impacts of child maltreatment. However, our study demonstrated that health and welfare professionals are not equipped through preservice education for foundational skills that underpin interprofessional practice for prevention and responses to child maltreatment. Without foundational skills for interprofessional practice, health and welfare professionals cannot deliver seamless public health responses to children experiencing adversities, perpetuating unnecessary and often severe impacts of maltreatment. Further research is needed to objectively map the nature and scope of IPE for child maltreatment and explore opportunities for developing and implementing IPE about child maltreatment into preservice health and welfare professional curriculum. Importantly, future work must first identify foundational knowledge, skills, and values required by all health and welfare disciplines to establish common principles that underpin a shared interprofessional ambition to reduce child maltreatment.

Authorship contribution statement

Lauren Elizabeth Lines: Conceptualization, Investigation, Writing – original draft, Writing – review & editing, Formal analysis, Project administration. **Tracy Alexis Kakyo:** Formal analysis, Data curation, Writing – original draft, Writing – review & editing, Vizualization. **Helen McLaren:** Investigation, Methodology, Writing – review & editing. **Donna Hartz:** Methodology, Investigation, Writing – review & editing. **Nina Sivertsen:** Methodology, Writing – review & editing. **Alison Hutton:** Methodology, Writing – review & editing. **Megan Cooper:** Methodology, Investigation, Writing – review & editing. **Lana Zannettino:** Methodology, Writing – review & editing. **Julian Grant:** Methodology, Writing – review & editing.

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Ethical statement

- This project involved human research.
- The submitted manuscript is based on research that was subjected to a full review by an institutional ethics committee:
  - o Name: Flinders University Human Research Ethics Committee
  - o Project Number: 5930
  - o Approval date: 13/02/2023

Conflict of interest

The authors have no relevant financial or non-financial interests to disclose.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.colegn.2025.08.007.

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