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Preservice education for interprofessional public health responses to child maltreatment: Australian stakeholder perspectives of key regulatory, sociocultural and professional challenges

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Abstract

Background: Child maltreatment is an international public health issue that requires interprofessional collaboration across all sectors providing services for children and families. Effective collaborative interprofessional responses are underpinned by professionals who are equipped with knowledge, skills and values to respond to children's complex health, wellbeing and developmental needs. However, little is known about how health and welfare professionals are equipped during preservice education to prepare for interprofessional public health responses to child maltreatment. **Purpose:** Using a qualitative World Café approach, this study aimed to engage key professional stakeholders in discussions about what is needed in child protection interprofessional education for preservice health and welfare professionals in Australia. **Research Design and Study Sample:** Three online roundtables were held with a total of twenty-five participants, inclusive of nurses, midwives, and social workers, in education, research, and practice. **Data Analysis:** Inductive analysis identified how the interplay of broader political, sociocultural and regulatory factors results in failure to equip graduates for interprofessional public health responses to child maltreatment. **Results:** Key challenges included a perceived lack of leadership from governments, no shared interprofessional

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definitions, inadequate resourcing for early support, and local barriers to implementing interprofessional education. Coordinated national leadership by and across governments and professional regulatory bodies was identified as essential to underpin a shared vision and adequate resources for sustained change. **Conclusions:** As change gathers momentum, higher education institutions are optimally positioned to address challenges of interprofessional education for public health responses to child maltreatment for all professionals who will work with children. Ongoing commitment is needed across all sectors, including government, professional regulators and higher education, to establish a shared vision that underpins interprofessional understanding of roles and core knowledge, skills and values for graduates.

Keywords
Interprofessional education, child protective services, health professional, allied health, child maltreatment, public health

Introduction/background

Child maltreatment impacts over 1 billion children globally each year, with lifelong and intergenerational impacts upon children, families and communities (Hillis et al., 2016). The World Health Organization defines child maltreatment broadly as all forms of *'physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power'* (World Health Organization, 2022). Child maltreatment is most prevalent when there are adverse family and community circumstances – such as parental mental illness, discrimination, housing insecurity, intergenerational trauma, lack of social capital and economic opportunities (Higgins et al., 2022; Middleton et al., 2019). Given the complex interplay of individual, community and societal factors contributing to child maltreatment, there is a need for comprehensive prevention and early support through coordinated interprofessional and intersectoral responses (Featherstone et al., 2016, 2017).

There is increasing advocacy for public health responses that provide comprehensive tailored support for all families and communities to prevent child maltreatment and enable children to thrive (Higgins et al., 2022). Internationally, policies often acknowledge that child maltreatment requires effective, coordinated prevention and early support services (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016, Commonwealth of Australia, 2021, Her Majesty's Government, 2023), yet numbers of children removed from families by statutory child protection services continues to grow.

In Australia, responses to child maltreatment are underpinned by the Safe and Supported National Framework for Protecting Australia's Children 2021-2031 (hereon the *National Framework*). The *National Framework* outlines the need for a cohesive national approach to early and targeted supports for families delivered by a capable child and family workforce (Commonwealth of Australia, 2021). The child and family workforce is defined broadly, but includes '*practitioners from a range of professional backgrounds with different qualifications, knowledge and skills*' (Commonwealth of Australia, 2021). Practitioners work across three tiers of child protection practice: 1) universal services for all families, 2) targeted support for families experiencing adversity and 3) statutory responses for children at imminent risk of severe harm (Russ et al., 2022). Although a public health approach emphasises universal and targeted tiers for prevention, increasing numbers of children are reported for

investigation and enter out of home care (Australian Institute of Health and Welfare, 2024; Russ et al., 2022). Children experiencing disadvantage or from First Nations communities are often overrepresented in the statutory tier which compounds experiences of trauma, often with intergenerational consequences (Australian Institute of Health and Welfare, 2024; Jones et al., 2024; Keddell, 2018).

This emphasis on reporting individual cases of maltreatment arises from a Western neoliberal focus on individual responsibility over collective community capacity to raise children in safe and enriching environments (Keddell, 2018; Lonne et al., 2021). An added challenge is a lack of clarity about the responsibilities of different professions working across universal, targeted and statutory tiers (Lines et al., 2022; Russ et al., 2022), with professionals across all three tiers often lacking skills for best-practice family partnerships in risk-averse child protection cultures (Lonne et al., 2020). Consequences for children and families include missed opportunities to intervene leading to unmet needs and compounding trauma experiences with lasting intergenerational consequences (Duthie et al., 2019; Jones et al., 2024).

In Australia, three key professional groups who work with children and families are nurses, midwives and social workers (Grant et al., 2018). Preservice education for nurses, midwives and social workers has regulatory or national education standards to ensure graduates enter the workforce as safe and competent practitioners (Australian Association of Social Workers, 2021; Australian Nursing & Midwifery Accreditation Council, 2024). Higher education providers are responsible for equipping nurses, midwives and social workers with core knowledge, skills and values for enacting a public health response for child maltreatment. However, there is a lack of agreement about what competencies graduates require to meet regulatory requirements and enact this public health response (Lonne et al., 2013, 2020), even though proposed professional competencies include trauma-informed practices, cultural safety and interprofessional collaboration (Flemington et al., 2021; Jones et al., 2024). Trauma-informed practices focus on resilience and addressing impacts of trauma (Middleton et al., 2019) while culturally safe practices recognise centrality of culture through a strengths-based lens (Flemington et al., 2021). Consistent application of trauma informed and culturally safe approaches are founded upon interprofessional collaboration (IPC), defined as '*multiple health workers from different professional backgrounds work[ing] together with patients, families, carers and communities to deliver the highest quality of care*' (World Health Organization, 2010).

Given the complexity of sociopolitical contexts where future professionals will be expected to prevent and respond to child maltreatment, our research explored curriculum content across nursing, midwifery and social work preservice education to identify whether it incorporates IPE for a public health response to child maltreatment in accordance with the *National Framework* (Commonwealth of Australia, 2021). Phase One (Lines et al., 2025) aimed to explore interprofessional education in child protection curriculum for preservice nurses, midwives and social workers in Australia through an online survey and semi-structured interviews. Phase Two (current study) aimed to engage key professional stakeholders in discussions about what is needed in child protection interprofessional education for health and welfare professionals in Australia.

Phase Two produced two key findings. The first finding (current manuscript) presents the broader regulatory, sociocultural, and professional context, as inextricably linked with the capacity of educational institutions to equip graduates for an interprofessional response to child maltreatment aligned with the *National Framework.* The second finding describes specific competencies graduates require for an effective interprofessional public health response to child maltreatment aligned with the *National Framework* (Lines et al., 2024).

Methods

Design

We used a World Café method for this study which is reported using COREQ guidelines to promote comprehensive description of the methodological process (Tong et al., 2007) (Supplemental Online One). A World Café approach facilitates dynamic, collaborative discussions amongst participants, aimed at 'creating a living network of collaborative dialogue around questions that matter' (World Cafe Community Foundation, 2015). A World Café format can be flexibly adapted to different research questions, but is based on seven key steps: 1) Setting the context, 2) Creating a hospitable space, 3) Exploring questions that matter, 4) Encouraging everyone's contributions, 5) Connecting diverse perspectives, 6) Listening for patterns and insights, and 7) Sharing Collective Discoveries (World Cafe Community Foundation, 2015). A World Café approach is reported as a successful way to leverage expertise of diverse stakeholders to inform policy and practice change (Broom et al., 2013; Dray et al., 2023).

Setting the context. The World Café approach offered an opportunity to establish and strengthen networks between key leaders in nursing, midwifery and social work education and open dialogues around interdisciplinary work in child protection. The methodology enabled insights into how we are educating the future workforce for a public health response to child maltreatment through several online roundtable discussions. We invited the participation of key Australian stakeholders via email, providing them with detailed information about the research aims, methods and team members. Stakeholders were defined as 1) professionals who provide preservice nursing, midwifery and/or social work education at university and 2) leaders from national professional organisations/associations (i.e. Australian College of Nursing, Australian College of Midwives, Australian Association of Social Workers) and 3) authors who have published in this field and 4) practitioners who work in child protection. Invitees could attend personally or nominate a proxy from their organisation. Participants who were involved in the earlier phase (Phase One) of this research were also invited (Lines et al., 2025).

Creating a hospitable space. In an adaptation of the World Cafe methodology, we held three online roundtable discussions via Microsoft teams in October 2023. The online format enabled researchers to engage with a wider geographical (national) network while maintaining elements of physical interaction through video technology (Dray et al., 2023). Partway through each session, participants were divided into smaller groups using the breakout function in Microsoft Teams. Each roundtable was attended by a diverse representation of key professional stakeholders, including nursing ($n = 13$), midwifery ($n = 4$), social work ($n = 6$) and other fields within child protection ($n = 3$) (See Table 1). Participants played various roles in child protection, contributing to a rich and multidisciplinary dialogue (See Table 2): educators ($n = 10$), researchers ($n = 2$), practitioners ($n = 11$) and other relevant roles ($n = 2$). The diverse mix of professionals working in child protection contributed to fostering of a familiar environment characterised by shared experiences.

Facilitators in the roundtables were all female members of the research team with extensive experience in research and higher education, summarised as follows: Roundtable One (MC, NS & LL) Roundtable Two (LZ, LL) and Roundtable Three (DH, LL). Two roundtables had First Nations representation by a facilitator (NS, DH). Thus, each roundtable had at least one representative from disciplines of nursing, midwifery and social work promoting authentic interprofessional discussions.

Table 1. Summary of professions that participated in roundtable discussions.

	Nurse	Midwife	Social worker	Other[a]
Day one	2	-	2	-
Day two	4	1	1	1
Day three	7	2	3	2
Total	13	3	6	3

[a]Health researcher, dietician, and practice development.

Table 2. Summary of roundtable participants' roles.

	Lecturer	Clinician	Researcher	Other
Day one	2	1	1	—
Day two	4	2	1	—
Day three	4	8	—	2
Total	10	11	2	2

Table 3. Summary of roundtable agenda.

Agenda item	Description/Aims
Introduction (20 mins)	• Welcome, overview and purpose • Summary of key project findings
Breakout group discussions (30–40 mins)	• Brainstorming and discussions guided by written question prompts (Supplemental Online Two)
Large group discussions (30–45 mins)	• Ask each group and individual participant to share key points and build upon others' contributions • Summarise key discussion points and thank participants

Exploring questions that matter. The roundtables followed an agenda to provide structure and focus for the discussions (See Table 3), and participants were advised to take breaks and/or leave at any time. Discussions began with the facilitator introducing the event by outlining expectations and summarising the World Cafe principles, including the importance of respectful communication and valuing each person's contributions. Next, the facilitator shared key project findings to set the context for the roundtable. The first portion of the findings presented a systematic scoping review aimed at understanding the current state of interprofessional education in child protection for preservice health and welfare professionals (Lines et al., 2024). Next, the facilitator shared results from a survey and interviews conducted for study two (Lines et al., 2025). Key points centred around ways Australian educators in nursing, midwifery, and social work are equipping preservice students for future IPC in a public health response to child maltreatment and opportunities for the future.

Encouraging everyone's contributions. Following the facilitator's presentation, participants were invited to share feedback, thoughts and perspectives in breakout group discussions (Broom et al., 2013). Each breakout group was allocated around 30 mins for discussion, guided by specific

questions relating to the research question (Supplemental Online Two). Participants engaged in dialogue to determine how to better prepare the future workforce, identify potential barriers, facilitators, or contextual factors, and discuss practical actions that could be implemented to enhance preservice education in child protection. For each small group discussion, one participant self-nominated as note taker to capture the essence of discussions.

Connecting diverse perspectives. Connecting diverse perspectives involves participants moving from one group to another to explore alternative thoughts and experiences (World Cafe Community Foundation, 2015). We connected diverse perspectives by facilitators 'visiting' different breakout groups, and afterwards asking participants from each breakout group to share their key points with the larger group. Due to limitations of time and online breakout group technology, participants did not have opportunities to rotate amongst small groups.

Listening for patterns and insights and sharing collective discoveries. Participants from the smaller breakout groups reconvened into the larger group, which included all participants and their facilitators. The professional characteristics of participants are summarised in Tables 1 and 2; personal demographics such as age, gender and ethnicity were not collected. In this larger group setting, participants shared insights and findings from their small group discussions. The larger group discussions on the three respective days lasted 33, 39, and 82 mins respectively. To ensure accurate record-keeping and facilitate further analysis, larger group discussions were audio recorded and transcribed via Microsoft Teams.

Data management and analysis

The transcripts were cross-checked for accuracy by two researchers (LL & TK) and deidentified. Transcripts were not returned to participants for feedback because they contained data from multiple participants, but participants were invited to email the research team with any feedback or concerns. Transcripts, participant notes and facilitator notes were imported into NVivo (version 12). Data analysis was guided by Braun and Clarke's principles of inductive thematic analysis (Braun & Clarke, 2023). Transcripts were coded by LL and TK with differences addressed through discussions to build consensus. Key themes and subthemes were discussed with the research team and subsequently organised into two major findings each with its own unique themes.

Ethical consideration

The study was approved by Flinders University Human Research Ethics Committee (Project 5930). All participants provided written informed consent.

Findings

A total of 25 participants engaged in roundtable discussions over three non-consecutive days, representing disciplines inclusive of nurses, midwives and social workers. Inductive analysis of data showed two key findings. Finding One (current manuscript) related to broader regulatory and sociocultural contexts that influence professionals' work to prevent and respond to child maltreatment extending beyond individual educational institutions. Finding One highlighted how professional stakeholders perceived that comprehensive multisectoral leadership is necessary for transformation within the higher education sector to enable effective interprofessional education for

public health responses to child maltreatment. Within Finding One, there are three main themes reported in narrative detail in this manuscript and supported with further indicative quotes in Supplemental Online Three. Finding Two (Lines et al., 2024) related to the specific knowledge, skills and values required by graduates to work inter-professionally with children and families to prevent and respond to child maltreatment.

Theme 1: Transformational leadership is required to build shared understandings and champion interprofessional support for families across all sectors

Consistent leadership was needed across all levels of child maltreatment services including national and state/territory governments, regulatory bodies for professional standards, service providers and tertiary education institutions. Participants explained that leadership to drive collective action is necessary to underpin interprofessional practice for a public health response to child maltreatment. At present, there are multiple different stakeholders at every level, yet there is '*not necessarily a consistent approach or a national approach*' (RT 3) which hampers streamlined action. Leadership was needed to establish shared goals and definitions so that '*everyone is getting the same message*' (RT 3) to drive consistent directions for change.

For example, there are variations in conceptualisations of child maltreatment for the general public: '*people's understanding of what constitutes child abuse and neglect… that's not necessarily a common understanding*' (RT 2) and within professions: '*differences in opinions amongst professionals, even within the same services*' (RT 3). Furthermore, there is no shared understanding of what it means to protect children from maltreatment – with child protection often synonymous with statutory services. Prevention and early support for families are not embedded into understandings of child protection: '*public health approaches aren't particularly well understood… even by professionals… because we've established a protective system, that it's model of service delivery is reporting investigation and removal and… that's what we do*' (RT 1). Within this model of service delivery, child protection is perceived to belong to 'experts', such as social workers and child protection services: '*CP [child protection] can be understood as business of SW [Social Work]*' because '*SW [are] considered the professionals with the knowledge about CP*' (RT 3). Conversely: '*different health and allied health disciplines will say, you know, that child protection isn't us*' (RT 1). Without clearly defined expectations, professionals are unsure of their own and others' roles, and perceive child protection as a responsibility to be deferred to other professionals or departments.

Perceptions of child protection are shaped by professional regulation which are integrated into standards for preservice education and professional practice. At present, these standards are created and perpetuated within disciplinary siloes without interprofessional governance to inform education and practice for interprofessional responses to child maltreatment. Participants recognised that professional regulatory bodies have a core role in IPC, but it is currently not clear what these roles are: '*Australian Association of Social Workers, AHPRA [Australian Health Practitioner Regulation Agency] … what their roles might be in actually supporting… an interprofessional curriculum*' (RT 2). Participants identified barriers to achieving synergies and consensus across professions: '*it can be quite tough trying to get around professional rivalries*' (RT 1) and '*there's always issues of power and status*' (RT 3). The heart of conversations reflected a lack of shared vision about what graduates should know, do, and value for competent interprofessional practice in child protection: '*we don't actually have the before picture of what we expect in our educational requirements… so we're not actually starting from a place of knowing what we want people to learn as minimum standards*' (RT 3). This absence of shared vision was complicated by the nuances of each professional groups' lived experience of practice and the role hierarchies produced by the discourses inherent in each

profession. In addition to consistent understandings informing collective action, leadership was needed to reconstruct the '*reactive*' (RT 2) crisis driven system, to create a proactive prevention and family support system. Key elements of concern related to perceptions of funding as insufficient or inconsistent – with participants describing prevention and early support services being discontinued: '*we were supposed to have this second level of [nurse] home visiting for anyone who fell into those at-risk categories… and they cut the funding for that. So yeah, so that's, that's your prevention gone out the window'* (RT 1). Without priority for sustained funding in comprehensive family support services, it was difficult to enact the fundamental '*universal base, that child protection is everybody's business'* (RT 3).

Although acknowledging prevention and early support requires extensive resourcing, participants described how existing resources could be leveraged through effective leadership. For example, consolidating existing professional education and best-practice guides, and building community capacity to champion support for families experiencing adversities. Leveraging existing resources was especially important in lower resource settings, such as '*rural and remote area[s]*' (RT 1). However, consolidation of existing resources requires the sustained leadership, action and capacity building over time. A core element includes rebuilding trust in child protection services which has a history of poor transparency and '*lack of closure of the loop of care when reporting does happen*' (RT 2). It will take time and commitment to build cultures of open communication and transparency to facilitate interprofessional partnerships with communities.

Theme 2: Building non-stigmatising and culturally safe systems of early support

Establishment of non-stigmatising and culturally safe supports must underpin shared interprofessional conceptualisations of public health responses towards child maltreatment. Non-stigmatising systems are founded upon an equity lens, recognising all families need support and resources to enable children to thrive: '*what we need… is a language of support and assistance to all families*' (RT 1). Universal services such as primary healthcare and children's education and care are applicable to all families, while other families with higher levels of adversity may require additional supports. Participants recognised the stigma attached to families that need additional help as '*quite often the language of receiving help… is stigmatising*' (RT 1) and how needing help is often conflated with the adversarial 'reporting' nature of child protection. It was also recognised that stigma can be exacerbated by the education/training professionals receive, which is often based on a '*response language rather than prevention*' (RT 2). This discourse was also frequently reflected in roundtable discussions with comments such as: '*all professionals should have knowledge and responsibilities – awareness, knowledge, reporting, who to contact for reporting, referrals*' (RT 3). Non-stigmatising systems require a foundational acceptance that all families need support, and an understanding that a system of reporting only serves to perpetuate stigmatisation.

Participants recognised the broader implications of working within a system geared towards individual crisis response rather than comprehensive prevention and early support. At the ground level, this was experienced as having a lack of resources to support professionals' prevention and early support, summarised as a system that is: '*Reactive v Proactive, [and] funding [is] needed*' (RT 2). Participants experienced firsthand family support services that were 'cut': '*[there used to be] nurses' visits to families after birth, but the program funding was cut* (RT 1). Participants recognised the harmful impacts of current system responses, explaining that the '*system is abusive to everybody (not protecting children or staff)*' (RT 1). Specifically, this included experiences of staff '*workload'* and '*burnout'* (RT 2 & 3) and managing emotionally or ethically challenging situations (RT 1-3). To this end, participants acknowledged the need for comprehensive support for staff, including

individual self-care, that is underpinned with interprofessional understanding: '*emotional support between different professionals needed*' (RT 2), and strengthened by organisational cultures that are trauma informed at all levels: '*trauma informed organisations ... [provide] an authorising environment to actually do trauma informed work in a way that is trauma informed*.' (RT 3). In this way, staff can be supported to work with families in authentically supportive ways that acknowledge histories of trauma.

Theme 3: Educational opportunities and challenges

In addition to national leadership to drive change, there are challenges and opportunities specific to preservice education. There is national regulation of educational preparation for health and welfare professions, but the absence of a shared approach to interprofessional responses to child protection inhibited opportunities for preservice IPE in child protection. Participants recognised that graduates are not well prepared, and that change would require pushing for '*a national agenda where APHRA [Australian Health Practitioner Regulation Agency] and other regulating authorities really mandate the inclusion of... better preparation*' (RT 2). However, they also recognised that '*if it's not on the University Accord radar then it's very difficult to get certain content into curricula*' (RT 3). Without this clearly defined national requirement, implementation of child protection content is variable: '*The core concepts are now broader, and they're expressed differently'* (RT 1) and '*we can include it in the curriculum, but with or without assessment that will change the students' engagement*' (RT 3). Some universities have a specific marketing focus and do not prioritise inclusion of child protection: '*we really focus on aged care or... whatever and that's how they brand their program'* (RT 1). Furthermore, there are structural barriers in curriculum that specifically impede IPE, inclusive of clinical placements – where clinical hours are often an explicit requirement: '*placement lengths are so different... not impossible but the pragmatics will need careful consideration'* (RT 1).

Another frequently expressed view was that there may not be enough room in each profession's curriculum to incorporate interprofessional child protection content. Curriculum for health and welfare professionals was described as '*crowded'* (RT 1), '*jam-packed'* (RT 2) and '*squash[ing] too much into our undergraduate [curriculum]*' (RT 3). In addition, '*work[ing] that interprofessional stuff in there is actually a real challenge*' (RT 2) because there was competition for curriculum space amongst '*lots of competing special interest areas'* (RT 2). There is also a tendency for child protection to be offered as an elective for '*people who are specifically interested*' (RT 1) or as additional training modules for professionals to '*put in their CVs [curriculum vitae]*' (RT 2).

Discussion

This study explored what is needed to equip future health and welfare professionals in Australia to enact collaborative public health responses to child maltreatment aligned with the *National Framework*. To achieve this aim, key professional stakeholders including educators, researchers and practitioners shared their perspectives in interdisciplinary online roundtables. Importantly, while education institutions are responsible for delivering preservice education, many broader sociocultural and political factors impacted the capacity of educational institutions to effectively equip graduates for future work with children and families. Consequently, there is a need for national leadership and collective action that is geared towards emboldening a public health response to child maltreatment. This will help to create educational environments that equip graduates to engage in and mobilise coordinated public health responses that enable all children to thrive.

Unified national leadership across all levels of governance in the child protection space is needed to underpin cohesive and sustained change. Effective leadership must be coordinated and integrated including various agencies and stakeholders such as government departments, non-government organisations, healthcare providers, and law enforcement (Lonne et al., 2020). Leadership means these agencies would work together cohesively to streamline efforts, reduce duplication, and enable comprehensive support for children at risk. These findings are aligned with Australian and international recommendations for effective prevention and responses to child maltreatment (Commonwealth of Australia, 2021; Violence Prevention Alliance, 2020; World Health Organization, 2021).

The need for shared understandings where leaders in child protection work together to develop policies that prioritise the safety and well-being of children is recognised internationally. The next step is to ensure these policies are implemented effectively across different regions and communities, addressing local needs while adhering to national standards (Harries & O'Donnell, 2019). At present, policies lack detail about roles and responsibilities of professionals, making it difficult to prepare for cohesive interprofessional responses (Lines et al., 2022; Russ et al., 2022). A key part of policy is to shift from reactive interventions for suspected cases of maltreatment towards a well-resourced, comprehensive system of universal and early supports to reduce adversities and the prevalence of child maltreatment (Commonwealth of Australia, 2021; Daro & Karter, 2019). Currently there is insufficient funding for prevention and early support services, and our findings, like many other researchers, highlight the need for leadership and accountability for adequate investment in prevention and early support.

All professionals working with children have responsibility for their wellbeing, yet children and families have multiple needs across health, welfare and education requiring interprofessional responses (Hood et al., 2022). Interprofessional Education (IPE) can assist health, welfare and education students to develop capacity to engage in collective thinking and multidimensional problem-solving to holistically respond to families' needs (World Health Organization, 2010). However, research indicates that resistance to IPE is historical, stemming from educational silos where health disciplines have created distinct curriculum, professional identities, and learning cultures that evolved in isolation (Christian et al., 2020; Lines et al., 2024). Clinical placements in disciplines such as nursing, midwifery, and social work, are focussed upon individual assessment rather than interprofessional collaboration, thereby failing to reflect realities of practice. As highlighted by Lines et al. (2024), there is limited research on pre-service IPE in child protection - despite several professions' primary work in this space. This may reflect a culture of resistance to working together, reinforced through institutional inertia in higher education (Mowafi & Al-Hasan, 2024), both of which can further complicate educational culture responsible for impeding uptake in pre-service education.

Interprofessional education (IPE) leverages each discipline's strengths, and equips students with strategies, knowledge, and skills that go beyond what can be achieved by discrete disciplines. Educational cultures that value IPE help to develop workforce readiness (Bogossian et al., 2023), but our current study indicated unmet learning needs for IPE in child protection. Reasons for not incorporating IPE were primarily speculative, such as regulatory or degree accreditation requirements, however these cultures of resistance feed into the inability to imagine innovative ways to manoeuvre discourses of dissent and make IPE in child protection in pre-service learning part of mainstream higher education culture. In addition to broader regulatory issues, there are practical and logistical challenges related to coordinating timetables, curriculums, and assessment methods to ensure students from various disciplines have meaningful IPE experiences (Hood et al., 2022; Liaw et al., 2023). Further work is needed to explore ways to address local barriers to IPE alongside an

examination of the broader political, regulatory, and professional challenges that inhibit interprofessional collaboration to promote a more effective public health response to child maltreatment.

Study findings highlight a lack of understanding from practitioners across disciplines about whose remit child protection falls within. Some participants described broader misperceptions that child protection is the responsibility of the social work profession, despite other professionals, including nurses and midwives, being intrinsically involved pre-conceptually, during childbearing years and throughout early childhood (Grant et al., 2018; Nursing and Midwifery Board of Australia, 2018). While nurses and midwives are often first to learn of factors that may increase the likelihood of child maltreatment (Everitt et al., 2022; Wyllie & Batley, 2019), there is a disconnect between recognition of risk factors and actions that could be taken individually or collaboratively. Despite professionals' fundamental role and exceptional opportunities for prevention and early support to families during pregnancy and childhood (Grant et al., 2018), this is not widely considered core to professionals' roles. Consequently, participants felt child protection content was not prioritised in curriculum, describing a common rhetoric of there being 'no room' within 'crowded' curriculums. We argue that curriculum content is determined by what competencies professionals require to meet the population's needs, suggesting that despite vast numbers of individuals impacted by childhood adversity and/or maltreatment, child protection is simply not prioritised within health and welfare professional curriculum.

As documented internationally, early intervention and support can be protective and may minimise the downstream events that precede or result in child removal (Higgins et al., 2022). As such, it is essential that there are clear and reciprocal expectations and understandings of the roles and responsibilities of each professional group or discipline in creating safe environments for children (Keedle et al., 2023). It is also essential that intra and interdisciplinary communication is enhanced to ensure that families or children at risk do not fall through the cracks (Higgins et al., 2019). To date, key factors known to lead to improved outcomes may be limited or even absent within preservice discipline specific education (Bradbury-Jones & Broadhurst, 2015; Taylor & Bradbury-Jones, 2015). As such, there is a pressing need to broach disciplinary boundaries within preservice education to enhance and instil interprofessional education that brings about mutual understanding and a cohesive approach to care, especially where there are psychosocial complexities (Ali et al., 2022; Keedle et al., 2023; Long et al., 2006; McGarry et al., 2015). Focus at the undergraduate or pre-practice level may provide a platform on which to translate this interdisciplinary approach in the clinical context, and further research needs to explore innovative solutions.

Importantly for any care provision, and especially care provided when child maltreatment is present or suspected, are models of care that enhance relationships between families and caring professionals (Kirk & Duschinsky, 2017; Lines et al., 2020). These models may facilitate opportunities for non-judgemental, open communication that enable early support and ongoing engagement (Lines et al., 2020). While the value of relational care and particularly models of care that offer continuity of carer (commonly offered by nurses and midwives) are known to minimise the need to escalate to child protection authorities, these models are not always readily available to those who would benefit most (Austin et al., 2022; Jones et al., 2024). Working towards models that facilitate relational care, such that families can build trust and confidence in their care providers, is likely to break down the stigmatisation that is commonplace and enhance culturally sensitive and safe care (Lonne et al., 2021; Seekamp et al., 2023). The relationships built may in turn offer opportunities for early intervention and support that can mitigate against escalation, investigations and child removal (Daro & Karter, 2019; Lonne et al., 2020). Further research is needed to identify and evaluate models of care that teach relational care within interprofessional contexts.

Effective collaboration is essential not only for prevention and early support, but also therapeutic responses for children who are harmed by maltreatment (Middleton et al., 2019). Crucially, cohesive leadership is essential to embed these same principles of public health and interprofessional collaboration into statutory responses to child maltreatment (Higgins et al., 2019; Kirk & Duschinsky, 2017). Children who have experienced maltreatment often have multiple and complex health, developmental and psychosocial needs – which are most effectively met through cohesive intersectoral case management (Bross & Mathews, 2019; World Health Organization, 2021). Thus, while prevention and early support services form the largest component of a public health approach to child maltreatment, skills for interprofessional collaboration are necessary for seamless integration across all service tiers (Lonne et al., 2020; Russ et al., 2022).

Strengths and limitations

A key strength of this study is that it is the first to explore professional stakeholders' perspectives about how to equip the future workforce for interprofessional public health responses to prevent child maltreatment. An additional strength is the diversity of participants originating from different disciplines and contexts relevant to child and family health or welfare. A limitation of the study is that only professionals with a specific interest in interprofessional education and/or working with children and families participated, which could mean that the views of the broader workforce may not be reflected. Another limitation is that participants were only from health and welfare professions – primarily nursing, midwifery and social work. Thus, perspectives of other key professions who have opportunities to prevent and respond to child maltreatment, such as psychologists and early childhood educators, are not represented. Furthermore, this study did not include perspectives of children, young people or families; future research must incorporate perspectives of these service users to ensure solutions are tailored to their needs.

Conclusion

Despite ongoing national and international calls for collaborative public health responses to child maltreatment, preservice education is not equipping key professions to enact prevention and early support. Although the higher education sector is responsible for preservice education, the broader socio-political contexts shaping responses to child maltreatment mean that coordinated national reforms are required to transform child protection curriculum in the higher education sector. First, cohesive national leadership by governments is necessary for sustained reform towards a public health response to child maltreatment. An outcome of this reform must include explicit policy recognition, definitions, and resources to leverage collaborative responses across universal, targeted and tertiary sectors. At the same time, professional regulatory bodies need to establish a shared vision for interprofessional roles and competencies across all professions working with children and families, acknowledging unique nuances and strengths of each discipline. As broader changes driven by a shared vision gather momentum, higher education institutions can address local challenges to integrating interprofessional education into curriculum for professions who will work with children. However, further work is needed across all sectors to establish shared interprofessional understandings and core competencies for graduates who will enact public health responses that enable all children to thrive.

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Supplemental Material

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References

Ali, P., McGarry, J., Younas, A., Inayat, S., & Watson, R. (2022). Nurses', midwives' and students' knowledge, attitudes and practices related to domestic violence: A cross-sectional survey. *Journal of Nursing Management*, *30*(6), 1434–1444. https://doi.org/10.1111/jonm.13503

Austin, C., Hills, D., & Cruickshank, M. (2022). Models and interventions to promote and support engagement of first nations women with maternal and child health services: An integrative literature review. *Children*, *9*(5), 636. https://doi.org/10.3390/children9050636

Australian Association of Social Workers. (2021). *Australian social work education and accreditation standards (ASWEAS)*. Australian association of social work. https://ao.aasw.asn.au/document/item/13629

Australian Institute of Health and Welfare. (2024). *Child protection Australia 2021–22*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/child-protection/child-protection-australia-insights/contents/about

Australian Nursing & Midwifery Accreditation Council. (2024). *Australian nursing & midwifery accreditation council*. https://www.anmac.org.au/

Bogossian, F., New, K., George, K., Barr, N., Dodd, N., Hamilton, A. L., Nash, G., Masters, N., Pelly, F., Reid, C., Shakhovskoy, R., & Taylor, J. (2023). The implementation of interprofessional education: A scoping review. *Advances in health sciences education: Theory and Practice*, *28*(1), 243–277. https://doi.org/10.1007/s10459-022-10128-4

Bradbury-Jones, C., & Broadhurst, K. (2015). Are we failing to prepare nursing and midwifery students to deal with domestic abuse? Findings from a qualitative study. *Journal of Advanced Nursing*, *71*(9), 2062–2072.

Braun, V., & Clarke, V. (2023). Thematic analysis. In F. Maggino (Ed.), *Encyclopedia of quality of life and well-being research*. Springer. https://doi.org/10.1007/978-3-319-69909-7_3470-2

Broom, M., Brady, B., Kecskes, Z., & Kildea, S. (2013). World cafe´ methodology engages stakeholders in designing a neonatal intensive care unit. *Journal of Neonatal Nursing*, *19*(5), 253–258. https://doi.org/10.1016/j.jnn.2012.12.002

Bross, D. C., & Mathews, B. (2019). Chapter 18: Framing child protection as a public health law issue. In D. S. B. Lonne, D. Higgins, & T. Herrenkohl (Eds.), Re-visioning public health approaches for protecting children. Springer.

Christian, C. W., Finck, K. R., Connolly, C., Jaffee, S., Greeson, J., Garcia, A., Carlough, S. L., & Watts, C. L. (2020). Tear down those walls: The future of graduate education in child and family advocacy.

International Journal on Child Maltreatment: Research, Policy and Practice, *3*(3), 307–315. https://doi.org/10.1007/s42448-020-00057-3

Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities*. https://www.acf.hhs.gov/sites/default/files/documents/cb/cecanf_final_report.pdf

Commonwealth of Australia. (2021). *Safe and supported: The national framework for protecting Australia's children 2021-2031*. Commonwealth of Australia. https://www.dss.gov.au/the-national-framework-for-protecting-australias-children-2021-2031

Daro, D., & Karter, C. (2019). Chapter 8 universal services: The foundation for effective prevention. In B. Lonne, D. Scott, D. Higgins, & T. I. Herrenkohl (Eds.), *Re-Visioning public health approaches for protecting children* (pp. 113–126). Springer Nature. https://doi.org/10.1007/978-3-030-05858-6_8

Dray, J., Palmer, V. J., & Banfield, M. (2023). 'Keeping it real': A qualitative exploration of preferences of people with lived experience for participation and active involvement in mental health research in Australia. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *27*(1), e13934. https://doi.org/10.1111/hex.13934

Duthie, D., Steinhauer, S., Twinn, C., Steinhauer, V., & Lonne, B. (2019). Understanding trauma and child maltreatment experienced in Indigenous communities. In B. Lonne, D. Scott, D. Higgins, & T. Herrenkohl (Eds.), *Re-visioning public health approaches for protecting children* (*9*, pp. 327–347). Springer Nature. https://doi.org/10.1007/978-3-030-05858-6_20

Everitt, L., Stulz, V., Elmir, R., & Schmied, V. (2022). Educational programs and teaching strategies for health professionals responding to women with complex perinatal mental health and psychosocial concerns: A scoping review. *Nurse Education in Practice*, *60*, Article 103319. https://doi.org/10.1016/j.nepr.2022.103319

Featherstone, B., Gupta, A., Morris, K. M., & Warner, J. (2016). Let's stop feeding the risk monster: Towards a social model of 'child protection. *Families, Relationships and Societies*, *7*(1), 07–22. https://doi.org/10.1332/204674316X14552878034622

Featherstone, B., Morris, K., Daniel, B., Bywaters, P., Brady, G., Bunting, L., Mason, W., & Mirza, N. (2017). Poverty, inequality, child abuse and neglect: Changing the conversation across the UK in child protection? *Children and Youth Services Review*, *97*, 127–133. https://doi.org/10.1016/j.childyouth.2017.06.009

Flemington, T., Lock, M., Shipp, J., Hartz, D., Lonne, B., & Fraser, J. A. (2021). Cultural safety and child protection responses in hospitals: A scoping review. *International Journal on Child Maltreatment: Research, Policy and Practice*, *4*(1), 5–33. https://doi.org/10.1007/s42448-020-00065-3

Grant, J., Gregoric, C., Jovanovic, J., Parry, Y., & Walsh, K. (2018). Educating professionals who will work with children in the early years: An evidence informed interdisciplinary framework. *Early Years*, *41*(1), 48–63. https://doi.org/10.1080/09575146.2018.1488819

Harries, M., & O'Donnell, M. (2019). What are the risks and obstacles in implementing a public health approach to the well-being and protection of children? In B. Lonne, D. Scott, D. Higgins, & T. I. Herrenkohl (Eds.), *Re-visioning public health approaches for protecting children*. Springer. https://doi.org/10.1007/978-3-030-05858-6

Her Majesty's Government. (2023). *Working together to safeguard children 2023*. https://assets.publishing.service.gov.uk/media/65803fe31c0c2a000d18cf40/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf

Higgins, D., Lonne, B., Herrenkohl, T., & Scott, D. (2019). Chapter 1: The successes and limitations of contemporary approaches to child protection. In B. Lonne, D. Scott, D. Higgins, & T. Herrenkohl (Eds.), *Re-visioning public health approaches for protecting children* (*9*, pp. 3–17). Springer Nature. https://doi.org/10.1007/978-3-030-05858-6_1

Higgins, D. J., Lonne, B., Herrenkohl, T., Klika, J. B., & Scott, D. (2022). Core components of public health approaches to preventing child abuse and neglect. In R. D. Krugman & J. E. Korbin (Eds.), *Handbook of child maltreatment* (2nd ed., pp. 445–458). Springer. https://doi.org/10.1007/978-3-030-82479-2

Hillis, S., Mercy, J., Amobi, A., & Kress, H. (2016). Global prevalence of past-year violence against children: A systematic review and minimum estimates. *Pediatrics*, *137*(3), Article e20154079. https://doi.org/10.1542/peds.2015-4079

Hood, K., Cross, W. M., & Cant, R. (2022). Evaluation of interprofessional student teams in the emergency department: Opportunities and challenges. *BMC Medical Education*, *22*(1), 878. https://doi.org/10.1186/s12909-022-03954-y

Jones, M., McLaren, H., Brodie, T., Bishop, J., York, K., & Edney, L. (2024). Stakeholder experiences collaborating with my place: A service supporting pregnant and young parents in the child welfare system in metropolitan Adelaide. *International Journal of Adolescence and Youth*, *29*(1), 2367116. https://doi.org/10.1080/02673843.2024.2367116

Keddell, E. (2018). The vulnerable child in neoliberal contexts: The construction of children in the Aotearora New Zealand child protection reforms. *Childhood*, *25*(1), 93–108. https://doi.org/10.1177/0907568217727591

Keedle, H., Stulz, V., Conti, J., Bentley, R., Meade, T., Qummouh, R., Hay, P., Kaye-Smith, H., Everitt, L., & Schmied, V. (2023). Psychosocial interprofessional perinatal education: Design and evaluation of an interprofessional learning experience to improve students' collaboration skills in perinatal mental health. *Women and Birth: Journal of the Australian College of Midwives*, *36*(4), e379–e387. https://doi.org/10.1016/j.wombi.2023.01.001

Kirk, G., & Duschinsky, R. (2017). On the margins of the child protection system: Creating space for relational social work practice. *Child & Family Social Work*, *22*(2), 963–971. https://doi.org/10.1111/cfs.12316

Liaw, S. Y., Tan, J. Z., Lim, S., Zhou, W., Yap, J., Ratan, R., Ooi, S. L., Wong, S. J., Seah, B., & Chua, W. L. (2023). Artificial intelligence in virtual reality simulation for interprofessional communication training: Mixed method study. *Nurse Education Today*, *122*, Article 105718. https://doi.org/10.1016/j.nedt.2023.105718

Lines, L., Hutton, A., Grant, J., Cooper, M., Hartz, D., Zannettino, L., Kakyo, T., Starrs, R., McLaren, H., & Sivertsen, N. (2024). What is known about interprofessional education in child protection for preservice health and allied health professionals? A systematic scoping review. *Trauma, Violence, & Abuse*, *25*(4), 2657–2671. https://doi.org/10.1177/15248380231221279

Lines, L., Kakyo, T., Cooper, M., Nivertsen, N., Hutton, A., Zannettino, L., Hartz, D., Grant, J., & McLaren, H. (2024). Graduate qualities for preservice health and welfare professionals for collaborative prevention and early intervention for child maltreatment: A qualitative study. *Nurse Education in Practice*, *81*. https://doi.org/10.1016/j.nepr.2024.104176

Lines, L. E., Kakyo, T. A., Grant, J. M., & Hutton, A. (2022). Invisibility of nurses and midwives in the public health response to child abuse and neglect: A policy reivew. *Collegian*, *30*(2), 222–229. https://doi.org/10.1016/j.colegn.2022.09.002

Lines, M. L. E., Grant, J. M., & Hutton, A. (2020). How can we work together?' Nurses using relational skills to address child maltreatment in Australia: A qualitative study. *Journal of Pediatric Nursing*, *54*, 1–9. https://doi.org/10.1016/j.pedn.2020.05.008

Lines, L., Kakyo, T., McLaren, H., Hartz, D., Sivertsen, N., Hutton, A., Cooper, M., Zannettino, L., & Grant, J. (2025) (In press). Are we educating the future workforce for interprofessional responses to child maltreatment? An exploratory study. *Collegian*.

Long, T., Davis, C., Johnson, M., Murphy, M., Race, D., & Shardlow, S. M. (2006). Standards for education and training for interagency working in child protection in the UK: Implications for nurses, midwives and health visitors. *Nurse Education Today*, *26*(1), 11–22. https://doi.org/10.1016/j.nedt.2005.05.011

Lonne, B., Flemington, T., Lock, M., Hartz, D., Ramanathan, S., & Fraser, J. (2021). The power of authenticity and cultural safety at the intersection of healthcare and child protection. *International Journal on Child Maltreatment: Research, Policy and Practice*, *3*(4), 393–408. https://doi.org/10.1007/s42448-020-00053-7

Lonne, B., Harries, M., & Lantz, S. (2013). Workforce development: A pathway to reforming child protection systems in Australia. *British Journal of Social Work*, *43*(8), 1630–1648. https://doi.org/10.1093/bjsw/bcs064

Lonne, B., Higgins, D., Herrenkohl, T. I., & Scott, D. (2020). Reconstructing the workforce within public health protective systems: Improving resilience, retention, service responsiveness and outcomes. *Child Abuse & Neglect*, *110*(Pt 3), 104191. https://doi.org/10.1016/j.chiabu.2019.104191

McGarry, J., Baker, C., Wilson, C., Felton, A., & Banerjee, A. (2015). Preparation for safeguarding in UK pre-registration graduate nurse education. *The Journal of Adult Protection*, *17*(6), 371–379. https://doi.org/10.1108/jap-12-2014-0043

Middleton, J. S., Bloom, S. L., Strolin-Goltzman, J., & Caringi, J. (2019). Trauma-informed care and the public child welfare system: The challenges of shifting paradigms: Introduction to the special issue on trauma-informed care. *Journal of Public Child Welfare*, *13*(3), 235–244. https://doi.org/10.1080/15548732.2019.1603602

Mowafi, O., & Al-Hasan, M. (2024). Sustainability in education. In H. Alshurafat, A. Hamdan, & J. Sands (Eds.), *Sustainable Horizons for business, education, and technology: Interdisciplinary insights* (pp. 115–134). Springer Nature. https://doi.org/10.1007/978-981-97-2981-4_10

Nursing and Midwifery Board of Australia. (2018). *Midwife standards for practice*. https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD18%2f25281&dbid=AP&chksum=kYbO0%2bO7kx9I%2fBlvmKH%2bwg%3d%3d

Russ, E., Morley, L., Driver, M., Lonne, B., Harries, M., & Higgins, D. (2022). *Trends and needs in the Australian child welfare workforce: An exploratory study*. Institute of Child Protection Studies. https://apo.org.au/node/317233

Seekamp, S., Ey, L., & Tsiros, M. D. (2023). Partnering with families known to child protection in an interprofessional context. *Child Abuse & Neglect*, *125*, 106426. https://doi.org/10.1016/j.chiabu.2023.106426

Taylor, J., & Bradbury-Jones, C. (2015). Child maltreatment: Every nurse's business. *Nursing standard (Royal College of Nursing (Great Britain): 1987)*, *29*(29), 53–58. https://doi.org/10.7748/ns.29.29.53.e9636

Tong, A., Saunsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32 item checklist for interviews and focus groups. *International Journal of Qualitative Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Violence Prevention Alliance. (2020). *Violence prevention through multisectoral collaboration: An international version of the collaboration multiplier tool to prevent interpersonal violence*. https://cdn.who.int/media/docs/default-source/documents/child-maltreatment/collaboration-multiplier-tool8592ec0e-de31-4231-89c7-0dcfc3977cb2.pdf?sfvrsn=83d5a006_1&download=true

World Cafe Community Foundation. (2015). A quick reference guide for hosting world café. https://www.theworldcafe.com

World Health Organization. (2010). *Framework for action on interprofessional education & collaborative practice*. https://www.who.int/hrh/nursing_midwifery/en/

World Health Organization. (2021). *Ending violence against children through health systems strengthening and multisectoral approaches* World Health Organization. https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R17-en.pdf

World Health Organization. (2022). *Child maltreatment*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/child-maltreatment#:~:text=It_includes_all_types_of,of_responsibility%2C_trust_or_power

Wyllie, E., & Batley, K. (2019). Skills for safe practice–A qualitative study to evaluate the use of simulation in safeguarding children teaching for pre-registration children's nurses. *Nurse Education in Practice*, *34*, 85–89. https://doi.org/10.1016/j.nepr.2018.11.009