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Interprofessional Collaborative Practice for Child Maltreatment Prevention in Japan: A Literature Review

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This literature review explored the factors promoting interprofessional collaborative practice for the child maltreatment prevention in Japan. We searched the Japanese database of ICHUSHI-web, focusing on studies published between 1990 and 2015. The studies were examined for methodological quality using the critical appraisal checklists. We initially identified 161 articles and finally selected eight studies that met the selection criteria and were analyzed. The Collaborative Practice Circle based on the Interprofessional Education for Collaborative Patient-Centered Practice framework, was used as a conceptual framework to analyze the data and to discuss the review findings. Data analysis continued until categories were saturated using content analysis. Five categories as interactional factors, two categories as organizational factors and three categories as systemic factors were identified. The findings revealed that interactional factors were composed of practical competencies and experiences of professionals. Our findings also indicate that educational programs for improving practical competencies of professionals at the individual level and establishing a system of training and human resource development at the organizational level are required. Further research is warranted to examine the impact the challenges outlined in the interactional factors, the organizational interventions and support for clients.

INTRODUCTION

There is widespread acceptance that children have the right to grow up in safe and stable environments, protected from abuse and neglect, and to have their developmental needs attended to [33]. Equally, there has been globally growing recognition that child maltreatment is a significant public health concern as well as a serious social problem [3]. Child maltreatment is defined as, all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the under 18-year-old child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power [35]. Recent research suggests investments in prevention go well beyond protecting children from maltreatment. Also, in preventing maltreatment's devastating consequences, such as lifelong physical and mental health problems, considerable treatment and health-care costs and lost opportunities in education and employment [13].

The complexity of child maltreatment requires interprofessional collaborative practice to provide prevention, intervention and appropriate care by specific organizations and the community [4]. The advantages of working together as a team to protect children include anxiety reduction, improved quality of care and communication [20, 26]. However, it is important to recognize that collaboration exists not only within a team, but also in the context of a larger organizational setting and more and more frequently, between organizations as in health care networks, which exercise significant influence on the team [8]. The successful prevention of child maltreatment also requires a multipronged and cross-system response for shoring up resources to ensure child well-being and safety.

In Japan, the Child Abuse Prevention (CAP) Act was enacted in 2000, the CAP Act and the Child Welfare Act have been revised repeatedly over 15 years [22]. Various measures to prevent maltreatment and protect children who have suffered maltreatment along with health support for pregnant women were introduced during the revision

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of the law and include; home visiting services for all parents of new infants before four months of age; strengthening of the foster parents' system and confirmation of the child's safety within 48 hours after receiving notification. Despite all these measures, the number of child maltreatment (including suspected) incidents reported to Child Guidance Centers which are primarily responsible for child protection, has increased more than fivefold since 2000 in Japan. Moreover, the number of child maltreatment incidents reported from medical organizations to the Child Guidance Centers was only 2% of the total reported numbers. Hence, the Japanese Ministry of Health, Labour and Welfare declared in 2016 that necessary measures will be taken including, strengthening the collaboration between medical and allied sectors including the Child Guidance Centers, the nationwide establishment of the comprehensive support centers for Maternal and Child Health, and expansion of seamless support from the period of pregnancy to that of child rearing especially until pre-school age [23]. New actions for preventing child maltreatment begin in the community, and the guidelines for these actions require increasing collaborative practice at the individual, organizational and systemic levels [24].

Previous international researches have highlighted the important contribution of interprofessional work to prevent child abuse and neglect. The professional's positive attitudes and willingness to collaborate are factors that affect interprofessional collaboration [9, 11, 2]. Cleaver and Walker [6], Green et al. [11], and Clarke [5] have shown that knowledge of the tasks, responsibilities and methods used by other professionals, reduces mistrust and increases interprofessional action. Chanmugan suggested the legal framework of healthcare and welfare in each nation, may affect collaborative practice because the strict secrecy clauses in health care makes professionals sharing of information difficult [2]. These findings indicate that promoting/inhibiting factors on interprofessional collaborative practice possibly, are at various levels from personal as professionals to system as law.

Interprofessional collaborative practice for child maltreatment prevention has also been gradually expanding in Japan. Although knowledge gained from research overseas as mentioned above may be available in Japan, there is a need to examine and determine what is suitable for use in the Japanese system given there are various differences among countries such as culture, legal framework and social systems. Therefore, it is necessary to analyze interprofessional collaborative practice for child maltreatment prevention from the Japanese context. Despite this, few studies have uncovered the factors promoting collaborative practice among various professionals and organizations in Japan. To address this lack of research, we conducted a literature review with the aim of identifying factors that promote interprofessional collaborative practice for the child maltreatment prevention in Japan.

METHODS

Operational definitions

Interprofessional collaborative practice: In this study, we defined interprofessional collaborative practice for child maltreatment prevention as defined by the World Health Organization [34] as, the process and response by which different health and social care professionals work together to provide effective and comprehensive care for preventing child maltreatment.

Child maltreatment: Child maltreatment was referenced from the Child Abuse Prevention Act in Japan as follows; 1) includes four types, 'physical abuse', 'sexual abuse', 'psychological abuse' and 'neglect'; 2) acts similar to abuse by cohabitants other than parents as one type of neglect by parents; and 3) involves indirect damage to children (e.g. domestic violence witnessed by children).

Prevention: Prevention was defined from the point of view of public health as follows [4]; 1) primary prevention: prevention of child maltreatment by detecting the high-risk families and providing support; 2) secondary prevention: early detection of abuse and early response to prevent serious abuse problems; and 3) tertiary prevention: prevention of recurrence of abuse by physical and mental care (abused children and perpetrators) to ensure the life and safety of children.

Search strategy for the identification of relevant studies

We conducted a literature review for relevant articles using ICHUSHI-web, which is an internet article search service based on an exhaustive collection of Japanese medical sciences literature, thereby seeking suggestions that promote the interprofessional collaborative practice for the child maltreatment prevention in Japan. Before undertaking the article search using ICHUSHI-web, PubMed and Web of Science were used for database search. In PubMed and Web of Science, the search strategy of "(#1: child abuse OR child maltreatment) AND (#2: family) AND (#3: prevention) AND (#4: interprofessional relation OR patient care team OR multi-institutional systems OR community networks OR collaboration) AND (#5: Japan) "was fed into the search engines. Six articles were extracted from PubMed, and two was from Web of Science. One article was extracted from both search engines. However, the articles were not concerned with interprofessional work for child maltreatment prevention. Therefore, no relevant article was identified at the time of the literature search using PubMed and Web of Science.

We focused on studies published between 1990 and 2015. In Japan, the Child Welfare Act was revised substantially in 2016 and the new actions for preventing child maltreatment began based on the revised law. The revision of the Child Welfare Act in 2016 was recognized as the important turning point for child maltreatment prevention, because the role of each professionals and function of interprofessional collaboration were required to be strengthened. Hence, we intended to utilize the findings of this research in order to facilitate the new framework since 2016. For the reasons mentioned above, we explored the factors promoting interprofessional collaborative practice for the child maltreatment prevention for the period until 2015. The following search expression in Japanese, (#1: child abuse/TH OR child abuse/AL) AND (#2: family/AL) AND (#3: prevention/AL) AND (#4: interprofessional relation/TH OR collaboration/AL) OR (#5: patient care team/TH OR collaboration/AL) OR (#6: multi-institutional systems/TH OR collaboration/AL) OR (#7: community networks/TH OR collaboration/AL) AND (#8: DT=1990:2015), was fed into the ICHUSHI-web. The references of related articles were used to identify additional relevant studies. Articles were excluded if they were not (1) research conducted in Japan; (2) concerned with interprofessional work; (3) concerned with child maltreatment; and (4) published in a peer-reviewed journal. Articles were then removed if upon full-text review, they did not meet the criteria as outlined above.

Initial search yielded a total of 161 articles. These articles were screened on the basis on titles, abstracts and full text. Articles were excluded because they were not (1) research conducted in Japan (n=0); (2) concerned with interprofessional work (n=131); (3) concerned with child maltreatment (n=29); and (4) published in a peer-reviewed journal (n=14) (including duplicates). Eventually, a total of 141 articles were excluded as they lacked relevance to the aims of the review.

Critical appraisal

The twenty studies selected were examined for methodological quality by the research team members, all of whom had experience with practice. The team was comprised of two public health nurses, one pediatric nurse, one midwife and one nursing educator. Disagreements were resolved by consensus. Two different critical appraisal checklists for quantitative and qualitative studies were used. The quantitative studies were examined using the standardized critical appraisal checklist from the Joanna Briggs Institute Meta-Analysis of Statistics, Assessment and Review Instrument for descriptive studies [15]. This checklist consists of nine questions. The qualitative studies were examined using the Critical Appraisal Skills Programme Qualitative Checklist [7]. This checklist consists of nine questions. Twelve studies were excluded based on the quality assessment. Therefore, eight articles were used in the final analysis.

Conceptual framework

The Collaborative Practice Circle [8] based on the Interprofessional Education for Collaborative Patient-Centered Practice (IECPCP) framework [27] were used as a conceptual framework to analyze the articles and discuss the review findings. This model was designed to guide the development of a practice among different professionals of various organizations and the factors influencing the model. In this model, the patient/client/family/community is at the core of the circle, and the health care outcomes of patient/client/family/community are influenced by professionals' collaborative practice. In addition, this model shows linkages between the determinants and processes of collaboration at several levels, including links among professionals (micro level), links at the organizational level between relevant organizations (meso level) and links among systems such as political, socio-economic and cultural systems (macro level). Therefore, interactional factors at micro level, organizational factors at meso level and systemic factors at macro level overlap influencing the outcome of each other.

Analysis procedures

The Matrix method was used to organize the contents of articles using column topics which were set on "published year", "principal author", "title of article", "journal name", "purpose of research", "research participants", "study design and methodology", "care/support subjects", "contents of care/support", "contents of interprofessional collaboration", "situation of child maltreatment" and "factors promoting interprofessional collaborative practice for child maltreatment prevention'. In order to analyze the trend of the research, we classified the articles according to their year of publication and their research design. In addition, contents analysis was applied to analyze the data. After meaning units were condensed, they were labeled with a code. The similarities and differences between the codes were then compared. Codes were categorized into subcategories according to the similarities between them. An interpretation of the underlying meaning which was identified in the subcategories was formulated into various categories.

RESULTS

Characteristics of analyzed literatures

Table I shows the review matrix on analyzed literatures. Of the eight articles, one (No.8) [31] was published in 2005, two (No.6, No.7) [1, 18] between 2006 and 2010 and five (No.1-No.5) [16, 17, 19, 21, 28] between 2011 and 2015. Five studies (No.3-No.7) [1, 18, 19, 21, 28] used qualitative research designs and three (No.1, No.2, No.8) [16, 17, 32] used quantitative research designs. Three of the qualitative studies (No.3, No.5, No.7) [1, 21, 28] used the qualitative descriptive methodology and two (No.4, No.6) [18, 19] used content analysis. All quantitative studies (No.1, No.2, No.8) [16, 17, 32] were postal questionnaire surveys. The participants of researches were medical, social and educational professionals. Nurses participated in six of the eight studies.

Factors promoting collaborative practice for child maltreatment prevention

Interactional factors, organizational factors and systemic factors promoting interprofessional collaborative practice for child maltreatment prevention are shown in Table II. For the results as seen below, categories of each factor were shown in brackets, and subcategories were shown in quotation marks.

Interactional factors

Five categories, [values/ethics], [roles/responsibilities], [communication], [teamwork], and [experiences] were identified as the professional factors. [Values/Ethics] included seven subcategories, “build a trust relationship with children, parents, families and other team members”, “embrace the individual differences that characterize families”, “maintain competence in one's own profession appropriate to practice”, “respect the privacy of clients while maintaining confidentiality in the delivery of team-based care”, “act with honesty and integrity in relationship with parents, families and other team members”, “manage ethical dilemma specific to child maltreatment” and “work in cooperation with those who provide care and contribute to the delivery of the prevention for child maltreatment”.

[Roles/Responsibilities] contained seven subcategories, “communicate one's roles and responsibilities clearly to parents, families and other professionals”, “forge interdependent relationships with other professions within and outside the health system to improve care”, “recognize one's limitations in skills, knowledge and abilities.”, “use the full scope of knowledge of professionals from health and other fields to provide care and prevent child maltreatment”, “explain the roles and responsibilities of other providers and how the team works together to provide care and prevent child maltreatment”, “communicate with team members to clarify each member's responsibility in executing components of a support plan” and “use unique abilities of all members of the team to optimize care”.

[Communication] included five subcategories, “listen actively and encourage ideas of other team members”, “communicate the importance of teamwork in clients/community-centered care and policies”, “facilitate discussions and interactions that enhance team function”, “Communicate with children, parents, and other team members in a form that is understandable, avoiding specific terminology when possible” and “respond respectfully as a team member to feedback from others”.

[Teamwork] encompassed six subcategories, “integrate the knowledge and experience of health and other professions to inform health and care decisions”, “engage self and others to constructively manage disagreements about roles and goals that arise among professionals and with parents, families and community members”, “perform effectively on teams and in different team roles in various settings”, “reflect on individual and team performance for individual, as well as team, performance improvement”, “apply leadership practices that support collaborative practice” and “describe the roles and practices of effective teams”.

[Experiences] contained two subcategories, “experience of support for abused children and perpetrators” and “experience of interprofessional collaborative practice”.

Organizational factors

Two categories, [formalization] and [governance] emerged as the organizational factors. [Formalization] included one subcategory which was “build the information sharing system within/outside of the organization”. [Governance] contained two subcategories which were “achieve the consensus on care and support for the children/parents/families as the organization” and “coordinate the function of relevant organizations to increase effectiveness of services and programs”.

Systemic factors

Three categories, [law], [education] and [policy] were identified as the systemic factors. [Law] contained one subcategory which was “develop legal framework unbound by the Personal Information Protection Act”. [Education] included one subcategory which was “improve education to enhance interprofessional collaboration”. [Policy] contained two subcategories which were “expand and improve government policies on maternal and child health” and “expand and improve government policies on welfare”.

Table I. Characteristics of analyzed literatures

No.	Author(s) and year	Purpose	Participants	Study design and methodology
1	Kamata et al. 2013	To identify challenges for nurses who provide support for child abuse prevention.	Pediatric nurses (n = 320)	Quantitative study, postal questionnaire survey
2	Kaneko 2013	To explor the applying social work in the family support centers for child abuse prevention.	Social workers (n = 43)	Quantitative study, postal questionnaire survey
3	Ootomo et al. 2013	To describe a collaboration system between midwives and public health nurses for preventing child abuse.	Midwives (n = 7), public health nurses (n = 5)	Qualitative study, semi-structured interviews, qualitative descriptive method
4	Kurihara et al. 2013	To explore collaborative system between community and medical organizations for preventing child abuse.	Public health nurses (n = 8), midwives (n = 3), nurse (n = 1), school nurses (n = 3), caseworker (n = 1), childcare worker (n = 3), nursing college teachers (n = 8)	Qualitative study, questionnare survey, content analysis
5	Matsumiya 2011	To describe functions of the child abuse prevention network.	Psychiatrist (n = 1), Medical caseworker (n = 1), a member of board of education (n = 1), counselor (n = 2), school social worker (n = 1), welfare caseworker (n = 1), welfare social worker (n = 2), public health nurse (n = 1)	Qualitative study, group interview, qualitative descriptive method
6	Kikuchi 2009	To examine factors to function networks for child abuse prevention.	Members of the regional conference for child abuse prevention (n = 15)	Qualitative study, semi-structured interviews, content analysis
7	Arai et al. 2008	To explor linking systems for nurses in medical institutions and community health institutions for child abuse prevention.	Nurses (n = 6), public health nurses (n = 5)	Qualitative study, semi-structured interviews, qualitative descriptive method
8	Sorimachi et al. 2005	To investigate effective local care manageent systems for preventing child abuse.	Child care workers (n = 775), welfare workers (n = 22), public health nurses (n =44), others (n = 15)	Quantitative study, postal questionnaire survey

Table II. Factors promoting interprofessional collaborative for preventing child maltreatment

Factors	Categories	Subcategories	Article number
Interactional Factors	Values/Ethics	Embrace the individual differences that characterize families.	1,2,3,4,5
		Respect the privacy of clients while maintaining confidentiality in the delivery of team-based care.	1
		Build a trust relationship with children, parents, families and other team members	1,2,3,4,5,6,7
		Manage ethical dilenmas specific to child maltreatment.	1
		Work in cooperation with those who provide care and contirbute to the delivery of prevention for child maltreatment.	1
		Act with honesty and integrity in relationship with parents, families, and other team members.	5
		Maintain competence in one's own profession appropriate to practice.	5,6
	Roles/Responsibilities	Use the full scope of knowledge of professionals from health and other fields to provide care and prevent child maltreatment.	1,2,7,8
		Forge interdependent relationships with other professions within and outside of the health system to improve care.	1,2,3
		Recognize one's limitations in skills, knowledge, and abilities.	1,6,8
		Communicate one's roles and responsibilities clearly to parents, families, and other professionals.	2,3,4,6
		Use unique abilities of all members of the team to optimize care.	4,7
		Explain the roles and responsibilities of other providers and how the team works together to provide care and prevent child maltreatment.	6
		Communicate with team members to clarify each member's responsibility in executing components of a support plan.	6
	Communication	Listen actively, and encourage ideas of other team members.	1,4,8
		Facilitate discussions and interactions that enhance team function.	1
		Communicate with children, parents, and other team members in a form that is understandable, avoiding specific terminology when possible.	1
		Respond respectfully as a team member to feedback from others.	3
		Communicate the importance of teamwork in clients/community-centered care and policies.	4,7
	Teamwork	Integrate the knowledge and experience of health and other professions to inform health and care decisions.	1
		Engage self and others to constructively manage disagreements about roles and goals that arise among professionals and with parents, families and community members.	2
		Perform effectively on teams and in different team roles in various settings.	3
		Reflect on individual and team performance for individual, as well as team, performance improvement.	3
		Apply leadership practices that support collaborative practice.	3
		Describe the roles and practices of effective teams.	6
	Experiences	Experience of support for abused children and perpetrators	1,4,5,8
		Experience of interprofessional collaborative practice	1,4
Organizational factors	Formalization	Buid the information sharing system within/outside of the organization.	1,2,3,4,56,7,8
	Governance	Achieve the consensus on care and support for the children/parents/families as the organization.	1,4,6
		Coordinate the function of relevant organizations to increase effectiveness of services and programs.	2,3,4,6,7,8
Systemic factors	Law	Develop legal framework unbound by the Personal Information Protection Act.	1,4,7
	Education	Improve education to enhance interprofessional collaboration.	1,4,6,8
	Policy	Expand and improve government policies on maternal and child health.	2,3
		Expand and improve government policies on welfare.	2,3,5,6

DISCUSSION

Characteristics of analyzed literatures

Our results show the number of published articles increased between 2005 and 2015. The increase may be due to a greater awareness generated by the establishment of the Child Abuse Prevention Act in 2000 and subsequent improvements of the legal framework. Other findings indicate the number of qualitative studies were more than

that of quantitative studies. The qualitative studies were selected as appropriate approaches to best achieve the purpose of studies with their focus on exploring the effective collaboration among allied health professionals.

Factors promoting interprofessional collaborative practice for child maltreatment prevention

To the best of our knowledge, this is the first review of the literature to assess the existing evidence of factors promoting interprofessional collaboration for child maltreatment prevention in Japan. When compared with many Western countries, Japan has various systemic challenges in the prevention of child maltreatment. In particular, the lack of inter-sectoral cooperation, due to vertical administration, has hindered the implementation of interprofessional collaborative practice [25]. In the United States, for example, where efforts to prevent abuse of children started much earlier than in Japan, far greater numbers of child abuse cases are reported to and handled by child protection service agencies. Such agencies are staffed by far larger numbers of experts per capita than in Japan, and the police and the judiciary are more deeply involved in the effort to prevent child abuse. In this review, systemic, organizational, and interactional factors are identified, and the findings indicate that adjusting organizational and systemic factors promotes interprofessional collaboration. Additionally, the findings suggest that empowering interactional factors is also necessary for promoting interprofessional collaborative practice. In other words, in order to promote interprofessional collaboration in an effort to prevent child maltreatment in Japan, these three factors must be reinforced.

This review revealed that interactional factors were composed of four practical competencies (values/ethics, roles/responsibilities, communication and teamwork) and experiences, for interprofessional collaborative practice for child maltreatment prevention. Values/Ethics competencies intend for individuals, to work with other professions to maintain a climate of mutual respect and shared values on child maltreatment. Roles/responsibilities competencies indicate, to use the knowledge of one’s own role and those of other professions to appropriately assess and address the health care needs of children and families and to prevent maltreatment. Communicational competencies are designed so there is communication with children, families, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention of maltreatment. Teamwork competencies are aimed, to apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate children/family centered care for maltreatment prevention. Experiences mean, not only the experience of collaborative practice but also the experience of care for abused children and perpetrators. The Interprofessional Education Collaborative released four core competencies for interprofessional collaborative practice, which are ‘Values/Ethics for interprofessional practice’, ‘Roles/Responsibilities’, ‘Interprofessional Communication’ and ‘Team and Teamwork’ [14]. The four core competencies are very similar to the four categories saturated as interactional factors of this review. Therefore, these findings indicate high validity of this review.

Equally, our results show not only practical competencies but also experiences of professionals are required in order to promote interprofessional collaborative practice and to encourage improved outcome of child maltreatment prevention. Gaining experience of caring for abused children and perpetrators increase knowledge and practical information among professionals [31]. Experience enables the enrichment of professionals’ perspectives to suspect and to detect child maltreatment, and to enhance practical competencies for interprofessional collaborative practice for child maltreatment prevention. To be specific, professionals who have had experience in supporting abused children, try to collect information by communicating with children and family in a form that is understandable so as to avoid specific terminology when possible, and can be used for maltreatment risk assessment. Professionals integrate their experience and knowledge and share care decisions with other team members. This represents the very process of interprofessional collaboration for child maltreatment prevention. In other words, experience empowers interprofessional collaborative practice.

Ikeda's review of the international researches revealed one factor affecting decision making by social workers in cases of child abuse and maltreatment which was experiences of professionals [12]. Saeki et al. reported that experience can improve the practical competencies of public health nurses and reduce the challenges they face [30]. However, the findings of this study suggest the importance of accumulating experience for support of abused children and interprofessional collaborative practice, not just in terms of career development mentioned in other studies. This means that it is necessary to establish a system of team development at the organizational level for sharing experience and enhancing competences of collaborative practice for child maltreatment prevention. For achieving this, the first requirement is to focus understanding role boundaries and expectations within the team and learning how to balance the needs of professional identity and team identity. The second requirement is to engage in effective formal and informal communication, including negotiation and conflict resolution skills, ability to use a language of respect and dignity, and knowing what terminology and communication approaches to use with different professions and different individuals.

Regehr et al. reported that appropriate and quick decision-making responses are required by professionals despite complex and uncertain situations, when responding to child maltreatment [29]. Gillingham & Humphrey

claimed it is a top priority to improve the ability of the professional to deal with the complexity of the child maltreatment rather than spreading the assessment tools [10]. In short, these reports and our findings indicate educational programs for improving practical competencies of professional are required, not manuals. Our findings suggest the educational programs include the contents of empowering four practical competencies and deepening experiences.

Our results also showed the organizational factors were composed of 'formalization' and 'governance', and the systemic factors composed of 'law', 'education' and 'policy'. However, variations of subcategories of both factors are less than those of the interactional factor. One possible reason is that previous researches failed to uncover the organizational and systemic factors affecting interprofessional collaborative practice for child maltreatment prevention. The Collaborative Practice Circle, which is the conceptual framework of this review, provides the rationale that collaborative competencies will not necessarily improve outcomes if micro- meso- and macro- level support are not aligned in practice settings. Therefore, further research is warranted to reveal organizational and systemic factors promoting/inhibiting interprofessional collaborative practice for the child maltreatment prevention. In addition, the expected outcomes from further research will contribute to establishing the seamless framework for child maltreatment prevention in Japan.

Limitations of the study

The findings of this study may not represent all factors that exist in the current system, as the small number of analyzed articles published between 1990 and 2015 retrieved from the limited databases available may be considered a limitation of our study, due to a strict procedure and critical appraisals. A further limitation of this review may be that related literature was overlooked due to the combination of limited search terms used in the literature search. However, this does not lessen the need to further research the factors raised by the review in this study.

Implications for practice and future research needs

The findings highlighted in the three factors of this study have far reaching clinical and administrative implications for providers and administrators. First, various professionals can use the information from this study to further improve their competencies and to promote a collaborative team approach to holistic care and to assist in breaking down barriers that impede collaboration between professionals and organizations. Second, being made aware of the challenges provides administrative personnel with greater knowledge of the need to provide ongoing professional development training and update appropriate collaborative systems. Finally, additional research is warranted to examine the impact the challenges outlined in the three factors have on assessment procedures, interventions and support for clients.

CONCLUSION

This study explored the factors promoting interprofessional collaborative practice for the child maltreatment prevention in Japan. The factors identified provide information that can be used to improve the outcome. It further provides the opportunity for clinical professionals and administrators to use the information gained to put forward programs and interventions specific to the clients' needs. Participation in developing programs should be based on first-hand clinical experience and understanding of what is required to effect changes to the holistic care system. Significantly, the findings of this study can contribute to the efforts of promoting improved organizational and systemic collaboration in addition to professional development opportunities.

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REFERENCES

1. **Arai, Y., Yasutake, S., Kasagi, K., and Okamitsu, K.** 2008. An investigation on the supports and linking systems for nurses in medical institutions and community health institutions preventing child abuse [in Japanese]. Journal of Faculty of Health and Welfare, Prefectural University of Hiroshima. **8**(1): 101-115.
2. **Chanmugan, A.** 2009. Qualitative study of school social workers' clinical and professional relationships when reporting child maltreatment. Children & Schools. **31**(3): 145–161.

3. **Child Family Community Australia.** 2014. International approaches to child protection. What can Australia learn? CFCA PAPER **23:** 1-11.
4. **Child Welfare Information Gateway.** Child maltreatment prevention: Past, present, and future. Issue Brief, July 2017, 1-17. https://www.childwelfare.gov/pubPDFs/cm_prevention.pdf.
5. **Clarke, M.L.** 2000. Out of the wilderness and into the fold: the school nurse and child protection. Child Abuse Review. **9**(5): 364–374.
6. **Cleaver, H., and Walker, S.** 2004. From policy to practice: the implementation of a new framework for social work assessments of children and families. Child & Family Social Work, **9**(1): 81–90.
7. **Critical Appraisal Skills Programme.** Qualitative Research Checklist 31.05.13. http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf.
8. **D'Amour, D., and Oandasan, I.** 2005. Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. Journal of Interprofessional Care. **1**:8-20.
9. **Goebbels, A.F.G., Nicholson, J.M., Walsh, K., and De Vries, H.** 2008. Teachers' reporting of suspected child abuse and neglect: behaviour and determinants. Health Education Research, **23**(6): 941–951.
10. **Gillingham, P., and Humphreys, C.** 2009. Child protection practitioners and decision-making tools: observations and reflections from the front line. British Journal of Social Work. **40**: 2598-2616. doi:10.1093/bjsw/bcp155.
11. **Green, B.L., Rockhill, A., and Burrus, S.** 2008. The role of interagency collaboration for substance abusing families involved with child welfare. Child Welfare. **87**(1): 29–61.
12. **Ikeda, N.** 2016. A review of international research on decision making in cases of child abuse and maltreatment: suggestions to develop the quality of social work practice [In Japanese]. Japan Lutheran College and Theological Seminary. **50**: 77-88.
13. **Institute of Medicine, & National Research Council.** New directions in child abuse and neglect research 2014. https://www.ncbi.nlm.nih.gov/books/NBK195985/pdf/Bookshelf_NBK195985.pdf.
14. **Interprofessional Education Collaborative.** Core competencies for interprofessional collaborative practice: 2016 update. https://aamc-meded.global.ssl.fastly.net/production/media/filer_public/70/9f/709fedd7-3c53-492c-b9f0-b13715d11cb6/core_competencies_for_collaborative_practice.pdf.
15. **Joanna Briggs Institute.** 2011. Reviews' Manual. Adelaide, Australia; University of Adelaide.
16. **Kamata, K., and Ishihara, A.** 2013. Difficulties for nurses providing support for child abuse prevention [in Japanese]. Journal of clinical and educational psychology. **19**: 13-24.
17. **Kaneko, M.** 2013. The development of a child and family support network for working with involuntary family: the practice of the child and family support center in Tokyo [In Japanese]. Issues in social work: study report of the Japan College of Social Work. **59**: 41-62.
18. **Kikuchi, M.** 2009. Factors to function networks for preventing child abuse: through interview to the constituent members of the regional conference for children needing protection [in Japanese]. Bulletin of Kochi Women's University. Series of Faculty of Social Welfare. **58**: 1-14.
19. **Kurihara, K., Ushinohara, H., Hibi, C., et al.** 2013. Report of case conference on child abuse: awareness and information of participants [In Japanese]. Journal of Yokkaichi Nursing and Medical Care. **6**(1): 29-38.
20. **Lalayants, M. and Epstein, I.** 2005. Evaluating multidisciplinary child abuse and neglect teams: a research agenda. Child Welfare. **84** (4):433–458.
21. **Matsumiya, Y.** 2011. The problem-solving process in a case of child abuse by parents with mental health problems: based on investigation about the practice in Urakawa-town, Hokkaido [In Japanese]. Japanese Society for the Study of Social Welfare. **52**(3): 40-52.
22. **Ministry of Health, Labour, and Welfare.** Measures to prevent child abuse [in Japanese]. http://www.mhlw.go.jp/file/05-Shingikai-10901000-Kenkoukyoku-Soumuka/0000131912.pdf.
23. **Ministry of Health, Labour, and Welfare**. Overview of Act on Partial Amendment of Child Welfare Act, etc. Act No.63. http://www.mhlw.go.jp/english/policy/children/children-childrearing/dl/160802-01e.pdf.
24. **Ministry of Health, Labour, and welfare.** Guideline for Child Abuse Response [in Japanese]. http://www.mhlw.go.jp/seisakunitsuite/bunya/kodomo/kodomo_kosodate/dv/dl/130823-01c.pdf.
25. **Ministry of Health, Labour, and welfare.** Radical reinforcement of child abuse prevention measures [in Japanese]. https://www.mhlw.go.jp/content/000496811.pdf.

26. **Naish, J., Carter, Y.H., Gray, R.W., et al.** 2002. Brief encounters of aggression and violence in primary care: a team approach to coping strategies. Family Practice. **19** (5):504–510.

27. **Oandasan, I., and D'Amour, D.** 2004. Interprofessional education for collaboration patient-centered practice. Research & findings report. Ottawa, Canada: Health Canada.

28. **Ootomo, M., and Asahara, K.** 2013. Descriptive study on continuous mother-child care for the prevention of child abuse: collaboration between midwives and public health nurses in Japan [In Japanese]. J. Jpn Acad. Nurs. Sci. **33**(1): 3-11.

29. **Regehr, C., Bogo, M., Shlonsky, A., and LeBlanc, V.** 2010. Confidence and professional judgment in assessing children's risk of abuse, Research on Social Work Practice. **20**(6): 621-628. DOI: 10.1177/1049731510368050 http://rswp.sagepub.com

30. **Saeki, K., Izumi, H., Uza, M., and Murashima, S.** 2007. Factors associated with the professional competencies of public health nurses employed by local government agencies in Japan. Public Health Nursing, **24**: 449-457. DOI: 10.1111/j.1525-1446200700655x

31. **Saimura J.** 2008. Research on how to deal with abuse in related institutions such as nursery schools and schools [In Japanese]. Report on 2004-2006 Health and Labor Sciences Research Grant.

32. **Sorimachi, Y., Adachi, M., Iwasaka, M., et al.** 2005. Toward effective local care management systems for preventing child abuse: a study of institutions and child care providers in the vicinity of Minami-Tama public health center [in Japanese]. J. Natl. Inst. Public Health. **53**(1): 74-79.

33. **World Health Organization.** Global status report on violence prevention 2014. http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/.

34. **World Health Organization.** 2010. Framework for action on interprofessional education & collaborative practice. Geneva, Switzerland: WHO.

35. **World Health Organization and International Society for Prevention of Child Abuse and Neglect.** 2006. Preventing Child Maltreatment: a guide to taking action and generating evidence. Geneva, Switzerland: WHO.