SAME, BUT DIFFERENT:
CONTEMPORARY CHILD AND FAMILY HEALTH
NURSING PRACTICE IN NSW

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DOCTOR OF PHILOSOPHY

Charles Darwin University
September 2005
Certificate of authorship originality

I hereby declare that the work herein, now submitted as a thesis for the degree of Doctor of Philosophy of the Charles Darwin University, is the result of my own investigations, and all references to ideas and work of other researchers have been specifically acknowledged. I hereby certify that the work embodied in this thesis has not already been accepted in substance for any degree, and is not being currently submitted in candidature for any other degree.

____________________________________
Signature of the candidate

___________
Date
Acknowledgements

Hard to believe the day has finally come to write these words. It has been a long three and a half years, but worth it and the words of Julia Byford at one of my earliest student seminars linger in my mind. She said ‘the only good thing about a PhD is a submitted one’ and she was right. Still, my apprenticeship into the world of research, though troublesome, was as broad as it was deep. My master (who should in fact be called a mistress, but for the loaded connotations such a word carries) was the inspiring Lesley Barclay, supervisor, mentor and friend. I thank her from the bottom of my reluctant heart for without her, I surely would not be writing these words today. Not only did she support me in the production of this work, but she offered so many other opportunities to grow and learn, in her ever-present optimistic view of the world.

I would like to acknowledge the hard work and dedication of the child and family health nurses who so bravely allowed me to peer into their professional lives, to discuss, explore and critique the very bones of their practice. Each one of them works with endless dedication and should remember that the critique in these pages is directed at the systems that prepare and support them, and not the individuals themselves.

To the unique and nurturing environment that is the Centre for Midwifery and Family Health at UTS, I thank you for your support, both pre-and-post Lesley’s departure. Students who accompanied me on my journey and I on theirs include Setyowati, Athena Sheehan, Carolyn Briggs, Chris Hendry, Jane Svenson and Margie Duff, amongst others. Most of them have successfully completed their studies and are evidence of the success of the unique model of regular student groups and group supervision that Lesley established and Caroline Homer continues today. The left and right arms of Lesley’s supervision model whilst at UTS were Virginia Schmied and Marg Cooke. Both of these supervisors gave me tremendous support and encouragement and I consider their role in the development of this thesis essential. Upon my defection to Charles Darwin University, Virginia remained my second
supervisor and continued her support and availability despite moving on herself to new adventures. She was particularly helpful in the last weeks when she knew my impatience to submit was affecting the final touches and steadfastly kept me on track until the last minute.

To my family, I thank you for your enduring support throughout the long life of this work. I hope to hold the PhD that my mother, Bev Fitzgerald would have achieved in her own lifetime, had it provided her with different opportunities. However, a different life might not have made me who I am today. She is a great source of wisdom and support. I thank my sisters, Lee and Rachel, for their friendship and my brother Mike for his calm reminder of the importance of birds and the beauty of the animal world.

To my midwifery family, I thank the inspirational women who guided, befriended and nurtured me since arriving in Sydney over four years ago. Caroline Homer, Pat Brodie, Nicky Leap, Sally Tracy and the many friends and colleagues in the midwifery world, thank you for your support and kindness.

To my non-midwifery friends, thanks so much for putting up with me for such a long time, particularly those who were not afraid to ask ‘what is it your PhD is about again?’. Catie Clot, Vivien and Christian, Doon and Roy, David and Micheal and finally Libby Bowell, I treasure your support and friendship so thank you.

Finally, to the woman who brings out the best in me, my partner and life-long soul mate, Sue Kildea. Without her, my light is not as bright, nor my song as strong. May we continue to grow and learn together, for many more years to come.
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<td>Area Health Service</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>‘Blue book’</td>
<td>Personal Health Record: a comprehensive booklet given to all women having a baby in NSW hospitals. It provides information on health and relevant services related to children aged 0-5 years and serves as a hand-held-record.</td>
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<td>CAFHNA</td>
<td>Child and Family Health Nurses Association</td>
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<td>CALD</td>
<td>Culturally and linguistically diverse</td>
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<td>C&amp;FH</td>
<td>Child and Family Health</td>
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<tr>
<td>DoCS</td>
<td>Department of Community Services: a government service responsible for the welfare of children, including the management of children suspected of child abuse or neglect.</td>
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<td>EDS</td>
<td>Edinburgh Depression Scale: a standardised questionnaire administered to all mothers to identify those at risk of postnatal depression. Used to be known as the EPDS or Edinburgh Postnatal Depression Scale but as the tool is now used antenatally, the 'postnatal' has been dropped from the title.</td>
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<tr>
<td>FTE</td>
<td>Full-time equivalent</td>
</tr>
<tr>
<td>GPs</td>
<td>General Practitioners: family medical officers located in the community</td>
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<tr>
<td>IBIS</td>
<td>Ingleburn Baby Information System: A comprehensive family assessment form</td>
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<tr>
<td>NESB</td>
<td>Non-English-speaking background</td>
</tr>
<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council (United Kingdom)</td>
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<td>NSW</td>
<td>New South Wales, the State in Australia in which the research was undertaken</td>
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<tr>
<td>NSW Health</td>
<td>The Department of Health in NSW</td>
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<td>PHN</td>
<td>Primary Health Nurse</td>
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<td>SSWAHS</td>
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<td>UHHV</td>
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Abstract

Child and family health (C&FH) nursing services in New South Wales (NSW) have undergone rapid change in recent years. This is largely in response to policy change bought about by the implementation of 'the Families First’ initiative of the State Government.

This thesis utilised a health services research framework to explore, describe and analyse contemporary C&FH nursing practice and identify the major factors which impact on their ability to effectively support families. An ethnographic approach guided data collection and analysis across three different practice settings, reported as case studies. Case Study One explored C&FH nursing practice as provided to families through individual consultations in the home or the health centre. The second case study investigated the C&FH nurse as a facilitator of groups for parents with new babies. Finally, the third case study explored C&FH nursing practice as a member of a multidisciplinary team.

The research identified the complexity of current C&FH nursing practice and a change in the philosophy that underpinned their practice that was difficult to adopt. While the findings across the three case studies were varied, one outcome apparent throughout the thesis was that nurses predominantly continue to frame their practice within an expert model. The nurses also struggled to deliver new service models whilst maintaining access to all families.

Some explanations for the tensions experienced by the nurses relate to the age, educational preparation and leadership within the workforce. Other factors relate to the structures and management systems that were evident within the health service that employs them. Without suitable recognition and attention to the some of the key findings of this research, the C&FH nursing workforce will not achieve its maximum potential in the support of families with young children.
Prologue

I am, or was, a bush nurse, or more formally, a remote-area nurse. A clinical nurse and midwife with a decade-long history of working with remote Indigenous Australians. My particular interest was, and is, in child health and most of my time working in remote Australia was in this field. The poor health of Indigenous Australians is no secret and malnutrition in young children, particularly aged six months to two years, is a huge problem. Working in remote areas, I would see young, healthy, breast-fed babies aged between birth and six months with rolls of fat lining their abdomens. These young babies would have clear, chocolate-coloured skin and clear eyes that sparkled with happiness. I knew the babies and their mums well and would immunise, do ‘check ups’ and regularly plot their increasing weight and length on the growth charts, complimenting their mothers on how well their babies looked. At the four-month immunisation I would use an Indigenous-specific poster to begin talking to the mothers about introducing foods. I would suggest some common foods that I knew were popular to give to the babies. The mothers smiled, nodded their heads and politely listened. Yet I knew from their eyes, the mothers did not think their babies were old enough for food, and I knew they would not be giving their babies any solid food, but still I went through the motions.

At around the age of six months these babies would falter in their growth, and over the ensuing months I would start to see them more regularly. I would talk about food more frequently as their skin became infected with scabies, their eyes lacked lustre, and their little bodies lost valuable iron stores. Some mothers would quietly nod their heads in agreement, others would tell me they gave their children vegetables, fish and bush tucker, all the things they knew I wanted to hear. These babies would present frequently with diarrhoea and respiratory illness, often requiring transfer to hospital. Their immune system was challenged and their bodies susceptible to the many infections that circulated within the community. By the age of ten or twelve months, the bright happy eyes that used to dance with pleasure at my smile, now would not look at me, cringing in fear into the secure hollows of their mothers’ neck. The
mothers were more withdrawn, not as friendly, anxious that I might ‘growl’ them, even though I tried really hard not to show my frustration at not being able to make a difference.

Why didn’t these mothers give their babies food other than breast milk? I still don’t know the answer to that, though I do know that I was largely ineffective in improving the health of those babies. The only things I knew to do were medical. I crushed up and dissolved tablets to treat parasites, injected liquid iron to treat anaemia, gave them intramuscular penicillin to treat their infected scabies. These babies would continue to falter in growth, their weight and length measurements crossing lower centiles as I continued to measure and plot and screen for organic causes of failure to thrive, even though I knew the causes were nutritional. Some babies would come into the health centre daily, others weekly, and I would weigh and plot, giving encouragement and congratulations over the smallest of weight gain. By between 18 months and two years of age, these babies would finally turn the corner. The growth charts would show a line that had been more or less static for a year, slowly climb at or around the third centile, never showing catch-up growth, merely indicating the slow steady growth of an underweight, short-statured child like so many of his or her peers.

So why was I ineffective? I don’t really know the answer to that question either but I suspect that it may have been something to do with my inability to address the other social determinants of these families’ health. But it was more than that. I knew that I did not understand the mothers. And they perhaps did not understand me. I used to think ‘if only I could get into their heads I could understand them more’. But I can’t get into anybody else’s head, nor can they get into mine (thank goodness). Instead we have to develop models that maximise the opportunities we have to understand each other.

When circumstances bought me to Sydney four years ago, I was given the opportunity to undertake a PhD. I thought about the privilege of having three years of supported time to answer any question I wanted to ask. I also thought of all those babies who I,
and the health system, had failed. My question then was obvious. How can we be more effective at what we do? This thesis is not about Indigenous children. As already mentioned, circumstances bought me to Sydney. But it is about child health nurses and it is about being more effective. I hope the lessons learnt from this research help practitioners and health systems everywhere become even a little bit better at what they do.
Chapter One

Introduction
Chapter One: Introduction

This thesis sets out to explore, describe and analyse child and family health (C&FH) nursing practice in contemporary Australian health services. The research was undertaken as a result of witnessing a workforce undergoing times of rapid change in response to policy directives that were impacting on the structure and practice of C&FH nursing services. Understanding and supporting changing practice were further challenged by the limited information about the role and scope of practice of the C&FH nurse available in the health literature, particularly within the Australian context.

This thesis seeks to contribute to the understanding of contemporary C&FH nursing practice in an area of Sydney, New South Wales (NSW), Australia. It attempts to identify the major factors which influence their ability to effectively support families. The intention of the research was to produce a pragmatic thesis that is accessible to, and relevant for, the policy-makers and workforce who guide and provide C&FH service delivery in NSW.

Of particular interest throughout the thesis is the support of families with the greatest health needs. Families who are most disadvantaged in society are known to have the poorest health and are the least likely to seek out preventative health services (NSW Health, 1999). Child and family health nursing services are therefore of greatest importance in the areas that service these communities. It is also the more challenging for health services staff to provide services for families who do not share the same social and cultural values (Spence, 2001). For these reasons, this thesis focused on C&FH nursing practice in areas with high rates of families who are marginalised from health services, by either income or language.

Health services have responded to a growing evidence base that promotes the support of parents in early parenting, in order to maximise the social, emotional and physical health of future societies. This chapter outlines the evolution of this evidence, the
subsequent response by many health systems and the implications the policy response has had on the C&FH nursing workforce in NSW.

**The Early Years**

In recent years there has been increasing recognition of the role of parenting in contributing to the social health of a functioning society (Mustard, 1996). Postnatal anxiety and distress have negative effects on infant attachment and have been found to respond to early intervention programs (McMahon et al., 2001). There is also growing evidence that childhood experiences are closely linked to later adult functioning (WHO, 1998).

The ability for parents to nurture and care for their infants is now known to have a direct consequence on how children develop, their capacity to learn, their behaviour and ability to regulate their emotions (McCain & Mustard, 1999). There is now evidence that children living within poor family functioning or socio-economic disadvantage suffer poorer health than those in well-functioning families and affluent environments (AIHW, 2003). These inequalities that produce social gradients in health affect society as a whole and not only those living in poverty (Mustard, 1996).

Children who receive inadequate, or inappropriate stimulation in early life, are more likely to develop learning, behavioural or emotional problems in later life, with increased incidence of boys involved in juvenile delinquency and crime (Mustard, 1996). There is also increasing evidence that adult diseases such as diabetes, heart disease and mental health conditions are influenced by the environment from conception to five years of age (McCain & Mustard, 1999).

While the health and wellbeing of children in Australia is improving overall, a recent report highlights continuing issues of concern (AIHW, 2005). Obesity in childhood is increasing exponentially, with 18% of boys and 22% of girls aged between two and 14 years being overweight or obese. The social and emotional health of children is also a cause for concern. For example, the number of children under child protection orders
increased 47% between 1997 and 2001 (AIHW, 2005). The increasing rates of children under care and protection orders suggest that many parents continue to struggle in providing appropriate care and support for their children.

**PARENTING SUPPORT**

Parents from all socio-economic levels can benefit from advice and support in enhancing their parenting skills (McCain & Mustard, 1999). Research has shown that parent-perceived emotional, instrumental, and informational social support is associated with more sensitive and responsive maternal behaviour among both high-risk and low-risk populations (Barnes & Freude-Lagevardi, 2003).

Parents draw on information and support around childrearing from three main sources: media (including pamphlets and the Internet amongst the traditional forms of television, newspapers, radio and magazines); group work (including playgroups, parent groups, semi-structured and structured education and therapeutic groups); and, individual approaches such as informal networks, telephone help lines, professional advice (nurses, social workers, teachers and doctors) and voluntary schemes such as volunteer breastfeeding counselling and home visitors (FaCS, 2004a). Supportive interventions from professionals have traditionally been provided by nursing and social work disciplines (Lojkasek et al., 1994). In 2001, 68.6% of 3,500 NSW parents surveyed reported that they needed parent support services (NSW Health, 2002a) with C&FH nursing services most commonly identified as the main source of professional support these parents accessed (NSW Health, 2002a).

**POLICY RESPONSE**

The World Health Organisation recommends that government policy should address the psychosocial and material needs of families with young children, as both of these factors can cause long-term ill-health. Further, they identify that Governments should support families, encourage community activity, combat social isolation, reduce material and financial insecurity and promote coping skills (WHO, 1998).
Many governments now aim to improve support to parenting through policies and programs. Such policies include: Sure Start (DfEE, 1999) and On Track (The Home Office, 2000) in the United Kingdom; Healthy Families America in the United States (Harding et al., 2003); Strengthening Families in New Zealand (New Zealand Government, 2004); and Stronger Families (FaCS, 2004b) and Positive Parenting Programs (Sanders, 1999) in Australia.

The National Health and Medical Research Council (NHMRC) of Australia recommends that most children and families would benefit from ongoing contact with a universal system that is responsive to their needs (NHMRC, 2002).

Ideally parent concerns and risk factors would be systematically elicited and addressed; a range of graded interventions offered in context; longitudinal follow-up would occur to take into account the changing nature of development and risk and protective factors; seamless referral and follow-up systems would be put into place in community networks; and the whole system would be underpinned by a system of quality assurance to ensure that structures and processes are consistent with contemporary knowledge (NHMRC, 2002 p224).

Many states and territories in Australia have, or are developing, whole-of-state government strategies for a more integrated response to the needs of children and their families. These include: the Early Years Strategy in Western Australia; Families First in New South Wales; the Putting Families First policy framework developed in Queensland; Every Chance for Every Child in South Australia; Our Kids Action Plan in Tasmania; A Vision for Territory Children and Children’s Policy Framework in the Northern Territory; and the Best Start strategy in Victoria.

The C&FH nurse has been identified as the key service agent in the promotion and improvement of maternal, infant and family health in many of these policies. In NSW, the importance of the C&FH nurse workforce has been identified as the key
implementation arm of the health policy component of the Families First initiative (NSW Health, 2002b).

**Families First: the NSW experience**

The Families First initiative was introduced in three Area Health Services (AHS) across the state of NSW in 1998 with full roll-out completed by late 2004 (Office of Children and Young People, 2002c). The policy incorporates involvement and activity from the following government departments: health; community services; aging and disability; education and training; and, housing (Office of Children and Young People, 1999). It also offers funding to non-government services including: family support services; neighbourhood centres; family counselling services; general practitioners (GPs); childcare services; volunteer programs; disability services; and, other services that support families (Office of Children and Young People, 1999). The policy was designed to increase the effectiveness of early intervention and prevention services in helping families to raise healthy, well-adjusted children (Office of Children and Young People, 2002c).

The broad aim of the initiative is, ‘through a coordinated network of services, to support parents and carers raising children and help them to solve problems early before those problems become entrenched’ (Office of Children and Young People, 1999 p.1). Maternity and C&FH nursing services were identified as having an important role in the delivery of information and support to all families. This included families who did not traditionally use their services (Office of Children and Young People, 1999). The policy implementation strategy promotes both physical and social assessments of the child, and family, to identify stressors early and apply timely referrals to other support services (Office of Children and Young People, 2002c).

Community programs fulfil an important role in the support of families with infants and young children and are also supported by the Families First initiative. Some of these programs include volunteer home visiting, playgroups and childcare services (Office of Children and Young People, 1999). Extra resources are also offered to
services that could assist families requiring additional support. These agencies include speech therapy, counselling services, mental health, child protection and special education. Community strengthening activities are supported and include nutrition programs, social support groups and other community events (Office of Children and Young People, 1999).

The principles underpinning the Families First initiative are provided in the following box.

- Empower parents to be active in decisions which affect their lives. There is no one ‘right’ way to raise children. Parents have varying goals and values. The support and guidance they receive should help them to build on their own strengths and those of their children.

- View parents as experts who know what is best for their family. Parents have choices. Support should be non-judgmental and aimed at helping families to determine their own needs and decide what is best for them.

- Link families to the services best able to meet their needs. To prevent problems from becoming entrenched requires early intervention by professionals who work with families to assess their needs and then link them to services which can provide the required support.

- Have a holistic view of each family. This means focusing on the whole family, how they relate as individuals and how the needs of each individual affects other family members.

- Seek and take into account feedback from families about the service received. Families should have the opportunity to provide feedback about the benefits and pitfalls of the service provided.

- Provide flexible services in convenient settings. Families can be supported in a variety of ways and settings: in the home; in the centres; and in the community. Flexibility makes it easier for families to take advantage of what services have to offer, particularly families who do not traditionally use them.

- Work with families as a team. The teamwork approach operates at two levels – within the service itself and across the service network. Staff and volunteers who understand one another’s roles, complement one another’s skills and knowledge, and maintain good communication will give better support to families. Most importantly, families are part of the team.

- Ongoing training and development opportunities. Staff and volunteers should have access to opportunities to enhance skills and competencies.

(Office of Children and Young People, 1999 section 1, page 1)
In response to the broader government policy of the Families First initiative, and in order to implement a consistent state-wide approach to the provision of universally available home visiting, NSW Health developed policy guidelines to support the services undertaking these activities (NSW Health, 2002b). The ‘Supporting Families Early: Families First Health Home Visiting Practice Guidelines’ (the Health Home Visiting Guidelines) is the only health policy document related to Families First and was released in draft form in October 2002. At the time of writing (August 2005), these policy guidelines are yet to be endorsed but remain available in draft form.

The Health Home Visiting Guidelines state that universal home visiting is to be offered to all families following the birth of a baby, with families identified as needing additional support to receive ‘sustained’ home visiting (NSW Health, 2002b). Sustained home visiting is recommended to commence as early as possible in the antenatal period, for those families identified as vulnerable, and should continue for at least two years (NSW Health, 2002b). A ratio of one nurse to every 25 families is the recommended staffing level for sustained home visiting (NSW Health, 2002b). No guidelines around staffing levels required for universal home visiting postnataally and routine centre services that are currently offered in NSW appear to have been calculated.

The NSW policy documents outlined above were informed by, and are consistent with international literature guiding services providing parenting support. Effective health care services require a sound and robust policy platform as well as the expertise and capacity of the workforce to implement it (Bridgman & Davis, 2000). Organisation restructure and culture change are known to effect the motivation, morale and working practices of a profession (Lewis & Urmston, 2000). Little is known around how, or if, the C&FH nursing workforce was consulted throughout the development of the

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1 ‘Vulnerable’ within the UK literature usually refers to families with children at risk of child abuse. In Australia the term tends to be used in relation to individuals, groups of individuals or families at risk of poor social, physical or psychological health (Johnson et al., 2003).
policies, how they were prepared to implement the policies, how the policies would affect their practice and most importantly, how the change in practice would affect the families they serviced, or did not service. This thesis attempts to address some of these issues as it explores, describes and analyses contemporary C&FH nursing practice in several study sites across Sydney, NSW.

The Study Setting
At the time of this research being conducted (2001-04) health services in NSW were managed by 17 Area Health Services (AHSs) across the state. Sydney, as the capital of the state and largest city in Australia with a 2001 population of 4.1 million people (ABS, 2004) contained four of these 17 AHS. Each AHS in Sydney is further divided into three to five sectors. Three teams of nurses from three sectors across two of the four AHSS in Sydney were invited to participate in this study.

Aims of the Research
The overall goal of the research was to inform improvements to C&FH nursing practice.

This could be achieved through the following objectives:

- To examine the impact of policy on the health system and the C&FH workforce
- To explore and describe the role of the C&FH nurse across three practice settings
- To identify the skills and processes used by C&FH nurses to facilitate parent groups
- To explore the process of C&FH nurse engagement in a multidisciplinary working group

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On January 1, 2005, NSW Health services were restructured from 17 AHSs to eight. As this research was conducted prior to this time, the AHSs referred to are as they existed before they were restructured.
• To analyse the effectiveness of C&FH nurses working with marginalised groups
• To identify factors that facilitate or hinder the ability of C&FH nurses to be effective in their role

It is hoped that the knowledge generated from this research will contribute to the academic development of the profession as well as informing policy-makers of some of the key issues around implementing significant policy reform within this sector of the health workforce.

The research was conducted in an eclectic and pragmatic way, using case studies and a health services research approach. Case Study One explores C&FH nursing practice in providing support to families through individual consultations in the home or the C&FH centre. Case Study Two explores and describes C&FH nursing practice as provided through facilitation of groups of parents with new babies. Finally, Case Study Three examines the capacity of C&FH nurses to engage in a project with a multidisciplinary team supporting infant nutrition in the Vietnamese and Arabic communities.

THE THESIS STRUCTURE
This chapter has outlined the rationale behind the development of the research. It has provided an overview of the major policy changes affecting C&FH nursing practice, particularly the Families First initiative in NSW. This chapter has also provided an outline of the study setting and a summary of the three cases chosen to explore the topic of enquiry.

Chapter Two provides an overview of the literature around C&FH nursing. A background of the profession within Australia is provided, including a brief history of the profession, available workforce figures and educational preparation. Due to the limited material available, information around the C&FH nursing practice in Australia is minimal. Consequently this resulted in an emphasis on literature from the United States.
Kingdom (UK), and the similarity of practice models and service structures is described.

Chapter Three describes the methodology used to examine contemporary C&FH nursing practice within the three case studies. Health services research is introduced and extended to provide a suitable framework to support the research. The ethnographic approach used to guide the data collection process is presented and data analysis is also discussed.

Chapter Four introduces the reader to Case Study One, in which C&FH nursing practice is examined as practitioners support families through individual consultations, either in the home or the health centre. Seventeen nurses across two sectors of an AHS participated in in-depth interviews and 13 of these participants are observed in clinical practice. Perceptions around the role and major components of practice are identified and discussed, as well as how practice has changed over the past five years as a result of the Families First initiative.

Chapter Five continues the analysis of Case Study One and presents some of the challenges that affect the ability of C&FH nurses’ capacity to support individual families. These challenges are presented in two parts; those that were identified as health service components and those difficulties that were considered professional in origin.

Chapter Six presents Case Study Two, which explores and analyses C&FH nursing practice through the provision of support to families in new parenting groups. Child and Family Health Nurses who facilitated a new model of parenting groups that drew on the principles of partnership agreed to participate. In-depth interviews with the participants, and observations of the nurses facilitating the groups provided the data. The case study aimed to identify what new skills are required by the C&FH nurses who facilitate this new model of parent group.
Chapter Seven explores another component of C&FH nursing practice through Case Study Three. Removed from clinical practice, a group of nurses undertake an action research project to develop resources for community groups, through collaboration within a multidisciplinary health team. The process of the nurses’ engagement in, and participation within the group is explored and discussed.

Chapter Eight integrates the major findings from the three case studies and discusses the implications of this research for the C&FH nursing profession and the services and policies governing their practice. The findings of the research are explored within the context of policy implementation, the educational preparation and ongoing support of the C&FH nursing workforce. Key considerations around leadership within the profession are presented.

Chapter Nine draws conclusions about contemporary C&FH nursing practice in NSW, Australia. Key recommendations are made around how policy-makers, health systems and the C&FH nursing profession can be strengthened to prepare, involve and support this important workforce in their role of supporting families in early parenting.
Chapter Two

Literature Review
Chapter Two: Literature Review

INTRODUCTION
In order to investigate and explore contemporary C&FH nursing practice in NSW, it was necessary to review the literature around parenting support and C&FH services. A search strategy was conducted of electronic databases from 1980-2003. Information was sourced from CINAHL, Nursing at Ovid, Ebsco, Medline, PubMed, Sociofile, Academic Search Elite, the Cochrane Database of Systematic Reviews, PsycINFO and Factiva. Key words included: child and family health nurse; child health nurse; health visitor; maternal and child health; early childhood nurse; and, community nursing. The literature review included Australian health reports, policy documents and searching backward from reference lists.

Information available around C&FH nursing services in the Australian context is very limited. It appears, however, that the role of the Australian C&FH nurse is similar to the health visitor in the United Kingdom (UK) and the child health nurses in Sweden. Therefore the information presented in this chapter draws heavily on the literature from these two countries. The paradigms that inform C&FH nursing practice are described and the role and functions of the C&FH nurse outlined. The appropriateness of the service to marginalised groups is considered along with the values and attitudes of C&FH nurses in providing services to these groups.

CHILD AND FAMILY HEALTH NURSING SERVICES
Publicly funded C&FH services are available in most industrialised countries other than the United States (Schonberg et al., 1998). In Australia, C&FH services are universally available and free of charge to all children aged between birth and five years (NSW Health, 2002b). The services aim to improve the health and wellbeing of infants and young children so that optimal physical, emotional and social development is possible (Ochiltree, 1991).
Nursing staff provide health services to ‘well’ children and their families in many countries, although these are through different models and working titles. In the United Kingdom they are termed health visitors. In Scandinavian countries they are child health nurses, in New Zealand they are known as Plunkett nurses and in North America, public health nurses. In Australia, the title varies across the States and Territories and includes: maternal and child health nurses (Victoria and the Australian Capital Territory); child health nurses (Western Australia, Queensland, and the Northern Territory); child and youth health nurses (South Australia); and, child and family health nurses in New South Wales and Tasmania.

Child and family health nursing practice across the world differs from other nursing specialties in a number of ways. Hospital-based nurses work within a curative and remedial model of health care (Gibbings, 1995). Generalist community nurses (known as district nurses in the United Kingdom) deliver a functional and practical service where illness is the focus of concern (Gibbings, 1995; Symonds, 1991). Community nurses who provide services to adults have been described as curative care, whilst those involved with mothers and children are described as providing preventative care (Jansen et al., 1996). Health visitors in the UK are not considered to provide a ‘hands-on’ service and are concerned primarily with health promotion and illness prevention (Symonds, 1991). Indeed, health visiting is often described as being closer aligned to social work and education disciplines (J. Clarke, 1975; Elkan, Blair et al., 2000). In the UK, ambiguities between the role of social work and health visiting exist (Malone, 2000). It is not known whether similar ambiguities are found in Australia.

New South Wales Health policy documents require health professionals to make social assessments of the whole family to identify problems that may be addressed (NSW Health, 2002b; Office of Children and Young People, 2002c). Child and family health nurses work within a public health paradigm of prevention of illness through screening and surveillance and the promotion of health (Keleher, 2000). There is no other age group for whom universal, free and ongoing support services are provided (Mayall & Foster, 1989). This access to ‘normal’ families through the universal service differs
from most other health professionals who access clients in times of sickness or crisis (Ling & Luker, 2000). The only other comparable health service is the provision of antenatal care by midwives and doctors. Like the midwife, C&FH nurses have the educational and professional preparation to deliver holistic care, often without the need to refer to another worker (Jackson et al., 2004).

Much of the nursing education and literature is directed towards the nurse in the hospital where ‘good’ nursing is associated with ‘caring’ (Abdullah, 1995). The concept of ‘care’ is viewed as the central focus of nursing behaviours, processes and intervention modalities (Dougherty & Tripp-Reimer, 1985). T-shirts, bumper stickers and coffee mugs proclaim ‘nurses care’ (Barbee, 1993). Abdullah (1995) defines caring as:

> when one has a commitment to help and assist another person when they are *incapable* of carrying out specific functions associated with their physical, psychological and psychosocial needs (Abdullah, 1995 p.715), emphasis added.

Child and family health nurses do not undertake tasks which their clients are unable to carry out themselves. Most nurses have their work practices formed in the hospital setting before taking up community-based nursing. If their focus remains founded on ‘caring’ or ‘fixing’ principles, they will be largely ineffective in practice because one of the major aims of C&FH nursing practice is to increase the capacity of parents to provide the optimum care of their children (CAFHNA, 2001). Working outside the institution requires a very different working style and undergraduate education systems do not prepare the nurses adequately to do this (Carberry, 2001).

In NSW, C&FH nurses are in contact with over 95% of all new mothers (NSW Health, 2002a). Unlike other health encounters, many recipients of C&FH nursing services do not approach the service, rather, the service seeks them out (K. Chalmers, 1992). The service is offered as a ‘routine’ visit to all mothers with new babies. This universality aims to reduce stigma and promotes acceptance of the service (NSW Health, 2002b). In the UK, universal services also reduce clients’ perceptions of being ‘checked up on’
Throughout this ‘routine’ assessment the C&FH nurse assesses the family for potential health needs and additional support. Through home visiting, C&FH nurses are one of the few health professions who enjoy access to the private domains. Thus they are ideally positioned to identify and assist families, provide ongoing support and to advocate for changes at a policy level (Darbyshire & Jackson, 2004a).

The work of C&FH nurses, like health visitors, is neither widely understood or valued (Traynor, 1993). This is largely due to the difficulties in measuring illness prevention and justifying the service in terms of cost effectiveness (Fatchett, 1990; Traynor, 1993). Aspects of care such as acceptance, empathy and rapport are much more difficult to measure compared to the more ‘concrete’ indicators such as numbers of developmental abnormalities identified through screening or immunisation rates in the community (Elkan, Blair et al., 2000). These difficulties have been compounded by a long history of C&FH nursing practice not being adequately explained or defended in both Australia (evident through the lack of published literature), and the UK (Fatchett, 1990). In a recent review of education in Australia, the author noted the lack of Australian research on the changing models of nursing care (Heath, 2002). This lack of research has also been noted in the health services field (Duffield et al., 2001).

**History of C&FH nursing services in Australia**

In Australia, the first trained C&FH nurse was a health visitor employed in Sydney in 1904 and baby clinics were operating from 1914 (Gandeivia, 1978). Due to medical concern that baby clinics were an intrusion into private medical practice, the service was initially only available to infants under one year of age and to those unable to pay fees (O'Connor, 1989). Nurses providing services to families were also under strict medical supervision. Child and family health nursing services have always excluded the treatment of sick infants: hence its common term ‘the well baby clinic’ (Reiger, 1985). As the medical profession realised the nurses were not replicating medical services, the services slowly became available to more mothers until becoming a universal service by the late 1920s (O'Connor, 1989).
The focus of C&FH services in the early 1900s was the reduction of mortality and morbidity through educating mothers on hygiene and infant care (Van Krieken, 1991). Following the end of World War Two, the emphasis of the nurses’ practice moved towards early identification and treatment of preventable conditions and the monitoring of childhood growth and development (O'Connor, 1989).

Since the 1970s, health and family functioning have been increasingly influenced by social disruption involving child maltreatment, domestic violence, drug dependence, single-parent families and increasing mental illness (Clements, 1992). From the 1980s, C&FH nursing practice changed from a predominantly procedure-oriented role to one of counselling (O'Connor, 1989). This was in response to increasing awareness of the socio-economic influences on health and the focus of illness prevention through health promotion (O'Connor, 1989).

Today, most parents will access the service, particularly parents of first-born children, in the first year of the child’s life. In a recent NSW survey, 92.1% of parents with children aged between birth and four years reported using the service, with 78% of these infants attending the service within the first four weeks of life (NSW Health, 2002a). The most recent Australian data reports a national attendance rate of C&FH centres of 89% in 1995, with the highest uptake of services recorded in Victoria (97.4%) (Al-Yaman et al., 2002).

In each state and territory in Australia all mothers are issued with a ‘personal health record’ (Ochiltree, 1991). This booklet is a hand-held record of the child’s growth and development, immunisation and health status. It also contains health promotion material and lists of relevant emergency and non emergency telephone numbers. In a recent survey in NSW, 98.3% of parents with children aged between birth and four

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3 In NSW, due to the colour of the cover of the personal health record, it is universally known as ‘the Blue Book’ and will be referred to as such throughout this thesis.
years of age reported owning a ‘blue book’ with 76.5% reporting currently using it (NSW Health, 2002a).

**Child and family health nursing education**

The provision of health services to children and their families is recognised as requiring specialised knowledge and expertise (NSW Health, 1999). Child and family health nurses have received formal educational preparation in Australia since 1921 (O’Connor, 1989). In NSW, these training programs were offered initially through Tresillian, followed by Karitane\(^4\), mothercraft centres that continue to offer education programs today.

Most countries that offer education for C&FH nurses and their equivalents require pre-existing qualifications as a registered nurse and/or midwife (Ochiltree, 1991). This issue has been receiving increasing attention in both the UK (Clay, 2003; Cowley, 2003) and Australia (K. Mason, 1999). Whilst workforce numbers are reducing, the expectation of the C&FH nurse’s role has increased (NSW Health, 2002b). Some commentators are therefore questioning the practicalities of requiring C&FH nurses to have both general nursing and midwifery as prerequisites for C&FH education in both Australia (K. Mason, 1999) and the UK (Cowley, 2003).

Until 1987, C&FH nursing in NSW was registered as a recognised nursing specialty by the state regulation authority (NRB, 1989). In 2001, the UK also removed health visiting from the register as a specific subspecialty of nursing (Cowley, 2003). Accreditation and monitoring of C&FH nurse education programs are now the responsibility of the facilities offering the programs, when this occurs in the tertiary sector (K. Mason, 1999; NRB, 1989). For courses offered outside the tertiary sector, such as the Graduate Certificates offered in NSW by the College of Nursing,

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\(^4\) Karitane and Tresillian are both tertiary referral services providing intensive specialist support and care for complex parenting issues. There are four residential units NSW, all located in Sydney.
Lack of national or state regulation of C&FH nursing practice in Australia has resulted in education that varies considerably in terms of course length, nomenclature, level, theoretical and clinical practice requirements, mode of delivery, cost and entry requirements (K. Mason, 1999). In Victoria and Tasmania, C&FH nurses must be prepared to graduate diploma level to work as a C&FH nurse in these states. New South Wales, South Australia and Western Australia offer graduate certificate and graduate diploma courses, whilst in Queensland nurses can access graduate certificate education in paediatric, child and youth nursing. Most institutions offer their courses on a part-time basis and many by distance.

New South Wales currently produces approximately 120 graduates in C&FH nursing per year across four education providers. The College of Nursing provides 60 positions, Tresillian (transferring to the University of Technology, Sydney (UTS) in 2006) averages 30 per year and the University of Western Sydney (UWS) (in partnership with Karitane) has approximately 22–25 graduates each year. The Sydney South West Area Health Service (SSWAHS) also provides education for approximately eight students per year.

The SWSAHS course was developed in response to the implementation of the Families First initiative. Prior to 1999, generalist community nurses services in this AHS provided ‘cradle to the grave’ care, including child health, school health, palliative care and aged care. With the introduction of the Families First initiative, the community nurses were divided into two streams, child and family health, and the generalist stream. The AHS identified that there were insufficient specialist skills and knowledge amongst many of the nurses coming into the C&FH stream. It was in response to this need that the AHS developed a graduate certificate course in child and family health. Nurses working in the area of C&FH were released from work every Wednesday afternoon to attend education sessions provided by the Area (personal
communication, Sally Rickards, C&FH course coordinator, SWSAHS, 20 April, 2003).

Tresillian and the College of Nursing offer distance mode courses to students and attract students from other Australian states and overseas. The graduate certificate in each institution is offered part-time and is equivalent to four part-time subjects (150 hours each) over two semesters (600 hours total) (College of Nursing, 2005).

The cost of postgraduate education was identified as a major barrier which is contributing to the current skills shortages in nursing (Crowley & West, 2002). Currently the Tresillian course costs $2,700 for the graduate certificates but this will increase to approximately $4,000 in 2006 when it transfers to UTS. The University of Western Sydney offers places at a cost of approximately $2,000 for a graduate certificate, with the option of continuing on to a graduate diploma. The graduate certificate via SWSAHS incurs a cost of $1,000 per student and is heavily subsidised by the Area Health Service. The College of Nursing charges $3,400 for its course but 50 of the 60 places are fully funded by NSW Health. A summary of the institutions offering C&FH nursing education in NSW is presented in Table 1 below.
In addition to funding of the majority of the College of Nursing course positions, NSW Health also provides funding to backfill clinical positions to allow release of staff to attend the face-to-face lectures provided by the College of Nursing. In support of other education providers, scholarships are also available through NSW Health to support nurses working in the public health system to access accredited post-graduate education courses. In 2005, NSW Health received 23 applications for C&FH nurse courses and provided scholarships for 13 Tresillian placements ($2,500), six University of Western Sydney (Karitane) placements ($600 per subject with three or four subjects applied for), two Sydney South West AHS placements ($1,000), and one

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5 Higher Education Contribution Scheme (HECS): a federal government education subsidy scheme whereby universities are funded for a certain amount of places. Subsidies are forwarded onto students who have the option of repaying university fees when in the workforce. Most HECS places are for undergraduate positions but the university may offer some of the HECS places as postgraduate positions.
College of Nursing application for $1,800 (personal communication: Linda Brookes, Scholarships Officer, NSW Health, 15/4/05).

Currently, NSW recommends the minimum qualifications for nursing staff employed in the C&FH nursing services to be a Registered Nurse with post-registration qualifications in Child and Family Health Nursing. Other desirable qualifications include completion of a psychosocial assessment skills workshop, advanced counselling skills, lactation certificate, midwifery, Graduate Diploma in Infant Mental Health (NSW Health, 2002b).

Midwifery is no longer an entry criterion requirement in the Karitane and College of Nursing courses and will cease to be a requirement for the Tresillian course on transfer to UTS in 2006. Midwifery in other Australian states, such as Victoria, remains an essential criterion for all students accessing their maternal and child health courses which are only available through the tertiary sector and offered at graduate diploma level. Child and family health nurses from NSW therefore could not gain employment as maternal and child health nurses in Victoria.

It is clear that there is a lack of consistency in the duration, design and level of award for C&FH nurses across NSW and Australia. Similar inconsistencies in the preparation of midwives have been highlighted as contributing to the workforce shortage crisis currently being experienced in the midwifery profession (Tracy et al., 2000). The lack of discussion in the Australian child health literature suggests the debate has yet to be raised in this country.

The C&FH nursing workforce
The average age for all employed nurses in Australia was 42.2 years in 2001, an increase from 39.3 years in 1995. The proportion of nurses aged 45 years or greater increased from 29.5% to 41.7% over the same period (AIHW, 2002). Whilst reported in age groups rather than specific ages, these statistics are confirmed in NSW reports.
which state that the greatest age range of registered nurses is between 45 and 49 years of age (NSW Health, 2003b).

Child and family health nurses tend to be older, with an average age of 47.0 years (AIHW, 2002). Across Australia, a total of 3,167 nurses were employed in C&FH nursing services in 2001. This was 1.5% of the 201,753 total clinical nursing workforce and showed a 12.4% increase between 1997 and 2001 (AIHW, 2002). In NSW in 2002, 819 nurses, or two per cent of the total registered nurse population, indicated they were working in the area of C&FH (including full and part-time positions) (NSW Health, 2003b). Significantly more nurses (1,821) indicated they had undertaken postgraduate education in C&FH (NSW Health, 2003b). This suggests that many nurses with C&FH qualifications are choosing not to work in the area.

Australia-wide, male nurses comprise only 1.1% of the C&FH nursing workforce compared to the total number of male nurses 8.4% registered in Australia (AIHW, 2002). This is significantly more than the nine male nurses who were working as a C&FH nurse in NSW in 2002 (NSW Health, 2003b).

In 2004 there were 634 full-time equivalent C&FH nurses employed by Area Health Services across NSW (NSW Health, 2005). Sixty-six of these positions were newly created positions funded by the Families First initiative (NSW Health, 2005). The distribution of these positions across the state is not consistent. Staffing levels to birth ratios also varies considerably across AHSS (NSW Health, 2005). As can be seen in Figure 1 below, some AHSSs, such as South Eastern Sydney (197 per FTE), have a much higher birth rate per full-time C&FH nurse than comparable areas such as Northern Sydney (125 per FTE).
The number of C&FH nursing positions outside the public sector is difficult to ascertain. A number of private agencies offer C&FH support, and pharmacies in Australia are increasingly offering services to parents by employing nursing staff. Many private services are also available from individual nurses (with or without formal C&FH nursing qualifications). There is no monitoring or regulation around the quality of these services or the preparation or experience of the staff.

**The Child and Family Health Nurses Association**

Professional societies fulfil an important role in the leadership, mentoring and promotion of clinical excellence of professional groups (Davidson et al., 2004). They achieve this through the development of policy documents, publication of journals and

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newsletters, conduct of scientific meetings or conferences, and sponsorship of research and attendance at professional meetings (Davidson et al., 2004). The professional association that represents C&FH nurses in Australia is called the Australian Association of Maternal, Child and Family Health Nurses, with individual associate organisations in most states and territories. In NSW this organisation is the Child and Family Health Nurses Association (CAFHNA) with a membership of 400 (Briggs, 2004). It is not known if these members are all working in the area of C&FH nursing, but if they were, they would constitute 50% of the workforce.

THEORETICAL UNDERPINNING OF C&FH NURSING PRACTICE

Since the 1980s, C&FH services began to incorporate the principles of primary health care and health promotion within their practice (O’Connor, 1989). The philosophy of primary health care is promoted in pre-service education programs (Fowler, 2005) and is one of the three domains in the competency standards document set by the profession (CAFHNA, 2000).

The World Health Organisation expresses primary health care as:

*Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination ... It is the first level of contact with individuals, the family and community with the national health systems bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing care process.*

(WHO, 1978 p.2)

Primary health care is particularly suited to C&FH nursing as it supports a holistic model of health that is influenced by the social and economic inequalities that exist in society (WHO, 1978). Primary health care is also concerned with prevention and early intervention though community-based services (WHO, 1978).
Community participation is an essential component of primary health care (Werner & Sanders, 1997). It extends from the involvement of the community to genuine ownership and control by community members. Thus, the implementation of primary health care relies on the shift of power and control from the health system to the community and the individual client. The difficulties of this occurring has been identified as a major reason for the lack of success of primary health care (Werner & Sanders, 1997).

Primary health care directs governments to co-ordinate health with other government sectors, and to co-operate within a ‘spirit of partnership’ (WHO, 1978 p.2). These principles are remarkably similar to the language used in the policies developed in the late 1990s, directing whole-of-government services in the support of parents. One such example of this type of policy can be found in NSW in the Families First initiative (Office of Children and Young People, 1999).

The biomedical model
Primary health care challenges the biomedical model that has dominated health services in the Western world throughout the last century (Werner & Sanders, 1997). The biomedical or ‘disease’ model originates in medicine and seeks to identify actual or potential problems in the form of abnormal or pathological conditions or behaviours (Hawksley et al., 2003). A major assumption of this model is that predictions can be made of the individuals most likely to suffer from particular conditions and then labelled ‘high’ or ‘at risk (Elkan, Kendrick et al., 2000). Examples of C&FH nursing practice that reflect the biomedical model include growth monitoring, the screening for abnormal development such as language and motor skills. The major failing of the biomedical model is that it ignores the underlying socio-economic and political causes of health problems (Werner & Sanders, 1997).

Child and family health nursing does not sit well within the biomedical model, due to its longstanding awareness of the social, economic and cultural influences on health (Clements, 1992). But as health services have continued to be dominated by the
biomedical model, C&FH nurses struggle to incorporate social models of health into its practice.

**Child and family health nursing models**

As long ago as the early 1980s, health visitors in the UK highlighted the conflicting and opposing approaches to C&FH services. Robinson discussed the polarisation of approaches that she defined as ‘problem-centred’ versus ‘relationship-centred’ approaches (Robinson, 1982). Since that time numerous other authors have distinguished these two approaches under a variety of similar terms and definitions.

Chalmers and Kristajanson distinguished three models of Canadian community nursing: the ‘public health’ model; the ‘community participation’ model; and, the ‘community change’ model (K. Chalmers & Kristajanson, 1989). Billingham presents three other models for health visiting in the UK: the ‘preventative’; the ‘radical political’; and, the ‘self-empowerment’ models (Billingham, 1991a). Mayall and Foster (1989), also from the UK, discuss the ‘individualist’ models whereby health visitors perceive and address problems solely from an individual perspective versus the ‘structural’ model, which gives consideration to the social and environmental factors which affect health and explain behaviour.

Twinn proposes ‘individual advice-giving’, ‘environmental control’, ‘psychological development’ and ‘emancipatory care’ as models that guide the health visitors’ practice in the UK (Twinn, 1993). The ‘environment’ component of Twinn’s paradigms consists of a collective and non-directive approach to practice, that necessitates a true partnership between professional and client. This involves taking practice into the community, networking with other practitioners and services, and community outreach. However, Twinn states that she does not believe that health visitor education has adequately prepared workers to the level of expertise and confidence they require to work within such an approach (Twinn, 1993).
The many different models defined above can be categorised into two overarching and opposing philosophies that appear to guide C&FH care in Australia: the expert model and the partnership model. These two models will inform the remainder of this thesis and form a basis for investigating, exploring and analysing C&FH nursing practice in Australia and they are described below.

The expert model
The expert model originates from a health care system that relies on routinised practices and applies a biomedical or disease model (Jiwani, 2000). The ‘expert’ health practitioner works with a set of physiological symptoms that inform a diagnosis based on deficits, disease or disorders. The expert model is synonymous with the ‘disease’ and ‘cultural behavioural’ models identified by Parton (1985), the ‘problem-oriented’ approach identified by Robinson (1982) and Mayall and Foster (1989), the ‘public health’ model highlighted by Chalmers and Kristajanson (1989), the ‘preventative’ model outlined by Billingham (1991a) and the ‘individual advice-giving’ model discussed by Twinn (1993).

The expert model and its associated equivalents outlined above incorporate the ‘traditional’ components of C&FH or health visiting services (Twinn, 1993). Within this approach the practitioner determines the health needs of the clients and offers advice, education and other strategies to address these needs. It maintains domination and control of the health interaction by the professional (Elkan, Kendrick et al., 2000). Within the expert model, health visitors in the UK have been traditionally seen as authority figures who would disapprove of parenting practices that did not fall into the social norm of the time (Malone, 2000).

The use of the expert model within child health and child care agencies has been increasingly challenged, as it fails to recognise the centrality and extent of the parents’ role in childrearing, particularly around addressing problems that relate to the social, emotional and environmental influences of parenting (Davis et al., 2002). In an area as complex as parenting, the expert model fails to recognise the level of control the
parents have over information they may give the nurse or the amount of advice they will accept or disregard.

Given that early parenting is a time when many parents feel unsure of their ability to parent (Nystrom & Ohrling, 2004), the expert model potentially enhances parents’ vulnerability and feelings of inadequacy (Davis et al., 2002). It fails to recognise the expertise of the parents. As Davis and colleagues state:

> Without the parent’s knowledge of the child, themselves, their history and current situation, no helper will be able to understand nor formulate possible solutions. Without the parents’ efforts and skills, no problem management strategies could possibly be implemented (Davis et al., 2002 p.49).

However, Swedish author Wikander (1995) suggests that the paternalistic approach, defined as the nurse’s taking responsibility and giving advice as a response to a worried mother’s question, may be indicated in some C&FH nursing services (Wikander, 1995). She uses the example of advice around the crying infant given by C&FH nurses in Stockholm to demonstrate that the mothers expect nurses to have expert knowledge on techniques to reduce crying in infants (Wikander, 1995).

The expert model may be useful where a confident mother with good support seeks advice on a specific physical condition such as a rash on a baby’s skin or the presence of oral thrush, but for many other mothers, issues around parenting are intrinsically tied up in maternal self-esteem and confidence (Rogan et al., 1997). For those mothers, the expert model is flawed, as the didactic approach of prescriptive advice can undermine maternal confidence and reduce self-esteem (Davis et al., 2002).

**The partnership model**

Other models have been proposed that provide an alternative to the expert model. These models all promote similar principles but draw from a variety of concepts including; ‘partnership’ (Davis et al., 2002; Dunst, 2000; Guilliland & Pairman, 1995), ‘empowerment’ (Byrne, 1999; Cilliers & Terblanche, 2000; Houston & Cowley, 2002;
Unger & Nelson, 1990; Westley & Waters, 1988), ‘family-centred’ (Dunst et al., 2002) and a ‘strengths-based approach’ (Darbyshire & Jackson, 2004b; Office of Children and Young People, 2002c). Components of the partnership model can also be found in the ‘social model’ where health visitors working in communities appear to focus on support networks and empowerment (Craig, 1998).

These models all transfer the focus of professional attention away from ‘problems’, ‘deficits’ and ‘weaknesses’ and instead suggest the strengths-based approach or an empowerment model, which orientates the professional towards developing a collaborative and equal partnership with families, focusing on building family assets (De Jong & Miller, 1995). A major assumption of these models is that all families have strengths and capabilities and are more likely to respond to interventions that build on these rather than identify weaknesses and deficits (Darbyshire & Jackson, 2004b; Dunst et al., 2002; Unger & Nelson, 1990).

Rather than the expertise lying with the professional, there is an increasing emphasis on the expertise of the mother and that, with support, she and her infant will discover their own way rather than learning to adopt some ‘right way’ defined by a clinician (Barnes & Freude-Lagevardi, 2003). Family-centred partnership involves professionals and family members working together in ‘pursuit of a common goal’ and is ‘based on shared decision making, shared responsibility, mutual trust and mutual respect’ (Dunst, 2000 p.32). Many have recognised, however, that it is a definition that is difficult to operationalise. Parents and professionals will often report different characteristics of ‘partnership’ (Dunst, 2000).

An important feature of the partnership model is to build rather than threaten the mother’s self-esteem. Working in ‘partnership’ with families ‘empowers’ them to parent more effectively and builds on ‘strengths’ as identified by them. Working in a strengths-based or partnership model does not deny the expertise of the professional, it merely identifies the complementary expertise of the parent (Davis et al., 2002). The partnership model is particularly important when working with marginalised groups.
who are historically mistrustful of ‘experts’ or authority figures (Unger & Nelson, 1990). An important component of successful empowerment or partnership models occurs when the health professional believes in the client’s ability in understanding, learning and managing situations (Dunst & Trivette, 1996).

The primary target of most supportive interventions which utilise partnership approaches is commonly with the mother, and any benefits to the infant come about indirectly (Barnes & Freude-Lagevardi, 2003). This contradicts many C&FH nursing services that are viewed as being ‘baby-focused’ rather than ‘mother-focused’ (Knott & Latter, 1999).

The aim of partnership models that focus on family strengths is to increase participants’ capabilities and feelings of self-worth (Barnes & Freude-Lagevardi, 2003; Darbyshire & Jackson, 2004b), rather than see themselves as ‘incompetent and dysfunctional’ (Alison et al., 2003 p278). It is essential that services based on a partnership model build skills and capacity rather than create dependency (Kemp et al., 2004).

The health professional assists with problem-solving, acting as a resource and facilitator but rarely as an expert. However, the practitioner cannot undertake the role of facilitator and resource person without the active participation of the client. Essential to the concept of the partnership approach is the quality of the interaction with the client. Often referred to as the ‘client-centred’ approach, it recognises client choice in an environment of clients’ perception and identification of health needs (Twinn, 1993). Involving clients in actively creating their own resources is more likely to lead to sustained behaviour change and improved health (Davis et al., 2002). Dispensing advice and information without such involvement will likely inhibit development and independent mobilising of internal resources (Cowley, 1999; Houston & Cowley, 2002). However, some clients may prefer not to work in partnership with the practitioners (Waterworth & Luker, 1990). This may occur if they feel too overwhelmed to make any contributions of their own, or if they perceive self-
participation as weakness, or incompetence, on behalf of the practitioner (Barnes & Freude-Lagevardi, 2003). A key strategy to promote partnership involves the establishment of the relationship between provider and client early and proactively, as it is difficult to establish a relationship in crisis situations (Kemp et al., 2004).

When the professional leads the interaction and imposes her/his own (expert) agenda, the opportunity for the clients to make choices and take control of their own life is diminished (Zerwekh, 1992). Much of the literature around C&FH nursing services promotes a relationship between the professional and the client that is based on mutual participation. This involves the sharing of perspectives and reaching mutual understanding through the recognition of each other’s beliefs, values and expertise (Kendall, 1993). Successful partnership models also rely on clearly articulated role delineation with the level of formality appropriate to the relationship, and the strengths of each partner recognised and valued (Kemp et al., 2004).

Health visiting services are more effective when the nurses respond to the clients’ own perceptions of their needs (Knott & Latter, 1999). Within the partnership or empowerment model, nurses assist the clients in feeling valued, to have an active part in the decision-making process, and allow the clients to make the right choices for them within the process (Davis et al., 2002).

Empowerment has been described as ‘recognising, promoting and enhancing people’s ability to meet their own needs, solve their own problems, and mobilise the necessary resources in order to feel in control of their own lives’ (Gibson, 1991 p.359). Adopting this model can be difficult for health professionals who work within ‘the hierarchical, paternalistic organisations that resist power redistribution between the different levels of responsibility’ (Houston & Cowley, 2002 p.664).

The extent to which professionals can empower others has received some attention in the health literature. Wallerstein and Bernstein (1994) and others (Houston & Cowley, 2002) question whether one privileged group can empower others from its position of
dominance or whether people have to take power and empower themselves. Mowforth (1999) further challenges the concept of partnership by arguing that the relationship between client and nurse can never be equal because one person is sharing vulnerability, and also because of professionalism and the assumed boundaries that constrain the professionals’ own behaviour. However, nurses can help individuals develop, secure and use resources that will promote or foster a sense of control and self-efficacy (Gibson, 1991; Rodwell, 1996).

Under the partnership model, the ability of mothers to accept advice indicates a dynamic relationship where the mother can be engaged on her own terms (Wilson, 2001). However, if the relationship between nurse and client was that of equal partnership, mothers would not need to lie or conceal information (Wilson, 2001) and may be sufficiently confident to openly reject advice. Resistance to child health services and concealment of information have been identified as a response to the power and ‘perceived social control function of health visiting’ (Bloor & Macintosh, 1990 p.169). Clients who refuse to take advice or information delivered by the health service are often labelled ‘non-compliant’ or ‘deviant’ (Norton, 1998; Whitehead, 2001).

To effectively support parents, Barnes and Freude-Lagevardi (2003) recommend a program model that is positive, non-deficit, culturally sensitive, ecological and matched to participant needs (Barnes & Freude-Lagevardi, 2003). However, they caution that professionals may have a heavy sense of their own authority which is incompatible with programs that respect parents as advocates, and as the most significant influence in their children’s lives (Barnes & Freude-Lagevardi, 2003). Shared decision-making between professionals and parents is important and it may be the qualities of the staff (rather than their professional status) that appear to influence program success, more than the particular type of training staff members receive or the roles they play (Barnes & Freude-Lagevardi, 2003).
The ‘strengths-based approach’ is one of the major principles that underpin the policy of ‘Families First’ currently directing C&FH nursing practice in NSW (Office of Children and Young People, 2002c). The NSW Health Department advocates that partnerships need to be created between health service providers and parents (NSW Health, 1999). However, working in partnership with parents requires a major paradigm shift from the traditional role of caring ‘for’ to working ‘with’ (Byrne, 1999). Many nurses would deny that they have power or exercise that power over clients (Mowforth, 1999). However, contemporary wisdom suggests they must acknowledge that power exists before they can redress the balance from the expert model and consider both partners equal (Davis et al., 2002).

Combining paradigms in practice
The tensions between the health visitor’s role as one of ‘mother’s friend’ and a ‘policing role’ have existed since the 1950s (Malone, 2000) and continue to influence C&FH nursing practice today (Fagerskiold, 2000). It is not known, but is suspected that similar tensions can be found in Australian C&FH nursing services. Despite the opposing nature of the expert and partnership models, health visitors in the UK are often found to use a combination of approaches (Billingham, 1991b; K. Chalmers, 1993; Cowley, 1995) or use different approaches in different situations (Twinn, 1993). In Europe, C&FH nurses have identified the changing role to now incorporate more emphasis on parental empowerment (Ellefsen, 2001).

Other research into health visitor practice in the UK describes interactions between health visitors and consumers that are dominated by health visitors who use an individualist ‘top down’ approach (Foster & Mayall, 1990; P. Pearson, 1991). They suggest that health visitors are not aware of clients’ views of health visiting, and clients are not aware of what health visitors can offer (P. Pearson, 1991). Research has shown that health visitors often control the interaction, suggesting that they perceive themselves as advice-givers and health experts (Kendall, 1993). In Sweden, lack of sufficient time is thought to increase the risk of the C&FH nurse adopting the authoritative or expert approach and controlling the interaction (Fagerskiold, 2003).
De la Cuesta suggests that health visitors in the UK are placed between the world of ‘policy’ and ‘people’ with both the policy-makers and the clients each having separate agendas, based on respective views about health care needs (De la Cuesta, 1993). Whilst the core of health visiting policy is the monitoring of child development, health visitors were found to use a combination of tactics to make their services acceptable, relevant and accessible to clients (De la Cuesta, 1993). These are key principles of primary health care (WHO, 1978).

It appears that C&FH nurses are influenced by a range of models when providing support to parents of young children. Whether these models are determined by the needs of the parents, the provider or the health system is less clear. In order to understand these influences further, it is necessary to first clarify, what it actually is that C&FH nurses do.

**ROLE OF THE C&FH NURSE**

There has been a long-standing difficulty in articulating the nature of C&FH nursing or health visiting practice (Cowley, 1995). The central purpose of health visiting in the UK (K. Chalmers, 1992; Houston & Cowley, 2002; D. Williams, 1997) and C&FH nursing in Australia (Ochiltree, 1991) is to promote health and prevent illness.

The Child and Family Health Nurses Association in NSW has identified the following principles that guide practice:

- *Nursing care is grounded in principles of primary health care and health promotion*
- *Nursing practice is at an advanced level and is customarily autonomous*
- *Nursing practice is within the ethical and legal parameters of child and family health nursing and, wherever possible, is evidence-based*
- *There is continuity of care with long term involvement with families*
- *Engagement with the client family occurs in a supportive and non-threatening environment*
- *Knowledge of the local community and local needs inform practice*
• *Child and family health nursing services are linked to other parental and children's health and welfare services in the local community*

(CAFHNA, 2001 p.3)

NSW Health identifies the skills and knowledge required by the C&FH nurse to adequately support parents and their families, as shown in Table 2 below:

Table 2: Skills and knowledge of C&FH nurses in NSW

| Child health and development | Normal growth and development  
Infant nutrition and feeding  
Infant mental health  
Physical care of the infant, including strategies to manage common health and behavioural issues |
|-------------------------------|----------------------------------------------------------------------------------|
| Infant and parent interaction | Increase parental understanding of development and child relationships  
Encourage positive parenting behaviours  
Teach parenting skills, such as responding to the infant's cues  
The use of floor time and other strategies for encouraging self-directed play |
| Client-centred principles of care | Ability to focus on strengths and capabilities  
Focus on solutions  
Ability to build self efficacy |
| Counselling skills | Interpersonal skills  
Build rapport and therapeutic relationship  
Recognise stages of behavioural change  
Provide coaching/mentorship to promote attachment and bonding |
| Parent's health issues | Including contraceptive advice, pap smears, breast examination, fatigue and sleep deprivation |
| Community development and networking skills | Knowledge of parenting support services and parenting information services  
Provide network of social support and access to other parents  
Facilitate access to community resources |
| Use of Health Care Interpreters | *(NSW Health, 2002b p.47)* |

Much of the international literature also describes the role of the C&FH nurse under the broad aim of ‘prevention of illness and promotion of health’ (Keleher, 2000; Symonds, 1991; Wikander, 1995). *How* they do that is often described in abstract and...
theoretical terms such as ‘giving and receiving’ (K. Chalmers, 1992), ‘searching for health needs’ (K. Chalmers, 1993), ‘marketing the service’ (De la Cuesta, 1994a), undertaking ‘fringe work’ (De la Cuesta, 1993), and ‘enabling and mediating’ (De la Cuesta, 1994b).

The functions undertaken by the C&FH nurse in providing services to families of young children have been summarised from the international literature (largely from the UK) to include: monitoring the growth and development of the infant; health promotion and health education (usually to the mother); psychosocial support (again, usually to the mother but encompassing the needs of the whole family); and referring to other agencies for additional support. These categories of behaviours within the role are further described below.

**Growth monitoring, screening, surveillance and family assessments**

Growth monitoring consists of routine measurements to detect abnormal growth, combined with some action when this is detected (Panpanich & Garner, 2004). Within the UK, weighing babies has been reported as the ‘ticket’ to child health services for many years (Sefi & Macfarlane, 1985) and this activity continues to dominate the health visitors’ practice (Knott & Latter, 1999). Growth and development screening and surveillance activities are the focus of most interactions between C&FH nurses and clients in Sweden and this is largely in accordance with local program policy and guidelines set by the employer (Baggens, 2001). In Victoria, Australia, many consumers identify the role of the maternal C&FH nurse to be synonymous with weighing and measuring babies (DHS, 1998).

The procedure of weighing and measuring babies occurs frequently in consultations with health visiting services in the UK, even when there is no overt need to do so (Bownes et al., 2000). The historical focus of a child health service that weighs babies has led to over-servicing of some clients who present for a baby weigh weekly or fortnightly, even though their babies were thriving (Fulford, 2001). Furthermore, Bownes (2000) reports that, for many mothers, checking the infants’ weight is the
primary reason for attending the service (Bowns et al., 2000). However, monitoring the weight too frequently may lead to parental anxiety if a baby is not gaining weight. Mothers may feel responsible for poor weight gain which in turn could affect their self-confidence and future accessing of C&FH nursing services (Panpanich & Garner, 2004).

In a recent systematic review conducted by UK researchers, there was insufficient reliable information to demonstrate that routine growth monitoring is of benefit to child health in both developing and developed country settings (Panpanich & Garner, 2004). The authors were therefore unable to offer recommendations around whether health professionals should actively pursue children to obtain measures of growth at arbitrarily defined intervals (Panpanich & Garner, 2004).

Screening tests have been used in clinical practice and in population programs for many years, with the number of conditions screened for gradually expanded. A screening test is not intended to be diagnostic, but differentiates those who are likely to have a condition from those who likely do not (NHMRC, 2002). Screening activities that are undertaken by C&FH nurses in Australia include growth and development checks that screen children for abnormal growth parameters, gross and fine motor skills, hearing, language and speech (NSW Health, 2003a). Universal screening for pervasive development disorders and autism in the UK has found high rates of detection and referral for these conditions, with subsequent improved outcomes from early intervention (Terbruegge et al., 2004).

The detection of subtle variations in development and behaviour of children, through routine screening and surveillance, has been identified as an important component of the C&FH nursing practice (J. Williams & Holmes, 2004). Loss of these surveillance activities universally in the UK has recently been criticised as failing to provide the opportunity to detect and refer developmental disorders as early as possible (Terbruegge et al., 2004).
A recent Australian review of health screening and surveillance by the NHMRC found little evidence to support many screening programs (NHMRC, 2002). This document reports insufficient evidence to make a recommendation around screening for development, language, preschool visual acuity, height and failure to thrive. However, there was fair evidence to suggest screening for obesity. The report recommends routine weight monitoring at birth, at 6-8 weeks, and at 8-12 months as part of routine clinical care (NHMRC, 2002). The report advised against the use of individualised checklists of milestones being used as developmental screening tests, although such checklists continue to be incorporated in many C&FH nursing services (SWSAHS, 2004).

The difficulties in many of the screening and surveillance programs in early childhood are found in the pass/fail nature of screening tests that are not appropriate to be applied to complex, multi-dimensional areas such as development, language, behaviour and psycho-social issues (NHMRC, 2002). The report suggests that these conditions are likely to benefit from early support and should be addressed by ongoing surveillance rather than a one-off screening test. Essentially, surveillance should equate to periodic screening over time (NHMRC, 2002). It could consist of:

Any activities that lead to identification of risk – eliciting parental concerns, physical examination, informal observations, obtaining information from other sources, measurement of growth, administration of tests and procedures, referral for further assessment. These activities may be initiated by professionals but involve a partnership with parents (NHMRC, 2002 p.223).

In this way, surveillance can be seen as actively involving parents by eliciting and responding to their concerns, putting these concerns into an historical and family context, and providing advice and information (NHMRC, 2002).

Surveillance guidelines, however, have also been seen to promote routinised practice that can reduce opportunities for client-led interactions. In Swedish research that observed 44 clinical encounters between health visitors and clients, growth monitoring
and topics around development of the infant dominated most of the consultations (Baggens, 2001).

The benefit of routine monitoring and surveillance, therefore, appears to be controversial. However, it continues to play an important part of C&FH nursing practice. Elkan and colleagues (2000) claim that screening tools are not able to measure coping mechanisms in individual families. To this end, professional judgment is an important component of health visitor practice (Elkan, Kendrick et al., 2000). Health visitors in the UK have been found to use their own professional judgment over assessment guidelines when making family assessments (Appleton & Cowley, 2004).

Health promotion
Most of the literature discusses the education and advice that C&FH nurses offer to family within the health promotion model (Norton, 1998). Questions have been raised, however, over whether it is health promotion that the nurses are engaging in, or if they are actually delivering health information and education (Whitehead, 2001). It is important to clarify the two approaches. Health education refers to:

Those activities, which raise an individual’s awareness, giving the individual the health (ill health) knowledge required to enable him to decide on a particular health action (Mackintosh, 1996 p.14).

Some claim health education is based on the expert model within a biomedical framework that focuses on disease prevention (Whitehead, 2001). Conversely, health promotion is an important principle of primary health care (WHO, 1978) and has been defined as:

invol(ing) social, economic and political change in order to ensure the environment is conducive to health. Health promotion not only encompasses a nurse educating an individual about his health needs but also demands that the nurse plays her part in attempting to address the wider environmental and social issues that affect people’s health (Mackintosh, 1996 p.14).

Same but different. Chapter Two: Literature Review
Using the above definitions, nurses, including health visitors, predominantly provide information within a health education model rather than health promotion (Mayall & Foster, 1989; Whitehead, 2001). Furthermore, in Sweden, a study on nurses’ advice to parents on infant crying demonstrated that the information the nurses provided was based more on tradition than scientific fact and relied more heavily on their own experience over new research (Wikander, 1995).

Referring and networking
As a universal, free service, C&FH nurses in Australia, and health visitors in the UK, are the major source of referrals to other agencies that provide services to families with infants and young children (Edgecombe, 2000; Elkan, Kendrick et al., 2000). Child health practitioners in Sweden have a longstanding history of informing and facilitating the referral of families to other services and resources (Baggens, 2001). In Australia, both policy documents (Office of Children and Young People, 2002c) and professional guidelines (CAFHNA, 2000) highlight the importance of referral to other services within the C&FH nursing role. Not only do C&FH nurses offer referrals to other health professionals, they also provide information about community services and neighbourhood groups that provide social support and promote community cohesion (Office of Children and Young People, 2002c).

Psychosocial support
The transition to parenting is known to be a significant life event during which many parents feel vulnerable and under confident (Nystrom & Ohrling, 2004; Rogan et al., 1997). Confidence and self-esteem greatly affect parenting abilities. A key principle that should underpin all education and support for parents is to recognise the concerns and interests of the parents involved and acknowledge that it is not only what parents know or do, but also how they feel about themselves and their children (Davis et al., 2002). Our views of ourselves are shaped by the messages we receive from those around us (Pugh et al., 1994). Research shows that many parents in the UK have had negative experiences when health professionals unwittingly undermine their
confidence, and doubt their own ability to parent (Knott & Latter, 1999; Pugh et al., 1994).

**FACTORS THAT INFLUENCE THE EFFECTIVENESS OF C&FH NURSING PRACTICE**

The ability of C&FH nurses to improve health outcomes appears to be influenced by a number of factors that facilitate effective practice. Again, most of the literature around this area originates from the UK and Europe. The major factors include: the quality of the relationships between the user of the service and the health professional; screening and assessment tools; clinical supervision of staff; location and type of service; inter-professional collaboration; engagement with the users of the service, assessment and identification of client needs. These factors will now be explored as well as documented consumer opinion and traditional non-users of the service.

**Relationships**

Ongoing contact and continuity of care between the nurse and client are seen to promote a positive relationship between the two and foster trustworthiness and mutual respect (Fagerskiold, 2000). A systematic review of early interventions in enhancing mental health in children and families in the UK was recently undertaken (Barnes & Freude-Lagevardi, 2003). The authors stated that without a reasonably satisfying therapeutic relationship between the practitioner and the client, any intervention or support program may be of little consequence (Barnes & Freude-Lagevardi, 2003). Effective relationships are:

*Built on partnerships, mutual respect and a shared sense of purpose, with an emphasis on reciprocity, that allows people to give as well as receive – not on a judgmental view of inadequate parenting* (Pugh et al., 1994 p.222).

However, in a large UK study that interviewed both health visitors and users of the service, Mayall and Foster (1989) reported that some mothers are unwilling to allow a relationship between themselves and the practitioner to develop (Mayall & Foster,
The relationship must develop trust which ‘acts as a condition which will produce the cooperative relationship needed’ (De la Cuesta, 1994b p.453). When trust in the relationship has not been established, research has shown that clients may ‘block’ the offer of services from the professional (K. Chalmers, 1992). Trust is required before clients will disclose information and be open to the sorts of supports the health visitor can offer. Trust therefore leads to a ‘coalition’ between the clients and the nurse (De la Cuesta, 1994b p.454).

When health visitors consider that policy directives interfere with their ability to establish or maintain a relationship with the client, some have been found to undertake non-policy work to assist in client engagement (De la Cuesta, 1993). Policy-makers in Australia recognise the value of relationships in the provision of services. The importance of establishing relationships with clients is repeatedly mentioned in NSW policy documents (NSW Health, 2002b), but how this is operationalised or supported is not described.

**Use of screening and assessment forms**

Screening and assessment forms have been increasingly incorporated into C&FH nursing services in order to support the nurse and standardise practice. Needs assessment tools used by health visitors in the UK aim to provide equity by ensuring that all clients are asked the same questions and, therefore, offered the same opportunity to reveal their needs (Houston & Cowley, 2003). Secondly, the objectivity implied by the questionnaire would help to demonstrate to funding bodies that the health visitors are meeting specific and identified needs (Houston & Cowley, 2003).

Whilst the increased documentation requirements are recognised by some staff as an improvement in the standardisation of care and accountability, the sheer volume of it was reported in the UK to interfere with the nurses’ ability to engage clients (W. Barker, 1996). Similar problems have also been described by Appleton (1996) in the UK, where health visitors reported that over one third of their time was spent on
clerical duties. Other health visitors have criticised collecting large amounts of data that do not adequately portray their work (Traynor, 1993).

Protocols and guidelines in Australia largely encourage the use of screening and assessment tools, though the impact on C&FH nursing has not been evaluated.

**Clinical supervision**

Isolation and lack of professional support has been identified as a key factor in the C&FH nursing satisfaction in Australia (DHS, 2004). Clinical supervision is considered an important strategy in improving Australian network linkages, enhancing referral structures and improving the quality of C&FH nursing services (DHS, 2004). New South Wales Health encourages regular clinical supervision to be offered to all C&FH nurses providing home visiting services (NSW Health, 2002b).

Clinical supervision has been described in the UK as an exchange between practising professionals, either individually or in groups, which enables them to develop their professional skills (Butterworth & Faugier, 1992). Though its origins are found in the psychoanalytic and counselling areas of mental health, clinical supervision has become increasingly implemented within nursing in Australia (Yegdich & Cushing, 1998), the UK (Clouder & Sellars, 2004) and Scandinavia (Teasdale et al., 2001).

The NSW branch of CAHFNA recently released guidelines for clinical supervision for C&FH nurses (CAFHNA, 2003). Within the document it recommends that all C&FH nurses have access to regular group supervision sessions and nurses with additional needs have access to individual supervision sessions as required. Key guidelines and principles for clinical supervision are summarised in the following box.
It is not known, however, if these principles have been implemented or evaluated at a practice level in C&FH nursing services across Australia.

**Location and mode of service**

Another factor that may affect the ability of the C&FH nurse to effectively engage families is the type and location of the service. Child and family health nursing services in both Australia (Ochiltree, 1991) and the UK (Cowley, 1996) have a long history of offering services to families in a variety of locations and programs. These include individual services with the home or the health centre; or by the provision of parenting groups located at the health centre or other community venue.

**Home visiting**

Home visiting has been identified as an important vehicle for the identification of vulnerable families in the UK (Appleton, 1996). Many health visitors recognise that visiting the family in the home is preferable to seeing them in the centre, as they
believe the mother is more relaxed and more open to discussing various topics (Mayall & Foster, 1989). Home visiting programs have also been found, in other research, to be associated with an improvement in the quality of the home environment (Kendrick et al., 2000).

Two large systematic reviews on home visiting have occurred in the UK within the last five years. Elkan and colleagues undertook a systematic review of international studies (using randomised controlled trials as the key methodology) and a selective review of UK health visiting literature (using criteria less rigorous than controlled studies) to assess the effectiveness of domiciliary home visiting. In total, 102 studies were reviewed, finding sufficient evidence to suggest that home visiting resulted in

- Improvements in parenting skills and in the quality of the home environment
- Amelioration of several child behavioural problems, including sleeping behaviour
- Improved intellectual development among children, especially among children with low birth weight or failure to thrive
- A reduction in the frequency of unintentional injury, as well as a reduction in the prevalence of home hazards
- Improvements in the detection and management of postnatal depression
- Enhancement in the quality of social support to mothers
- Improved rates of breastfeeding.

(Elkan, Kendrick et al., 2000 p.iii)

They also found some indication that home visiting produces costs savings, particularly in hospital costs (Elkan, Kendrick et al., 2000).

Barnes and Freude-Lagevardi, in their 2003 overview of the literature, looked at over 90 early intervention programs to enhance mental health in children and families and found similar results in home visiting. They included randomised controlled studies as well as small-scale research, case studies and previous reviews of the literature (Barnes & Freude-Lagevardi, 2003). They concluded that home visiting can be effective in enhancing parenting, reducing childhood injuries, reducing the likelihood
of abuse or neglect, enhancing parent-child relationships, improving parental attitudes and teaching skills, and the overall quality of the home environment (Barnes & Freude-Lagevardi, 2003).

Like Elkan et al. (2000b), Barnes and Freude-Lagevardi (2003) found that the most dramatic and broad-based outcomes employed professionals (for example, nurses) rather than trained lay-worker volunteers. Much of David Old’s work in the USA has used either nurses or paraprofessionals\(^6\), as home visitors to support high-risk families throughout pregnancy and early childhood (Elkan, Kendrick et al., 2000). In a recent comparison between nurse home visitors and paraprofessionals, Olds found that nurses produced outcomes that were twice as effective as the paraprofessionals (Olds et al., 2002). Olds equates the success of nurses in the support of families to be due to their competence in managing the complex clinical situations often presented by at-risk families. He explains that the nurses’ abilities to:

\[
\text{competently address mothers’ and family members’ concerns about the complications of pregnancy, labour, and delivery, and the physical health of the infant, are thought to provide nurses with increased credibility and persuasive power in the eyes of family members’ (Olds, 2002 p.157).}
\]

He also refers to the high ethical standing the nurses have in the community as well as their ability to teach mothers and family members to identify emerging health problems and to use the health care system (Olds, 2002).

A randomised controlled trial of nurse home visiting of vulnerable families in Australia, whereby C&FH nurses provided home visits to the intervention group families weekly until six weeks, fortnightly until three months and monthly until 12 months (Fraser et al., 2000). Results showed a reduction in maternal distress and improvements in maternal-infant attachment at six weeks postpartum (Armstrong et

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\(^{6}\) Paraprofessionals were workers with no health qualifications who shared many of the social characteristics of the families they visited.
al., 1999) though these results were not sustained at 12 and 18 months (Fraser et al., 2000).

Due to the absence of universal services, research in the USA has largely consisted of randomised controlled trials, targeting high-risk groups in relatively controlled environments. Whilst Elkan and colleagues (2000b) recognise that randomised controlled trials are the ‘gold standard’ in scientific research, they highlight that this methodology cannot always be generalised to ‘real-life’ situations. They further highlight the difficulties in assessing the complex health visiting service using controlled trials compared to discrete health interventions (Elkan, Kendrick et al., 2000). Australian researchers have also questioned the relevance and applicability of randomised control trials in addressing the needs of the socio-economically disadvantaged (Aldrich et al., 2005).

Whilst home visiting services were traditionally incorporated into C&FH nursing services in Australia, they were targeted at specific families, rather than universally, with only the most in need receiving a visit in the home (O'Connor, 1989). This differs from the UK system, in which universal home visiting has a longstanding history in health visiting services (Cowley, 1996). Universal home visiting has been recommended for C&FH nursing services in Australia (Nossar & Hudson, 2001). The implementation of the Families First initiative in 1998 aimed to have all NSW families with a new baby being offered a home visit by the C&FH nurse by the end of 2004 (Office of Children and Young People, 1999).

In NSW in 2001, 36.3% of families reported that they had received a home visit, though only 37.3% of these visits were by a C&FH nurse or midwife (NSW Health, 2002a). As the Families First initiative was only implemented in three of the 17 Area Health Services at this time, this figure is not surprising, but does indicate that some C&FH services were offering home visiting at this time.
Child and family health centres

Child health centres in the UK have been described as busy, unfriendly facilities with no privacy and limited opportunities for individual interactions (Fagan, 1997; Sefi & Grice, 1994). There is limited information in the Australian literature around how C&FH centres are structured or perceived by users. Most C&FH centres offer services through individual consultations by appointment, ‘drop-in’ or by telephone (NSW Health, 1999). Many nurses also run groups for parents or new mothers, which provide support, education and an opportunity to network with other new parents (NSW Health, 1999).

Child and family health nursing services in Australia are located in residential areas which aim to facilitate easy access for families. In NSW there are approximately 500 C&FH centres across the state (NSW Health, 1999). Most of the C&FH centres are in free-standing buildings, although gradually some have been incorporated into generic community health facilities (O'Connor, 1989). These centres, known commonly as ‘baby clinics’ were, and remain, well supported by most mothers. In 1976, a survey revealed that approximately 87% of mothers in NSW attended regularly (O'Connor, 1989). The usual pattern of attendance at the clinics in the mid-1970s consisted of weekly visits until the baby was six weeks old, then fortnightly extending to monthly until nine months of age, and then bimonthly or as necessary (O'Connor, 1989). This attendance was in accordance with the local guidelines at the time.

Current recommendations for C&FH nursing contact in Australia include the recommended development checks as outlined in the Personal Health Record – that is, between birth and four weeks, six to eight weeks, six to eight months, 18 months, two and a half to three and a half years and four to five years (NSW Health, 2003a). However, the service is theoretically available to all families at any time during birth to five years and is particularly well accessed by families in the first six to twelve months of a child’s life in Australia (Ochiltree, 1991), and in other countries where universal services exist, such as the UK (Bowns et al., 2000) and Scandinavia (Fagerskiold, 2000).
Parent groups

In addition to the provision of C&FH nursing services being offered on an individual basis, either in the home or the health centre, C&FH nurses also commonly provide education and peer support in group format (NSW Health, 1999). Within C&FH nursing services, group interventions are also considered more cost-effective than those interventions provided individually (Elkan, Kendrick et al., 2000). They may be less stigmatising, with participants likely to benefit from peer support, and deprived or abused children benefiting from exposure to an environment that is more favourable to their development (Elkan, Kendrick et al., 2000).

‘Mothers’ groups were introduced in New South Wales by C&FH nursing services in conjunction with the Mental Health Association in 1961 (O'Connor, 1989). Whilst the availability of parent groups is not universal in NSW, as it is in Victoria (Edgecombe et al., 2001), many nurses have years of experience running groups. Usually mothers groups are ‘closed’ to a predetermined number of participants, and run as a short-term ‘course’ of around six weeks, for two to three hours each session. Generally babies are eight weeks or older before the mother is provided with an opportunity to attend a group (Clune, 1999; Freeman & Lamb, 1997). Specific, predetermined topics on common parenting issues are covered each week, often with guest speakers who are professionals in the field. In this style of group, the role of the nurse is central, and s/he is seen as the leader or expert in the group. This parent group model still dominates most of the C&FH services in Australia though many nurses successfully encourage group discussion and peer support (Edgecombe et al., 2001). A new model of parenting groups has recently been introduced into one area of Sydney and is investigated and reported in Case Study Two of this thesis.

7 Previously called ‘Mothers groups’ the term has recently been changed to ‘Parent’ groups to reflect the increasing attendance of fathers at the groups. However, it is still acknowledged that the vast majority of attendees are women (Edgecombe et al., 2001).
In the extensive systematic and selective review of health visiting, Elkan and colleagues (2000) identified the noteworthy features of successful parenting groups. These included: voluntary participation; a non-expert model with respect for mothers and their expertise; acknowledgement that there is no right way of parenting; emphasis on parental strengths, modelling, mutual support and partnership in problem-solving; and linkage to other community services of the integrated family centre (Elkan, Kendrick et al., 2000). The skills of the group leader to engage the discussion with the parents interests and concerns, focusing on the parents strengths, ideas and beliefs, and valuing what parents bring to the group, also appear to be critical to the success of parenting support programs (Pugh et al., 1994).

**Inter-professional collaboration**

Another factor that will influence the effectiveness of C&FH nurses in supporting families is their ability to work within a multidisciplinary team. Whilst in both the UK and Australia, health visitors and C&FH nurses have traditionally worked autonomously and in isolation, there has been an increasing demand for these practitioners to work collaboratively with health and other agencies in a ‘whole-of-government approach’ to supporting families (DfEE, 1999; Office of Children and Young People, 2002c).

Collaboration between health visitors and other health professionals in the UK has been found to be problematic (Taylor & Tilley, 1990). Interagency conflict is well documented between social work and health visiting professions in the UK (Malone, 2000; Mayall & Foster, 1989; Taylor & Tilley, 1990). Health visitors have reported insufficient resources in external agencies to permit referrals (Appleton, 1996). This leads to health visitors in the UK reporting that they frequently undertake the duties of other health disciplines, such as social work, which contributes to the blurred boundaries, and at times inter-professional rivalry (De la Cuesta, 1993).

The roles of social workers and C&FH nurses overlap, as both disciplines are concerned with individuals in their social context (Mayall & Foster, 1989). Child
health nurses in Sweden have reported that there is a reluctance in some professional groups to share information about a client (Fagerskiold, 2000). So too, generalist nurses in Australia have reported tensions between themselves and other health professionals including doctors (Jones & Cheek, 2003).

Child and family health nurses in NSW have reported concern by midwifery and other professions over the deterioration of their role, highlighting the professional boundary issues experienced by these two service groups (Vaughan, 2005). In Victoria, Edgecombe reports on confusion between midwifery and C&FH nurse services about what day, post-birth, families should be linked in to universal C&FH programs (Edgecombe, 2004). Due to the limited published literature around inter-professional collaboration between C&FH nurses and other health disciplines in Australia, this will be the focus of inquiry in Case Study Three of this thesis.

**Engagement, assessment and identification of client needs**

The ability of the C&FH nurse to be effective in the support of families in parenting requires adequate engagement of the client and the appropriate assessment and identification of their client’s needs. The term ‘engagement’ is used by McCain and Mustard to mean an ‘active responsive involvement’ (McCain & Mustard, 1999 p.5). Whilst these authors are referring to engagement between caregivers and infants, a similar definition can be applied to C&FH nurses and their clients.

Chalmers (1993) describes several processes whereby health visitors aim to identify health needs in clients. Health needs are determined and identified as being ‘client initiated’, ‘easily seen’, ‘gradually opened up’ or ‘remain hidden’ (K. Chalmers, 1993). Processes that Chalmers (1993) identified health visitors using to uncover health needs, included: questioning; using illustrations from other client situations; normalising; and responding to cues. The amount of energy directed at client support varied greatly and was dependent on the health visitors’ conceptualisations around the clients’ social worth. When the health visitors believed the clients would not respond
to their attempts of help, they withdrew what they offered and reduced their service to what was routinely required (K. Chalmers, 1993).

In the UK, as in Australia, participation in and access to C&FH nursing services is voluntary. Practitioners in the UK are therefore mindful of the importance of gaining and maintaining access with their clients in order to carry out their work (De la Cuesta, 1994a; Luker & Chalmers, 1990). Based on her doctoral work in health visiting within the UK, De la Cuesta (1994) identified the strategies practitioners use to ‘market’ their service. These include raising awareness of the service, selling themselves and displaying the service, adjusting delivery by bargaining, pacing the visit and maximising opportunities (De la Cuesta, 1994a). She also identified that health visitors tailored the content of the consultation to meet the needs of the client, negotiated and compromised, and finally, offered non-routine support (De la Cuesta, 1994a p350). All of these strategies identified by De la Cuesta were undertaken by the health visitor to maximise the potential of gaining the client’s trust and co-operation. There is no published work in Australia that explores the strategies or extent to which C&FH nurses in this country attempt to gain and maintain access to their clients, particularly those disadvantaged families who may benefit most from the service.

**Consumer opinions of the service**

The effectiveness and appropriateness of C&FH nursing services can be informed by assessing consumer opinions of the service. Studies have shown conflicting results around consumer satisfaction with C&FH nursing services across a number of countries. In the UK, some studies have shown high levels of satisfaction and reported a non-authoritarian, facilitative style in health visiting (Bowns et al., 2000; Cowpe et al., 1994; Machen, 1996). Others, however, report that mothers find the nurses to be baby-focused (Knott & Latter, 1999), authoritarian, judgmental, patronising and belittling (Mayall & Foster, 1989).

In Australia, a consumer survey in Victoria found high levels of satisfaction amongst service users (DHS, 1998), though other Australian research has found that some
parents find the style of the nurses to be ‘bossy’ (Ochiltree, 1991). A recent survey of children’s health in NSW reported high (92%) usage of C&FH nursing services of parents with children aged 0-4 years (NSW Health, 2002a). However, the survey did not seek to elicit specific customer satisfaction of the service. They did ask the families to report on reasons why they never used the service or why they ceased using the service. The response to these questions were that the families never, or no longer felt, that they needed the service, or that they used other services (NSW Health, 2002a).

Complaints from consumers from C&FH services in Victoria, Australia include:

- lack of continuity of service from the same nurse
- lack of focus on the needs of the parent
- lack of service report in respect of the ‘terrible twos’ stage
- lack of experience in and knowledge of issues related to children with severe disabilities
- lack of information provision on alternative services and products
- bias of nurse towards breastfeeding
- service cutbacks and their impact on quality of, and access to, services
- lack of access to the service after hours
- lack of integration of service provision and information dissemination across centres within the area
- need for improved quality of facilitation and presentation skills during information sessions

(DHS, 1998 p.6)

The services offered to parents in Australia have been found to be varied, with the personality and style of the professional being influential on the satisfaction of the client (Ochiltree, 1991). The manner and attitude of the health visitor in the UK is important, with most women preferring a non-directive, non-didactic approach and a discussion between equals (Mayall & Foster, 1989). Women in the UK have reported that it is up to the mothers to decide when to seek assistance, and unsolicited advice from health visitors was not welcomed (Mayall & Foster, 1989).
People will only seek out encounters where there is a perceived benefit. Interactions that the client perceives do not benefit themselves or their baby, or create feelings of lack of self-worth or powerlessness, are naturally avoided (K. Chalmers, 1992). Child and family health nursing services are particularly helpful for parents in the first few months following the birth of a first child and for mothers who lack adequate social contacts (Mayall & Foster, 1989). Social networks often provide most of the mothers’ advice and information on parenting subjects and when such networks are not available, C&FH nurses can provide this information (Mayall & Foster, 1989).

The effectiveness of C&FH nursing services is influenced by the clients’ previous experience with the service and anti-establishment or anti-authority attitudes (Luker & Chalmers, 1990). Consumers of services in Sweden have indicated that they value professionals who are partners who they can trust and who respect and care about them, who are highly committed, flexible, empathic and able to imbue participants with a sense of their own value, special qualities and skills (Barnes & Freude-Lagevardi, 2003).

In Chalmers’ (1992) research involving 45 health visitors, she describes the reciprocal control that both the practitioner and the client exert when interacting. The health visitor firstly establishes access to the client and offers health information and surveillance in a routine prescriptive way, whilst assessing the particular needs of the client and responding with attempts to offer support around those needs. The client can then decide how much she wants to disclose, and how much of the health visitor’s information she will act upon. Similarly, the health visitor can act upon a cue, or request for assistance, or s/he may not. In this way, both clients and health visitors regulate what they give and receive in the interaction (K. Chalmers, 1992).

**Non-users of the service**
Another indicator of the effectiveness of C&FH nursing services is those groups who do not traditionally access them. Low self-efficacy, impaired feelings of competency
and control and poor organisational skills are common characteristics of families with additional needs that impair their ability to engage with the health care system (NSW Health, 2002b).

Groups not accessing C&FH services in NSW were identified in a 1984 survey as being poor families, migrants, single parents and those at ‘high risk’ of adverse health outcomes (O’Connor, 1989). In a three-state study on C&FH services in Australia, Ochiltree (1990) found non-English-speaking mothers were three times more likely not to use the service than other mothers. Barriers for non-English-speaking families in accessing health services included lack of English language skills to be able to effectively negotiate services, lack of knowledge of the health system and those who provide services and lack of awareness by health providers of individual cultural needs (NSW Health, 1999). They also found that the lower the income of the mother, the less likely she was to use the services. This has also been found internationally (Mayall & Foster, 1989).

The pattern of use and non use of services (that is, why those who need it most use it least) was first described by Hart in 1971 as the ‘Law of Inverse Care’ (Hart, 1971). Health services have long expected middle-class women to be more responsive to health advice due to the common attitudes and values that these women share with scientific and professionally orientated experts (Reiger, 1985). Middle-class families are also often better able to articulate their needs and gain access to health services (D. Williams, 1997). Child and family health services in Australia (DHS, 1998), and abroad (Gerrish & Papadopoulos, 1999) have been criticised for not adequately catering to the needs of families who live in non-traditional family situations.

Women from minority groups in the UK suffer more than other mothers in terms of lack of day-care facilities, low income and poor-quality housing (Mayall & Foster, 1989). New arrivals to Australia have similar burdens, often being isolated from family and other support networks. Though many health visitors in the UK recognise the right of ethnic groups to maintain their own culture, they often have difficulties...
implementing this view into their practice (Mayall & Foster, 1989). The tendency of health practitioners to conceptualise culture as a discrete entity, independent of socio-economic circumstances is also problematic (Mayall & Foster, 1989). Experience shows this attitude may also be challenging for health professionals in Australia (Eckermann et al., 1998). Furthermore, viewing the behaviour of ethnic groups in terms of cultural practices that do not conform to the norms of the mainstream culture promotes negative stereotyping (Mayall & Foster, 1989).

Children of low socio-economic status families in Australia are less likely to breastfeed, more likely to develop long-term illnesses, and less likely to attend preventative and early intervention services such as C&FH nursing services (Moon et al., 1998).

Health visitors have reported that families from marginalised communities are often suspicious about the role of the health visitor and are sceptical about the relevance of the service (De la Cuesta, 1993). This is thought to be due to the past experiences of the client, as well as the particular needs and circumstances of the health interaction (De la Cuesta, 1993). In these situations health visitors report that they offer additional support that fall outside their core business and include offering transport, food, money and liaising between the client and other services (De la Cuesta, 1993).

Other marginalised groups
Marginalisation has been defined as ‘the process through which persons are peripheralised on the basis of their identities, associations, experiences and environments’ (Meleis, 1999 p.95). People who are marginalised from the health service are not only those of different ethnic ‘culture’ from that of the health professional. The concept of ‘culture’ requires some clarification, as it plays a significant role in the delivery and access of a health service (Daniel, 1993).

A common notion of culture consists of the shared meanings, values, attitudes and beliefs of a group. It is often assumed to mean a ‘finite and self sufficient body of
beliefs, customs and traditions’ (Price & Cortis, 2000 p.237). The term frequently appears to refer to the ‘other’ or ‘out-group’ but not the ‘in’ or majority social group. The dominant group generally assumes that only minority groups have cultures and cultural needs (Price & Cortis, 2000) and often fail to recognise their own ‘culture’ and its rules.

Focusing on ethnic components of a person’s culture ignores the differences within that group created by economics, poverty and politics. Middle-class women in Britain, Egypt and Brazil, for example, may have more in common with each other than the uneducated, low-income women within the same countries (Meleis et al., 1992). Furthermore, culture cannot be examined, explored or understood without consideration of the politics, or the history that influence it, including the power relations within the group (Meleis et al., 1992). It is ‘differentness’ rather than ‘culture’ that influences the relationship between health provider and client (Spence, 2001).

Culture is also defined by one’s professional group. Nursing tends to be a white, female-dominated profession with little representation from other ethnic groups (Stokes, 1991). The small numbers of nurses who do come from minority groups are socialised into the profession of nursing and subsequently care for clients from the perspective of the dominant culture.

When people are marginalised they are denied power and access to resources (Meleis et al., 1992). In-depth knowledge about marginalisation results from an understanding of how these groups are treated, the processes by which they are marginalised and how their culture or identity contribute to their marginalisation (Meleis et al., 1992). Knowledge and understanding also comes from observing the responses and attitudes of health care professionals when servicing populations which differ from the Caucasian, middle-class heterosexual majority, because of the colour of their skin, their accent, their language proficiency, their gender, their religion, their dress or their sexual orientation (Meleis et al., 1992).
Our health systems were established to meet the needs of the white dominant culture, and until this is rectified, the needs of people who are not part of the dominant group will not be met (Culley, 1996). Similarly, health systems reflect the culture and values of the highest-status professional. Policy documents often acknowledge the barriers to health service delivery to marginalised groups, particularly the non-English-speaking communities (Office of Children and Young People, 2002c; Victoria Ministerial Taskforce, 1991), but these documents define the difference by language and behavioural practices. Doing this focuses the notion of ‘other’ as the cause of the ‘problem’, and ignores problems of individual and institutional racism (Swedson & Windsor, 1996).

Nurses as a marginalised group

As a profession, nurses themselves have traditionally been the working-class group of the health hierarchy. Like teachers, they have been ignored or even silenced in policy decisions (Ulichny, 1997). Their position on the periphery of health care makes nurses the marginalised group of health providers. When people are marginalised they are denied power and access to resources (Meleis et al., 1992).

Nurses are often unaware of their position of lack of power within the hierarchy of health professionals or that they are oppressed as a group (Jeffs, 2001). Nursing, within health, is dominated and oppressed by the medical profession (Meleis, 1999). This oppression is linked to the domination and oppression of women (Harden, 1996) and to medical hegemony (Freshwater, 2000).

Nurses lack autonomy, accountability and control over their own profession (Harden, 1996). Nursing knowledge has also been identified as being marginalised due to its late arrival in academia (Meleis, 1999). As a result of this lack of credibility, our research is not considered rigorous or scientific, and nursing research does not attract the same interest in external funding as does medical research (Meleis, 1999).
Like all marginalised groups, nurses have a great deal of knowledge (Hall et al., 1994). Subordinate groups often develop strategies of resistance towards those in power (Hall et al., 1994). The behaviour of the nurses is suggestive of the resistance demonstrated in oppressed groups. The imbalance of power, centred on images and perceptions of status, knowledge and training between the individuals, all create unbalanced contributions (Braye & Preston-Shoot, 2000). This is especially relevant where these images and perceptions are internalised by those occupying ‘less powerful’ positions (Braye & Preston-Shoot, 2000).

Within nursing, the C&FH workforce is further marginalised as it exists in the subgroup of community nursing (Keleher, 2000). Acute care nursing has had longstanding status as the dominant paradigm, largely due to the fact that education was traditionally located within the hospital (Keleher, 2000). This led to the concentration of the illness model and the subsequent lack of policy interest in community-based nursing services (De Santis, 1994; Lea, 1994). The dominance of the medical model continues to influence health services, both in the hospital and the community (Keleher, 2000).

These influences are particularly significant in the C&FH nursing workforce, where tension may occur between the medical model that dominates health services and the models of primary health care that underpin C&FH nursing practice (CAFHNA, 2000). Further influencing this tension is the introduction of a policy such as the Families First Initiative, which also challenges the traditional expert model. This thesis attempts to explore the challenges these influences have on C&FH nursing practice. The influences of marginalisation will also be considered in Case Study Three, when C&FH nurses’ ability to collaborate effectively with other professional groups is explored.

**CONCLUSION**

Child and family health nurses fulfil a range of functions in the support of parents in caring for their child. The literature confirms that to be most effective, the nurse must
reflect on her/his own culture, values and attitudes and to offer a service that is led by the client’s needs and carried out in a way that focuses on the strengths of the family working in partnership with the health professional. Despite these philosophies being described in the UK since the 1980s, many nurses in the UK (Mayall & Foster, 1989) and Sweden (Baggens, 2001) struggle with this approach and continue to work within the expert paradigm where they control the interaction and fail to work in partnership with the mother and her family. This is particularly evident in C&FH interactions with marginalised families (Knott & Latter, 1999).

To be effective, C&FH nurses are required to have advanced skills in group facilitation that enhance maternal confidence and self-esteem, as well as promoting peer support. They must also have expertise in a range of maternal and child health behaviours and conditions. It is unknown whether it is the personal characteristics of the nurses, their nursing education, or the institutions that employ them adequately prepare and support these nurses to achieve this. These questions are further impeded by the lack of knowledge and information available in the Australian literature on the C&FH nursing workforce.

As Western countries become increasingly multicultural, C&FH nurses have been challenged to offer support that considers differences in culturally informed values and belief systems. There are also higher expectations to meet the health and social needs of marginalised groups who traditionally did not access the service, yet who could greatly benefit from additional support, if such support were offered in a way that met their needs.

The major paradigms of contemporary C&FH nursing practice continue to reflect the principles of primary health care which is based on partnership, community participation and preventative health (WHO, 1978). What is becoming more apparent, though, are the difficulties of practising within a primary health care model when working within an entrenched ‘expert’ health system (Werner & Sanders, 1997). The more recent publications use nomenclature such as ‘partnership’, and the ‘strengths-
based approach’ to reflect principles that have been embedded within the primary health care for nearly 30 years. It remains to be seen whether this new terminology has been more successful in changing practice than the primary health care rhetoric of the past or whether it is the health systems themselves that are the major barrier to working differently.

The NSW Health department has developed policy guidelines, and provided significant resources, to improve and co-ordinate the network of services that provide support to families. This thesis attempts to explore this further in light of some of the issues raised in this literature review within an Australian context, where nurses are being required to work in a very different way from how they have traditionally worked. The next chapter outlines the methodology that was used to apply the research and the methods undertaken to explore the current practice of C&FH nursing in Australia.
Chapter Three

Methodology and Methods
Chapter Three: Methodology and Methods

INTRODUCTION

The purpose of the study was to explore, describe and analyse C&FH nursing in NSW, at a time of rapid change that challenges nurses to work in new ways. A methodology that is compatible with the research context and approach is required to answer the research question. The methodology must be appropriate to the setting of C&FH nursing practice and support the exploratory orientation of the research aims.

This chapter outlines the methodology and methods that guided this research. The focus of the enquiry was around the C&FH nursing practice and the effectiveness of nursing practice in supporting parents. This required an investigation of practice within the context of the health system that directs practice. This research therefore falls within a health systems research framework as it considers the policy, organisation and workforce issues that influence practice (Haritos & Konrad, 1999). Three case studies are presented and analysed. Each employed an ethnographic approach to guide the exploration of C&FH nursing in a range of settings.

The role of the researcher also requires recognition and consideration within the context of the study being undertaken, particularly in qualitative research (Lindlof & Taylor, 2002). This chapter describes some of the reflections and analyses of the author around my role in the study.

HEALTH SERVICES RESEARCH

Health services research is becoming increasingly used to investigate the structure, process and effects of health care services (Haritos & Konrad, 1999). Health services research provides descriptive data on the organisation and operation of the health care system and analyses relationships between and among components (Aday et al., 1998). This thesis is particularly interested in ‘examining the impact of health policy on the delivery system and the individuals and populations affected by these initiatives.
(Aday et al., 1998 p12). It therefore provides a useful framework to describe and analyse the effects of the Families First initiative on the C&FH nursing workforce.

Health services research often pursues evidence of service quality or patient safety through the assessment of performance indicators and health outcomes data (Luft & Adams Dudley, 2003). For this reason, health services research has been identified as being located within a positivist paradigm (Haritos & Konrad, 1999). However, there has been increasing recognition that health services research needs to adopt qualitative and sociological approaches that explore the contextualisation of health systems (Haritos & Konrad, 1999). When health services embark on a process of change, in-depth understanding of the social systems of managers, professionals and other staff groups is essential (Ong, 1993).

Health services research produces knowledge about the performance of a health care system (Aday et al., 1998). Within nursing systems within the United States of America, it has been acknowledged that there is currently little knowledge around the role and effectiveness of nursing care (Kurtzman, 2004). Given the dearth of literature on contemporary C&FH nursing practice in Australia, similar conclusions can be drawn in this country.

Health services research has been criticised for documenting problems without exploring or testing interventions that are solutions-oriented (Steinwachs, 2004). However, a review of the literature identified that very little research has occurred in Australia around C&FH nursing practice. Documentation and exploration of practice is therefore necessary before any attempt is made to address possible inadequacies. Health services research is interested in creating and encouraging change (Needman, 2004). But to do that it is necessary to understand why the workforce is ‘performing the way they are and acts the way they do’ (Needman, 2004 p.460).

The focus of research on the practice and place of C&FH nursing within the health system challenges the traditional flow of knowledge from policy to practice and
attempts to generate knowledge that will inform the ‘language and work’ of health services and health policy-makers (Blumenthal & Thier, 2005 p.9). By studying the process of how C&FH nurses offer services to families ‘encompasses the transactions between patients and providers in the course of actual care delivery as well as the environment and behavioural transactions exacerbating health risks’ (Aday et al., 1998 p.11).

Little evidence was found in the literature around researchers applying health services research to the individual or professional response to policy change and the dynamics of the system. This is surprising, given the role particular workforces have in the implementation of many policies and the importance nursing has in the delivery of health services (Kurtzman, 2004; Steinwachs, 2004). This research therefore utilised a health services research framework to incorporate the individual and professional response to policy change. This required thoughtful application and considerable reflexivity on behalf of the researcher to produce insights that assisted in the identification and explanation of factors that influence contemporary C&FH nursing practice.

This thesis seeks to ‘create new knowledge which is relevant to policy and practice in the health services field’ (NHMRC, 2005 p.4). This will require dissemination of research results and practical recommendations that can be utilised within health services. Dissemination, through conference presentations and publications, has been occurring throughout the research period. This dissemination has been particularly relevant to Case Study Two, where promotion of a new model of parenting groups has been successful in the widespread implementation of the model in other Area Health Services.

**STUDY DESIGN**

The design employed in this research was descriptive and exploratory, aiming to gather rich qualitative data about what C&FH nurses in NSW do as part of their everyday practice. Health services research guided the researcher in carefully studying
the issues, the social structures and their cultural and political context affecting health services (Daniel, 1993). For the C&FH nursing workforce, this included the skills they perceived they need in contemporary practice and the barriers that impede their ability to carry out the role expected of them within an environment and system that is changing.

An ethnographic approach was employed to guide the data collection process within the three case studies. Bie Nio Ong describes the usefulness of ethnographic approaches in health services research, as it assists in ‘understanding subjectivity, experiences and processes, (which are) all important aspects of human relations in organisations (Ong, 1993 p.42).

The ethnographic approach allowed the researcher to describe what people in some particular place or status ordinarily do, and the meaning they ascribe to what they do under ordinary or particular circumstances (Wolcott, 1999). The rich descriptive element of ethnography (Wolcott, 2001) allowed me to explore and describe the perceptions and understandings of the role of the C&FH nurse within the changing policy context.

Ethnography also describes a culture (Jordan & Yeomans, 1995). I was interested in the changing ‘culture’ of C&FH nursing practice under recent policy initiatives. The ethnographic approach is capable of uncovering the complexity and richness necessary for understanding the process of change at both organisational and individual level, including the relationship between the two (Ong, 1993). As a member of this culture, I attempted to engage with this in two ways, as observer researcher, and, as a member of the culture.

Hammersley (1992) explains that ethnography helps with the

\[ \text{Discovery of unanticipated aspects of the policy process and investigation of how policies are actually implemented, detecting deviations from how they were} \]
intended to be implemented that could be significant for policy outcomes (Hammersley, 1992 p.125).

In order to describe and understand the culture and practice of the C&FH nurse in contemporary settings, clinicians were observed and interviewed in three different settings that produced three separate case studies. Whilst some researchers consider the use of case study to be a form of methodology (Stake, 2000b; Yin, 2003) I regard Wolcott’s (2001) description of case study more useful. Wolcott (2001) employs the case study as a convenient, indeed preferable, format for reporting research rather than as a strategy or methodology for conducting research. Each case study in this research is described individually as a ‘stand-alone’ case, although many of the factors that impacted on practice were found to be relevant to one or more case studies (Stake, 2000a).

Qualitative approaches such as those employed in this research have been criticised for their poor generalisability and limited application to wider settings (Bryar, 1999; Gray, 1998). However, others argue that by conducting research in ‘real-life’ environments, the believability and thus the internal validity are strengthened (Pegram, 1999). Furthermore the in-depth nature of this research technique provides greater understandings than most quantitative methods can provide, which can provide benefits to generating understandings in other settings (Bryar, 1999; Gray, 1998).

METHODS
The concepts of health services research provide guidance by ‘describing, analysing, and evaluating the structure, process and outcomes’ of the health care system (Aday et al., 1998 p.11). This thesis concentrated on describing and analysing the process of C&FH nursing services. The following section provides an overview of the data-collection methods used in this research.
Data collection

A range of data-collection techniques were used that were flexible and capable of studying the process of change and the adaptation taking place within the health system (Ong, 1993). This included focus groups and individual in-depth interviews, the purpose of which was to describe C&FH nurses’ perspectives around their practice and to explore the meanings nurses make of the events and experiences of their professional lives (Grbich, 1999). Observation was an additional technique used as a unifying activity within the research (Wolcott, 2001), and was undertaken to further investigate and understand the practice of the C&FH nurse.

Participants and Setting

To capture a diverse and wide range of experiences, C&FH nurses from three sectors across two metropolitan Area Health Services in Sydney were invited to participate in the research. A total of 36 participants (Case Study One, 17 nurses; Case Study Two, 14 nurses; and, Case Study Three, two nurses, two nutritionists and one health promotion worker) were interviewed. In addition to being interviewed, 13 C&FH nurses in Case Study One were observed in clinical practice, each for eight hours, whilst 12 nurses in Case Study Two were observed facilitating mothers’ groups. Observation time for Case Studies One and Two totalled 100 hours.

The nurses in Case Studies One and Two were initially approached through their managers. I was able to access groups of 20-30 nurses in each setting following the approval and support of their manager. In Case Study Three, I was involved in a collaborative project and approached all members of the working group individually, inviting them to participate.

Further information about the data collected in each case study is presented in the relevant chapters, but a brief overview of each follows.
Case Study One: C&FH nursing practice in the provision of services to individual families

Case Study One was carried out in two sectors of a large Area Health Service in metropolitan Sydney. These sectors provided services to some of the most culturally diverse and disadvantaged areas in Sydney as identified by national census data (ABS, 2004). In both sectors I was invited to attend a staff meeting to introduce myself and explain the research to the nurses. Several nurses volunteered to participate at these staff meetings and further recruitment occurred following the commencement of data collection. Nurses I interviewed and observed usually recommended and introduced me to colleagues whom they believed would be happy to participate.

Observations allowed me to collect data focusing on how the nurses provided services to clients. These data were supported by the information they provided during interviews. I spent one full day with the nurses observing them in a range of settings. Two of the 13 nurses observed in clinical practice worked exclusively in a health centre. These were older nurses who didn’t drive or had chronic back injuries that prevented them undertaking home visits. Most nurses did both home visits and saw clients in a health centre and I attempted, mostly successfully, to observe them in both settings.

Case Study Two: C&FH nursing practice in the facilitation of parent groups

As in Case Study One, I approached the nurses through their manager, explained my research project at a staff meeting and invited participation. The research centre through which I was enrolled to undertake my PhD had previous research experience with this sector of a large Area Health Service. Consequently the nurses and managers had a good relationship with the supervisors of the research. This promoted the support and enthusiasm of the nurses involved in running the parent groups (called ‘Earlybird’), as they recognised it was an opportunity to report on and publish what they believed was a unique and successful program.
Semi-structured, in-depth interviews were held with the four key staff members who established the parent groups and the one Chinese-speaking C&FH nurse who ran Chinese-speaking groups. Three focus groups were held with all 12 C&FH nurses who were leading parent groups in this sector.

In order to understand and explore the process used with the groups, and to document examples of the facilitation skills identified by the nurses, observations of Earlybird sessions were carried out in each of the six centres that offered the program. One session was observed in five of the centres, whilst six consecutive sessions were observed in the sixth centre, resulting in a total observation time in this case study of 25 hours. The consecutive sessions were observed to gain some perspectives on issues covered over the time an average woman would attend, which was usually six weeks.

**Case Study Three: the role of the child and family health nurse in inter-professional collaboration**

Case Study Three provided an opportunity to explore how C&FH nurses worked collaboratively with other health professionals in a project aimed to improve infant nutrition in Vietnamese and Arabic families. The project involved actively engaging clinicians in an action research project. The focus of this case study was not the action research project itself, which is reported elsewhere (Kruske, Barclay et al., 2004), but the engagement and participation of the C&FH nurses in the process of the project. Further information about the methodology used in this Case Study is provided in Chapter Seven.

Though the project itself lasted for three years, the nurses’ involvement spanned less than 12 months of this time. During these 12 months, all working-party members (two nutritionists, one health promotion worker and the two nurses) were aware that my PhD was occurring concurrently, and consented to my investigating the nurses’ involvement in the project. All members of the working party also consented to in-depth semi-structured interviews. These were undertaken towards the end of the
project to give the members an opportunity to reflect back on the nurses’ involvement, and their contribution to the final project outcomes.

**PERSONAL REFLECTIONS ON THE DATA-COLLECTION PROCESS**

I approached data collection with some reservations. Observations and questioning were skills I had developed and refined throughout my twenty years of practice as a nurse and midwife. In a research sense, however, what I chose to observe, how I recorded it and what questions I asked would affect the results of my work and the rigour of the research (Roulston et al., 2003).

I was also sensitive to the role I played in the data-collection process. Researchers share a role in the production of knowledge and meaning through the interview process (Holstein & Gubrium, 2003). Just as the nurses were not passive vessels from which I could extract information, my role as a researcher was not a neutral one (Holstein & Gubrium, 2003). The awareness of my potential to influence the knowledge and meaning created with each field encounter was initially burdensome.

I was conscious of the need to develop rapport with the nurses, both on an individual level and as a group. The quality of rapport between researcher and the subject is crucial (Grbich, 1999). Rapport occurs when two parties who may or may not agree with each other on everything acknowledge the other’s viewpoint as valid and worthy of respect (Lindlof & Taylor, 2002). I foresaw many of the concerns and questions the nurses would have, but not be able to articulate, about myself and the research. These included: what will she think about my practice; what does she want to know; what sort of questions will she ask; what will she do with the information; can I be honest; who will benefit; will I be exploited and how? I had openly acknowledged these potential concerns when I addressed the nurses as a group at the staff meeting. However, I needed to address most of the issues again when I first arrived in the morning for the eight-hour observation with the nurse.
I was also conscious of the way I looked and dressed. I believed this also affected the way the nurses would view and receive me and would influence the rapport I tried to establish. Having read and reflected extensively on assumptions and stereotypes as I prepared for this research, I was acutely aware of how easily and commonly these occur and how initial judgments influence how we react to and accept people. Lindlof and Taylor (2000) recommend the researcher dress in a way that reflects the cultural environment. I aimed to appeal to two very different groups, firstly, the nurse with whom I would work for the day and secondly, the families we would visit on behalf of the health service. I aimed to dress in a casual way that was clean and tidy. After several home visits where I found myself sitting on the floor, I adapted my dress to a more comfortable one, and found that trousers were more appropriate than skirts and dresses to wear.

Interestingly, sometimes I found myself hesitating to appear in clothes of good quality and was reluctant to wear lipstick. This was more notable with Caucasian families of particularly low socio-economic status, such as residents of an urban caravan park I visited. I believed these families had more distrust in the health service than other marginalised groups, though I am not sure whether this was an accurate assumption. Families from Asian countries who had suffered under dictatorships in their previous homelands experienced similar distrust of government authorities (Rossiter & Yam, 2000). Perhaps it was because I was not familiar with this cultural group that I did not feel the urge to dress in a particular way. However, I believe that Asian families expect professionals to dress in a professional manner and may have disapproved if I had attempted to ‘dress down’ as I did with the Caucasian families who were in difficult socio-economic circumstances. Most of the time I was unaware of what families we would be visiting and I would be influenced by the criteria of being clean, tidy and comfortable and ‘fitting in’ with the environment as much as possible.

Researcher self-disclosures are one way to engage the participants’ interest and pave the way for a productive interview (Dunbar et al., 2003). I would therefore endeavour to chat lightly about myself upon meeting the nurses and disclose the challenges I was
having undertaking the PhD and how I missed clinical work. This served two purposes. Firstly it was designed to reassure the nurses that I wasn’t an ‘academic’ to whom they could not relate. Secondly, I was a peer and momentarily removed from clinical work. I would mention my clinical experiences of working with Aboriginal families in Arnhem Land. This would elicit a professionally respectful response in some (although not all) of the nurses. Through such disclosures I hoped to establish common experiential ground as it has been identified as a useful strategy in interviewing (Dunbar et al., 2003).

There were some nurses with whom I felt a stronger ‘connection’ and initially I was concerned how this could affect the quality of data I was collecting. Lindlof and Taylor (2002) reassured me that I could still achieve rapport whilst disapproving of the person’s values, ethics, or conduct. My opinion of each participant was also influenced by what I observed in their clinical practice. There were many clinical actions I saw nurses perform that I did not condone and I found it difficult at times to temper my urge to speak out. Nor could I understand some of the nurses’ professional manner. However, I would remind myself of my role as researcher and observer and not interfere. I would sometimes attempt to explore why they behaved in a particular way when I interviewed them later. However, many times I resisted this because I was afraid they would feel I was criticising them and this would influence the trust we had established and therefore affect the remainder of the interview.

My own history of having worked in many different settings and extensive non-Western world travel has exposed me to a great variety of professional and personal experiences. This exposure may have supported me to be more effective in extracting the complexities from the research, both during data collection and throughout analysis. Referred to as ‘requisite variety’ or ‘tolerance for ambiguity’, Lindlof and Taylor (2002) suggest that the more competing beliefs a person is able to entertain, the more open that person will be to the mystery of real social action.
Making assumptions in data collection

It was interesting to recognise the connection between my initial research interest (the influences of ethnicity and social class in the C&FH nurses’ relationship with the client) and its application in data collection. My relationship with the participants was influenced by these same attributes and it most likely influenced the assumptions the nurse made about me and I about them. I also noticed how I ‘worked up’ or ‘played down’ various components of my identity, depending on whom I was trying to engage (Lindlof & Taylor, 2002).

My identity was a white, 40-year-old, female, C&FH nurse who disclosed various experiences and frustrations of working with marginalised Aboriginal communities in remote settings. I hoped these traits would assist me in accessing the field and the promotion of empathy and understanding would result in maximising the quality of data (J. Mason, 2002). I expected to have advanced knowledge of many of the issues when compared to a researcher who was not a C&FH nurse. However, an outsider, who is not a member of the group, can sometimes understand aspects of the culture that I, as a member, would take for granted (Dunbar et al., 2003). Furthermore, my readings had also taught me that there is much diversity within groups and it was impossible to locate myself within the world of all professional participants, as many would inevitably belong to subgroups.

I found myself accessing a series of subgroups within the Health Service sectors. During my attempts to become accepted as one of the group, I risked becoming involved with the in-house politics and being cajoled into choosing sides. In Case Study One, there were obvious divisions between the older and younger nurses, between the loyalists and non-loyalists of the previous manager, and between each of the geographical nursing teams – defined by the clientele residing in the areas. Those nurses who worked in the white, middle-class suburbs appeared to be less valued by those nurses who worked in the culturally diverse and lower socio-economic status suburbs. However, I was oblivious to these issues when I began the observations and interviews and soon realised I had to maintain a neutral distance. I also had to accept
that I was not a peer, nor did I have to be ‘liked’ to be a good researcher. Similarly, in Case Study Two there was dissention amongst the nurses around who had initiated the new parenting groups, who were seen as ‘better’ facilitators and whose individual style was best suited to the program. Whilst it was important to remain in a neutral position as an external researcher, there were constant attempts to persuade me to do otherwise.

**Observations**

Observation is commonly used alongside interviewing in ethnographic research studies (Tedlock, 2000). Nowhere is sensitivity to culture and subculture more important than in health research, and observations are often the best way to achieve an understanding of workplace culture (Daniel, 1993). Lindolf and Taylor (2002) classify observation in qualitative research into three categories. The ‘Observer as Participant’ involves, as the name implies, someone who becomes a member of the group and is involved in the group’s activities. The ‘Complete Observer’ observes from a location where the participants are not aware they are being observed (Lindlof & Taylor, 2002). In this research I classify myself in the ‘Participant as Observer’ category, as I entered the field as an openly acknowledged investigative observer but did not participate in the group’s activities (Lindlof & Taylor, 2002). With this type of observation, everyone who interacts with the researcher, knows in some way, that they are contributing to the area of interest (Grbich, 1999).

In Case Study One, on the days I visited their workplace as a participant observer, the nurse explained to the families that I was undertaking a study on C&FH nursing practice and reassured them it was the nurse I was watching, rather than them. The families therefore understood that I was observing their consultation with the nurse but would not have an active role. The mother was given the option for me to leave the room though no families asked for this. In Case Study Two, the facilitator of each group explained to all participants that my research interest was in the skills of the nurse and requested permission for me to observe the groups.
When I started observations I had to consciously remind myself to relax, be non-judgmental, and try not to prematurely analyse or interpret what I was observing (J. Mason, 2002). Having to decide what to record as data whilst undertaking observations was initially concerning to me, as I realised I would never get the opportunity to observe that particular event again. This is paradoxical, as the researcher will only understand what is important, or not important, as the research progresses (Lindlof & Taylor, 2002).

Whilst in the field I documented as much as I could, observing the consultations between the mother and the nurse in Case Study One, and throughout the parent groups in Case Study Two. Lindlof and Taylor (2002) refer to these recordings as ‘scratch notes’ which should be developed into field notes within 24 hours of the event. Jotting down events as they occurred was possible in the centre situation but more challenging, and sometimes impossible in the home. During some home visits I was able to sit discreetly away from the interaction between the nurse and the mother where written recording was possible.

In some situations during Case Study One, however, I felt the recording of any written notes was totally inappropriate. These times were always in the client’s home and mostly involved complex families with high needs, such as women with a history of substance abuse or young families living in very poor housing. I felt these families (where often the partner was present) could carry a mistrust towards authority or government agencies and my scribbling of notes in the corner could cause them stress or aggravation. In these occasions, I would audio-record discussions about the family with the nurse in the car as we travelled to the next home visit. I would also audio-record my recollections of the day’s events as well, as my initial thoughts and interpretations, in the car during my hour-long drive home at the end of the day. This information was then transcribed and elaborated upon either that evening or the next morning. It was important that these field notes were developed in this way. It is recommended that observations are written up within 12 hours, to maximise recall (Grbich, 1999). On the occasions I was unable to immediately record data onto the
computer, my recollections had dimmed and I was aware the quality of the data was compromised (J. Mason, 2002).

Field notes provided a critical, first opportunity to write down and hence to develop initial interpretations and analyses (Emerson et al., 2001). Along with the transcriptions of the interview data, I was able to review and reflect on my technique as a researcher and the direction the research was taking. Due to this process, I occasionally adapted the questions I was asking, or altered the techniques I used, when recording observation data.

The focus was on the experience of the nurses within the context of a normal day. Clients were not the focus. Any observations that involved the presence of a client in the home or centre were observed and recorded from the standpoint of the nurse’s responses and actions, and did not contain identifying links or data regarding any individual woman or her family.

THE INTERVIEWS

Interviews are particularly suited to understanding the participants’ perspective and experience (J. Mason, 2002). They were selected as a methodological tool because the nurses’ experience was considered central to the research question. As a researcher I expected the nature of the nurses’ experience to result in words that could only be uttered by someone who has ‘been there’ (Lindlof & Taylor, 2002).

I applied the respondent technique of interviewing described by Lindlof and Taylor (2002) and used a series of open-ended questions to clarify the meanings of common concepts and opinions of the nurses. At the same time I was attempting to determine what influenced the nurses’ behaviours (Grbich, 1999).

Initially I approached experienced C&FH nurses because I was interested in the experienced nurses as sources of valuable data (Kellehear, 1993). However, I soon
realised that I needed to include the experiences of younger and less experienced nurses to capture participants who are not fully acculturated.

Lindlof and Taylor (2002) recommend that interviews be conducted at a time when the participants are relaxed, free from outside pressures and occur in a place safe from interruptions where comfort and confidentiality can be met. In my experience in Case Study One, this was not always possible. It was much easier to accomplish, however, in Case Studies Two and Three. In Case Study One, I usually arranged to undertake the observation and interview all on the same day. This was done for several reasons, firstly so I would not have to interrupt the nurse on two occasions and secondly, I myself faced logistical difficulties in travelling to the area. Thirdly, I wanted to use situations I had noticed during the observations, to explore with the nurses during interview. This resulted in the challenging situation wherein I needed to request to conduct an interview lasting between 60 and 90 minutes, at the end of a work day when both the participant and the researcher would prefer to be going home. I therefore explained to the nurse at the beginning of the day that, with her permission, I would turn on the audio recorder and interview them at opportune moments throughout the day. Hence I collected data in a variety of times and settings, including in the car on the way to home visits, in the centre waiting for the next client, over lunch, or occasionally back at the health centre after seeing all of the clients.

This resulted in, at times, fragmented data collection. Occasionally I ‘lost the moment’ when we arrived at the next client’s house, the next appointment arrived at the centre, the phone would ring or we would be interrupted by a colleague who didn’t realise we were taping. To minimise the effects of these disruptions I would note by hand where we had been interrupted and remind the nurse what we had been discussing when we had the next opportunity to record.

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8 All participants were female
I believe the benefits of interviewing in this way outweighed the disadvantages. The nurses appeared to appreciate that I did not expect them to stay back after work. They were more relaxed with the interview occurring as ‘conversation’ throughout the day and we could sometimes also discuss incidents that had occurred with a mother as soon as the consultation was completed whilst fresh in the mind of both myself and the nurse.

The use of audio-recording was important as it captured the interview exactly and, when transcribed, reproduced the discourse (Lindlof & Taylor, 2002). It also allowed me to participate more fully in the interview. Initially I didn’t trust the recorder to work reliably, but this anxiety lessened after the first few interviews. This distraction, as well as a preoccupation with wondering if what the nurse was saying was addressing my research question, or thinking ahead to the next question, all affected my ability to adequately listen in the first few interviews (Roulston et al., 2003). This is commonly seen in novice interviewers (J. Mason, 2002) and reduces with experience.

I developed a list of general questions referred to by Lindlof and Taylor (2002) as an ‘interview schedule’ (discussed further in the relevant case studies). This technique was used to ensure that all nurses would receive approximately the same questions, although I used spontaneous probes to allow for clarification or elaboration (Lindlof & Taylor, 2002). The use of an interview schedule is recommended for respondent interviews and can be seen to increase the reliability and credibility of the data (J. Mason, 2002).

In my earlier interviews the first question I asked the nurses was ‘how would you describe your role as a C&FH nurse’? I soon learned that this was difficult to answer for some nurses and I felt it made some of the nurses anxious. I therefore restructured the interview schedule and asked a question around the nurse’s professional history. For example, ‘tell me your story about being a C&FH nurse’? The promotion of participant self disclosure about such things as their work history appeared to help
participants to feel comfortable talking about themselves (Lindlof & Taylor, 2002). I endeavoured to use a descriptive and exploratory technique to encourage the nurses to discuss their role and practice. This was to avoid them feeling like I was undertaking a critical analysis of their role and practice, which may have made them feel judged and criticised.

Another common problem with novice interviewers is to miss the opportunity to elaborate on a subject (Roulston et al., 2003). I would often not discover this until I was transcribing, when I would realise I had failed to adequately extend the nurse’s viewpoint or further explore an attitude. This highlighted the need to transcribe the interviews as soon as possible, as I would learn from my mistakes and rectify the problem before proceeding with more interviews.

There is considerable variety in how people transcribe, though detailed transcriptions are encouraged as they offer a true and accurate record of the interview (Roulston et al., 2003). I would endeavour to transcribe verbatim but soon began to omit inconsequential information such as discussing the traffic, or the finer details of a tapestry course one nurse did in the 1980s. However, I soon learnt to monitor for signs of fatigue when I was transcribing as I noticed I sometimes became bored with the information and began to be less selective on what I would transcribe. I realised this was suboptimal, as it is impossible to decide what is going to be important data, particularly when tired. I therefore resumed almost complete verbatim transcription, omitting only the obviously unrelated, and took a break when fatigued.

The ethics involved in data collection
There were several nurses, particularly in Case Study One, in whom I detected a change in their attitude by the end of the day I had spent with them. At the beginning of the day some of the nurses seemed aloof and detached and showed little interest in the research. They were slightly nervous or anxious, and understandably guarded. I felt it was important not to attempt to interview them immediately and would allow
some time to develop rapport. By the end of the day, however, some of the nurses complimented and congratulated me on the work that I was doing. One nurse said:

_It is really important that a nurse like yourself is doing this sort of stuff. You know, actually one of us. We need people like you – I couldn’t do it but I think it is great that you are doing it_ (CN9.2).

Another nurse asked me at the end of the day what other nurses I would be working with in her team. When I told her I didn’t know, she suggested several whom she thought would be ‘good’. She offered to ring one of them immediately as this particular nurse was going on long-service leave at the end of the week and worked in one of the clinics that serviced mostly culturally diverse clients. She said to the other nurse on the phone;

_You know Sue who is doing the research? It is really important what she is doing because she will be able to change things for us, you know. She is doing really great stuff on how we work and our role and stuff. Will I put her on and she can talk to you?_ (CN15.1).

The effort and sensitivity I had invested in building rapport and trust was effective with these nurses. They had become supporters, advocates and recruiters for the study.

I had never mentioned my ability to ‘change things’ for the participants. I felt guilty for being so friendly and ‘charming’ or ‘seducing’ them into disclosing their thoughts and experiences. For not only was I probably not going to able to change things for them (at least not in the short term), but I was possibly going to criticise their work practices.

Researchers are asked to avoid harm (non-maleficence) and to produce some positive and identifiable benefit (beneficence) (Murphy & Dingwall, 2001) and I wondered if I were betraying their trust. Patai (1991) states that truly ethical research is impossible and the research relationship is irreducibly oppressive and exploitative. However, Wolf (1996) suggests exploitation only occurs when researchers use their power to
achieve their objective at real cost to the participant. I do not believe that there was any real cost to the participants in my research. The only ‘cost’ would be disappointment, if or when they discover that I am critical of their practices, in spite of my intentions to focus on systems rather than individuals.

The data collection process was therefore not easy. At first glance it was a relief to be away from the computer and books and back in the land of ‘real’ mothers and babies. But data collection was much more important than watching nurses work and talking to them about their practice. It was a significant journey into qualitative research methods and learning how to explore and understand that attitudes and behaviours of a group a nurses and their marginalised clients. It raised issues that I could never have predicted and taught me the importance of reflection, not only in clinical practice, but in the intellectual journey of academic writing.

**DATA ANALYSIS**

The qualitative analysis software program Atlas TI, Version 5, was used for the storage, organisation and retrieval of the data.

Data were analysed using qualitative content analysis whereby the application of codes were developed with an emphasis on the ‘why’ and ‘how’ aspects of contextual interpretation, rather than a focus on numerical strengths (Grbich, 1999). Analysis occurred on three levels. The first level involved careful reading of the data whilst data collection was still in progress. This was important to identify gaps in information to be addressed in later interviews or observations (Grbich, 1999). Second level analysis involved the application of codes or themes that addressed broad categories such as ‘role’, ‘education’, ‘inter-professional collaboration’, etc. This involved several readings and rereading of the data. The broad categories were then further subdivided into subcategories under the original heading. For example, under ‘role’, subcategories emerged such as ‘psychosocial support’, ‘networking’ or ‘monitoring’ (Grbich, 1999).
As suggested by Wolcott (2001), I attempted to make this dimension of the study as strong and as systematic as possible. I found myself becoming increasingly challenged over the multiplicity and complexity of the analysis results and questioned my ability to produce neat, single explanations. Wolcott, however, reassured me that good qualitative research ought to reveal complexity rather than reduce itself to single and simple explanation (Wolcott, 2001).

The use of description in the data analysis also caused anxiety as I questioned my ability to conceptualise the results into deep and theoretically based meaning. Wolcott, here, was reassuring again, warning novice researchers of the dangers of ‘intrusive analysis’ that presents little of the data and too much of the researcher’s opinion. He highlights, instead, the benefits of allowing the data to speak for itself and recommends the subtle balance between description and interpretation (Wolcott, 2001).

However, it was also necessary to trust my ability to draw conclusions from the analysis in a way that could explain the results within a health services research framework. The perceptions and observations of the 33 participants required consideration within the context in which they worked and the dynamics of the system that employed them. Additionally, I was required to place the findings within the context of the wider profession, that is, C&FH nursing. By doing this, it was hoped that the research findings would be useful to individual members of the workforce, the professional association that supports the workforce, the employers who employ them and the policy-makers who direct their practice.

**CONCLUSION**

In this chapter health services research has been introduced and explained as a useful and appropriate framework to be used to guide the research. This chapter has outlined the three case studies that would employ an ethnographic approach and use qualitative methods to explore contemporary C&FH nursing practice within the context of changing policy. It has also described how personal reflexivity guided data collection.
and analysis. I have situated myself within the research and presented some of my own considerations and challenges in the journey of data collection and analysis. I have attempted to establish a methodologically sound platform from which to describe the case studies that follow in the next three chapters. The following chapter introduces Case Study One, wherein C&FH nursing practice in the provision of support to individual families is investigated.
Chapter Four

Case Study One:
Provision of Services to Individual Families
Chapter Four: Case Study One: Provision of Services to Individual Families

INTRODUCTION
The majority of C&FH nursing services in NSW are provided as individual interactions between the C&FH nurse and the family, usually the mother and her infant. The next two chapters explore, describe and analyse C&FH nursing practice when providing care to individual families, either in the home or the C&FH centre. Nurses working with clients disadvantaged by language or income were the focus of this study, because these families are known to have greater health needs (NSW Health, 2002a) and traditionally do not access the service (Aldrich et al., 2005; Ochiltree, 1991). Working with disadvantaged families also provides particular challenges for nurses that are different from those encountered in providing services to mainstream population groups (Spence, 2001).

This chapter provides an overview of the location in which the nurses worked and describes the ethnographic methods used to explore and analyse C&FH nursing practice in this particular setting. The data presented are based on the nurses’ own perceptions of their role and how this role has changed over the past 20 years. Of particular interest are the changes experienced since the implementation of the Families First initiative and its associated policy and guidelines. Chapter Five examines some of the challenges and barriers in the nurses’ ability to be effective, in the context of shifting policy and health service delivery.

METHODS
Aims
- To explore the role of the C&FH nurse working with disadvantaged groups and describe how that role has changed since the implementation of the Families First initiative (Chapter Four).
• To identify factors that impact on the ability of C&FH nurses to effectively provide support to families disadvantaged by language or income (Chapter Five).

Ethics approval
Ethics approval was sought and obtained from the Area Health Service (AHS) responsible for the service as well as the University of Technology, Sydney’s Human Research Ethics Committee. Information statements and consent forms supplied to the participants are provided in Appendix One and Appendix Two.

SETTING
The AHS where this research was undertaken differed significantly from other AHSs in NSW, due to the restructuring of the C&FH nurses’ role that occurred in the late 1980s. Child and family health nurses at that time were amalgamated with generalist community nurses and given a new title, ‘Primary Health Nurses’ or ‘PHNs’. Primary Health Nurses offered home-based care within the community to clients from the ‘cradle to the grave’, having responsibility for early childhood, palliative care and aged care. Child and family health nurses completed a one-month education module on generalist community nursing and the generalist nurses received similar preparation in C&FH. In the late 1990s, with the implementation of the Families First initiative, PHNs were restructured back into two streams, C&FH and generalist nursing, with the latter group retaining the title of PHNs.

Two sectors (out of a total of five sectors within one large AHS servicing 12,000 births annually) were approached for this research. These sectors were chosen because of the large numbers of non-English-speaking families and public housing communities within them. Both sectors contain large variations of wealth and ethnicity with nurses in each sector working in suburbs of middle-to-high income families through to suburbs featuring many low-income and disadvantaged families.
Sector One is located within the south-western suburbs of Sydney, approximately 25 kilometres from the Sydney city centre. It was chosen for its large proportions of non-English-speaking residents, including recent arrivals and refugees. Sector Two is situated on the urban fringe of Sydney, approximately 35 kilometres from the city centre, and includes both urban and rural communities. It was chosen due to the large proportion of public housing estates that fall within its boundaries and because it supported almost double the C&FH nursing staff per birth ratios than Sector One. As shortages of human resources are often cited as a major barrier to effective care in the health industry (Crowley & West, 2002), it was thought useful to explore and compare these issues within the sectors.

**Sector One**

Based on data collected in the 2001 national census, the local government area (LGA or ‘council’) situated in Sector One contains a larger percentage of people born in non-English-speaking countries than any other local council in Australia (Department of Immigration and Multicultural and Indigenous Affairs, 2003). Over 50% of residents in the LGA were born overseas, with over 95% of these being from a non-English-speaking country (ABS, 2002).

The Sector One population is characterised by ethno-religious cultural diversity resulting in unfamiliarity with Western/European cultures, different languages and levels of English language proficiency and difference in terms of availability of existing networks (family, cultural, social) from which social support can be derived (Sector One City Council, 2003).

Residents from non-English-speaking countries were shown by the council profile to have a higher degree of social disadvantage when compared to English-speaking residents in the same area and non-English-speaking people in other areas of Sydney (Sector One City Council, 2003). This area also has high proportions of asylum
seekers and refugees on Temporary Protection Visas\(^9\) with limited ability to work or seek publicly funded medical assistance (Sector One City Council, 2003). Many of these clients have experienced severe trauma, are unfamiliar with Western society and its laws, have limited proficiency in English, and come from cultures with different parenting, work and social practices. Hence these individuals and families require extensive assistance and support.

Within this LGA, children under the age of ten were almost twice as likely to be at risk of poverty as Sydney children overall and more likely to live in households where there are no employed adults. The proportion of children aged 0-4 years living in households with incomes of less than $400 a week was twice as many as Sydney as a whole (Sector One City Council, 2003). Sector One also suffers from low rates of Internet access, poor transport, and high rates of imprisonment (over twice the Sydney rates), all of which contribute to social isolation and disadvantage (ABS, 2002).

**Sector Two**

Situated on the south-western fringe of Sydney, Sector Two has a total population of 145,860 people, who reside in both urban and rural areas (ABS, 2002). There are suburbs within this area that suffer a significant degree of low socio-economic status. Some of the more disadvantaged suburbs targeted in this research show higher proportions of children under four years of age (13.9% in one suburb versus 8% across the area and 6.7% across Sydney) (Sector Two City Council, 2003). Across Sector Two, Arabic (2.3%), Spanish (1.8%) and Filipino (1.5%) represented the largest proportions of languages other than English spoken in the home (ABS, 2002).

A weekly income of less than $400 a week was reported to be as high as 43.8% in one of the suburbs included in the research, 23% across the area, and 16.9% across Sydney. The unemployment status was reported to be 30.6% in the targeted suburb,

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\(^9\) A Temporary Protection Visa (TPV) is a temporary two year visa given to some refugee applicants. TPV holders do not qualify for publicly funded health or education.
8.5% across the area, and, 6.1% across Sydney (Sector Two City Council, 2003). As expected, public housing (rented from the government) was high in the targeted suburb, at 80.9%. This was compared to 14% across the area and 5.1% across Sydney (ABS, 2002).

**Study participants**

Child and family health nursing services are provided by a team of 24 nurses (17.96 full-time equivalents (FTEs)) in Sector One and 43 nurses (36.91 FTEs) in Sector Two. Only those nurses who were providing services in the suburbs reporting high levels of disadvantage by either ethnicity or income were invited to participate in this research (n=25). After contacting the managers of each of the teams, I was invited to present the research to the nurses at a staff meeting. Following presentation of the research, all nurses working with disadvantaged groups were invited to participate.

A total of 17 C&FH nurses out of a possible 25 across the two sectors agreed to participate in the research. Fifteen of the nurses were engaged in clinical practice and two were employed in managerial or policy positions within the AHS. The nurses were aged between 26 and 62 years of age, with a mean age of 47 years and a median age of 49 years. Eleven of the 17 nurses (65%) were also registered midwives and all held formal qualifications in C&FH nursing. The range of years’ experience as a C&FH nurse was between two years and 36 years, with a mean of 14 years and a median of 10 years.

These data are summarised in Table 3 below.

**Table 3: Age and years’ experience of nurses**

<table>
<thead>
<tr>
<th></th>
<th>Range</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>26-62 yrs</td>
<td>47</td>
<td>49</td>
</tr>
<tr>
<td>Years’ Experience</td>
<td>2-36 yrs</td>
<td>14</td>
<td>10</td>
</tr>
</tbody>
</table>
Two of the nurses were members of the Child and Family Health Nurses Association (CAFHNA), the professional association of the C&FH nurses. Four of the fifteen nurses were born in countries outside Australia, with three of those four speaking languages other than English as their first language. Twelve C&FH nurses worked full-time and five worked part-time. Two of the fifteen nurses held degrees in nursing, one held a degree in social science, two had graduate diplomas in community health and one held a master’s in community health, specialising in midwifery. Table 4 summarises the educational qualifications for the 17 participants.

Table 4: Educational qualifications of the nurses

<table>
<thead>
<tr>
<th>Hospital program</th>
<th>Degree (nursing)</th>
<th>Midwifery</th>
<th>C&amp;FH certificate</th>
<th>Grad Dip Comm. Health</th>
<th>Master’s</th>
<th>Other</th>
<th>CAFHNA member</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=15</td>
<td>2</td>
<td>11</td>
<td>17</td>
<td>2</td>
<td>1</td>
<td>1*</td>
<td>2</td>
</tr>
<tr>
<td>% 88%</td>
<td>12%</td>
<td>65%</td>
<td>100%</td>
<td>12%</td>
<td>6%</td>
<td>6%</td>
<td>12%</td>
</tr>
</tbody>
</table>

*(social science and psychiatric nursing certificate)

**Differences in service provision across the two sectors**

Due to autonomous administration between the five AHS sectors, marked variations were found in the structure of services across the two sectors. Both sectors managed the teams of C&FH nurses from a ‘base’ community health centre and each nurse serviced one or two C&FH centres within a specified geographical area. Sector One nurses were responsible for families with children aged from birth to five years, whereas Sector Two nurses catered to families with children up to fifteen years of age (though the vast majority of their workload was consumed within the 0-5 year age range). Differences between the sectors in terms of staffing level, age range of clients and number of centres offering C&FH services is provided in Table 5 below.
<table>
<thead>
<tr>
<th></th>
<th>Staffing FTEs</th>
<th>Number of C&amp;FH Centres</th>
<th>Birth ratio per 1 FTE*</th>
<th>Age range of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector One</td>
<td>17.96</td>
<td>16</td>
<td>1:162</td>
<td>0-5yrs</td>
</tr>
<tr>
<td>Sector Two</td>
<td>36.91</td>
<td>30</td>
<td>1:105</td>
<td>0-15yrs</td>
</tr>
</tbody>
</table>

*determined through home visit referrals*\(^{10}\)

Centre hours across both Sectors varied according to the size and demographic of the community they serviced. Some of the busier centres were open five days a week, the majority were open two or three mornings a week and some centres were only open once or twice a week. Several C&FH centres in Sector Two were open for three hours every fortnight.

Minimal home visiting had historically been part of the service across the two sectors and appeared to target high-risk families only. Since the implementation of the Families First initiative in 1998, universal home visiting was introduced and all families are now offered the first visit as a service in the home. This first visit is supposed to occur within two weeks of discharge from the hospital.

‘Drop-in’ clinics\(^{11}\) have been a longstanding characteristic of C&FH nursing services in NSW and across Australia. Mothers\(^{12}\) traditionally were encouraged to attend

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\(^{10}\) Available data on births was restricted to local public hospitals only. As many women birthed out of area, the most reliable data to use to determine staff ratios came from the referrals they received to undertake a home visit. This included discharge summaries from maternity services for all women residing in the local geographical area. Data were sourced from Families First Statistics 2003-04 and provided by the AHS.

\(^{11}\) ‘Drop-in’ clinics are C&FH centres that are open to families to attend during the stated hours and no appointment is required.

\(^{12}\) Mothers have, and continue to be, the main users of C&FH nursing services. Whilst fathers, grandparents and other carers also present to and are included in these services, the nurses usually referred to the carer of the infant as the mother and hence this is used predominantly throughout this chapter.
weekly until six weeks and fortnightly until six months for a weight check and to address any other concerns or problems experienced by the mother. In addition to universal home visiting, Sector One also provided drop-in services once or twice a week at three of the 16 centres, with the remaining 13 centres offering services through individual appointments only. Health and development checks as recommended by the NSW Personal Health Record (or ‘blue book’) were offered in this sector at a formal appointment. ‘Drop-in’ clinics were offered for weight checks or if the mother had any concerns or queries. Appointments are provided in 30-minute time slots and in some centres these times are booked out for up to six or eight weeks in advance.

Home visiting services were also provided by the staff of Sector Two. In addition, the 30 C&FH centres in this sector were available as ‘drop-in’ services only with health and development checks carried out in this time.

The facilities that housed the centres also varied across, and within, the two sectors. Some centres were housed in modern contemporary spaces, others shared community venues in shopping centres or community cottages, and several operated from temporary buildings located in school grounds.

Data collection
Data were collected during 17 formal interviews, each audio-recorded, and 13 days of participant observation. Fifteen of the 17 participants were involved in clinical practice as C&FH nurses. Following interview, two participants had transferred to centres that serviced predominantly Caucasian, middle-class communities. As the focus of this research was around the nurses servicing families disadvantaged by low income or language, these two nurses were excluded from observation. The remaining 13 C&FH nurses were observed in clinical practice each for one working day. Of the 13 nurses, four were observed seeing clients in the home, four in the health centre and five of the nurses were observed in both the home and the centre. Due to paperwork and other administrative duties that had little relevance to the research, each nurse

Same but different. Chapter Four: Case Study One

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averaged approximately six hours of clinical observation in each working day. This resulted in a total of 75 hours of observation data being collected. Field notes also supplemented observation data. A total of 55 nurse-client interactions were observed during the 75 hours. Of those, 17 interactions took place in the home and 38 occurred in the health centres. A breakdown of the number and type of client interaction is shown in Table 6 below.

Table 6: Number and type of nurse-client interactions observed

<table>
<thead>
<tr>
<th></th>
<th>Drop-in</th>
<th>Appointment</th>
<th>Total</th>
<th>‘No Show’ *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Centre</td>
<td>23</td>
<td>15</td>
<td>38</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>First Visit</td>
<td>Subsequent visit</td>
<td>Not home</td>
<td></td>
</tr>
<tr>
<td>Home Visits</td>
<td>12</td>
<td>5</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>Total clients seen</td>
<td></td>
<td></td>
<td>55</td>
<td></td>
</tr>
</tbody>
</table>

* ‘no show’ refers to the number of women who did not present for allocated appointment times – 14 out of a possible 29 appointments did not present.

A semi-structured in-depth interview, lasting between 45 and 90 minutes, was carried out with each of the 17 participants. To reduce potential inconvenience to the nurses, most interviews were conducted in stages throughout the day that the observations occurred, with large sections carried out at lunchtime, driving in the car on the way to see a client, or waiting for a client to arrive at the health centre. To explore issues raised within a particular consultation with the client, additional data were also collected opportunistically between clients if time allowed. Data were collected over an eight-week period from October to November, 2003.

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13 The C&FH centre refers to the venue from which the C&FH nurse worked and saw clients. However, the nurses most often referred to services run from the Health Centre as ‘clinics’. ‘Clinics’ usually refer to the service run from the centre – that is, a three hour clinic was offered, for example, on a Monday morning from 9-12 noon, either as a ‘drop-in’ or by appointment. Throughout data-collection, however, the participants often used the terms ‘clinics’ and ‘health centre’ interchangeably.
Open-ended questions directed the interview to explore the role of the C&FH nurse working with families disadvantaged by language or income. Categories of questions included the experience of the nurse, their role as a C&FH nurse and how that role had changed, factors which influence their ability to fulfil their role, information about the client group they serviced, collaboration with other service providers, and finally, the education they had received to prepare them for both the role and working with their particular client group. A full list of questions is included in Appendix Three.

**Data analysis**

Data collected yielded 678 pages of transcribed interview data for analysis using qualitative content analysis (Grbich, 1999). Interviews were transcribed verbatim and entered into the qualitative software program Atlas TI, Version 5. Analysis occurred on three levels. The first level involved careful reading of the data whilst data collection was still in progress. This was important to identify gaps in information to be addressed in later interviews or observations (Grbich, 1999). Second-level analysis involved the application of codes or themes that addressed broad categories such as ‘role’, ‘education’, ‘inter-professional collaboration’, etc. This involved several readings and rereading of the data. The broad categories were then further subdivided into subcategories under the original heading. For example, under ‘role’, subcategories emerged such as ‘psychosocial support’, ‘networking’ or ‘monitoring’ (Grbich, 1999).

**RESULTS**

The findings presented in this chapter centre on the role of the C&FH nurse and how that role has changed since the implementation of the Families First initiative, implemented in this AHS in 1998. The findings are presented and discussed in light of other research relevant to the particular category. The major components of practice were categorised into four areas: growth monitoring and surveillance; education and health information; referral and networking; and, psychosocial support. These broad areas are discussed in detail below. Firstly, data on how the nurses’ role had changed under Families First is presented.
**The Role of the C&FH Nurse**

The C&FH nurses’ perceptions of their role indicated a broad range and diversity of skills and knowledge. The role was heavily influenced by the service structure and workload expected of them by the AHS. The range of responses and the practice observed in data collection suggested some of the nurses encompassed a more contemporary practice whilst others continued to focus on the more traditional aspects of the C&FH nursing role.

**Growth Monitoring and Developmental Assessments**

Growth monitoring and development assessment were reported by all nurses as one of the major components of their role. Checking the infant’s weight, length and head circumference followed by a physical assessment dominated the observed clinical encounters. The physical assessment depended on the age of the infant. For example, the first visit of a newborn usually involved a head-to-toe examination of the infant including fontanelles\(^\text{14}\) (size and tension), face, including mouth (to exclude cleft palate), torso, genitalia, anus, skin, limbs and hips (checking for dysplasia or ‘clicky hips’). Reflexes were also checked, depending on the age of the infant, which for a newborn included the startle and the walking reflexes.

The weight, length and head circumference were measured as recommended by the development checks\(^\text{15}\) listed in the ‘blue book’, but all nurses carried out a minimum of a weight and often a length assessment each time they saw an infant. There was an AHS policy directive that any anthropometric measurements (weight, length and head circumference) taken should be recorded at the top of the progress notes for each consultation (SWSAHS, 2003). This documentation directive promoted easy identification in subsequent visits by other practitioners but highlights the importance still placed on the measurement of infants and children within C&FH nursing practice.

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\(^\text{14}\) The ‘soft spot’ on the baby’s head where two or more sutures meet.

\(^\text{15}\) Development checks are recommended at birth (attended in hospital), 1 to 4 weeks, 6 to 8 weeks, 6 to 8 months, 18 months, 2½ to 3½ and 4 to 5 years.
This was further confirmed through the interviews with the participants and through observations of their practice. Growth monitoring and surveillance have also been found to dominate health visiting practice in the UK (Knott & Latter, 1999).

The regular and frequent weighing of babies is not supported by Australian research. An NHMRC review found insufficient evidence to support screening for failure to thrive, though there was fair evidence to support screening for obesity (NHMRC, 2002). The NHMRC recommended that routine monitoring of weight occur at birth, 6-8 weeks, and 8-12 months, although it emphasised that this should not constitute a ‘screening program’ (NHMRC, 2002). Participants in this research, however, identified that the monitoring of the infants’ growth provided a legitimate and often acceptable reason to gain access to a family. The-long standing tradition of growth monitoring within the C&FH nursing profession resulted in a service that was acceptable to most families in the community. The nurses identified that other health professionals such as social workers and psychologists had less obvious access to clients and might not be as acceptable. The participants in this research reported that many babies did not require the frequency of weighing that occurred, but it is what the parents wanted of the service. As this nurse explained:

*I guess the sort of things that families value about nurses is the stuff about monitoring the growth and development, I think they do value that, even though we are kind of saying that that is not all that important but it gives you a bit of an entrée into a family depending on how you use it. I think also our understanding of some of the common childhood illnesses and disease processes. They rely on the nurse to help them identify when things are abnormal, I think that is what sets us apart from all the other counselling-type professions who say they can do our job (CN16).*

The weighing of babies has also been reported to be the ‘ticket’ to health visiting in the UK and a major reason why women access the service (Bowen et al., 2000; Sefi & Macfarlane, 1985).
Education and health information

Closely linked to the traditional role of growth monitoring, and continuing to dominate C&FH practice today, was the role of the nurse as ‘educator’. The nurses strongly believed the focus of their practice was in the promotion of health and the prevention of problems. The nurses provided this information to women primarily on an individual basis, although many nurses were also involved in structured parenting groups covering common topics around parenting such as sleep and settling, childhood safety and infant nutrition (such as breastfeeding and introduction to solids).

Examples of health information and advice given by the nurses included, ‘here is a pamphlet on the ages and stages of your baby’s growth so you can help her reach her milestones through play’ (Obs:CN1.1), and ‘it is important that you place him on his back to sleep, do you know the recommendations around the prevention of SIDS\(^\text{16}\)?’ (Obs:CN8.1).

The distribution of health information pamphlets, and the adhoc prescription of advice, support the biomedical model of disease prevention and do little to involve the client or contextualise their experience (Whitehead, 2001). This approach reinforces the client as the passive recipient of health care, often blaming the victim for non-compliance (Norton, 1998; Whitehead, 2001). Many of the C&FH nurses provided written information for the parents to read at another time, as they believed it was difficult to remember everything that was said during the consultation. The parents could then decide if the information provided was relevant to their needs or not.

The nurses believed that they had a responsibility to assist each parent to support their infant to achieve his or her maximum potential. This involved practices which

\(^\text{16}\) SIDS: sudden infant death syndrome, or ‘cot death’
encouraged development such as ‘tummy time’\textsuperscript{17}, the importance of play and self-feeding as well as suitable nutrition and sleeping behaviours.

\textit{I’ll help them with the parenting skills, like just general mothercraft or what they can do to help their baby develop … or talk to them about nutrition and solids, when to start it and give them information on what sort of solids (CN2.1).}

There were many instances recorded in the observation data where the nurse promoted infant development and provided reassurance and education around infant behaviour and common problems. The women asked an enormous variety of both common and unusual questions, some examples of which include: ‘why is my baby’s skin dry?’, ‘my baby’s legs sometimes twitch when I change his nappy, is that normal?’, ‘how often should he poo?’, ‘why do her eyelids move so fast when she is asleep?’, ‘when can I put her in a jolly jumper\textsuperscript{18}?’, ‘why do his feet turn in?’, ‘is his penis too small?’. All of these questions and anxieties expressed by the mothers were about normal infant development and behaviours and the nurses were able to ‘normalise’ them and reassure the mother. This breadth of knowledge and wisdom in bringing concerns down to confidence-building interactions indicates the uniqueness and expertise of the nurse that could not be replicated by many other professionals.

Support around breastfeeding was also seen as an important component of the nurses’ role. Despite this, breastfeeding rates in both sectors were much lower than state and national averages. The nurses reported that the low breastfeeding rates were linked to the high levels of socio-economic disadvantage in both sectors, which is known to affect breastfeeding rates (Dykes, 2003; Hamlyn et al., 2002). As one nurse working in a large public housing area observed, ‘\textit{a lot of these girls never intend to breastfeed,}

\textsuperscript{17}‘tummy time’ consists of the young infant (2-6 months old) spending increasing amounts of time lying on his or her abdomen while awake. This practice is known to improve strength in the neck and upper body. It is widely advocated amongst C&FH nurses to promote development.

\textsuperscript{18}A ‘jolly jumper’ is a soft harness suspended from a door frame with a coiled spring. It keeps the babies upright and allows them to bounce themselves in a reflex action as their feet come in contact with the floor. Adequate head control is required to do this safely.
they just don't want to … Quite often it will be 'nah my boyfriend doesn't want me to' (CN7.2).

Some of the nurses reported to be self-conscious of appearing ‘to push breastfeeding too hard’ in fear that it will ‘drive clients away. I am here to support them so it is a fine line’ (Obs:CN7.2). This seemed more of a concern when the nurse had ongoing contact with the woman. That the mother was continuing contact with the nurse suggested she liked this C&FH nurse and felt safe and comfortable. The nurse was reluctant to be seen to be ‘pressuring’ her and felt this pressure to breastfeed could potentially compromise their relationship. In one consultation in the centre I observed the mother of a three-week–old infant who was beginning to wean her baby off the breast and the nurse simply said to the mother ‘maybe the breast isn’t best for you’ (Obs:CN7.2). There was no attempt by the nurse to explore the reason for weaning, nor encouragement or support to continue to breastfeed.

The tension between being liked by the woman and promoting good parenting practices was identified by one participant as a problem. She described it in this way:

Like this idea of seeing people for health outcomes was confused with just seeing people because it made them feel better, because they liked them and it made the clients feel better. But when I said things like ‘what health outcomes have been achieved’, some of the nurses don’t even understand that they are looking for health outcomes (CN17.1).

The nurses were also a source of information for many other non-health issues as well. For example, their knowledge of benefits and resources was observed when one nurse informed a mother that if her husband earned less than $32,000 per year, she was entitled to childcare for her three young children, three days a week (Obs.CN8.1). Other examples of non-health information nurses offered included entitlements to public housing, tenancy matters, and where to access non-English-language books from the library.
Some C&FH nurses promoted their role as a community resource by providing information and education on particular subjects as requested by other community services, such as playgroups, schools, and church groups. This would involve the nurse presenting sessions on topics such as toddler behaviour or sleep and settling as a guest speaker. Often the nurse would co-ordinate or liaise with a fellow health professional, such as a nutritionist, to present information on introducing solids.

The nurses in this case study were shown to deliver information in the health education model described in Chapter Two rather than a health promotion model. This supports research findings from the UK wherein health visitors were also found to primarily deliver health information (Mayall & Foster, 1989; Whitehead, 2001). By doing this they often ignored the health experiences of the client and separated the individual from the social, physical and environmental context in which they lived (Norton, 1998). There is a growing body of evidence that suggests health education advice often fails to produce any behavioural change, because the links between knowledge, beliefs, attitudes and behaviour are extremely complex and are influenced by many factors other than information (Cowley, 1997; Mackintosh, 1996; Norton, 1998).

Health education embodies a range of values and attitudes that may not be shared by the recipients of health care (Bloor & Macintosh, 1990). When health education occurs as ‘dialogue’ in equal partnership between practitioner and client, the nurse acknowledges the limitations of her/his own knowledge and values the knowledge of the other person (Mayall & Foster, 1989). However, when delivering health education within the expert model, the nurse has predetermined objectives and sets out to change behaviour to meet these objectives (Mayall & Foster, 1989). This model is less likely to be effective, because people’s co-operation is required for behavioural change to occur (Mayall & Foster, 1989).
Referral and networking

Referral to other services was repeatedly mentioned as an important aspect of C&FH nursing practice, often at a cost of their own skills. One nurse described: ‘we used to manage lots of things but we now refer on so instead of becoming a better counsellor I have probably lost some of those skills because we are supposed to refer on all our depressed clients’ (CN10.2). All of the nurses believed that they were now operating with many more referral agencies in the community than ever before. This differs from research from the UK and Sweden which has found a decrease in the amount of agencies to which health visitors may refer their clients (Appleton, 1996; Baggens, 2001).

The nurses saw their role as a gateway to a whole range of other services that could support mothers and their babies. Some of the more common services they referred to were influenced by the area in which they worked. These included language-specific services for non-English-speaking clients, counselling services, secondary and tertiary parenting services (such as Jade House or Karitane19), speech pathologists and the Department of Community Services.

A second feature of the referral component of the C&FH nurses’ role was to link their clients to community-based, non-government services that were seen to offer social support and reduce isolation. Many of these services were newly available as a result of funding through the Families First initiative and included mothers’ groups, volunteer home visiting, playgroups, ethno-religious groups and morning teas. The range of services now available required the nurses to be aware and updated on current facilities and services within their immediate community, as well as in the broader area. Many of the nurses had photocopied leaflets, developed locally and at low cost, to give to women with relevant information and contact numbers. I observed the nurses offering this information on each first home visit and on subsequent visits if the

19 Secondary and Tertiary referral services for families with parenting issues such as sleep and settling or breastfeeding problems.
opportunity arose. The promotion of participation in community activities and creating supportive networks has been described as a community development approach to C&FH nursing services (Whittaker & Cowley, 2003).

The nurses repeatedly commented that their role was only to inform the woman of the services and the uptake of the service was the responsibility and choice of the client. Five of the 17 nurses reported that many women were not accessing this optional and extra support. One of the reasons the nurses believed was responsible for the lack of uptake of additional services in the research setting was the woman’s ethnicity. Women, particularly those who had not been in Australia for very long, and who did not speak English as their first language, were particularly difficult to engage in community activities. Some nurses believed the partners of these women were also influential in whether the women participated, with some husbands preventing access by the wives.

**Psychosocial support**

Concurrent with these other aspects of their practice described above, many C&FH nurses readily identified an equally important, though harder to describe service, that one nurse summarised by saying ‘just being there for the mother’ (CN4.2). Other nurses described a similar concept and labelled this as ‘supporting’, ‘listening’, ‘encouraging’, ‘enabling’, ‘empowering’, ‘reassuring’ and ‘guiding’. As another nurse explained ‘I think sometimes all they need is to be told they are doing a great job and they are really a good mother. I think that means a lot’ (CN7.2). This aspect of their practice is harder to measure and more difficult for the nurses to document, given the restrictions on their time placed on them by the AHS. Nonetheless, it seemed integral to the success of both initial engagement with women and ongoing access. ‘Supporting the families to enjoy their children, and their role of parents’ (CN9.2) was also described.

Ways in which the nurses expressed or demonstrated the provision of psychosocial support to families was by the nurses’ indicating interest in the mother and providing
ongoing confirmation and reassurance that she was doing a good job. Phrases I heard that captured this affirmation of the mother included ‘you ought to be congratulated’ (Obs: CN9.2), and ‘you are doing such a great job’ (Obs: CN2.1). The majority of the nurses demonstrated reassuring statements of this kind, although there were occasions where nurses were not observed providing such phrases of support.

The nurses often showed an ability to understand or empathise with the client, attempting to see the situation from the woman’s perspective. Examples of this ability was evident in such comments as ‘that must be really difficult as a single mother’ (Obs: CN7.2) and, ‘you must find that very stressful’ (Obs: CN2.1). Another nurse seeing a 20 year old mother followed up on a previous consultation by asking ‘has that falling out with your friend, that you were telling me about last time, all settled down?’ The woman replied that it had and the nurse said ‘I am glad because I saw how it really affected you that day. It was a bad time because we all feel vulnerable when we have just had a baby’ (Obs: CN9.2). This C&FH nurse validated the mother’s experience, remembering the discussion and recognising its impact, whilst offering the opportunity for the mother to further discuss it. These examples demonstrate the important aspect of the nurses’ role that allows them to recognise and address social wellbeing and distress as well as physical health and development issues.

Emotional support was identified as being most important when working with ‘disadvantaged’ groups because many of these women had so little support in other aspects of their lives. Poor self-esteem and low confidence in their ability to parent also were seen by the nurses to contribute to the complexities in their lives.

These mums have never had role models; they haven’t learnt basic life skills and no one has ever told them that they can achieve anything. By listening to them and reassuring them maybe I can help them believe in themselves and their ability to parent (CN7.2).

The psycho-social aspects of maternal support have been a longstanding component of C&FH nursing practice both in Australia (O’Connor, 1989) and abroad (J. Clarke,
Chalmers identified that much of the health visitors’ psychosocial support in the UK concentrates on reassuring parents, normalising infant behaviour and parental emotions (K. Chalmers, 1993). By incorporating an holistic approach the health visitor includes not only the mother-child dyad, but extends to the whole family (Cowley, 1995). These aspects of C&FH nursing practice are receiving prominent attention in policy documents and guidelines as part of the Families First initiative in NSW (NSW Health, 2002b).

Environmental, cultural and community influences on the family unit also guide the practitioners’ practice (Cowley, 1995). Cowley’s work showed that compassion and the ability to listen and engage the family on its own terms contribute to successful nurse-client relationships. In a UK study on the role of the health visitors in supporting vulnerable families, Appleton (1996) reported actions that included: the offer of an accessible service; boosting parenting skills and parents’ self-esteem; encouragement; advocacy; provision of advice; and, working in partnership with clients.

One nurse felt she had to defend her role in providing reassurance to management, with the justification that her clientele was very isolated. She disclosed that her manager questions her practice because many women were frequently using the service, calling them the ‘worried well’.

But maybe the reassurance I provide them gets them through the next week. Maybe you can’t measure outcomes as far as breastfeeding rates or crime prevention but for some of these women, their weekly or fortnightly visit to me is a highlight (CN9.2).

The ‘preventative’ aspect of this nurse’s work was recognised by herself but not her manager.

An important aspect of the nurses’ practice was to support families to improve their ability to parent. As one nurse expressed:
I think the best way to change behaviour long term overall - it has to come from within and our job is to help that happen, to inspire them to want to change from within, not just because we told them to or that kind of thing - you know an intrinsic sense of ‘this is right for me’ (CN17.1).

Whilst the intent to assist parents to maximise each child’s potential was evident in all of the nurses’ practice, the importance of their potential to be achieved from within each mother was only described by one C&FH nurse. As the nurse explained:

And this is not achieved through weighing babies or checking milestones which some nurses still base their practice on. It is about supporting them to be in the environment where that change is possible and where the woman wants to make that change (CN17.1).

### Child protection

Much has been written in the UK literature around the importance of the health visitors’ role in child protection (Fagerskiod, 2000; Malone, 2000). This often led to conflict in the health visitors role as they juggled the dual role of ‘mother’s friend’ and the ‘welfare police’ (Malone, 2000). The nurses in this study did not identify with a policing role, although they did clearly express some responsibility for supporting families for which child abuse and neglect was an issue.

Health visitors have reported on the stigma of ‘welfare’ (De la Cuesta, 1994b). The Australian C&FH nurses in this research found that this was not much of an issue, particularly in the very disadvantaged suburbs. In Sector Two, where there were high rates of families in public housing, the agency responsible for child protection, the Department of Community Services (DoCS) had a visible presence due to the number of clients in the community. The nurses believed this resulted in a lack of stigma that may be present in other, more affluent suburbs.
The nurses spoke openly of their legal obligation to report suspected neglect. The C&FH nurses concentrated on promoting the positive aspects of the DoCS service – that it was there to support parents and minimise the chances of the removal of children where possible. The C&FH nurses often accessed DoCS services to assist the mothers in issues around housing and the acquisition of material resources when necessary. This was also seen to promote the positive aspects of the agency.

**Bringing it together in practice**

An example of how the C&FH nurse incorporates all areas of practice within one consultation is provided in the box below.

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**During a centre visit for a six-week development check, the mother of a breastfed six-week-old baby reports that she has introduced several bottles of formula a day, as she perceives her supply is inadequate. The nurse attempted to acknowledge the experience from the woman’s perspective (unbiased, non-judgmental). She empathised by recognising that it is difficult when the baby cries a lot, particularly when it is depriving the mother of sleep. She congratulated her on breastfeeding this long, (strengths-based approach). She then informed her that it takes about six weeks for breastfeeding to become fully established and one of the signs of that is that the breasts no longer feel as full as they did in the early weeks of breastfeeding (inform, educate). The woman responded that this is exactly what had been happening for her. The nurse told the woman that many women feel that they don’t have enough milk at this time, particularly when it commonly occurs when the infant is having a growth spurt and is hungrier than usual (reassuring, normalising). The mother nods in agreement. The nurse weighs the baby and plots the measurement on the graph, showing the mother the normal growth curve and informing her that her baby’s weight gain is excellent and indicative of sufficient milk intake (monitoring, congratulating, reassuring). The nurse goes on to say the hardest part of breastfeeding is in the first six weeks and most women, if they get to that time, they are usually ‘home and hosed’. However, if the woman really doesn’t feel like she can cope when the baby is screaming (listening), sometimes a bottle of formula makes all the difference (respecting) but she needs to be aware that, as they have discussed before, breastfeeding is a supply and demand thing and when the baby receives formula the breasts don’t think as much breast milk is required (guiding). The nurse then asked ‘so I suppose it all depends on how much you want to breastfeed’. When the woman said she**

*Same but different. Chapter Four: Case Study One* 105
thought the first six weeks of breast milk were the most important for the baby because of all the antibodies and she was going back to work in a month or so, so she thought it wasn’t so bad to start the bottles now. The nurse replied ‘every drop of breast milk is good for the baby but the research shows that four months is the shortest time they think the baby should receive breast milk to get the maximum benefits, but you need to do what is right for you’. The woman then indicates she will try to keep breastfeeding.

The above example allows the nurse to promote breastfeeding in a way that acknowledges the woman’s experience, informs her of the evidence and recognises it is ultimately the mother’s decision. The mother is also reassured that the nurse will support her in whatever she does.

Rarely did the C&FH nurses compartmentalise or undertake discrete components of their role. Most commonly, as described in the above exemplar, the nurses were seen combining all aspects whilst responding to the mothers’ needs. Responding to the client’s own agenda resulted in the nurses adapting their practice and offering support in whatever way was meaningful to the client. This was evident in some of the nurses supporting women in tasks such as assisting them in filling out TAFE enrolment forms, or organising a telephone connection. Such support interfered with the planned intention of the visit that may have been a weight or a development check but was necessary to allow the client to refocus on the child, following resolution of the particular issue. Cowley (1995) refers to this adaptability as ‘shifting focus’. This also related to the ability of the nurses to act on health-promoting opportunities as they may arise with the mother or other individuals in the household. For example, when the grandfather of an infant went outside to smoke a cigarette, the nurse praised his efforts and highlighted the benefits this action would have on the infant. By doing this it was hoped that the brother-in-law, also a resident in the household, but one who smoked inside, would be more responsive to the idea.
The broad range of skills and knowledge reported by the nurses reflects the magnitude and diversity of the role that, at times, illustrated the contradicting expectations of the women and the service. As one nurse described:

>You have to know all the usual things like growth and development, skin rashes, milestones, and stuff but you also have to have all those psychosocial skills, plus know who are the right people, have all the networks and do it in a way that empowers the woman. Tell me how easy you think it is to do all that in a one-hour first home visit??? (CN5.2).

**Perceptions of how C&FH practice has changed**

The purpose of the research was the investigation of contemporary C&FH nursing practice. It was therefore necessary to explore what meaning or philosophical foundations underpinned the C&FH nurses’ practice. Following discussions on how the C&FH nurses perceived their role in the support of families in early parenting, the nurses were asked how they thought this role had changed. The ability of the nurses to reflect on these changes was dependent on the length of time they had worked as a C&FH nurse, although even those recently qualified offered information on how they thought the service was different under the Families First initiative.

Many of the nurses had experienced significant changes in the way C&FH nursing services were provided throughout their careers. In the 1970s and 1980s the nurses were based in health centres throughout the AHS. For example, one nurse explained:

Twenty years ago it was total drop-in and it was chaos because people would come in, there would be two nurses, five days a week. You would look out and the room would be absolutely ‘chock a block’. That puts the pressure on you to move, you know, and you may not pick up what you wanted to be cause you were in this state of go, go, go (CN15.1).

There were inconsistencies, however, in the C&FH nurses’ responses to changes in their individual practice. Some participants believed the way they practised was the
same now as it was 20 years ago others had no hesitation in reporting significant practice changes. The question ‘how do you think your practice has changed since you started working as a C&FH nurse?’ prompted a thoughtful and reflective response from the majority of the participants. One nurse summarised the responses when she replied, ‘well, it’s the same I suppose, same but different’ (CN3.1).

A shift in focus
The C&FH nurses described a shifting focus that reflected the changing philosophical underpinnings of practice. This shifting focus was categorised as: expert versus partner; baby versus family focus; and physical versus holistic health. These concepts are presented below and the challenges the nurses faced in adopting these paradigm shifts are discussed in more detail in Chapter Five.

Expert versus partner
Participants were asked if and how they thought the role had changed over the years. All of the nurses believed the role was now less authoritarian. Traditionally the nurses would ‘sit in the clinic all day and wait for the mothers to come to you. We did baby checks and told them how to parent’ (CN13.2).

Another nurse explained:

I think back then the philosophy was the same but the practice was more of an authoritative role, giving the parents information, making sure they were doing things right, um, more of a focus on … making sure that the child didn’t have any problems, a more thorough medical check, more an information-giver. This has slowly changed to a way of trying to equip the parent to seek out information themselves and draw on their strengths more than just imparting our strengths (CN3.1).

Another nurse reflected:
I used to go very ‘gung ho’ and throw the bible at them ‘you shall’ (laughs) and then realised that as soon as they walked out the door they would do what they want, so now I use other techniques to try and find out, um, you know what they are doing and subtly ask them to make the changes. You know, by asking ‘what are your concerns and how we work together to address your concerns’ (CN1.1).

Researchers in the UK have advocated for health visitors to work in partnership with mothers since the 1980s (Robinson, 1982) and early 1990s (Foster & Mayall, 1990). Ellesfsen (2001) reports parents are now approached as partners in a ‘participant relationship’ in her study of the changing practice of the health visitor in both Scotland and Norway (Ellefsen, 2001). However, many other studies have indicated little evidence of health visitors encouraging client participation, with most nurses dominating the conversation, and controlling the interaction (Baggens, 2001; Kendall, 1993; Mayall & Foster, 1989).

An example of one nurse’s attempt to work in partnership is now provided. A Caucasian woman living in public housing with limited resources presented for the six-week check of her newborn son – her sixth boy. One of her other children was autistic. Her Edinburgh Depression Scale (EDS) score was zero. The woman was polite but reluctant to disclose much information about herself. The C&FH nurse tried a variety of ways to offer support without being authoritarian. Her phrases included ‘how are things going?’, to which the woman replied ‘fine’. A little later, ‘Do you have any concerns?’, and ‘is being a mother this time what you expected?’ (a prompt question from the data collection form) and ‘with having six sons, are you managing to get some time to yourself?’ (also an adaptation of a question on the data collection form). She later informed the mother about a volunteer home visiting service, maybe ‘to give you some time out’, but the client politely refused.

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20 An EDS score of zero suggests no indication of maternal distress, although some women may conceal their distress by choosing not to answer truthfully or fail to understand the nature of the questions.
Following the appointment the nurse said to me:

*She had six boys, planned pregnancy, obviously wanting a girl, one autistic son, and I did the best I could ... I'm prodding, well I was hoping I was prodding, you know, if you don't want to tell me this way, maybe you will tell me this way but she was ‘no, no, no’. So what can you do? And she will come out but she needs time. It is all about relationships* (Obs:CN1.1).

The mother may not have any desire to enter a partnership with the C&FH nurse, particularly if, through her experience with the service for her other five children, she was not exposed to the partnership model. The mother may have brought her six-week infant for the recommended growth and development check and required no other service from the C&FH nurse. Similarly, questions regarding her expectations of being a mother may have been unexpected and intrusive for a woman who had five other children. A further explanation for the woman’s reluctance to disclose personal information to the C&FH would be a previous negative experience with the health service. Finally, another explanation could be, as the nurse suggested, that with time, the opportunity to build a partnership will be enhanced as mutual trust is established.

*Baby-focused versus family-focused*

The above scenario also demonstrates another aspect of practice wherein the nurses reported a change in practice since the implementation of the Families First initiative. That is, that the service is now much more mother-focused when previously it was more baby-focused. Although the nurses had always tried to support the mother, traditionally, they believed the focus of practice was checking the baby, monitoring his or her growth and ensuring the infant was reaching his or her milestones. Parenting advice and education was primarily around promoting optimal growth and development of the child, whereas *‘now we are able to offer the parents more support and link them to other support services’* (CN6.1). The rationale behind this change seemed obvious because *‘if the mother isn’t functioning, neither will the baby’* (CN7.2).
There were numerous demonstrations observed in the nurses’ practice around this focus of supporting the mother. Questions from the family assessment form included: what family support she had; if she managed to get time to herself away from the baby; how she rated her own health and the health of her baby; if she has someone she trusts to leave her baby with when she goes out; and, assessing her mental health with the EDS form. These questions appeared to act as ‘prompts’ and supported the nurses’ change of practice. As one nurse explained ‘some of the mothers nearly fall off the chair when we ask them “but how are you?”, as if nobody has ever asked them that question before’ (CN15.1). Further evidence of woman-focused care occurred in many observations wherein the nurse offered information on other community services such as playgroups or mothers’ groups.

There was strong evidence that the C&FH nurses identified the importance of maternal health in their delivery of services, with most of the nurses describing this aspect in interview, as well as demonstrating it in the observations. This concern for the mother was not found in a UK study that found single mothers perceived health visitors as primarily interested in the infant, with minimal enquiries or interest into their own wellbeing (Knott & Latter, 1999).

**Physical health versus holistic health**

Juxtaposed alongside being more mother-focused, the nurses reported that their practice was now much more holistic. Previously the nurses just focused on infant growth and development, whereas now they are concerned with all aspects of the woman’s life that affect her ability to parent. One of the principles of the Families First initiative states;

‘Have a holistic view of each family. This means focusing on the whole family, how they relate as individuals and how the needs of each individual affects other family members’ (Office of Children and Young People, 1999 Section One, p.16).

This principle is particularly relevant for disadvantaged groups. As one nurse who worked in a particularly disadvantaged suburb with 90% public housing, explained:
These women live in such chaos. Promoting breastfeeding means nothing when you are living with a violent de facto and don’t have enough money to pay the rent. I do heaps of stuff that isn’t strictly ‘nursing’. I help them fill out forms, I organise computers for them (from a charity that distributes second-hand computers to those in need), I pick them up and take them to their appointments at the hospital… I even listen to them tell me about the ins and outs of their family dramas which is often way more information than I need to hear… But you do what you do so they feel like you care … so our role is so much broader than just sitting in a clinic waiting for the mothers to bring their baby in for a check-up (CN7.2).

The tasks that the nurse related above have also been documented in health visiting in the UK (De la Cuesta, 1993). Termed ‘fringe work’ by De la Cuesta (1993), non-policy work undertaken by the health visitor that enhances the relationship with the client includes the offering of transport, food, money and liaison between the client and other services.

Most of the C&FH nurses in this study identified ‘support’ before ‘education’ as the most important aspect of their role. This differs from Mayall and Foster (1989) who found that health visitors in the late 1980s identified education as their most important purpose. Mayall and Foster also discuss the health visitors’ focus on protection of children and their role in identifying child abuse. The Australian C&FH nurses in this research did not mention ‘child abuse’ per se, though they did discuss child protection issues. But they never indicated in any way that they felt a responsibility for the child’s wellbeing. That responsibility belonged to the mother or carer of the child. This contrasts with research on nurses caring for children in the acute-care settings, in which nurses described their role as protectors and advocates of the babies (Fenwick et al., 2003).

**Accessing traditional non-users of the service**

The current service model, particularly the initial home visit offered to all parents of a newborn baby, had resulted in the nurses accessing many more clients, including those
families who did not traditionally use the service. ‘The idea is to catch more women in the system, make it easier for mums to access the service’ (CN16). All of the nurses agreed that they now saw significantly more families than prior to the implementation of the Families First initiative. As this nurse explained:

Basically, before, it was the people who fronted up to the clinic who got a service and if you didn’t front up you weren’t necessarily actively chased up - I mean we’d get the discharge summary and the policy was that you would try twice to contact these people so if you have a phone number you would make a phone call but you wouldn’t go out and knock on doors. Whereas now we actively seek them out (CN16).

In this way it was expected they would access the ‘hard-to-reach’ clients and those families who would traditionally not come to the service. ‘We now engage families with the service in a much more proactive way and in doing that we sell the benefits of the service’ (CN3.1).

As a result of universal home visiting, the C&FH nurses now saw families who traditionally did not access the service, including those from ethnic minority groups. The nurses believed these families did not have similar services in their home countries and so were unfamiliar with the service in Australia. Other traditional non-users of the service included families from lower socio-economic groups. The nurses reported that these families had a longstanding mistrust of government services (due to the forced removal of children in some cases) and whose lives were often too chaotic to seek the C&FH services. These observations by the nurses are supported by Ochiltree (1990) who, in a three-state study on C&FH services in Australia, reported that non-English-speaking mothers were three times less likely to use the service than other mothers. She also found that the lower the income of the mother, the less likely she was to use the services (Ochiltree, 1991).

The ability to access these disadvantaged groups was seen to be supported by service systems, as explained by one participant:
It’s been about having systems in place that allow them (the nurses) to know what families are there and allowing them to have time and access to them and contact with them. When they get out there, I think they have to start to promote the service as an entry service into a whole range of other services. And I think too that the families still want the ‘weigh and measure’ so they have to promote that as well but it is not the be all and end all of the service (CN1.16).

Establishing relationships and developing trust in women and families from disadvantaged groups were seen to require different skills, and were more challenging than visiting middle-class mothers in the home.

But just learning about them and respecting them, letting them know I do respect them and where they live and who they are and whatever. And not being seen to be passing judgment or being better than them. Because if you do that, they will be off and you won’t see them again’ (CN4.2). And, as another nurse commented ‘attitudes and body language I think puts people off .... So I do things like ... sitting on the floor and playing with the children, which I enjoy anyway (CN3.1).

The nurses identified that there were significant differences in the type of support families needed in the different geographical areas they serviced. Women in the more affluent areas were described as having higher levels of postnatal depression, ‘middle-class’ women often had issues around isolation than women from lower socio-economic circumstances, who suffered financial stress and more social dysfunction.

Women from disadvantaged areas were seen to be more resilient, as the following quote demonstrates:

They have got survival skills. They are close knit; they seem to know one another. They rely on each other before they let an outsider in. They’re resourceful when they want to be and that is what I mean by survival skills I suppose. When I was in _____ (a middle-class area) I would have mothers with issues and they would be a
Blubbering mess but these guys can have so many issues but they keep going. It’s just how they live (CN10.2).

When the 17 nurses were asked if they did or acted any differently when servicing these disadvantaged groups they all denied that they did. All 17 insisted that they ‘treated everybody the same’. However, on closer questioning, several did concede that they did use a different approach, as the following extract shows:

I dress more comfortably for one thing because you are on the floor a lot … In a way I approach them differently, speak to them differently. I think I do this because it is in the home and it is more relaxed (CN3.1).

But there was also general agreement across the participants that they adhered to a certain level of professionalism. As this nurse suggested:

I suppose (my behaviour changes) to some extent. I am the type of person who is informal and who will sit on the floor. You go by the clients’ cues as well. If you have a client who is looking at you thinking why is she sitting on the floor I go by what they want. I won’t come down to some levels. I have done joint visits with other services and some of them use really bad language and I won’t use the poor degree of language that the family uses just because I am visiting them, and some other services really act inappropriately, I think (CN10.2).

Most of the nurses who worked with socially and linguistically disadvantaged groups enjoyed their work and often found it more satisfying than working in the more affluent suburbs.

I actually like the richness of multicultural, very much so. And I like the challenge of educating, and strengthening of, people in the low socio groups. I just think that's where the education is - empowering and informing them. Some of these people haven't completed their education, for different reasons (CN4.2).
Some nurses were surprised how much they liked working with families with complex needs.

_**I would have chosen the middle-class clinics probably, if I had the choice in the beginning, but I really love this area. I think I would find it boring now (working in the middle-class suburbs). It is just so great seeing the changes**_ (CN7.2).

Two nurses also reported that they found the experiences of working with these families challenged some of their own beliefs and values.

_**And you can learn so many lessons from working in these areas. Just being exposed to all this makes you look at your own life and makes you come to terms with what is important in your life**_ (CN14.2).

And as another nurse described: ‘_**I thought this one woman was a bit backward actually but she's just never been given the opportunities**_’ (CN7.2).

One nurse commented on how she learnt so much from some of their clients:

_**Because it is different, you are learning so much you can appreciate everything, it is stimulating, you know and it is just lovely to know how people live and appreciate it. I just love it yeah, whereas I said ‘don't send me out there, (to a clinic servicing middle-class clientele) that is just a typical Aussie to me’ (laughs), yeah, just different people, isn't it?**_ (CN15.1).

_Seeing more women less often_

As a direct consequence of seeing more women, there was less ongoing contact possible with many of the families. The nurses reported that before ‘_**the clinic was always there for women. I used to see so many women every week until about six weeks and then every fortnight. Now you are lucky to see them once or twice before the baby is two months old**_’ (CN4.2).
Similar findings have been reported in community nursing in Sydney, Australia where Kemp et al. reported on nurses having to see more clients in less time, resulting in a decrease in the number of occasions of service per client (Kemp et al., 2005). Also in Victoria, Australia, increases in the population levels in some areas have had a negative impact on the ability of the C&FH nurses to meet community demand (ANF Maternal and Child Health Nurses Special Interest Group, 2004).

Although the Families First initiative had increased funding to all AHSs across the state, the nurses identified problems with being able to continue contact with women and offer services as frequently. As explained by one nurse:

“They told us about all the ideas that they had and what was SUPPOSED to happen and what it was supposed to do. Under Families First we do see families when they first come home from hospital but that seems to be where it BEGINS and ENDS. Because 10 years ago you saw the mothers within two weeks of that first visit and any problems they had, whether it was with their own self or with the baby or difference of opinion of parents, you saw them but now you don’t, you see there is nothing (no appointments available) for at least six to eight weeks after the first home visit (CN12.1).

The nurses believed this reduction in contact was detrimental for some women because ‘back then they got to know their nurse better’ (CN4.2). Time and paperwork requirements also resulted in less quality time with the women.

“I think you knew them a lot better, because you got to know them more, you had more time with them, you could talk to them, communicate with them, whereas now, with all the paperwork that you have to do there really is very little time to really listen to that mother very much (CN15.1).

More adequate referral mechanisms were also noted to reduce the contact time between the C&FH nurses and the families.
We do a lot of referring on more than taking it on ourselves. I suppose we are more family-orientated, but at the same time we are not encouraged to keep seeing them long term. When there are issues we are encouraged to refer them on rather than keep seeing them. From what I can make out years ago, you used to keep following them up and take on a lot more of the role and responsibility and that doesn’t happen so much anymore (CN10.2).

The consequences of this were seen on several occasions throughout the observation as the following example demonstrates.

A mother of a 10-week infant was worried about being able to express her breast milk, as she was about to return to part-time employment. Rather than offer any advice, the nurse immediately informed the mother of other agencies who may be able to assist her. These agencies included Jasmin Cottage, a secondary referral service for parenting issues and the Australian Breastfeeding Association (ABA\(^\text{21}\)). The C&FH nurse provided the telephone number of the referral centre but did not provide any means of locating or contacting the ABA.

(Obs:CN7.2).

However, a few of the nurses observed the traditional model of care may have resulted in over servicing some of the clients.

We used to have a system of weekly for the first 6 weeks, then it was bi-weekly for the next 6 weeks and then it was monthly or whatever after that depending on what occurred. But some clients used to like to come weekly anyway. And now they (management) say that that (frequency of contact) didn’t necessarily improve outcomes but how would you know? (CN15.1)

\(^\text{21}\) The Australian Breastfeeding Association is a large, community-based self-help group, recognised as a leading organisation of people interested in the promotion and protection of breastfeeding.
Another nurse reported the current service was ‘trying to discourage those mothers who came weekly for no reason. They now just come for those major checks but we still get a lot of mums who are very unsure’ (CN13.2).

Many of the nurses believed the ‘preoccupation’ with first home visits significantly impacted on the amount of ongoing contact they could have with women and their families. Some of the nurses believed that by focusing on every woman receiving one home visit, the service they could provide was being compromised, particularly with the staffing shortages that Sector One was experiencing, as illustrated here:

But the problem is being so short staffed, I wonder could it be that some mums could be seen in the clinic. If there is a full staff load, sure we can all go off and do the home visits, but when there is so many waiting to be seen, I think maybe they don’t all need the home visit (CN15.1).

Centre visits versus visiting in the home

Only two of the 17 nurses interviewed disagreed with the introduction of universal home visiting. This disagreement was due to the impact it had on resources, rather than the concept of home visiting itself. Most of the nurses found this new approach to their work beneficial to the families and rewarding for themselves. The C&FH nurses believed it was beneficial on two levels. Firstly, the ability to establish a rapport with the mother was enhanced due to the relaxed and informal venue of the home, and secondly, the information available in the home environment was more informative. As one nurse described:

I think it is a fantastic way to see a lot more than you would in the clinic. The mother is more relaxed, you see how the family relates, generally - sometimes they put on a different face for us. But we see a lot in the home that we would have no idea about if they just came to the clinic (CN11.1).
Many health visitors in the UK also recognise that visiting the family in the home is preferable to seeing them in the centre, as they believe the mother is more relaxed and more open to discussing various topics (Mayall & Foster, 1989).

**Applying the strengths-based approach**

Another consequence of seeing an increased number of women and supporting them in a more holistic and family-focused way, was that the nurses observed that they needed to practise in a way that was less judgmental. This may also relate to the changing cultural mix of contemporary Australian society. As one nurse explained, ‘I think we have to be more open-minded, we have to be continually aware of the different ethnic mixes and their needs’ (CN4.2).

Rather than identifying new skills or tasks as part of their changing role, the nurses talked about how they practised that was so different from the past. This new way of working was readily identified by some of the nurses as a ‘strengths-based’ approach.

*Whereas before we were more an information-giver, this has slowly changed to a way of trying to equip the parent to seek out information themselves and draw on their strengths more than just imparting our strengths* (CN3.1).

How they did that was ‘to look at the positives rather than look at the negatives’ (CN6). Or, as another nurse explained:

*By trying to encourage them that they have the resources to do a good job as a parent, pointing out areas in their own family supports, friends, their own culture and their community that they can draw on for support and guidance* (CN3.1).

In working with disadvantaged families this ‘strengths-based’ style of approach was seen to be being particularly rewarding.

*Finding in the clients what they are good at and what they are able to achieve by themselves. Just any small thing can be huge for them. Just encouraging them, like they mightn’t have been out of the house and then you find that they have come to a playgroup and that is really quite big, you know* (CN7.2).
Several nurses, however, commented that this approach to practice was sometimes easier said than done. This nurse described the difficulties in sometimes meeting the needs of the client when she said:

I mean they are trying to change it ... where we just sit and listen. (This) isn't meant to be about us giving advice but when it comes to the crux, they come to you for advice so you end up giving advice (CN10.2).

**Adhoc practice versus standardised service systems.**

Another component that influenced the nurses’ change in practice was the AHS standardisation of systems in the form of documentation and referral guidelines. Documentation requirements, such as the family assessment, promoted uniformity in the way nurses assessed and recorded their activities. It also ensured a more comprehensive service. As told by one nurse:

Before was just a little card, like a flip-over piece of paper and I think by having a decent file which is much more professional and the way it has been written out and devised that you don’t miss things that you might have missed in the past (CN15.1).

Even the way the women are identified was radically different.

What happens now is we have the central intake system where we actually have somebody who goes in and checks the birth register for all of the hospitals locally and we print out a discharge summary from the obstetric database. That gets printed remotely to each of the five sectors so they get that information the day the woman is being discharged and in each sector that information then goes to the child and family health nurse who makes an appointment (CN16).

All of these systems were seen to improve services. Guidelines and business plans also determined which women should be seen first.
We prioritise what is important. We have a business plan which states that breastfeeding is to be promoted. Our rates are very low so breastfeeding is prioritised so if mother has any breastfeeding concerns she is the one we go and see first (CN1.1).

Primary health care revisited
The C&FH nurses’ perceptions around changes in practice described significant changes in the philosophies underpinning their practice. Major changes included working in partnership with families in a non-authoritative, strengths-based approach in a way that empowered families to take responsibility and control of their own lives. Furthermore, the nurses identified a more holistic approach to services, wherein the whole family is considered within the context of the social, emotional and environmental factors that has influenced its life. All of these principles are reflected in the principles of primary health care, established in the late 1970s and integrated into C&FH nurse education since the 1980s. It appears that the principles of primary health care have been reframed into new terminology but with the same intention. Of interest is the observation that though the Families First initiative reflects the same principles as primary health care, there is no reference to them throughout the documentation.

SUMMARY
The way C&FH nurses provide services to families has changed significantly for this group of nurses. Though many had worked in a generalist capacity as primary health nurses throughout the 1990s, their previous expertise in services around early childhood continued to be applied in their practice. The introduction of the Families First initiative had resulted in a major restructure of services and brought many of the C&FH nurses back to professionally specific positions they had held in the 1970s and 1980s. But the way in which they now worked was very different. The changes in practice reported by the nurses have been summarised in the diagram in Figure Two below.
Figure 2. Perceptions of change in C&FH nursing practice

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<tr>
<th>Pre-Families First</th>
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<td>Expert</td>
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<td>Ad hoc practice</td>
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<td>Minimal documentation</td>
<td>More accountable through documentation</td>
</tr>
<tr>
<td>Minimal contact with hard to reach groups</td>
<td>Improved access to hard to reach groups</td>
</tr>
</tbody>
</table>
CONCLUSION

The role of the C&FH nursing in the sectors studied in south western Sydney can be categories into four major areas: the monitoring of growth and development; education and health information; referral and networking; and, finally, psychosocial support. Whilst these components of practice seem to have always been part of the C&FH nurses’ role, the way in which the services are delivered appears to have undergone a significant change. The paradigms that guide the nurses’ practice have also been challenged as they are now directed to work in partnership with clients using the strengths-based approach that underpins the Families First initiative. The nurses are also accessing more families who may not have previously accessed the service, through the universal home visiting program. Social and environmental influences in each family’s situation are now considered through the standardisation of family assessment tools and improved referral pathways. It appears the Families First initiative has resulted in some positive changes in the way C&FH services are offered and how the nurses practice within those services.

However, there have also been some negative consequences of policy implementation with the nurses reporting they are not adequately resourced to provide continuing support to many of the families. This issue is further explored, along with other challenges that impact on the nurses’ ability to effectively provide support to families in early parenting in the following chapter.
Chapter Five

Case Study One:
Challenges to Changing Practice
Chapter Five: Challenges to Changing Practice

INTRODUCTION

As part of the investigation and exploration of contemporary C&FH nursing practice in the delivery of services to individual families, it was necessary to explore factors that impacted on the ability of the nurses to be effective. There appeared to be a tension between the need to provide the traditional service of monitoring the infant’s growth and development, and providing advice on parenting issues (‘expert model’) with ‘being there’ for the women (strengths-based or partnership model). The nurses were asked what they believed interfered with their ability to provide effective services to women and their families. This chapter presents the findings in two parts. In Part One, the nurses’ perceptions of the barriers to working effectively with families are presented. These factors appear more organisational in nature and reflect health system influences. Part Two discusses some of the professional and personal characteristics that appeared to influence the nurses’ capacity to effectively support parents.

PART ONE: C&FH NURSES’ PERCEPTIONS OF FACTORS IMPACTING ON THEIR ABILITY TO EFFECTIVELY PROVIDE SERVICES

Data pertaining to these findings were elicited from discussions in the interviews around the questions; ‘What are some of the things that impact on your ability to do your job?’; and, ‘Tell me some of the things you don’t like about your job’. Data were also drawn from observations of the nurses in practice. The findings are presented under the following categories: establishing relationships; documentation; differing expectations; staff rotation; under-resourced referral services; centre hours, staffing levels, and other service barriers.

Establishing relationships

Sixteen of the 17 nurses interviewed identified that the effectiveness of their practice was significantly diminished by the lack of opportunity to get to know the woman and
to gain her trust through a continuing relationship. As one nurse explained ‘it takes few visits to build up a relationship’ (CN6.1). The first home visit was identified as being the most important visit in establishing a relationship.

In the time you spend with her in the home, for one or two hours, by the end of the visit you’ve really established a good rapport … so when she sees you at the clinic, she is really thrilled (CN14.2).

As important as the first visit was in establishing a rapport, ongoing contact was also described as imperative. ‘You can only learn a little bit about them on the first contact’ (CN4.2).

NSW Health policy directs the C&FH nursing services to develop a confidential relationship based on mutual trust (NSW Health, 2002b). The NSW Health policy document on home visiting states: ‘the nurse should engage with the woman (and her partner) and establish rapport prior to asking sensitive questions’ (NSW Health, 2002b p.23) but does not provide suggestions on how long this may take to occur. However, it can be assumed the policy-makers expect the rapport to be quickly established because they mandate that a comprehensive primary health assessment be carried out by the C&FH nurse on the first universal health home visit within two weeks of the birth (NSW Health, 2002b). According to NSW Health home visiting guidelines, women requiring additional support are supposed to be identified antenatally and introduced to the C&FH services at this time (NSW Health, 2002b). However this was only occurring in one particularly disadvantaged suburb in Sector Two and was made possible by a one-off alternative funding arrangement.

Sound relationships between health provider and client can be presumed to lead to increased parental self-confidence and self-esteem, which in turn will have a positive influence on the child’s health and development (Fagerskiold, 2003). Health visitors in the UK have identified that a ‘good’ relationship is necessary in order to change behaviour, but such relationships may not exist (Mayall & Foster, 1989). Alternatively, some mothers will not allow a relationship to develop (Mayall & Foster, 1989).
Ongoing contact between the nurse and client is seen to promote a positive relationship between the two and foster trustworthiness and mutual respect (Fagerskiold, 2000). A successful relationship is described by De la Cuesta (1994b) as an ‘enabling’ factor that allows health visitors to get to know the client, to gain and maintain access to the home, and to ensure reciprocity. Writers in the UK and Sweden suggest that a successful relationship is considered necessary for the health visitor or C&FH nurse to gain the client’s co-operation (De la Cuesta, 1994b; Fagerskiold & Ek, 2003). Child health nurses in another Swedish study have reported that the relationship between the professional and the client is more important than giving advice (Wikander, 1995). Others suggest that the relationship between the client and nurse is more significant than any of the other professional skills that practitioners may use in health visiting services (Twinn, 1993). Research with some health visitors showed more holistic, family-oriented care was enabled by longstanding relationships between the health visitors and their clients (Cowley, 1995).

However, the C&FH nurses in this study concluded the AHS targeted and prioritised having all women ‘seen’ in the home within two weeks of birth. As this nurse explained, ‘the focus is on the first visit, it is the indicator they use for us doing our job. Not establishing relationships or doing follow-ups’ (CN10.2). Within the current AHS structures there was very little opportunity for the mother to see the same nurse on subsequent visits. Whilst the nurses all worked within a given geographical area, they usually shared it with several other nurses. They also had to attend first home visits in other areas if that particular team was experiencing difficulties accessing all new babies.

Our biggest priority is to get the first home visit done by the time the baby is two weeks old. So if I don’t have many new babies and another area does, I have to go and do some for them (CN4.2).

Even if the nurse attends the first home visit in her own area, there are no attempts to ensure their availability for any further visits at the C&FH centre. ‘It really depends. If
*I see them in my area, I might be the one at the clinic but I might not*’ (CN14.2). This problem was further complicated in Sector One where several of the nurses did not do any home visits due to their inability to drive or for health reasons. These nurses were all centre-based and had no opportunity to do the first visit unless the woman refused a home visit and bought her baby to the C&HF centre.

Establishing relationships was reported by the participants as also being important for the women. As one nurse explained in the C&FH centres staffed by only one nurse:

*You do find your numbers are up because they know it will be you who is there and they will attend regularly. The moment they come and they find you are not here, the numbers start dwindling. They get disappointed* (CN4.2).

Whilst client perceptions of the service were not included in this study, other Australian research has documented clients’ criticisms of C&FH nursing services over the lack of continuity of care with the same provider (DHS, 1998). The ability of C&FH nurses to provide continuity of care in this study was significantly impaired in both Sectors One and Two.

**Sector One**

A common scenario in this Sector would be that a C&HF nurse would visit a woman in the home within two weeks of birth (though this may not occur until 4-6 weeks of age due to staffing shortages). Here she does the initial comprehensive family assessment, according to local AHS and NSW Health policy (NSW Health, 2002b). If there are no problems identified in this visit, the nurse will inform the woman of her nearest C&FH centre, and invite her to visit any time to the ‘drop-in’ facility. This drop-in service, however, is only available in three of the 16 centres. The nurse will then suggest she makes an appointment for the next development check, recommended at six to eight weeks of age. As these checks are not done in any of the drop-in clinics in Sector One, due to the time they take to complete (30 minutes are allocated), women are advised at the first home visit to make the appointment as soon as possible, as most of the centres are booked out for 6-8 weeks in advance. If the woman does choose to utilise either the drop-in or appointment system, she may or
may not see the same nurse. Throughout the observations, however, it was most commonly a different nurse.

If, at the first visit in the home, the woman was having difficulties such as breastfeeding or sleep and settling issues, the nurse would usually offer one follow-up visit in one week’s time ‘to check the baby’s weight’. If there were still difficulties at this time, the woman would be referred to the secondary service. The C&FH nurse from the secondary service would then offer a total of four visits, two to four hours in length. If the parenting issue was not addressed within this time, local protocols determined the woman must be referred onto another agency such as Karitane or Jasmin Cottage. Following ‘discharge’ from the secondary service, the woman was then referred to her local centre. Further follow-up support within the home was not usually available in Sector One due to staffing resources, with the exception of one nurse who regularly visits a particularly disadvantaged caravan park with long-term residents. The other C&FH nurses appeared to spend all of their time attending first home visits or staffing health centres.

As Sector One has minimal drop-in facilities available, a woman would commonly be seen for the first time when her baby is two to four weeks old, and then have to wait six or eight weeks before she could gain an appointment to see another C&FH nurse. The nurses did state that if there were any pressing issues the woman was concerned about, she could ring the general ‘intake’ number that was staffed by a member of the C&FH nursing team. If this C&FH nurse could not address the mother’s problem

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22 The secondary service is unique to this Sector and involves several C&FH nurses from the team designated to provide more intensive support for women having difficulties. Whereas primary service C&FH nurses are allocated 60 minutes for first home visits and 30 minutes for follow-up visits, Secondary C&FH nurses are allocated 2-4 hours per visit for a total of four visits. At the time the data was being collected, only one C&FH nurse was working in this capacity due to staff shortages (previously there had been two).

23 Residential or day stay facilities that offer extensive support around parenting issues.

24 Individual clinic numbers were not given out to the mothers. A central number was staffed during office hours by a C&FH nurse who could offer phone advice.
over the telephone she would refer the woman to another secondary agency such as Karitane, or, if resources allowed, a home visit would be organised by one of the three nurses who serviced her area. However, no attempt would be made to send the same nurse who had seen the woman previously.

As a result of the service structure in Sector One, if a woman had parenting problems, she may see three or four different nurses in the first six to eight weeks of her baby’s life. Beyond six weeks of age, the number of nurses the woman saw would depend on the centre she was visiting and how many nurses were located there.

**Sector Two**
Due to the improved resources in staffing numbers in Sector Two, the care seemed less fragmented, although many of the nurses ‘helped out’ by conducting first home visits in other suburbs if there was a demand. Typically, a woman was visited in the home within two weeks of discharge from the hospital. If there were any problems identified, that same nurse could elect to continue to visit her in the home (even if it was not her allocated suburb) until the nurse was satisfied that this intensive support was no longer required. This support was not referred to as ‘sustained home visiting’ as it does not meet the requirements of this service as per Families First guidelines and would usually only continue for two to four weekly visits. The mother would then be referred to her local centre. The lack of continuing home visits was surprising, given the high rates of disadvantage in the areas I researched and the policy guidelines that promote additional support for those families in need (NSW Health, 2002b). These guidelines state:

> Families who require additional support do not necessarily use universal health promoting, early intervention services or seek help when problems arise. In a targeted approach to service delivery these families will be offered additional

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25 Sustained home visiting as per the NSW Policy involves weekly visits until the infant is six weeks of age, followed by fortnightly visits until six months of age and then monthly visits until two years of age (NSW Health, 2002b).
support in their home over a 2 year time frame - to be known as sustained home visiting (NSW Health, 2002b p.36).

Some of the nurses did report continuing home visits (though not as often as recommended in the guidelines) for a minority of clients. These families were usually also under the care of the Department of Community Services (DoCS) and regular contact with the C&FH nursing services was a requirement of DoCS.

As all of the Sector Two centres offered drop-in services (none of the centres offered appointments), there were no issues around waiting for appointment times. Depending on which centre the mother elected to attend, (usually determined by where she lived), it may be staffed by only one nurse or up to six or eight nurses in the larger centres. Therefore, in Sector Two, a mother could typically have contact with one or two nurses in the first six weeks, or up to five or six if she elected to have weekly visits to the busy centre such as the one at the shopping complex where many C&FH nurses worked.

The fragmented care imposed by AHS structures had particular implications for women with complex needs. As explained by this participant:

With some of them you really need to see the same clients, especially in the disadvantaged areas, because they have already formed a bond with you and they feel safe and comfortable (CN14.2).

This was also articulated by another nurse:

In this area we deal with families who have longstanding problems with authority and government institutions. It is so important that they get to know and trust you if you are going to have any chance at all at supporting them (CN7.2).

Of the 13 nurses I observed in either the home or the centres, only three demonstrated ongoing relationships with clients. One nurse in Sector One regularly visited a caravan park with high rates of long-term tenants. The second nurse worked in another very disadvantaged area with 90% public housing rates and the third nurse worked in a
rural setting and was well known and liked by the women. The difference in the relationships that these nurses had with families compared to other nurses I observed was striking. In the situations where the nurses were known to the clients, both nurses and the mothers were relaxed and friendly, with the nurses enquiring after many other aspects of the women’s lives other than the baby. Examples included how a recent hospital appointment for the mother had been experienced, and whether another mother had managed to get enrolled in the TAFE\textsuperscript{26} course for which she applied. There appeared to be a mutual respect between the women and the three nurses and a comfortable ease. It was interesting to note that these three nurses also seemed the busiest. The first nurse did not have a centre in the caravan park, although they could have gone to a nearby C&FH centre in the adjoining suburb. The third nurse’s centre in the rural area was the only centre I observed that was busy, with 15 clients and infants or young children seen between 9.00 a.m. – 1.30 p.m., extending well beyond the 12.00 noon time at which the centre was supposed to close.

In contrast, most of the other 40 nurse-client interactions I observed were either home visits (14) or centre visits (26) where the majority of nurses did not know the women. Hence, an ongoing relationship was clearly impossible and the interaction was strictly professional and unfamiliar. The nurse was required to refer back to the client records to determine if there were any issues from the last visit or the discharge summary from the hospital, as they had no knowledge of the woman’s history. Questions were directed at the mother and answered by her with minimal response. A minority of visits I attended with the nurses included follow-up home visits, usually to check on breastfeeding problems or to check the weight of an infant who hadn’t regained its birth weight.\textsuperscript{27} Though these visits were brief and focused on the weight of the infant, the relationship between the nurse and mother was again significantly different from that in visits I observed with first-time clients, as they had met each other at the first

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\textsuperscript{26} TAFE: Technical and Further Education: a vocational education institution.

\textsuperscript{27} All newborns lose up to 10\% of their birth weight in the first few days following birth. Babies are expected to regain that lost weight by two weeks of age. Failure to do so requires close monitoring by the C&FH nursing staff.
home visit the previous week. This demonstrated how quickly it was possible to establish some degree of rapport and confirmed the importance of the relationship and the value of continuity of care-provider.

When asked what the rationale was for the lack of attempt to promote continuity of care between C&FH nurses and their clients, the nurses replied that the AHS believed that ‘continuity is in the chart. They believe that if we all give the same advice and as long as your documentation is up to date, anyone can continue the care with that client’ (CN13). This was seen to be one of the reasons the AHS was so particular with the quality of the documentation process.

**Documentation**

‘With all the paperwork that you have to do there really is very little time to really listen to that mother very much’ (CN12.1).

The documentation required by the service sequestered a large portion of the consultation time. For many of the nurses, the majority of the work time in both sectors was spent attending the first home visit within two weeks of the baby’s birth. In total, nine different forms had to be filled out at this visit – see Table 7 below.

Table 7: Documentation required at first visit

<table>
<thead>
<tr>
<th>Form</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHR1 Registration form</td>
<td>Front sheet of the medical records which contains demographic information such as age, date of birth, address, next of kin, details of local doctor etc.</td>
</tr>
<tr>
<td>Home visit safety checklist</td>
<td>Records information about the home and possible safety hazards such as the presence of outside lighting, dogs, drug and alcohol abuse, aggression and weapons on the premises. This form was designed to be completed via the telephone prior to the health professional visiting the home. However, many of the clients in some of the disadvantaged areas did not own a phone, resulting in the form being filled in during the home visit.</td>
</tr>
<tr>
<td>Ingleburn Baby Information System (IBIS) baseline form</td>
<td>A comprehensive family assessment form consisting of 44 questions that record a range of demographic, physical and social indicators. See below for further explanation.</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Family history</td>
<td>Recording maternal obstetric history and any family history that may affect the infant.</td>
</tr>
<tr>
<td>Genogram</td>
<td>Diagrammatic representation of the infant, mother, father, siblings and relevant extended family members.</td>
</tr>
<tr>
<td>Progress notes</td>
<td>Blank sheets of paper for manual documentation of continuing client consultations.</td>
</tr>
<tr>
<td>Percentile growth chart</td>
<td>Graphical representation of growth measured against population centiles as developed by WHO.</td>
</tr>
<tr>
<td>Developmental checklist</td>
<td>A checklist of expected milestones at relevant ages from 0-5 yrs.</td>
</tr>
<tr>
<td>EDS</td>
<td>Edinburgh Depression Scale: a standardised questionnaire administered to all mothers to assist in the identification of those at risk of postnatal distress.</td>
</tr>
</tbody>
</table>

The SWSAHS Documentation in Paediatric and Maternal File policy states that ‘All mothers who seek clinical consultation with the C&FH nurse in relation to her own personal health management must also have a clinical file commenced’ (SWSAHS, 2003 p.1). If such a file is required, more documentation is required in the form of:

- CGRI Registration Form
- Environmental checklist
- Family History Database/problem list
- Progress Notes.

Sector One nurses were allocated 60 minutes for each first home visit and 30 minutes for follow-up home visits or centre appointments. Sector Two nurses were allocated 90 minutes for all first home visits. Centre visits were only available as a ‘drop-in’, so no additional allocation of time in the centres was possible. Sector Two nurses appeared to have more flexibility with the use of their time, with some nurses
allocating up to two hours for a first home visit if the hospital discharge summary indicated issues that may require extra time, such as breastfeeding problems.

Obtaining the information from the women was achieved in a variety of ways. Most of the participants reported that they were supposed to obtain much of the information through conversational means and some nurses were observed to be more skilled at doing this than others. But given the sheer volume of the information to be collected, nurses had little option but to open the file and start from the top and work their way through. This approach to obtaining information did little to promote a relaxed and informal atmosphere in which a relationship could be developed. All 13 nurses observed in practice offered the mothers the opportunity to ask questions, and most new mothers did respond with queries, but the environment in which these questions were asked and answered did not promote a partnership model. This first home visit was also the first time the new mother had met with a nurse from the service, apart from the phone call when the time for the home visit was arranged.

In addition to the documentation required at the first home visit outlined above, the C&FH nurse was also required to inform the woman about the services of the C&FH nursing team (including an AHS ‘rights and responsibilities’ brochure), the location of nearby C&FH centres, centre times, and telephone numbers. The nurse would then guide the mother through the ‘blue book’, highlighting relevant telephone numbers, recommended development checks, growth charts and the immunisation schedule. Additional information given to the woman included mothers’ groups and other support services relevant to the local community. Written information about these services was placed in the front sleeve of the blue book for further reference for the mother, should she require it.

**IBIS: The Ingleburn Baby Information System**

Due to the broadening role of the C&FH nurses to incorporate physical, psychological and social health in their practice, and to enable the collection of data on key health and social indicators of mothers and infants, a system had been developed by the AHS
called The Ingleburn Baby Information System (IBIS). Computer-scannable forms are filled out by the C&FH nurses at each occasion of care with clients of the service. Two forms exist for C&FH nursing services. A baseline form, with 44 fields, is filled out for each new client, usually at the first home visit within two weeks of the infant’s birth. In addition to maternal and infant demographic details, codes for the staff member and C&FH centre are recorded. Other information recorded includes growth measurements, breastfeeding status, information on weaning from the breast, sleep and settling patterns, support for the mother, employment status of both parents, financial details, accommodation status, access to transport, smoking and other drugs, and how they would rate their own and their infant’s health. A copy of the baseline IBIS form is included in Appendix Four.

Follow-up IBIS forms are used with any subsequent visit the infant has with the service and consist of 26 questions along similar categories used in the baseline form. All IBIS forms are scanned onto a central AHS-wide database (the Maternal and Infant Network or MINET) which records all activities between women and the public health service through the three phases of the maternal and child health care continuum: pregnancy, infancy and early childhood, finishing when the child enters school (Phung et al., 2001).

The type of questions asked and recorded warrants further discussion. The IBIS form contained difficult and sensitive questions. Many of the nurses had difficulty asking these questions and the nurses reported they felt some mothers, particularly those from disadvantaged areas, were reluctant to answer or answered untruthfully. Questions included, for example, ‘would you say your financial situation was very difficult or very good (on a scale of one to ten), or what sort of accommodation they lived in (do you have a mortgage, do you rent privately, publicly etc). As one nurse explained:

   *Some mums get really shocked that we are asking all these personal questions. Like they expected you to come and check their baby and the next thing you are asking them about their financial situation* (CN10.2).
Many nurses thought the AHS was forcing a type of service onto the families that many did not expect or desire, as expressed by this participant:

*You know, they (the parents) might just want to come and weigh their baby and they don’t want anything else to do with you ... and we’ve got to respect that* (CN14.2).

Some nurses saw the process now required of them at the first visit was an ‘interrogation’, which ultimately turned some women way from the service. Houston and Cowley (2002) reported that health visitors in the UK also found that the assessment tools upset and angered clients, who felt interrogated and anxious when the tools were used. The C&FH nurses in this study felt some women were reluctant to come to the centre for a weigh of their baby in fear of being asked too many personal questions.

Use of an inflexible and proscribed series of questions and data collection appeared to inhibit the nurses’ ability to determine and address issues that are important to the woman. The use of the assessment tools therefore conflict, in some respects with the strengths-based approach that is a major principle of the Families First initiative (Office of Children and Young People, 2002c).

Similar problems have been reported in the UK where, although health visitors are most effective when they function in a non-directive, supportive way, encouraging their clients to set their individual agendas, this approach is often not legitimised within managerial and medical agendas (Elkan, Kendrick et al., 2000). Child and family health nurses in Australia, along with their counterparts in the UK, work within the framework of the employing organisations and are required simultaneously to both detect and refer actual or potential problems (mandated by the statutory authority in the area of child protection) but also to work in partnership to empower women and their families. This dilemma is seen as nurses attempt to balance their accountability to their clients, their managers and the profession’s regulatory body (Baggaley & Kean, 1999; Zerwekh, 1992).
Nurses who worked in the public housing areas reported that many of the mothers were very suspicious of some of the social questions they had to ask.

*Particularly the question on how many people live in the house. You know the boyfriend is there and they start stuttering, ‘he is only here visiting’ because it is obvious that she is claiming single parent benefits… so I just tell her, ‘I have nothing to do with Centrelink’*, I just want to see if you have enough support* (CN14.2).

Interestingly, despite these comments at interview, I never observed any of the nurses explain to the mothers why they were asking these questions. In one first home visit I witnessed the mother ask the nurse ‘why are you asking these questions?’ and the nurse replied ‘don’t worry, we don’t do anything with it, it just sits on a computer’ (Obs:CN1.1). Most nurses I observed began the questionnaire with the statement *‘I have to ask you some questions’*. Four of the 13 nurses observed in clinical practice informed the woman *‘you don’t have to answer the questions if you don’t want to’* and started out with the expected details about demographics, birth details, breastfeeding etc, but then moved into the social questions without any further explanation.

The majority of Sector One nurses resented filling in the IBIS forms for each client contact. When asked ‘what benefits do you think collecting this information has for the nurses or the mothers?’, a typical response included ‘Nothing absolutely nothing. Just extra work’ (CN2.1). More of the Sector Two nurses identified that the purposes were for the organisation of services and to monitor public health outcomes like breastfeeding rates, but all 15 nurses working in clinical practice across the two sectors complained that they never received any feedback on any of the data that they collected. They had been recently told that the teams could access their own statistics off the AHS computer network but as one nurse pointed out:

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28 Centrelink is the agency responsible for administering government support for pensions and unemployment benefits.
We don’t have the time or the skills to do that. I am sure there is lots of useful information in there but we need someone to help us understand our own community and identify areas we do well in and what we could target or improve (CN4.2).

Interestingly, a peer-reviewed publication about the IBIS and MINET databases reported strong clinician involvement in its development and the ‘availability of information from the datasets to assist the nurses to monitor clinical effectiveness as well as the health of mothers and infants at a population level’ (Phung et al., 2001 p.107). It also reports the database ‘has become a powerful means of providing feedback on outcomes of care to clinicians’ and takes ‘the final step towards “closing the loop” in feeding clinical information back to the clinicians who can effect change’ (Phung et al., 2001 p109). However, lack of feedback was cited as one of the most frustrating components of collecting the information and, in over five years of data collection, no one could recall receiving any practical feedback.

Having to obtain all the information in the first visit prior to the establishment of any relationship with the woman was also negatively commented upon.

They have never set eyes on you before and you ask them all these really personal questions. I don’t even believe they answer honestly most of the time, which says a lot for the usefulness of the data anyway (CN5.1).

Some nurses were observed to be more thorough in obtaining the information than others. It was compulsory for all C&FH nurses to complete an IBIS form for each client contact of service. Most of the nurses systematically went through each question on each form, whilst a minority completed some forms, such as the demographic forms systematically, and then chatted with the mother about topics on the IBIS form whilst assessing the baby (weight, length, head circumference and physical examination). These two techniques had their own advantages. Systematically going through the forms allowed comprehensive attention to all issues raised in the forms as
well as complete and accurate reporting. However, this approach interfered with the ability of the client to lead the discussions and promoted a didactic, expert-led approach to services.

Research in the UK has found the use of formal checklist systems interfered with the ability of the health visitor to establish a relationship with the client and prevented them working in partnership with the client setting the agenda (Houston & Cowley, 2002). According to Houston and Cowley (2002), health-assessment tools used in servicing non-English-speaking clients were clearly ineffective in determining needs and could have a detrimental affect on the access of services. Checklists or ‘tickboxes’ also had questionable validity in the screening of child abuse and neglect in Appleton’s study on the role of health visitors in working with vulnerable families (Appleton, 1994). In their systematic review on domiciliary home visiting services, Elkan and colleagues identified numerous deficiencies in the use of checklists and screening tools when used for the identification of at risk families. They concluded by recommending the combination of both objective assessment tools alongside the professional judgment of the health visitor in prioritising families who require more intensive care and support (Elkan, Kendrick et al., 2000; Elkan et al., 2001).

A checklist style of needs assessment has also been found to undermine health visitors’ professional judgment (W. Barker, 1996). In a long process of developing a tool for use by health visitors in assessing family needs, Houston and Cowley reported that the health visitors felt that the paperwork interfered with their ability to do their ‘real work’, and stopped the health visiting process. They also felt that the paperwork was meeting the needs of the health visitor over that of the clients needs (Houston & Cowley, 2002). Similar complaints around the increasing requirements in documentation have also been reported to interfere with community nurses’ ability to deliver care in Australia (Kemp et al., 2005).

Appleton and Cowley (2004) found inconsistent use of formal guidelines in the identification of families requiring additional support. Out of 56 consultations with
women and health visitors observed, only five of the practitioners provided evidence of using formal guidelines (Appleton & Cowley, 2004). The authors report that the presence of core guidelines suggests elements of management control which interfere with professional judgment of the health visitor (Appleton & Cowley, 2004).

Some nurses used the form as a guide and either gained whatever information they could through conversation and then referred to the form for points they had missed, or referred to the form intermittently throughout the consultation. In contrast to the systematic collection of information from the mothers, a minority of nurses did not refer to the documents and relied on conversation (and memory of the questions) to elicit the answers. Using this approach, the atmosphere was more relaxed and much less didactic and intimidating for the mother. However, many nurses using this technique omitted several questions that were listed on the forms and failed to fill in those particular questions, leading to incomplete family assessment and data collection. Completion of many of the fields in the IBIS forms was mandatory and the data collection centre would return incomplete forms back to the nurses for further completion. This led to approximately one third of the nurses observed ‘making up’ the answers.

At the end of one of the morning clinics I was observing I offered to assist the nurse in filling in the ‘dots’ of the computer scannable form (many of the nurses lightly marked the fields during the consultation and densely filled in the dots with a special pen at the end of the clinic due to the time this entailed). When I came across fields the nurse had not marked, I asked the nurse ‘what should I fill in here?’, the nurse replied ‘Just mark ‘good’ - the mothers always say “good” so I just fill that one’ (ObsCN2.1). The lack of importance some of the nurses placed on collecting the data was reflected at times by unreliable data collection, as seen in this example. This would affect the validity and reliability of the data results and indicates the lack of importance and understanding the nurses had about data collection.
Regular chart audits were undertaken by management as part of the AHSs’ quality assurance programs to ensure consistency in the paperwork. One nurse commented on what she described as an obsession of the AHS in making paperwork the main focus of the service. As she explained:

*Because it is not your main focus and they are measuring your performance on your paperwork and that is not what it should be about. We are all professionals, we should be doing our paperwork properly and we should have to take responsibility for that* (CN10.2).

This same nurse commented on the policy directing them to record the weight (dressed and bare), length and head circumference at the top of each new entry.

*And sometimes that is not the most important issue at that time and ... people get caught up in the habit of doing the weight and comparing it with last time and that is all they do. And they probably have missed all those other things, so I don’t think you should worry about where the information is written* (CN10.2).

Practice guidelines are developed to ensure consistency of approach amongst practitioners (Appleton & Cowley, 2004). However, this routinised practice appeared to interfere with the mother setting the agenda and the nurse responding to what was important to the mother. Similar findings have been reported in the UK, with Cowley suggesting the use of didactic protocols that specify the exact nature of client contacts is likely to inhibit opportunities to prevent problems and promote responsive and sensitive services and client led interactions (Cowley, 1995).

Time spent on recording the necessary documentation was further impeded by the lack of adhesive labels for each page of the client record. The use of computer-generated adhesive labels is universally employed in all major hospitals. One of the nurses, who came from the hospital sector two years previously, found the lack of these labels an unnecessary waste of time. As she explained *'It was my mission when I first got here to get us sticky labels and I whinged and whinged but they reckon they can't configure the machines or something ridiculous'* (CN7.2).
Universal versus targeted

Many nurses identified a management ‘obsession’ (CN7.2) with the one-off universal home visit. As the main Families First performance indicator in health (NSW Health, 2005), all nurses identified an AHS pressure to ensure each new mother received a home visit within two weeks of birth, sometimes or often, at the expense of all other services. Sustained and long-term home visiting by a known professional has been shown to improve health outcomes in high-risk populations (Korfmacher et al., 1999; Olds, 2002; Olds et al., 1998). It is not known whether single home visits by an unknown professional are effective at improving health outcomes.

Policy documents initially promoted a universal visit to all families and sustained home visiting being offered to families identified in need (NSW Health, 2002b). These policy guidelines developed by NSW Health (2002b) were released in draft form in 2002. It has been suggested in the media that there is currently no infrastructure to support the sustained home visiting (Horin, 2005a). Without additional funding, it appears the policy will not be fully implemented.

Health visitors in the UK report similar frustrations when attempting to provide a core service of universal home visiting (Appleton & Cowley, 2004). Limited time and resources result in health visitors reporting they are unable to build up relationships with clients over time and rely instead on the quality of an ‘immediate relationship’ (Appleton & Cowley, 2004 p.79).

Staff rotation

Frequent centre rotation also affected the nurses’ ability to be fully effective in supporting families and being a member of the community. The staff in Sector One did not have set rotation times, but all of the participants had been moved in the past 12 months. In Sector Two staff were rotated every two years and the rationale for this was reported to be ‘so that your practice is standardised because what used to happen in the past is that some nurses used to stay for years in one place and do their own...’
thing’ (CN14.2). The nurses saw the potential benefits of the rotations to ‘increase your skills and learn new things’ (CN7.2) and ‘prevent burn-out and becoming too involved’ (CN4.2). But the nurses also recognised the disadvantages of leaving their areas. As one nurse explained:

The bad part of it is that it takes so long to get to know your community and for your community to accept you, the doctors and things like that, and all of a sudden it is time for you to move (CN14.2).

And another nurse commented

I have been here for 18 months and it is finally starting to sink how the picture works and who is who. The mothers in this area took ages to open up and trust me (CN7.2).

At the time of data collection, staff rotation in Sector Two was due to occur in several months’ time. The C&FH nurses were not yet aware which centre they would be transferred to and whilst some nurses were not concerned about where they were to go, others reported it as being a significant issue. Sector Two serviced a wide range of levels of advantage across the suburbs and most of the anxiety came from nurses working in the more affluent areas who did not want to work in the disadvantaged suburbs. One nurse said ‘some of the girls have told me that if they get ______ (one of the more disadvantaged suburbs in the sector) they will leave (CN7.2).

When questioned further on the appropriateness of sending these nurses to the areas of complex needs when they did not want to work there, the nurses were ambivalent. One nurse pointed out:

But if we want to standardise practice, they have to be exposed to this sort of thing because we shouldn’t have some nurses who can work in say ______ (a disadvantaged suburb) and some who can’t. If you are a nurse you need to be exposed to all this because that is how you grow (CN14.2).

But others thought otherwise.
There are some personalities who can’t connect so well … nurses come with their own influences on how they have been brought up and where they live and their standards. But even though I am saying that there are some people who can’t do it so well, I don’t think it is fair because you are always going to get a comfortable community nurse who will only be happy to work in the affluent areas. And you can learn so many lessons from working in these areas. Just being exposed to all this makes you look at your own life and makes you come to terms with what is important in your life (CN7.2).

Thirteen of the 15 clinically practicing nurses interviewed worked in disadvantaged areas and agreed that the skills required to support these families differed from those needed when working with middle-class clients. ‘The families here are much more complex and many are totally dysfunctional. It is very important not to be judgmental, and to look for small rewards’ (CN.10.2).

Under-resourced referral services
All of the C&FH nurses acknowledged that there are now many more referral agencies in the community than ever before. However, many referral agencies seemed under-resourced, and one of the major issues around referring women was when the agencies couldn’t accept them. As one nurse explained:

That upsets me more I think (than having no service available), because often I have seen the client and I’ve said, there is this service, this service and this service and finally they have agreed to it and then I contact the service and the service turns around and says ‘oh there is a six-month waiting list’. And I feel I have put this woman’s hopes up to say yes, there is a light at the end of the tunnel and then to find that the service out there can’t manage, and I have to come back to that woman and say I am sorry, you are back to square one (CN1.1).

The availability of services appeared to depend on the area in which the women lived. One nurse describes:
I am lucky because ______ (name of suburb) is so well networked, I have done a few home visits in the other suburbs and it just staggers me because you can identify things and then you can't refer them. I tried to get one woman into family support29 and they said she couldn't get in but if that same woman lived in _____ (her area) she would get in instantly. I worry about being moved to an area that still has disadvantaged women but they don’t have the same resources (CN7.2).

This inequality of availability in services was repeatedly identified by the nurses as a frustrating component of their work. It appeared that the comprehensive family assessment that the nurses were now undertaking was identifying many more issues for families, but the health system lacked the resources to address them.

Lack of interpreter resources was also problematic. Booking an interpreter required lengthy phone calls, often being placed on hold for prolonged periods and some language groups could not provide interpreters for many weeks. This resulted in some women not receiving a visit until the child was over four or six weeks of age. This delay in the first visit was well past the time the nurse could be most effective, particularly in the area of breastfeeding support where duration rates in some of the NESB groups, such as the Vietnamese, were significantly lower than in other groups (Rossiter & Yam, 2000).

Lack of resources has been identified as a barrier to support for families in the UK, leaving the health visitor as the sole health professional servicing families at risk of child abuse and neglect (Appleton, 1996). Other European countries such as Sweden also report on the decreasing availability of other health professionals to refer families to for additional support (Baggens, 2001; Fagerskiold, 2000). Absence of adequate referral agencies leads to increasing pressure and stress on the nurses to undertake more specialised responsibilities such as social work (De la Cuesta, 1993). The C&FH nurses in this study all identified that many more referral agencies were now available

29 Family Support Workers provide counselling support to families.
but that they were poorly resourced and unable to support the number of families that required them.

**Staffing levels**
Staffing levels also significantly affected the nurses’ capacity to practise effectively. At the time of data collection, Sector One had five full time positions unfilled, either through maternity leave, long-service leave and sick leave. As this was all paid leave, it was not possible to seek staff replacements. The staff in this Sector were all extremely overworked and under stress. Though the clinics I observed were all underutilised, there was a significant backlog of clients requiring their first home visit. As the major indicator was that the first home visit be attended within two weeks of birth, there was considerable stress amongst the staff to achieve this.

All of the nurses in Sector One mentioned how difficult things were at the time of the interviews, and reported that with a full complement of staff, they may be able to provide better services to their clients. In addition to low staffing levels, this Sector had replaced four team managers in the previous two years. Such interruption in team leadership further contributed to the teams’ problems. As one nurse said, ‘we are in real trouble at the moment, real trouble’ (CN12.1).

It was of interest that the staffing levels were much more stable in Sector Two where the ratio of C&FH nurses to birth numbers was significantly better (one nurse to 105 births) than that of Sector One (one nurse to 162 births). It was not possible to establish whether the higher numbers of staff to birth ratios contributed to the decreased staff turnover and reduced number of unfilled positions. The nurses interviewed from Sector Two appeared significantly less stressed. For example, they did not complain as vehemently about the paperwork, and overall seemed happier in their work. Kemp and colleagues (2005) found similar results in their review of community nurses in Sydney. Where nursing teams had experienced increases in staffing levels, these nurses responded positively to the changes in work requirements.
However, when there was no increase in staffing resources, the nurses were much more negative in their comments about work loads and change (Kemp et al., 2005).

**Centre hours and services offered**

Further factors within the health service that the nurses felt impacted on their ability to effectively support families included the hours of operation within the centres, which the nurses’ reported were inconsistent. Long waiting times and restricted opening hours have been identified as serious deterrents to the use of health visiting centres in the UK (Mayall & Foster, 1989).

Very few of the centres were open five days a week and none were open all day. Some of the smaller centres were open from 9.00 a.m. to 12 noon every second Monday or from 9.00 a.m. to 12 noon on the first and third Thursday of every month. If a mother wanted to access the service, the health centre would more likely not be open (in Sector Two), or she couldn’t get an appointment (in Sector One). Furthermore in Sector Two, there were up to three C&FH centres located in one suburb, all open on different days. The rationale for this was so that there was one centre within walking distance for all women in the community. However, it resulted in the service having to maintain many more centres, open for only a few hours every week or every second week. This would result in many women not accessing them because of confusion about opening hours. Another factor influencing opening times was the placement of several C&FH centres within public schools. The education department that provided the venue for these centres (mostly demountable buildings) insisted that they not operate within school holidays. As one nurse working in a suburb with high public housing pointed out;

*These mothers are hard enough to access as it is, let alone only being opened once in a blue moon. If they were thinking about coming down I am sure they wouldn’t bother if they thought we wouldn’t be open* (CN10.2).

Lack of use of many of the centres was confirmed through observations where, in all but one centre (the rural centre) I visited in Sector Two, the centres were quiet with few or no women in attendance.
The nurses held conflicting views about the difference in ‘drop-in’ versus appointment services at the centres. Most of the nurses in Sector One, where only appointments were available in the majority of the centres, believed that appointments as the only service option were inadequate, as they led to long waiting lists and the inability for women to access support if they needed it. As one nurse said:

*You sort of push yourself to get through the visit in half an hour and you have got all of these forms to fill out, you know. The service now, as far as I'm concerned, prioritises the new baby, so they get seen then but to see them again is almost impossible, you are so overbooked … you don't see them again until say til eight or nine weeks and by then they have weaned their babies and put them on the bottle* (CN12.1).

Though there was a reported six-to-eight week waiting time to gain an appointment, during my observations, 14 out of a possible 29 appointments were not kept. This resulted in long periods of time when the nurse would have nobody in the centre. Appointments that booked clients did not attend (known as ‘no shows’) also resulted in the waste of interpreter resources. Interpreters frequently travelled significant distances for one appointment to find the client did not turn up. Because of the long waiting lists, appointment times were often made many weeks in advance and it was not surprising that the women would forget. The nurses tried to minimise ‘no shows’ by phoning the mothers to remind them, but this was only done on the morning of the centre and by then many of the mothers did not answer the phone or told the nurse they had forgotten and made other arrangements. Each of the four C&FH centres I observed in Sector One had at least two women not turn up for appointments. In one full-day clinic I observed, six women out of a total of 10 appointments did not attend or cancelled on the morning of the appointment. In another morning clinic I observed, out of a total of six possible appointments (one for every half hour from 9.00 a.m. to 12 noon), only two clients turned up.
Drop-in clinics, the only option for women living in Sector Two, were also criticised by some of the participants for placing too much stress on the C&FH nurse, who was unable to give the woman the attention she required.

You are under so much pressure cos you've got this mum in tears and a waiting room full of mothers, it really can get very stressful (CN15.1).

However, of the six centres I visited in Sector Two, only one rural centre was busy. The remaining clinics I observed were largely empty. This is partly due to the areas of particular disadvantage that I targeted in my research, as lower socio-economic status groups are known to under-utilise health services in Australia (Ochiltree, 1991; O'Connor, 1989). Several clinics that I did not observe were reported to be very busy, particularly those located in shopping centres.

The most common reason for dissatisfaction of the service in low-risk women in the UK was lack of appointment systems and subsequent delays experienced by mothers when attending clinics (Bowns et al., 2000).

Creating an environment that promotes client access

There were several other factors that appeared to impact on the ability of the C&FH nurses to effectively support parents. These factors included providing a welcoming and attractive environment that promoted a professional, contemporary and relevant service for families. This environment should encourage families to attend and make them feel welcome when they did arrive.

The image of the centres

Though not identified by the nurses as a deterrent to client access, the poor image of many of the C&FH centres was significant to an observer. The quality of venue varied across the two Sectors but many were cold, small, unattractive and sparsely furnished. Minimal health promotion posters adorned the walls and the furniture was limited and unattractive. The consultation rooms typically contained a desk with one chair for the C&FH nurse and two chairs for clients. They also contained a small table supporting a rigid wooden measuring board. This table was the only space available for the mother.
to undress the infant and had to be done at an awkward angle with the infant lying across the table and inside the measuring board frame. Filing cabinets containing the records usually stood in the corner of the room, typically near a sink. There were never toys or playthings to entertain older babies or toddlers. Most of the clinics were only open a few days a week, so had a musty unused odour. Waiting areas were also typically small and uninteresting, with a few posters on the wall and an old pamphlet-stand with minimal inclusion of health-promotion pamphlets. Many nurses asked mothers to take soiled nappies away with them, as they had infrequent cleaning services to empty the bins. The centres all had a telephone, but no facsimile machine or computer.

The waiting rooms were also usually empty and provided no opportunities for women to meet other mothers. This was due largely, in Sector One, to most of the clinics being structured as 30-minute appointment times. This staggered the arrivals of the clients. In Sector Two, the centres that I visited were largely empty, due to lack of attendance by the clientele.

There have been similar complaints raised in Victoria over the inappropriate, outdated and poorly maintained facilities in the buildings that house their maternal and C&FH nursing services (ANF Maternal and Child Health Nurses Special Interest Group, 2004).

Cowley (1999) suggests that cold, dreary and unwelcoming clinics act as a barrier to the health visitors’ ability to enhance client resources for health. Whilst the clients’ perceptions of the facilities were not examined in this research, it can be assumed that the venues described would not maximise client access.

*Dress code*

The AHS dress code was another contentious issue amongst the nurses. The nurses all wore plain clothes (not uniforms), but were restricted in their choice of dress by occupational health and safety rules which insisted on closed shoes, did not allow
shorts or jeans and insisted on a ‘conservative’ appearance. This level of control over what to wear was seen by some nurses to influence how they related to their clientele. As one nurse explained:

One time I turned up (to a meeting following a morning clinic) in jeans and ____ (manager) said ‘why are you in jeans’ and I said ‘well if I am all done up in a dinner suit the clients would hardly want to come and see me’. They are hard enough to attract as it is (CN10.2).

Another nurse said:

I keep getting in trouble for wearing jeans but I could no longer wear a dress as I could court shoes because that’s not me and they (the clients) know it’s not me and so it would take me ten times longer to establish the relationship than it would with me wearing what I’m comfortable wearing (CN9.2).

Refreshments

Another AHS policy that impacted on the potential to engage families with the service was the availability of refreshments for the families. As one nurse pointed out:

You know, it sounds petty but it is the little things like allowing the mums to make themselves a cup of tea. We have women wait quite some time in some of the clinics. When I first came I used to encourage them to make themselves a cup of tea, you know and chat amongst themselves. But I had to stop that because of occupational health and safety. In case one of them burnt themselves or their babies (CN14.2).

Computer access

Lack of computer access also impacted on the C&FH nurses’ practice. None of the centres had computers, but there were three machines in each of the Sectors’ ‘base’ centres for use by the C&FH nurses. There was no Internet access for any of the nurses, but they could access the NSW Health site via the Intranet. Many of the nurses conceded poor personal computer abilities, but the system denied opportunities for
their skills to be developed due to slow log-in times and lack of Internet access. They also lacked opportunities to access education on information technology, despite recent recommendations from a national review of nursing education for long-term staff who are not technically proficient on computers to receive such education (Crowley & West, 2002).

They make you feel like a kid if you want to get information from the net. I have to go to my boss or the educator if there is any information I want off the net. Besides the system is so slow, it can take up to 45 minutes to get on sometimes and sometimes you can’t get on at all. I can’t believe in today’s age we aren’t more encouraged to use the computers (CN11.1).

Lack of computerised records also impeded efficient service. Whilst general client information was computerised, their records were stand-alone files and were kept in the C&FH centre the woman was designated to visit. As already mentioned, many centres were only opened a few hours every day, so if someone rang the intake number or the base centre for information on a client it would not be possible to access the records immediately. Also ‘if a woman turned up at another clinic where her record wasn’t held, you can’t get any information unless the woman’s home centre was being attended and the nurse wasn’t busy with a client and picked up the phone’ (CN15.1).

**PART TWO: PROFESSIONAL CHALLENGES TO CHANGING PRACTICE**

During the interviews, discussion around factors impacting on the ability of nurses to be effective in practice drew many insights into and criticisms of health systems, structural difficulties and problems with management. There was very little insight shown by the nurses into their own personal positions and attributes that contributed to the quality of service the families received. Some of the nurses were able to identify other nurses who were struggling with the changing role, but no nurse was able to
reflect on personal challenges she experienced, or her under-preparation for the changing practice.

It has already been established that the change in practice of the C&FH nurses was significant. Most of the nurses had longstanding experience of being the authority figure, located in a C&FH centre, servicing mainly those women who chose to come to the service for the monitoring of the infant’s growth and development. Now they were expected to be a professional who accessed all women in the community, visited them in the home and invited them to the service as an active partner in their care. This change in practice was difficult for some of them. As one participant observed:

*Some of the staff who have been nursing for over 20 years in the field are struggling the most because they wouldn’t have had that kind of approach before. You know, the old role of C&FH nurse was very authoritarian, the communication wasn’t such a big deal because the women just did what they were told* (CN17.1)

This was confirmed throughout the observations. In spite of the changes reported by the participants, some of the C&FH nurses in clinical practice still maintained a more traditional approach. This was evident by observing them approaching the consultation with the client in an efficient and task-oriented way, asking the women questions in a didactic manner. For example many of the nurses were found to methodically enquire, ‘what is the baby drinking, how much and how often? How many wet nappies per day?’ in a heavily routinised format. The nurse would then feed back information to the woman in a way that secured her position as the expert where she had gathered all necessary information so she could now instruct or grade the woman’s performance. A typical response would be ‘*I am happy with baby’s weight gain and he is doing all the right things*’, and would often follow this up with such comments as ‘*you are doing very well, mum*’ (Obs:CN8.1).

As already mentioned, several of the nurses could identify colleagues who were struggling with the new role. One participant observed:
If you asked anyone in the team, they ..., even the people who struggle with communicating with people, agree with the principles of Families First. But, they don’t know what to do … or they believe they can’t do it (CN17.1).

The concern from some of the nurses related to the ability of others to change their practice and this was repeatedly confirmed throughout observations. Their approach remained authoritative, in spite of good intentions.

The following example demonstrates the difficulties some of the nurses had in changing practice. One nurse in the C&FH centre had completed an assessment on a 12-month-old girl whose mother had commented was a fussy eater. The nurse said to the mother, ‘She’ (the child) ‘is doing well, I am not worried about her. There is just the food, you have to try harder with that’. The nurse later followed up with the comment, ‘she seems very possessive of you. You should try to get her to playgroup to mix with other children’ (Obs:CN8.1).

This child, I believe, was showing normal shyness around strangers (there were two of us in the room). Offering her opinion around ‘possessiveness’ left no opportunity for the nurse to explore if the mother had any concerns around the child’s behaviour (which she didn’t). Rather, the nurse’s comments were more likely to raise the mother’s anxiety over an issue that was not in any way a problem, nor was it potentially detrimental to the child’s health. Similarly with the food intake, the child’s growth was well within normal parameters. Rather than reassure the mother and explore whether food was an issue for the mother, the nurse instructed her to ‘try harder’. These comments could be expected to have a negative effect on the mother’s confidence regarding her ability to parent her child and shows little evidence of ‘supporting the mother’, working with the mother’s strengths, or allowing the mother to set the agenda.

Another nurse was filling in the paperwork following a developmental check on an eight-week-old infant in the centre. The mother, a Cambodian woman, was dressing
her baby on completion of the physical examination and left the baby alone on the
table (within the rigid measuring board frame) to get a fresh nappy from her bag. The
nurse instructed her through the interpreter in a strict authoritative voice:

Just then you left the baby on the table. No. You should not do that. You must
always stay with the baby. Don’t leave the baby alone on the table, or the bed or
the sofa (Obs:CN2.1).

Whilst this could be seen as a health promotion exercise to prevent injury to the baby
through a fall, it shows little sensitivity of the woman’s strengths, determining what
issues are a concern for her and working together to address them. Rather it would be
reasonable to expect it to diminish the mother’s confidence, as the woman was clearly
embarrassed in front of the nurse, myself and the interpreter.

Educational issues
Another factor that appeared to contribute to the ability of the C&FH nurses to adopt
the changing practice was the age and education of the staff. Eighty-eight per cent of
the 17 nurses were over 40 years of age. As one nurse commented ‘it is such an aging
workforce. I think we are all about the 45 age mark’ (CN7.2).

The nurses were aged between 26 and 62 years of age with a mean age of 47 years and
a median age of 49 years. The range of years’ experience as a C&FH nurse was
between two years and 36 years’ with a mean of 14 years experience and a median of
10 years.

Eleven of the 17 nurses (65%) were registered midwives and all held formal
qualifications in C&FH. Sixty-five per cent (11/17) of the nurses had received their
C&FH qualification prior to 1992. Only three of the 17 nurses had undergone
undergraduate nursing preparation within tertiary institutions. The remainder had
received pre-service education within hospital education programs, prior to the
availability of tertiary education programs.
Apart from the four nurses currently undertaking the graduate certificate course in C&FH nursing, (at no cost to the students and with all lectures delivered in work time), the majority of the participants had not attended any formal education courses since the 1980s and 1990s. Apart from their education to become registered nurses, midwives and C&FH nurses, only three of the 17 nurses had received further tertiary education, one as a degree in social sciences and two in graduate diplomas in community health.

Research has found that some nurses are ambivalent about the need for academic and professional development and would prefer to remain in direct patient care (Yam, 2004). This was evident in this study by comments that reflected an almost universal disinterest in obtaining further education. These nurses identified themselves as either being ‘too old to bother with more study’ (CN2.1) or were younger but had external commitments of young children.

One participant, however, provided some interesting insights into the paradox of C&FH nurses having to come from a background of acute-care nursing. Coming from, and working within, a health care industry that was dominated by the medical model was identified by this participant as a significant barrier to the ability of some of the nurses to change practice. This is seen in the following quotation.

*I struggle a little bit to think that RN preparation is what we need. I think that if we spend three or four years talking to people about diseases and disease processes and then get 6 or 12 months, part-time, talking about family functioning. This does not prepare you to work within wellness models of care ... about working with families in partnerships. It is difficult to make that shift, but I also think what is normal growth and development and all those sorts of things is really important too ... I wonder whether we need something like direct-entry midwifery where ... the training scheme concentrates on working with families within the context of community development and health promotion and family support. More the sort of training that somebody needs so it is kind of like a bit of mix between what they*
would currently get as a C&FH nurse but perhaps more welfare and community development (CN16).

Currently in the UK, the Nursing Midwifery Council (NMC) has indicated that health visitors will soon be able to access direct-entry courses, alongside other public health practitioners such as midwives. Such public health course curriculums will continue to contain a nursing and midwifery component but prepare students to work within social models of health care, and dilute the influence of the biomedical model that continues to dominate nursing education (Clay, 2003). This will result in health visiting graduates being available in the workforce in three or four years, rather than the six or more years it is currently taking for health visitors (and C&FH nurses in Australia) to achieve their qualifications.

Proponents for direct-entry health visiting argue that health visitors spend three years as an undergraduate of nursing learning about wound care, ward rounds and clinical skills, followed by a much shorter course (a minimum of 32 weeks) (Clay, 2003) that involves insufficient time to prepare students for the complexities inherent in public health (Haughey & Cowley, 2000). Cowley contends that a more logical approach would include a three-year undergraduate degree program which includes the nursing elements necessary for health visiting practice but with more emphasis on the public health aspects currently underrepresented in post-graduate health visitor curriculums (Haughey & Cowley, 2000). Critics against the direct-entry health visitors program contend that knowledge of illness and disease are inextricably woven into health visiting practice, particularly as health visitors in the UK service other community groups such as asylum seekers and the elderly (Haughey & Cowley, 2000).

A C&FH nurse in this research believed the biggest barrier in changing practice was the significant paradigm shift required by the nurses to become partners with women and their families in a way that developed strengths rather than identifying and working on deficits. For C&FH nurses, trained in a model wherein the nurse was the expert and the authority, and having worked within that model for 15 years or more, it
is unreasonable to expect them to quickly adapt to an opposite model, as this requires a complete new set of skills. As explained:

(Nurses) need to know how to engage and be conscious of where and when the relationship is changing ... how to challenge appropriately, define your own and their boundaries ... understand what advocacy means and how to empower people. There is nobody in the team who knows how to do that (CN17.1).

When asked about what sort of training the participants had received in preparation or support in their new roles under Families First, eight of the 17 nurses gave vague and non-specific responses. Five nurses couldn’t remember receiving any training at all, whilst two others thought they may have been on leave when this was offered because they could not recall any training. As one nurse said ‘they keep telling me that I went to training but I can’t remember this. I told them I was on holiday … but they say my name is down as already been’ (CN2.1).

The younger nurses, and those who had not come from years of working in the health system, appeared to embrace the concept of the strengths-based approach more successfully. Five of the 17 participants (29%) had completed their C&FH nursing education within the last three years, four of them through the AHS developed-and-run certificate course. These five nurses could all readily define the strengths-based approach and describe the implications this philosophy of care had on their practice. The other nurses were mixed in their understanding of a strengths-based approach.

When asked about the strengths-based approach, a third of the nurses could not articulate what it meant to them or how it influenced their practice. Some of the nurses appeared confused when describing the term as the following quote indicates:

Strengthening their weaknesses, building onto their weaknesses. And encouraging them in good decision-making practices, and I mean it’s education. It’s informing, it’s advising, it’s valuing them and explaining the reasons why this is beneficial to
them and their children. And identifying their strengths, identifying their weaknesses, and that’s an ongoing thing (CN10.2).

Four of the fifteen nurses, all long-term C&FH nurse employees of the service, could not describe what the strengths-based approach meant to them.

The lack of preparation for the implementation of the Families First initiative that some of the nurses reported was challenged by one participant, who claimed:

There has been lots of AHS training. (Following) a consultancy on what training we needed, there was stuff about counselling, understanding social policy and capital, what is Families First. At a local level we had half-day counselling sessions, social capital, domestic violence, drugs in pregnancy training, … stacks and stacks of training. I have had said to me from one older nurse, ‘I can’t do open ended questions, I wasn’t trained like that, I don’t know how to do what you do’ (CN17.1).

The difficulties in applying a strengths-based approach were evident in many of the consultations I observed and is illustrated in one example in the box below.

| A young mother in her early twenties brings in Frank, her four-month-old boy. She is first-generation Lebanese, is well dressed, as is her infant. |
| The nurse welcomes the mother to come into the room. |
| Nurse: How is it going with Frank? |
| Mother: Good, he is sleeping through the night now. |
| Nurse: Excellent! Aren’t you lucky? And what milk is he having? |
| Mother: S26. |
| Nurse: How much? |
| Mother: Three and a half scoops. |
| Nurse: How do you measure half? |
| Note: (the manufacturers do not recommend using half-scoops, due to the difficulties in being precise. The nurse does not mention this at this stage) |
| Mother: Just half, I thought I would gradually grade him up. |
Nurse: And what are his poos like?
Mother: OK.
Nurse: Hard? Soft?
Mother: Soft.
Nurse: The reason I ask is they don’t usually promote half-scoops
Note: (doesn’t mention why or who ‘they’ are)
Mother: no response.
Nurse: Do you have any questions?
Mother: Yeah. Now he is four months what about solids, I have tried a little bit of Farex.
Nurse: Well they (doesn’t say who) have changed it until closer to six months.
Mother: Yeah, I had heard that.
Nurse: Yes the problem is the commercial food companies still promote four months, but they think close to six months is better because of allergies and especially with Frank who is managing to sleep through the night. Have any relatives been trying to persuade you? (to introduce solids).
Mother: They all have their two cents’ worth. My mother-in-law says ‘I fed all mine after 40 days’ and I said ‘good for you’.
Nurse weighs and measures Frank, and records all measurements in the records.
Nurse: You are doing a lovely job, everything looks good.
(The nurse begins to do a full inspection of the baby whilst asking questions around development such as ‘Is he having tummy time? Is he vocalising?, Reaching out for toys? The mother reports that Frank is doing all those things, suggesting normal development for a four-month-old)
Nurse: So you’ve got some good support at home?
(a question from IBIS)
Mother: Yeah, lots.
(no exploration of what sort of support).
Nurse: The other thing about waiting to feed them closer to six months, they say is that they should have more head control so they can hold their head up properly.
Mother: Yeah so they can swallow and stuff.
Nurse: And also that their bodies are more mature and can digest it and as I said before the allergies.
Mother: I did try him with Farex but he wasn’t interested.
Nurse: You will find a big difference over the next few months where he will become a lot more interested. Do you find that he is looking at his hands at all?
Mother: Yeah, a lot.

The Nurse is scanning her eyes across the IBIS form and finds the following question.

Nurse: Do you find you can get out of the house by yourself at all?
Mother: I have my mum and my mother-in-law but I usually take him with me anyway.

Nurse: Well you are doing a great job, he looks very well cared for. Any other questions?
Mother: No.

Nurse: Will we make another appointment for his six month check then?
Mother: OK.

Appointment is made and mother leaves.

(Obs:CN1.1).

The above example demonstrates the C&FH nurse attending the consultation in a traditional, routinised and proscriptive format. The nurse has clearly been assessing information around nutrition, elimination and the developmental achievements of the infant for many years and it forms the cornerstone of her practice. However, interspersed with these traditional questions, the nurse enquires about the mother’s social health and types of support, but the enquiries are also positioned within a structured and didactic framework. There is no evidence of a strengths-based approach or working in partnership with the mother.

It appeared difficult for many of the nurses to undertake the complexity of tasks and style expected of them. They were required to deliver the fundamentals of C&FH nursing practice, the growth and development checks, as directed by NSW Health, the AHS as well as client demand, but do this in a way that provided the opportunities to explore other aspects of the woman’s life that may assist her in improving her ability to parent and decrease social morbidity.

Similar difficulties have been documented in the UK. In a large study on health visiting in the late 1980s, Mayall and Foster (1989) found very few health visitors operated in true partnership models. Many health visitors operated somewhere on a continuum between the partnership and expert models (Mayall & Foster, 1989). Some
health visitors were typically found to support the notion of partnership, but they attempted to guide mothers’ behaviours in the direction that the health visitors identified as correct (Mayall & Foster, 1989).

**Professional development**

Capacity-building of the workforce through ongoing education is an important component of any health service (NSW Health, 1999). The nurses in this research provided conflicting information regarding the ongoing education that had been provided and what was still needed. Sector One nurses came together every Wednesday, but this time was usually spent at a staff meeting, though professional development sessions education were occasionally provided in this time. The Sector Two nurses, the better resourced team of the two Sectors, were almost universal in their complaints about AHS professional development. Every Wednesday afternoon they met at the base centre for education. As one nurse stated, when asked what education she had received to assist her in working with disadvantage groups:

> We have a lot of training. I can't think what I've done. I’ve been here for 23 years. I have done so much training that I’m sick of it and now when we have to go, I kick up a stink, saying I'm not going … but I still have to (CN13.2).

This response was not uncommon with the Sector Two participants. Many of them felt that professional development and staff meetings were too frequent and kept them from ‘doing our job’, which was seeing the women. As one nurse explained ‘when nurses go off to conferences and courses that puts stress on the rest of the team so (whilst staffing levels were not at full capacity) we have decided to put all that on hold (CN11.1). Health visitors have also stated difficulties in attending courses for professional development, due to lack of replacement staff for clinical commitments (Doolan, 1997).

When asked what they thought they needed to assist them in doing their job more effectively, many of these same nurses stated that they wanted more opportunities to learn and further update their knowledge and skills. They did not regard the weekly
educational inservices as providing such opportunities and felt they deserved some autonomy to choose and participate in forms of education outside the AHS. Three nurses referred to wanting to attend conferences (only one clinical nurse had been to a conference in the last five years) and other external courses, or being supported to undertake university programs. However, the expectation from the nurses was that this education be provided in work time, with full financial support provided by the AHS for the nurses to attend.

One nurse was discussing her educational achievements in the 1980s and said ‘you’ve got to keep training and being educated, otherwise subtly things go by you and you miss out on things and if you want to be professional you should (keep being educated)’ (CN1:1). However, this nurse and all of her long-term colleagues had not undertaken any further education since the 1980s. Two nurses confided that they were biding time until their retirement, with one of them saying ‘I will only do what I have to do – the mandatory inservices, because they make me go’ (CN 9.2).

Discussions around education regarding working cross-culturally were similarly vague and non-specific. Most nurses recalled attending the AHS cross cultural workshop that was compulsory for all staff, but when asked what they remembered learning that assisted them in their practice, they were largely non-committal, with the exception of one nurse who claimed it ‘was extremely inappropriate … treating those people like they had 15 heads and came from a different universe’ (CN9.2). Many of the nurses discussed learning ‘on the job’ and any training they had received ‘just verified for me that you have to start looking at it from their perspective’ (CN1.1).

The NSW Health Department introduced a state-wide education program called ‘Family Partnerships’ training in 2004. The program is based on the Parent Advisor model from the UK by Hilton Davis and colleagues (Davis et al., 2002). It is a 40-hour program delivered over ten half-day workshops. Seminars and role-play activities assist health providers to improve their communication and listening skills and to work in partnership with families. Currently the program is being rolled out across the state, with facilitators being trained in each AHS to promote sustainability of the
program. As the data for this case study was collected in 2003, none of the participants had undertaken the program.

Clinical supervision

Both Sectors One and Two had attempted to run monthly group clinical supervision sessions the previous year. The sessions had lasted several months and had been abandoned in both sectors, due to lack of attendance by the nurses. Thirteen of the 15 nurses in clinical practice reported that the sessions were useful, with only two describing that they believed clinical supervision was a ‘waste of time’. The reason the sessions did not continue was thought to be due to staffing shortages in Sector One (the sessions were held on a Tuesday when most of the nurses had clinical commitments). It was not known why the sessions were abandoned in Sector Two. The nurses in Sector Two reported that clinical supervision was about to recommence for those interested but one participant suggested there was minimal interest amongst the staff when she said ‘they put out an expression of interest but I think only three of us, out of 40 nurses put our hand up and said we wanted it reinstated’ (CN7.2).

Clinical supervision has been identified as having benefits related to professional development and support (Darley, 1995; Goorapah, 1997) and accountability (Rafferty et al., 2003). The improved skills gained through professional development and support are claimed to indirectly improve health outcomes through higher quality of care (Stokoe & McClarey, 1995). Clinical supervision is also thought to enhance reflective practice and life-long learning (Goorapah, 1997).

Regular clinical supervision is recommended by both the professional association (CAFHNA, 2003) and NSW Health guidelines around home visiting also support it (NSW Health, 2002b).

Whilst it is not possible to force the staff to attend the clinical supervision sessions, it is management’s responsibility to provide the infrastructure to make the sessions as
accessible as possible. Provision of the sessions when nurses usually undertook clinical work was seen as a barrier for the nurses to access clinical supervision.

**Working with families from different backgrounds**

The nurses’ own life experience and value systems also appeared to influence their own ability to effectively support families. All of the 17 participating nurses were currently, or had previously, worked with groups disadvantaged by language or income. They usually demonstrated a broad understanding of cultural and social influences on parenting behaviours. However, many of the nurses expressed frustrations with the reluctance for particular cultural groups to adapt parenting practices that the nurses felt were detrimental to the infant’s health and development. This is demonstrated in the following quotation.

> There are little things culturally, like habitual, but sort of backward and not so healthy for the baby. Like putting sugar in the milk because they think it will make the baby healthy. Or starting solids really early because their parents did and that their culture as well, you know, starting Farex at six weeks. There is one culture – some Chinese and even some Vietnamese who don't hold the baby much, they think it is bad to hold the baby. They think it is spoiling the baby. They also hold them flat because they believe if you sit them up, it is bad for their back. So those babies don’t get held very much sometimes and they get very flat heads (CN3.1).

Whilst early introduction of solids is not recommended, due to the increased risk of food allergies and diarrhoeal disease secondary to food pathogens (NHMRC, 2003), other practices, such as ‘getting flat heads’ from not being picked up has not been shown to be detrimental. This nurse requires reassurance that parental behaviours such as the amount of time the child is held is socially constructed and without evidence to support the enforcement or promotion of western practices. This same nurse also described some of the tensions she felt when providing services to these families. ‘It is very hard to show them a different way without making it look like I am putting down their culture and don’t respect them and making them think that I am not just wanting to impose my western way on them’ (CN3.1).
The above quote demonstrates a need for skills development and guidance. Minority groups are often seen as inferior and nurses tend to negatively stereotype (Bowler, 1993; Foster, 1988). As other nurses explained ‘they do what their culture tells them to do and that is so frustrating because it is so time-consuming and you know you are hitting your head against a brick wall’ (CN11.1), and, ‘I repeat myself over and over and still nothing changes’ (CN2.1). These comments suggest a lack of insight and inadequate educational preparation for working with cross-cultural groups. United Kingdom researchers have also identified that educational preparation is inadequate for nurses to work effectively with minority groups (Gerrish & Papadopoulos, 1999). Child and family health nurses could be assisted and supported to undertake reflective learning around the types of issues outlined above, through forums such as clinical supervision.

Another nurse demonstrated a similar conflict in the way she tried to reassure families around choice of formulas and contradicted current evidence. We were discussing the cost of formulas and how some mothers with scarce financial resources were paying high prices for a new formula that contained fatty acids, marketed to improve brain development in the infant. She reported to me:

   *I tell the mothers that my mother had eight kids and we were all breastfed except for the last one (who is) the smartest of all of us and the only one who has been to university and he was raised on Carnation milk* (Obs:CN.3.1).

Again, this nurse may benefit from the opportunity to discuss these beliefs in a peer group with skilled and appropriate guidance such as clinical supervision.

**Use of language**

During observations, several nurses used language that could be seen to impede the promotion of equal partnership between the woman and the nurse. Language such as ‘mum’ or ‘mummy’ when addressing the woman, or ‘bubby’ for the infant was employed by several of the nurses in a way that was demeaning and disempowering. Another phrase used by many of the nurses when complimenting the mother was

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‘good girl’. As many of the nurses were over the age of 45 or 50, and most of the mothers were in their twenties, use of the term ‘good girl’ promoted the (experienced/expert) maternal role of the nurse and the (novice) daughter role of the new mother. Nurses have been found to demonstrate similar language in hospitals settings and patients have reported such terminology to be disrespectful and demeaning (Henderson, 2003). Use of this type of language is suggested to be used to enforce compliance and interfere with the notion of partnership between nurse and client (Henderson, 2003).

Cowley (1999) found a negative or belittling attitude or response from the health visitors resulted in compromising the mothers’ ability to develop or generate their own resources. Comments in this research such as ‘you should try harder’ (Obs:CN8.1) or ‘I am not happy about bubbys milk intake’ (Obs:CN15.1) are counterproductive when attempting to enhance the capacity of families to parent.

**Taking the service to the home**
The paradigm shift required of the nurses in changing practice to a more family-focused, strength-based approach was also impeded by the organisational components that standardised practice and measured performance by way of chart audits. This was demonstrated in the way in which many of the nurses conducted home-visits, particularly the first visit. Rather than maximise the benefits of working with families within their homes, the observation data revealed that on most occasions, the nurse was seen to transfer the services of the centre to the woman’s home. This was most apparent when the nurses undertook the first home visit. After being invited in by the woman and enquiring into her welfare, the nurse would launch into the required paperwork before unpacking the scales and measuring board and proceeding to weigh, measure and inspect the infant. There was little opportunity to relax and learn about what issues were important from the woman’s perspective, apart from perfunctory enquiries often asked by way of ‘any questions, queries or concerns’ (Obs:CN1.1). The nurses often used this phrase in a manner that allowed minimal exploration or dialogue. The consultations were dominated by the need to complete the paperwork.

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and undertaken the newborn check. Growth, development and physical aspects of care have also been found to dominate the work of C&FH nurses in Sweden (Baggens, 2001), and health visitors in the UK (Kendall, 1993).

**Weak professional identity**

Five of the 17 nurses believed that they were not given enough professional respect for the work they did. As described by this nurse:

*The AHS like to think they have a handle on every single one of us and that I don't think I just speak for myself here that we don't feel as though for the sort of work that we do that we're sort of given professional trust enough (CN13.2).*

The five nurses felt that the service did not place enough value on the skills and expertise the nurses brought to the service. Although all of the participants in this research had formal qualifications in C&FH nursing, the ability to recruit staff had become so difficult that some AHSs were recruiting generalist nurses into the role with no specific C&FH nursing expertise (personal communication; M Balanski, Families First Project Officer, SWSAHS, April 2003). As one nurse explained:

*Where you have nurses who are working in the system who are saying well really, basically anybody can do this, umm, then I think that is a shame. I think C&FH nurses should be promoting themselves as a professional group and that this is a perfect time to be doing it with the focus of Families First and the political spotlight on early childhood (CN16).*

Two nurses expressed frustrations about what they sensed was apathy and poor professional standards amongst their colleagues. One nurse reported ‘we shoot ourselves in the foot, especially if we don’t want to change or we are not keeping up to date, bad practice ruins opportunities for working relationships (CN17.1).
Several of the nurses believed that C&FH nursing had traditionally been a less important or valued job, compared to other nursing sub-specialties. One nurse who had left the hospital system two years previously explained:

*I always thought it (C&FH nursing) was a great job but it was for the older ones. (Before) I wanted to be in the frontline, where all the excitement was and I think it is still like that really (CN7.2).*

Another nurse who had transferred from maternity services five years previously felt the profession had a poor image within both professional and community circles. She reported:

*My old mates at the hospital tell me ‘I hear it is a bit cushy out there and you guys don't do much’. And then there is the ‘oh I had a neighbour who was told to give such and such at this age’. So they all reckon we don't know what we are doing (CN10.2).*

A weak professional identity of this group of C&FH nurses was also evident through their lack of membership in their professional association. The Child and Family Health Nurses Association (CAFHNA) of NSW has a membership of 400 out of 819 nurses (NSW Health 2003b) working across the state. However, only two of the 17 nurses participating in this research were members of this Association. This is a considerably lower proportion than can be found in the state membership. Furthermore, almost one third (5/17) of the participants had never heard of it and only one fifth (4/17) could describe what the Association did. Several of the nurses who had heard of the Association identified it by the Competency Standards that had been developed by CAFHNA and were used in recent performance appraisals in Sector One. When the nurses were asked why they weren’t a member of the organisation, most just shrugged their shoulders and three indicated that they should belong, yet, as one participant (who had been a C&FH nurse for over 30 years) said, she ‘hadn’t gotten around to it’ (CN15.1). Roberts (2000) suggests that lack of participation in professional organisations is related to oppressed group behaviour which reflects a lack of pride in one’s own group and a desire not to be associated with it.
Lack of clinical leadership was also seen to impact on the practice of the C&FH nurses. Though there were Clinical Nurse Consultants (CNC) positions within other AHSs across the state of NSW, there was no funding for this position within this Area. The CNC role is vital to professional growth in nursing, as it provides leadership by encompassing clinical, education and research components with liaison responsibilities with key internal and external partners (McCormack & Garbett, 2003). As one nurse commented, ‘We need someone on staff to do all the evidence-based stuff, do research, back up our practice, and to see what we can do with our IBIS data’ (CN14.2).

**Implementation of the Families First initiative**

Many of the nurses appeared frustrated at the lack of consultation and collaboration over changes in their role bought about by the implementation of the Families First initiative. Whilst most of the nurses could see the benefits of the initiative, there appeared to be little preparation or ongoing support for the nurses who were required to fulfil the strategies, particularly given the significant changes in practice that they required. As this nurse explains, ‘I suppose you could say it was dumped on us but a lot of us are quite willing to go ahead with it and just go with it cos you can see advantages of it’ (CN15.1).

This lack of consultation was seen by the nurses as a confirmation of their low status and lack of importance within the AHS and NSW Health. ‘I think there is lack of appreciation of our role, the importance of our role, the value of it’ (CN15.1). This lack of recognition was thought to be partially due to the invisibility of the profession, but also because the non-acute nature of the C&FH nursing service resulted in minimal importance being attached to it. As explained by this participant:

> I think they think it is still a well baby service so whenever it suits them, whenever they are getting pressure from Families First, for instance they want reports and they see the stats, and they say that is terrible … but as soon as they are not under that immediate pressure, then it is like, but you are a well baby service. We have
got so many shortages in health, how can we help you. Your clients aren’t sick (CN17.1).

This C&FH nurses in this study believed that C&FH nurses held no power nor did they participate whatsoever at a decision-making level.

We have very little (power). We are real grass roots level I’d say and I would like to think that those with the power could have enough decency at least to come and say, well what do you think, what do you feel out here, what are your experiences, or sit with us as a forum in all the different areas because we all have different issues. We are dictated to, yet professionally we are expected to keep right up there and be accountable (CN4.2).

The way in which NSW Health distributed funding, and how the AHS further allocated money and other resources received criticism by one of the participants who felt it was done hastily and contributed to some of the difficulties the C&FH nurses experienced in adapting to the change. This was particularly problematic in this setting, as this AHS was the first recipient in the rollout of funding. As one participant described:

They (Families First) were too dumb thinking about just the whole concept that you just give a whole bunch of people money and they will know exactly what to do with it and that they’d be fair and that everyone would have the skills to run with it - they never really investigated enough, I don’t think, and put in the training. And of course they never even considered consulting with the profession who were actually working with families and had been doing so for years - us (CN17.1).

DISCUSSION

The diverse and unique nature of C&FH nursing practice is underpinned by a range of skills and knowledge not found in any other health or allied health professional group. The participants of this research demonstrated and articulated significant changes in practice as a result of recent policy changes. However, the changes in practice were
inconsistent across the participants and resulted in both losses and gains with regard to effective service delivery. These changes have been required by state-wide policy initiatives (Families First) and supported by local Area Health services and structures. However, several barriers and constraints continue to affect the C&FH nurses’ capacity to fully embrace the changes that would allow them to work in partnership with women using a strengths-based approach.

Using or misusing their expertise
This research confirms that C&FH nurses hold a particular expertise and access to families that assists and supports them in early parenting. It is a service commonly sought out by mothers and other carers, particularly when caring for their first child.

The function of monitoring the growth and development of the infant does not have the prominence that it had previously, as the nurses recognised the importance of maternal support in promoting optimal family functioning. However, the monitoring of growth and development continues to dominate all of the nurses’ practice. By taking a baby’s weight the nurse interprets its meaning by plotting it on the graph and assessing whether the weight gain is sufficient, according to the guidelines of infant growth. This act of weighing and measuring the infant may impede the nurses’ ability to surrender the role of expert unless it is used as a vehicle to offer other components of the service. Growth-monitoring can be used as an opening to an encounter and give legitimacy to the relationship between the nurse and the client.

Monitoring infant growth and development remains a significantly important aspect of the C&FH nursing practice by gaining access to, and acceptance by, the families they service. Families continue to approach the nurses for advice about normal and abnormal infant and early childhood behaviour. Throughout the observations, knowledge of and skills in normal infant development and behaviour appeared to be the primary expectation of the clients accessing the service.
The structure of the service promotes the expert model

The Families First initiative promotes the importance of establishing relationships between nurse and client within a strengths-based approach (Office of Children and Young People, 2002c). However, the time allocation of sixty minutes in Sector One to fulfil the requirements of the first visit impeded the ability of the nurses to establish a relationship with the client. Establishing a relationship with the client was further thwarted by minimal opportunities for further home visits and a six-to-eight week wait for appointment times in Sector One. In Sector Two, a longer, 90-minute time allocation for first home visits provided a more relaxed environment in which rapport could be more easily established. However, there were no attempts in either sector to guarantee continuity of care with the same service provider. The ‘drop-in’ services offered in Sector Two were seen through observations to be poorly supported by the clientele in areas of disadvantage. However, the nurses reported long waiting times in the more popular centres.

The importance of additional support being provided to families who require it is stressed in state-wide policy documents (NSW Health, 2002b). However, the focus of this AHS was one initial home visit for all families of a newborn child. This was due to inadequate funding being provided by NSW Health, and also the difficulties in maintaining a full staffing complement, particularly in Sector One. ‘One-off’ universal home visiting is not known to improve health outcomes (Elkan, Kendrick et al., 2000) and improvements in health found in the international literature has resulted in long-term visiting by nurses or other para-professionals (Elkan, Kendrick et al., 2000; Olds et al., 2002).

There is currently no recommended ratio of C&FH nurses to births and care would have to be taken in developing formulas that incorporate the levels of disadvantage within the population. Data from Victoria reported a ratio of one full-time maternal and child health nurse to 140 births in 1995 (ANF Maternal and Child Health Nurses Special Interest Group, 2004). New South Wales Health report 634 full-time equivalent C&FH nurses across the state (NSW Health, 2005) and 85,890 live births in
This results in a ratio of 135 births to each full-time C&FH nurse. The resource implications of providing a staff ratio of one per 25 births for sustained home visiting, as recommended in the NSW Health home visiting guidelines (NSW Health, 2002b) is clearly beyond reach of this AHS.

Without sufficient resources to adequately provide the services required, C&FH nurses provide rushed consultations wherein the main objective was to complete the prescribed paperwork. Lack of sufficient time within a consultation increases the risk of the nurse being seen as authoritative or controlling (Fagerskiold, 2003). It appears that the policy directions around C&FH nursing services contradict the requirements of working in partnership.

**Continuity of care**

There appeared to be minimal attempts by either the AHS or the nurses to encourage continuity of care between the nurses and the individual women. There were only three of the 13 nurses observed in clinical practice who appeared to have any ongoing relationship with women. Two of these nurses worked in particularly disadvantaged areas, and one worked in a rural setting. These three nurses displayed great interest and empathy with the women they serviced and undertook more of the non-policy aspects of their work that Twinn (1993) termed ‘fringe work’. The remaining 11 nurses appeared to be less committed to the individual families. Rather they were systematically attending first home visits to decrease the never-ending pile of visits that had to be dealt with.

Regular staff rotation also impeded the ability of the C&FH nurses to engage and work with the community. The key to successful engagement with the community is the local trust that is developed over time and is dependent on the staff being locally based and involved in the local community (Kemp et al., 2004). Frequent rotation of staff would not only affect the nurses’ visibility in the community, it would impede nurses’ motivation to become involved when they knew they would be leaving in two years, or less.
**Health centres**

The structure of service provision through the C&FH centres was found, through this research, to be inefficient. When collecting observation data, 14 out of a possible 29 appointment times in Sector One were not attended, leaving large gaps of time in which the nurse was idle. When considering the six-to-eight week waiting time for appointments, it can be suggested that the many ‘no shows’ in Sector One were an indication of poor service management. Due to the delay between making and attending appointment times (six to eight weeks), high rates of non-attendance could be expected. The nurses attempted to minimise this by telephoning the women on the morning of the appointment. However, many women could not be contacted this way and a more efficient strategy would be reminding the women one or two days before the appointment.

Opening hours in Sector Two varied largely across the Sector, with some health centres only opening for one three-hour clinic once a week or once a fortnight. The rationale behind this was to have more centres across the sector available to support families. However, given the low numbers of families observed accessing the centres, it does not support this strategy. Furthermore, staffing and equipping many centres results in sparsely furnished, poorly ventilated and unappealing venues. Health visiting centres in the UK have been described as busy, unfriendly facilities with no privacy and limited opportunities for individual interactions (Fagan, 1997; Sefi & Grice, 1994). The C&FH centres in this research all contained private consulting rooms, but could be considered to be unfriendly and unwelcoming venues. Child and family health centres should be housed in generic community health centres or in shopping centres, and need to be bright, professional, modern and welcoming.

**Lack of consultation from policy-makers.**

The Families First initiative provides strong direction for services to provide support for parents, based on sound international evidence. The C&FH nursing workforce was identified as the implementation arm of the strategy, as its service systems were
already in place and it was the only professional group that had acceptable and universal access to all new parents. However, there was no evidence of consultation with the practitioners who were required to implement the changes. The majority of the nurses were critical of this lack of consultation. The nurses felt well supported by their direct manager, but largely did not feel valued or supported by higher management. They were also unable to explain the organisational structure of the AHS or identify key personnel within the system. Poor change management is known to result in resistance to change (Grossman & Valiga, 2002). These findings will be further discussed in Chapter Eight.

**Their education promotes the expert model**

Educational preparation for C&FH nursing in NSW currently is offered at a graduate certificate level and occurs predominantly outside the tertiary sector (see Chapter Two). Sixty-five per cent (11/17) of the participating C&FH nurses had received their C&FH qualification prior to 1992. Only four of the 17 nurses had undertaken education since the implementation of the Families First initiative. Although the qualifications these nurses had received were also outside the tertiary sector, the course was developed by the AHS in response to the Families First initiative and reflected the change in practice required in C&FH nursing service provision. The lack of tertiary-based programs in C&FH nursing and the absence of master’s programs also contribute to the minimal opportunities for C&FH nurses to further their education and contribute to research and other scholarly development.

The nurses’ education and training to prepare them for the changes in practice required by the Families First initiative was often reported to be nonexistent, though one participant thought they had received sufficient preparation. Any education they did receive appeared largely ineffective, given the difficulties the nurses showed in working in partnership with families. These difficulties were compounded by the age of the nurses in the study. Eighty-eight per cent of the 17 nurses were over 40 years of age (range 26–62, mean 47, median 49. These figures compare similarly with the UK, where the latest available figures (2001) show that 75% of health visitors are over 40
years of age (Cowley, 2003). Years’ experience as a C&FH nurse in this study ranged from two–36 years (mean 14, and median 10). The age of the nurses and the length of time many of them had been practising in traditional models would suggest a major challenge to readily incorporate new models of working into their practice. The educational influences on C&FH practice will also be more fully discussed in Chapter Eight.

**CONCLUSION**

The C&FH nurses in this research have undergone significant changes in the way they provide support to families in early parenting. There were some examples in the data that showed sensitive and supportive attempts to work in partnerships with women in a way that identified their strengths and provided opportunities for the client to lead the consultation. However, the changes were not universal across all nurses or consistently demonstrated at all times.

It appears that there are two major areas that affect the C&FH nurses’ ability to effectively provide support to families in early parenting. Despite sound state-wide policies supporting the Families First initiative, local health service structures significantly impaired the ability of the nurses to fulfil their role. The ability of the nurses to establish ongoing relationships with the families was impeded by lengthy documentation, frequent staff rotation and lack of access to the same service provider. Health centre venues were unappealing and the hours of operation were infrequent.

The second major area of influence was the professional challenge for the C&FH nursing workforce to successfully adopt new ways of practice in the support of families. The nurses are an aging workforce with limited educational preparation and a long history of working in traditional models. Lack of interest in their professional association and ongoing professional development suggest an oppressed and invisible workforce that feels undervalued and insignificant. These issues will be further discussed in Chapters Seven and Eight.
The following chapter will consider another group of C&FH nurses who have also undergone significant change in the way they practise to support families through parenting groups.
Chapter Six

Case Study Two:
Facilitation of Parent Groups
Chapter Six: Case Study Two: Facilitation of Parent Groups

INTRODUCTION

In conjunction with offering individual services to parents of young children, C&FH nurses in Australia have a long history of conducting parent groups as part of their service (O'Connor, 1989). Traditionally, the groups run as weekly education sessions over a course of six to eight weeks, in an attempt to assist mothers in the development of parenting skills. The social aspects that often resulted from bringing the women together were recognised as a secondary benefit (McConville, 1989). In the late 1990s a group of C&FH nurses in Eastern Sydney established a new form of parenting group called the ‘Earlybird’ program. This innovative program required significant changes in the way C&FH nurses facilitated the groups. This chapter reports on the ethnographic approach used to investigate and explore C&FH nursing practice in this particular setting. Of particular interest is how Earlybird differs from traditional parent groups, and how the C&FH nurses responded to the required change in practice. Factors that impact on the nurses’ ability to effectively run the groups are discussed and how the program fulfils the principles of the Families First initiative is also considered.

Whilst the research had particular interest in how C&FH nurses are adopting or developing new models to service disadvantaged communities, the demographics of the population serviced by the Earlybird program were largely middle-class. There was, however, representation of families from non-English-speaking backgrounds. Furthermore, the Earlybird program was an innovative and unique program that incorporated the principles of Families First and utilised a strengths-based approach.

30 Previously called ‘Mothers’ groups’, the term has recently been changed to ‘Parent’ groups to reflect the increasing attendance of fathers at the groups. However, it is still acknowledged that that the vast majority of attendees are women (Edgecombe et al., 2001).
There is little information in the health literature on open, unstructured groups or on the role of the nurse as a facilitator of these groups. It was valuable therefore, and within the goals of this thesis, to explore the processes that enabled the C&FH nurse to provide service to groups of women and their families in a way that should lead to increased confidence and improved parenting skills.

**BACKGROUND**

Many C&FH services across NSW conduct new parent group programs to provide information on early parenting issues and available resources in the community (NSW Health, 1999). Meeting other parents in similar social situations has been identified as a strategy to improve social networks and lead to greater self-esteem (Zachariah, 1994). By comparing their own babies with others of similar age, new mothers are reassured that they are providing good care and their babies are not abnormal (Carolan, 2004; Pearl, 1994). New mothers report they feel a strong need to talk about being a mother and feel more accepted doing this with other new mothers (Carolan, 2004; Pearl, 1994). The act of hearing feelings, thoughts and dilemmas similar to one’s own publicly vocalised by other people, can be powerful and liberating, and group interaction is a potent tool for teaching, learning and reflecting (Sure Start, 2002).

Parent groups are seen to benefit new parents by way of informally supporting parents to access information and establish relationships (Edgecombe et al., 2001). Women caring for young infants, including those from non-English-speaking backgrounds, have requested the opportunity to meet with other mothers in early parenting (Butchart et al., 1999; Office of Children and Young People, 2003) and to receive more information (Farbman Moran et al., 1997).

Mothers’ groups were introduced in New South Wales by C&FH nursing services in conjunction with the Mental Health Association in 1961 (O’Connor, 1989). Whilst the availability of parent groups is not universal in NSW, as it is currently in Victoria, many nurses have years of experience running groups (Edgecombe et al., 2001).
Usually mothers’ groups are ‘closed’ to a predetermined number of participants, and run as a short-term ‘course’ of around six weeks, for two to three hours each session. Generally babies are eight weeks or older before the mother is provided with an opportunity to attend a group (Clune, 1999; Freeman & Lamb, 1997). Specific, predetermined topics on common parenting issues are covered each week, often with guest speakers who have known professional authority in the field. The role of the nurse is central, and s/he is seen as the leader or expert in the group. Women with mental health issues or postnatal depression have been typically excluded in the belief that involvement in the groups would not be beneficial for these women (Lawson & Callaghan, 1991; McConville, 1989).

The use of traditional mothers’ groups, where the expertise remains with the nurse, highlights the position of women as passive recipients of information and reinforces medical hegemony (Reiger, 1999). Additional to the position of the nurse as expert, group work has historically been used to enforce social control, by telling others what is wrong with them and/or how they should change (Benjamin et al., 1997).

There has been an increasing tendency to adopt more client-directed groups wherein the participants set the agenda and determine their own goals and resources (Rodwell, 1996). The health professional remains a member of the group and is respected by the group for the contribution s/he makes as a nurse, midwife and educator. Allowing the women to identify their own needs and set their own agenda, the nurse promotes empowerment of the group which results in enhanced self-esteem, the ability to set and reach goals and a sense of control over one’s life (Rodwell, 1996). The combination of peer and professional support should focus on networking and communication with other mothers, learning health information, and receiving motivational strategies to enhance parenting skills (Canuso, 2003). Research has indicated that the presence of formal (professional) and informal (family and friends) support reduces stress, facilitates better coping mechanisms and provides role models for parents, as well as links to other sources of parenting information (Unger & Nelson, 1990).
The skills of the group leader to engage the parents in discussion around their interests and concerns, focusing on the parents’ strengths, ideas and beliefs, and valuing what parents bring to the group, appear to be critical to the success of parenting support programs (Pugh et al., 1994). To be an effective facilitator, the group leader must surrender the role of ‘expert’ and facilitate learning by encouraging the sharing of ideas and experiences among participants. Facilitation relies on communication skills that include active listening, clarifying, questioning, summarising, observing, probing and giving feedback (Asselin, 2001; McFadzean, 2002). The facilitator must also show impartiality, be able to interpret information, be sensitive and have the ability to put people at ease with each other (McConville, 1989). Canuso (2003) defines the professionals’ role to be: unobtrusive, yet interactive; guiding the discussions to dispel myths; suggest alternative strategies that are more health-enhancing; reinforce positive practices; and, promote connections among the participants.

Effective facilitators require the ability to develop and manage group dynamics (McFadzean, 2002). They believe the group members have the expertise and ability to achieve the outcomes (Asselin, 2001). The facilitators must therefore be aware of their own values and biases that may interfere with this (Davis et al., 2002).

**WHAT IS EARLYBIRD?**

During the late 1990s, C&FH nursing staff in South East Sydney recognised that first-time mothers were waiting for up to three weeks before they could first access the service. By then, many had weaned to artificial formula, due to breastfeeding problems. Focus groups with some of the clients were held by the Area Parenting Coordinator as part of a review of parent education services. Results showed a request for new mothers’ groups to be offered earlier than were currently available at that time, from eight weeks post-birth, (Clune, 1999).

Thus, the Earlybird program was introduced as one strategy to reduce the isolation of new mothers and improve breastfeeding duration rates. The program was adapted...
from the UK-based ‘Deptford model’ (Leap, 1993; Leap, 2000) to provide both professional and peer support for families as soon as possible after birth. The groups are offered in six of the 10 C&FH centres across the area. They are ‘open’\textsuperscript{31}, run on a continual basis for women with babies up to eight weeks of age and are part of the free universal C&FH service offered to all parents of young children.

The aims of the Earlybird program include: the promotion of mother-to-mother support; to increase the satisfaction and confidence of new mothers and their families; to improve breastfeeding rates, and; to heighten maternal and infant attachment (South Eastern Sydney and Illawara Health Service, 2005).

The philosophical underpinnings of the program include combined partnership and peer support. Here, the key principles of the partnership model combine with the content expertise of the C&FH nurse to allow the parents immediate access to relevant information (South Eastern Sydney and Illawara Health Service, 2005).

It was expected that the C&FH nursing staff of the sector would adopt this new program, and this required significant changes to the way they traditionally ran parent groups. It was the ability of the C&FH nurses to change their own practice that was the focus on inquiry of this research.

**METHODS**

**Aims**

- To describe how and why the Earlybird program was developed.
- To describe the C&FH nurses’ practice within the context of the Earlybird program.

\textsuperscript{31}Women access the groups whenever they choose and no bookings or appointments are required. Thus, no barriers restrict the women from attending early. This option is in contrast to the ‘closed’ model wherein a set number of women register and attend.
• To identify the skills and processes used by the C&FH nurses to facilitate the groups.
• To identify factors that impact on the ability of C&FH nurses to effectively provide support to families through the facilitation of parenting groups.

Ethical approval
Ethics approval was sought and obtained from the Area Health Service (AHS) responsible for the service as well as the University of Technology, Sydney, Human Research Ethics Committee. The information statement and consent form supplied to the participants are provided in Appendix Five and Appendix Six.

Participants
All C&FH nurses employed by the AHS Sector that offered the program were invited to participate. The total number of nursing employees was 19, servicing 10 centres, though several staff worked part-time. The nurse unit manager and the parent education co-ordinator involved in the training and establishment of the groups were also invited to participate. Fourteen C&FH nurses agreed to participate. These included twelve C&FH nurses working in clinical practice, one nurse manager, and one parent education co-ordinator.

Details of the twelve nurses who participated in the research are summarised in Table 8 below. The nurses were all slightly older than the national average of C&FH nurses, which is 47 years of age (AIHW, 2002), and all of them were very experienced in the area of C&FH nursing.

Table 8: Age and years’ experience of nurses

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<tr>
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<th>Range</th>
<th>Mean</th>
<th>Median</th>
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<tr>
<td>Age</td>
<td>43–60 yrs</td>
<td>52.25</td>
<td>53.5</td>
</tr>
<tr>
<td>Years’ Experience</td>
<td>5–20yrs</td>
<td>13.08</td>
<td>15</td>
</tr>
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</table>
Eleven of the twelve nurses were also registered midwives and all of the nurses had held a certificate in C&FH nursing. All except one of the nurses had undertaken inservice education specific to the running of the Earlybird program prior to group commencement, although only seven of the twelve nurses had received accreditation. All of the nurses had conducted parent groups as part of the C&FH service prior to facilitating the Earlybird program. The education qualifications of the participants are provided in table form below.

Table 9: Educational qualifications of the nurses

<table>
<thead>
<tr>
<th>Hospital program (nursing)</th>
<th>Degree (nursing)</th>
<th>Midwifery C&amp;FH certificate</th>
<th>Grad dip adult ed</th>
<th>Other</th>
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<tr>
<td>N= 12</td>
<td>0</td>
<td>11</td>
<td>12</td>
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<td>% 12%</td>
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<td>92%</td>
<td>100%</td>
<td>17%</td>
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* lactation certificate

**Data collection**

Data were collected by means of five audio-recorded formal interviews and three focus groups, as well as 25 hours of participant observation. Semi-structured, in-depth interviews were held with the key stakeholders and focus groups were held with all 12 C&FH nurses running Earlybird groups within the AHS sector. Observations of Earlybird sessions were carried out in each of the six centres that offered the program. One session was observed in five of the centres, whilst six consecutive sessions were observed in the sixth centre.

Two of the sessions lasted 90 minutes, three ran for 120 minutes, two sessions finished after 150 minutes and two sessions with more than 15 women participating lasted for 180 minutes. This resulted in the total amount of observation data time of 25 hours.

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32 Accreditation required the parenting education co-ordinator sitting in and observing a number of sessions and providing the opportunity for the nurse to reflect on her practice as a facilitator.
When collecting observation data, the facilitator introduced me as a researcher interested in the skills required by the nurse to run the program, and sought permission from the families for me to sit in on the session. I then sat with the participants in a chair that formed part of the circle, although I would try to position myself in a discreet position away from the doorway, as there was usually movement of women and babies to and from the group. Data were recorded manually in a notebook and further field notes added on completion of the group. These notes were then entered onto a computer and further elaborated upon later on the same day.

The set of questions used in the interviews and focus group discussions to explore the nurses’ perceptions of the Earlybird groups can be found in Appendix Seven. Questions were based around how the groups came about, how the groups are run, the advantages and challenges of running the groups, and what skills the facilitators required to successfully run the groups.

**Data analysis**

Data were analysed using qualitative content analysis whereby the data were categorised by codes into themes that emphasised the ‘why’ and ‘how’ contexts of the Earlybird program (Grbich, 1999). Analysis occurred on the three levels explained previously in Chapter Three. The first level involved careful reading of the data whilst data collection was still in progress (Grbich, 1999). Second-level analysis developed the themes that addressed broad categories such as ‘skills’, ‘advantages’, ‘education’ etc. These broad categories were then subdivided into subcategories under the original heading. For example, under ‘skills’, subcategories emerged such as ‘give up control’, ‘resist the urge to rescue’ and ‘to empower’. Data collected via participant observation were used to confirm, elaborate and support themes identified in the interview and focus group data (Lindlof & Taylor, 2002).
RESULTS

How the change in practice came about

The research participants reported that, initially, the main aim of the program was ‘to increase numbers in breastfeeding and to continue breastfeeding duration’ (FG1:6:12). However, as the program developed, additional benefits were identified. ‘All of the other bits about networking etc. came later … But the main aim was to see the woman early before she gave up (breastfeeding) and give her the help she needed to continue to breastfeed (FG1:6:12).

Whilst the Families First initiative had yet to be implemented within this AHS, the principles of the initiative were known and were influential in the development of the Earlybird program. As one of participants commented, ‘Families First was about working in different directions with families’ (FG1.6:5). Although the nurses felt the program they were developing was largely autonomous, most were aware of the need of the Earlybird program to be positioned within Families First directives. As one participant explained;

With Families First coming in, we knew they wanted us to support parents who are caring for a new baby, assist families who need extra support and strengthen the connections with the communities. Earlybird does all of that (CN2.3:3).

Approximately half of the nurses were happy to be involved with the new program. Some, however, felt they had little option but to co-operate with a major service delivery shift over which there had been little consultation or control.

I felt we were being pushed into something that hadn’t been fully looked at and was a couple of people’s idea and we were told ‘you will do it this way and no other (FG1.6:71).

Preparation of the nurses to support the change in practice

Concurrent to the establishment of the Earlybird program, a series of workshops were held for all educators undertaking parent education groups across the AHS. This
included both antenatal and postnatal services. The C&FH nurses were informed that the workshops were compulsory and accreditation as a parent educator was considered essential for all nurses conducting groups. The nurses received 12 hours of baseline training in three, four-hour workshops over three weeks. The education focused on adult learning and generic facilitation skills in the running of groups.

Following the baseline education, the C&FH nurses were then expected to become accredited following the observation of one of their groups by an assessor from the Accreditation Working Party. Failure to be observed in practice within six months of completing the training was supposed to result in an inability to become accredited. The nurses were also told that non-accredited educators would not be able to conduct parent groups. However, due to a reduction in available staff to assess the nurses, and reluctance by the nurses to arrange a time to be observed, five of the 12 C&FH nurses working in clinical practice had not become accredited. Furthermore one of the participants did not receive the baseline training. However, all of the nurses had experience running parenting groups prior to the implementation of the Earlybird program.

The combination of health providers of both antenatal and postnatal groups at the workshops appeared to influence the suitability of the workshops for the C&FH nurses. The nurses reported that there was more emphasis on the closed, structured group model used in the antenatal setting, than the open, unstructured model required in the Earlybird program. The majority of the C&FH nurses found that the training had not adequately prepared them for the Earlybird program. ‘The training was more for closed groups than open groups – we had other professionals in the group like antenatal educators’ (FG1.6:62). The nurses felt that the activities and strategies promoted in the training for use in the antenatal setting were inappropriate for use in the Earlybird groups.

*You can split antenatal groups up because they are focused and have paid money etc., but mothers are up and down, busy with babies, don’t listen all of the time. It’s a very different situation* (FG1.6:65).
A visiting midwife, Nicky Leap, who had implemented the Deptford antenatal and postnatal groups in the UK, was invited to present a three-hour workshop on open groups. The workshop consisted of the presentation of a video on the Deptford program and the use of role-play as a technique to practice the style of facilitation required to run open groups. The attendance at this workshop was optional and resulted in only three of the C&FH nurses attending. Those who did attend reported that they did not consider it relevant to their practice as again, it was heavily attended by hospital-based midwives undertaking antenatal parent groups and the focus was antenatal and midwifery care. In the Deptford model, parent groups are commenced in pregnancy and the antenatal women continue to meet in the postnatal period. However, due to the structure of services, the ability to commence the groups antenatally is not available within this AHS.

Some of the nurses could identify that the Earlybird program required a completely new approach from how they had traditionally worked with families. Whilst the nurses seemed confident about their knowledge and skills around child health issues, they identified a lack of knowledge and experience around facilitation, as demonstrated in the following quotation.

_We haven't had much (training) specific for Earlybird – like how to run an open group, how to ask open questions, how to invite the other mothers to share their experiences without feeling put down or how to deal when one of them say something really heavy and how to deal with that at all (FG3.7:19)._  

One nurse who had not received any baseline training preferred individual consultations to the Earlybird groups. She found the individual consultations ‘more relaxed’, and in the groups she stated that ‘I worry that the mothers give each other bad advice’ (EBG.Obs5.0199). These comments suggest that she was inadequately prepared or supported to facilitate Earlybird groups.
The participants also identified that the Earlybird program was not suited to all C&FH nurses as described by one participant. ‘Some nurses don’t like groups – not many but some’ (FG2.8:38). Lack of confidence was also reported to influence a nurse’s ability to effectively run the groups, as did lack of training, group skills and personal style. Another nurse commented, ‘I think you have to be a special person to do Earlybird or have some sort of special training to do it’. (CN2.3:5). Others reported the problems resulted from lack of training and ongoing support. All of the nurses described problems experienced by some of their colleagues in facilitating the groups. They believed that staff should not be ‘forced’ into running the groups, as is evident in the following quotation.

*Use staff who want to do it – for those who are not comfortable with group work should not have to do it because they won’t do it well* (CN1.1:47).

A commitment to the principles of the program was also considered to be important. If the nurse did not or could not believe in a sharing partnership with the women it would be difficult to be committed to fulfilling the aims of the program. As one nurse explained:

*They have to have a real belief in it. There are a couple of the nurses who are a bit half hearted about it* (CN3.4.49).

**The Earlybird program**

Recruitment of women

Upon receiving the discharge summary from the maternity services, the C&FH nurse would then ring the mother and outline the services they provided. This included individual consultations and the Earlybird program. Home visiting was not offered in this AHS at this time, due to the staged roll-out of the Families First Initiative. The

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33 This AHS received Families First funding in 2004. Data collected for this case study occurred in 2002.
nurse would then invite the mother to either the next Earlybird group or an individual consultation.

Several nurses found the biggest challenge was attracting women whom they thought would benefit. They clearly tried to encourage some women to attend more than others and talked of ‘pushing’ the groups onto women they thought would benefit. As one participant described: ‘the ones who I consider who would really benefit from the group don’t use it’ (FG3.7:2).

Some women were just not interested in coming to the groups and preferred the traditional service of individual consultations.

Sometimes they want the one-to-one. They want to hear what you say, not what the other mums have to say. It depends on what the woman’s expectations of the (C&FH) service is (FG2.8:27).

Some of the nurses were anxious that they were pressuring the women to attend groups when perhaps they would prefer an individual appointment. One nurse found it difficult to promote the program ‘because they wanted a one-to-one’ (FG1.6:23) and another was concerned if the mothers feel they have to come – (it causes) more pressure’ (FG1.6:49).

This was confirmed in a comparative study that occurred concurrently, comparing women’s experiences of Earlybird versus individual consultations undertaken by myself and colleagues (Kruske, Schmied et al., 2004). In that study, some women reported that they do not require the type of support offered by the Earlybird program and are not interested in socialising in the early weeks of parenting (Kruske, Schmied et al., 2004). Many of the women in the Earlybird study who did not attend the groups preferred a formal consultation with the C&FH nurse where the nurse is seen as an authority on child health issues (Kruske, Schmied et al., 2004).
The nurses reported that first-time parents were more strongly represented, but women with more than one child were welcome and provided wisdom and knowledge from previous parenting experiences. Partners, relatives and friends were also invited, with fathers and grandmothers commonly participating. Contrary to other parent groups (Lawson & Callaghan, 1991; McConville, 1989), women with mental health problems, including postnatal depression, were actively encouraged to attend the groups.

The first visit
There was significant variation amongst the style and structure of the Earlybird groups across the six centres that offered the program. Some centres continued to offer all clients an individual appointment as their first visit to the service before offering subsequent visits through the Earlybird program. This was because these particular nurses believed that the first visit, which entailed obtaining a lengthy history as well as carrying out the newborn screening and development check as part of NSW guidelines, was inappropriate to carry out immediately preceding the Earlybird groups. Other centres conducted these first visits, including the newborn check, immediately before or after the Earlybird program. The half-hour time period from 9.30 to 10.00 a.m. was allocated to these first visits, and provided the opportunity for any woman to weigh her baby if she chose to. It also provided the opportunity for women who had been to the service before to arrive and settle in at a relaxed pace that acknowledged the difficulties of getting out of the house with a newborn infant.

Growth monitoring
Scales were available at all groups for any mother to weigh their infant. This would occur either in the half-hour period before the group began or on completion of the session. Some nurses encouraged the mothers to weigh and record the weights of their own babies. However, other C&FH nurses were concerned that a mother, who may be neglecting her baby, ‘might see all the other babies putting on weight and feel like she must lie’. These nurses felt they had a professional responsibility to oversee the process.
Another nurse invited the mothers to weigh their infants at the end of the groups in a private room with the nurse present. This nurse thought it was important to provide the opportunity for the women to have ‘one-on-one’ time with the nurse and ask any questions they may have been unable to in front of the other women.

These different opportunities offered to the women around weighing their babies reflect varying degrees of trust by the nurses of the mothers to care for their infants. Davis et al. (2002) report that professionals must believe in the parents as experts in their child’s care to be able to work effectively in partnership. By not trusting their ability to weigh and record their own babies weight suggests the nurses may not have this required level of trust. Parents, particularly those who are vulnerable or marginalised will often not disclose information if they don’t feel that they are trusted (Davis et al., 2002). Encouraging the mothers to have individual consultations at the end of the group sessions also suggests a reluctance of the nurse to believe that the women could have all their needs met in the group process. This could reflect the nurse’s desire to hold onto a degree of control and power through the need to assist women via an individual consultation.

In the centres where the nurses supervised the mothers weighing the babies prior to the session, many mothers would attempt to ask questions around particular aspects of care of the infant. In response, the nurse would ask the mother to keep that question for the group, and if they were still concerned, they could come and see the nurse following the session. For example, in one session a mother asked the nurse when weighing her infant:

I was wondering if I have been feeding her too often’, to which the nurse replied ‘that is a common question that lots of new mums ask. Can we leave it and bring it up in the group so we can see if other mums have the same concerns? (EBG Obs1:3.1).

The mother seemed to accept this response and later raised it in the group. The nurses used this strategy to prevent the women from having all their questions answered by
the nurse before the session, negating the need to come to the group. It also promoted discussion within the group and, importantly, provided the opportunity for the mother to learn from other mothers. By offering to be available at the end of the session, the nurse also ensured that the woman would not have to go home without her issue being satisfactorily addressed.

**Venue**

Five of the six centres offered the groups in the local C&FH centre where the nurse was based, and one centre conducted the groups in the antenatal education room at the local hospital. Most of the C&FH centres within the AHS are ex-residential houses located in residential areas. They were mostly old houses with fittings and fixtures from the 1970s or 1980s and had not been updated or adapted for use as a C&FH centre. The groups were mainly held in the waiting area of the centres which would previously have been the living area. Many of the centres are opened only two to three days per week, and the rooms often lacked natural light and ventilation. This resulted in a dark and musty atmosphere, secondary to the age of the building and lack of regular use and ventilation. The nurses considered most of the venues were inappropriate for the groups, due to the lack of rooms large enough to accommodate 10–15 mothers with prams. Due to lack of space, prams were often kept in adjacent rooms. This could cause the mothers to become anxious if their babies were asleep in the prams, as the mothers weren’t confident they could hear them. If the prams were permitted to stay with the mothers, the size of the prams often obstructed the vision between the participants.

Women have identified the importance of a pleasant and welcoming environment when accessing postnatal care (Butchart et al., 1999). Although the nurses in this study identified problems with the majority of venues, the program appeared well supported by the clientele (Kruske, Schmied et al., 2004).
Incorporating clinical services in the program

The nurses provided information and other clinical services through the group that would usually be carried out in the C&FH centre setting. The undertaking of clinical duties in the group was identified as an important aspect of the program, as it prevented a ‘doubling up’ of services, requiring the mother to visit the groups for social support and the centre for weights and health check-ups. It also was thought to draw women who would not usually seek out social support groups.

As well as the newborn developmental assessment and baby weighs being available, the nurses ensured that, without being overtly didactic, key parenting or infant information was addressed over an eight-week period. Information covered included: mother–infant attachment, age-appropriate behaviours, contraception, sudden infant death syndrome (SIDS), and postnatal depression. These issues could almost always be woven into the conversations and discussions that were initially raised by the women. Therefore, as this nurse explained:

There is some structure to the group that includes information that we obviously have to cover over a period of time. We cover immunisation, safety and things like that. It is open in that there is coming and going and it is not a set six-week thing (FG1.6:15).

These aspects of the service established that Earlybird program as a unique combination of professional and social support service and again, it was considered a very important professional obligation for the nurses to impart this knowledge.

In one of the larger, more structured Earlybird groups, the C&FH nurses formalised much of this clinical information by documenting and summarising key points each week by referring to a list on a whiteboard. They began by referring to housekeeping points such as refreshment facilities, where the toilets were located and nappy-changing facilities. They then covered other key health issues, including: the six-week check for the mother, including where to go and what it entailed; immunisation for the infant at eight weeks including options of providers; and, the six-to-eight week check for the infant, as recommended in the ‘blue book’. Finally, the nurse would discuss
other groups available after Earlybird which included groups for infants aged between two to six months. These topics were discussed every week in this way because these particular nurses believed they had a professional responsibility to provide this information in the event that a woman only had one contact with the service.

The smaller groups seemed more informal, with the mothers more familiar to the C&FH nurse and each other. These smaller groups also demonstrated much more informal chatting and story-telling, whereas the bigger groups tended to adhere more to parenting topics. The nurse in one of the smaller groups said very little and the session was mostly a social interaction. The nurse contributed as a peer or fellow mother (if she was one) rather than a health professional, although at times she would contribute to the conversation as a nurse with expertise on particular parenting issues.

Contrary to the informal ‘chatter’ in the smaller groups, there appeared to be more support between the women in the larger groups. In the larger groups, most mothers with older babies were observed to be genuinely trying to help the newer mothers, by recognising their difficulties and reassuring the less experienced woman that ‘it does get better’. These larger groups were not as social, but they seemed to be more supportive around parenting than the smaller groups that were more informal.

In all of the groups there was considerable activity, with mothers getting up with unsettled babies or leaving the room to breastfeed or change their baby’s nappies. This practice seemed to be accepted amongst the group as unavoidable and was therefore tolerated with minimal distraction occurring.

**Facilitation**

Most of the Earlybird groups were run by two facilitators, although two of the smaller centres were only staffed with one facilitator. The second or ‘co-facilitator’ role was flexible and varied across the centres in the amount of input the nurse had in the groups. Some groups reported that the two facilitators had equal representation and input, whilst other groups used the co-facilitator for observation and to assist and
provide extra support for an individual woman if required (although the nurses agreed this happened very infrequently). The ability of the co-facilitator to ‘rescue’ the facilitator when she got ‘stuck’ was also identified by the nurses as being important. As one nurse explained:

Last week in my Earlybird Group one of the mothers brought up her problems with intimacy with her husband and then a whole lot of things were bought up in group in detail – and I mean detail. By the end the co-facilitator took over and it was great. I had never had to deal with that before. I really enjoyed it but it was exhausting for me (FG3.7:50).

Documentation was also considered an important role of the co-facilitator. The second nurse would note down any particular issues raised by each participant for subsequent documentation in the health records. The ability to observe the group and note any problems a woman may be facing was also identified: ‘The second person can help you pick up the mums you might be worried about’ (FG1.6:84).

Documentation was therefore an important aspect of recording professional duties of the service. This was considered by the nurses to be their legal responsibility. There appeared to be a certain amount of awareness amongst the nurses that their practice must be accountable and transparent. As several nurses described:

Keeping an eye on the issues discussed. For legal reasons they have to write things down in case there is a DoCS\textsuperscript{34} case (CN3.4:14).

And

We have to be very careful to document properly (FG1.6:76).

The ability of the nurses to trust the women seemed to be related to concerns by the C&FH nurses over their professional and legal obligations. Practices such as:

\textsuperscript{34} DoCS: Department of Community Services, the government agency responsible for supporting families with children known or suspected of being at risk of child abuse or neglect.

\textit{Same but different. Chapter Six: Case Study Two}
overseeing the weighing of babies; the co-facilitator’s requirement to document each woman’s issues throughout the group for later transcription into the record; the concern that it was difficult to ‘keep an eye’ on all of the women in the groups; and, the chance they may ‘miss’ something. Every one of the nurses reported one or more of these concerns. All of these practices indicate ongoing influences of the ‘we know best’ expert model where women are seen as recipients of health care advice that required the experts to supervise and instruct (Reiger, 1999). It also reflects the litigious culture of the Australian health care system, wherein service providers in child birth and child welfare are frequent recipients of accusations of negligence and misconduct, though there is little history of C&FH nurses being amongst those accused.

The presence of two facilitators in most of the groups provided the opportunity for nurses to support each other. The ability to support and debrief at the end of each session was identified as being extremely valuable. ‘You definitely need two people to run the group. It can be very draining and tiring’ (FG3.7:47). Having a co-facilitator was also identified as providing support and feedback. This is of particular importance for inexperienced and under-confident facilitators.

If two of us do a group we feedback to each other at the end of the session and that is really good. The whole thing is much less stressful with two people (FG2.8:33).

There seemed to be a high level of trust and respect between the two nurses who ran the group and this was considered to be very important.

Facilitation styles of the nurses varied significantly. A few nurses showed consistent and sound facilitation, whereby mothers were continually engaged to contribute and share their experiences. Some nurses, however, did not demonstrate evidence of promoting the sharing of information and expertise amongst the women. Other nurses were inconsistent and intermittently deflected questions back to the group, whilst at other times, maintained control by answering all enquiries. The size of the group appeared to influence the style and practice of the facilitator. In the smaller groups the nurse was more informal and participated in the general social interaction of the
group. In the larger groups the nurse was less social, but appeared to use the experiences of the participants to generate peer-led learning more effectively.

**Introductions and networking**

The nurses would commence the groups by asking the participants to go around the circle and introduce themselves and their babies, including the babies’ age, followed by a description of how their last week had been. The introduction and description of the week would often lead to detailed discussions of the particular issues that had been raised. One topic would often lead to another, which could result in up to 20–30 minutes passing before the next woman was introduced.Whilst many of the issues were pertinent to most of the women in the group, this model of introduction would often result in the last women of the circle not introducing themselves until the session was nearly over. It was observed that when mothers were not introduced until the very end of the session, most people had become unsettled and were ready to leave and thus didn’t give the last women the same attention as the women who spoke at the beginning of the session.

Many of the nurses failed to introduce themselves and name tags were not used in any of the groups. In the smaller groups the nurse appeared to be well known to the women. However, in the larger groups it was assumed that many women would not know the nurse’s name until they had attended several sessions. The lack of attention to knowing each other’s names in the larger groups diminished the opportunity for the women to get to know each other and establish networks that may continue beyond the group. It also prevented the women being able to address the nurses or other mothers personally by name.

It was observed that a few of the mothers had established friendships that resulted in social contact outside the group. This usually occurred in sub-groups of two or three women, rather than the whole group. Due to the ‘open’ process of the program, one or two women would join the group every week, and one or more would leave as their babies turned eight weeks of age.
Observations showed, in all of the Earlybird groups, that the nurse was the focal point. This was particularly evident at the beginning of the session when the women would ‘report’ their week. Whilst this description of the week intended to inform all participants present, the eye contact of the woman talking was usually directed to the nurse. It was how the nurse responded at this early stage of the session that would determine the degree of input the other women made, both immediately and for the remainder of the group. In many instances the woman would describe her week and inevitably ask a question about some aspect of parenting. Some of the questions, such as ‘when will I get my period?’ and ‘how long before my caesarean wound is fully healed?’ were beyond the knowledge of the group participants and the nurse would provide the answer. However, in many other instances, the skilled facilitator would deflect the question back to the group with such prompts as ‘has anyone else had this experience?’ and, if so, ‘what did you find helped?’. The unskilled facilitator would directly answer the questions before moving on to the next woman to ask her to describe her week. Even without skilled facilitators, women in most of the groups would begin to contribute to the conversation as the session progressed. However, in poorly facilitated groups, the amount of group discussion and participation was always controlled by the C&FH nurse.

Involvement of other family members

Family and friends in the form of grandmother, husband, sister, aunt or friend were welcome in the Earlybird program. This resulted in at least one ‘non-mother’ present in each of the groups observed and several present each week in the larger groups. Many of the fathers had taken time off work for the first two to four weeks of the child’s life and so were available to attend in the early weeks. Each of the nurses made a significant effort to acknowledge the presence of the family member and include them in the discussions. Some of the nurses would utilise the presence of a father or grandmother to discuss the role of family in the support of the mothers and the importance of their contribution to the young infant’s life. For example, observation data from one of the groups shows:
The nurse asks M7’s husband how he is doing. He replies that they are all doing well. He has noticed the baby getting stronger, including the cry. He didn’t want to try a dummy but after hearing the group last week he decided they should try it and it has worked well. He has also seen by the handout given out at the group last week that the babies tend to have a stormy period around five weeks and their baby is five weeks now (EBG Obs1:3.01).

In most of the groups the nurses invited the family members to introduce themselves and comment on the week they have had as their ‘turn’ round the circle came to them. After one grandmother talked of her experience with her grandchild, the nurse encouraged the mothers to recognise the roles of other family members who have been affected by the birth as well. She added that it was ‘OK to ask these people for help as most of the time they want to be useful but perhaps don’t know how’ (EBG Obs1:1.12).

One nurse was observed to often link the role of support people to the changes in contemporary society where people are more mobile, very busy and often isolated from family. This particular nurse referred to traditional societies that always carried their babies around with them, even when working. She proposed that unsettled babies in Australian culture perhaps reflected us trying to separate the mother and infant too soon by such practices as putting them in another room to sleep or by using a pram instead of carrying them. She would also use the presence of a woman from a different cultural background as a positive example, asking them to describe particular practices, specific to their culture. One such example was staying indoors for 40 days with female relatives doing all domestic work, leaving the mother only to rest and feed her baby. The Caucasian women responded with signs of envy at the possibility of having such support. By pointing this out the nurse not only validated the cultural

35 All participants in each group were numbered as they were situated around the circle. Mothers were all ‘M’s, fathers, ‘F’s, grandmothers ‘GM’s etc. ‘M7’ refers to the seventh mother in the group.

36 The baby calendar is a handout available to parents that describes possible ‘stormy periods’ in a young infant’s life that are characterised by increased periods of unsettled behaviour.
practices of the woman from that background but encouraged respect and tolerance for other cultural behaviours.

In another example, seen through observations, a nurse said to a mother after she has finished talking ‘I notice you have your mum with you today’. The grandmother looked embarrassed but soon relaxed when the nurse asked her to describe how she felt waiting for the baby to arrive. Following the grandmother’s description of feeling excited, nervous and worried for her daughter, the nurse highlighted that many other people are waiting for the baby to come and not to be afraid to ask for help. She then asked the older woman to describe her role as a grandmother (EBG Obs1:4.8).

Following discussion of the grandmother’s role, the nurse continued the thread of conversation by then turning to a father in the group and commenting ‘Dads do a lot of the same sorts of things, don’t you’. To which the father replied that he did feel a bit left out sometimes when his partner was feeding the baby. This prompted a quick response from his partner who told the group how good he was and how he did so much around the house to support her. This comment both validated her partner’s role and reaffirmed its importance. This exchange led to other women asking how they could get their partners to do more and there was a general discussion on how unsupportive some partners were as well as some strategies to try such as communication and inviting them to an Earlybird group to learn from the other, more supportive fathers.

Attracting fathers and grandmothers to the groups was considered by the nurses to be an important component of the Earlybird program as it provided an opportunity to address practices, not evidence-based, that may cause problems for the baby. As one nurse explained:

If they come with their partners or grandparents, particularly if they are other nationalities, the grandparents will support their children in the ways they hear from the group, not the old ways they did in their culture (FG3.7:4).
The nurses recognised the significant influence family members have on new mothers around parenting practices and recognised the advantages of informing husbands and grandmothers on contemporary parenting practices through the combination of professional and peer support groups such as Earlybird.

**SKILLS REQUIRED TO BE AN EFFECTIVE FACILITATOR**

The nurses were asked what skills they thought were needed to run the Earlybird groups. There was a wide variation in the responses, with some nurses able to articulate the requirements more readily than others. The following facilitation skills have been categorised and labelled according to the words that the nurses used to describe what skills they thought were important for the nurses to have to run the Earlybird program. They include: let the women talk; giving up control; don’t judge or discriminate; good group skills; sound knowledge base; resist the urge to rescue; to empower; and, to support women’s emotional health. These categories are discussed below.

‘Let the mothers talk’

Several respondents identified that one of the major responsibilities for them was to promote peer learning and group discussion ‘I tell them it is the mothers with all of the experience and every baby is different’ (FG2.8:6). Another nurse identified that the mothers should share their experiences when she said, ‘we are there to facilitate – the mothers actually contribute and share the problems’ (FG2.8:7). One nurse recognised the essential difference between the open and closed group models when she said ‘I have done closed groups since 1980, but I always felt frustrated with them as I felt families were wanting something other than listening to speakers’ (CN1.2.25).

In order to ‘let the mothers talk’ some of the nurses identified that this required a change in their role from that of ‘expert’ to ‘facilitator’.

*When there is a problem it is shared between the group. It is not us sitting up the front saying ‘you do this or that’, but we can go around the group and ask if*
anyone else has had that problem and how did they deal with it. Sometimes it is still hard to do that (FG3.7:29).

A number of nurses exhibited insight and were reflexive on how they used to practice and the benefits of this new model. Some of the nurses expressed the difficulty of this transition, as they had to adopt a very different style of working from which they had employed previously. ‘I know that I did a lot of telling the women what to do, rather than creating the open conversation’ (FG3.7:12).

The information shared amongst the women was not confined to aspects of parenting such as breastfeeding or infant care. The nurses reported that the women discussed many aspects of parenting that the nurses individually could not provide.

*They learn from the experiences of others – which bras are better, what sanitary pads to buy, cloth versus disposable nipple pads. Stuff that nurses couldn’t possibly know* (CN1.1:31).

The nurses reported that by observing and sharing experiences amongst the group, the women were reassured that they were not alone, as many other mothers voiced the same problems. This ‘normalised’ the experiences and ‘reassures the women that many of the issues such as breastfeeding struggles and sleep and settling are commonly found in other families’ (FG2.1.89).

Two of the fourteen participants suggested there was no change in practice required to facilitate Earlybird groups compared to the closed, structured groups they had traditionally undertaken. They described the program as the opportunity to answer questions to a group of women rather than individually. As one nurse said, ‘the mothers all sit around in a circle and ask questions or are given information. I haven’t had speakers out but I don’t think the mums want it – they are happy just to ask their questions’ (FG1.1.10).
Nurses varied in their ability to encourage group discussions. The following scenario was observed in one of the sessions I attended and provides an example of the facilitator promoting group discussion.

A mother described her baby as being ‘windy at night’. She was reluctant to massage in case she massaged in the wrong direction. The nurse asked the group if there is any wrong way to massage the baby. A few replied a tentative ‘no’. The nurse then asked the group what other things they do to help settle the baby. This resulted in a long discussion on different methods including bringing the baby’s knees up to the chest, gripe water, bathing the baby and relaxing the baby. The nurse then asked ‘what happens when babies cry’? The women responded how stressed they feel, and how helpless. The nurse summarised that these are normal experiences and our instincts tell us to go to the baby. This particular nurse often said to the group ‘who is the best mother for your baby’? Women who have heard the question before would confidently reply ‘the baby’s own mother’.

(Obs1.3:23)

The above scenario was seen to be a powerful confirmation that each woman is the best mother for their baby and resulted in several smiles from the faces of the women in the group.

In another example, the facilitator showed excellent skills at promoting group discussion.

M3 (baby is 7 weeks old): I can hear myself in what Kelly said (M2 whose baby is two weeks old). My baby wouldn’t go in the bassinet. The facilitator asks her what she learned to do.

M3: Wheat packs in the bed, clock in the room and all that but it was basically a time thing, I think.

The facilitator then talked about attachment and separation and how difficult it can be for some babies.
M1 I found the wrapping technique that ______ (the facilitator’s name) demonstrated last week really successful.

The co-facilitator said another mother last month had tried using a worn t-shirt as a bottom sheet in the baby’s bed so it smelt of her milk. The facilitator then pointed out that all of these techniques are mimicking the mother by keeping them warm (wheat packs) wrapping them (in utero), dummy (suckling).

M5: It does get better.

M8 (her baby is 7+ weeks): It used to be so hard.

M3: It feels insane.

M7 (this is her first visit with a three week old baby): I feel like a milk factory. No one tells you this will happen. I thought he was the only one who behaved like this.

M6: You learn to just go with the flow.

This above scenario is an excellent example of facilitated group discussion with seven out of a possible 11 women contributing to the conversation. Such participation indicates a relaxed, informal environment where the women feel safe and confident to contribute. It also demonstrates the significant support and reassurance the more experienced mothers are offering M2 and M3 as mothers with younger babies coming to the group for the first time.

Other nurses were able to articulate some of the skills required to promote group discussion. ‘We take the back seat and get the women to share experiences and information’ (FG2.1.24). Yet when these same nurses were observed in practice, they showed inconsistencies in their approach and often blocked the opportunity for the group to discuss a topic by answering the question directly. In groups where this discussion wasn’t encouraged, the dialogue was awkward and slow at times. Usually there would be a more talkative mother amongst the women who would contribute, but overall the quieter mothers had very little input. These less talkative women may still have found the groups useful (as indicated by the groups’ popularity, even when they were not facilitated to the same skill as some of the other groups).
An example of failing to promote group discussion was observed when a first generation Greek Australian woman in her early twenties with a four-week-old baby reported to the group. ‘She (the baby) is unsettled sometimes and wants to be held. She has been breastfeeding a little more often this week but I think it was a growth spurt and is starting to settle down’ (EBG Obs2.037). There was no input from either of the two facilitators present or any other mothers, so the conversation moved to the next woman. This had been an excellent opportunity to discuss growth spurts, to encourage this mother to inform other mothers (particularly with younger babies who may not have experienced them yet) what growth spurts were, at what stage her baby had experienced them and what could be done to deal with them. The nurse could also have used the other members of the group to contribute their experiences. But as nothing was said, the topic moved on to the next woman and any mothers with younger babies would have been left wondering what a growth spurt was.

In another example the nurse attempts to respond to the woman’s concerns but fails to enlist the knowledge and experience of the other group members.

A mother with a two and a half week infant was breastfeeding but having ‘a few problems latching him on. Last night he cried from 7.00 p.m. to 2.00 a.m. I don’t know why’ The nurse replied ‘about 80% of all babies have an unsettled time in 24 hours that lasts two to four hours. This did not mean that there is anything necessarily wrong with your baby and it definitely does not mean you, as the mother is doing anything wrong’. She then proceeded to suggest ways to minimise or eliminate problems including; ‘making sure the baby is fed and clean; if he is tired try rocking, a firm pushing of the pram back and forth over a small bump in the floor sometimes works, put him in a pouch, try a bath, not a cleaning bath with soap but a relaxation bath which is a deep (30 cm) bath of nice warm water’. The facilitator than added this period of unsettledness usually settles down by eight to ten weeks of age’.

(EBG Obs3.033).

37 A growth spurt is a short period of several days where the infant is unsettled and feeds more frequently and often results in a small but significant increase in growth.
Whilst the mother in the above example appeared grateful for the nurse’s suggestions, the information kept the expertise with the nurse and failed to address the self-esteem of the first mother by reassuring her that many other women have the same experiences. It also lacked the potential to recognise and reinforce to the members of the group that many of the other mothers had actually tried most or all of the techniques. The nurse also failed to address the woman’s problem of the infant latching onto the breast.

In comparison, in another group, the nurse recognised that a woman was having problems with breastfeeding and facilitated discussion amongst the group.

A woman of a seven week infant said ‘My main concern is lack of sleep. He is unsettled during the day and is getting enough on the breast - he put on two kilograms in two weeks!!! I feel like a cow. I feed and change. I have a friend whose baby is on the bottle and he sleeps all day’. The nurse asked the rest of the group if they have heard about the formula-fed babies who ‘sleep all day’. This prompted a general discussion about feeding. One mother said ‘try not to compare babies as I have had two and they were both completely different babies’. Another mother said ‘you sound like you are struggling with the breastfeeding and want to give him the bottle’. A third woman said she just gave a bottle once in a while and still breastfed. The original mother was very interested to hear this. Another mother reassured her that if giving a bottle was going to relax the mother, it wasn’t a bad thing. The facilitator reminded the group that many people think that you must either exclusively breast or bottle feed but many women successfully manage both and there were examples in the room of babies getting formula for just a few days and then going back to just breast. This is confirmed by one of the mothers. The nurse then pointed out that whilst many women do combine both successfully, they should monitor how much formula they are giving, as even one bottle a day may compromise the breastmilk supply, which all the women seemed to be aware of.

(EBS Obs1:4.013).
Whilst acknowledging the groups’ experiences of combining some formula with breastfeeding, she validated and respected their decision and situated it in the reality of their mothering experiences.

‘Promote peer support’
The nurses reported that by sharing information and experiences, the women were able to provide each other with social support, reduce their isolation and network with each other outside of the groups. ‘It is great for networking. Sometimes it is the only social outing some of these mothers have’ (CN4.2:28).

The benefits of social support and its relation to improved health outcomes are well documented (Oakley et al., 1996; Quittner et al., 1990). Support in early parenting has been found to result in higher parental satisfaction, higher self-esteem and decreased stress (Koeske & Koeske, 1990).

The peer support offered in the groups was particularly successful in the Earlybird groups due to the narrow age range of the infants. With all babies aged between birth and eight weeks, the mothers could readily identify with most of the issues raised, although there was enough range between the ages for the newer women to learn from mothers slightly more experienced with babies just a few weeks older. The mothers with older babies could relate to situations the newer mothers were in, as they had been experiencing the same problems just a few weeks earlier. The opportunity to observe babies a few weeks older also prepared the newer mothers for what was ahead, whilst reassuring them that things do change quickly and difficulties such as breastfeeding become easier. As one nurse explained:

*It prevents a lot of problems that could happen. That is because they can see the older babies and can see it gets better. For the one to one women (women who access individual consultations rather than attend groups), they don't see what is down the track and when they do it is panic stations* (FG3.7:34).
Most parent support programs, both structured and unstructured, endeavour to promote social support within the groups. Most of the studies that have evaluated parent groups have found them overwhelmingly beneficial to the women who attended (Abriola, 1990; V. Clarke et al., 1995; Gordon et al., 1995; Hanna et al., 2002; Lawson & Callaghan, 1991; Scott et al., 2001). In the parent groups reviewed in the literature, all appeared to provide the groups as a closed, structured model (Abriola, 1990; Edgecombe et al., 2001; Gordon et al., 1995; Lawson & Callaghan, 1991; Scott et al., 2001).

Social support, reducing isolation and networking that resulted from the groups were repeatedly identified by the nurses as being beneficial for the women. Whilst women vary in what motivated them to access support groups (Kruske, Schmied et al., 2004), the nurses reported peer support as one of the most significant advantages of the groups. An evaluation undertaken in Victoria in 1995 reported that those nurses identified education being the most important aspect of the mothers’ groups, whilst the mothers reported the most important aspect was the social support (V. Clarke et al., 1995). There was an agreement amongst the nurses in this research, however, that there appeared to be fewer opportunities for the women to continue to meet as a group beyond the life of the Earlybird group. This was because of the open nature of the program, wherein women were constantly entering and leaving the group, which negated the opportunity to continue to meet outside the program as a group.

Some nurses highlighted the need for flexibility in models of C&FH services, as some women were ‘not the group type’ or were suitably supported amongst their own community. One nurse demonstrated that it was important to keep an open mind as to whether all women require the support of the Earlybird program when she said ‘that is because lots of women have so much family support in the community and social networks they just don’t need us’ (FG1.6:29).
There appeared to be different levels of peer support generated within the groups and this was dependent on the skills of the facilitators to promote group discussion and the sharing of knowledge.

‘Giving up control’
As a consequence of ‘letting the women talk’ and ‘promoting peer support’, a minority of the nurses were able to identify the necessity for the nurses to shift from being the ‘expert’ to ‘partner’ and the need to surrender control. The Earlybird program requires the nurse to relinquish control and work in partnership with the group participants. In contrast with the expert model, the partnership model promotes discussions based on what the client identifies as a need, rather than the professional ideal of what they think the client needs (Houston & Cowley, 2002). Clients’ beliefs in their own abilities influence their ability to change behaviours (Dines, 1994). To effectively do this, nurses must transfer control from themselves to the client, allowing them to assert control over the factors which affect their lives (Gibson, 1991).

Whilst the training workshop some of the nurses participated in had included the importance of developing relationships with the women in partnership, few identified the significant role change that needed to be undertaken. One nurse expressed how important it was to ‘acknowledge the change of power that must occur’ and ‘give up control’ (CN4.14) for the groups to run successfully. Another nurse described how she ran the groups in a way that showed a sound ability to understand the concepts of partnership.

‘We try and work out the problem together. So it is a change from authority where I am the nurse and I will tell you what to do. We are equal now and we will solve the problem together’ (FG2.8:9).

An example of one facilitator encouraging the women to control and participate in the groups can be seen in the following excerpt from observation data.
M2: My husband wants to stop the dummy – he is worried he will still be using it when he is three.
M5: I think dummies are a gift from God.
M6: I was told dummies were bad.
Facilitator: Why do some people think they are bad?
M6: Because they get confusion between the nipple and the dummy
M4: My baby has breast, bottle and dummy and she doesn’t get confused.
M8: the midwife in the hospital told me I wasn’t allowed to have one but we bought one on the way home from hospital.
Facilitator: There is some evidence that the use of dummies can lead to problems with breastfeeding in the first few days of life. But once the baby and mother are happy that breastfeeding is established, usually there are no problems introducing the dummy if you feel you would like to.
M4: Before I bought a dummy, I felt like she was going to suck my nipples off.
M6: I feel like sometimes she is not really feeding, only sucking, using me as a dummy.
Facilitator: Sucking is an instinctive newborn behaviour and you are right, she will suck on your breast without feeding if she can.
M6: That’s it then. I am buying one on the way home.

(EBG Obv1:5.119)

This was followed by a general discussion on what dummies were available and which were the best. The facilitator used the group’s knowledge to inform the mother that there was no perfect dummy, although the bigger (and cheaper) teats seemed to be more popular, as the infant could get the dummy to the back of the palate, which is where the nipple was positioned when breastfeeding.

Unfortunately, there were many more instances, in the observations, of the nurse not offering control of the conversation to the women, as the following example demonstrates. A mother asked the nurse facilitating the group what sort of dummy to buy. The nurse replied that she thought the ____ brand to be the best, but gave no indication why. There was no opportunity for the other women to give their opinions.
Again, the nurse retains control and expertise amongst the group and fails to engage the knowledge and experiences of the other group members.

Another example of the facilitator not using the opportunity created by one mother’s comments to promote group control and participation follows:

M1: *My baby won’t take a bottle. I have tried everything, all different teats. I have to go back to work and am worried he will starve when I am away.*
Facilitator: *Try warming up the teat with hot water so it is soft and then put some EBM on the outside of the teat before you offer it to him.*

(EBG Obs4.087).

In groups where the nurses remained in control, and did not promote the sharing of knowledge amongst the mothers, some women were still able to share information. In one group where there was very little group interaction, one mother said the following when it was her ‘turn’ to speak.

‘I would also like to share with the group that I have found some great colic medicine called ‘Brewers Natural Medicine’. It was recommended to me by the midwife and it is all natural and you can get it from the health food store at _______. I have used it five times and it has worked every time so unless it is a very big coincidence I think it is good’.

(EBG Obs 3.115)

Unfortunately the nurse did not promote further discussion of this topic, and the discussion soon moved on to the next woman in turn to speak.

‘Cultural differences’

Whilst some nurses were able to identify the importance of power and expertise, several others recognised how their own value system affected the success of the groups. One nurse reported it was important for nurses to ‘*lay aside their values and be non-judgemental*’ (CN1.1:11) whilst another identified how necessary it was to ‘not
discriminate or stereotype women – you know, respect the different cultures’ (CN4.2:22).

It was evident from the focus group and interview data that not all nurses managed to be non-judgemental. One nurse, for example, struggled with understanding how low socio-economic status families prioritised their expenditure when she said ‘their idea of having things are buying a new $2,000 stereo but their fridge is empty’ (FG1.6:34). Several of the nurses believed the ‘hard-to-reach’ clients ‘didn’t know what was good for them’ and therefore the women who accessed the groups ‘seem to be more sensible’ (FG3.7:30).

The majority of the nurses reported their groups to be generally homogenous. Many of the nurses reported scant representation of young mothers, or women from non-English-speaking backgrounds. As one nurse said ‘I found most of the women are Anglo-Saxon, middle income (and are) quite well educated’ (FG1.6:27). These observations are consistent with the socio-demographic characteristics of the area, with the local municipality reporting that the average income of its population was slightly higher than the mean Sydney income per household (SES Council, 2003).

In the central sector serviced by some of the nurses, approximately one third of the community are born outside Australia, with China being the most strongly represented group (SES Council, 2003). Chinese-language Earlybird groups facilitated by a bilingual nurse are available for this community. The C&FH centre with the largest non-English-speaking composition of Earlybird groups included 56% Australian born, 14% Asian (usually not Chinese-speaking), 12% European, 10% Middle Eastern and 8% ‘other’ (SESAHS, 2001).

Some of the more southern suburbs in the area consisted of largely Anglo Australian families, with very few women from disadvantaged communities. During observations many women coming to the groups were of Southern European descent, such as Greek or Macedonian, but they were all first generation, spoke English as their first language.
and did not appear disadvantaged in any way. Other suburbs contained significant Middle Eastern communities, who were reported not to access groups as a rule. For example, ‘the women around ______, who are Arabic don’t tend to come to any sort of group – even the well-educated Arabic women’ (FG1.6:28).

Many Asian and Middle Eastern cultures adhere to the traditional cultural practice of staying at home for 40 days post-birth (Rice, 1998). The nurses recognised and reported the impact this practice had on mothers accessing the Earlybird groups.

*We have cultural problems because the Chinese don’t come out of their house for a month and the Arabic folk are more or less the same. So getting them (to the groups) in the week of discharge is a real badge of honour. If you manage to get them there (it is) because you have to break down their cultural things* (FG1.6:10).

It is interesting to note that this nurse expressed an achievement in the form of ‘badge of honour’ to attract women to groups when their culture expects them to stay in doors. Whilst the intent is to provide early and additional support to women from these groups, there is little sensitivity exhibited in this data of the need to stay at home or the consequences for women of not being able to adhere to cultural practices. Another nurse proudly reported how she imposed her Western beliefs upon a client whilst disregarding a woman’s traditional practices, when a liaison nurse rang the centre to make an appointment for a client during a 40-day lying-in period:

*She (the liaison nurse) said something like ‘she won’t want to leave the house for an appointment, it’s their culture’ and I said ‘it’s not mine. – You tell her I will organise it for next Tuesday’* (prior to the end of the 40 day period) (FG1.6:11).

These quotes demonstrate a lack of respect for the woman’s cultural practices amongst a minority of the nurses. The majority of nurses recognised that whilst it is preferable to offer breastfeeding and parenting support in the early postpartum period prior to
women weaning to formula or becoming distressed with an unsettled infant, this must be done within the possibilities and practicalities of individual cultural practices.

Language and ethnicity seemed to be the biggest barrier identified in attracting non-English-speaking women to the groups. Some nurses thought the main barrier was the ability to speak English:

*I have a couple of Chinese girls who are coming to the 'anglo' group and their English is quite good. I tried to include a Korean lady whose English wasn't very good … but she only came twice* (FG1.6:33).

Another nurse agreed ‘women who don't have good English won’t come and if they do come it will only be for one or two visits’ (FG2.2.55).

However, other nurses did not think the Earlybird groups catered equally well to everyone in the community. As one nurse said ‘they (first-generation Asian or Arabic women) don’t come even though they are Australian born and can speak English like everyone else’ (FG1.6:37) and another thought that ‘people all like to mix with their own people even those who speak good English’ (FG1.6:38).

‘Group skills’
The nurses participating in the research had many years’ experience in running groups, though in the traditional closed and structured model. However, only a few of the participants could readily identify some of the key factors necessary in the running of groups. Generic group-work skills were identified and included ‘good listening skills’ (CN1.0.64), ‘be welcoming’ (CN4.1.05), ‘identify people with special needs’ ‘not belittle’ (CN1.0.69), (CN4.1.07), ‘Flexibility – dealing with difficult clients but still keeping the group cohesive’ (CN3.0.89), ‘bring a mother back who is dominating the group’ and to have ‘tact, patience, confidence’ (CN4. 1.11).

Two of the research participants also identified group skills particular to the open, unstructured Earlybird model, including the ability to, ‘be informal’, ‘have the skills to promote group discussion – draw information out of them without directly asking a
question’ (CN1.0.71), ‘encourage diversity of conversation’ (CN1.0.69), and, ‘be able to manage the group, to deal with mothers who are giving incorrect advice’ (CN4.1.03).

‘Use our expertise sensitively’

Although there was a focus on promoting the sharing of knowledge amongst the women, the nurses identified the professional responsibility of providing evidence-based information when required. As this nurse explained:

There are some things that the mothers simply don’t know. We are there for a reason and that is our expertise as a C&FH nurse. And the women want that, they look at us for our expertise. Otherwise, any old person could run the groups. We certainly use our expertise, but it is how you use it that is the issue – you have to use it sensitively (FG1.4.9).

There were many examples of this type of expertise being offered by the nurses, and this demonstrates the importance of both professional and peer support in the success of the Earlybird program. Questions from the group where such expertise was requested include: the cause and treatment of thrush; contraception; prevention of Sudden Infant Death Syndrome (often introduced around discussions of co-sleeping or bed-sharing); clarity of the infant’s vision; why babies sneeze, etc. All of this information was of relative importance to the mothers and often was not available from the other women.

The nurses also recognised that some behaviours and practices around parenting were problematic or potentially dangerous, and they had a professional responsibility to correct this and provide current information. This required the nurses to have a sound knowledge base to support what they were saying as well as the skill to provide the information in a way that would not embarrass or humiliate the women. As one nurse explained, as facilitators:
Use your diplomacy skills to disagree with what someone is saying ‘yes, but …’.

We can use our medical knowledge to report what the medical experts say (CN1.1:15).

The necessity of having to interject with current Western knowledge is problematic when addressing parenting practices from non-Western cultures, particularly when such practices are not harmful to the infant. The introduction of solids prior to six months is a widespread practice amongst some ethnic groups in Sydney. There is now strong evidence from NHMRC\(^{38}\) to support the nurses informing the group of the current recommendations. However, other practices, such as co-sleeping, are much more ambiguous in the potential harm to the infant, but still some nurses are intervening in ways that may alienate the women and disregard cultural practices. As one nurse said:

*Lots of the ethnic ladies co sleep with their babies. I have to tell them that this is not recommended and can lead to cot death*\(^{39}\) (FG1.3.6).

There were some other practices of the nurses observed that demonstrated a lack of application of evidence in practice. The scenario below is an example of this and also shows a lack of sensitivity and support on the part of the nurse.

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\(^{38}\) National Health and Medical Research Council have produced guidelines that provide evidence that support the new recommendations of delaying the introduction of solids until six months of age (NHMRC, 2003).

\(^{39}\) Co-sleeping is not linked to Sudden Infant Death Syndrome unless the mother is a smoker (Rosenberg, 2000). Current SIDS recommendations in Australia caution parents of the dangers of infants getting caught under adult bedding or pillows, entrapment between the mattress and the bed and parental smoking when bed-sharing (SIDS and Kids, 2004). Furthermore, it is proposed by some that there is an alternative opinion that co-sleeping is protective of the risk of SIDS, due to the increased arousal caused by the movement and noises produced by the parents (Sullivan & Barlow, 2001).
A young, shy Indian girl in her early twenties with a baby aged 5½ weeks had her turn around the group. She said ‘the biggest problem is that she (the baby) sleeps in a bassinette in our bedroom and keeps me awake at night snuffling or playing’. To which the nurse suggested ‘buy a walkman’. (EBG Obs2:005).

This was obviously meant in jest but seemed inappropriate for any new mother. The nurse then diverted the topic and told the group that ‘babies don’t sleep in utero. They close their eyes but they don’t sleep’. She added that their ‘lungs don’t mature until eight years of age’. The atmosphere in the room was tense and awkward. None of the mothers responded to these statements which were not evidence-based and had little to do with the problem the woman was having sleeping with the noises of her infant.

This same mother later admitted this was the first time she had taken her baby out of the house. She had her aunt in Australia helping but she had returned to India the week before. The mother said ‘It is very stressful leaving the house. I am worried the baby might need feeding in public.’ It was clear that this was a significant issue of concern to the woman. Yet again, the nurse was less than helpful and said ‘don’t worry about that. Most people are quite tolerant these days’ (EBG Obs2:005).

These responses from the nurse diminished the legitimacy of the woman’s concerns, failed to allow the woman to further explore the issue, provided statements around uterine life and lung maturity that were not evidence-based, and severed any possibility of allowing other mothers to express the similar concerns or provide reassurance.

‘Resist the urge to rescue’

Several of the participants recognised and articulated the traditional response of the nurse, which was to diagnose a problem and provide information and advice to remedy it. This model was not appropriate in the Earlybird program, as explained by one of the nurses: ‘we have to give up being the expert and our need to “fix” things –
you know, resist our urge to rescue women’ (CN3.4:12). The nurses who could successfully manage this would encourage the women to work through issues with the support of the group, which often led to the woman identifying her own solutions. ‘Have the confidence to leave a struggling mum and letting her run a couple of weeks within the groups without running to help her’ (CN1.1:20). This nurse identified the importance of allowing the women to increase their own capacity at their own pace.

There were also examples of nurses maintaining control and offering solutions as demonstrated below.

<table>
<thead>
<tr>
<th>M6 (of a five-week-old infant): ‘I am concerned about my baby’s skin which goes red and blotchy; sometimes she gets red spots with white points and she looks irritable as if they are itching her. I don’t know if it is maybe my diet but I don’t know’.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator: ‘Have you eaten anything different?’</td>
</tr>
<tr>
<td>M6: ‘no’.</td>
</tr>
<tr>
<td>Facilitator: ‘Have you applied anything to the rash?’</td>
</tr>
<tr>
<td>M6: ‘No’.</td>
</tr>
<tr>
<td>Facilitator: ‘We will have a look at her skin after the class’ (my emphasis).</td>
</tr>
</tbody>
</table>

Hormonal skin rashes are extremely common in this age group. The nurse does not reassure the woman that this is probably what it is, nor does she allow the woman to be reassured by other mothers who may have had a similar experience. By checking the baby’s skin after the session, the nurse remains the expert and the woman the recipient of the nurse’s expertise. By using the term ‘class,’ the nurse reinforced a didactic model of learning where the nurse is the teacher and the mothers are the students.

As a sharp contrast, the same topic is handled very differently in another Earlybird group with another facilitator.
M4: (of a four-week-old infant): ‘He has spots on his face – looks like a pizza face.’
Facilitator: ‘Have any other mothers, particularly with the older babies, had similar problems?’
Reply: a unanimous ‘Yes’.
A lively discussion ensued with mothers agreeing that it was due to hormones, it was worse after feeding or when the baby was distressed, and does disappear.
M8: ‘I wish someone had told me before. Angela (her baby) had the rash all over her face when she was christened. I would only let them photograph her from a distance!!’
Only after the discussion had come to a quiet and natural close the nurse reassured the mother that hormone rashes often occur around three to five weeks, last only a few weeks and don’t need any creams or lotions applied.

‘To empower’

Some of the nurses used the term ‘empowerment’ as a significant part of a facilitator’s role in the Earlybird program. One nurse said her role was to ‘empower the women to solve their own problems with support of other mothers’ (CN4.2:16), whilst another stated her goal was to ‘empower the mothers, not to look after them’ (FG3.7:15).

The nurses reported that the Earlybird groups ‘increased independence’ (CN4.1.11), ‘encouraged the women to think’ (FG2.2.33), and decide ‘what aspects of advice or information they will utilise or disregard’ (FG3.5). They also thought the women became ‘empowered’ (CN1.055). Whilst some nurses were concerned the weekly contact could encourage dependence on the service, most believed that when women solved their own problems and increased their confidence, independence increased rather than dependence.

*The main aim of the group is to encourage independence and you can't do that and still control them. We want to empower the women to solve their own problems with support of other mothers* (CN4.1.01).
Part of the promotion of empowerment and control by the women was the ‘open’ philosophy of the program, whereby women could select if and when they wanted to come to the groups. This is in contrast with the traditional structured, closed groups, wherein attendance was available to a set number of women who were required to book into the entire six-to-eight week program. As this nurse explained, ‘If a woman doesn’t come for a few weeks she doesn’t have to feel like a naughty girl. They are getting the help when they need it’ (FG1. 6:8). In spite of this flexibility, many women did not miss a week.

Whilst several of the nurses expressed the importance of the women being empowered throughout the process of the Earlybird group, little of this was seen in practice. This could indicate the gap between knowing you should be doing something and the realities of doing it in practice. However, some of the nurses identified the benefits for women in working through issues in early parenting, through dialogue with other women. This demonstrates insights and personal skills that contrast with their long careers of working in a model of practice that imposed authority and expertise.

Of the participants who raised the notion of empowerment, all discussed it as something they ‘gave’ the women. These comments reveal lack of awareness of the concept that one person can’t ‘empower’ another, particularly a health professional in a position of relative privilege (Wallerstein & Bernstein, 1994). Rather, power must be taken, and only the women could empower themselves (Houston & Cowley, 2002). Although they did not articulate the theoretical critique that surrounds the term, many of the nurses could identify the environment that the nurses could provide for empowerment to occur, and included the women taking control, sharing experiences and solving their own problems.

‘Support women’s emotional health’
All of the participants recognised that early parenting was a challenging time for most new parents and the role of the nurse in supporting the women’s emotional health was identified as an important component of their role in the Earlybird program.
The scenario below demonstrates one of the many positive examples of supporting women in this area.

A mother stated: ‘he has been in a feeding frenzy for the past week … have been a bit depressed and a bit teary, don’t know why. James (her toddler) is very hard. … I am OK I think. I am going to go to cognitive therapy soon. I am not suicidal, just feeling like I am not coping … inadequate’. The facilitator asked if any one else in the group felt like that and a few of the mums said they did ‘when my baby cries’ and they ‘can’t settle him’, or ‘when I thought I was going to have to stop feeding him because I didn’t have enough’. Another woman said ‘I feel guilty for my partner not getting enough sex, feel like an inadequate mother when my baby won’t settle for me but does for my husband – I worry he doesn’t like me’. The nurse then suggested that the early months of parenting are particularly hard for most women, and are much more difficult to cope with when their baby cries a lot or the mothers don’t get enough sleep. She asked the group how we could help ourselves get through the first few months. One woman said ‘I was so depressed a month ago. I didn’t know what I was doing, I felt like I was the worst mother in the world. But it does get better’. There was a quiet lull in the group so the nurse commented, ‘OK, so knowing it gets better, that helps. Any other things we can do when we are in the thick of it’? To which there were several suggestions from the group including, ‘ask for help’, ‘talk to your partner’, ‘take time out’, ‘try to give yourself some pampering like having a bath’. The nurse also informed the woman that professional support was also available if she felt that she needed it.

Some nurses reported that there seemed to be an increase in emotional stability and confidence in parenting skills, including women who were suffering postnatal depression (PND). Women who were experiencing, or identified as being at risk of, PND were encouraged to come to the Earlybird program. The nurses believed that witnessing the struggles and strategies experienced by other women appeared to

*Same but different. Chapter Six: Case Study Two*
normalise the experiences of women with PND and reassured them that things got better relatively quickly.

*I have two mums with depression – one is really bad and they are coming to the groups and I think they are really improving. They just don’t realise how most women find it as tough as they do* (FG2.1:33).

Several of the nurses identified that supporting women emotionally was difficult for them, both in the Earlybird groups and individual consultations. These difficulties have been reported elsewhere and have been suggested to relate to the inadequate educational preparation of C&FH nurses (Morse et al., 2004). Comments such as, ‘*some of these women have so much emotional baggage, I can’t do much about it*’ (FG2.234) and, ‘*sometimes it is really hard because I just can’t make it better for them – they have to take that crying baby home*’ (FG1.345) suggest it may also relate to the traditional role of the C&FH nurse to ‘fix it’.

The above comments also suggest the nurses are still working within the expert model. Within this model, the C&FH nurse is trying to determine the health needs of the clients and responds by offering advice, education and other strategies to address these needs (Twinn, 1993). By doing this the nurse maintains domination and control of the health interaction (Elkan, Kendrick et al., 2000). The Earlybird program is supposed to operate within a strengths-based approach, wherein C&FH nurses work in partnership with women and families. In this model, the role of the nurse is not to ‘fix it’ but to support the woman to address and solve the problem herself (Barnes & Freude- Lagevardi, 2003).

The majority of the nurses participating in the research could articulate the change in practice that was required to facilitate the Earlybird groups in a way that satisfied the aims of the program. Demonstrating these skills in practice, however, was difficult for most of them. It appears that the majority of nurses struggled with adopting a paradigm that was the opposite to the one that traditionally underpinned their practice,
that is, to surrender the expert model and incorporate the philosophies of the partnership model.

These difficulties were further explored by asking the participants what they perceived to be the benefits and challenges to themselves, as C&FH nurses, of running the program.

**Perceptions of the Professional Implications of the Program**

The nurses were asked to describe what they thought were the advantages and disadvantages of the Earlybird program, either for themselves, as facilitators, or for the C&FH profession. The main themes identified included: increased job satisfaction; stress; lack of management support; and recognition of the importance of their role. These main points will now be discussed.

**Increased job satisfaction**

Some nurses reported the Earlybird program resulted in a more stimulating and rewarding professional experience, compared to the one-to-one consultations in which the nurse was required to have all the information. Not only did the women learn from each other, the participants identified that the nurses also learnt from the mothers. One nurse reported ‘we are always learning and being stimulated’. (CN1.1:37). The relationship between the nurse and the group was thought to be non-hierarchical and the nurse was not expected to always have the answers. ‘We all learn from each other – nurses can’t possibly have all that knowledge’ (FG2.1:33).

Before Earlybird the nurses were ‘bored with saying the same thing over and over again’ (CN4.2:1). The decrease in repetition of information resulted in more enthusiasm when the nurses were involved in individual consultations. The nurses reported that the Earlybird groups freed up more appointment times for women who did not access the groups, or for group attendees who required additional professional support. ‘I like the variety of both (Earlybird groups and individual consultations). We now have more appointments for those who really need it’ (CN1.1:40).
The potential for women to access the groups within one or two weeks of birth was identified by many of the nurses to be crucial in their ability to provide support and prevent problems, and this led to increased job satisfaction. As explained by this participant:

*It is so much more rewarding to help them before the problems are insurmountable. Like, seeing them get over the first few weeks of breastfeeding problems and persevering* (FG2.1.02).

**Stress**

Many of the nurses identified stress for the facilitator as a particular disadvantage of running the group. Some nurses suggested the stress was due to being under-prepared to run the course with insufficient training.

*I have always thought that Earlybird training was really inadequate and I didn’t feel secure in what I was doing and didn’t trust what I was doing. I personally found it very stressful – I still do, to be honest* (FG3.7:10).

This stress was alleviated by the presence of a second nurse in the role of co-facilitator and also promoted debriefing at the end of the session. The stress and high levels of energy involved in running the groups took: ‘a lot more emotional energy for the staff. There are lots of issues that go on simultaneously. It is also extremely tiring’ (CN3.4:18).

Working in partnership is recognised to be more tiring than the expert model (Davis et al., 2002). Some of the nurses found that dealing with the group was very difficult, particularly when there was a disruptive member, or someone who dominated the conversation. One nurse found individual members particularly difficult.

*People can really drain you, and possibly they shouldn’t be in the group if they are that demanding. I find that a bit of a challenge, when you are trying to manage a group and the woman wants to talk to just you* (FG2.8:39).
The remarks above indicate both a lack of adequate preparation to run the courses and insufficient ongoing support for the facilitators.

There was also a concern amongst some of the nurses that quieter members of the group were not getting as much attention as they would in individual consultations. They thought they did not get the opportunity to get to know the quieter women as well in the groups, as this nurse explained:

*I felt I was losing track with one mother because the other women were talking all of the time so I didn't know if she was OK. But on one-to-one I would* (FG1.6:50).

This demonstrates the difficulties and challenges faced by some of the nurses in using facilitation skills that could assist the quieter women to contribute to the group. Another nurse discussed strategies she would use in this situation.

*The quiet ones I usually put them next to someone who is friendly. Or I ask them a few questions and try to acknowledge their good answer and try to make her feel comfortable and encourage them to join into the group* (FG2.1.89).

It was evident that some nurses were more skilled than others at utilising generic group skills.

**Lack of management support**

Lack of commitment from the health service was identified by some nurses as a barrier to the program. Though the program was implemented within the current budget, some felt a pressure from higher management to justify two nurses attending each session. As one nurse explained, ‘*I know they (management) want us to cut back to one facilitator ... they are just not behind us. There is talk of closing some of the centres down*’ (CN4.1.5). This was compounded by the perception of the nurses of an overall lack of investment from management in C&FH services. For example, ‘*Management do not see how important our role is and our role in prevention*’ (FG3.2.36).
Recognition of C&FH nursing services within the health system

Many of the nurses reported the frustrations they felt over the lack of importance and recognition of the C&FH nursing role by the wider health system. The nurses believed as a workforce, they suffered poor professional recognition and respect. This was evidenced by the lack of infrastructure in their workplace. One nurse suggested that ‘computers and photocopiers would be nice’ (FG3.2.17) whilst another expressed frustration at not having access to information technology; ‘we don’t have email or Internet access. Everybody sends out information on email now and we don’t know anything about multicultural issues’ (FG3.7:56).

Some of the centres did not have facsimile (fax) machines whilst others had them but ‘it uses thermal paper so I can’t copy through my fax’ (FG3.2.23). Receiving information through the fax was also problematic, as the information could not be placed in the infants’ health record on thermal paper, due to fading of the text. Information received on thermal fax machines would have to be taken to the central office for photocopying before transporting back to the C&FH centre for filing in the infant’s health record. Documents were often lost and misplaced in this way.

There appeared to be an overall frustration that the health service did not recognise or acknowledge the important role the nurses believed they provided in supporting families and preventing problems. The nurses believed they were seen as a workforce who ‘put babies on scales and walk away’ (FG3.7:55). They felt management didn’t appreciate the important preventative work the nurses did, not only in physical health by, ‘stopping people going to hospital’ (FG3.7:56), ‘babies being fed cow’s milk at three or four months and later on getting kidney disease (FG3.2:41), ‘the early introduction of solids’ (FG3.7:59) and ‘normal understanding of safety so you don’t have them drowning in swimming pools (FG3.7:60). They also discussed their role in

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# Footnote

40 NSW Health has established a website called the Multicultural Communications Website. It acts as a central collection point of all NSW Health-approved health information resources for non-English-speaking communities. All pamphlets are available to download and print locally. For agencies such as the C&FH nurses who do not have access to the Internet, the same resources are available by facsimile.
emotional health such as ‘stopping mental breakdowns’ (FG2.1.12), and, ‘keeping families together, (and) helping women understand normal behavioural patterns of their two-year-old so they don’t bash their child (FG3.7:60).

When discussing the C&FH nursing service within the health system and Families First initiative, the participants felt undervalued. ‘We are at the bottom end of the hierarchy’ (FG3.7.56), one nurse said. They believed they were uniquely positioned to support families and ‘do all this preventive stuff that the government want done with Families First but nobody realises it … I think our job is more important than GP’s and doctors’ (FG3.7:62).

**DISCUSSION**

The Earlybird program appears to offer a unique service using the combination of professional and peer support to assist new families in their transition to parenting. The interviews suggested that many of the nurses were able to identify the key differences in the program compared to traditional closed and structured groups. In practice, however, many of the nurses have difficulty working outside the expert model. Educational preparation was clearly insufficient and incorporating clinical duties into the program may further impede the nurses relinquishing the role of expert.

**The first visit and other clinical duties within Earlybird**

The requirements for the first visit within this AHS were substantially less than those in the other AHS detailed in Case Study One. At the time of the research being undertaken, social assessments, such as the lengthy IBIS forms utilised in Case Study One, were not being conducted within this AHS.

It is interesting to note that some of the nurses undertaking the Earlybird groups asked the women to undertake an individual consultation for the first visit, prior to encouraging them to attend the Earlybird groups. Other nurses incorporated this first visit either immediately before, or after, the Earlybird group. When the first visit was undertaken at this time, the assessment usually involved the nurse checking the details
on the maternity unit discharge summary and performing a physical assessment of the newborn. This coincided with the substantial activity at the venue and there was little opportunity to explore psycho-social aspects of the mother and her family. Compounding this was the lack of privacy offered in some of the venues to explore these issues.

The capacity to weigh the babies weekly was well supported by the users of the service. When the scales were available for use unsupervised by the nurses, this practice allowed control of the activity by the women. However, when supervised by the nurses, this activity was a continuation of traditional practices and ensured control of the encounter by the nurses. The deflection of questions from the mother to the group when weighing their infants also firmly positioned the nurse in control of the interaction.

**Closed and structured compared to open, semi-structured groups.**

The availability of both professional and peer information and support for women and their families in an open, unstructured and ongoing weekly group appears to be a unique component of the Earlybird program. In the Earlybird program the women need to wait between one and seven days, depending on what day of the week the groups are being held. Access to information and support in the first few weeks of parenting has been reported as being important to some women (Butchart et al., 1999). In the closed and structured groups, women must register and secure a place, and then wait until the next program starts before accessing support.

The mean age of babies in closed, structured groups has been reported to be between three and four months (V. Clarke et al., 1995; Clune, 1999), with others reporting the range between three and 17 weeks (Scott et al., 2001). This age range is too broad to successfully meet the needs of all attending parents (Clune, 1999). Women have also reported the need to access groups earlier than is traditionally offered (V. Clarke et al., 1995; Clune, 1999). Earlybird participants all have babies ranging between birth and eight weeks. This is narrow enough for most topics to be relevant to most of the...
women, as well as broad enough for the women to learn from the older babies and more experienced mothers.

In the closed and structured groups, C&FH nurses ‘teach’ the mothers various aspects of parenting and co-ordinate visiting ‘experts’ to come and give information. Although the establishment of informal networking and social support is a major aim of many of these structured programs (Edgecombe et al., 2001; Lawson & Callaghan, 1991; Scott et al., 2001), the emphasis lies with expertise that is external to the mothers. Whilst there is a strong promotion of the women networking and establishing contact beyond the life of the group, there appears to be limited acknowledgement of the expertise of women around parenting. Rather the sessions are structured around ‘topics’ and the provision of information (Edgecombe et al., 2001). The use of ‘open’, ongoing groups are therefore rare in C&FH services, although they have been successfully used in the discipline of social work (Lyons, 2000).

Closed, structured groups rely on selected ‘topics’ that will be discussed at each session. Whilst some mothers have input as to what topics they would like to receive and the nurses are encouraged to promote social support (Edgecombe et al., 2001), such a model remains didactic and ‘expert’ in nature. In contrast, Earlybird groups have no set agenda and each week the women go round the group and describe their week and ask any questions they may have. This model encourages ownership of the group by the women who set their own agenda and promotes empowerment, which in turn promotes self-esteem (Rodwell, 1996).

In many of the structured, closed groups the women often continue to meet for long periods beyond the life of the group (V. Clarke et al., 1995; Lawson & Callaghan, 1991; Scott et al., 2001). In Earlybird, it was observed that groups of two or three women became friends and would see each other outside the group. However, this did not happen for all women or to the same extent that is reported in closed group programs. This was possibly due to the high turnover of women in the group. In Earlybird, the ‘open’ nature of the program resulted in mothers coming to the group.
with infants as young as five or six days old as other mothers were leaving with infants aged eight weeks. Each week one or two new mothers would arrive and one or more leave.

However, the nurses could have been more proactive in the promotion of networking and the establishment of friendships beyond the groups. None of the groups used name tags for the facilitators, the participants or the babies. The use of name tags in groups is recommended, as it encourages the use and memory of other people’s names (Hamer, 1997). It is also known to be popular with mothers in similar parent groups (Edgecombe et al., 2001). Failing to introduce each participant at the beginning of the session also failed to promote the members becoming familiar with each other. Whilst it was good practice to give everyone an opportunity to describe their week and address any concerns or issues that the woman may have, it would have been more beneficial to do a quick introduction of name and baby’s age to ensure each woman had an opportunity to know each other’s name. In other research, nurses have reported the importance of the introductions and use of name tags (Scott et al., 2001).

The size of the group is also important. The nurses identified that ‘twelve promotes conversation, three is hard’. The ideal number of participants in support groups is recommended to be between four and ten (Hamer, 1997). Smaller than this can result in too little variation in interaction, thoughts and ideas due to life experiences, and larger than ten may affect the establishment of group cohesion and trust among group members (Hamer, 1997). This was seen in some of the larger Earlybird groups where up to 15 participants were present. Additionally, these sessions lasted over two and a half hours, and it was evident that the mothers and babies were restless and some members left prior to the group’s closure.

The nurses could also promote increased networking and social time by encouraging the women to partake in refreshments following the main session. Whilst this facility is offered, most of the women leave the group on completion of the more formal discussions. In the larger groups of women these discussions usually lasted for two
hours. If the groups were kept to a maximum of twelve, they would be expected to finish earlier and the possibility of more women staying for refreshments and social interaction would be enhanced.

**Ability of the nurses to apply strengths-based approach**

Depending on her/his skills the nurse, as facilitator, has the potential to assist new parents to reduce isolation, ‘de-pathologise’ problems, reduce stigma, improve problem-solving skills and manage self-doubt and insecurities (Gitterman, 1994). There was a great variation in facilitation skills demonstrated amongst the nurses. Differing levels of skills and knowledge in C&FH nurses in facilitating parent groups have also been demonstrated elsewhere (Edgecombe et al., 2001). In a 1997 consumer survey of the Maternal and Child Health Services in Victoria, recommendations included a need for improved quality of facilitation and presentation skills of the nurses (Department of Human Services, 1997). During this research, most of the nurses were able to identify the skills required to facilitate groups. However, observations revealed difficulties for many of them to incorporate the skills and philosophies into practice.

There appeared to be three types of nurses facilitating Earlybird Groups: the unskilled; inconsistent; or skilled facilitator.

*The unskilled facilitator*

Some nurses had difficulty either articulating or demonstrating any of the facilitation skills necessary to promote the sharing of knowledge between the women. They appeared to view the Earlybird program as an opportunity to answer the same questions to a group of women rather than individually. These nurses answered the questions posed by the mothers, maintained control of the group and held onto the expertise. One nurse expressed concern that the groups provided an opportunity for the women to give each other ‘bad advice’, indicating a lack of ability in acknowledging the expertise of the women’s own experiences. Benjamin (1997) describes this type of facilitator as ‘authoritarian’, where the nurse (and some of the mothers) believes the
nurse knows what is best for the group. Mayall and Forster (1989) suggest that health visitors believe their large body of ‘factual’ knowledge produces an expertise that is superior to the knowledge and expertise of the families they service. The comments and clinical practice of these nurses would suggest the same. This ‘expert’ model of facilitation is appropriate in emergency-type situations where urgent tasks need to be undertaken (Benjamin et al., 1997) but is not useful in situations where participants have shared expertise. In other research, women have expressed dissatisfaction with groups when nurses run them in a way that is perceived to be ‘too didactic’ (Scott et al., 2001).

The nurses who did not encourage group discussion also demonstrated the most insensitive and unprofessional examples of practice, and at times gave inaccurate advice Providing information such as babies don’t sleep in utero is incorrect and misleading. If women were to discover that babies do sleep in the uterus and lungs are mature (though the air passages are small) at birth, the nurse and the profession’s reputation would be compromised, and trust and respect by the mother and community in the service would be greatly diminished. Many mothers appeared to gain some benefits from going to the groups, as evidenced by their repeat visits. However, the ability of the nurse to enhance self-esteem and increase confidence in the mothers’ capacity to parent was diminished in these nurses. Perhaps they are the facilitators referred to in the focus groups and interviews as the nurses who simply ‘don’t like groups’, or, ‘shouldn’t be forced into doing it’. Perhaps it takes a ‘special type of person to run Earlybird’. More likely these nurses require additional support and education.

The inability of these nurses to articulate or demonstrate the capacity to understand the different philosophy of care required in Earlybird could indicate a lack of initial training, inadequate supervision and ongoing support. It could also reflect a lack of leadership in management, which needs to be aware of staff members who require additional support or education. Additionally, the ability of the nurses to be self-reflexive, have the capacity to meet the needs of the women over the needs of
themselves, and the level of security they hold in their personal and professional lives can all affect the ability to skillfully facilitate this group model (Davis et al., 2002).

The inconsistent facilitator
A second group of C&FH nurses was able to identify and articulate the key skills required by the nurses to facilitate the groups in a way that would enhance the sharing of knowledge of the mothers. They also could explain how these skills and processes would benefit the women. However, this group of nurses showed a lack of consistency in demonstrating these skills in practice. At times they would demonstrate some of the facilitation skills they had discussed in the focus groups, skills such as allowing the women to set the agenda, or working out problems as a team. Occasionally they could deflect a question back to the group or ask the other mothers if they had experienced that particular problem. Many times, however, they would abandon this approach and answer the question directly.

In a large study on health visiting in the UK in the late 1980s, Mayall and Foster (1989) found very few health visitors operate in true partnership models. Many health visitors operated somewhere on a continuum between the partnership and expert models (Mayall & Foster, 1989). Some health visitors were typically found to support the notion of partnership but they attempted to guide mothers’ behaviours in the direction that the health visitors identified as correct (Mayall & Foster, 1989). These factors also appear applicable to the inconsistent facilitators in this research.

Working in partnership with women requires more time and energy than maintaining control and working within the expert model (Davis et al., 2002). The nurses all reported how tiring the groups were. Without full understanding of and commitment to the partnership model, it is expected that the facilitator could easily revert to the more comfortable model of answering questions than letting the group talk. Much of the eye contact and conversation is often directed at the nurse by the mothers. It is therefore understandable how the poorly prepared and skilled nurse could respond by directly answering the questions and providing advice, rather than the more time-consuming
and emotionally draining strategy of deflecting the questions back to the group and encouraging group support. Elsewhere, nurses have demonstrated sound knowledge on content issues but lack the ‘process’ skills of facilitating groups or supporting mothers in the postnatal period (Edgecombe et al., 2001; Morse et al., 2004).

This type of facilitator showed some insights into what was required to facilitate groups but was limited by lack of training, experience, role modelling or support by management. They appeared to require additional support in the form of extra training, modelling or mentoring. This could be achieved by pairing up with a more experienced facilitator for several sessions. Co-facilitation with another nurse, known to be a skilled facilitator would be a cost-efficient, easy to arrange (transferring staff short term) strategy, and could quickly lead to increased confidence in the facilitator.

*The skilled facilitator*

A third type of facilitator articulated and demonstrated the necessary skills required by the nurses to facilitate the groups. They described how much these skills benefited the women in terms of increased confidence and improved capacity to parent. They also showed significant insight into some of the structures, such as power and control, which influenced the ability of the women to become empowered. These nurses repeatedly responded with sensitive, thoughtful answers to the questions posed to them in interviews and focus groups. Furthermore, in clinical practice, they demonstrated consistent, repeated high-quality facilitation skills when running the groups.

There appeared to be a higher degree of ownership and pride in the program amongst these staff members. It seemed that these nurses were more reflexive in their own practice and more able to relinquish the expertise of their position. They were more ‘mature’ in their professional responsibilities and more secure in their position within the relationship of health provider and client. This seemed to assist them to recognise and respect the knowledge and expertise amongst the mothers and to trust all women’s ability to parent effectively with the right support and environment. Working in a
strengths-based or partnership model does not deny the expertise of the professional, it merely identifies the complementary expertise of the parent (Davis et al., 2002) and this was evident in the practice of these C&FH nurses. The numbers of the nurses in this third group, however, was unfortunately very few.

This skilled group of nurses also identified the importance of being aware of their own values and the importance of not discriminating or passing judgement. This is an essential component of being a reflexive practitioner, as critical self-reflection of the nurse in evaluating their own attitudes, beliefs and values promotes health care that is open-minded and non-judgmental (Jeffs, 2001).

**Supporting practice change from expert to partner**

The age of the nurses ranged from early 40s to late 50s and only two of them had received tertiary education in the form of a graduate diploma in adult education. Child and family health nursing is an aging workforce, whose practice has been largely unchallenged and unchanged over the past twenty or more years that many of them have been working. This lack of contemporary education could also be influential in the inability of many of the nurses to articulate and practise within a strengths-based approach. The Families First initiative had yet to be introduced to this Area Health Service and hence no training in the strengths-based process of practice had been available.

It has been established that to work effectively the Earlybird program requires a significant change of work practice by the nurses. It requires a paradigm shift from that of the ‘expert’ to that of the ‘partner’ facilitator who promotes an environment for the women to become empowered and to believe in their ability to parent successfully. The training the nurses received is clearly insufficient in assisting most facilitators to do this. The nurses almost universally expressed this themselves. Training and education is a fundamental requirement in supporting nurses to change their practice (Heath, 2002). Training around the provision of information to nurses, without attention to process or skills development, has been shown to fail to improve postnatal
outcomes elsewhere (Morse et al., 2004). Health services in the UK (Lipley, 1998) and Australia (Department of Human Services, 1997) have recognised health providers require additional training in group work and facilitation. Skills in active reflection and evaluation of practice are critical in helping nurses become effective when interacting with all clients (Benham, 2001), and appear to be lacking in some of the nurses involved in this research.

Following baseline training, ongoing support and supervision are then required. Supervised practice with appropriate feedback, not only expedites the learning process, but will increase the level of proficiency eventually reached (Davis et al., 2002). It has been recognised by other work in this area that some nurses will require more training and support than others (Edgecombe et al., 2001) and in a Victorian evaluation, over 50% of nurses requested further skill development in running groups (V. Clarke et al., 1995).

Several of the nurses reported that they found the groups stressful. Inadequate training and preparation was thought to contribute to their feelings of stress, as well as the physical and mental energy required to run the groups. Scott et al. (2001) also noted in their research that some nurses found groups ‘anxiety provoking’.

**Professional issues**

Some of the nurses expressed frustration about the value and respect placed on their work by management and policy. Benjamin (1997) reports that good facilitators require traits such as: self-assurance; an interest in others; a willingness to learn from others; generosity; and, a healthy self-esteem. Lack of these attributes indicates reduced confidence and security in the nurses’ own role in health care teams. It is unrealistic to expect the nurses to exhibit these characteristics when they perceive themselves ‘at the bottom of the hierarchy’ and poorly understood and undervalued by management and policy structures. It is also unfair to expect nurses to demonstrate an ability to work in partnership with women in a strengths-based approach that surrenders control and expertise. For nurses to work effectively in a model that
strengthens women’s capacity to parent requires management support, adequate training and ongoing supervision (Davis et al., 2002). The Earlybird program appeared largely deficient in these three areas. However, in spite of this lack of support and preparation, the nurses are attempting to deliver an innovated and unique model of parenting groups that is well received by the mothers and their families.

**CONCLUSION**

Earlybird is a theoretically informed and potentially important program aimed at promoting new mothers confidence, and self-esteem around their ability to parent. The open nature of the groups encouraged early access for new mothers and the unstructured format ensured that the mothers set the agenda and discussed those issues that were most important for the women. The combination of professional and peer support ensured mothers received information around the practical aspects of parenting as well as reassurance around normal infant behaviour and common parenting problems.

The skills in facilitating groups in a way that recognised the expertise and strengths of the women as mothers varied between the nurses. Most of the nurses felt that they did not receive adequate training and this was reinforced throughout the observations of the groups. Some of the nurses showed excellent ability to relinquish the position of power and promote mother-to-mother support. However, most of the nurses were unable to demonstrate this.

To successfully facilitate the Earlybird groups requires a significant shift in paradigm from the traditional C&FH nursing model wherein the nurse was considered the expert who advised and guided the mother on suitable parenting strategies, either in individual consultations or in the traditional closed and structured groups. When these preceding points are coupled with that of an aging workforce with minimal postgraduate education, serious problems arise. Further compounding problems include a profession that, until recently, was largely ignored, invisible and undervalued. They are poorly supported from management, work in isolation in old,
run-down centres, and have little infrastructure to support communication and professional development in the form of IT access.

This chapter reported on the changing practice of C&FH nurses delivering services to families in the form of parenting groups. The following chapter explores the capacity and contribution of C&FH nurses working across disciplines to improve health outcomes for families in the area of infant nutrition.
Chapter Seven

Case Study Three:
Inter-professional Collaboration
Chapter Seven: Case Study Three: Inter-professional Collaboration.

INTRODUCTION

Child and family health nurses have traditionally worked individually and autonomously. While some of them may have had good working relations with other health and non-health agencies, they appear to have rarely collaborated on projects or worked closely with other health professionals in multi-disciplinary teams. Increasingly, however, C&FH nurses are being required to work across agencies for the benefit of co-ordinated family support.

Families First and NSW Health policy documents provide guidelines that support multi-agency and cross-disciplinary models of support for families (NSW Health, 1999; NSW Health, 2002b; Office of Children and Young People, 2002c). These policy and related guidelines recognise that improved co-ordination of activity across the health system is necessary and promote greater collaboration across C&FH nursing and health promotion services (NSW Health, 1999; NSW Health, 2002b; Office of Children and Young People, 2002c). This requires commitment and the opportunities to develop strong, positive relationships between the service providers, rather than token exchanges of information.

Little is known about the capacity of the C&FH nurse to work with other disciplines. This chapter uses a multi-disciplinary project aimed at improving infant nutrition in Vietnamese communities, as a case study, to explore the role of the C&FH nurse in working with other health professionals to improve child health. After initially trying to engage a group of C&FH nurses to lead the project, control of the project was assumed by other health professionals. The barriers affecting the engagement and participation by the C&FH nurses are explored, and implications for this for the profession discussed.
BACKGROUND
In 2001 I was employed as a project officer for a project titled ‘A Healthy Start to Life, Supporting Families around Infant Nutrition’. One of the projects aims was to increase and strengthen the capacity of C&FH nurses to work with disadvantaged communities in ways that increases women’s capacity to make healthy dietary choices for their infants and toddlers (Centre for Family Health and Midwifery, 2004). The project provided a unique opportunity to explore and describe the role of the C&FH nurse in an environment that was not considered traditional, and reflected their changing practice.

METHODS
As with the preceding two case studies, this study was located within a health systems research framework that applied qualitative approaches to investigate and explore C&FH nursing practice in the participation of a multi-disciplinary working group. The intention of this case study is not to report on the project itself, rather the role of the C&FH nurse within the project.

Aims
- To describe the process of involving a group of C&FH nurses in a project to improve infant feeding practices in Vietnamese families.
- To explore and analyse the C&FH nurses role within the project
- To identify factors that impacted on the ability of C&FH nurses to effectively engage or provide leadership in the project.

Action Research (AR) was the chosen methodology for the project because of its concern with ‘actual’ rather than ‘abstract’ practices and its capacity to learn about the actions of particular people in particular places (Kemmis & McTaggert, 2000). The central principles of AR include collaboration between researcher and practitioners, finding solutions to practical problems, and changing practice while developing an explanation of this change process, its rationale and consequences (Inger & Schwartz-
Barcott, 1993). It therefore also provides the researcher with the opportunity to examine and understand the process of change.

The process of action research examines a) what people do, b) how they interact with the world and others, c) what they mean and what they value, and d) the discourses they use to understand and describe their world (Kemmis & McTaggart, 2000 p.598). It involves continual cycles of planning, acting, reflecting and evaluating (Kemmis & McTaggart, 2000).

The principles of action research described above are similar to the principles of ethnography applied within a practice-based project (Jordan & Yeomans, 1995). Action research is a useful methodology to facilitate and explore practice change and the factors that impact on the change (Kemmis & McTaggart, 2000). The intention of this case study was the exploration of the nurses’ involvement in the project rather than the outcomes of the project itself. Therefore, the same ethnographic approaches employed throughout this thesis still applied to this case study and assisted with data-collection procedures and analysis. The focus of the study was to investigate the role of the nurse in a multi-disciplinary health promotion project on infant feeding, and applied ethnographic approaches to an action research project.

It was understood that I carried a dual role. As a project officer, I would assist in the development of the strategies, and as a doctoral student I was interested in documenting and examining the process that occurred as the project progressed. The university and the AHS where the work was being carried out granted ethics permission for both the project and my doctoral work. The ethics committee, C&FH nursing service and all partners and participating organisations understood my dual role and consented to this occurring. See Appendix Eight for a copy of the information statement and Appendix Nine for the consent form used in this case study.
IN VOLVING THE NURSES

In June 2001, the coordinator of the Healthy Start project and I met the manager of the C&FH nurses (Manager 1) to discuss the project and explore the possibility of establishing an action research group with the nurses. The manager confirmed that there were nutritional problems in infants within the Vietnamese community and expressed interest in working together with the nurses to address some of the problems.

In October 2001, I met with all C&FH nurses by attending their weekly staff meeting. There were 13 nurses present at the discussion out of a total of 25 nurses on the team. The range of experience in the group was between six and 13 years’ working in the C&FH area. In order to identify with the nurses as a clinician rather than an academic, I introduced myself as a C&FH nurse. I then described the project, explaining that one of the purposes of the project was supporting C&FH nurses to utilise the principles of community development to support families make healthy choices around infant nutrition. This was followed by a discussion around the challenges they, as C&FH nurses, faced in working effectively with the Vietnamese families. Broad strategies around how to promote nutritious feeding patterns within the Vietnamese community were also discussed.

VIETNAMESE INFANT FEEDING PRACTICES

Most of the nurses expressed a sense of frustration at the lack of impact they seemed to have on feeding practices with the Vietnamese population. They spoke freely of some of the feeding practices that they considered unhealthy or inappropriate. There were four major problems identified in relation to poor nutrition in these infants. These included: the overuse of milk in infants and young children over twelve months.

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41 The following detail is developed out of field notes recorded throughout the activities associated with this project.

42 For the purpose of anonymity and to provide ease of reading, managers and nurses involved with the project have been numbered Manager 1, Nurse 1, Nurse 2, etc to describe the members of the Action Research Group (ARG).
of age; over-pureed food resulting in lack of texture in the diet of young children; the early cessation of breastfeeding; and conflicting advice given to mothers by general medical practitioners (GPs).

Overuse of milk
The major concern the nurses raised with regard to Vietnamese infant feeding practices was the overuse of milk. This applied to the use of formula in infants and cow’s milk in children over twelve months. As one nurse stated:

_Some mothers will force-feed milk into their infants whilst they are asleep. They actually set the alarm to wake themselves up at three in the morning to force-feed these kids. It doesn’t matter what we tell them. They are obsessed with getting milk into these kids_ (Field notes, October 31st 2001).

There was little discussion or reflection by the nurses about why some mothers may be doing this.

Lack of texture in the diet
Another common problem the nurses described was the overuse of pureed foods and lack of textured foods in infants and toddlers. Increasing ‘lumpiness’ in the infant’s diet is important for both nutritional and developmental reasons (Rice, 1998). The nurses believed many Vietnamese mothers were reluctant to leave lumps in the food of young children due to fear the child would ‘choke’. Anecdotally, the nurses reported cases where children up to two years of age were still receiving pureed foods.

Early breastfeeding cessation
Early weaning due to breastfeeding problems was also highlighted as a problem. Insufficient milk supply was commonly given as a reason by women, but the nurses believed it was the strong influence of grandmothers and the mother-in-law that was most influential. These women were seen as authority figures in the family. The nurses perceived that they thought western formula was superior to breast milk and an indicator of wealth. This was claimed to be one of the main influences on mothers.
weaning to formula. Some of these reasons identified by the nurses for the high weaning rates in this population are also strongly supported in the literature (Tuttle and Dewey 1994; Rice 1998; Nguyen 1999; Rossiter and Yam 2000).

General practitioners
The nurses who participated in the first meeting were of the opinion that many of the GPs in the area had a negative influence on infant nutrition. The nurses reported the GPs often gave inappropriate information to Vietnamese families around infant nutrition, such as advising women to wean to formula if the baby was unsettled, or to introduce solids before four months. The nurses believed the mothers placed more authority on the GPs than themselves, following the doctors’ advice over that of the nurses, and were resentful of this. Additionally they had noted that the GPs rarely referred women to the C&FH nursing service for feeding problems or other support where the nurses believed they had superior knowledge and skills.

Suggested strategies
The nurses identified a number of strategies and suggestions in this meeting that they believed would address some of the issues and problems that had been raised. These included:

- Work with the Division of GPs to improve their knowledge and practice and promote referral to other health professionals
- The use of ethnic radio and newspapers to target the mothers and mothers-in-law with correct information about feeding practices
- Meeting pregnant women prior to birth to establish relationships that would continue with the same provider postnatally
- Educating school-aged Vietnamese children about good infant feeding practices based on the evidence
- Working with the home-visiting Vietnamese volunteers to ‘spread the message’ on sound evidence-based nutrition practices.

(Field notes, October 31 2001).
The nurses were invited to consider becoming involved in an action research group (ARG) to develop and implement some of these strategies. We planned to meet with any nurses interested in becoming a member of an ARG in a few weeks’ time. I took notes and prepared a summary of the meeting that was emailed out to Manager 1 who agreed to circulate the document to the all team members, including those nurses who had been unable to attend. Following the meeting, I recorded in my field notes:

They (the nurses) all seemed experienced and confident in what they do and had a good grasp of the infant feeding practices of their local Vietnamese population, but were frustrated by the lack of impact they seemed to have. They reminded me of myself working with Aboriginal families. It didn’t seem to matter what you did or said as a practitioner, it seemed to have little effect on the people you are trying to help. The nurses were open to the suggestion of exploring options and strategies to make their work more effective. Manager 1 was a little sceptical about the nurses becoming involved. She said she finds it hard enough even getting the nurses to come to the Wednesday meetings.

(Field notes October 31 2001).

The Action Research Group (ARG)

The project co-ordinator and I returned five weeks after the first nurses’ meeting. The initial plan to meet after four weeks was postponed by Manager 1 because of other commitments. Three nurses and Manager 1 were present, and a fourth nurse had expressed interest but was unable to attend this meeting. We presented the concept of action research to the group, including the process of plan, act, reflect and evaluate (Kemmis & McTaggart, 2000) that would guide the group’s activities. I expressed disappointment that only four from a team of 25 nurses were interested in participating. The nurses thought as the project progressed and we could ‘show them what we were doing’ more might become involved (Field notes, December 6, 2001).

Although the group initially agreed to have monthly meetings, a total of six meetings only took place throughout the following twelve months. Three meetings were postponed and two meetings were cancelled. A further scheduled meeting did not
proceed when only Nurse 3 and I attended, as the nurse did not feel comfortable continuing without her peers or manager present. The intention to form subgroups to develop strategies never eventuated. The fourth nurse who was unable to attend the first meeting never joined the group. The nurses did not progress ideas or strategies from one meeting to be next. I was frequently faced with the request from one or more of the nurses participating in the project, ‘can you tell us what it is we have to do again?’ Manager 1 volunteered to undertake tasks; however, these were often not done due to her other commitments. Staffing levels were not at full capacity and the clinical demands of practice dominated the team’s time.

While problems with infant feeding remained a concern to the group, the time to explore solutions did not seem possible. The AHS had recently undergone major reforms of clinical services and activities under the Families First initiative. Manager 1 recognised that the ARG provided an opportunity to fulfil some of the requirements of the Families First initiative, but there was inadequate time or skills amongst the nurses to undertake the required activities.

An opportunity arose to work with another team of health professionals in a nearby locality that experienced similar infant nutrition problems. The focus of this second working group was infant feeding and iron deficiency anaemia (IDA). Given the difficulties in achieving the goals within the current ARG, it seemed appropriate to change strategy and encourage the nurses to collaborate with this other working group.

The Bottle Feeding Group (BFG)
In January 2002, I had received a phone call from a health promotion officer in a nearby sector inviting me to attend an inaugural meeting of interested professionals on the subject of excessive bottle use in Arabic and Vietnamese communities. I began to attend monthly meetings with a group of nutritionists, health promotion officers and ethnic health workers. The meetings were facilitated by the health promotion manager

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43 Each AHS was made up of several sectors. There were five sectors within this AHS.
It was immediately apparent that the ARG and BFG shared similar issues and concerns around infant nutrition in particular communities. I therefore attempted to amalgamate the two groups by suggesting the attendance of the C&FH nurses with whom I had been working. The BFG working group members did not receive this suggestion enthusiastically, although there was no overt resistance. It appeared they considered that the contribution of nurses was not considered to be valuable or important. One of the group said to me ‘you can invite the nurses if you want to’ (Field notes May 16, 2002), suggesting that she personally did not consider their attendance to be of value to the group. Unfortunately, despite numerous attempts to get the nurses to attend the BFG meetings\(^44\), it was eleven months before Nurse 1 and Nurse 3 from the ARG eventually joined the working party. By then the group had become firmly established and the nurses were not easily incorporated as group members.

From the outset I was open about my dual role as project officer and doctoral candidate to members of the BFG, and expressed my desire to continue to examine the practice of the C&FH nurses and their involvement with this group. All participants in the BFG were happy for this to occur and also consented to be interviewed at a later date. The involvement with non-nursing health providers in the project, including my intention to interview them, had been included in the original AHS and University ethics submission and had been approved.

Meetings for the BFG were held regularly every four to six weeks and were well attended. Only one meeting had to be cancelled in over 24 months of meetings, because of other commitments by several working party members. The regular attenders included two health promotion managers (from adjacent sectors within the same AHS), two nutritionists (representing two AHSs), and myself. Irregular attendance came from ethnic health workers and the C&FH nurses once they became involved. When one of the health promotion managers went on six months’ maternity

\(^{44}\) I spoke to Manager 1 many times over the course of the eleven months, encouraging the nurses’ attendance. I also raised it when I attended the ARG meetings that were occurring concurrently though not nearly as frequently throughout the year.
leave her position within the BFG was promptly taken up by her replacement (another health promotion officer).

When they did eventually attend the meetings, the ARG nurses were always very quiet. It was difficult to establish whether Nurse 1 and Nurse 3 were there under duress (at the insistence of their manager\(^4\)). It appeared they did not feel confident to contribute to the discussions. In spite of my continued attempts to involve the ARG nurses by directing conversation to them, and including them in electronic mailouts during the development of resources, they did not answer any of the emails and only provided limited verbal feedback at the meetings. The other members of the BFG became increasingly frustrated with the lack of productivity of the nurses between meetings and their inconsistency in attending meetings. I found myself defending them, telling the group that the nurses had very demanding clinical workloads and had probably never been involved in a project such as this one before.

In May 2003, I telephoned the nurses’ manager to discuss another matter. Conversation drifted towards the BFG and I mentioned to the manager that the nurses were very quiet at the BFG meetings. She replied ‘it is demoralising, that is why. They think the others treat them like idiots’ (Field notes, May 5, 2003).

Although progress from the BFG was slow, we did move forward and eventually identified and produced several resources to improve infant nutrition. The BFG worked, although less formally, as an ARG. We identified a problem, developed strategies and constantly reviewed and adapted the plan as the project developed. These steps are well accepted as part of the action research cycle (Kemmis & McTaggart, 2000)

\(^4\) I had been consistent in my encouragement with Manager 1 to release the nurses to attend the BFG which in turn may have caused Manager 1 to insist that the nurses attend.
Outcomes of the BFG.

There were several outcomes and resources produced from the work of this group. A pamphlet outlining common problems related to bottle feeding was developed for parents and an ethnic radio campaign was produced which targeted grandparents and husbands. A ‘fact sheet’ of key issues around the introduction of solids was produced for health professionals and presentations around infant nutrition were provided to GPs at local professional development seminars.

BFG Outcome One: Pamphlet for parents.

This pamphlet was directed towards families experiencing difficulties around the introduction of solids. It was developed in English before translation into Vietnamese and Arabic. As a group we discussed the anecdotal and literature-based evidence on feeding problems and iron deficiency anaemia in Arabic and Vietnamese communities. I wrote a literature review and informed the group of the issues and strategies identified by the nurses from their experience working with Vietnamese families. The BFG group agreed on four major messages for inclusion in the pamphlet. These messages were based on problems specific to bottle use in these communities and included: the overuse of cow’s milk; lack of textured foods in the diet; lack of cup use; and, infants being put to sleep with bottles.

The development of the pamphlet was largely undertaken by the two nutritionists in the group. I was not invited to contribute, nor was anyone else, although the pamphlet was discussed at each meeting. The nutritionists would work on the pamphlet and bring it to the monthly group for discussion and input. Their ‘expertise’ in the area of infant nutrition seemed to exclude the value of other group members. A significant example of this that was raised in the development of the pamphlet was the wording around introducing solids ‘about’ six months but ‘never’ before four months. The National Health and Medical Research Council (NHMRC) infant feeding guidelines (still in draft form at that stage) had recently changed from recommending the introduction of solids from four to six months to the new recommendation of ‘around six months’. Nurse 1 and Nurse 3 reported their concerns early in the development of
the pamphlet. They were concerned that by saying ‘by six months but never before four months’ was not sufficiently encouraging of families to wait until six months.

Early introduction of solids was a significant problem in the families serviced by these nurses and this was the only issue either nurse contributed to, at length, throughout the duration of the project. One of the nurses said at one of the meetings ‘And as long as you write “not before four months”, they (parents) are going to think it is OK to feed from four months’ (Field notes, Jan 20 2003). The nurses had showed the draft pamphlet to their manager, who also refused to endorse it. She said the AHS policy stated that exclusive breastfeeding should occur until six months. The manager appeared quite influential on the nurses’ thoughts and activities on the project. I rang to speak to her about the issue of wording on the document and she was very firm on the issue and said ‘It has become a power thing. We have such little power and so we are holding onto this one. They don’t know the real issues because they don’t see families. Not all families anyway (Field notes, May 5, 2003). The nurses presented copies of the AHS policy documents to the BFG that confirmed that exclusive breastfeeding was recommended until six months of age. However, the nutritionists maintained their stance and refused to capitulate.

Nutritionist 2 stated that the guidelines had been originally developed by World Health Organisation because of the poor water supply in the developing world making the introduction of solid foods unsafe. She believed, despite the recommendations from other authorities such as the NHMRC, that it was safe to offer solids prior to six months and after four months. The new dietary guidelines at that time were still in draft form but due for release very soon. I contacted the NHMRC working-party member responsible for this section who provided the following text, as it would appear in the released guidelines.

Exclusive breastfeeding to the age of about six months gives the best nutritional start to infants … The needs of children may differ and some will require the introduction of solids at an earlier age than six months, but not before four months.
Growth monitoring on a regular basis with an accurate scale and methodology provides the most objective measurement of the need for supplementation. Delay in the introduction of solid foods beyond six months may result in iron deficiency with the problems of delayed growth and cognitive development (NHMRC, 2003 p.306), emphasis added.

The new wording did not sufficiently provide clear direction to resolve the issue for our group. Nutritionist 2 from the BFG, however, strongly believed all health promotion, including our resources, should promote the introduction of solids by six months and never before four months.

After six months of dialogue and many versions of the draft document that continued to contain ‘but not before four months’, the nutritionists eventually capitulated and we all agreed to the following text: Babies need foods other than milk from about six months of age. Between six and 12 months, children need to increase the variety of foods they eat. We then liaised with ethnic health workers in the community health team and accessed some groups of Arabic and Vietnamese mothers to test if the messages and layout were appropriate for these communities. With some minor adjustments, the pamphlets were accepted and made available in English, Vietnamese and Arabic. All versions included the main points, with minor variations in how they were worded to suit specific translations.

**BFG Outcome Two: Fact Sheet and Background Paper.**
The second resource developed by the BFG was a Fact Sheet and Background Paper for both C&FH nurses and GPs. Both documents aimed to provide relevant evidence-based information on infant feeding, with particular reference to Arabic and Vietnamese communities. Access to other resources, and information promoting referral to other services when necessary were also included. The materials highlighted the high prevalence of iron deficiency anaemia in Arabic and Vietnamese communities, how feeding practices contributed to the problem and suggestions on how to screen families for the deficiency. They also provided web addresses for
online\textsuperscript{46} resources for both parents and health professionals, and promoted referral to other support services such as volunteer home visiting and lactation consultants.

As I had taken the initiative initially, and began the development of the Fact Sheet and Background Paper, this document was largely prepared by myself, with repeated attempts to involve all members of the BFG. I received significant input from Nutritionist 1, and infrequent although constructive feedback was provided from Nutritionist 2. The nurses gave no feedback in meetings or email, despite repeated invitations directly from me to do so.

The materials (Fact Sheet and Background Paper) were developed as two complementary resources. The Fact Sheet was a summary version of the Background Paper with key points and recommendations. It was decided by the group, and confirmed following consultation with the local Division of GPs, that the doctors may not read a long document and would prefer to read something more concise. It was agreed by the BFG that we should also provide more comprehensive explanations for health professionals to understand reasons behind policy change and some of the existing practices in these two groups. Therefore, the longer Background Paper, containing the evidence and rationale, was developed to complement the shorter Fact Sheet.

\textit{BFG Outcome Three: ethnic radio campaign.}

An education campaign targeting Arabic and Vietnamese communities was developed. The ARG nurses originally identified this concept, although it was never developed with them beyond the central ‘idea’. The strategy was adopted and developed by the BFG. I encouraged the involvement of the nurses from the ARG. Due to their infrequent attendance at the BFG meetings and lack of response to email contact, the nurses did not contribute to its development. Manager 1 maintained interest in this

\textsuperscript{46} Online refers to information available on the Internet in an electronic version, usually allowing the user to print out the information if required.
strategy and wanted to apply for additional funding to audio-tape the sessions so they could later be given to families. Manager 1 organised a lunch for Vietnamese workers within the AHS to discuss the strategy and we received some valuable suggestions which I relayed back to the BFG. Despite my offer of support to Manager 1 in the development of a funding proposal, the funding application forms were never submitted.

There were three messages broadcast in each language (Arabic and Vietnamese), covering different aspects of the campaign, and tailored to each community, their different cultures and feeding practices.

The three Arabic messages addressed the:

- Risk of dental decay and middle-ear infections associated with settling young children with bottles;
- Promotion of solid foods containing iron; and,
- Discouraging the introduction of solid foods prior to six months of age.

The Arabic Radio Station 2ME broadcasted a total of 69 messages from 25 February to 5 April 2004, in the prime time slots from 7.00 a.m. to 9.00 a.m. and 10.00 a.m. to 12 noon.

The Vietnamese messages included the:

- Risk of dental decay and middle-ear infections associated with settling young children with bottles;
- Promotion of solid foods containing iron; and,
- Promotion of increasing texture in the infants’ diet.

The SBS Vietnamese program was chosen to broadcast the Vietnamese messages, as their research showed that 73% of the Vietnamese community listens to this station. They delivered one message per day for one month.
BFG Outcome Four: Division of GPs professional seminars.

The HPM2 contacted one of the Divisions of GPs and arranged an invitation to present issues on infant feeding to GPs. These seminars fulfil GP registration requirements and attract education points as part of their professional development. The HPM1 also arranged a similar workshop in another sector of the Division. The aims of both presentations were to: highlight the problems of infant feeding in the Vietnamese and Arabic communities; suggest best-practice diagnosis; management and treatment of iron deficiency anaemia; and, promote referral to other health and community services to further support families.

The first session was on May 13 2003. Although the strategy of improving communication and providing information to the GPs was raised by both the ARG and the BFG, the session was organised by HPM2 from the BFG. When I suggested that the nurses become involved in the presentation, the working-party members asked in what capacity the nurses could contribute. They said a nutritionist (not on the BFG but connected with it through her manager, HPM2) was presenting the results of the iron deficiency project she had undertaken last year. I then spoke to the GP liaison midwife who had attended two of the ARG meetings in early 2002. I asked if the nurses could attend the information session as part of the audience. She said this was not possible, as the event was paid for by the GP division and was for GPs. However, she could invite a C&FH nurse representative to be a speaker to describe and present their services to the GPs.

Manager 1 from the ARG accepted and the invitation was circulated, advertising three speakers. The first speaker was the nutritionist, who was allocated 45 minutes to present the results of her project on iron deficiency anaemia in South East Asian and Arabic communities. The second speaker was advertised as a representative of the local C&FH nursing service. This person was given ten minutes to discuss the role of the C&FH nurse and the introduction of solid foods. The third speaker was a paediatrician, with a 45-minute allocation for a presentation on breastfeeding.
I spoke to Manager 1 on the telephone one week before the session. She said that she was unsure if she could go because it was ‘parent teacher night’ at her daughters’ school. She had asked the other nurses but none of them wanted to go. She had also asked Manager 2 but she was also reluctant to attend. Manager 1 said:

*What is the point anyway? We have only got ten minutes. What can I say in ten minutes … We feel a bit gypped really*. She felt it ‘typical that the doctor and nutritionist get 45 minutes and we get a lousy ten!’ (Field notes, May 5th 2003).

The day before the information night I emailed Manager 1 and asked if she planned to attend. She replied by email the following day, three hours prior to the engagement ‘*oh yes, what fun!*’ She did not, however, attend, instead sending Nurse 1 who told me Manager 1 had asked her to do it at 5.30 p.m. that afternoon, 90 minutes before the event. Nurse 1 offered no explanation as to the reason Manager 1 could not attend. The audience consisted of myself, the HPM2 from the BFG, the nutritionist presenting her project on iron deficiency anaemia and 28 GPs. Nurse 1’s presentation lasted less than four minutes and consisted of her nervously reading directly from an overhead with no eye contact with audience. The information she read came from a document developed the previous year by Manager 1 to place in the resource folder of the GPs. The text that Nurse 1 read is included in Appendix Ten.

All 28 GPs filled out the evaluation form that included individual scores for nutritionist, paediatrician and the C&FH nurse presentations. The nutritionist and paediatrician received significantly more favourable scoring than the C&FH nurse. It appeared that an opportunity to promote the role of the C&FH nurse and the potential benefits they could offer the GPs and their clients had not only not been effective, but may have further reduced their standing vis à vis other disciplines. Nurse 1’s performance contrasted sharply to the professional and informative ‘powerpoint’ presentations given by the nutritionist and paediatrician. The following day Manager 1 replied to an email from the day before and said ‘*as you can see I did not attend, hope it went OK, family demands that I completely forgot about kept me from coming*’.
INTERVIEWS WITH THE BFG MEMBERS

Follow-up, semi-structured, and face-to-face interviews were conducted in late 2003 with the two nurses involved in the project and the three remaining active members of the BFG – two nutritionists and one health promotion worker. Questions for the health promotion worker and the nutritionist were constructed and directed around: what they thought the role of the C&FH nurse was; what their experiences of working with the profession had been; what they thought were some of the positive experiences and the difficulties they had when working with this group; and, how they thought the C&FH nurse’s role could be enhanced. See Appendix Eleven for the full list of questions used in the interviews.

Results

The allied health professionals

Two of the three working-party members had no prior experience of working with C&FH nurses before. They had difficulties describing the nurses’ role as the following quotations demonstrate. ‘I have never really thought about this so I will be guessing’ (BFG3) and, ‘to me nurses are nurses and I haven’t thought a lot about the different ways they are organised or exactly what they do’ (BFG1). When they attempted to describe what they thought their role involved they mentioned: ‘They run clinics, basically kind of checks of babies, putting the baby to sleep, settling your baby, different things. I think they do breastfeeding’ (BFG1), and: ‘Monitor the child’s growth I would presume with measurements and weights and talking about the child’s health with the mother’ (BFG3). It is interesting to note that these perceptions of growth monitoring and general advice mirror the public’s perception of the C&FH nurses’ role (DHS, 1998).

The third member, a nutritionist, had a long history of working with C&FH nurses and indicated insight and appreciation into the important work that C&FH nurses did.

Something like 95% of all families are seen at least once by the C&FH nurse. I think that is certainly the highest rate of contact of any health professional full stop, it really is very important work that they do. And the capacity to work
preventively is huge. To try and stop problems before they are unmanageable (BFG2).

I was unable to determine why this member of the BFG had such significantly different work experiences with C&FH nurses compared with the other nutritionist who had never worked with this professional group before.

When asked to reflect back on their experiences of working with C&FH nurses on this particular project, all three participants identified that though their practical experience could have potentially provided important guidance of the project; their inability to dedicate sufficient time to the resources was disappointing. There were several suggestions as to why they seemed unable to participate adequately in the project. The first was that their clinical workload prevented them from having the time required to participate, as seen in the following comment.

Nobody allowed them designated time, one morning off or whatever to keep on top of it and do it and contribute. So I think that is a real disadvantage for the whole group and for them (BFG.1).

Other possible reasons these allied health professionals thought affected the nurses’ limited ability to contribute included ‘confidence that what they were saying was OK’ (BFG2), and, ‘previous experience in this sort of project’ (BFG1). One of the members interviewed perceived that the nurses lacked confidence in making decisions and preferred to refer back to their manager for confirmation when she said ‘they haven’t been given the authority by the nurse unit manager or whoever to actually make a decision and say yes we can or can’t do that’ (BFG1). Another working-group member added;

I don’t think in their workplace, they have ever been allowed to do that, it has never been part of their business, and they don’t have that broad picture knowledge (BFG3).
This ‘broad picture knowledge’ was referred to frequently by all the allied health professionals. They perceived that the C&FH nurses had an ‘individual’, rather than ‘population’ focus to their work and this interfered with their ability to contribute to a project such as this one. As this participant described:

*I suppose the majority of their work is based on one-to-one … It is probably harder for them to try and pull back and look at the more population-based work that they might be able to take on* (BFG1).

She elaborated further by saying ‘if you asked if they do health promotion work I think they would relate that more to giving parents advice’ (BFG1).

The interviewees thought the nurses ‘were not very forward thinking in this area’ (BFG2) and ‘they don’t seem to think that community development has much to do with their work’ (BFG3).

When asked if the participants thought this may have something to do with their education, they reported that they thought the nurses had sound knowledge around infant nutrition but were limited in how they applied it. One member reported that she thought the nurses required a deeper understanding of health promotion, ‘not just as patient education but looking at it based on the Ottawa charter and how you build in systemic change’ (BFG1).

The working-party members were asked how they thought the nurses were perceived by other health professionals. Like themselves, they did not believe most other health professionals really understood what they did, as there were limited opportunities to work closely with them. As this member explained:

*They are always out and about and it is difficult to keep track of who is who and where they are at. When they do come in they are coming in to do all their business so they might access the computer, the fax the photocopier, getting their supplies … or they have their weekly meeting so I think it is actually quite hard to interact with other team members* (BFG2).
The comment above suggests the nurses were perceived as being involved in ‘busy’ clinical work and this did not include planning, developing or thinking work. Though the working-group members expressed a level of frustration and disappointment about the lack of contribution by the nurses in the project, they all identified the expertise the nurses offered. The two members who had no prior experience with the nurses now felt they understood their roles much more. As this comment demonstrates:

*I actually enjoyed working with them. It was frustrating, they never gave feedback on the resources but I understand their situation a little better and think their manager has to validate to them that this type of work is important. They have never been allowed to do that, it has never been part of their business, so they haven’t been able to develop that broad picture knowledge* (BFG3).

Overall, the allied health members of the working party were less critical in interview than their behaviour had suggested over the life of the project. This could be explained by the timing of the interviews that were held towards the end of the project. By then many of the outcomes had eventually been achieved and much of the stress of the project had diminished. Also I was aware that my history as a C&FH nurse could influence their responses in the interviews. Additionally I felt that I had defended and played advocate for the other nurses many times throughout the life of the project, which could also influence their responses.

Finally, the perception of both the health promotion officers and the nutritionists that they have a more community-development focus in their work warrants further consideration. The BFG did not demonstrate any intentions in involving the community in addressing infant nutrition. They appeared more comfortable identifying the problem from a professional perspective with no consumer and little cultural input. This kept the power and expertise with the professionals and demonstrated a lack of acknowledgement of ownership or existing knowledge in the community members. Although there had been some input from the ethnic liaison
workers and we tested the pamphlets in focus groups with community members, this involvement appeared tokenistic rather than truly participative.

The nurses

The two nurses who participated in the working group were also interviewed. When asked how they found the experience of working on the project, one of them laughed nervously and replied:

I felt each one was committed but each one was looking at it from a different perspective. I think we just, um, (pause), put it this way, I think they were working really well together, I think our staff weren’t able to contribute because we ended up having no staff so we had to cancel all meetings, so they made all the decisions … (long pause), but I never really felt part of the group, really. Maybe because we didn’t get there enough, but I never felt really welcome (BFG4).

She elaborated later ‘some have their own, um, power situations. They seem to feel nobody can do it as well as they can. That is their agenda and you just let it go’ (BFG4).

The second nurse felt the inequality alluded to in the above quote was related more to what the other working-group members thought about nurses as the following remarks demonstrate. ‘There is that attitude towards nurses, that we are the lower rung of the health professionals’ (BFG5), and:

I feel that they consider us a less educated, sort of ‘you didn’t get a high enough score in you HSC (High School Certificate) to get into what we are doing so you did nursing’. So there is that little bit of scorn or lack of respect (BFG5).

The nurses reported that these experiences were not specific to the members of the working party and that they applied to many other health professionals with whom they had professional contact. These professionals included social workers, psychologists, GPs and speech therapists. This nurse explained:
Lots, not all, but lots are difficult to try and work together – some of them are very
defensive, and some of them are very unwilling to give us any little bit of
information. I don’t know, they see it as a threat or that we are questioning them
and their practices or whatever (BFG5).

Similarly, these perceptions of feeling poorly valued and not respected by allied health
professionals were not unique to the nurses working in BFG. As part of the interview
data collected in Case Study One, one of the questions I asked the 17 participants was
to describe their experiences of working across disciplines in health. Whilst some
nurses reported positive experiences, the majority thought that many of the other
health professions didn’t understand what it was that C&FH nurses do, and, didn’t
really value them. The medical profession was identified as being the most reluctant to
work collaboratively, as this nurse explained. Some of the doctors of course, they still
carry on and think they run the world and don’t like to recognise that other people
have skills and knowledge’ (CN14.2).

Social workers and psychologists were thought to be protective and secretive over
their clients, often not feeding back information on the grounds of confidentiality.

We are the primary (service). That means we usually have to give them the
information about the mother but they, when you ask them for feedback, they say
they can’t because of confidentiality (CN2.2).

One C&FH nurse discussed her experience of regular cross-disciplinary team
meetings.

I think it is still the aim of Families First to get together and see how best we can
provide a team service to problem families, but it wasn’t working very well and I
don’t think they meet any more, it wasn’t working for them (CN5.1).

Feedback from referral agencies was usually via the mother or sometimes verbal if the
nurse rang the agency.

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Yeah some give you feedback sometimes. They will ring you up or I ring them. Physios are good, speechies aren’t too bad, they sometimes give you feedback but mostly you rely on the mums. It’s the usual, some are good some are not so good. But it is improving. Even the doctors tend to be a little more open to us ringing them up and I even get the odd referral from them which is a change from the past. You still get the odd one who likes to be king of the mountain but I think Families First has improved our image overall (CN10.2).

The success of cross-disciplinary collaboration was thought by one participant to be reliant on how well the other health professionals knew and understood the C&FH nursing role. As she explained;

The ones who work with us, like the speechies and before, the counselling team, they know what we do and I guess the ones who respect us already think or know that we do a broad job. We do the family assessment and they say ‘you guys are the experts in that and I don’t understand all the things that you do fully but we know that you are good at that stuff (CN17.1).

The other health professionals, however, who don’t have much contact with the C&FH nurses were found, by the participants to be the most judgemental, as this nurse reported.

They (doctors) think that all we do is weigh and measure babies. I think as medical students or when they are doing their GP training, they should come out here and spend a day with us. Just to give them an idea that we really do an awful lot more than just weigh babies (CN15.1).

Some participants thought this ‘experience’ with the nurses should also be extended to the policy-makers as demonstrated in the following:

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I would like to think that those with the power could have enough decency at least to come and say, well what do you think, what do you feel out here, what are your experiences, or sit with us as in a forum in all the different areas, because we all have different issues. We are dictated to, yet professionally we are expected to keep right up there and be accountable (CN4.2).

**DISCUSSION**

There were several issues highlighted through my experience with both the ARG and the BFG. These included some of the difficult, though not unique challenges, around undertaking action research. There were also difficulties in motivating the nurses to be involved. When they did become involved, the challenge was to make the group effective. It appeared that the nurses were themselves marginalised from the other health professionals. This factor seemed to affect the nurses’ ability to be productive once they were involved in the BFG. It was also interesting to note that the materials that were eventually produced by the group were aimed to provide ‘information’ for groups who were deficit in knowledge – firstly the clients and secondly nurses and general practitioners.

**Professional boundaries**

Community nurses in Australia have recognised the need for increased collaboration with other health disciplines in order to meet the needs of the community (Kemp et al., 2005). This reflects the longstanding problems around professional boundaries that have existed between nurses and other health professionals, both in Australia and abroad. Health visitors in the UK have reported that social workers fail to recognise the expertise of their profession and often fail to act on referrals to the social work team (Taylor & Tilley, 1990). Social workers, on the other hand, view health visitors as ‘fussy, pedantic and prone to panic’ (Taylor & Tilley, 1990 p.14).

Similarly, health visitors have reported previously that general practitioners also did not value or understand the work that they do (Mayall & Foster, 1989; Traynor, 1993). This is thought to have improved since the placement of health visitors within general
practitioner practices in the UK. This placement has resulted in an increase in referrals from the GPs and an improved understanding of the health visitor role (Ellefsen, 2001). Such placement, however, risks the health visitor service becoming increasing medicalised (Elkan, Kendrick et al., 2000).

The extent to which professional groups can successfully work together is related to the hierarchy of professions that is differentiated by full and semi-professional status (Hudson, 2002). There appeared to be a belief amongst the allied health members of the working group that the nurses’ education was of a lower standard than theirs. This was suggested in comments such as the nurses ‘were not very forward thinking (BFG1) and ‘don’t seem to think that community development has much to do with their work’ (BFG3).

It appeared that practitioners from health promotion and nutrition had a long history of working together. However, apart from one nutritionist, the nurses and the allied health staff had no experience of working with these professional groups before. This led to poor understanding and recognition of each other’s role and expertise. Successful inter-professional collaboration has been strengthened when the team is situated in the same building (Hudson, 2002). This did not occur in this case study. Co-location in the same building forces groups to socialise together, improves the frequency and quality of information-sharing and promotes personal dialogue and the development of respect and trust between professionals from different backgrounds and status (Hudson, 2002).

Difficulties in working across disciplines commonly occur when there is a lack of understanding or recognition of the roles and responsibilities of the different team members (Kemp et al., 2004). This was evident in this research when only one team member showed some insight into the role and scope of practice of the C&FH nurse.
As well as the traditional professional boundary issues that appeared to influence the relationship between working-group members, the methodology employed to undertake the research also provided some challenges.

**The challenges of Action Research**

Much is written on the benefits of utilising AR in implementing practice-based change (Kemmis & McTaggert, 2000). Many successful AR projects have been reported within the discipline of nursing (Inger & Schwartz-Barcott, 1993; Lindsey et al., 1999; Marrow, 1998). A common principle in action research is that practitioners initially identify the problem (Kemmis & McTaggert, 2000). However, it is also recognised that practitioners rarely have connections with academics and do not know how to go about instigating a research project (Ospina et al., 2002). As a result, it is researchers who more commonly approach clinicians (Ospina et al., 2002).

Whilst there was no debate as to the existence of significant problems around infant nutrition in the Vietnamese community, the problem itself and suggestion to work together to address it was introduced to the nurses by outsiders, the project officer and myself. This could have been one of the reasons for the poor interest from the potential team of nurses, with only three out of thirteen nurses volunteering to become involved. It could also be the reason for the lack of energy and commitment from the ARG, in spite of apparently mutual ‘best intentions’. This is highlighted in the following field notes.

*There seemed to be a level of apathy amongst the group. They identified a need to do something because whatever they were doing didn’t work but they wanted to be told what to do. To be given small easy tasks that didn’t require a lot of effort. They said the other nurses (not involved in the project) couldn’t be bothered in doing extra work because it just wouldn’t work. I also get the sense of them being suspicious of research. That they thought why should they help me? That the research wouldn’t help them and it was all a one-way street. I have the sense of me needing them more than them needing me. And they knew that (Field notes April 6, 2002).*
With the ARG I felt I was constantly trying to prove the worth or value of what we were trying to do. I recognised that a major challenge for practitioners and researchers is to build enough trust that they can work together as partners (Ospina et al., 2002). I attempted to close the pervasive gap between practitioners and academics by appealing to them as a peer first and a researcher second. I initially considered myself as an insider with a shared history with the C&FH nurses. I came from, and understood, the culture of C&FH nursing with experience in working with marginalised groups. In spite of my efforts to appeal to the nurses as a fellow C&FH nurse, I never felt accepted by the group as a peer, or as someone with relevant clinical experience. I felt that I was perceived to be an academic. Perhaps it was my poor (though developing) research skills that prevented the group’s success. The nurses may have felt a lack of investment in the project or mistrust towards the researcher’s motives. This behaviour is commonly seen in research involving marginalised groups (Hall et al., 1994).

Another basic tenet of AR is the democratic process that places the researcher as an equal member of the team (J. Mason, 2002). Although I strived for acceptance amongst the group by virtue of our shared professional paths, my position as a researcher ensured I was never accepted as an equal. Although I didn’t feel like an academic, this was how I was perceived. The nature of being an academic, with the luxury of full-time study and the intellectual growth that accompanies this, reinforced unequal positions of power. The authority of academics and researchers, most of whom are white and middle-class, writing about the lives and beliefs of those oppressed can be seen to reinforce the inequitable relations within society (Ulichny, 1997).

Another challenge of AR is that practitioners are often busy people who are deeply committed to their work and who may have little time or energy for research (Ospina et al., 2002). While the C&FH nurses had enthusiasm for the project, the tasks associated with it were not their first priority.
In addition to the problems of professional boundaries and the challenges of AR discussed above, several other factors could be identified that appeared to impact on the ability of the nurses to effectively engage in the project. These include: a lack of time; the changing role of the C&FH nurses and the associated stressors under the Families First initiative; the value and visibility of the C&FH nurse.

**Finding the time: lack of legitimacy of non-clinical work**

Prior to the formation of the BFG, the nurses participating in the ARG identified strategies that may address the nutritional problems found in Vietnamese families. Similar strategies were developed independently by the BFG. The nurses in the ARG lacked the time, skills and motivation to carry out the tasks required to move the project forward. The BFG maintained regular meetings that managed to carry out the aims of the project, albeit slowly. Apart from the nurses, the majority of the BFG members had no clinical commitments. The nurses identified that their clinical workload was their first priority. In the UK, health visitors have also seen their responsibilities to be around clinical work (Hyett, 2003). This has been thought to exclude them from the decision-making process and reinforces a collective lack of empowerment (Hyett, 2003).

Clinical responsibilities also appeared to be the priority for the health system, as management often restricted the nurses’ availability to attend meetings, due to staff shortages and high clinical work demands. The involvement of the manager within the first ARG team was difficult. Manager 1 appeared interested and committed to the project but the other demands of her work were constantly restricting her ability to carry out tasks and duties related to the project. Every meeting we had she was vocal, interested and productive and volunteered for several tasks between meetings, such as organising quotes, inviting Vietnamese leaders to a meeting, raising funds or developing scripts. These tasks were largely never completed.
The nurses never demonstrated the same enthusiasm to the project as the allied health professionals. Their lack of contribution suggested they turned up because they were told to, perhaps by their manager. They seemed to lack the initiative or motivation to take an idea and develop it. The ARG nurses frequently criticised and gave examples of poor advice given by GPs to women around infant feeding. They seemed less able to locate their own practice in the problem. They were older nurses, without tertiary education, and this could have been partially responsible for their lack of critical or self-reflective practice. There was no evidence of taking responsibility or acknowledging their contribution to the problem. It must be recognised that despite the lack of motivation exhibited by the nurses, these nurses should be acknowledged for their contribution. Only three nurses had volunteered out of a team of 25, 13 of whom were at the initial meeting. It is not known why these other nurses did not volunteer to be involved.

The dominance of Manager 1 in the ARG meetings left little opportunity for the other nurses to contribute. Alternatively, Manager 1 could be seen as filling the void left by the nurses’ inability to be involved. Manager 1 demonstrated a strong commitment to improving the service of the C&FH nurse workforce in her area. However, she expressed a frustration with the nurses’ ability to do so. She told me that she believed, out of the 25 nurses in her team, only five showed any commitment to their work. She felt some of the nurses had ‘a real victim mentality and can’t see the opportunity of change’ (Field notes, May 9, 2002).

**Changing roles: policy influences**

The Families First policy promotes the collaboration of professionals across the service network to improve services for families (NSW Government, 2002). Embedded in the language of ‘collaboration’ and ‘partnership’ comes the suggestion that the participants working in partnership are equal. This is rarely the case in reality and different professions and organisations come to partnerships with different values, levels of power, levels of commitment and resources (Peckham, 2003). Genuine teamwork involves recognising and utilising participants’ specific skills and expertise.
and requires practitioners to be confident in their role and expertise and to feel supported by their employing organisation (Naidoo et al., 2003). However, in this project the nurses were unable to feel that any of their expertise was recognised, nor did they feel supported by their organisation.

The Families First initiative advocates regular communication and care planning between these workers and includes the mutual development of resources (NSW Health, 2002b). The nurses involved in this study had not been involved in a project of this type before and the other working party members had limited experience working with the C&FH nursing workforce. The manager of the nurses recognised that the project met the expectations of the health service but could not sustain the level of involvement required to be effective. This inadequate performance had implications for the nurses’ position within the BFG team, which all of the nurses believed was unequal.

Nurses being visible and valued
There were many occasions when the nurses felt poorly valued by other professional groups. Manager 1 felt ‘gypped’ at the ten-minute allocation given to them at the GP Division education session when the paediatrician and the nutritionist were given 45 minutes each. The ARG nurses felt ‘demoralised’ in the BFG meetings and were looked down upon by the allied health professionals. The nurses’ inability to be effective within the team, however, validated and reinforced the negative view the other health professionals had of them.

My own relationship with the nurses was more strained than with most of the other working-party members. My position as a researcher seemed much less threatening to the members of the BFG compared to the ARG with the nurses. In the BFG I felt more like a ‘researcher’ but less like a ‘nurse’. Within the BFG the C&FH profession seemed to be perceived as a workforce that requires training and information rather than as a source of knowledge and expertise. This was evident by the inability of the BFG team to recognise the potential for input by nurses becoming members of the
group. There was the sense amongst the BFG, that nurses are trained to carry out tasks, be the doctors’ helper, a workforce that was directed by the real ‘experts’. I believe the ARG nurses sensed this, but instead of offering expertise and input that would challenge these beliefs, the nurses withdrew and were silent, reinforcing others’ beliefs. The timetable of the GP seminar night demonstrated a lack of professional acknowledgment when the paediatrician and nutritionist were given 45 minutes to present and the C&FH nurses were allocated ten minutes. The lack of professional presentation by the C&FH nurse representative on the night, again reinforced these negative opinions of the other professions.

My background as a nurse did not appear to achieve prominence amongst the BFG, as I was representing a university that had secured significantly funding for the infant nutrition project. However, despite this, with Nutritionist2, I felt constantly dismissed, devalued and disregarded. Her relationship with the other members was cordial and professional. With myself, she never acknowledged me or addressed me unless this was necessary. I found myself constantly attempting to ‘charm’ her, almost subconsciously. But instead of treating her professionally and expecting reciprocity, I was aware that I reinforced her knowledge as superior to mine. Her expertise around the science of infant nutrition was indisputably superior but she failed to recognise that my experience of working with families or understanding of the complexities of infant feeding was also significant and important to the project.

The nurses did not demonstrate initiative when the ARG was formed. They reluctantly joined the BFG but offered very little input. Their reluctance to contribute could be explained by Braye and Preston-Shoot (2000) who suggest that internalised oppression results in the belief of hopelessness around speaking out and the inability to contribute anything of value. The nurses criticised (at times legitimately) the attitudes of the other health professionals towards them and the resources that were produced. Manager 1 refused to use the pamphlet, although she would not come to the meetings to negotiate its modification. Manager 1 did not come to the GP Division information night because there was ‘no point’ in only having ten minutes. She did, however, send
Nurse 1 who presented an unprofessional and inadequate presentation that portrayed a workforce that was not relevant or contemporary.

Other health professionals interpret these behaviours as an indication of nurses’ inability to effectively contribute to decision-making or resource development. It reinforces the inequalities in status and power that nurses experience in health service delivery. It also results in the health service not supporting the workforce in contributing to projects such as this one. As Area Health Service employees, the nurses all had email addresses, but due to lack of computers in the workplace and poor computer literacy, they rarely used these. It was therefore difficult to communicate with the nurses via email, which was the most common form of communication amongst the group. The nurses also did not have workplace Internet access, nor did they read professional journals. Reading or writing journal articles is commonly not considered legitimate nursing work (Mulhall, 1997). This suggests a lack of professionalism and commitment to nurses’ role in the workplace.

It has been reported that clinicians have neither the desire nor the practical skills to undertake research, due to the clash between the discipline-based orientation of the academic/researcher and the practice-based orientation of the clinical nurse (Mulhall, 1997). The nurses’ clinical duties took up most of their time and their representation at a working group was unconventional. As clinicians, they had limited exposure to the process of working groups or research projects.

**CONCLUSION**

This chapter used an action research project as a case study to investigate and explore the participation of C&FH nurses collaboration with other health team members. Many barriers were identified that influenced the nurses’ ability to participate and contribute to the project. Lack of time, experience and available staff were major contributing factors. However, more significant professional issues prevented their full engagement and participation. These broader factors appeared influenced by educational preparation, ongoing professional development and clinical and
professional leadership that reduced the confidence and capacity to contribute. These factors have appeared to significantly influence C&FH nursing practice in all three different practice settings examined in this thesis, namely, when delivering services individually, in small groups or to the wider community through the development of resources by being members of a multi-disciplinary team. These issues are further explored in the following chapter.
Chapter Eight

Discussion
Chapter Eight: Discussion

INTRODUCTION
This chapter discusses the major findings of the thesis within the context of contemporary health services in NSW. The research was undertaken in response to the growing political recognition of the importance of the C&FH nurses’ role in supporting parents, reflected in policy development. The analysis identified the complexity of the role of the NSW C&FH nurse and tension amongst these service providers as they struggle to embrace their changing role and maintain access to all families.

Health services research was chosen for its ability to produce knowledge about the performance of a health care system (Aday et al., 1998). By focusing on the relationship between the provider and the policy, health services research provided a useful framework within which to describe, analyse and explore the changing practice of a sample of the C&FH nursing workforce. Using an ethnographic approach and qualitative data provided a rich description of three different components of C&FH nursing practice. It also led to a deeper understanding of the issues that affect C&FH nursing practice so that recommendations could be made around addressing some of the issues. The examination of the three Case Studies allowed me to study C&FH nursing in-depth and in the varying contexts in which they practiced (Ong, 1993).

When considering C&FH nursing within the context of the health system that employs them, there are several possible explanations for the difficulties they had in undertaking their role. This chapter draws together the major findings of the research within a health systems framework that explores the ‘dynamics of a system’ (Hope, 2004 p.446). This enabled me to explore, not only with the C&FH nurse workforce and how they practise, but the environment within which they practise (Steinwachs, 2004).
The aim of the research was to explore, describe and analyse contemporary C&FH nursing practice and to identify the major factors which influence the ability of the nurses to effectively support families. This was achieved through the examination of practice within three contemporary settings.

Case Study One examined C&FH nursing practice in the support of families through individual consultations, either in the home or the health centre. Major components of the role were found to include four main areas: monitoring and surveillance; health promotion; referral and networking; and psychosocial support. These aspects of their role have been longstanding and essential components of C&FH nursing practice for many years. However, it is the way in which these services are provided and the philosophy that underpins their practice that has changed so dramatically in recent years.

Case Study Two explored the way C&FH nurses facilitate new parent groups in one Area Health Service in metropolitan Sydney. The nurses were found to offer support to families in a way that normalised newborn behaviour, provided information, promoted peer support and encouraged networking. Again, the provision of parent groups within child health services is not new, and has been a longstanding part of C&FH nursing practice. It is the way in which they are provided and the model of facilitation that was found to be innovative and contemporary.

Case Study Three explored the process of C&FH nurses’ engagement in, and participation within an action research group with other health disciplines. The nurses were found to have difficulty in effectively contributing to the group. This was due to issues of professional boundaries, lack of time, perceptions of being devalued and others lacking recognition of the nurses’ expertise. It also found poorly developed skills and knowledge of the nurses to work beyond clinical service delivery in partnership with other health team members.
There were similarities across the three settings that impacted on the ability of the nurses to be effective. Some of these included: the nurses feeling poorly valued by senior management and decision-makers; service structures that inhibited client access by failing to promote professional and contemporary environments within which to practice; and inadequate preparation and support to promote change in the way C&FH nurses practise. The most important finding, however, was the inability of the majority of nurses to consistently apply a strengths-based approach or paradigm of partnership now considered essential if they are to maximise their effectiveness. Explanations of some of the factors which impacted on this group of nurses’ ability to embed the philosophies of partnership into practice were related to aspects of policy, service structure, leadership and educational preparation of the C&FH nursing workforce. These influences will now be discussed.

**Policy**

Many governments have attempted to tackle health inequality. However, the local implementation of these efforts to do so is often hampered by ‘deficiencies in performance management, insufficient integration between policy sectors and contradictions between health inequalities and other policy imperatives’ (Evans, 2003 p.170). The most robust and rigorous policy platform may fail if adequate attention is not given to the implementation process (Palmer & Short, 2000).

Bridgman and Davis (2000) identify several conditions necessary for successful policy implementation. These include the theoretical platform on which the policy was formed; the involvement of a range of agencies; how field workers are engaged; and how the policy is continuously evaluated. These points will now be considered in relation to the implementation of the Families First initiative in NSW and its impact on the C&FH nursing workforce.

**Theory or evidence-base to policy**

Bridgman and Davis (2000) claim that all policies are based on implicit theories and if these theories are poorly informed or are not evidence-based, the policy will fail. The
Families First policy was informed by rigorous, well-tested and broadly accepted evidence from a range of disciplines. This includes the evidence around attachment and secure relationships to mental wellbeing (Bowlby, 1988; Fonagy, 1998), the crucial first three years of brain development and its relationship to social, emotional and environmental factors (Perry, 1993), and poor nutrition in fetal and early life being linked to chronic disease in adulthood (D. Barker, 1995). All these theories are extensively documented and well accepted by the scientific community. Home-visiting by a known professional has also been well researched and has demonstrated improved health outcomes in certain study populations (Korfmacher et al., 1999; Olds, 2002; Olds et al., 1998). However, this home-visiting research had been applied on complex families with high needs and involved long-term frequent contact with the health home visitor over a period of several years (Olds, 2002).

Families First promoted a universal health home visiting service wherein all families would be offered a minimum of one home visit within two weeks of birth (NSW Health, 2002b). Whilst the policy documents suggest continuing visits to all families identified as having additional needs (NSW Health, 2002b), this component of the policy (sustained home visiting) has only been implemented in two or three isolated settings (Community Builders, 2005; Kemp, 2005). This is despite the evidence that it is sustained home visiting that has demonstrated efficacy. To date there is no evidence that a single one-off visit to a family is effective at all. Yet it appears, from observation and other data collected in this research, that the universal home visit is the major activity of interest for NSW Health and has had a profound impact on C&FH nursing services.

A second piece of evidence that was neglected in the design of the Families First initiative was the importance of an ongoing relationship between the practitioner and the client (Davis et al., 2002). The Families First framework highlighted the importance of working in a strengths-based approach and supporting families to become empowered to develop their own solutions (Office of Children and Young People, 2002c). It is difficult or perhaps impossible to achieve this goal in the absence
of a relationship between client and provider. However, the policy documents give no consideration to the importance of providing a service by the same practitioner where possible. Known as ‘continuity of carer’, the impact of this ongoing relationship between practitioner and client is well researched in the midwifery field. Research in continuity of carer has repeatedly shown to lead to greater satisfaction of services for women (Homer et al., 2000), and midwives (Sandall, 1997), as well as lower interventions in birth (Homer et al., 2001; Waldenström & Turnbull, 1998) and improved birth outcomes (I. Chalmers et al., 1996).

Whilst use of the term ‘continuity of carer’ is not employed by authors in the area of C&FH nursing, recognition of the importance of ‘trust’ is identified as requiring an ongoing relationship with the provider (Barnes & Freude-Lagevardi, 2003; Fagerskiold, 2000; Pugh et al., 1994). As seen in Case Study One, there was no attempt by the managers, as implementers of the policy, to facilitate a context within which ongoing relationships between the C&FH nurses and the families could be established. This appears to have been a significant oversight in the implementation of the Families First policy. Previously the women could access the C&FH nurse of choice through the centre. Results from Case Study One indicate decreasing centre hours that have resulted from resourcing the universal first home visit, implemented under the Families First initiative. This has led to diminished access that women have to a known C&FH nurse. This, in turn, reduced the possibility of establishing relationships to facilitate and build on family strengths.

Number of agencies
The Families First initiative promoted the co-ordination of agencies in a whole-of-government approach. Agencies responsible for implementation of the Families First initiative included Health, Community Services, Education and Training, the Department of Housing and the Department of Aging and Disability (Office of Children and Young People, 1999). The intention of the government was to improve effectiveness of the initiative by the co-ordination of services in a whole-of-government approach (Office of Children and Young People, 2002c). However,
Bridgman and Davis (2000) suggest that policies frequently fail if responsibility is shared between too many players.

Whilst the success of the policy within other agencies is beyond the scope of this research, there are significant resource shortfalls within the health sector. Hill (1997) suggests that when central government does not explicitly fund programs but gives funds to another organisation to distribute resources, problems can occur. This occurred in Families First when the Cabinet Office distributed money to all five main departments (Health, Community Services, Education, Housing, and Aged and Disability). Health then further distributed funding to the 17 AHSs. This widespread dissemination of funding dilutes the accountability and responsibility for ensuring the policy is implemented in the way that was intended by the policy designers (Bridgman & Davis, 2000).

**Involvement of field workers**

The success of any system is dependent on the investment, commitment and ownership of those stakeholders who are closest to the point of service delivery (Jones & Cheek, 2003). It is remarkable that, while nurses make up the biggest percentage of the health workforce (Holmes & Gastaldo, 2002), yet they are so poorly represented in senior policy positions (Antrobus, 1997). Whilst this may be changing slowly in some nursing and midwifery positions, there is scant evidence of similar representation from C&FH nursing. Currently in NSW Health there is one full-time position dedicated to C&FH services and this is currently occupied by two social workers (job-sharing). Similarly, the senior policy analyst for maternal and child health who sits within the Nursing and Midwifery Office and supports professional issues in maternal and child health is a midwife with no C&FH background. It appears likely that lack of representation contributes to new professional initiatives being developed at policy level that support midwifery services but limited activity around addressing the many problems affecting the C&FH nursing workforce. The inability of nurses to influence decision making at a policy level is not unique to the nursing subspecialty of C&FH nurses. It is rare to find major service delivery reform that is initiated and implemented...
by those who deliver the service, as most changes are initiated as a top down approach (Ellefsen, 2001).

This lack of representation at senior policy level is likely to have negative implications in the visibility and recognition of the C&FH nursing workforce. Beyond the lack of C&FH nurse representation at the senior policy level, there appears to have been little consultation with the C&FH nurse workforce during the development of the Families First initiative. It is recognised that the ‘fieldworkers’, or the ‘grass roots’ workforce who will eventually implement the policy, often have more expertise in the area (Hill, 1997), and therefore should be involved in the policy design (Aroksar et al., 2004; Bridgman & Davis, 2000).

In a 2002 Australian Senate inquiry into nursing, more adequate and equal representation on decision-making bodies was recommended (Crowley & West, 2002). In a submission to the Senate inquiry the Child and Family Health Nurses Association (NSW) (CAFHNA) raised the problem of the lack of consultation in the Families First initiative. CAFHNA stated that:

> There appears to be an unspoken expectation that nurses will take up the burden incurred by staff shortages and extra workloads. In plain terms, our members complain that they ‘get dumped with extra work and that it is often without consultation’. In our view this amounts to system abuse.

(Crowley & West, 2002 p.188).

The lack of relationship between the nurses and the policy-makers was apparent in this research by the C&FH nurses’ inability to name people higher in the organisational hierarchy than their immediate manager or the department leader. Most commonly the C&FH nurses referred to these people and positions as ‘them’. Many of the nurses in all three case studies reported that they felt poorly valued by the service and that senior health team members were not aware of the important work they undertook in the support of new parents.
Generalist community nurses have also been reported elsewhere to feel invisible, unimportant and victims of the organisations (Holmes & Gastaldo, 2002). Even though the C&FH nurses complained that many senior management and other health disciplines were not aware of what occurred within C&FH nursing, neither did the nurses exhibit any interest in informing themselves or learning about policy issues that affected their practice. This study confirmed observations by Antrobus (1997), that nurses commonly function in a ‘black hole’ and don’t know what is going on in the broader policy context whilst other practitioners, managers and policy-makers have little insight into current developments within nursing practice.

**Continuous evaluation**

The evaluation of policy implementation presents particular challenges (Rudd, 1996). The extremely complex nature of implementation processes requires attention that does not focus on outcomes, per se, but rather on the activities or processes involved in its implementation. This excludes the outcomes as far as the success or failure of the policy efforts (Rudd, 1996). Bridgman and Davis (2000) highlight the importance of continuous evaluation if a policy is to evolve and become more effective.

The only known state-wide evaluation to have been applied to the Families First initiative was a process evaluation on each of the three pilot areas in which it was initially implemented. The results of this evaluation, whilst being completed in 2002, have not yet been released. To date there are two evaluation documents available. One is a report outlining the methodology used for the process evaluation undertaken on the three pilot Areas from 2000-03 (Office of Children and Young People, 2002a). The second evaluation document available is a framework of indicators that were recommended for inclusion in long-term outcome evaluation of the Families First initiative (Office of Children and Young People, 2002b). The long-term outcome evaluation of Families First has yet to be undertaken.
Some of the results of the pilot AHSs evaluation are provided in a 2004 document ‘A Families First guide to implementing sustainable and effective child and family service networks in New South Wales’ (Office of Children and Young People, 2004). This report documented significant improvements across the three pilots in networking and collaboration between government and non-government areas (Office of Children and Young People, 2004). Some of these achievements included:

- *New child and family policy and service networks established and existing ones strengthened*
- *Relationships developed between parts of the service network that historically did not exist*
- *Families reporting improved supports*
- *Innovative service delivery approaches to families, strengthening their available support base*
- *In some areas, working more effectively with Aboriginal families and communities*
- *Widespread support for Families First and its approach among a diverse and wide-ranging set of practitioners, policy-makers, researchers and academics.*

(Office of Children and Young People, 2004 p.4)

Considerations specific to health or universal home visiting were not included in this report. An evaluation of universal health home visiting in the Central Coast Area Health Service, NSW was carried out over nine months from August 2002. The evaluation reported that the service was well accepted by the families and 93% of all families with a newborn in the area underwent a psycho-social assessment (Central Coast Health, 2005). No health outcomes were reported as part of this evaluation.

**SERVICE STRUCTURE**

Much of what C&FH nurses have to offer clients is determined by the organisational structure and work processes that are essential factors in the delivery of a service (Ellefsen, 2001). For example, the time allocated to centre or home visits, the availability of referral agencies, and material resources, all influence what the nurses
perceive they can offer families (K. Chalmers, 1992). When resources are limited, as seen in Case Study One (Chapter Four) and Case Study Three (Chapter Seven), the C&FH nurse may reduce the service to prescriptive routine collection of the required data and administration of health information.

**Adequate time and resources**

Adequate resources are also crucial for successful policy implementation (Bridgman & Davis, 2000; Hill, 1997). The most common complaint by the nurses in Case Study One was the lack of time and shortages in staff. The nurses in Sector One were particularly stressed by their workload and many felt they lacked the time to do their job properly. This contrasts with the evidence around effective home visiting which was based on research in situations where the health visitor was known by the family and continued to visit for up to two years after the birth of the child (Olds et al, 1998). Research-based randomised controlled studies, such as those by Olds have been criticised for producing unrealistic and ideal settings which are difficult to replicate when rolled out as part of universal health services (Elkan, Kendrick et al., 2000).

The form of support, known as ‘sustained home visiting’ was recognised in the NSW Health policy on Health Home Visiting (NSW Health, 2002b) as an important component of comprehensive services to families. However, to date, NSW Area Health Services are not providing these services. It has been proposed that this is due to the resource implications of sustained home visiting (Horin, 2005b). Adequate resourcing of sustained home visiting has been reported in the media to cost an additional $20 million per year (Horin, 2005a). New South Wales Health recommends one C&FH nurse for every 25 families requiring sustained home visiting (NSW Health, 2002b). The Health Home Visiting Guidelines (NSW Health, 2002b) have yet to be endorsed by NSW Health and remain in draft form three years after release. It could be extrapolated that the reason behind the delay in endorsement is because NSW Health is unable to provide the resources to implement the sustained home visiting, which is a key component of the guidelines.
By spreading available resources too widely, the effectiveness of the policy is diluted and credibility is lost (Whiteford, 2005). This appears to have occurred with the Families First initiative in relation to C&FH nursing services. The program designers supported universal home visiting to all families with sustained home visiting being offered to those families with additional needs. Unfortunately, the most important component of the initiative, sustained home-visiting has not been resourced adequately (Horin, 2005b). This was particularly evident in Case Study One, in which C&FH nursing serviced populations of high socio-economic deprivation and social disadvantage but were unable to provide sustained home visiting.

An evaluation in the Central Coast Area Health Service found that of the 93% of all families with a newborn visited by the service, 33% had been identified as vulnerable, using NSW Health guidelines (Central Coast Health, 2005). Additional support, however, could not be provided to these families, due to lack of resources (Central Coast Health, 2005). Furthermore, 11% of women were identified as being at risk of postnatal depression, with five per cent of women being identified of having significant risk of a major depressive episode (Central Coast Health, 2005). The Central Coast report confirms the findings of this research that current resources cannot provide appropriate levels of support for those families who require it. This may have serious consequences for a health service that can identify families in need of additional support, but are unable to provide the further services to supply it.

**Organisational constraints**

Clinical practice is influenced by an organisation’s structure and organisational behaviour is directed through the use of policies (O'Rourke, 2003). There were many structural factors within the organisation that affected the C&FH nurses’ ability to be effective. Organisational constraints known to affect productivity include lack of time, inadequate budget, insufficient tools, equipment or supplies, unclear instructions, unrealistic levels of performance, a lack of assistance/help from others, and a poorly designed work environment (Cogin, 2004).
In Case Study One, the AHS directed the nurses’ practice around family assessment and documentation through assessment forms such as IBIS. Yet rather than facilitate the effectiveness of the C&FH nurses, the extra workload in completing these requirements, and the emphasis on data collection inhibited the ability of the nurses to be effective. The ability of nurses to engage effectively with a family on their first, and often only encounter, and work in partnership with them in a strengths-based approach, was seriously inhibited by filling in up to seven forms with over 95 questions that required answering.

The nurses in both Case Study One and Case Study Three believed their managers held unrealistic expectations of what they could achieve. The policy directive of working within a strengths-based approach appeared to be accepted by some of the nurses in principle, yet the resourcing constraints and lack of established relationships prevented this from occurring. Similar observations have been made with health visitors in the UK. Elkan and colleagues (2000) observed that high workloads forced health visitors to provide physical care and health information, in contrast with working in partnership, which is known to have been more effective. Working in partnership is recognised to require more time and resources (Davis et al., 2002). Time restrictions also prevented health visitors from developing community development, a health promotion approach or public health activities (Elkan, Kendrick et al., 2000).

In addition to the unrealistic workloads, the work environment in this research also impeded productivity. Many of the centres were opened infrequently, were closed in school holidays, were old, musty and unattractive for clients and staff. Computer and email access were limited and staff had no access to the Internet. These environments did little to support efficiency within the workforce.

48 Ingleburn Baby Information System: computer scannable forms filled out by the C&FH nurses at each occasion of care with clients of the service. See Chapter Five.

Same but different. Chapter Eight: Discussion
Supporting change

The majority of the nurses across the three Case Studies suggested they felt unprepared and unsupported in the changes to practice that were required of them. Grossman and Valiga (2002) provide a number of principles to be considered in leading change. These included:

- **A change in one part affects other parts and other systems.**

  The change in services to incorporate a universal home visit for every new family led to changes in the way health centre services were offered. In Case Study One the nurses perceived that this led to a decrease in service quality due to the inability to maintain health-centre-based services. Conversely, in Case Study Two, the nurses reported that the Earlybird groups led to an increase in availability of appointments at the Health centre and this was seen as a positive outcome of the program.

- **People affected by change should participate in the making of change.**

  The results of this research suggest that where there was less involvement of the nurses in the design of a program, it was less effective. The participants in Case Study One had no knowledge of themselves or their peers being involved in the development or implementation of the Families First initiative. In Case Study Two, however, two of the nurses were involved in the design of the Earlybird program. These two nurses were very supportive of both the program and the change of practice that resulted.

- **People should be informed of the reasons for the change.**

  The understanding and acceptance of the reasons for change was inconsistent across the nurses in all three Case Studies. In this study, when the nurses could express an understanding of the reasons behind the policy, they were much more likely to support it. This was particularly evident in Case Study Two: when the nurses showed an understanding of the philosophical changes of the model of facilitation with clients, they were more likely to adapt their practice.
- **Concrete and specific feedback about the process of change will enhance its acceptance.**

In addition to the perceived lack of initial consultation, there was also a lack of feedback regarding the many aspects of changes occurring in practice. In Case Study One, there were many additional documentation requirements, particularly around the IBIS form. The C&FH nurses across the AHS had been collecting significant data on all clients for five years. All participants in the research confirmed that none of the C&FH nurse teams had received any feedback about this data, how it was used or its importance.

- **People need assistance in dealing with the effects of change.**

Many of the nurses in this research were found to be challenged by the required change of practice. One avenue to support these nurses could have been through clinical supervision (Clouder & Sellars, 2004). Clinical supervision was available in Case Study One, but was poorly accessed by the nurses. The major reason given for this lack of access was time, although it could also reflect a lack of awareness by the nurses of the importance and usefulness of clinical supervision. Reflective practice is also considered an essential component of continuing professional development (Redfern et al., 2002) and could have been useful in assisting the nurses to deal with the required practice change. Without exposure to ongoing tertiary education, it was unlikely that many of the participants had been formally educated in the concepts of reflective practice or were familiar with the value or ‘supervision’.

Grossman and Valiga also identify that the greatest barriers to change include ‘decreased resources, lack of support, resistance, poor communication and the pressure to get the daily work done’ (2002 p.151). It is therefore considered remarkable that many of the nurses in this study managed to develop and participate in change to the extent that they did.
As the implementation arm of the Families First initiative, and the sole provider of universal C&FH support, C&FH nurses could, and should, have significant influence over the development, implementation and effectiveness of policy. This has been highlighted by nursing academics (see, for example, Antrobus, 1997). However, this does not appear to have been the case in the areas where this research was undertaken.

In addition to the factors already mentioned, the research reported in this thesis has identified several factors that may contribute to the lack of recognition, voice and visibility of the C&FH nursing profession. The two most important factors that this research identified include leadership and education. These will now be considered.

**Leadership**

The literature around leadership in nursing has received significant attention in the last decade. Weak leadership has been cited as one of the main reasons attributed to nurses’ longstanding inability to influence policy development (A. Pearson & Borbasi, 1996). The need for strong nursing leadership in Australia has been identified in a range of reports addressing the current recruitment and retention problems (Heath, 2002) and the provision of a skilled and well-informed nursing workforce (J. Daly et al., 2004).

Differences between management and leadership have been identified and defined (see, for example, Holmes and Gastaldo 2002) with leadership now described as being primarily concerned with change (Schwartz 1991). Burns (1978) first employed the term ‘transformational leadership’ to describe a form of leadership where ‘leaders and followers raise one another to higher levels of morality and motivation’ (Burns, 1978 p.20). As such, transformational leaders work with teams to become empowered, to embrace and implement change, and to improve performance (Holmes & Gastaldo, 2002). This form of leadership has been found to be particularly useful in the nursing profession, where traditionally nurses have not been encouraged to take responsibility for decision-making and change (McCormack & Garbett, 2003). The principles of transformational leadership are also found in clinical governance, where nurses are
encouraged, as individuals, to embrace change through reflective practice (Tait, 2004). There were no examples of strong leadership or transformational leadership within the sectors where the research was undertaken.

**Clinical leadership**

Leadership in the clinical or practice setting has been discussed in a variety of terms including: ‘clinical leadership’ (Cook, 2001); ‘clinical governance’ (Tait, 2004); ‘practice developers’ (McCormack & Garbett, 2003); and, ‘consultant nurse’ (Higgins, 2003). Such a plethora of titles does little to standardise or clarify the classification of nursing roles (W. Daly & Carnwell, 2003). However, all of these titles reflect a practitioner with clinical expertise in the area in which s/he works, who promotes excellence in care through education, research and consultancy (Higgins, 2003).

Clinical leaders focus on working with individuals as a mentor or supporter, providing feedback and guidance on performance (McCormack & Garbett, 2003). They also liaise with middle management and act as advocate and representative of the specialty workforce (Dawson & Benson, 1997). Finally they must be encouraged to respond to, and work with, policy agendas as part of their work (McCormack & Garbett, 2003).

Clinical leadership has traditionally offered limited career opportunities and had relatively poor status compared to academic, management and political domains (Antrobus & Kitson, 1999). However, clinical leaders are becoming increasingly recognised for their key roles in facilitating and enabling creativity and innovation necessary for the development of practice. Borbasi and Gaston (2002) for example, suggest that nursing leadership now, and in the future, will be found in practice-related positions rather than in the areas of administration or education.

Health visitors in the UK have been noted to be reluctant to take up leadership positions (Hyett, 2003). Similar observations have been made within nursing in Australia (Duffield & Franks, 2001). Proposed reasons for this in the UK include a workforce that traditionally worked as autonomous practitioners in a flattened
hierarchy, the belief that their professional focus is with clinical duties, and the inability to get access to the decision-making arena (Hyett, 2003). These same issues can be applied to C&FH nurses in this research. The C&FH nurses resented being taken away from the clinical area when it was suggested they attend meetings or undertake other activities, viewing their ‘work’ as being with the clients.

Whilst clinical activities continue to be the foundation of their practice, C&FH nurses must recognise the broader responsibilities and the benefits of undertaking activities away from the clientele. Such activities could include participating in multidisciplinary working groups (Case Study Three) or their own continuing professional development. There seemed to be little understanding that these activities would or could lead to better outcomes for their clients. Without transformational leadership to support their participation, these activities could be potentially more disempowering for the nurses. Case Study Three appears to suggest this occurred.

Clinical nurse consultants in C&FH nursing
Clinical nurse consultants (CNCs) were introduced in Australia in the mid-1980s and appear closely aligned to the Clinical Nurse Specialist in the US and the Advanced Practitioner in the UK (Jannings & Armitage, 2001). The role was created as part of a new career structure that recognised clinical expertise, with the aim of improving staff retention, job satisfaction and client care (Koch, 1990). Education is an important component of the CNC role, with informal education the most common type of education carried out (Jannings & Armitage, 2001). Clinical nurse consultants have reported improved job satisfaction, communication and leadership (Koch, 1990).

Clinical leaders can be powerful agents in encouraging and supporting practitioners to follow particular courses of study (McCormack & Garbett, 2003). The clinical leaders in C&FH nursing in NSW are the clinical nurse consultants (CNCs). Currently there are 17 C&FH nurse CNCs across NSW, although there is lack of equity in their distribution, as nine of the 17 AHSs have no CNC positions. Neither of the two AHSs where this research was undertaken had a CNC position in C&FH nursing. This
appears to reflect a lack of recognition of the importance of the role within leadership positions across these AHSs.

The C&FH nurse CNC group meets six times a year in Sydney (Fitzpatrick, 2005). It is potentially a powerful group as the members represent the C&FH nurse workforce, have access to the clinicians and have clinical expertise. In 1999, NSW Health stated a commitment to:

*Work with respective professional organisations and universities in addressing the gaps in existing training and continuing education to ensure a workforce has adequate knowledge skills and expertise in child health* (NSW Health, 1999 p.40).

To date there is no formal link between the CNC group and the NSW Health department.

It is necessary for governments to recognise the expertise in groups such as the CNCs to enable these leaders to influence and shape policy and practice and assist in making policy effective (Antrobus & Kitson, 1999). However, to do this, these clinical leaders need access to power sources and that language used within each ideology (academic, political and management) for them to be influential (Antrobus & Kitson, 1999). These skills require higher levels of education and professional maturity than was demonstrated in the professionals who participated in this research. Though there are 17 CNC positions across NSW, the majority of C&FH nurses in these positions do not hold qualifications at master’s level or higher (personal communication, Karolyn Vaughan, Chair CNC group, February 6 2005). This could indicate that few of the CNCs have the education or experience to be effective in the policy arena. The absence of CNC positions in the two AHSs involved in this thesis provides little opportunity for leadership and support for the clinicians across the Areas.

**Professional leadership**

There is very little published literature in Australia in the field of professional leadership in nursing in general (Cook, 2001), and minimal in the area of C&FH nursing. There is also a dearth of Australian research on nursing in relation to evolving
models of healthcare, and a lack of evaluation of models of education and training has also been noted (Crowley & West, 2002). Midwifery, however, has been very active professionally over the last decade, with significant professional involvement in the development and implementation of a number of new models of service delivery. This has resulted in improved choices of care for women and increased autonomy for midwives. The increasing profile of midwifery in Australia is evident in the recent changes in the *NSW Nurses Act* which has become the *Nurses and Midwives Act* in 2005 (Brodie, 2005). This significant change recognises the professional autonomy of midwives beyond being a nursing specialty. Similar recognition occurred nationally when the Australian Nursing Council became the Australian Nursing and Midwifery Council (Brodie, 2005). The national professional association for midwifery, the Australian College of Midwives Incorporated, is heavily involved in many national forums such rural and remote maternity services and safety and quality in maternity care (ACMI, 2005).

Professional societies fulfil an important role in the leadership, mentoring and promotion of clinical excellence of professional groups (Davidson et al., 2004). There are currently two professional associations that claim to represent C&FH nurses in NSW. The Australian Confederation of Paediatric and Child Health Nurses (ACPCHN) is a national body with branches in each state. The NSW branch was unable to provide numerical information on the membership of C&FH nurses within this group (personal communication, B Cavelletto, president, ACPCHN, NSW Branch, April 2005).

The membership of the second association, CAFHNA, is currently just over 400 members (personal communication, A Partridge, Secretary, CAFHNA November 2004). Whilst it is not known if all these members are currently employed in the workforce, NSW Health currently has 634 full-time equivalent positions (NSW Health, 2005) with data from the Registration Board identifying 842 nurses who self-identified working in the area of C&FH nursing (NSW Health, 2003b). Although part-time staffing would explain the differences in these numbers, it does indicate that
CAFHNA is well supported by the workforce. How involved these members are in their professional association is not known. In long-term follow-up of tertiary-based postgraduate students, Pelletier and colleagues found in increase in the participation in professional organisations (Pelletier et al., 1998).

There is a longstanding tension between ACPCHN and CAFHNA. Whilst ACPCHN represents both paediatric and C&FH nurses, CAFHNA represents only C&FH nurses. Supporters of CAFHNA claim that the philosophical underpinning of C&FH nursing is primary health care and partnership models through which C&FH nurses strive to increase the confidence and capacity of families to provide the best environment for their children to develop (CAFHNA, 2000). This is in direct opposition to the expert model that dominates acute care services, such as paediatric nurses, who predominantly work with sick children and their families. Supporters of ACPCHN, however, believe that paediatric and C&FH nurses have:

More philosophical beliefs, child and family developmental background, and aspects of nursing care that are common to their scope of practice, than those that are different (ACPCHN, 2000 p.6)

The findings of the three Case Studies presented in this thesis suggest that one of the biggest barriers to the C&FH nurses being effective in the support of parents is the ability to consistently work within a partnership model. The philosophical differences in practice between paediatric and C&FH nurses would suggest that leadership from CAFHNA would be more appropriate to assist practitioners towards working within a partnership model under the Families First initiative.

One of the major roles of professional associations includes political lobbying and professional representation (Davidson et al., 2004). Unfortunately, neither ACPCHN, nor CAFHNA have shown the professional leadership or developed a profile that could be comparable to professional groups such as midwifery in the last ten years in Australia.
The political influence of CAFHNA can also be appraised by its visibility within the NSW Health department. Midwives currently seek four appointments per year with the Chief Nurse of NSW, to both raise the profile of the profession and bring any particular issue to the attention of the most senior nursing position in the state (personal communication, P Brodie, President, NSW Midwives Association May, 2005). Representing C&FH nurses, CAFHNA met the Chief Nurse for the first time in April 2005. This indicates the presence of political awareness and professional maturity in the midwifery profession that is only just becoming realised within CAFHNA. Representatives of ACPCHN have yet to make formal arrangements to meet with the Chief Nurse to discuss either paediatric or C&HN nursing issues. However, the president of the NSW branch of ACPCHN is employed as a senior policy analyst of paediatric services as part of the State-wide services branch of NSW Health.

Midwifery and other nursing subspecialties, such as mental health and critical care, have introduced credentialling as a means of self-regulation for their particular specialty areas, so that nurses and midwives may demonstrate their competence and be publicly accountable for the services they provide (Crowley & West, 2002). Credentialling has not been raised as a potential project within CAFHNA, despite the uncertainties and risks of their current role and scope of practice, and a lack of recognition, it appears, or their importance.

Child and family health nurses are perfectly situated to challenge the traditional role of nurse as handmaiden to the physician and carer of the sick (Yam, 2004). Child and family health nurses work autonomously with minimal medical supervision or authority and are situated in the community, working with families in a wellness model. As governments continue to support primary health care services with policy initiatives such as Families First, C&FH nurses are in a powerful position to assert their importance and value to the health industry. By demonstrating their effectiveness in the cost-driven, resource-stretched environment of health, nurses can potentially consolidate their power base to improve their relative position in society (Yam, 2004).
To achieve this, however, they must have their value recognised, and it is through education that this will be strengthened and supported. Tertiary-based, post-graduate coursework has been found to lead to increased professional behaviours and a marked improvement in clinical confidence (Pelletier et al., 1998). In order to have good leadership you also need adequate preparation (Moiden, 2002).

**EDUCATION**

All nurses require appropriate initial and ongoing educational preparation for the nursing workplace, whatever that workplace is (Jones & Cheek, 2003). Nurses are being increasingly asked to not respond to change in practice, but to take the responsibility to identify the need, then initiate and lead the change themselves (Nursing Midwifery Council, 2004).

As outlined in Chapter Two, the minimal requirement for employment as a C&FH nurse in NSW includes a post-graduate certificate in C&FH nursing. Currently, in NSW, nurses are achieving these qualifications through three institutions, Karitane (based at University of Western Sydney), Tresillian (based at the University of Technology, Sydney from 2006), and the College of Nursing. The College of Nursing stands outside the tertiary sector, although its courses must be accredited by the Department of Education and Training.

The provision of post-graduate nursing education in a non-tertiary setting in contemporary times is questionable. Education is a strong social force in influencing the direction an occupational group may take towards professionalisation (Gerrish et al., 2003). In a review on the professionalisation of nursing, Yam (2004) reported that it is university-based education that is central to the professionalism of nursing. Tertiary education has resulted in a workforce that has a strong code of ethics, professional recognition and continuing education to maintain nursing competence (Yam, 2004).
New South Wales is the only state in Australia to provide C&FH nurse education outside the tertiary sector. Whilst the College of Nursing courses are more affordable to nurses, due to the significant funding subsidy provided by NSW Health, many nurses are not being exposed to the benefits of tertiary education. This could also have a negative effect on the professionalisation of the workforce as a whole.

In the UK, it is required that all community nurses undertaking specialist education undertake 50% of the total program time in clinical practice (Nursing Midwifery Council, 2004) out of a minimum 32-week program (Clay, 2003). Practical experience in the graduate certificate courses currently available in NSW is either one week at the College of Nursing or four weeks at Karitane and Tresillian. This minimal time in the clinical setting appears inadequate to sufficiently prepare C&FH nurses in NSW for practice. Most of the students in the programs are working in acute-care areas, such as paediatrics and midwifery. Based in hospitals, the need to change their nursing practice from an expert model to one of partnership with clients is challenging for students. Yet this is what is expected when they enter the field of C&FH nurse with minimal access to direct peer support or supervision, after they graduate.

The consequence of the inadequate initial preparation and minimal clinical exposure for C&FH nursing students in NSW is that AHSs have to provide extensive orientation programs to upskill these nurses in order for them to provide C&FH services. Currently C&FH nurses working across NSW undertake short-course education in the following areas:

- Generic orientation, including, occupational health and safety, documentation etc.
- Immunisation (if immunisation services is part of their job description)
- Domestic violence training: use of screening tool
- Child protection: mandatory reporting training
- Suicide risk and assessment
- Working with aggressive clients
- Lactation

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• Postnatal distress and the use of the Edinburgh Depression Scale
• Family partnership training

Much of this education could and should be provided in the initial education for C&FH nurses. This further supports the argument for C&FH nurses to be educated to a minimum level of graduate diploma. A graduate diploma is likely to more adequately meet the learning needs of the C&FH nurse workforce. The Karitane graduate certificate course via UWS does articulate with a graduate diploma, as will the University of Technology, Sydney next year when it hosts the Tresillian course. However, it is assumed that these universities will not offer the minimum of a graduate diploma level whilst competing institutions (the College of Nursing) continue to offer graduate certificate courses, particularly when this program is heavily subsidised by NSW Health. Once working in the area of C&FH, nurses could be encouraged to pursue further education that would enhance and build on this sound foundation of professional practice.

**Ongoing education for C&FH nurses**

There is increasing recognition that nurses across all subspecialties require continual professional development in order to respond to the rapidly changing nature of health care (Jones & Cheek, 2003; Nursing Midwifery Council, 2004). Engaging in scholarly activity is essential for nurses so that, as key members of the health care team, they can generate the science that underlies their practice (Davidson et al., 2004). Of the 25 C&FH nurses invited to participate in the action research project in Case Study Three, only three volunteered. Of these only two continued involvement for more than twelve

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49 The NSW state-wide education project available to all NSW Health employees working with parents and children. Based on the Parent Advisor Model from the UK, it consists of 10 x 4-hour sessions, usually over 10 weeks. It aims to enhance health professionals’ ability to provide parents with assistance while endeavouring to enable parents to improve: problem solving abilities, self-esteem, self efficacy, interactions with their children and thereby foster parental development and wellbeing (Davis et al., 2002).
months. This could indicate a lack of interest in or understanding of scholarly activity across the team. However, the lack of resources and staffing that contribute to this must also be acknowledged.

The difficulties the nurses had in engaging with other members of the action research project team also suggest a lack of knowledge and skill to work with other health disciplines beyond the traditional focus of clinical service delivery. Like the health visitors in the UK (Hyett, 2003), the C&FH nurses in this research identified their key responsibility to be clinical. To maximise their effectiveness, C&FH nurses must develop skills and knowledge that improve their capacity to work in a broader capacity that extends beyond clinical service delivery. Their broader contribution must then be supported by health service management.

It has been noted that nurses are ambivalent about the need for academic and professional development (Yam, 2004). The overall educational achievement of the nurses in this research, across the three Case Studies, was low. Out of a total of 31 participating nurses, four had undertaken a graduate diploma (two in adult education and two in community nursing) and only one had received master’s level education (a master’s in community health, majoring in midwifery). Whilst there is no state or national data available on the educational achievements of the C&FH nurse workforce, results from this research are cause for significant concern. Post-graduate education at master’s level has been found to enhance the legitimacy of nursing as a profession, improve the authority of the practitioner and strengthen the power and status of nursing by exercising leadership and influence (Gerrish et al., 2003). With only one of 31 nurses achieving education to this standard, little can be expected of the workforce in terms of exercising leadership and influence.

Access to staff development was an issue of concern identified in a Senate review into nursing (Crowley & West, 2002). Across the three Case Studies in this research, access to education external to the AHSs appeared restricted. However, most of the nurses reported an overwhelming choice of inservice education provided by the AHSs.
There was also evidence of widespread reluctance to attend these education sessions with the C&FH nurses reporting that they could not afford the time away from their clinical responsibilities. This indicates an overburdened workforce and a lack of recognition by the participants of the importance of continuing education. It could also suggest the educational sessions offered to the nurses are not considered by them to be relevant or important to their needs. Importantly, only two of the 31 C&FH nurses interviewed in this research had attended a professional conference in recent years.

Recent recommendations from the Senate review into nursing included the introduction of compulsory continuing education as a condition for annual renewal of practice rights (Crowley & West, 2002). However, some have claimed that this action could drive more nurses from the profession and, given the current acute nursing shortages experienced in Australia, is unlikely to be adopted (Jackson & Daly, 2004). Continuing education is also important for the incorporation of research and evidence into practice.

It is difficult to identify the best way to encourage the current C&FH nurse workforce into undertaking academic studies. The participants in this research were largely hospital trained and had no tertiary exposure. Yam (2004) suggests that all nurses should be encouraged to work towards a degree before moving into advanced and higher level practice. This is unlikely to occur, given that the average age of C&FH nurses in Australia is 47 years (AIHW, 2002), and is exacerbated by the current workforce shortages.

New South Wales Health has recognised the need for further education of staff in working with families in a strengths-based approach. In 2004, it funded a two-year project for a state-wide education project called Family Partnerships, based on the Parent Advisor model by Hilton Davis and colleagues (Davis et al., 2002). This education program was not available to staff during the 2002 period of data collection for this research. However, state-wide implementation of the program is occurring in 2004-05. Whilst the benefits of the program are beyond the scope of this thesis, the
program aims to result in long-term improvements in the capacity of staff to work in a partnership model with families.

The C&FH nurse and research

Intrinsically tied to ongoing education is C&FH nurses’ involvement in research and the validation of their practice. As a relative newcomer to tertiary-prepared education, nursing does not have a strong research base and does not attract the generous funding that many medical schools succeed in attracting (Duckett, 2004). However, the development of clinically based academics is resulting in increasing evidence and credibility of nursing and is slowly raising the nursing profile as an evidence-based discipline in its own right (Duckett, 2004).

The absence of literature around the C&FH nurse in Australia is indicative of the lack of leadership and research into the profession. Generalist community nurses in Australia have been found to have: poor articulation of practice; diminished involvement in policy decision-making; underutilisation in health services; and, untapped potential within contemporary health care (Brookes et al., 2004). Brookes and colleagues (2004) suggest that the absence of published literature reflects the minimal influence that community nurses have in research and policy-making. The observations made by Brookes et al. support the findings of this research into C&FH nursing practice.

The C&FH nurses in this research had minimal experience in research. This lack of exposure could partially explain the difficulties the nurses in Case Study Three faced in engaging in the project. For C&FH nursing to move forward, key decision-makers in both the education and health services need to collaborate with the leaders of the profession. Together they can address the challenges identified in this research, particularly around the initial preparation and ongoing education of the C&FH nurse workforce.
SAME BUT DIFFERENT

Most of the C&FH nurses in the three Case Studies presented in this thesis had worked for many years in the profession and had a wealth of experience. Most of them had become C&FH nurses at the time when primary health care and community development was being introduced into health and education systems. Of all nursing subspecialties, C&FH nurses are best positioned to offer a primary health care service. Child and family health nurses are based in the community and work with well families to promote both the physical and psycho-social aspects of health to optimise family functioning.

Many of them have been doing this for years, but within a health system that remains dominated by medicine, pathology, and the expert model. The Families First initiative has challenged these longstanding influences and promotes primary health care, once again, using the same principles but different language. The resulting change to practice was well summarised by one nurse who, when reflecting on her changing practice described it as the ‘same’, but on further reflection added, ‘same but different’.

The C&FH nursing workforce continues to feel the tension between the policy that determines their practice and the families they service. As the only workforce with access to all families, the C&FH nurse struggles to support them. The degree to which nurses work in partnership ranges on a continuum from gatekeeper in authority to that of working in partnership. This tension in the role is exacerbated by a health service that expects them to monitor, screen and detect problems (expert model); give health information (expert model); provide psycho-social support (partnership model); and, support community networking while acting as a conduit to other secondary and tertiary services (partnership and expert model). These tensions will not abate as long as this range of skills and knowledge continue to be of assistance to, and be expected by the community they service.

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The nurses did not want to stop any of these various components of their role. They acknowledge the range of services they offer and the skills and knowledge that make the profession unique and of such value. As one nurse said, ‘that is what sets us apart from all the other … professions who say they can do our job’. The participants in this research were hard-working, well-intended, highly experienced C&FH nurses who have continued to provide, in the main, high-quality support to families for many years. There are, of course, significant improvements to be made to maximise their effectiveness, and no one strategy will encompass all needs. This requires restructuring of the education service that prepares them, the health system that employs them, and the leadership within the workforce itself.

**LIMITATIONS OF THE RESEARCH**

This research was conducted in two of 17 Area Health Services (AHSs) that existed across that time across the State. Both AHSs were located within metropolitan Sydney and were chosen for their high rates of cultural diversity and marginalisation. Therefore, this research did not explore issues that may be unique to rural and remote areas or socio-economically advantaged or monocultural communities. One AHS had been working within the principles of the Families First initiative for several years, whilst the second AHS had not implemented the initiative at the time of data collection. It is clear, given the variation of service structure seen within one AHS described in Chapter Four, that the role and scope of practice of C&FH nurses is not standardised across NSW.

The nurses who participated in the research were self-selected and may have not have represented all nurses working within their team, or their AHS. The small number of participants (33 C&FH nurses) represents less than 10% of the C&FH workforce in NSW. Furthermore, as a qualitative piece of work, the findings cannot be generalised to all nurses working within C&FH services across the state or nationally.

The age and experience of the participants, however, is comparable to state and national available data, and the role and scope of practice is congruent with much of
the literature presented in Chapter Two. Furthermore, presentation of the major findings and recommendations from this research at a state conference with over 300 delegates (Kruske, 2005) was enthusiastically received. Many in the audience reported similar challenges in their own areas and it appears that there is some acceptance of the generality of these findings.

**CONCLUSION**

The three Case Studies undertaken in this thesis indicate some significant deficiencies in both the initial preparation and ongoing education of the C&FH nurse workforce. The skills required for C&FH nurses to adequately and effectively support families in early parenting in NSW appear beyond the current education preparation available to them. To work in a partnership model using a strengths-based approach requires a major paradigm shift in the way nurses traditionally care for clients. This will not be achieved in a distance education program that offers one to four weeks of clinical exposure. It is unrealistic to expect nurses to embrace their new responsibilities if no additional education is provided (Baggaley & Kean, 1999). The necessity to change paradigms has been recognised by NSW Health and is attempting to be addressed through the state-wide education project, Family Partnerships training. However, many of these issues could be addressed within a reformed basic C&FH nurse education.

A graduate diploma is the minimum requirement these nurses should achieve before working with families. Strong and motivated clinicians should then be encouraged and supported to undertake further studies at a master’s and doctoral level. Only then will the current culture of the workforce be challenged, with leadership demonstrating the benefits of life long learning and evidence-based practice.

Leadership, education and policy implementation are clearly linked, as are the ability and motivation for nurses to undertake and participate in research. Changing practice will only be successful with strong leadership that links the policy, education, and clinical fields together. The following chapter outlines the recommendations that have
been produced from the findings of this research, to assist stakeholders to provide the support that will further strengthen the effectiveness of the C&FH workforce.
Chapter Nine

Recommendations and Conclusions
Chapter Nine: Recommendations and Conclusions

INTRODUCTION

This research explored C&FH nursing practice in three contemporary practice settings across Sydney, NSW. These included: the provision of support for families on an individual basis, either in the home or the health centre; the provision of support in a group setting; and, finally, the contribution of expertise to a multi-disciplinary working group to improve infant nutrition. This thesis has provided an opportunity to explore contemporary C&FH nursing practice from a sample of the workforce and deliberate on the challenges that impact on their ability to effectively support families in parenting.

The findings across the three Case Studies were varied, but it was apparent that nurses’ practice across all three Case Studies was not underpinned by a consistent philosophical approach or model. The majority of nurses observed in practice worked within the traditional expert model, with only a few demonstrating effective engagement with the clients in a partnership or strengths-based model. In a health care industry that is relying increasingly on evidence-based practice, and consistent professional standards of care, these findings give rise for concern.

This research examined the practice of these nurses within the context of rapid national and state policy change impacting on families and early childhood. In NSW the strategy was called the Families First initiative, but similar policies and programs have been introduced through all other states and territories across Australia.

It appears that in spite of the best intentions, and informed by strong international evidence, the health component of the Families First implementation has not been as successful as was hoped. This is largely due to the insufficient resources to implement the sustained home visiting that is required to provide the long-term support to improve outcomes for families in need of additional support. The findings of this research suggest that, within the Areas investigated, the provision of one home visit to
all families of a new baby will do little but result in a significant decrease in the availability of other C&FH nursing services. The suggestion that universal health home visiting is being carried out at the expense of other important C&FH nursing services is also being reported across the state (Central Coast Health, 2005; NSW Health, 2005).

A positive effect of the Families First policy has been the recognition of the C&FH nurse workforce for the important service it provides, and the potential, with greater support, to be even more effective. However, to achieve this several things need to occur. These will be outlined in the following recommendations that have resulted from this research.

**Policy**

It is recognised by NSW Health that the provision of services to children and families requires particular knowledge, attitudes and expertise (NSW Health, 1999). To date there is little evidence that the C&FH nurse workforce is acknowledged or valued as experts in this field, or has been consulted widely in developing policy or practice to increase its effectiveness. This is essential if C&FH nurses are to provide the necessary leadership to improve the practice environment for the practitioners and, most importantly, for the families.

To enhance the opportunities for improvements in policy design and implementation, as well as ownership and commitment by the workforce of policy initiatives, the following is recommended.

**Recommendation One:**

A child and family health nurse is appointed to a senior policy position to assist in the design and implementation of policy affecting services to families.
**Recommendation Two:**
Health departments promote regular meetings with the key clinical groups such as the C&FH CNC network.

**SERVICE PROVISION**
This research indicates a need for those responsible for service delivery at the local AHS level to consider options to improve the effectiveness of C&FH services. One key area is the service structure that currently restricts the opportunities for C&FH nurses to establish ongoing relationships with women and their families. Health services also need to reconsider the location, availability and appeal of the C&FH centres. Many of these centres are closed most of the time, are musty and poorly presented and provide no appeal as modern, warm and contemporary settings.

**Recommendation Three:**
Establish service structures that promote continuity of care by the same C&FH nurse for all families.

**Recommendation Four:**
Review centre-based services and restructure to provide modern, welcoming venues with less centres open more often, in accessible areas.

Health services must prioritise relationships between the practitioner and client, particularly families with additional needs. Appropriate funding must be provided to promote the introduction of C&FH services to families with additional needs in the antenatal period. Whilst recommendations for this to occur are provided in the Health Home Visiting Guidelines produced by NSW Health (2002b), there are clearly insufficient resources for this to be possible.

If further funding is not possible, another consideration for improving the effectiveness of services to new families is to examine the suitability of improving collaboration with the midwifery workforce to assist in undertaking the
‘comprehensive family assessment’. Currently, NSW Health policy states this assessment will be offered by the C&FH nurse at the first home visit within two weeks of birth (NSW Health, 2002b). This assessment then occurs in the absence of any relationship between the C&FH nurse and the woman, as in the vast majority of cases this is their first encounter.

The vast majority of pregnant women voluntarily attend antenatal services and receive midwifery care in the postnatal period. Whilst many midwives continue to provide fragmented care in medical models, continuity of care is becoming increasingly available to women in NSW. This is in response to NSW Health policy that actively promotes midwifery-led models of care (NSW Health, 2000). Many of these midwifery models of care can be successfully provided in the community (Homer et al., 2000) and include a postnatal visit in the home by the midwife. This provides an ideal opportunity for this midwife, who already has a significant relationship with the woman, to undertake the ‘comprehensive family assessment’.

If more continuity of care midwifery models were available to women across NSW, the midwife could identify those families with extra needs and involve the care of C&FH nurses in antenatal care. This is consistent with the policy guidelines (NSW Health, 2002b) and would, in turn, relieve much of the burden of C&FH nurse services undertaking home visits to all women. Rather than provide a home visit to everyone in the community, the C&FH nurses could spend their time carrying out sustained home visiting to support those families who need it without compromising drop-in and centre-based services. For those families who still would like the support of the C&FH nurse, this could be accessed through the health centre as has always occurred traditionally. In this model, the families who don’t traditionally access the service are still catered for and supported, but the majority of women who do access the service can continue to do so through the health centres.

**Recommendation Five:**
Policy-makers review the current Universal Home Visiting policy to incorporate midwifery services in the comprehensive family assessment where continuity of care models exist.

Collaboration between C&FH nursing services and other professional groups such as midwives, nutritionists, and health promotion workers requires support through activities such as joint planning, programs and activities, as well as team support to individual families through case conferencing (Kemp et al., 2004). Currently, many professional groups continue to work in isolation from each other, despite the encouragement of collaboration through the Families First initiative (Office of Children and Young People, 2002c).

**Recommendation Six:**

Health services promote greater interdisciplinary collaboration through joint programs and team case conferencing.

**EDUCATION**

Combining the findings of this research in the context of contemporary education provision, and the opinion of education scholars in nursing, it is the belief of the author that the current education programs for C&FH nurses are inadequate. To maximise the effectiveness of the C&FH nursing workforce and decrease the amount of short-course education that is currently provided to new C&FH staff by the AHSs, it is necessary to provide high-quality preparation-for-practice education at a tertiary level. This will bring C&FH nurse education in line with other high-quality providers, both here in Australia (Victoria and Tasmania) and overseas (United Kingdom).

To ensure that the graduate diploma curriculum adequately prepares the C&FH nurse for practice, improved communication must occur between the universities, the professional association (CAFHNA), and the workforce (for example, the C&FH nurse CNC network).
**Recommendation Seven:**
That CHFN education is provided at a graduate diploma level through the tertiary sector.

The transfer of education into the tertiary sector could result in an initial decline in the number of student enrolments, due to the increased cost involved. To decrease the possibility of this occurring, NSW Health could make full scholarships available to cover course fees. Scholarships are currently available that cover approximately 60% of course fees. However, these scholarships are not widely known to the nursing community. This information needs to be more widely accessible to the C&FH nurse workforce.

**Recommendation Eight:**
Health departments support the transfer of education to the tertiary sector by providing scholarships to students undertaking C&FH nurse education with improved access to clinical practice.

The current undergraduate preparation of nurses is directed towards preparing nurses to work in acute care. This is reasonable, considering the majority of nurses work in the acute-care sector. However, the skills and knowledge for working in the community require a very different preparation and philosophy from that of expert to that of partnership. This research has identified the difficulties nurses have in changing those paradigms. An alternative is to restructure the current undergraduate programs available and offer an undergraduate program in community nursing. The community nursing degree could share many of the core subjects with nursing, but offer students a different philosophy of practice that emphasises psycho-social health and the benefits of working in partnership with individuals within a community framework. These programs would be underpinned by the principles of primary health care and community development. A community nursing undergraduate program could offer various streams such as ‘generalist community nursing’, ‘child and family health’, ‘aged care’ and ‘palliative care’. This form of undergraduate preparation would negate
the need for the graduate certificate or graduate diploma in pre-service knowledge and skills. Instead, these postgraduate courses would further develop the skills and knowledge of the C&FH nurse to the level of advanced practitioner.

**Recommendation Nine:**

**Education providers collaborate with the workforce to explore the potential of working towards a three-year undergraduate program in community nursing.**

**LEADERSHIP**

Changing practice will only be successful in an environment that has strong leadership to develop a vision for the role and provide the support to ensure the vision becomes reality.

It is imperative that all CNCs have the skills and knowledge to provide the leadership that must be part of the CNC role. Whilst it is recognised that there are currently insufficient graduates of master’s programs to support it as an essential criteria, employers should expect successful applicants to work towards this educational qualification and provide adequate support for the staff member to achieve it.

**Recommendation Ten:**

**Employing bodies mandate that all CNCs hold a minimum of a master’s level or be actively working towards it.**

To improve the profile of C&FH nurses, to improve the evidence that guides C&FH nursing practice and to support the clinicians in accessing tertiary research and education, a clinically based academic appointment in essential. In midwifery the first clinical chair was appointed in 1992. Victoria has had a clinical chair in maternal C&FH nursing (the Victorian equivalent of C&FH nurse) since the mid-1990s. In both areas, these appointments have had a dramatic impact on service delivery and the quality of clinically based research. It would be expected that the appointment of a clinical chair in C&FH would reap similar rewards.
**Recommendation Eleven:**
That universities and health services combine resources for the appointment of a clinical chair in child and family health nursing.

As the professional association which represents the C&FH nurse workforce, CAFHNA must recognise its responsibilities and potential to influence. However, to achieve this, it must be visible and strategic. This can be achieved through the development and publication of relevant documentation that supports the profession, such as competency standards and scope of practice, frequent meetings with policy-makers and education providers, and regular, relevant media releases.

**Recommendation Twelve:**
That CAFHNA asserts itself as the leading professional association for C&FH nurses and invites consultation, advice and collaboration with health service issues relevant to C&FH.

The professional strength and status of the C&FH nurse workforce will be further strengthened by collaboration with C&FH nurse providers in other states and territories. Developing national standards for nurse education, combined with appropriate quality-assurance processes, is an important part of the process of ensuring that quality education of the nursing workforce. It is beneficial for the profession, the policy-makers and the users of the service to have clear national guidelines that reflect a united, consistent and high-quality education program and scope of practice for C&FH nurses.

**Recommendation Thirteen:**
The development of national standards recently recommended by the Australian Association of Maternal, Child and Family Health Nurses (AAMCFHN, 2002). This requires the collaboration and support of all states and territories in Australia and must include the development of national education standards.
RESEARCH

This thesis identified a lack of published research in Australian in the area of C&FH nursing. Research is vital for describing and promoting the important role C&FH nurses provide in the support of families in the community. It is also necessary to provide the evidence to continue to build on, and improve practice, as well as demonstrate its effectiveness.

Recommendation Fourteen:
Increased research in the area of C&FH nursing in Australia.

Some of the questions this study has identified, that require further investigation include:

- What are the community needs of C&FH nursing care?
- How available is the service for all families, when they need it?
- Do we over-service some women and under-service others?
- Does contact with the service actually lead to improved outcomes?
- What is the ideal ratio of C&FH nurse staff to births or clients that incorporates socio-economic factors and high levels of need?
- How can we link current measures of maternal confidence and family functioning as a key indicator of quality service provision?

CONCLUSION

Child and family health nurses provide an important service in the community. The service is accessed by the vast majority of new mothers and is highly valued by the clientele it services. The importance of the service has become increasingly recognised in the last five years, as policy-makers heed international research around the benefits of supporting new families. This thesis attempted to explore the changing C&FH nursing practice in three contemporary settings in Sydney, NSW in response to major policy change.
This research has exposed a committed workforce that has been working in the same way for many years. Some of the nurses were in partnership, working with families’ strengths, long before the literature gave this any credibility. Others continue to work within the more traditional model of expert and adviser. With support, the C&FH nurse workforce can potentially be a powerful voice in the improvement of service provision and support for families in NSW and Australia.
Reference List


ACPCHN. (2000). *Competencies for the specialist paediatric and child health nurse*. Sydney: Australian Confederation of Paediatric and Child Health Nurses.


Same but different. References 323


Haughey, F., & Cowley, S. (2000). Do you have to be a nurse in order to be a health visitor? *Nursing Times*, 96 (47), 16.


*Same but different. References*


*Same but different. References*
http://chetre.med.unsw.edu.au/early_childhood.htm


*Same but different. References* 329


*Same but different. References* 333


Same but different. References


Appendices
How the child and family health nurse can work more effectively with culturally diverse groups

Nurses working with culturally diverse groups have extensive knowledge surrounding how best to support these communities. You are invited to participate in interviews being carried out by Sue Kruske as part of her doctoral work which is investigating how the child and family health nurse work effectively with culturally diverse communities. You were selected as a possible participant in this study because you work as a child and family health nurse with one or more culturally diverse groups.

If you decide to participate, Sue will make arrangements with you to meet at a mutually convenient location where she will interview you for approximately 60 to 90 minutes. The interview will be audio recorded and Sue will transcribe the interviews onto the computer in a way that you will not be identified. She will also observe you in practice for one working day. Any new information that could influence your decision to remain in the study will be provided to you.

We cannot and do not guarantee or promise that you will receive any benefits from this study, but it is hoped that you will gain an increase in personal and professional satisfaction and enjoy being involved in the project. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. If you give us your permission by signing the consent form document, a publication in a journal is expected to result. In any publication, information will be provided in such a way that you cannot be identified.

Sue Kruske: Centre for Family Health and Midwifery. University of Technology, Sydney. PO Box 123 Broadway. Phone: 95142981
Virginia Schmied: Centre for Family Health and Midwifery. University of Technology, Sydney. PO Box 123 Broadway. Phone: 95142977
Lesley Barclay, Centre for Family Health and Midwifery. University of Technology, Sydney. PO Box 123 Broadway. Phone: 95142977

NOTE:
This study has been approved by: The University of Technology, Sydney Human Research Ethics Committee and the South Western Sydney Area Health Services, Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Research Ethics Officers at UTS, Ms Susanna Davis (ph: 02 95141279, Susanna.Davis@uts.edu.au). Or SWSAHS via Ms Jennie Gretch (ph: 02 - 98285727, jennie.gretch@nsw.gov.au). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.
APPENDIX TWO: CASE STUDY ONE CONSENT FORM

I ______________________ agree to participate in the research project: **How child and family health nurses works effectively with culturally diverse communities** being conducted by Sue Kruske from the Centre for Family Health and Midwifery, phone 95142981, of the University of Technology, Sydney, for the purpose of her doctoral degree.

I understand that the purpose of this study is to document the experiences of child health nurses working with culturally diverse groups.

I understand that my participation in this research involves Sue Kruske observing me whilst I work with clients. It will also involve one interview lasting between one and one and a half hours. The interview will be audio-recorded and returned to me for verification.

Before signing this Consent Form, I have been given the opportunity to ask any questions relating to any possible physical and mental harm I might suffer as a result of my participation. I have received satisfactory answers to any questions that I have asked.

If I decide to participate, I am free to withdraw my consent and to discontinue my participation at any time without prejudice. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

I understand that if I have any questions relating to my participation in this research, I may contact the project officer, Sue Kruske, on telephone 95142981, who will be happy to answer them.

I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

Signed by

Witnessed by

NOTE:
This study has been approved by UTS and SWSAHS Human Research Ethics Committees. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact Ms Susanna Davis at UTS (ph: 02 95141279, Susanna.Davis@uts.edu.au). Or SWSAHS via Ms Jennie Gretch (ph: 02 - 98285727, jennie.gretch@swsahs.nsw.gov.au). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Same but different. Appendices 337
APPENDIX THREE: CASE STUDY ONE: QUESTIONS FOR C&FH NURSES

EXPERIENCE
Can you tell me your career in nursing, from when you trained in General. How has the role changed since you started working as a CFHN?

ROLE:
How would you describe your role as a CFHN?
What parts of your job do you enjoy?
What are some of the things you don’t enjoy?
How has Families First supported you in this changing role?
How does IBIS affect your work as a clinician?
How does IBIS affect the service for the mothers?

CLIENTELE:
How would you describe the families you provide a service to?
(prompt re ethnic or marginalised groups if necessary)
What is the most disadvantaged group you work with?
Why do you think they are disadvantaged?
What do you like about working with this group?
What do you find difficult or challenging about working with this group?
(prompt for the behaviours particular to this group that they find difficult to understand).
Can you recall a case of working with a family from a marginalised group had a positive impact?
Can you recall a case of working with a family from a marginalised group had minimal impact?
What are some of the strategies you use to gain acceptance with ‘hard to reach’ clients.
How do you act/dress/talk/speak differently when working with these groups?
Are there any groups you would be uncomfortable working with?
(prompt D&A clients, mental health, lesbians, Hare Krishnas or JW).
Can you tell me how the attitudes and values of the nurse may affect the service that is given to the clients?
Do you use written resources to provide information to your clients? How are they helpful or not helpful?

COLLABORATION:
Can you give me some examples of where you have worked with other health professionals in providing services to families?
(prompt also for the development of resources or professional development).
How do you think CFHNs are considered by other professionals?
Which professional groups do you find easiest to work with?
Which professional groups do you find the most difficult to work with?

EDUCATION:
What courses, conferences or professional training have you done in the last few years?
How do you access information that might influence or update your practice?
Can you remember any cross-cultural education being provided in any of these courses? What about education on this issue from your employer?
How do you think your employer can assist you in working with this group?
What does CAFHNA mean to you?
Can you tell me of your experiences with clinical supervision?
APPENDIX FOUR: BASELINE IBIS FORM

**SOUTH WESTERN SYDNEY AREA HEALTH SERVICE**

**I.B.I.S. PAEDIATRIC BASELINE**

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Staff Code</th>
<th>Date of Birth</th>
<th>B.W. grams</th>
<th>D.W. grams</th>
<th>Length cm</th>
<th>HC cm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Day</td>
<td>Month</td>
<td>Year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Hospital: Bankstown | Bondi | Camden | Campbeltown | Fairfield | Liverpool | Other |


8. Feeding status: | Weaned | Weeks | Months | |

9. How is breastfeeding going?: Well | With difficulty |

10. Breast problems:

11. Feeding problems: 12. Solids commenced <4 months | Solids commenced >4-6 months |

16. Since the birth of your baby, how much of the time did your baby seem:
a) To have trouble sleeping? | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
b) To be a demanding baby? | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
c) To be content? | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
d) To be a difficult feeder? | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
e) To be difficult to comfort? | All of the time | Most of the time | Some of the time | A little of the time | None of the time |

Theresa Lanyon, NORT | July 2000

Same but different. Appendices 339
APENDIX FIVE: CASE STUDY TWO INFORMATION STATEMENT

SOUTH EAST SYDNEY AREA HEALTH

How the child and family health nurse can work more effectively with culturally diverse groups

Nurses working in with culturally diverse groups have extensive knowledge surrounding how best to support these communities. You are invited to participate in interviews being carried out by Sue Kruske as part of her doctoral work which is investigating how the child health nurse work effectively with culturally diverse communities. You were selected as a possible participant in this study because you undertake mothers’ groups in the Early Bird program.

If you decide to participate, Sue will make arrangements with you to meet at a mutually convenient location where she will interview you alone or in a focus group for approximately 60 to 90 minutes. The interview will be audio-recorded and Sue will transcribe the interviews onto the computer in a way that you will not be identified. Any new information that could influence your decision to remain in the study will be provided to you. Sue will also observe you whilst you are running the Early Bird groups to document the process by which the groups are run and the particular skills you use as a facilitator.

We cannot and do not guarantee or promise that you will receive any benefits from this study, but it is hoped that you will gain an increase in personal and professional satisfaction and enjoy being involved in the project. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. If you give us your permission by signing the consent form document, a publication in a journal is expected to result. In any publication, information will be provided in such a way that you cannot be identified.

Sue Kruske: Centre for Family Health and Midwifery. University of Technology, Sydney. PO Box 123 Broadway. Phone: 95142981
Virginia Schmied: Centre for Family Health and Midwifery. University of Technology, Sydney. PO Box 123 Broadway. Phone: 95142977
Lesley Barclay, Centre for Family Health and Midwifery. University of Technology, Sydney. PO Box 123 Broadway. Phone: 95142977

NOTE:
This study has been approved by UTS and SESAHS Human Research Ethics Committees. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact Ms Louise Abrams at UTS (ph: 02 95141279). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.
APPENDIX SIX: CASE STUDY TWO CONSENT FORM

SOUTH EAST SYDNEY AREA HEALTH

I ______________________ agree to participate in the research project: How child and family health nurses works effectively with culturally diverse communities being conducted by Sue Kruske from the Centre for Family Health and Midwifery, phone 95142981, of the University of Technology, Sydney, for the purpose of her doctoral degree.

I understand that the purpose of this study is to document the experiences of child health nurses working with culturally diverse groups, including the Early Bird groups.

I understand that my participation in this research involves Sue Kruske observing me whilst I run the Early Bird groups. It will also involve one interview or focus group lasting between one and one and a half hours.

Before signing this Consent Form, I have been given the opportunity to ask any questions relating to any possible physical and mental harm I might suffer as a result of my participation. I have received satisfactory answers to any questions that I have asked.

If I decide to participate, I am free to withdraw my consent and to discontinue my participation at any time without prejudice. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

I understand that if I have any questions relating to my participation in this research, I may contact the project officer, Sue Kruske, on telephone 95142981, who will be happy to answer them.

I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

________________________________________  ____/____ /____
Signed by

________________________________________  ____/____ /____
Witnessed by

NOTE:
This study has been approved by UTS and SESAHS Human Research Ethics Committees. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact Ms Louise Abrams at UTS (ph: 02 95141279). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.
APPENDIX SEVEN: CASE STUDY TWO PROMPTS FOR INTERVIEWS AND FOCUS GROUPS

How did Earlybird Groups come about in the area? What is your recollection of the rationale for the groups?

If you had to describe Early Bird to another C&FH nurse what would you say about the aims/process/content and how you run the group?

Thinking of your clinic setting, who are the mothers that come to Earlybird Groups?

How do the mothers come to hear about the groups?

What do you believe are the advantages for women and families who attend Earlybird Groups?

What makes a group run well?

What are the disadvantages of attendance at Early Bird Groups? I’d like you to suggest reasons why some women may not find these groups helpful.

Tell us about the training that you have undertaken in order to facilitate these groups.

What was the most useful skills/knowledge you gained and put to use from the training?

Now in retrospect, what are the other things that would have been important in baseline training?

What do you really enjoy or like about facilitating these groups?

What do you dislike about facilitating these groups?

Hypothetically, if management were to suddenly decide groups were not valuable and cut them out, how would you feel?

Describe for us any changes that you would like to make to the way the groups are running at present.

If this model is to continue, what further skills/training would you like?
APPENDIX EIGHT: CASE STUDY THREE INFORMATION STATEMENT

Ethics approval number: 03/053

How the child health nurse can work more effectively with culturally diverse groups

You are invited to participate in interviews being carried out by Sue Kruske as part of her doctoral work which is investigating how the child health nurse can work more effectively with culturally diverse communities. You were selected as a possible participant in this study because your work can relate to the same professional issues as that of the child health nurse.

If you decide to participate, Sue will make arrangements with you to meet at a mutually convenient location where she will interview you for approximately 30 to 60 minutes. The interview will be audio recorded and Sue will transcribe the interviews onto the computer in a way that you will not be identified.

We cannot and do not guarantee or promise that you will receive any benefits from this study, but it is hoped that you will gain an increase in personal and professional satisfaction and enjoy being involved in the project.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. If you give us your permission by signing the consent form document, a publication in a journal is expected to result. In any publication, information will be provided in such a way that you cannot be identified.

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NOTE:
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APPENDIX NINE: CASE STUDY THREE CONSENT FORM

I ______________________ agree to participate in the research project: How the child and family health nurse can work more effectively with culturally diverse communities being conducted by Sue Kruske from the Centre for Family Health and Midwifery, phone 95142981, of the University of Technology, Sydney, for the purpose of her doctoral degree.

I understand that the purpose of this study is to document the experiences of child health nurses working with culturally diverse groups. I understand that my participation in this research will involve one interview lasting between thirty and sixty minutes. The interview will be audio-recorded and transcribed onto a computer in such a way that I will not be identified.

Before signing this Consent Form, I have been given the opportunity to ask any questions relating to any possible physical and mental harm I might suffer as a result of my participation. I have received satisfactory answers to any questions that I have asked.

If I decide to participate, I am free to withdraw my consent and to discontinue my participation at any time without prejudice. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

I understand that if I have any questions relating to my participation in this research, I may contact the project officer, Sue Kruske, on telephone 95142981, who will be happy to answer them.

I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

________________________________________  ____/____ /____
Signed by

________________________________________  ____/____ /____
Witnessed by

NOTE:
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Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.
APPENDIX TEN: TEXT READ BY C&FH NURSE AT GP INFORMATION

NIGHT

The _______ Child and Family Health Service would like to support General Practitioners in their very busy and vital role of supporting children and their families. Below is a checklist of how we can help if a family presents with any of the identified concerns. All the child health nurses are qualified Child and Family Health specialists. We provide a home visiting service 7 days a week for concerns. We also have groups and clinic appointments. We use our bi-lingual nursing staff or we use interpreters for all families who have limited or no English.

This service is FREE

COMMON CONCERNS FOUND AT THE INFANT’S PERSONAL HEALTH RECORD CHECKS AND BETWEEN VISITS

★ Breastfeeding problems - Refer to _____ (name of child health nursing service) which include home visiting lactation consultants
★ Bottle feeding problems - Refer to _____, who has outreach feeding team.
★ Mother isolated/lack of supports - Refer to _____ – who will home visit and link into appropriate volunteer services to support her.
★ Difficult to settle or prolonged crying infant with no medical cause identified - Refer to _____, for sleep & settling group or individual support and education, we will also refer to the family care cottage or residential units as needed.

Phone: XXXXXXXXX
APPENDIX ELEVEN: CASE STUDY THREE QUESTIONS FOR INTERVIEWS WITH WORKING GROUP MEMBERS (NON-NURSES)

ROLE:
How would you explain the role of the C&FH nurse in supporting parents?
Explain some of the situations in which you have worked with the C&FH nurse previously.
What are some of the positive experiences you have had in working with the CFHN on this project?
What are some of the difficulties?
How do you think their role could be enhanced?
How do you think their educational preparation differed from your own?

DEMOGRAPHIC details such as age, work experience and cultural background.