

Caring for families with complex needs during the perinatal period: Knowledge, skills and attributes of nurses practising within a primary health care framework

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A thesis submitted in fulfilment of the requirements for the
Degree of 'Doctor of Philosophy'

Sydney Nursing School
University of Sydney

2017

Certificate of Authorship and Originality

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information and literature used are indicated in this thesis

Signature of Candidate

A handwritten signature in black ink, reading "Anne-Lyse De Guio". The signature is written in a cursive, flowing style. The first name "Anne" is written with a large, stylized 'A'. The last name "De Guio" is written with a large 'G' and a small 'De' in front of it.

Name

Anne-Lyse De Guio

Acknowledgements

I was able to complete this PhD because of the support, encouragement and guidance from several people who generously and patiently accompanied me during this lengthy and arduous but also fulfilling journey.

Professor Mary Chiarella, my principal supervisor and Professor Jennifer Fraser demonstrated unimaginable patience and kindness when I stopped believing that I could complete the thesis. They not only encouraged me but also challenged me to refocus on the task, to be true to my data, and to remember that my research was foremost about mothers, infants and families. They provided me with invaluable expert guidance and repeatedly challenged my thinking. Mary's admirable eloquence led me to transform the challenge of having a French speaking background into the appreciation of the English language and what I called the discovery of beautiful words. For this I will be for ever grateful. Thank you both.

I am grateful to Dr Cherry Russell who helped me with the final editing and formatting of the thesis.

To Doug, my wonderful, gentle, patient husband and companion who sometimes had to remind me that it was time to take a break, time to spend with our beautiful children Gerome and Grace and also time to share with our families and friends. Without his kindness and generosity I would have never completed this study.

I also like to give a special thanks to my dear friend and colleague Julie Maddox. Julie, you so generously made yourself available to discuss, reflect and argue the role of child and family health nurses, and the needs of parents facing multiple challenges that they never anticipated. I talked about mental health, you talked about child and family health, we talked about primary health care and we always talked about the future of our babies. We share the vision of a world where all children are safe and parents are empowered to help them reach their full potential.

I am grateful to the experts and the nurses who generously shared their knowledge and expertise and the mothers who so willingly agreed to tell the story of their journey into early parenthood. Thank you for trusting me. Without your generosity this thesis would not have been possible.

Finally I dedicate my work to my father who was the source of my motivation. Papa, I am sorry that you are no longer with us but wherever you are I know that you are so proud of me.

Abstract

New scientific evidence on the importance of the early years on a child's life trajectory led to sweeping reforms in maternal and child care and in strategic responses to prevent child maltreatment. Child Family Health (CFH) nurses, who play a pivotal role in the implementation of those reforms are expected to be adequately prepared for the broad changes required for their roles in working with families with complex needs during the perinatal period. Those families identified through universal antenatal and postnatal psychosocial assessment are likely to benefit from extra nursing support and targeted early interventions.

Method

The mixed method study was designed to explore the knowledge, skills and attributes of nurses who care for families with complex needs in the first two years of the infant's life. The level of expertise at which the nurses practised was investigated and the benefits for nurses of interprofessional education was examined. The investigation was conducted from three different perspectives: an international expert panel in the field of early childhood; mothers who identified themselves as having complex needs and who believed they had been cared for by CFH nurses; and CFH nurses who had delivered or were currently delivering early interventions to families with complex needs. Results were triangulated to demonstrate the extent to which the findings converged.

Data collection

A three rounds Delphi technique consisting of an initial questionnaire followed by a survey and finally a feedback to 12 experts was the first study. The second study used in-depth interviews to explore the nursing care experience of 10 mothers. In the third study semi-structured interviews were used to seek out the experience of 12 nurses who supported families with complex needs.

Results

The results showed that CFH nurses did not belong to one homogenous professional group. Instead they assumed various roles ranging from universal home visiting and psychosocial screening to more advanced roles in the care of families with complex needs. The service model in which the nurses worked were particularly significant since it partly determined their scope of practice. Mental health competencies, combined with the ability to practise within a public health framework, were identified as important elements of the role. A robust understanding of socio-ecological theory, a commitment to principles of prevention and early intervention, strengths-based approaches and collaborative practice were put forward as core knowledge and skills of contemporary CFH nurses.

Contents

Certificate of Authorship and Originality	i
Acknowledgements	ii
Abstract	iv
Chapter 1: Introduction	7
1.1 Conceptual Framework	7
1.1.1 A Socio-Ecological Framework for Early Childhood	7
1.1.2 The Science of Early Childhood Development	8
1.2 Socio-Political Context	11
1.2.1 Development of CFH Nursing in Australia	11
1.2.2 The Australian Child and Family Welfare System	13
1.2.3 Australian Early Childhood Care Reform	14
1.2.4 Protecting Australian Children: A Public Health Approach.....	16
1.2.5 Families NSW-Supporting Families Early	17
1.3 Aim and Significance of the Study	19
1.4 Research Questions	22
1.5 Organisation of the Thesis	23
1.6 Conclusion	24
Chapter 2: Literature Review.....	25
2.1 Search Strategy	25
2.2 Key Concepts	27
2.2.1 Maltreatment, Adversity, Risk and Resilience	27
2.2.2 Family Vulnerability.....	28
2.3 A Public Health Model to Support Families with Complex Needs	29
2.3.2 Tiered Model of Service Provision.....	33
2.4 Nursing Competence	39
2.4.1 Advanced Nursing Practice (ANP).....	41
2.4.2 Competence of CFH Nurses	42
2.5 Interprofessional Education and Practice	47
2.5.1 The Interprofessional Debate.....	48
2.5.2 Nursing Perspective	49
2.6 Conclusion	50
Chapter 3: Research Design and Methods.....	52

3.1 Research Design.....	52
3.2 Study 1: Seeking Expert Consensus	55
3.2.1 Method.....	55
3.2.2 Participant Selection and Recruitment.....	56
3.2.3 Procedure	58
3.2.4 Data Analysis.....	60
3.2.5 Ethical Considerations	61
3.3 Study 2: Mothers’ Experiences of Nursing Support	62
3.3.1 Method.....	62
3.3.2 Participant Selection and Recruitment.....	63
3.3.3 Procedure	64
3.3.4 Unanticipated Issues	66
3.3.5 Data Recording and Analysis	67
3.3.6 Ethical Considerations	68
3.4 Study 3: Nurses’ Experiences of Caring for Families with Complex Needs During the Perinatal Period.....	69
3.4.1 Method.....	69
3.4.2 Sampling and Recruitment	70
3.4.3 Data Recording and Analysis	72
3.4.4 Reflexivity	73
3.4.5 Ethical considerations.....	75
3.5 Triangulation of the Data from the Three Studies	75
3.6 Conclusion	75
Chapter 4: Results Study 1: Seeking Expert Consensus	77
4.1 Round One Results	77
4.1.1 Research Question 1	78
4.1.2 Research Question 2	81
4.1.3 Research Question 3	83
4.2.1 Elements that Reached Consensus.....	85
4.2.2 Elements of Relevance that did not Reach Consensus	87
4.2.3 Postgraduate Nursing Education.....	92
4.2.4 Interprofessional Education	93
4.3 Summary of Study 1 Results.....	95
4.3.1 Core Knowledge, Skills and Attributes for Nurses Caring for Families With Complex Needs	95
4.3.2 Nurses’ Indicated Level of Practice.....	96

4.4 Conclusion	97
Chapter 5: Results Study 2: Mothers' Experiences of Nursing Support.....	98
5.1 Characteristics of Participants	98
5.2 Staff Status and Experiences of Care.....	100
5.2.1 Staff Status.....	100
5.2.2 Positive and Negative Experiences with Nursing and Midwifery Care.....	102
5.3 Mothers' Accounts of what Nurses Do.....	103
5.3.1 Assessment of Infant Growth and Development	103
5.3.2 Parentcraft Education.....	104
5.3.3 Assessment of Maternal Psychosocial Risk Factors	105
5.4 Perceptions of How Nurses and Midwives do their Work	106
5.4.1 Interpersonal Skills and Attitudes of Nurses	107
5.4.2 Inconsistency of Information and Advice.....	110
5.4.3 Family-centred Care	110
5.4.4 Cultural Sensitivity	110
5.5 Mothers' Breastfeeding Experiences.....	111
5.6 Other Sources of Support and Guidance	112
5.7 Conclusion	113
Chapter 6: Results Study 3: CFH Nurses' Experiences of their Role	115
6.1 Characteristics of the Participants.....	115
6.2 Knowledge, Skills and Attributes	118
6.2.1 Knowledge for Effective Practice.....	118
6.2.2 Core Skills for Effective Practice	129
6.2.3 Core attributes for Effective Nursing Practice.....	133
6.3 Advanced Level Practice	135
6.3.2 Mentoring and Supervision to Enhance Nursing Practice	136
6.3.3 Tier Framework for Nursing Practice.....	137
6.4 Interprofessional Education	138
6.4.1 Nurses' Perspectives on Interprofessional Education.....	138
6.4.2 Components of an Interprofessional Curriculum.....	140
6.5 Conclusion	141
Chapter 7: Discussion and Conclusion	143
7.1 Core Knowledge, Skills and Attributes.....	147
7.1.1 Mental Health and Care	147
7.1.2 Parentcraft Skills.....	151
7.1.3 Public Health Model for Child and Family Health Nursing	154

7.1.4 Continuity of Care	155
7.1.5 Psychosocial Risk Assessment	157
7.1.6 Breastfeeding.....	158
7.1.7 Core Attributes of CFH Nurses	159
7.2 Comment on Study 2 Results	161
7.3 Strengths and Limitations of the Research	163
7.4 Implications for Clinical Practice and Education	166
7.4.1 CFH Nurses Practising at Advanced Level	166
7.4.2 Pathways of Care for Early Intervention	167
7.4.3 Primary Health Care Nursing for Families with Mental Illness	168
7.4.4 Implications for Nursing Education.....	169
7.5 Conclusion	171
References	174
Appendices	192
Appendix 1: Key Developments in Early Childhood Research and Policy.....	192
Appendix 2: Literature review. Manuscripts graded as highly relevant.....	195
Appendix 3: Ethics Committee Approval.....	198
Appendix 4: Study 1 Participant Information Statement.....	201
Appendix 5: Study 2 Participant Information Statement.....	203
Appendix 6: Study 3 Participant Information Statement.....	205
Appendix 7: Study 1 Consent Form	207
Appendix 8: Study 2 Consent Form	209
Appendix 9: Study 3 Consent Form	210
Appendix 10: Study 1: Round 1 Questionnaire	212
Appendix 11: Study 1 Round 2 Questionnaire	214
Appendix 12: Study 1 Round 3 Final Feedback to Experts.....	221
Appendix 13: Study 1 Round 1 Glossary	224
Appendix 14: Study 2 Original Mothers' Recruitment Pamphlet	225
Appendix 15: Study 2 Simplified recruitment pamphlet	226
Appendix 16: Nurses' Recruitment Pamphlet	227
Appendix 17: Skills and Attributes: Comparison between Davis's family partnership model and expert panel's opinions	228

List of Tables

Table 3.1	Mapping of interview questions and domains of inquiry across the three studies.....	45
Table 3.2	Delphi study: Profile of experts.....	49
Table 3.3	Maternal characteristics, children's age, interview location and care of baby.....	56
Table 3.4	CFH nurses' professional characteristics.....	62
Table 4.1	Round one questions.....	68
Table 4.2	Knowledge category responses.....	69
Table 4.3	Skills category.....	70
Table 4.4	Attributes category.....	71
Table 4.5	Importance of knowledge elements.....	76
Table 4.6	Importance of skills elements.....	78
Table 4.7	Round 2 core skills elements reconsidered.....	81
Table 4.8	Importance of nurses' attributes.....	82
Table 4.9	Key elements in an interprofessional course.....	85
Table 5.1	Mothers' health characteristics.....	91
Table 5.2	Mothers' positive, negative and mixed experiences of care.....	94
Table 5.3	Number of mothers who had positive, negative or mixed experiences.....	94
Table 5.4	Mothers' descriptors of nurses' positive and negative interpersonal skills and outcomes.....	98
Table 5.5	Sources of support other than nursing.....	103
Table 6.1	Professional characteristics of the participants.....	106
Table 6.2	Core skills required for effective practice.....	102
Table 6.3	Core attributes required for effective practice.....	124
Table 7.1	Triangulation of findings for research question 1.....	135
Table 7.2	Study's findings: Summary of recommendations for practice, education and research.....	

List of figures

Figure 1.1	Environmental factors that impact positively or negatively on children’s outcomes	4
Figure 1.2	Families NSW: Supporting families early initiative.....	12
	.	
Figure 2.1	Flow diagram of study selection. Adapted from the PRISMA statement.....	19
Figure 2.2	Diagrammatic representation of the public health model for a holistic approach to the prevention of child maltreatment.	27
Figure 3.1	Schematic representation of study Delphi procedure.....	50
	.	

Chapter 1: Introduction

This thesis presents the findings from a mixed-methods study that sought to identify the core knowledge, skills and attributes required by Registered Nurses (RN) working with families with complex needs during the first two years of their child's life. For this study and throughout this thesis, the term perinatal was used to refer to pregnancy and the first two years. This was in accordance with the definition used in policy at the time. (see *Families NSW-Supporting families early maternal child health primary health care policy* (NSW Health, 2010a).

This chapter introduces the historical, scientific and socio-political contexts of the study. It begins by explaining the socio-ecological framework for early childhood and the science of early childhood development. This is followed by an overview of the evolution of Child Family Health (CFH) nursing in Australia and the development of the Australian child and family welfare system, early childhood care reform, the public health approach to the protection of children, and the New South Wales (NSW) Supporting Families Early initiative. I explain the motivation, aim and significance of the study. The chapter concludes with a statement of the research questions and a synopsis of the thesis structure.

1.1 Conceptual Framework

Early childhood is a crucial developmental period. The experiences that children have in early life and the environment in which they live can determine their life trajectory (Fox et al., 2015; Hunter & Price-Robertson, 2014; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Shonkoff, 2010). This section describes how socio-ecological circumstances impact on the life of children and their families and explains the scientific foundation for early childhood development.

1.1.1 A Socio-Ecological Framework for Early Childhood

There is compelling evidence that socially and economically advantaged people have greater life opportunities and better health, while those from lower socio-economic status backgrounds have reduced access to health services, education and safe housing (Bronfenbrenner & Evans, 2000; Marmot et al., 2010; Marmot, Friel, Bell, Houweling, & Taylor, 2008; Moffatt & Fish, 2013). Young children are particularly sensitive to adverse social environments because of the immediate and long-term impact on their health status (Halfon, Larson, & Russ, 2010). Safe housing and favourable working conditions, responsive social networks, accessible and affordable health services, quality infant-carer relationships and safe, nurturing environments are some of the requisites for children to thrive (Scott, 2013).

In contrast, poverty, social isolation, poor education, unemployment, limited or inaccessible child care, family conflict and violence, adverse life styles and parental mental illness, in particular maternal depression, are some of the social determinants that can have a profoundly negative lifelong impact on children (Halfon et al., 2010; Hand, Katz, Gray, & Bray, 2016; Hertzman et al., 2010; Stanley, 2001; Stanley, Richardson, & Prior, 2005). An extensive body of research has examined the cumulative effect of multiple social risks on the socio-emotional competence and cognitive outcomes of developing children. (Fleegler, Lieu, Wise, & Muret-Wagstaff, 2007; Jacobs, Agho, & Raphael, 2012; Larson, Russ, Crall, & Halfon, 2008). The findings indicate the importance of identifying psychosocial risks as early as possible, preferably commencing during pregnancy, to allow robust prevention strategies to be set in place.

Children are most susceptible to their environmental conditions during the first three years of life. Although infants can successfully adapt to rapidly changing environments, they cannot do so on their own. They need a nurturing and stable relationship with a capable caregiver to help them successfully mediate stressful events (Shonkoff, 2010).

1.1.2 The Science of Early Childhood Development

The development of the human brain begins during pregnancy and continues into adulthood, with the early childhood period being particularly significant. Before birth, the creation of simple neural circuits and skills provide the scaffolding for more advanced pathways and skills. Over time this process, if uninterrupted, supports the optimal development of cognitive skills, emotional wellbeing and social competence essential for the child's life health trajectory (Ferguson, 1998; Gunnar, Morison, Chilsholm, & Schuder, 2001; National Scientific Council on the Developing Child, 2010b; Schore, 2001; Shore, 1997a, 1997b).

Shaped by experiences in the first three years of life, billions of inter-related neural pathways are wired and pruned to result in effective brain development (Perry et al., 1995). This development cannot occur successfully without growth-promoting relationships (Bowlby, 1982; Schore, 2001). Research on the developing brain (National Scientific Council on the Developing Child, 2004; Shonkoff, 2014; Shore, 1997b) has confirmed what has been assumed for centuries: that children need nurturing, stimulating, responsive human relationships for all aspects of their growth and development (Karen, 1998). This new scientific knowledge not only provides understanding of how the architecture of the brain is created, but also identifies factors that can impair the wiring and sculpting of the brain, preventing children from reaching their full potential even when therapeutic interventions address identified deficits (Ahlander, 2002; National Scientific Council on the Developing Child, 2011). The quality of the young child's relationships with significant people, particularly parents, is essential for the development of competencies that are used throughout life (National Scientific Council on the

Developing Child, 2009c). These growth-promoting relationships—described as ‘serve and return’¹ interactions—are characterised by mutual emotional responses between the child and the parent. One of the most common of these ‘brain building’ activities takes place at feeding and settling times, when a strong intimacy characterised by rocking, soft touching, smiling and cooing results in multiple sensory stimulations that support the building of healthy neural pathways (McCain & Mustard, 2002).

Sadly, however, early experiences are not always positive and the infant may face stresses with which s/he is not equipped to deal. This produces chemical and neural responses that have potentially lasting adverse effects depending on the intensity and length of the stressful incident (National Scientific Council on the Developing Child, 2009b, 2010a, 2012). The presence of a consistent, supportive and dependable adult helps the child to learn to control the stressful event. Exposure to “strong, frequent or prolonged activation of the child’s stress management system” (National Scientific Council on the Developing Child, 2009b, p. 1) is referred to as toxic stress. Toxic stress results from chronically elevated stress hormones, such as cortisol and adrenalin, that have the potential to affect the brain’s long-term development, leading to learning, memory and cognitive deficits in adulthood (Glover, 2011; Gunnar et al., 2001; McCain & Mustard, 2002; McCain, Mustard, & McCuaig, 2011; National Scientific Council on the Developing Child, 2010a; Vermeer & Van Ijzendoorn, 2006). Exposure to toxic stress during pregnancy and in the early years not only alters developing brain architecture, but can also affect genetic expression. Such epigenetic modification, as it is known, results in undesirable permanent brain changes (National Scientific Council on the Developing Child, 2010a). Violent and chaotic families, substance misuse, extreme poverty, mental illness (including severe anxiety), and unsafe communities are some of the multiple risk factors often linked to toxic stress (National Scientific Council on the Developing Child, 2006, 2007).

In some circumstances, such as extreme poverty, social and emotional isolation, and maternal depression, children may not receive the ‘serve and return’ responsive interaction that they seek. The mother is often unable to respond to the child’s attention-seeking behaviours of babbling, facial expressions and gestures. This means that she is unable to provide the child with the experiences and stimulation that are necessary for healthy development and wellbeing (National Scientific Council on the Developing Child, 2012). Neglect may be difficult to identify, as the infant is often undemanding and quiet, making few demands on her/his carer. Nonetheless, the impact of neglect can be catastrophic as unstimulated neural pathways eventually disappear, resulting in permanent deficits that can only partially be repaired (National Scientific Council on the Developing Child, 2009a, 2012). The pervasive nature of neglect poses a real challenge to professionals, in particular CFH

¹ Refers to the back and forth activity in a game of tennis.

nurses, who are expected to recognise its occurrence and to assess its level of severity in order to intervene early (Glaser, 2000).

There is compelling scientific evidence that young children need safe, nurturing, consistent, reciprocal relationship-based care, starting in the antenatal period, to achieve their full potential in adult life (Shonkoff, 2014). Young children who experience a lack of emotional support, limited intellectual stimulation and poor access to resources need responsive and competent services that are accessible, effective and skilled to counteract stressors and enhance parenting capacity. The benefits of early interventions based on an ecological model of brain development (Fox et al., 2015) have been demonstrated internationally (Karoly, Kilburn, & Cannon, 2005; Kitzman et al., 2010; Shonkoff, 2014). Identification of risk factors promoting early interventions that address the various sources of adversity are essential to reduce risks and enhance parenting capacity (Benedetti, 2012). Child and maternal health services are well positioned as the first point of contact, with expectant mothers attending antenatal services and new parents visiting early childhood clinics (Kruske, 2007).

Figure 1.1 displays a conceptual model in which layers of influence at societal, community, relationship and individual levels interact and play a role in a child's development and the risk of maltreatment.

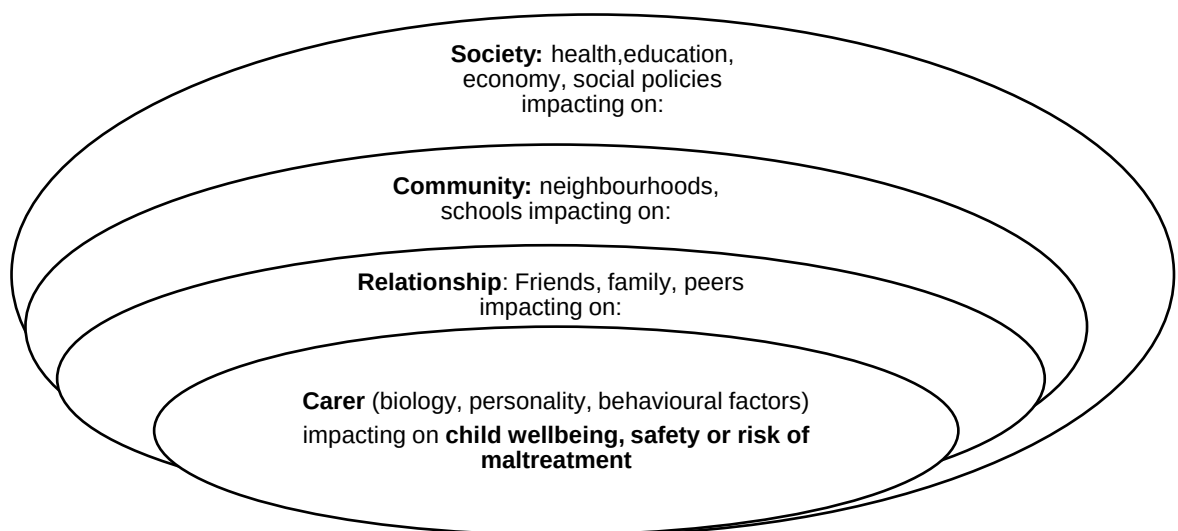


Figure 1.1. Environmental factors that impact positively or negatively on children's outcomes (World Health Organisation, 2002).

The following section outlines the historical and socio-political context within which Australian governments and service providers have responded to the need to provide safe and stimulating environments for children's growth and development.

1.2 Socio-Political Context

1.2.1 Development of CFH Nursing in Australia

During the first half of the 20th century, Australian infants were highly vulnerable, their chances of survival being closely linked to maternal health during pregnancy, childbirth and the period of lactation. According to NSW Health Department Archives (NSW Department of Health, 1972), increasing urbanisation—characterised by lack of sanitary control and sewerage, poor housing and limited and unsafe milk supply—led to an alarming increase in infant mortality from malnutrition and infectious diseases (Armstrong, 1939; Bryder, 2003; Featherstone, 2008). In his history of public health in Australia, Lewis (2003) records an infant mortality rate² of 77.6 per thousand births between 1906 to 1910, with a steady reduction to 52 by 1930 (Exley, 1932).

Those data were sufficiently disturbing to provoke a strong response from two broad social groupings (Armstrong, 1939). The first group, consisting mainly of volunteers coordinated by non-government organisations (NGOs), focused on the care and protection of the child when the mother was unavailable to parent the child herself (Tomison, 2001). In the early 1960s, following the identification of the ‘battered-child syndrome’ (Kempe, Silverman, Steele, Droegemuller, & Silver, 1962), the welfare of children was transferred to professionally staffed child protection services located within government departments. This second group concentrated on the health needs of the mother and child, which became the core business of a particular group of RNs then known as ‘baby health sisters’ (O’Connor, 1989, p. 103) but now referred to in NSW as CFH nurses.

The CFH movement continued to grow with the opening of baby clinics in Australia’s poorest industrial areas. Home visiting became integral to the role of CFH nurses when mothers from the most disadvantaged backgrounds did not attend the clinics. The CFH nurses’ role expanded to include advice to pregnant women and planning for their childbirth experience in hospital. By 1920, the national public health campaign that had, from its inception, targeted disadvantaged families had expanded to include all women irrespective of their socioeconomic background (O’Connor, 1989). CFH services that reflected local political, health and social requirements emerged in response to the rapid growth of baby health clinics throughout Australia (Kitchens, 2005). This uncoordinated service development is reflected in the contemporary multiplicity of CFH service models throughout Australia (Schmied, 2011). A detailed examination of this national development is beyond the scope and focus of this thesis.

The *Early Notification of Birth Act* (NSW Governor, 1915) ensured that nurses were made aware of all births in their geographical area (O’Connor, 1989). The infant welfare movement had grown to

² Death of a live-born baby within 28 days of birth.

become a complex network of clinics, outpatient departments and charitable organisations, all committed to improving the health of babies (Bloomfield, 1912). Comprehensive, coordinated community interventions supported by social, educational and economic changes throughout Australia led to a dramatic decline in infant mortality.

From early 1920, all 'Centre Sisters'³ taught scientific child rearing during the consultation sessions. Surveillance of the infant with a sharp eye on milestones meant that babies were weighed, measured, examined for abnormalities and tested for variations from the norm (O'Connor, 1989). Sleep, settling, nutrition, management of toddlers' behaviour and immunisation were part of the core business of CFH nurses who, up to today, continue to advocate strongly for the benefits of breastfeeding and the early implementation of routines (NSW Kids and Families, 2016). Those core practices were still very much in place by the end of the 20th century, supported by a plethora of documents, policies and practice guidelines that dictated what and how CFH nurses were to deliver expert knowledge to new parents (NSW Department of Health, 1972; O'Connor, 1989).

For the past 20 years and throughout Australia, community-based CFH nurses have remained at the forefront of care for infants and their mothers (Kruske, 2007). Their role as primary health care professionals has essentially remained unchanged, with a common goal of promoting the child's growth, development and wellbeing. CFH nurses focus mainly on parenting education, assessment of child and family needs and, when indicated, timely referrals to specialist services or to appropriate community agencies (Borrow, Munns, & Henderson, 2011; Fraser, Grant, & Mannix, 2014; Kruske & Grant, 2012). Although the model of CFH service delivery to families from birth to school entry varies from State to State and from centre to centre, it usually comprises a combination of home visits and centre-based clinics that provide one-on-one consultations and group education focusing on child development and parentcraft skills (Schmied, Fowler, Rossiter, Homer, & Kruske, 2014).

New scientific evidence about the importance of the early years on a child's life trajectory (Shonkoff, 2010; Shonkoff, Richter, Van der Gaag, & Butta, 2012) led to sweeping reforms in maternal and childcare practices and in strategic initiatives to prevent child maltreatment. Australian policies reflected a broad shift towards a socio-ecological framework underpinning early childhood service delivery (Australian Government Department of Health and Ageing, 2011) and led to practice change in the ways health professionals, and particularly CFH nurses, worked with parents (Fox et al., 2015).

The term CFH nurse usually refers to those nurses who have completed a course in CFH nursing (NSW Health, 2010a). Many nurses working in this particular field across Australia, however, have

³ Centre Sister was the term used for the specialist nurse who worked at the clinic.

not completed the specialty CFH nursing training. Accordingly, in this thesis the term CFH nurse is used to refer to all nurses who work with families with complex needs during the perinatal period.

1.2.2 The Australian Child and Family Welfare System

Those infectious diseases that killed infants in the 19th and early 20th centuries have now been all but eradicated in developed countries. The Australian neonatal death rate currently stands at 3.4 per 1000 births⁴ (Australian Bureau of Statistics, 2015). New knowledge in biomedical science, combined with a relatively fair and equitable health care system and significant improvements in social and economic circumstances, impacted favourably on the life trajectory of children born in the past 30 years (Commonwealth of Australia, 2009a; Nicholson & Sanson, 2003; Schmied, 2011).

This picture, however, is less clear-cut when health indicators other than rates of infant mortality and morbidity are examined. Abundant data indicate a relationship between socioeconomic inequality and an increasing rate of emotional, social and behavioural problems for children growing up in unfavourable environments (Alperstein & Nossar, 2003; Daro, 2010a; Marshall & Watts, 1999; McCain & Mustard, 1999; McCain et al., 2011; Zubrick et al., 1995) (Hertzman et al., 2010; Stanley et al., 2005). The phenomenon known as “Modernity’s Paradox” (Stanley, 2008, p. 2) describes the scenario in which Australia’s prosperity continues to rise but psychosocial and emotional problems affecting Australian children are becoming more prominent (Marshall & Watts, 1999; Nicholson & Sanson, 2003; Zubrick et al., 1995). Over the past 30 years, families have had to respond to dramatic environmental transformations in which complex economic, technological, political and societal changes have provided new opportunities, but also new challenges and constraints (Nicholson & Sanson, 2003; Scott, 2013; Stanley et al., 2005).

Australia has a long history of collaboration between early childhood professionals to assist families in need of extra support through the delivery of universal and targeted early interventions (Kemp et al., 2004; Scott, 2010). Nonetheless a small number of families continues to be exposed to environmental factors that impair their ability to raise their children safely (Allen Consulting Group, 2009; ARACY, 2010; Moore, 2012; Moore & McDonald, 2014; Moore, McDonald, Carlton, & O'Rourke, 2015; Woods, 2008). For this small group of parents, entering the child protection system may be the only option (Munro, 2011; Scott, 2013). Although a detailed discussion of the child protection system is beyond the scope of the present study, a brief overview is indicated because nurses who provide early intervention programs to families with complex needs are often involved in such cases (NSW Health, 2010a).

⁴ This excludes the Aboriginal or Torres Strait Islander (ATSI) population where the neonatal death rate is 6, nearly double that of other Australian babies.

Internationally, two distinct approaches to the protection of children are identified: the family support model, which promotes holistic family support, and the child protection model, which relies heavily on the court system to protect children from harm (Katz & Hetherington, 2006). The child support model based on prevention and early intervention is embedded within the public health systems of many, mainly European, countries. On the other hand, Australian states and territories operate under the child protection system, which is also called the ‘dualistic’ system since family support and court processes take place in two separate systems (Katz & Hetherington, 2006, p. 431). Both dualistic and family support approaches present advantages and disadvantages (Price-Robertson, Bromfield, & Lamont, 2014). The Australian child protection experience has encountered a number of problems, including an overwhelming number of child at risk reports (Allen Consulting Group, 2009). This prompted a recent review of the child protection system and the development of a public health model that focuses on the family as a whole and relies on strong interagency and interprofessional collaboration throughout Australian jurisdictions (ARACY, 2010; Fox et al., 2015). This model is discussed in more detail below.

1.2.3 Australian Early Childhood Care Reform

Over the past ten years Australia has joined the international community in recognising the benefits of supporting families early to ensure that children have optimal growth and development opportunities (Oberlaid, 2004; Stanley, 2002). There has been increased research to generate knowledge to guide the development of strategic plans, policies and reviews relating to early childhood issues. This section briefly reviews key government initiatives and reports underpinning the process of early childhood reform in Australia (Appendix 1).

In 2002, the Australian Government invested in a study of 10,000 Australian children—the Longitudinal Study of Australian Children (LSAC)—that would inform children’s key developmental outcomes, how those outcomes were linked to environmental circumstances and which factors impacted on children’s development (Department of Families Housing Community Services and Indigenous Affairs, 2009; Nicholson & Sanson, 2003). LSAC has already generated reliable prevalence data that is used to guide targeted studies of specific risk factors (Jacobs et al., 2012). Its findings have also informed development of new health-related public policies and planning of relevant services (Leggat, 2004).

The knowledge obtained from studies such as LSAC guided several key policy documents, frameworks and guidelines that were developed to “ensure that by 2020 all children have the best start in life to create a better future for themselves and for the nation” (Commonwealth of Australia, 2009a, p. 4). The five reports discussed below outlined key strategies for the development of early childhood systems that engaged with and responded effectively to families. They shared a common concern with the existing level of professional competence and the urgent need for workforce development.

Child Health and Wellbeing Reform Initiative (Department of Health and Human Services, 2006). This review of the main service delivery models across Australia examined key elements involved in successful early childhood services. It identified four action areas likely to enhance quality support to families with complex needs and to improve child health and wellbeing: optimal quality antenatal care; headline indicators to monitor ongoing progress; common national child health care competencies; and the development of a consistent cross-sectional national approach to identifying and supporting targeted families. The review identified levels of professional competence as a significant contributor to services gaps and, therefore, an area requiring urgent attention.

National Early Childhood Development Strategy: Investing in the Early Years (Commonwealth of Australia, 2009a). The Strategy built on the recommendations from the *Child Health and Wellbeing Reform* report to guide a comprehensive national response to the needs of children and their families in the context of a continually changing Australian social landscape. Although the document identified early childhood workforce development as a significant determinant of successful service provision, it also predicted difficulties in achieving this, notably in relation to the need for a fundamental cultural change to resolve multiple workforce issues and build a capable workforce.

National Framework for Universal Child and Family Health Services (Schmied, 2011). The Framework built on the 2009 Reform Strategy to provide a structure for enhancing existing universal health services.

National Framework for Child and Family Health Services: Secondary and Tertiary Services (Australian Health Ministers' Advisory Council, 2016). This complemented and built on the universal platform of health services delivery outlined in the *National Framework for Universal Child and Family Health Services*. Both documents highlighted the importance of professional competence for successful intervention with all families, including Aboriginal and Torres Strait Islander families. It identified the following core service elements that defined a capable CFH workforce: monitoring and responding to needs identified through universal developmental surveillance; managing risk; identification and further assessment of child and family needs; targeted responses for families with complex needs.

Early Childhood Development Workforce Research Report (Productivity Commission, 2011). The Report provided information on the status and quality of professionals and paraprofessionals providing early childhood care and education and family support to over 1.5 million children in Australia. While acknowledging the post-registration and post-enrolment qualifications of a majority of CFH nurses, the Report concluded that “research is required to determine the optimal

mix of skills and qualifications in the child health workforce” (Productivity Commission, 2011, p. xxii).

These five policy documents shared a common purpose of informing and guiding early childhood reform through improved quality and better coordination of CFH services. The documents also warned about the lack of preparedness of the current workforce and highlighted the urgent need for relevant workforce development that would include an interprofessional education component.

1.2.4 Protecting Australian Children: A Public Health Approach

Costly authoritative responses to the increasing number of notifications of children at risk have not significantly reduced the incidence of abuse and neglect (Australian Research Alliance for Children & Youth, 2008; Moore & Skinner, 2010). The *National Framework for Protecting Australia’s Children 2009-2020* (Council of Australian Governments, 2009) endorsed a national public health approach that was to drive changes across all systems. It was expected to champion coordinated planning and sharing of information across States and Territories. It would also ensure the collection of extensive data to inform new service models and innovative practices (Hunter & Price-Robertson, 2014). These initiatives occurred at a time of global change in relation to services for children and their parents.

A public health approach to the protection of children that enhances families’ resilience, problem solving and coping skills has been suggested as a conceptual model of care for the prevention of the maltreatment of children (Australian Research Alliance for Children & Youth, 2008; National Scientific Council on the Developing Child, 2010b; O'Donnell, Scott, & Stanley, 2008). The model puts forwards a framework in which collaborative approaches and coordination of family support agencies are encouraged.

Skilled CFH nursing services are particularly well positioned to identify early risk factors that can compromise the safety of children and to deliver targeted interventions that increase the parenting capacity of families at risk. In addition, O’Donnell (2008) highlights the benefits of collaboration between CFH and specialist services. Active partnerships between universal CFH services and mental health (MH) and drug and alcohol (D&A) services would be advantageous to services and parents. MH & D&A services, which currently do not focus on the parenting role, could expand to include the needs of the children through an intersectoral approach including transfer of knowledge.

While the vast majority of parents are considered to have the capacity to bring up healthy children, some families experience temporary challenges that may leave them vulnerable for a period of time. There is evidence that targeted interventions delivered by coordinated and integrated services result in positive outcomes (Fox et al., 2015). A small number of families, however, struggle with their parenting responsibilities, especially with their capacity to keep their children safe from abuse and

neglect. In 2007-2008, 55,120 children were identified by the child protection system as at risk of harm (Council of Australian Governments, 2009).

While the child welfare movement drove important early childhood care reforms internationally and nationally, two of the three studies that compose the thesis, focus on mothers and nurses in New South Wales (NSW). The next section provides a context for studies 2 and 3 by describing the NSW Health-Supporting Families Early initiative established to promote, through a range of interventions and programs, the health and wellbeing of families during the perinatal period. As previously stated, the perinatal period, defined within the mental health concept, encompasses the pregnancy and the following two postnatal years (NSW Health, 2010a).

1.2.5 Families NSW-Supporting Families Early

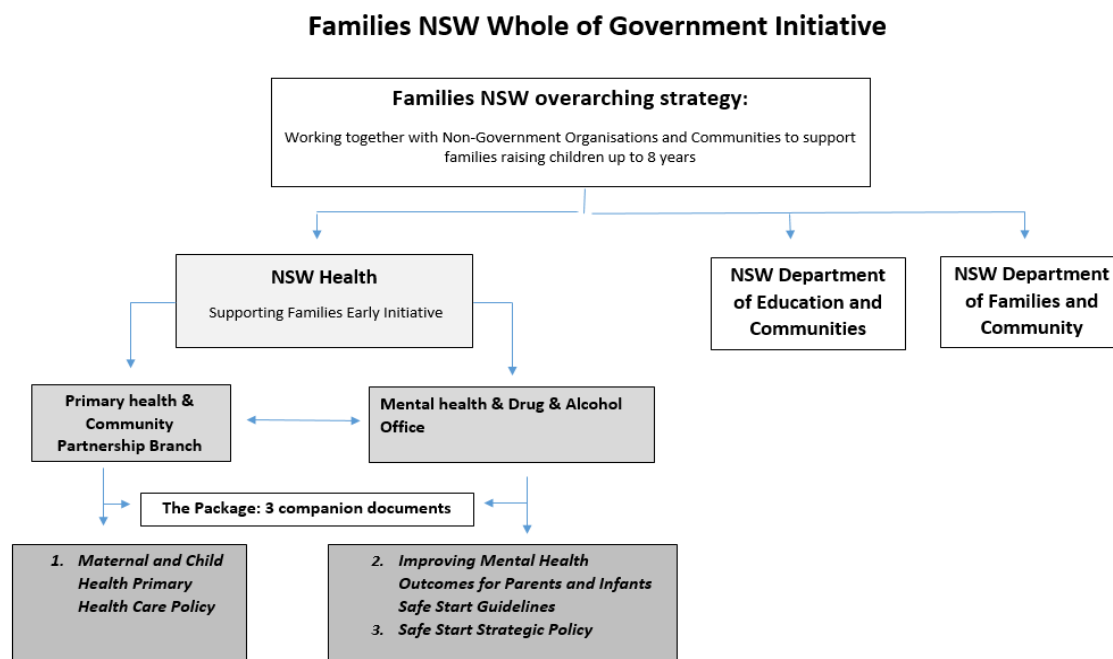
The NSW Government introduced the *Families NSW* strategy (initially called *Families First*) in 1999 (Fisher, Thomson, & Valentine, 2006) in response to concerns about the welfare of young children and the implications of early childhood experiences on children's health trajectory (Alperstein & Nossar, 2003; Thompson, Hoffmann, Fisher, & Turnbull, 2006). The *Families NSW* initiative was based on the understanding that, firstly, many of the factors that influence health reside outside of the health sector and, secondly, that poor health in turn leads to poor social and economic outcomes. This whole of government initiative was grounded in public health principles of prevention and early intervention to support families with infants and young children and to strengthen connections between communities and families (Hudson, 2000).

The responsibility of the NSW Department of Health within the strategy brought together the Primary Health and Community Partnerships Branch and the Mental Health and Drug and Alcohol Office to develop the Supporting Families Early initiative. Three companion documents underpinned the implementation of the Strategy:

- The *Maternal and Child Health Primary Health Care Policy* (NSW Health, 2010a), which identified a model for the provision of universal assessment, coordinated care and home visiting by maternity and CFH nursing services;
- The *Improving Mental Health Outcomes for Parents and Infants: Safe Start Guidelines* (NSW Health, 2010c), which outlined the rationale for psychosocial assessment, risk prevention/reduction and early intervention. It also proposed clinical pathways of care for the management of identified risks and described the broader roles of specialist services in addressing the needs of families with complex needs;
- The *SAFE START Strategic Policy* (NSW Health, 2010d), which outlined the core structure and elements required by specialist services, especially mental health services, to respond to the needs

of families with complex needs. The Safe Start program pertains to the clinical interventions and the services model of care that successfully support families with complex needs.

The three documents aimed to provide a robust foundation for nurses and midwives caring for families during the perinatal period (Fisher et al., 2006; Hudson, 1999, 2000). Figure 1.2 positions the Supporting Families Early Strategy within the Families NSW Initiative.



Figures 1.2 Families NSW: Supporting families early initiative

The *Maternal and Child Health Primary Health Care Policy* (NSW Health, 2010a) redirected the health monitoring of families in the early postnatal period from a predominantly centre-based CFH nursing service to a universal home visiting model complementing the centre-based program. The CFH nurse offered the family an initial home visit within two weeks of discharge from hospital. During the visit, a physical assessment of the newborn and a comprehensive assessment of the family's psychosocial needs were completed. In some cases, parents might volunteer information indicating that they are struggling with challenges that impair their ability to parent adequately and they would welcome extra support. In response, the nurse would encourage the development and implementation of a strengths-based care plan formulated with the parent. Depending on the nature of the family's needs, the nurse would provide a time-limited intervention or refer to local specialist services (NSW Health, 2010a) .

According to the policy, the successful implementation of the initiative depended on an accessible and skilled nursing workforce. It also assumed that all health professionals involved in the care of the

family, including specialist services such as MH and D&A workers, were accessible to and supportive of CFH nurses when families had complex issues such as mental illness or substance misuse (Wraith & Murphy, 2000).

The development and implementation of Safe Start in NSW took place alongside the release of the *Perinatal Mental Health National Action Plan* (beyondblue Perinatal Mental Health Consortium, 2008) and the accompanying *Clinical Practice Guidelines for Depression and Related Disorders* document (beyondblue, 2010). The Clinical Practice Guidelines were developed in response to the growing concern that postnatal depression had become a significant public health issue (M. Austin, Reilly, Milgrom, & Barnett, 2010; Hayes, 2010; The American College of Obstetricians and Gynecologists, 2015; Yelland, Sutherland, Wiebe, & Brown, 2009). Safe Start had two mandatory requirements for midwives and nurses: they would screen all women for psychosocial risks during the perinatal period and they would offer all families a home visit within two weeks of discharge from maternity services. The self-administered Edinburgh Depression Scale (EDS) (Cox, Holden, & Sagovsky, 1987a) was used to estimate the emotional state of the woman at the time of the psychosocial screening. The National Action Plan and the Clinical Practice Guidelines provided a strong stimulus to the implementation of Safe Start, especially in the key area of psychosocial screening.

Women identified with psychosocial risk factors would be encouraged to discuss their problems with the CFH nurse. The required level of family support and the nature of early interventions to promote positive parenting would be determined by a partnership process between the nurse and the mother. The Safe Start perinatal psychosocial screening targeted seven core variables, identified through a review of international studies, as significant in contributing to poor maternal and infant mental health (M. Austin & Priest, 2004; Belsky & De Haan, 2011; Carroll et al., 2005; Ferguson, 1998; Glover, 2011; National Scientific Council on the Developing Child, 2009b). These were: lack of support; major stressors in the past months; low self-esteem; history of anxiety, depression or other mental health problems; couple's relationship problems; adverse childhood experiences; and domestic violence (NSW Health, 2010a, p. 41). Theoretically, midwives and nurses were expected to identify families at risk of limited parenting capacity because of psychosocial challenges. However, concerns were raised about the nurses' ability to enquire sensitively, translate scores into nursing diagnoses and implement appropriate responses (M. Austin et al., 2010; Hayes, 2010; McCauley et al., 2012; Rollans, Schmied, Kemp, & Meade, 2013a; Yelland et al., 2009). This issue is explored in more detail in Chapter 2.

1.3 Aim and Significance of the Study

I was inspired to undertake this study in the wake of several career changes that led me to shift my professional interests from psychiatry to maternal and child health and from hospital- to community-

based nursing. As the importance of perinatal mental health⁵ care (M. Austin & Priest, 2004; M. Austin et al., 2010; beyondblue Perinatal Mental Health Consortium, 2008) was increasingly recognised, my training as both a mental health nurse and a midwife led to a number of opportunities in community health care services.

The Richmond Report (Australian Health Ministers Conference and Community & Disability Services Ministers Conference, 2006; Richmond, 1983) resulted from an inquiry into the institutional care of mentally ill and disabled people in NSW. The report advocated a decentralised, integrated model of care and support for psychiatric patients, most of whom were receiving long-term treatment in large institutions. Housing, employment, social inclusion and reduction of stigma were targeted along with health issues. Hospital beds were to be progressively closed and funding for comprehensive community services was to be increased. Acute psychiatric community interventions and follow-up were expected to lead to improved health outcomes. An enormous shift in knowledge and skills would be needed to prepare the workforce to meet the challenges of the new model of care (Korhonen, Vehvilanen-Julkunen, & Pietila, 2007). A change in the culture of professionals was also important for the effective delivery of community-based treatment to mentally ill people and their families (Owen, 2008; Williams & Smith, 2008).

Working with mentally ill adults in their home environment requires a socio-ecological approach, seeking out the support of families and significant others to enhance the person's resilience and prevent future relapses (Richmond, 1983). This model of care brought to light the existence of children, sometimes referred to as the "hidden children", who were in the direct and often constant care of mentally ill parents, usually mothers (AICAFMHA, 2001; Fudge & Mason, 2004; Maybery & Reupert, 2006). Mental health professionals, often unaware that their clients were also parents, did not routinely enquire about children. The growing awareness of the unique needs of parents with a mental illness and their children brought about significant new resources such as the Children of Parents with a Mental Illness (COPMI) initiative funded by the Australian Government since 2001 and targeting school age children and adolescents (AICAFMHA, 2001; Commissioner for Children and Young People WA, 2015; Owen, 2008). It also generated new research on the needs of the families and on the educational preparedness of professionals involved in the care of parents with mental health issues. Research findings (Maybery & Reupert, 2006; Maybery, Reupert, & Goodyear, 2006; Owen, 2008) consistently reported professionals' limited ability to assess parenting capacity and to work within the recovery model for mental illness.

⁵ Perinatal is defined in the mental health context as encompassing pregnancy and the first two years postpartum (NSW Health, 2010a, p. 56).

The Australian Infant, Adolescent and Family Mental Health Association (ICAFMHA) had also commissioned a scoping project (AICAFMHA, 2001) to identify the scale of the COPMI problem. Available statistical information was generally sparse and data relating to the 0-3 years age group were non-existent. Nevertheless, Australian data suggested that 21-23% of children under the age of 18 had at least one mentally ill parent, equating to around 300,000 children in NSW (Cowling 1999; Huntsman, 2008; Mayberry, L, Szakacs, & Reupert, 2005). A 2013 Western Australian retrospective population study (O'Donnell et al., 2013) reported a prevalence rate of mental illness in new mothers of 131 per 1000 births, a significant increase from 76 per 1000 births recorded in 1990. Prevalence rates were highest for mothers with a diagnosis of substance use disorder, depression, self-harm, neurotic disorders, adjustment and stress-related disorders (O'Donnell et al, 2013).

Mayberry and Reupert (2006) in their review of the workforce's capacity to respond to children whose parents have a mental illness asserted that those families were exposed to a fragmented approach to service delivery, with some services focussing on parents while others focused on the child. One critical study finding was the existence of significant knowledge and skills deficits among mental health professionals working with patients who were parents, notably in relation to: assessment of parenting capacity; provision of reliable parenting advice; knowledge of child development; and ability to recognise the impact of the illness on the child's growth and family wellbeing and to talk to the parent about the issue.

My long-term professional involvement as clinician, manager and educator in the COPMI and perinatal mental health movement led to ongoing participation in policy development within the Supporting Family Early initiative. It also involved some input into postgraduate education, including review of a CFH nursing curriculum. These undertakings generated reflection on the changed practice landscape of pregnancy and early childhood for all nurses working with families during the crucial perinatal period. I was curious about the inter-relationships between primary health care models that integrated health and mental health and the competencies required to translate them into practice. My initial assumption, as an insider involved in policy reform, was that existing education programs would mirror what I believed to be clearly defined workforce needs arising from significant changes in service models over the past 15 years. Closer observation, however, showed that the development and implementation of the Safe Start program, in which I had a particular interest, had not occurred in synergy with the review and update of existing course content that was necessary to enhance relevant nursing knowledge and skills. Accordingly, I challenged my assumption that CFH nurses were educationally well prepared to work safely and competently with families with complex needs during the perinatal period. I became convinced that an exploration of the expected knowledge, skills and attributes of CFH nurses working with families with complex needs would give me a greater understanding of a new nursing practice. This understanding would inform the review of existing

nursing curricula and the development of new curricula for nurses practising in the field of early childhood.

A review of the literature revealed a broad body of international and national research, with a strong focus on service delivery and practice principles (Cowley et al., 2013). It brought to my attention the complex and diverse professional backgrounds of clinicians who support families in primary health care settings. At the same time, I encountered unexpected difficulty in recruiting specialist nurses to participate in the study. What emerged was a complex picture in which nurses involved in the care of families with complex needs were not a homogenous group. Rather, they came from several professional nursing backgrounds, including specialist fields of expertise such as midwifery and mental health. Thus the need to identify the core competencies necessary for CFH nurses to achieve optimal health outcomes for families with complex needs during the perinatal period was indicated. The research inquiry would also expand into the domain of interprofessional education and practice, as strongly recommended in the literature (Burton, Hammick, & Hoffman, 2010; Kuipers, Ehrlich, & Brownie, 2014; Moore, 2008c; Tucker, Strange, Moules, & M'hagan, 2002).

In summary, I was motivated to undertake this research by my realisation that existing CFH nursing education programs might not be preparing nurses adequately for the multiple challenges involved in working with families with complex needs during the perinatal period. The role of nurses in the implementation of Safe Start was the catalyst that led me to examine the general competence level of all relevant nurses in order to inform curriculum review and development. Competence is herein defined as “the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area” (Nursing and Midwifery Board of Australia, 2010).

The aim of the research was to explore the core knowledge, skills and attributes required by RNs working with families with complex needs during the perinatal period. The research’s specific objectives were to identify gaps in CFH nurses’ knowledge and skills, generate insight into the level of expertise at which these nurses practise and investigate the potential benefits of interprofessional education in the implementation of early childhood and child protection reforms. It was anticipated that the findings would inform future curriculum development

1.4 Research Questions

- What knowledge, skills and attributes are required from RNs to provide adequate support to families with complex needs?
- Should registered nurses working with families with complex needs practise at an advanced level?

- Are there any benefits in interprofessional education for RNs working with families with complex needs during the perinatal period?

Three studies were designed to address the research questions. Study 1 sought consensus from National and International experts, Study 2 explored the experiences of mothers who received extended nursing care and Study 3 elicited CFH nurses' perspectives based on their personal experiences., Study 1 gives an understanding that even though the research was based upon clinicians and women in NSW, it had a national and international focus on a global concern for families with complex needs during the perinatal period.

1.5 Organisation of the Thesis

This chapter has presented the research background and context, explained the motivation for the study and stated the research questions, aims and objectives.

Chapter 2 provides a comprehensive review of relevant literature, notably literature related to the knowledge, skills and attributes required of nurses working with families with complex needs during the perinatal period, their practice level and the benefits of professional education.

Chapter 3 explains the choice of research design, identifies the ethical considerations that informed the implementation of the three studies, and describes the procedures that were followed for data collection, management and analysis in each study.

Chapter 4 presents the results of Study 1, Seeking Expert Consensus. This study used the Delphi technique to: draw an expert consensus on the core knowledge, skills and personal attributes expected from nurses working with families with complex needs during the perinatal period; determine if there was an expectation that these nurses were practising at an advanced level; and seek expert opinion on the role of interdisciplinary education to best meet the complex needs of these families. The findings from Study 1 provided a platform for Studies 2 and 3 by identifying priorities and core elements in child and family nursing knowledge, skills and personal attributes.

Chapter 5 presents the findings from Study 2, which involved interviews with mothers who received nursing interventions during the perinatal period.

Chapter 6 presents the findings from Study 3, which involved interviews with nurses who provide specialist interventions to families identified with complex needs during the perinatal period.

Chapter 7 triangulates the findings from the three studies, discusses their implications for clinical practice and education and concludes with recommendations for future research.

1.6 Conclusion

This chapter has contextualised the study in relation to key policy developments in Australia and internationally. It has explained the motivation for the project, presented the research questions, aims and objectives, and outlined the organisation of the thesis.

The following chapter reviews relevant literature in order to identify what is known about the existing knowledge and skill sets of nurses working with families with complex needs, what the latest research in the field of early childhood tells us about the educational requirements for an effective, skilled workforce and what gaps have been identified.

Chapter 2: Literature Review

This chapter presents a review of literature relevant to the three research questions. It examines key concepts that are central to the care of families with complex needs during the perinatal period and the models of care adopted by CFH nurses. Research on nursing competence in relation to the care of families with complex needs is examined and the relevance of interprofessional education to CFH nurses is appraised.

2.1 Search Strategy

The search was conducted between 2010 and 2015 using the following databases: OvidSP, ERIC, CINAHL, ProQuest Central and Informa Healthcare. Primary search terms included: nursing, early childhood⁶, child family health nurse, public health nurse, home visitors, competence, competency, expertise, capabilities, curriculum development, vulnerability, vulnerable families, complex needs, high-risk families, advanced practice, interdisciplinary education. A focused snowball review of reference lists was conducted in 2015 to ensure the most up-to-date high relevance sources were captured and analysed.

The search parameters were set to include only English language material from the last 15 years from both governmental and non-governmental sources. These included professional practice frameworks and position statements, reviews, policies and guidelines, reports, theses, conferences and other documents that helped to position the evidence within current nursing practice.

Some 124 articles were initially read to assess their relevance. Articles that focused solely on early childhood service models were excluded if they failed to mention nursing roles, competencies or curricula. While the generic/competency/competence/capability literature provided a plethora of articles, few manuscripts focused on CFH nursing competence⁷ in the Australian context. A large number of studies, however, examined specific aspects of CFH nursing knowledge and skills. Articles that included families' perception of nurses' knowledge and skills were also included. Sixty-six manuscripts, including 52 journal articles, met the inclusion criteria and were retained for analysis. The 66 manuscripts were graded according to high, medium and low levels of relevance and quality

⁶ The term 'early childhood' was used for the search rather than 'perinatal period' to avoid confusion between the traditional definition of the perinatal period (8 weeks postnatal) and the definition used in this thesis (the developmental phase from conception to 24 months).

⁷ In this thesis competence is defined as knowledge, skills and attributes.

and 34 manuscripts⁸ were graded as of high relevance hence, suitable for the review (Appendix 2). Figure 2.1 shows the four steps of identification, screening, eligibility and inclusion that were used to select the manuscripts included in the literature review.

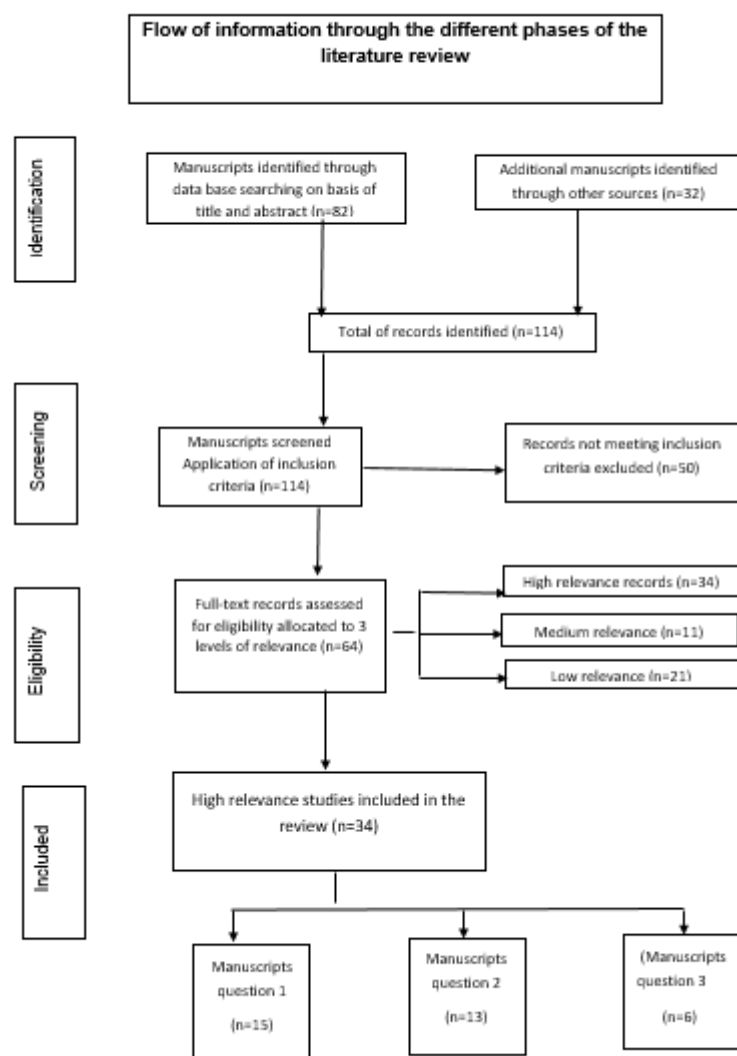


Figure 2.1. Flow diagram of study selection. Adapted from the PRISMA statement (Liberati et al., 2009, p. 68).

⁸ The 34 manuscripts included 17 from Australia, 5 from UK, 6 from Canada, 4 from USA, 1 from Spain and 6 from OECD.

2.2 Key Concepts

This section discusses a number of concepts that are central to understanding the role of CFH nurses in their work with families with complex needs. These concepts are maltreatment, adversity, risk and resilience, vulnerability and families with complex needs. Factors that impact on family functioning are examined.

2.2.1 Maltreatment, Adversity, Risk and Resilience

Concepts of maltreatment, adversity, risk and resilience are important as they contextualise the role of CFH nurses in promoting the health, wellbeing and safety of children and their parents. A sound understanding of their interrelationships is essential to identify families exposed to adversity, to measure and assess risks and to formulate interventions that protect children against maltreatment and enhance the family's resilience by reducing adversity (Benedetti, 2012; NSW Government, 2009, 2013; O'Donnell et al., 2008).

According to the World Health Organisation's definition:

Child abuse or maltreatment constitutes all forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (Butchart, Phinney Harvey, Mian, & Furniss, 2006a, p. 6).

Adversity is defined as "experiences of life events and circumstances which may combine to threaten healthy child development" while risk is defined as "the chances of adversity translating into negative outcomes for children" (Daniel, 2010, p. 233). In contrast, resilience refers to the "dynamic process encompassing positive adaptation within the context of significant adversity" (Luthar, Cicchetti, & Becker, 2000, p. 543).

These concepts, while routinely used in government and non-government documents relating to the protection of children, have been challenged, with critics arguing that they lack definitional clarity and rest on underlying assumptions about the relationship between exposure to adversity and negative outcomes (Mohaupt, 2008) (Daniel, 2010; Irenyi, L, Beyer, & Higgins, 2006; Munro, Taylor, & Bradbury-Jones, 2014; Taylor, Baldwin, & Spencer, 2008). It has been suggested, for instance, that a majority of children and adults are able to succeed in spite of exposure to significant adversities and that the presence of risk does not necessarily lead to child abuse or neglect (Lamont & Price-Robertson, 2013; Rutter, 2012). Others have questioned the assumption that individuals respond to extreme stress and adversity in a similar manner (Bromfield & Holzer, 2008). Rutter (2012) argues that resilience is an interactive concept characterised by vast individual differences in response to exposure to environmental adversity. In some circumstances, people exposed to distressing situations

may even increase their resistance to future stress through the “steeling“ or strengthening effect (Rutter, 2012, p. 341).

2.2.2 Family Vulnerability

It has been well documented that differences in socio-economic status translate into inequalities in physical, socio-emotional and language-cognitive domains of child development (Harris & Wells, 2016; Hertzman et al., 2010; Karoly et al., 2005; McCain & Mustard, 1999). While low socio-economic status does not automatically mean poor child and family outcomes, socio-economic disadvantages are more likely to impact negatively on family functioning and children’s life opportunities (Moore et al., 2015; Winson, 2007). Vulnerable families are sometimes referred to as “hard to reach families” (Rollans, Schmied, et al., 2013a). This label has been criticised, however, because it seems to imply that families are responsible for not accessing services rather than that services experience difficulty engaging and retaining specific groups of parents (Centre for Community Child Health, 2010). Engagement issues may have multiple causes relating to services themselves, barriers at family level and relational barriers (Carbone, Fraser, Ramburuth, & Nelms, 2004; Jordan & Sketchley, 2009; Woodhouse, Brown, Krastev, Perlen, & Gunn, 2009). Some common obstacles to engagement with families include: services not meeting the parents’ needs; rigid eligibility criteria; inflexible service models; day-to-day family stresses that limit the parents’ ability to keep appointments; insensitive, judgmental attitudes; parental fear of child protection services; and a lack of trust and confidence in the services (Carbone et al., 2004; Jordan & Sketchley, 2009).

To add further complexity, the term vulnerability itself is not easily defined. Despite its frequent use in the literature, it has different meanings to different writers who wish to demonstrate particular perspectives of the concept. For instance, the definition of vulnerable families used by NSW Health (2010c) in its Supporting Families Early initiative emphasises the impact of family problems on the need for specialist intensive interventions:

Families that, because of current circumstances and or life history and personality vulnerabilities, are likely to require specialist and intensive response from a number of services and or agencies (NSW Health, 2010c, p. 19).

Similarly, Paton et al. (2013) emphasise individual maternal characteristics such as teenage motherhood, low maternal educational status, low socioeconomic status, substance abuse, Aboriginality, refugee status, domestic violence, maternal mental illness and disability.

In contrast to this focus on individual problems and weaknesses, others adopt a socio-ecological approach. For example, the Centre for Community Child Health (2010, 2011) and the Australian Raising Children Network (2014) define vulnerability in terms of external experiences within social

and physical environments that enhance or impair families' strength and resilience. Their definitions focus on external characteristics that create risk for families but do not define them:

Marginalised and vulnerable families refer to those who are receiving little support in their family and parenting roles either from personal support networks or from community-based support services (Centre for Community Child Health, 2010, p. 1).

Sometimes, the wellbeing of families and children might be threatened by individual, parental or family circumstances. We call these 'vulnerabilities'. It means that something about the child, parent or family is creating a risk of poor physical or mental health (Raising Children Network, 2014).

Other terms used to identify vulnerable families (Mulcahy & McCarthy, 2006; Scott, 2010) include high-risk families (Marcellus, 2005), families with complex needs (NSW Health, 2010c), marginalised and disadvantaged families (McDonald, 2010; Paton, Grant, & Tsourtos, 2013), families that are vulnerable and at-risk (Fraser et al., 2014; Kemp, Anderson, Travaglia, & Harris, 2005) and high-priority families (Moules, MacLeod, Thirsk, & Hanlon, 2010). Although the term 'vulnerable' is most commonly used to define this specific population group, in this thesis the expression 'families with complex needs' is preferred since it more accurately captures the research focus on families that are not only exposed to vulnerabilities but are also experiencing multiple challenges.

The concept of vulnerability in families is often linked with the risk of child maltreatment and the consequent need for child protection. A public health model to prevent child maltreatment by providing extra support to families is discussed.

2.3 A Public Health Model to Support Families with Complex Needs

While more research is indicated to clarify the concepts of adversity, risk and resilience (Glaser, 2000; Hunter, 2012; Munro et al., 2014), there is widespread agreement that when families become vulnerable because of complex needs, their children may be at risk of maltreatment (Price-Robertson et al., 2014). All developed countries have their own individual child protection systems⁹ but those systems share a common characteristic: to be effective, they depend on well-developed inter-agency cooperation and communication (Katz & Hetherington, 2006). Prevention of child maltreatment can be approached in two different ways. The child protection approach, more prevalent in English-speaking countries, relies heavily on the legal system and the mechanism of mandatory reporting laws to rescue children. In contrast, European countries seek to ensure the safety of children by using a holistic approach to support the whole family and restrict use of the court system to extreme cases (Katz & Hetherington, 2006).

⁹ In Australia child protection systems vary from state to state and from territory to territory.

Australia has always had a child protection orientation that relies heavily on risk assessment and tertiary intervention responses¹⁰. The challenge faced by the overloaded child protection system is that a majority of notifications concern families experiencing chronic adversity. Those families, usually welcoming of extra support, can be traumatised by statutory interventions, resulting in lack of trust and engagement with services originally designed to protect them (O'Donnell et al., 2008).

In recent years, a national public health model for the support of families and the prevention of child maltreatment has been put forward as a more effective option to the crisis-focused, resource-intensive and ineffectual traditional child protection system (Council of Australian Governments, 2009; Jordan & Sketchley, 2009). This approach, while recognising that all families require extra support during the perinatal period, also acknowledges the importance of targeted interventions that can prevent intergenerational transfer of vulnerabilities (Butchart, Phinney Harvey, Mian, & Furniss, 2006b; Fox et al., 2015).

The World Health Organisation's public health model has been described as:

a concept with currency in many disciplines, including health, education and welfare. It is an epidemiological model that attempts to prevent or reduce a particular illness or social problem in a population by identifying risk indicators. Public health models aim to prevent problems occurring in the first place by targeting policies and interventions at the known risk indicators for the problem, quickly identifying and responding to problems if they do occur, and minimising the long-term effects of the problem (2006b, p. 13).

The public health approach, rather than focusing on categories of parents with particular behaviours that lead to child maltreatment, conceptualises all parents as moving along a continuum of needs. The complexity of those needs increases with the varying levels of risk and protective factors (Mullan & Higgins, 2014).

This section elaborates the key principles underpinning the public health model, namely: the use of screening tools to guide prevention and early intervention strategies; the tiered model of universal, targeted and treatment services; the collaborative integrated model of care; and the use of approaches that are strength-based, family-centred, child-focused.

2.3.1 Screening for Risk Factors

Although no single risk factor can be established as a predictor of child maltreatment, there is evidence that a complex interaction of risk factors occurring at different levels can lead to parental maltreatment of a child (Irenyi et al., 2006; Peters & Barlow, 2003; Rutter, 2012) (see Chapter 1,

¹⁰ In 2005/2006 there were 266,755 notifications of suspected abuse and neglect in Australia, almost nine times the number reported in England (O'Donnell et al., 2008, p. 325).

Figure 1.1). A prevention and early intervention approach that provides both early identification of families with risk factors and timely, accessible and effective interventions to support families and enhance parenting capacity requires reliable screening tools that can accurately identify high risk families (Munro et al., 2014; O'Donnell et al., 2008).

Australian policy documents strongly encourage psychosocial screening programs using the platform of CFH services to identify families deemed “at risk” (M. Austin et al., 2010; beyondblue Perinatal Mental Health Consortium, 2008; NSW Health, 2010a). Findings from risk research and international longitudinal studies in Australia and elsewhere have been used to develop screening tools that inform the weighing up of probabilities and make predictions about the likelihood of harm to children occurring (Australian Institute of Family Studies, 2002; Colvert et al., 2008; Cooklin, Donath, & Amir, 2008; Ferguson, 1998; Glover, 2011; Mullan & Higgins, 2014). These instruments have been adopted by CFH services as a means of identifying women with psychosocial issues associated with unfavourable postpartum outcomes, including child safety issues (M. Austin & Highet, 2011; M. Austin et al., 2010; Higgins, 2015; NSW Health, 2010d; Scott, 2013; Taylor et al., 2008).

There are a number of widely accepted screening tools for a range of risk factors including substance misuse (Taplin, Richmond, & McArthur, 2015), domestic violence (Australian Institute of Health and Welfare, 2015), and maternal mental illnesses such as depression and suicide risk (Cox, Holden, & Sagovsky, 1987b). Examples include the NSW Safe Start psychosocial questionnaire (NSW Health, 2010a), the Edinburgh Depression Scale (EDS) (beyondblue, 2010; NSW Health, 2010a) the Canadian Antenatal Psychosocial Health Assessment tool (Midner, Carroll, Bryanton, & Stewart, 2002) and the Australian Antenatal Risk Assessment Questionnaire (ANRQ) (Reilley et al., 2015).

Risk assessment, however, is not without its critics. Taylor, Baldwin and Spencer (2008) argue that most models of risk prediction are based on imprecise science with ethical, methodological and theoretical challenges. They contend that, while most parents want the best for their children and usually know when they need help, too often they cannot access it. Accordingly, they argue that policies that encourage screening for risk factors should also improve social justice and enhance favourable environments that strengthen families by initiating support during the perinatal period. They further caution about potential consequences of predictive screening. They ask whether clinicians can guarantee access to effective interventions that address individual behaviours and environmental adversities once parents are informed about specific risk factors. They also question whether parents are informed about potential harmful consequences resulting from punitive interventions that erode parental trust and self-efficacy. These writers conclude that, while predictive tools continue to be used, they should not replace sound professional judgement based on evidence and expert knowledge.

Two systematic reviews of predictive tools for child maltreatment (Daniel, Taylor, & Scott, 2010; Peters & Barlow, 2003) reported limited accuracy and inconsistent indications of how to recognise direct signals identifying children's safety needs. Daniel et al. (2010) examined 74 assessment tools across 63 studies. The findings indicated a broad range of inconsistencies and variations between the tools that did not allow for comparisons. The most reliable tool identified in the review had a positive predictive value of only 48%, meaning that over 50% of families were wrongly identified as being at risk of harming their children. Both reviews raised the ethical dilemma of stigmatising families in the absence of demonstrated effective interventions.

The human issues of communication, trust, relationships and anxiety are identified throughout the literature as impacting negatively on the accuracy of risk assessment (Benedetti, 2012; Cooper, Heterington, & Katz, 2003; Daniel et al., 2010; Huntsman, 2008; Munro et al., 2014). The way parents perceive risk to their children can be strikingly different to professional interpretations. In addition, the risk of having their children removed from their care in the near future is most alarming to parents who may not have the ability to envisage future long-term harm. Those parents, often marginalised and distrustful of outsiders, are fearful of human services. Consequently they are known to reject services and offers of support to avoid separation from their children (Huntsman, 2008).

In a qualitative study examining the effectiveness of a formatted health needs assessment tool (HNAT) in prioritising nursing workload, Cowley and Houston (2003) found that home visitors in the UK did not use the tool in the way that had been anticipated. The nurses had been encouraged to use open-ended questions and a conversational style when parents disclosed sensitive events or situations. Instead, a majority of nurses used the tool as a 'checklist', asking direct questions rather than listening to parents. Subsequently, some women's responses indicated fear, discomfort and increased stress levels. Similar findings were reported in an Australian ethnographic study (Rollans, Schmied, Kemp & Meade, (2013; 2013a; 2013c) in which the process of psychosocial risk and depression screening by midwives and CFH nurses was observed. While some women in the study reported mixed feelings about the questions asked, the quality of their experiences was closely connected to clinicians' communication skills, especially their ability to conduct the conversation in a sensitive manner.

These studies indicate that the use of risk assessment tools can be flawed, with potential negative outcomes for families. At the same time, there is growing awareness that these tools are being used at the expense of professional competence; they may, in fact, replace critical thinking and decision-making. Gillingham (2011), for instance, identified potential unintended consequences of health organisations favouring the use of decision-making tools at the cost of professional judgement and expertise. His ethnographic study showed that they were used as accountability tools rather than as instruments to guide critical thinking and decision-making. While acknowledging that such tools are

helpful in providing novice clinicians with an assessment framework, Gillingham warns that they cannot replace professional expertise.

In the past decade, the literature on risk and protection has undergone a paradigm shift in which professionals' attention has been redirected to positive outcomes in spite of exposure to significant adversities (France & Uttling, 2005; Mohaupt, 2008; Rutter, 2012). France and Uttling (2005, p. 80) described protective factors as "consistently associated with good outcomes for children growing up in circumstances where they are otherwise heavily exposed to risk" (p. 80). While there is still limited understanding of how protective and risk factors interact to protect the child, there is evidence that strong parent-child relationships and positive family and community support networks enhance family resilience and coping skills (Lamont & Price-Robertson, 2013). Although still in its infancy, the protection literature provides a framework for the strength-based model of practice that is discussed later in this section.

2.3.2 Tiered Model of Service Provision

This section outlines the conceptual model of service provision that underpins the public health approach. This three tiered model comprises: primary level services, which are the platform for universal prevention activities; secondary level services delivering targeted prevention and early intervention programs; and tertiary level services focused on identified cases of child maltreatment (see Figure 2.2).

Despite a general consensus on the benefits of a public health model underpinning CFH models of care (Moore & McDonald, 2014), it has been suggested that Australian CFH services are still fragmented, poorly coordinated and program-focused and that they tend to respond to crises once they have occurred (Fox et al., 2015; Valentine & Hilferty, 2012). Notwithstanding such criticisms, the International Council of Nurses (2012) has argued that 21st century primary health care nurses have a pivotal role to play in leading essential health services reforms, suggesting that "it is imperative for the reform that nurses' skills and abilities are harnessed and maximised" (p. 10).

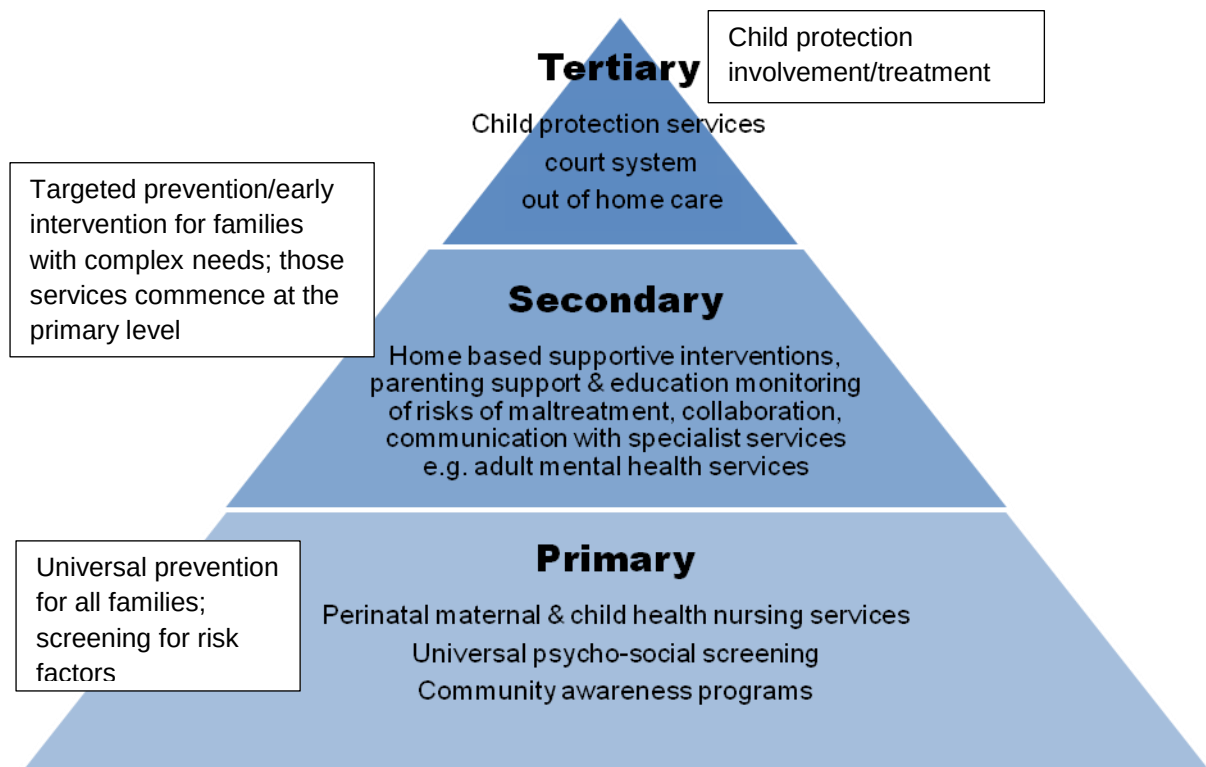


Figure 2.2. Diagrammatic representation of the public health model for a holistic approach to the prevention of child maltreatment. Adapted from Bromfield & Holzer (2008).

2.3.2.1 Prevention and early intervention

The scientific evidence from early childhood studies and the unsustainable cost of existing reactive interventions¹¹ were the main factors driving the redirection of services to a model of prevention and early intervention. In their review of research and practice for prevention and early intervention, Fox, Southwell, Stafford, Goodhue, Jackson and Smith (2015, p. 104) described the key elements of effective CFH service models as: being built around the child while responding to the family's needs; addressing potential problems before they happen; recognising and responding early to short-term and long-term issues; building family capacity; and measuring outcomes to ensure that interventions worked. According to France and Uttling (2005), if inclusive, flexible, family-centred programs supported by sound evaluation principles and research are to be effective, they need to be embedded within universal services.

Early childhood services are traditionally structured within a three tier system, as illustrated

2.3.2.2 Universal, targeted and treatment services

¹¹ In 2003 the long-term annual human and social cost of child abuse and neglect in Australia was estimated at approximately two billion dollars (Valentine & Hilferty, 2012).

in Figure 2.2. Primary level services (also referred to as universal services) are inclusive and non-stigmatising core health care services that promote health and wellness and are accessible to all families. Targeted or secondary services apply to a sub-group of families categorised as vulnerable because of identified risk factors. Treatment or tertiary services deliver long-term specialist interventions to families that meet specific criteria (Moore, 2008b; Schmied, 2011). Although long-established, the effectiveness of this model has been challenged by reported increases in poor health and wellbeing outcomes among children and young people (Commonwealth of Australia, 2009a; Karoly et al., 2005; Stanley et al., 2005).

Universal or primary level services are considered to be fairer and less stigmatising because they are offered to all families with young children. In theory they provide a structure within which to engage with parents, identify emerging issues and facilitate access to specialist services (Oberlaid, Baird, Blair, Melhuish, & Hall, 2013). Nonetheless, it has been argued that parents with complex needs often fail to engage with them (Daro, 2010b; J. Watson, White, Taplin, & Huntsman, 2005). Oberlaid et al. (2013) identified the following barriers to the implementation of effective universal services: competition between universal and targeted services for scarce resources; poor communication between early childhood professionals and specialist services; variable access to targeted services; and professionals' lack of conceptual understanding of the ecological model of child development.

Moore (2008b) argued that targeted services delivered within the universal service platform or by secondary level services are often risk-based and rely on professionals making decisions using specific selection criteria such as the Edinburgh Depression Scale (Cox et al., 1987b) or families' characteristics such as maternal age, mental illness, or past history of child maltreatment. Moffatt and Fish (2013) highlighted the difficulty in accurately determining eligibility for those interventions which could result in potential exclusion and inclusion errors. Another issue identified in the literature is the poor retention rate of families with complex needs in particular programs (Carbone et al., 2004; Huntsman, 2008; Moore, 2008b).

Tertiary level treatment services were found to be effective when tailored for small population groups with severe chronic issues (Karoly et al., 2005; Macvean et al., 2013; Shuhman, Foote, Eyberg, Boggs, & Algina, 1998). However, they were also found to be resource-intensive, with limited specialist access and a propensity to intervene when families were experiencing serious long-standing health issues (Moore, 2008b).

One suggested approach to the development of fairer, more effective models of service delivery is based on the concept of a health gradient. This is based on the premise that poorer people have poorer health because they have limited access not only to health services but also to housing, income and education (Marmot et al., 2008). The difference between the most and the least healthy in the population is called the health gap; on a graph, the health gradient represents the trajectory between

low socioeconomic/poor health status and high socioeconomic/high health status (Macdonald, Beeston, & McCullough, 2014; Marmot et al., 2010; Moffatt & Fish, 2013). The model of proportionate universalism—defined as “resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need” (Macdonald et al., 2014, p. 3)—is proposed as an effective strategy to reduce the social gradient in health. This model retains the universal approach but introduces a scale and intensity proportionate to the degree of need with a focus on improving the health of the most disadvantaged. The advantage of proportionate universalism is that it combines the strengths of traditional universal and targeted services (Cowley et al., 2013; Fox et al., 2015).

There is international agreement that a shift from treatment to a universal prevention approach is essential. Benedetti (2012) emphasises the importance of enhancing the capacity of universal services to increase their inclusiveness, accessibility and flexibility in order to reach a broader group of families with more diverse needs. In addition, Moore (2009) highlights the need for universal services to move from a risk-based approach to a response-based model of intervention.

A 2015 study explored how health and other professionals viewed the challenges and opportunities of implementing the Australian government’s *National Framework for Universal CFH Services* (Australian Government Department of Health and Ageing, 2011). Schmied et al. (2015) recruited participants from five Australian professional organisations—the Australian College of Midwives, the Maternal and Child Health Nurses of Australia, the Royal Australian College of General Practitioners, the Australian Practice Nurse Association and the Australian Medicare Local Alliance. Some challenges and inconsistencies were anticipated because of the complex national system of health care provision involving eight states and territories, a federal government and local government authorities. There was, however, congruence in the perspectives of all the professional groups, who reported consistently poor communication between fragmented services resulting in variable continuity of care and limited sharing of information between maternity and community services. Nursing workforce numbers and capacity- and skills-related issues limited the ability of CFH nurses to meet policy expectations and there was a general lack of clarity about role definitions. Most participants believed that collaboration and standardisation were essential for effective implementation of the National Framework. Key recommendations from participants included co-location of services, nurse liaison positions, regular multidisciplinary meetings and the introduction of interprofessional learning.

According to the literature review, services based on a public health model must be collaborative, integrated, strength-based, family-centres and child-focused to be effective.

2.3.2.3 A collaborative, integrated model of service delivery that is strength-based, family- centred and child-focused

There is ample evidence internationally and in Australia that a collaborative, integrated model of services delivery to support families during the perinatal period is essential for optimal health and social outcomes (Allen Consulting Group, 2009; Carbone et al., 2004; Council of Australian Governments, 2009; McCain & Mustard, 1999; McCain et al., 2011; Moore, 2008c; Moore & McDonald, 2014; Schmied et al., 2010). In their study of the European approach to integrating services for children, Katz and Hetherington (2006) reported two dominant cross-national themes: working together at professional and agency level and maintaining a focus on the family as a whole. Similar findings were reported from analyses of the Cuban *Educa a Tu Hijo* (Educate your child) CFH system (Keon, 2009; Tinajero, 2011). The Cuban program is universal, community-based and family-centred. It integrates health and education into a single service provision system that operates from the antenatal period up to five years of age. The program's objective is to achieve an optimal level of child development by engaging the active participation of parents through home-based and community education (Tinajero, 2011). Regular ongoing program evaluations indicated that, in Cuba, only 13 % of children reach school age with cognitive, socio-personal and motor skills issues, a figure that is half of the Australian and Canadian rates (Hertzman et al., 2010; Tinajero, 2010). Tinajero (2010) suggested that the participation of all sectors of society in the delivery of the program ensures its success and sustainability. However he also acknowledged that the Cuban political model—one political party and an autocratic centralised government—might not allow for replication in other countries.

Limited collaboration and integration of key services and agencies involved in the support of families, especially families with complex needs, during the perinatal period has been reported (Homer et al., 2009; Kruske, Barclay, & Schmied, 2006; Schmied et al., 2010; Valentine & Hilferty, 2012). From a review of models of collaboration in Australian primary health care settings between midwives, CFH nurses and general practitioners, Schmied et al. (2010) reported high levels of inconsistency in service models. They were fragmented across disciplines and agencies and were found to impede the ability of professionals to meet families' needs. Other studies (Homer et al., 2009; Kruske et al., 2006) indicated that universal services relied on referrals to other services or agencies with limited participation or information feedback. They also noted that CFH nurses were rarely involved in planning meetings and conference case management.

Valentine and Hilferty (2012) examined the factors involved in the failure of multi-agency child welfare initiatives to deliver coordinated interventions to families with complex needs. The study highlighted several central issues with inter-agency relationships, including poor communication, limited exchange of information and lack of understanding of each other's responsibilities, which led to role ambiguity. Most concerning was the review's finding that primary health care providers responsible for prevention and early intervention through universal service delivery did not always comply with legislative requirements. The authors identified a lack of basic awareness about child

safety, combined with an inherent tension in the clinical practice of engaging and supporting families and the role of surveillance as possible causes of the problem.

A strength-based, family-centred and child-focused approach to working with families with complex needs is located in an ecological perspective that recognises the importance of families' environments, the resilience of family members, the capacity of parents to care for their children and the belief that parents can learn and grow (Moore, 2008a; Scerra, 2011). Gottlieb (2014, p. 27) describes strength-based practice as "a practice shift from doing for to working with parents, from teaching and advising to learning from while recognising that relationships are essential to enable families to take control of their lives". Engagement and collaboration with families are essential for this practice shift to be effective (Gottlieb, 2014). This means giving families control over their lives by sharing decision-making, responding to priorities identified by them and building on their strengths. For this approach to succeed, universal services need to build their capacity to respond to the needs of families with complex needs through education in relationship-based and family-centred practices and by reviewing service models to reduce barriers to access (Centre for Community Child Health, 2010).

The findings from Haggman, Tanninan and Pietila's (2010) study of 30 families with young children indicated significant benefits from the strength-based, family-centred nursing intervention based on the McGill Model of Nursing (Gottlieb, 2014; Gottlieb & Gottlieb, 2007). In this model, the nurse supports parents to identify and build on their existing strengths and helps them to mobilise local resources. Positive outcomes included strengthening of parenthood and social support networks, decreased sleeping difficulties of children and enhancement of relationships between parents who also achieved personal growth and maturation.

The recent extensive review of the UK health home visiting program (Cowley et al., 2013; Donetto et al., 2013) demonstrated the importance of re-focusing from levels of vulnerability as a family's defining characteristic, to building on its strengths and resilience against the backdrop of home visiting. In addition to a strength-based approach, the research highlighted the importance of establishing a strong nurse-parent working partnership to promote the family's capacity building. At the same time, a review of the literature on research and practice for prevention and early intervention by the Australian Research Alliance for Children and Youth (ARACY)¹² recommended "grounding the systems in the core principles of a holistic approach, strength-based practice working in partnership with families and building capacity" (2015, p. 7).

¹² ARACY was established in 2002 to tackle major issues affecting the wellbeing of Australian children and young people. It is led by three key professional sectors: research, government policy and professional practice (Head & Stanley, 2007).

The literature review has informed on the various concepts central to the understanding of families with complex needs and the public health model indicated to support families with complex needs and reduce the risk of child maltreatment. It now explores the available evidence on CFH nursing competence.

2.4 Nursing Competence

This section discusses the concept of nursing competence, particularly in relation to CFH nursing, from an international perspective. Research on the competence of nurses working with families with complex needs during the perinatal period is examined and the issues around advanced practice nursing are explored.

The concept of competence has been extensively explored in the literature. A wide range of definitions has been proposed and various conceptual models have been used to explain its development from student/beginner to expert practice level (Benner, 1982; Chang, Chang, Kuo, Yang, & Chou, 2011; Chiarella, Thoms, Lau, & McInnes, 2008; Cowan, Norman, & Coopamah, 2007; A. Gardner, Hase, Gardner, Dunn, & Carryer, 2007; S. Smith, 2012; Vernon, Chiarella, Papps, & Dignam, 2012; R. Watson, Stimpson, Topping, & Porock, 2002). Some have defined competence as comprising a series of skills or competencies that can be objectively measured by assessing specific tasks (Benner, 1982; Eraut, 1998). For others, it is a complex multi-dimensional concept underpinned by theoretical knowledge and deep intuitive understanding of complex situations (Pijl-Zieber, Barton, Konkin, & Caine, 2013; Tabari-Khomeiran, Kiger, Parsa-Yekta, & Ahmadi, 2007). This thesis adopts the definition used by the Nursing and Midwifery Board of Australia (NMBA) (2010):

Competence refers to the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/ occupational area (p. 10).

The NMBA provides this description of nurses who are deemed competent:

They have competence across all the domains of competencies applicable to the nurse, at a level that is judged to be appropriate for the level of nurse being assessed (p. 10).

Several factors have been identified as contributing to the confusion surrounding the term competence. Importantly, competence can be examined from different contexts and perspectives, such as those of consumers (Calman, 2006), employers (NSW Health, 2011), regulatory agencies (Nursing and Midwifery Board of Australia, 2016b) and professional bodies (Child and Family Health Nurses Association, 2010) who, together with education agencies, define professional qualifications (Calman, 2006; S. Smith, 2012). The traditional definition of competence as the ability to perform tasks with desirable outcomes and according to expected standards (Benner, 1982; Eraut, 1998) is associated with the competency-based education model. While considered adequate to test core knowledge and basic skills of professionals, it has been criticised for its limitation in real life practice (Epstein &

Hundert, 2002). Khan and Ramachandran (2012) proposed that there are significant challenges in the assessment of performance involving complex domains associated with interpersonal skills, abstract problem solving or reflective practice, which are transferable to various clinical situations, including new ones.

The interchangeable use of the terms competence and competency, especially in the context of performance assessment, adds to the confusion around the notion of competence. According to Khan and Ramachandran (2012), “competency should refer to the skill itself while competence should refer to the ability to perform and the attributes of the clinician” (p. 920). These authors support the idea that competence is only a point in the spectrum of improving performance (Benner, Surphen, Leonard, & Day, 2010; Dreyfus, 2004). Competencies are still used as a benchmark for assessing nurses’ performance and developing job descriptions. It has been strongly argued, however, that a capability framework for practice standards would be more reflective of the complexity of the environment in which nurses now practise (O’Connell, Gardner, & Coyer, 2014; Roche et al., 2013). Finally the importance of nurses themselves leading the process of competence development to improve patient care has been emphasised (Khan & Ramachandran, 2012; S. Smith, 2012).

A report by the US Institute of Medicine, *The Future of nursing: Leading change, advancing health* (IOM, 2011), was released following significant changes in health care legislation that opened insurance cover to an additional 32 million Americans. While not dismissing the relevance of traditional competency-based education linked to task-based proficiencies, the report highlighted higher-level competencies that “represent the ability to demonstrate mastery over care management knowledge domains and that provide a foundation for decision-making skills under a variety of clinical situations across all care settings” (p. 200).

The report identified core competencies in areas such as clinical judgment, critical thinking, evidence-based practice, relationship-centred care, interprofessional collaboration, leadership and health promotion as crucial to furthering nurses’ abilities to practise at a higher level. It also included emerging competencies such as quality improvement and systems thinking as essential to the development of a highly educated nursing workforce. The design of new educational programs that would teach a unified set of core competencies across the nursing profession was strongly recommended. While the report targeted the needs of the new American health care insurance system, it was consistent with the views expressed in the international literature.

In their overview of the Australian competency movement in nursing and midwifery, Chiarella Thoms, Laws and McInnes (2008) examined the proliferation of advanced or specialist competency

standards¹³ and their shortcomings in the Australian context. A literature review identified 30 sets of specialist competencies developed between 1994 and 2006, including 2000 competency standards for CFH nurses. The authors, while recognising the value of specialist competency standards in enhancing nurses' professional standing, guiding the development of curricula and providing standards for licensing, questioned their validity for entry into a specialist area. It should also be noted that the overlapping of some competency domains for RNs, ENs, midwives and specialties suggests there could be merit in standardisation, but elaboration of this issue is beyond the scope of the present study. The following section examines the concept of advanced nursing practice in relation to the competence of RNs working in the speciality practice of CFH nursing.

2.4.1 Advanced Nursing Practice (ANP)

Up to the date of submission of this thesis the term 'advanced nursing practice' (ANP) had remained unclear. A recent review of the literature indicated broad agreement that it described a higher level of knowledge and skills and suggested practice autonomy, but the review did not extend beyond the legislative framework of registered nursing (G. Gardner, Chang, & Duffield, 2007). It had been argued that the term would remain unclear until role definition, scope of practice and regulatory mechanisms were established (Dowling, Beauchesne, Farrelly, & Murphy, 2013; G. Gardner, Chang, Duffield, & Doubrovsky, 2012). The ambiguity of the terminology was compounded by international confusion between the characteristics of the nurse practitioner (NP) and the characteristics of the RN in a specialty practice (G. Gardner et al., 2007).

In their review of advanced nursing roles in 12 OECD¹⁴ countries, Delamare and Lafortune (2010, p. 9) identified two key motivating factors for countries to develop ANP roles. First, it helps to improve access to care, especially in areas under-served by doctors such as rural and remote communities. Secondly, it promotes high quality care and patient safety in response to changing clients' needs while reducing health spending. The importance of effective education and training programs to ensure that nurses have the opportunity to enhance their skills and advance their practice was highlighted, along with the potential benefits of interprofessional education around new models of care that rely on greater teamwork.

Following investigation of the need for regulation of specialty areas within nursing, the Nursing and Midwifery Board of Australia (NMBA) differentiated between ANP and advanced practice nursing

¹³ The authors use the terms specialist and advanced competency standards interchangeably in the article.

¹⁴The Organisation for Economic Cooperation and Development (OECD), of which Australia is a member, consists of 34 countries; it was founded in 1961 to stimulate economic progress and world trade.

(APN) which, for the purpose of regulation relates to the Nurse Practitioner in the Australian context (2016a). The NMBA defines ANP as:

A continuum along which nurses develop their professional knowledge, clinical reasoning and judgement, skills and behaviours to higher level of capability (that is recognisable). Nurses practising at an advanced level incorporate professional leadership, education and research into their clinically based practice. Their practice is effective and safe. They work within a generalist or specialist context and they are responsible and accountable in managing people who have complex health care requirements. Advanced practice is a level of practice and not a role. It is acknowledged that advanced nursing practice is specific to the individual within their context of practice (2016a).

2.4.2 Competence of CFH Nurses

While there was an abundance of literature around nursing competence, there was relatively little on the roles and competency requirements of CFH nurses working with families with complex needs during the perinatal period. This gap is significant in view of repeated calls for urgent reforms in the delivery of CFH services in Australia and overseas (Australian Government Department of Health and Ageing, 2011; Australian Health Ministers' Advisory Council, 2016; Bailie, Laycck, Matthews, & Bailie, 2016; Karoly et al., 2005; Moore & Skinner, 2010). The drive to redirect services towards a child-centred, family-focused model has brought renewed attention to the education and training needs of professionals responsible for the delivery of innovative, effective, efficient and evidence-based interventions (Australian Government Department of Health and Ageing, 2011; Department of Health, 2011; Productivity Commission, 2011).

Concurrently with Australian reforms, the UK Department of Health set out *The Health Visitors Implementation Plan 2011-2015*, a new vision for its universal health home visiting program for families and children (Department of Health, 2011). The program was commissioned to review interventions, processes and outcomes of home visiting and to inform the development of a new evidence-based model for home visiting practice and services (Cowley et al., 2013; Donetto et al., 2013). One significant component of the research was to seek out the perspectives of 44 parents on their experience of engaging with home visitors. Families who received the 'Universal Plus'¹⁵ intervention were particularly targeted. Through in-depth semi-structured interviews, parents were asked about their personal experiences of valuable and enabling nursing interventions, the type of services they would prefer and the combination of professional team-working that had been most helpful to them (Donetto et al., 2013, p. 11). Although a majority of parents reported positive experiences and helpful interactions they also identified several factors that impacted negatively on

¹⁵ The UK Universal Health Home Visiting program consists of three levels: the Universal level, which underpins the entire program, provides health advice and support to all families; the Universal Plus level which provides families with time-limited additional support; and the Universal Partnership Plus level for families who, because of their complex needs, require ongoing help (Donetto et al., p. 5).

their experience including: a sketchy transition from midwifery to home care characterised by a lack of continuity of care and a lack of awareness of the home visitor's role; the parents' desire to have positive enabling relationships based on trust and a culturally sensitive approach; their perception that home visitors often did not have the time to listen to them and so they were unable to talk about their specific needs; the parents' preferences for two modalities of care in which centred-based interactions complemented home visiting; and the desire for more support for fathers.

One recurrent theme throughout the report was the need for improved initial nursing education for specific areas of practice followed by regular continuing professional development.

Recommendations were made for higher education institutions to support a systematic review of nursing programs to ensure that health home visitors would have the theory, knowledge and skills appropriate to the new service model on completion of their course (Watts, 2011). The process of visiting families in their own home and on their own terms, the formation of respectful relationships between parents and nurses and the opportunity for a comprehensive health needs assessment were identified as "interconnected core practices on which nurses' knowledge, skills and abilities were demonstrated" (Cowley et al., 2013, p. 194). Key areas of knowledge and skills highlighted in the report included public and community health, CFH and wellbeing and leadership. One of the program's premises was that families moved on the continuum between universal and universal plus services therefore all nurses should be expected to have relevant specialist knowledge, skills and attributes. Successful implementation of the vision was highly dependent on new standardised health home visitors' education programs that would adequately prepare nurses for their specialist practice (Watts, 2011).

There is national and international variation in the nomenclature used for nurses working in child and family health: public health nurses in Canada, family health nurse practitioners in USA, health home visitors in UK¹⁶, child and family health nurses in New South Wales, maternal and child health nurses in Victoria and the Australian Capital Territory, community child health nurses in Western Australia, and child health and parenting nursing services in Tasmania (Kruske & Grant, 2012) (Kemp et al., 2005). While 69 % of Australian nurses working in the field of CFH hold a relevant postgraduate nursing qualification (Productivity Commission, 2011), ranging from certificate to diploma to master's level, Australian postgraduate courses preparing nurses for this complex specialty area vary greatly. In addition, curricula do not always reflect the advanced theoretical knowledge and skills level indicated for this area of expertise (Kemp et al., 2005). In a mapping exercise on Australian educational programs offered to nurses and midwives working in CFH, Kruske and Grant (2012)

¹⁶ UK health home visitors must first qualify as nurses or midwives; then they need to take an approved program in specialist community public health nursing/health visiting.

examined the current postgraduate CFH nursing courses. The authors highlighted the programs' lack of professional registration through the Australian Health Practitioner Regulatory Agency (AHPRA) and argued that, while competency standards for NSW CFH nurses were developed (Child and Family Health Nurses Association, 2010), a national credentialing framework was needed to support the development of a national competency-based curriculum for CFH nursing (Pijl-Zieber et al., 2013).

The capability of Australian CFH nurses to engage in research activities that are essential to generate new knowledge and strengthen evidence-based nursing practice has been questioned. While hospital-based nurses are frequently involved in research-related activities, Comero and Kemp (2008) have argued that this is not the case for CFH nurses. In their community-based study of a large urban health service, the authors examined the participation of clinicians in research-based activities defined as reflective practice, quality improvement, evaluation and research. The study's findings indicated that, while CFH nurses were expected to adopt new roles and responsibilities in community settings, they were not provided the opportunities, resourcing, education or support to engage in coordinated research-related activities. Using evidence to inform practice is especially compelling for CFH nurses who are pivotal in the delivery of prevention and early intervention programs to families with complex needs (NSW Health, 2010c). Access to robust evidence developed from nurses' professional experiences, their implicit knowledge of how to do things, and reflection on their practice (Rycroft-Malone et al., 2004) is considered essential, but none could be identified in the recent literature.

The implementation of targeted prevention programs for Australian families with complex needs saw the emergence of new sustained nursing home visiting (SNHV) programs aimed at improving the health outcomes of those families. Several studies explored the existing and indicated nursing competences for this work. In NSW, Kemp, Anderson, Travaglia and Harris (Kemp et al., 2005) found that the CFH nurses were required to manage a significant practice paradigm change from short clinic-based interventions to sustained home visiting. They investigated differences between published CFH nursing competency standards and the roles of nurses working with families with complex needs and identified exemplars of an advanced level of practice. These nurses were not only able to apply their knowledge of health determinants by conducting comprehensive psychosocial assessments but also used fine observation skills when undertaking assessments of the early mother-child relationship. They demonstrated a broader focus on psycho-socio-economic issues and key learning interventions such as anticipatory guidance and allowed parents to take 'safe risks'. The nurses fostered problem solving by inviting parents' participation and by respecting their expertise in order to negotiate optimal health outcomes. Rather than relying on a traditional referral approach, they brought extra resources to parents by helping them to effectively navigate through systems. Finally, they demonstrated an ability to work from a strengths-based practice model supported by participation and cooperation. This highlighted nursing competencies required from CFH nurses working at an advanced level with families with complex needs.

In a descriptive qualitative study in Western Australia between 2006 and 2007, Barrow, Munns and Henderson (2011) explored the practice of 60 CFH nurses working with families and children, using work diaries and focus groups to collect data. The rationale for the study was the shift in clinical nursing practice from individualised care focusing on surveillance, screening and individual parent education and support, to a population health approach that encompasses health promotion, prevention and early intervention through the delivery of universal and targeted services. The aim of the research was to analyse the role of the Western Australian CFH nurses and the decision-making process involved in their practice. The study's findings documented an increase in complexities in families' health, including mental health issues and psychosocial needs, and greater cultural diversity with an increase in migrant and refugee population groups. The CFH nurses reported struggling to maintain their traditional role and meet the new expectations placed on them to engage in community development and capacity-building. Involvement in interagency collaborations requiring advanced communication skills was also reported to be challenging. As a consequence, the nurses saw their practice becoming reactive rather than proactive.

In South Australia, Fraser, Grant and Mannix (2014) conducted a scoping study of the role and experience of CFH nurses in developed countries, particularly Australia, in response to the perceived lack of a comprehensive definition in the literature. The review identified eight key themes defining the nurses' role: maternal mental health assessment and responses; assessment of parent-infant relationships; working with vulnerable and at-risk families; infant health surveillance including identification of atypical autism spectrum disorder; family support; health promotion activities; the development of therapeutic relationships with families; and child protection. The study had two main limitations: only the Australian grey literature was included in the review and the area of child protection examined was limited to a statutory intervention perspective.

Another significant study explored the role of Tasmanian CFH nurses caring for mothers with significant emotional needs. Shepherd (2011) reported on the ability of the nurses to successfully integrate the overt nursing function of monitoring the child's health and development and the hidden agenda of responding to maternal mental and emotional health issues. The mothers' main fear was loss of their children if they disclosed difficult personal circumstances. Shepherd used the scale carried by CFH nurses during their visits as a symbol of the complexity of the nurse's role. The simple act of weighing the baby became a powerful tool to engage mothers to talk about their feelings, fears and struggles. By following the mothers' lead, the nurses were able to gain the confidence of the women through the development of trusting relationships and genuine engagement identified as essential in the literature (Davis, 2009; Davis & Day, 2010). Shepherd argued that, while the nurses were unaware of the dynamics in place during their interactions with the mothers, they instinctively recognised the maternal distress and intuitively responded through weighing the baby.

The intuitive nature of nursing practice is described in the literature as an essential component of expert practice (Benner, 1984; Gobet & Chassy, 2008; Lyneham, Parkinson, & Denholm, 2009).

While processes of notification and referral are core elements of the traditional role of nurses in child protection, several relevant international and Australian studies have described a broader preventive nursing role that involves supporting families and children before they reach crisis point when abuse and neglect occur. A large qualitative study conducted in a rural region of Western Canada (Browne, Doane, Reimer, MacLeod, & McLellan, 2010) examined the working relationships of Public Health Nurses and higher priority families¹⁷. Two research questions guided the inquiry:

How do PHNs understand, contextualise, and address risk? How specifically do they relate and interact with families at risk in ways that promote health and ameliorate potential harm? (2010, p. 28).

In-depth interviews, focus groups and field notes from observations of six nurses were used to collect data from 25 high risk families and 32 nurses. The purpose of the study was to understand the process by which the nurses understood, contextualised and managed risk and the quality of their relationships with the families that promoted health and wellbeing and lowered the risk of harm. The researchers describe the relational approach used by the nurses as a method of examining families' strengths and the socio-environmental limitations that impact negatively on their health, as well as their illness experiences. In the relational practice endorsed in the study, the nurses contextualised local social inequities while they also understood and addressed adverse social circumstances. The nurses who worked relationally with families were able to maintain a fine balance between risk and capacity by taking a temporal view of families often exposed to unexpected socio-economic challenges. Flexibility, collaboration with families, nursing self-reflexivity and developing trust through transparency were identified as essential elements of success when working with families where safety risks are often an issue.

In a similar study, Marcellus (2005) explored the moral quandary faced by Canadian CFH nurses who positioned themselves within a nurse-client relationship based on trust and respect while caring for families with complex needs (defined as at-risk in the study). Because of serious child safety issues the participating families required monitoring and surveillance involving the Canadian legal system. Findings from the study demonstrated that if specific conditions were in place, even when family surveillance was involved, a moral, trusting nurse-parent relationship was possible and therapeutic. Those conditions included: the way the nurse entered the relationship, which could be affected by personal judgement and constructs—hence critical self-reflection was essential; the requirement for

¹⁷ 'Higher priority families' were identified using a specific validated tool called the Parkyn risk assessment, with a score above 9 indicating high risk requiring immediate nursing support.

engagement to be sustained since parents, silenced by their fears and mistrust, were likely to take time to willingly cooperate; and the need for ethical decision-making to be personalised because communications between nurses and parents relied on emotional engagement to be effective (Benner et al., 2010; Hartrick Doane, 2002).

In summary, the review of international and Australian literature identified new sets of knowledge, skills and attributes for CFH nurses. Those areas of competency were essential for nurses to practise collaboratively with other professionals with whom they share the care of families with complex needs. The recommendation for interprofessional practice, learning and education also appeared in most policy documents, reports and guidelines (Allen Consulting Group, 2009; Fox et al., 2015; Lohar, Price-Robertson, & Nair, 2013; Moore, 2009; Moore & McDonald, 2014; Schmied, 2011; Schmied et al., 2015).

2.5 Interprofessional Education and Practice

Interprofessional education refers to the process through which several professionals from different disciplines learn with, from and about each other's practice (Centre for Advancement of Interprofessional Education, 2002; Orchard & Bainbridge, 2010; Stone, 2009). Its main goal is to prepare professionals for collaborative and relationship-centred health care practice resulting in optimal health outcomes. Collaboration itself requires some clarification; in health care the term implies "collective action based on trust and good will towards a common purpose" (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005, p. 116).

The concept of an interprofessional approach to family health care is not new. In the early 1950s, the University of Washington's Child Health Centre offered common student experiences in disciplines including medicine, nursing, psychiatry, social work, nutrition, psychology, dentistry, dental hygiene and medical technology to promote a family-focused education within a primary health care framework (Baldwin, 2007). Interprofessional practice emerged from a shift to more efficient health care delivery, particularly community-based client care, and the development of advanced practice nursing (Gunn, 2016). The interprofessional reform developed in response to workforce shortages and quality and safety issues. Collaboration between key stakeholders, including those in the health system, government and health education, and professional bodies who were more likely to resist the change, was identified in the literature as essential to the success of the reform (Travaglia, Nugus, Greenfield, Westbrook, & Braithwaite, 2011). Teamwork, where team members are willing to work together and share a common goal, was proposed as a second essential element of success (D'Amour & Oandasan, 2005).

The term 'multidisciplinary' was used until the mid-1970s when the term 'interprofessional' became more popular, especially in relation to clinical practice. Both terms have been used interchangeably in

the literature (Baldwin, 2007, p. 34) although D'Amour and Oandasan (2005) argued that the two concepts were clearly distinct. Interdisciplinarity, they proposed, arose from concerns about fragmented disciplinary knowledge and was established as a mean of supporting early interaction, solidarity and interdisciplinary communication. In contrast, the concept of interprofessionality was a response to the alarming fragmentation of health care practice that resulted from silo-like divided professional responsibilities. Kuipers, Ehrlich and Brownie (2014) argued strongly that interprofessional practice was a necessary response to the increasing complexity in health care and the ensuing demand for a more flexible, dynamic, collaborative and highly skilled workforce.

In 2010 the WHO released its *Framework for Action on Interprofessional Education and Collaborative Practice* which had been produced by the Health Professions Networks Nursing and Midwifery Office within the Department of Human Resources for Health (WHO, 2010). The aim of the framework was to support the development of a “collaborative practice-ready health workforce underpinned by key principles of primary health care” (2010, pp. 13-14). The report highlighted six essential interprofessional learning domains: teamwork; roles and responsibilities; communication; learning and critical reflection; relationships with, and recognition of the needs of the client; and ethical practice.

2.5.1 The Interprofessional Debate

Interprofessional education has been hailed as a valuable and do-able solution to current difficulties in delivering efficient and effective services to population groups experiencing complex health issues. Nevertheless some have called for caution in regard to the potential blurring of the discrete disciplinary focus of professional curricula to support collaborative practice. This issue is regarded as particularly pertinent when dominant and powerful disciplines such as medicine are included in the educational approach (Brooks & Brown, 2002; Gunn, 2016). Pumar Mandez, Armayor, Navarlez and Wakefield (2007) investigated potential benefits of interprofessional education within Spain's health and social workforce. The researchers shared similar concerns about the potential risks of professional rivalry, role confusion, loss of professional identity and dilution of specialty curriculum content. They added a warning about the resource-intensive process of the educational reform when reduction of health costs was identified as a priority.

Several theoretical frameworks supporting the development of dynamic interprofessional collaboration in education and practice have been proposed (Burton et al., 2010; D'Amour et al., 2005; Orchard & Bainbridge, 2010; The Interprofessional Curriculum Renewal Consortium, 2014). Most of these address the process of interprofessional collaboration from a broad perspective of effective, safe and sustainable health care delivery. Tucker, Strange, Moules and O'hagan (2002) reported on the UK interprofessional framework developed to inform education and training of those working with children and young people in the UK. Their review highlighted three essential elements

identified by the researchers involved in the framework's development. These were: the adoption of interventions governed by an ecological approach that recognises the contextual environment impacting on the child's development and welfare needs; the importance of research skills that would evidence best practice; and the need for reflective practice underpinned by emotional intelligence and the development of critical thinking to enable students to take calculated risks (pp. 312-314).

2.5.2 Nursing Perspective

Despite a plethora of literature on the importance of collaborative practice and shared learning in the field of early childhood, specific research on nurses' perspectives on interprofessional education and practice was scant. Psaila, Schmied, Fowler and Kruske (2014b) explored the nature and extent of collaboration at the transition of care between midwives and CFH nurses in Australia. This followed an earlier descriptive study (Homer et al., 2009) that identified a duplication of service delivery complicated by the concurrent implementation of multiple transition-of-care models and a lack of formal mechanisms to promote collaboration and communication between midwives and CFH nurses. In the Psaila et al. study (2014b), participants agreed that professional collaboration was built on good communication and relationships in which common vision, goals and understanding of each other's roles and responsibilities were essential. They commented, however, that it took time to establish and was difficult to sustain without organisational endorsement, which was often lacking. Although 1753 midwives and CFH nurses participated in Phase 2 of the study, it only examined the provision of universal health services during the short transition period from maternity services to CFH nursing care. One significant finding from both studies was the alarming fragmentation and duplication of care resulting from service models that lacked a mechanism for collaboration.

In Sweden, where antenatal and postnatal care is delivered by two distinct, separately managed services, Barimani and Hylander (2012) explored strategies used by midwives and child healthcare nurses¹⁸ (CHN) to improve continuity of care for pregnant women and new mothers. The study involved two series of interviews with 20 clinicians and 21 mothers conducted one year apart, prior to and following the implementation of the continuity of care strategy. It also involved participant observation and documentary analysis. The data were collected from two distinct workplaces, a medical centre and a family centre. While much smaller than the Australian study, the use of in-depth interviews allowed clinicians to reflect on issues and barriers to continuity of care. It also had the benefit of examining continuity from the perspective of staff and mothers. The study's findings demonstrated that, while midwives and nurses implemented joint action in the family centre, staff in the medical centre had a vision of the strategies they should implement but were unable to initiate

¹⁸ In Sweden child healthcare nurses are employed as paediatric nurses or as primary healthcare nurses.

collaboration through joint action. Implemented joint action by midwives and nurses was identified by the researchers as a key element of success of the chain of care through the perinatal period.

The interprofessional education and practice debate has been ongoing for more than a decade and has promoted better understanding of complex health issues and more cohesive, integrated models of healthcare practice. Progress, however, is slow and there are few documented examples of successfully implemented strategies. Several frameworks for guiding interprofessional education and practice are available internationally, but the review of literature indicates a failure to translate theory into practice. It has been suggested that this poor outcome may result from lack of organisational leadership and political will (D'Amour & Oandasan, 2005).

2.6 Conclusion

A comprehensive review of the literature brought clarity to key concepts central to the care of families with complex needs. These included maltreatment, adversity, risk, vulnerability and resilience, all of which help to contextualise the role of CFH nurses in promoting the health, wellbeing and safety of children and their parents. This chapter also reported on the various studies that supported the development and implementation of evidence-based service models, with particular focus on the public health model that underpins the practice of nurses caring for families with complex needs. The discussion identified key elements of those services that were essential for optimal outcomes, including collaborative, integrated practice and strengths-based, family-centred, child-focused approaches.

The literature review provided strong evidence for urgent reforms in the areas of early childhood and child protection. It identified CFH nurses as key players in the implementation of those reforms. However, based on the review above several gaps were identified. While there was abundant literature around nursing competence, little evidence was found on the roles and competency requirements of CFH nurses working with families with complex needs during the perinatal period. Several Australian studies indicated that even though a significant practice paradigm change from traditional, short clinic-based interventions to sustained home visiting was advocated, nurses struggled to meet the new expectations placed on them. While professional expertise, particularly in the area of targeted interventions that can prevent intergenerational transfer of vulnerabilities, was seen as essential, few studies had explored the indicated level of nurses' preparedness to assume this complex role. Finally, despite findings of consistently poor communication between fragmented services and limited sharing of information between maternity and community services, research into interprofessional education and practice was scant. Evidence of high-quality collaborative practice and shared learning in the field of CFH could not be identified.

The findings from the literature review and the identified gaps in knowledge assisted with the formulation of specific research questions and the choice of mixed method design.

The following chapter describes the research design and method.

Chapter 3: Research Design and Methods

This chapter explains the choice of a mixed-methods research design for the study as a whole, which comprised three separate investigations. The methods and procedures of each component study are described in detail and the process through which their findings were triangulated is explained. Ethical considerations are discussed.

The aim of the research was to explore the core knowledge, skills and attributes required by RNs working with families with complex needs during the perinatal period. The research's specific objectives were to identify gaps in CFH nurses' knowledge and skills, generate insight into the level of expertise at which these nurses practise and investigate the potential benefits of interprofessional education in the implementation of early childhood and child protection reforms. The following research questions generated from findings from the literature review, played an important role in the design of the studies:

- What knowledge, skills and attributes are required from RNs to provide adequate support to families with complex needs?
- Should registered nurses working with families with complex needs practise at an advanced level?
- Are there any benefits in interprofessional education for RNs working with families with complex needs during the perinatal period?

3.1 Research Design

A mixed-methods design was considered as the most appropriate approach to collecting data for this study overall. The ability to collect and combine both qualitative and quantitative data allowed for a more complete understanding of the research inquiry.

The mixed-methods design is an approach where quantitative and qualitative methods, based on clearly formulated research questions, are used to collect and analyse data, integrate findings and draw inferences (Teddies & Tashakkori, 2009). This method, used to address the overall research aim and objectives, was chosen because one source of data would have been insufficient for the research inquiry and quantitative data alone would not have provided the depth of responses possible through qualitative interviews (Doyle, Brady, & Byrne, 2016). The research questions guided the

process of design that consisted of three separate projects/studies undertaken concurrently (Creswell & Plano Clark, 2011). While quantitative data analysis addressed the core elements that were assumed to define CFH nursing competence, qualitative analysis enabled deeper understanding and additional insight into those elements.

A convergent design meant that, while data collection and analysis of the three studies were conducted using a concurrent approach, findings from each study were compared and integrated through data triangulation, allowing for findings to be mutually corroborated (Creswell & Plano Clark, 2011; Doyle et al., 2016).

The research design was used to investigate the research questions from different perspectives in three separate studies: those of experts in the field of early childhood (Study 1); mothers who reported positive experiences as service consumers (Study 2); and experienced CFH nurses who were delivering early interventions to families with complex needs (Study 3).

In Study 1 the Delphi technique was used to elicit the opinions of a panel of 12 international experts on the following issues: the knowledge, skills and attributes required of nurses providing care to families with complex needs during the perinatal period; the level of nursing practice indicated for this population group; and the benefits of interprofessional education. This first study provided a platform for Studies 2 and 3 by identifying priorities and core elements in the research inquiry (Powell, 2003; Powell Kennedy, 2004). Study 2 used in-depth semi-structured interviews to investigate the personal experiences of mothers in families with complex needs who received nursing interventions. Study 3 used interviews with RNs who worked with families with complex needs to understand the dynamics of their experiences in responding to the mothers during the perinatal period. The three studies informed each other.

In study 1 a survey was used to collect quantitative data that had been scored by assigning numerical values to participants' responses. Qualitative content analysis was used for the management and analysis of data collected for the studies 2 and 3. This method, commonly used to analyse transcripts of semi-structured interviews (Gale, Heath, Cameron, Rashid, & Redwood, 2013), adopted an iterative approach that led to the generation of themes. Central to the method is the interconnected process of moving back and forth between transcribing, coding and categories refinement, and identification of emerging themes as the researcher becomes familiar with the data (J. Smith & Firth, 2011).

Table 3.1 displays the four domains of the research inquiry: nursing knowledge and skills, personal attributes, level of nursing practice and interprofessional education. It aligns these domains with the trigger questions used in the three studies, thus establishing the framework for triangulation of the data.

Table 3.1

Mapping of Interview Questions and Domains of Inquiry Across the Three Studies

	Study 1	Study 2	Study 3
Domain 1 Knowledge & Skills	What are the core knowledge and skills registered nurses (RN) require to work with families with complex needs during the perinatal period?	When the child & family health nurse visited you at home following the birth of your baby: What sort of things did she suggest to support you and your family? What type of questions did she ask about yourself and your baby? What sort of information did she provide you with? Did the nurse continue to visit you at home or did you go to the clinic for visits? When you think about the nurse caring for you and your baby can you describe the specific interventions undertaken that you feel were most helpful? Can you tell me how and why they were helpful? It might help you remember if you provide me with an example of a situation where a nurse was helpful	What do you think are the core knowledge and skills required for nurses to work effectively with those families during the perinatal period?
Domain 2 Attributes	To what extent do personal characteristics and attributes influence the successful practice of the RN working in the field of early childhood If you believe personal characteristics and attributes are important, what are they?	Can you describe some of the nurse's behaviours that you observed that gave you confidence in her? What about the nurse's attitude when she related to you and your family? If you have had more than one baby do you think that the way the nurse interacted with you during visits this time has changed since the last baby?	How relevant are personal characteristics and attributes to define professional competence in this field of practice? Can you identify them?
Domain 3 Level of nursing practice	Should nurses providing long term follow up be advanced practitioners? if you believe this how would you identify those practitioners	N/A	Should nurses working with families with complex needs be advanced practitioners? How would you identify those practitioners?
Domain 4 Interprofessional education	How appropriate is interprofessional education with a core curriculum for early childhood interventions?	Did the nurse seem to have different knowledge and skills from other health professionals, for example the hospital social worker or your doctor? How different was it?	How comprehensive and effective do you believe the education program that you received to prepare for your current role was and if you identify gaps what are they?

How might
interprofessional
education with a core
curriculum be structured?

Families with complex
needs often receive several
interventions from
professionals from various
disciplines. How
appropriate is
interprofessional education?

The study was approved by the University of Sydney's Human Research Ethics Committee on December 17, 2010 Protocol No: 13243 (Appendix 3). The protocol applied to each of the three studies. Ethical considerations common to all three studies were: participants were provided with a Participant Information Statement (PIS) documenting the aims, nature and procedures of the study (Appendices 4, 5, 6) and a Consent Form (CF) (Appendices 7, 8, 9) which they signed to indicate their willingness to participate in the study. In so doing, they acknowledged the voluntary nature of their involvement, their right to withdraw at any time and the confidential nature of their participation. Ethical considerations specific to each of the component studies are outlined in the relevant sections below.

The University of Sydney Research Data Management Policy and Procedures (Trehwella, 2014, 2015) were followed in relation to safe and secure storage and retention of the research data, primary material and research records for the applicable mandatory period. All data were stored electronically and password protected. A copy of the files was kept in an external hard drive located in a fire-proof safe at the student investigator's home. Hard copies were kept in a locked filing cabinet.

The following sections describe in detail the methods of data collection and analysis used in each of the studies.

3.2 Study 1: Seeking Expert Consensus

The aims of this study were threefold: to draw an expert consensus on the knowledge, skills and attributes expected from registered nurses (RNs) in order for them to provide adequate support to families with complex needs during the perinatal period; to determine if there was an expectation that these RNs should practise at an advanced level; and to seek the experts' opinion on the benefits of interprofessional education. This first study provided a platform for Studies 2 and 3 by identifying priorities and core elements in the research inquiry (Powell, 2003; Powell Kennedy, 2004).

3.2.1 Method

The Delphi technique is a group facilitation method used to elicit and refine the opinions of a group of experts who are selected because of their knowledge and expertise in a specific area of interest.

Linstone and Turoff (2002) describe the Delphi technique as a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem. It has been used extensively in health and nursing research (Hauck, Kelly, & Fenwick, 2007; Hung, Altschuld, & Fang Lee, 2008; Keeney, Hasson, & McKenna, 2001; Skulmoski, Hartman, & Krahn, 2007). The technique is particularly appropriate when knowledge is uncertain or incomplete or when innovation is sought, as was the case in the present investigation. Participants can challenge dominant beliefs and explore new thinking patterns that have not been identified in the literature, which can lead to new knowledge (Aichholzer, 2009; Yih-Tong & Scott, 2005) and contribute to what Linstone and Turoff (2002, p. 8) describe as “the development of collective human intelligence”.

The Delphi technique is a multistage process of combining experts’ opinions into group consensus (McKenna, 1994). It is iterative and sequential, using multiple rounds (iterations) in a feedback process (Hsu & Sandford, 2007). Each round builds on the information garnered in the previous round. Participants are able to consider the views of others and can share, modify or change their opinions in order to refine results and reach consensus. The number of rounds required to achieve collective agreement depends on the degree of consensus that is sought.

In the present study, the Delphi technique provided several advantages over more conventional face-to-face group communication methods such as conferences, committees or focus groups. Because the group was geographically dispersed, the use of electronic communication (email) provided a timely and cost-efficient means of sharing opinions. This process also addressed the issue of confidentiality (Hsu & Sandford, 2007; Tan et al., 2012) because participants could not be identified and had the added benefit of reducing the potential impact of dominant personalities on more compliant group members and the risk of group pressure for conformity (Hsu & Sandford, 2007). Finally it facilitated optimal sharing, modification and/or changing of opinion through the data collection. Butterworth and Bishop (1995) suggest that the Delphi technique not only adds objectivity to the research, but can also widen knowledge and stimulate new ideas through the feedback from various rounds.

3.2.2 Participant Selection and Recruitment

According to Baker, Lovell and Harris (2006), ‘experts’ in a Delphi panel should have explicit knowledge and understanding of the topic under investigation, appropriate level of experience and ability to influence policy. In the present study, experts were selected on the basis of their knowledge and experience in the field of early childhood, particularly in the area of early interventions for families with complex needs during the perinatal period. A purposive sampling strategy was adopted

to select panel members who would bring a wealth of information to the research topic (Teddies & Tashakkori, 2009).

The selection of the expert panel was influenced by the fact that (NSW Health, 2010d) identifies a range of professionals in fields as diverse as paediatrics, social sciences, economics and child and adolescent mental health as sources of expertise for the successful development and implementation of programs targeting families with complex needs during the perinatal period. Relevant areas of professional experience could include clinical practice, policy development, service management, planning, education or research. International participants could be included since there is global agreement about the elements of an optimal model of care for families with complex needs. Hence invitations to participate were sent to a wide range of professionals who were experts or informed advocates in the area and who were willing to participate in the study (Goodman, 1987).

The optimal size of a Delphi group is debated. Aichholzer (2009) recommends a minimum of ten participants, which takes into account the potential for some participants to drop out before the study's completion. Sixteen experts were invited to participate and 14 accepted by returning Consent Forms. One participant withdrew from round one because of unexpected family illness and a second did not complete the round one questionnaire. Two follow-up phone calls were made, and emails were sent to participants who had not returned the Consent Form and the responses to round one within four weeks. Twelve experts ultimately made up the Delphi panel.

Table 3.2 identifies the countries and Australian States in which the panel experts practised, their formal employment status and professional backgrounds. The experts were asked about academic qualifications, most of them commented on their status in relation to PhD only.

Table 3. 2

Delphi Study: Profile of Experts

Country/State	Position	PhD	Professional background
Australia NSW	2 SAFE START Coordinators	yes X 2	Nursing
5 experts	2 Academics	Candidate	
	1 Senior manager		
Australia Victoria	1 Senior manager		Nursing

Australia Queensland	1 Academic	yes	Nursing
Australia South Australia	1 Academic	yes	Social Work
Australia Western Australia	1 Senior manager	Candidate	Nursing
Canada	1 Academic	yes	Nursing
UK	1 Academic	yes	Nursing
New Zealand	1 Senior manager		Nursing

3.2.3 Procedure

Data collection was by email as the panel members were from Australia, Canada, New Zealand and the UK.

The first round of the Delphi cycle began with a set of six questions (Appendix 10) about the knowledge, skills and attributes of nurses working with families with complex needs, nurses' level of practice and the benefits of interprofessional education. The data were collected, analysed and converted into a structured questionnaire (Appendix 10) that formed the basis of the second iteration. This second iteration survey was divided into four sections: elements that reached consensus; elements that did not reach consensus but were perceived as worthy of further exploration; formal nursing qualifications; and interprofessional education. Participants were able to review and reconsider their responses in light of those from the rest of the panel. The process was considered complete when consensus was reached (Powell, 2003). In this study, consensus was defined as 50% or agreement among six respondents and was reached at the completion of the third round when the survey responses had been analysed and synthesised. The synthesised data were sent to the 12 experts for verification. The process is illustrated in Figure 3.1.

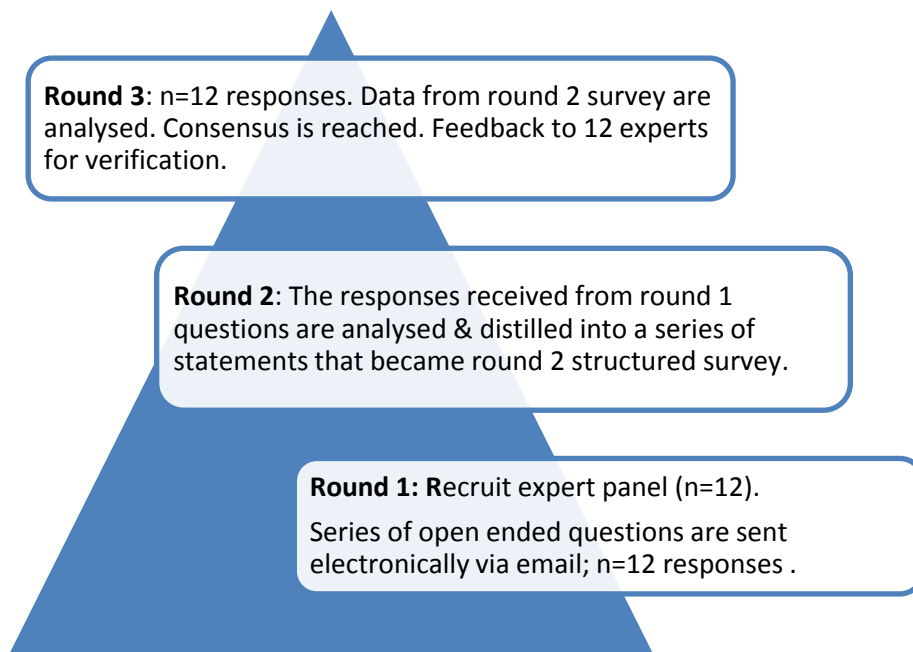


Figure 3.1 Schematic representation of Study 1 Delphi procedure.

The first round of open-ended questions was pilot tested and revised with the assistance of four local experts in the field of early childhood including an academic, two senior managers and a senior clinician. The purpose of the pilot was to correct ambiguous content and enhance the effectiveness of the data collection and management (Powell, 2003). The final six questions addressed the issues of: knowledge, skills and attributes of nurses working with families with complex needs; the level of their practice; and the relevance of an interprofessional curriculum for health professionals working with this population group. The participants were asked to answer in as much details as they wished to the following questions:

- What is the core knowledge and skills nurses require working with families with complex needs during the perinatal period?
- How relevant are personal characteristics and attributes when examining professional competence in the field of early childhood?
- If you believe personal characteristics and attributes are important, what are they?
- Should nurses providing long term follow up be advanced practitioners? If you believe this how would you identify those practitioners?
- How appropriate is interprofessional education with a core curriculum for early childhood interventions?
- How might interprofessional education with a core curriculum be structured?

The questions were open-ended to encourage rich responses from participants without influencing their decision-making (Goodman, 1987). The objective of round one was to generate ideas which were to be further explored in the second round.

Twelve participants signed Consent Forms (Appendix 6), which were returned by June 2011. Twelve completed round one responses were received in November 2011. A round two questionnaire (Appendix 10) was collated from the round one answers and sent electronically in June 2012 and twelve responses were returned by September 2012. Round three final feedback (Appendix 12) provided participants with one last opportunity to comment or clarify.

Consensus occurs when the opinions of participants converge through a process of informed decision-making (Konstantinou, Hider, Vogel, Beardmore, & Somerville, 2012). Operational definitions of consensus, however, vary greatly among researchers depending on the focus of the study (Keeney, Hasson, & McKenna, 2006). In this study, the threshold for consensus on each theme was determined as six or more participants agreeing with the element; that is, if 50% of participants were in agreement, a particular element would be identified as a core theme. This decision was influenced by the importance of the study outcome, limited resources and time constraints.

3.2.4 Data Analysis

Quantitative data analysis was used to identify items that reached consensus (Creswell & Plano Clark, 2011). Similar items were grouped together and categorised into main themes emerging from the first round of open-ended questions. In the first round, the research questions identified *a priori* categories for data analysis (Forman & Damschroder, 2008). The emerging themes were grouped into four new categories that formed the basis of the questions in round two. The responses were returned over a two month period. Observations and comments included in the responses were collected and a comment sheet was used to record initial impressions, thoughts and questions about the texts. The process was dynamic and flexible so that amendments could be made between rounds one and two. Care was taken to retain the wording used by participants. Round one was mainly concerned with formulating a list of elements that the panel identified as core elements. Round two focused on the level of importance of those elements using quantitative data analysis. Elements that occurred infrequently in round one were still presented in round two, giving the participants a chance to consider elements they might not have thought of initially, so that they were able to assess the elements' relevance in the second round (Hasson, Keeney, & McKenna, 2000).

Round one responses were coded and distilled into a series of statements reflecting the elements that had been identified by six or more participants. These formed the basis of the questionnaire used in round two to ascertain levels of importance attached to these elements. Participants were asked to agree/disagree with these statements using dichotomous (yes/no) responses or Likert scales. Although

a majority of the 12 participants agreed on key issues, no single issue achieved unanimity. Nonetheless, a majority reached consensus on a number of elements. Some elements that had not reached the designated level of consensus in round one were nonetheless considered sufficiently significant on the basis of the literature to be included in round two for further exploration.

The second round questionnaire was divided into four sections:

- elements that a majority (n=6-9) thought were important;
- elements that fewer than 6 participants mentioned. Participants were asked to consider these elements that they might not have commented on in round one but which, on reflection, they might see as important.
- the issue of formal nursing qualifications, which was commented on by several experts;
- the panel's feedback on interprofessional education.

A glossary drawn from the experts' responses in round one was appended to the questionnaire. Its purpose was to avoid ambiguity and clarify certain concepts that some experts had used (Appendix 12).

The final results were fed back to the 12 experts in round three. They were reminded that the threshold for consensus on each theme was agreement among six or more participants. Final comments were welcomed. One participant recommended changing the term perinatal mental health to perinatal and infant mental health to avoid the risk of forgetting the infant's needs while focusing on the parent. This and other issues related to mental health terminology are discussed in Chapter 7.

3.2.5 Ethical Considerations

Potential Delphi panel members received a study information package via email that included a letter of Invitation to Participate in Research (IPR) and a Participant Consent Form (PCF). The round one questions were included in the Invitation to Participate letter. No potential risks associated with participation were identified.

Records of participant feedback were de-identified following both rounds and in feedback communication. The round two questionnaire included a specific question about participants' qualifications and the de-identified nature of all personal information provided was reiterated in the request:

For the purpose of the study we would be most grateful if you would advise us of your qualifications. These will be included in a table as part of the study but will not be attributed to any responses or identifiable people.

3.3 Study 2: Mothers' Experiences of Nursing Support

The aim of the second study was again to address the three research questions, but with particular attention to the question, 'What knowledge, skills and attributes are required for registered nurses to provide adequate support to families with complex needs?'

The study explored the narratives of mothers describing nursing activities, the type of care they received, the way nurses cared for them and what they perceived as most helpful for them to deal adequately with the responsibilities of early parenting. The purpose was to record the thoughts, feelings and reactions of the mothers as parents of newborns in the context of the nursing intervention they received during the perinatal period (Minichiello, Aroni, Timewell, & Alexander, 1995). The unique perspective of these mothers was identified as an essential component in the exploration of the research questions.

3.3.1 Method

In-depth interviewing facilitates a clearer understanding of the significance of participants' experiences within their social, emotional and cultural world and belief system. Face-to-face interaction allows the researcher to hear, explore and facilitate rich narratives told in the participants' own words. It also enables the interviewer to observe the participant's behaviour and to assess the congruence between words and behaviour and the need for deeper exploration (Kajornboon, 2006).

The interviews were organised around the following set of semi-structured, open-ended trigger questions. These served to keep the conversation focused on the topic while allowing the mothers to expand their narrative as they wished. The open-ended questions were helpful to delve iteratively into the different aspects of the research questions leading to further exploration and probing into the participant's social and personal constructs (DiCicco-Bloom & Crabtree, 2006).

- When the child & family health nurse visited you at home following the birth of your baby:
 - What sort of things did she suggest to support you and your family?
 - What type of questions did she ask about yourself and your baby?
 - What sort of information did she provide you with?
- Did the nurse continue to visit you at home or did you go to the clinic for visits?
- When you think about the nurse caring for you and your baby can you describe the specific interventions undertaken that you feel were most helpful?
- Can you tell me how and why they were helpful? It might help you remember if you provide me with an example of a situation where a nurse was helpful.

- Can you describe some of the nurse's interventions and behaviour that you observed gave you confidence in her? What about the nurse's attitude when she related to you and your family?
- If you have had more than one baby do you think that the way the nurse interacted with you during visits this time has changed since the last baby?
- Did the nurse seem to have different knowledge and skills from other health professionals, for example the hospital social worker or your doctor? If so, how different was it?

3.3.2 Participant Selection and Recruitment

Information about the study was presented at the local monthly meeting of the Families NSW¹⁹ Child and Families Interagency Committee (the Committee). Members discussed the need to use appropriate, sensitive recruitment methods and avoid the labelling of families. Representatives from local CFH nursing services contributed to the development of a recruitment strategy.

The issue of sensitive recruitment was addressed by selecting organisations that provided support mostly to families with complex needs. Two non-government organisations (NGO), identified as A and B, volunteered to help seek out parents willing to be interviewed. Both NGOs run supported playgroups for families with complex needs as part of wider early intervention programs in disadvantaged communities. Supported playgroups have two main goals: to strengthen the parent–child relationship and to increase families' connections to their community (Commerford & Robinson, 2016; Lakhani & MacFarlane, 2015). Early childhood educators and family workers facilitate the groups, which run during school terms and are based in local public schools known as 'Schools as Community Centres' (SaCC)²⁰.

Two meetings and some electronic correspondence with the managers of A and B led to the formulation of an advertisement that would be displayed at each playgroup room (Appendix 14). Meetings were organised with the workers who lead the playgroups to ensure that they could provide clarification if parents approached them.

Five schools were identified as optimal locations. Although located within the same local health district, they serviced families from different cultural and socioeconomic backgrounds. The flyers inviting mothers from families with complex needs to participate were distributed to playgroup workers who alerted the mothers to the research. One month after this recruitment process had begun, playgroup workers suggested that a simpler advertisement should be developed, as the original was

¹⁹ Families NSW is a NSW Government early intervention and prevention strategy to help parents give their children (aged 0-8) a healthy start in life. It aims to strengthen communities to support families and to improve the way various agencies work together to provide families with timely, relevant services according to their needs

²⁰ SaCCs are provided by the NSW Department of Education and Communities as part of Families NSW.

too complex for some parents to understand, especially parents for whom English was not their first language. A second flyer was developed to replace the first one (Appendix 15).

Participants were self-selected according to the pamphlet criteria of struggling with being a parent and experiences of difficult times during pregnancy and after the birth of their baby. They were asked to tell about positive experiences of being supported by midwives and nurses.

Parents were recruited from local health districts where universal antenatal and postnatal psychosocial screening had been routinely conducted by midwives and nurses in local maternal and child health services for at least three years. While the sample was homogenous in regard to families with complex needs during the perinatal period, the parents' socioeconomic and cultural backgrounds were very different. This allowed for a wide range of mothers' stories to be heard. Playgroup workers informed the parents attending the five playgroups that the researcher would meet them to discuss the background and purpose of the study. A short briefing took place in each school five minutes prior to the beginning of the playgroup; parents had the opportunity to ask questions and were given a flyer about the study to take home. Three mothers organised an interview appointment on the day of the briefing.

The number of interviewees was influenced, but not determined, by the concept of saturation. This occurs when sufficient data have been obtained and further interviewing is unlikely to generate new information relevant to the research questions (Saunders, 2012). Limitations of time and resources also influenced the decision to accept a sample size of ten participants (Minichiello et al., 1995).

3.3.3 Procedure

Interview locations were negotiated with parents to ensure safety, privacy and minimisation of potential sources of distraction. For interviews conducted in local playgroups, arrangements were discussed with the playgroup coordinator prior to the interview taking place. Thirty to 60 minutes was allocated for each interview. The average duration was 35 minutes, with one interview lasting 70 minutes. A majority of mothers booked an interview time that suited them after discussing the PIS and Consent Form with their family.

During the planning phase, playgroup coordinators agreed to mind children during the time of the interview as long as they were notified ahead. Some children, however, refused to be separated from their mothers, especially when the location of the interview was out of the child's sight. One mother (M3) anticipated the problem and brought her own mother along to facilitate the interview.

Table 3.3 provides background information about the participants and the interview process, including language other than English spoken at home, the age of the children, and the location of the interview.

Factors that may have impacted positively or negatively on the quality of the interview were recorded in field notes.

Table 3. 3

Maternal Characteristics, Children's Age, Interview Location and Care of Baby

	Language other than English	Ages of child/children	Location of interview	Factors impacting on quality of interview
M 1		22 months	Playgroup	Child played with other children. Maternal supervision frequently required.
M 2		24 months	Playgroup	Child nursed by mother during the interview.
M 3	Greek	4years & 20 months	Playgroup	Grandmother supervised the child.
M 4	Greek	7years & 18 months	Playgroup	Playgroup coordinator supervised the child during the interview. School festival with loud music during the interview.
M 5	Fijian (very limited English)	Twins 20 months	Playgroup	Difficulties with recording. Combination of audio recording and note taking. Children nursed by playgroup coordinator.
M 6		20 months	Local coffee shop	Noise, lack of privacy but mother comfortable in the location of her choice.
M 7	Russian	22 & 2 months	Playgroup (community centre)	Oldest child distressed throughout the interview. Mother insisted on continuing.
M 8	Slovenian	6 years, 4 years Twins 9 months	Home	Father at home caring for twins.
M 9		10 years, 3 years	Home	Interview postponed twice because of family relocation. Interview

	Twins 14 months		conducted two days following the move.
M10	14 months	Local park	Baby at home with father.

3.3.4 Unanticipated Issues

Although playgroup coordinators were willing to mind children during the interview, some children were reluctant to be separated from their mothers. While some interviews were extended because of short interruptions when the children required attention, the mothers were still eager to proceed with their stories. Most interviews conducted in playgroups were challenging, as they took place in large rooms used as auditoria with many children interacting, singing and playing in the adjacent school yard. On one occasion, children attended their school sports festival outside the room where the interview was held. The option of postponing the interview until later was discussed with the mother, who chose to go ahead. To prevent the loss of valuable data, audio recording was combined with note taking and several interruptions to ask for clarification.

Despite the initial expectation that these mothers would have had positive experiences with services, the self-selection process meant that several participants did not fit this criterion. They simply wanted to tell their story to someone prepared to listen. On some occasions their narrative would drift from the topic question to extended accounts of negative experiences with a health facility or professional. . Nonetheless, it was felt that these stories (although not what had been anticipated or hoped for) were equally legitimate as sources of data for the study and should be included. This issue is discussed in more detail in Chapter 7. Consideration was given to recruiting some additional participants through child clinics, where mothers bring their infants for checkups, advice and immunisation and where presumably a degree of rapport would have been established between the mothers and nurses. However, the difficulties associated with seeking ethical approval from the local health district to recruit mothers, notably the lengthy delay this would involve, were deemed insurmountable within the study's timeframe

Mothers attending interviews were eager to share their experiences, but their stories were often about negative experiences that they perceived as traumatic. The temptation in the first four interviews was to ask the added question 'What should the nurses have done to help you better?' Mothers were happy to elaborate on what an ideal nurse should or could have done. However, this practice was discontinued on the advice of my supervisors that mothers could only imagine what good practice might look like if they had not experienced it. The risk of relying on data that did not assist with the research questions led to the decision not to use the responses to these hypothetical questions in the early interviews.

While mothers commented on the lack of support received from the nursing and midwifery staff, they often referred to alternative sources of support that they had received. As a result, data were collected about other people who were involved in supporting them.

3.3.5 Data Recording and Analysis

Digital-recording of the interviews permitted a systematic exploration of the content, including the way things were said, the tone of voice, the timing and the pauses that took place. Some hand written notes were taken during or immediately after the interview when the researcher was concerned that the recordings might be difficult to transcribe and when significant observations were considered relevant within the context of the interview. Interviews were first transcribed manually then recorded in word documents.

Qualitative content analysis which is primarily an inductive process where interplay between observed reality and concepts is ongoing, was used to analyse the text data with the purpose of identifying commonalities and variations in the mothers' narratives (Gross Portney & Watkins, 1993). Data collection and analysis took place concurrently allowing for the early development of a coding scheme²¹. Codes or categories were used to reorganise the data in a way that facilitated the interpretation of the data (Saldana, 2013). Categories containing sets of elements were identified in the first round of analysis. Each category was re-examined with the purpose of identifying themes. These were later organised into clusters to facilitate the identification of concepts used to answer the research questions.

As previously explained, exemplars of best practice were sought but, in fact, mothers had little to say about good nursing practice, preferring to talk about how the care they received was actually the antithesis of what best practice might look like. Initially I was unprepared for this and tried to get the women to hypothesise what best practice might look like. When the data were reviewed it became obvious that these hypothetical descriptors did not reflect the mothers' actual experiences. A potential flaw between the research question and the trustworthiness of the interpretations was threatening the credibility and authenticity of the research findings (Cutcliffe & McKenna, 2002; Thorne, 2008). Consequently the analytical approach was to re-examine the information based on the feedback received to obtain greater understanding of the participants' actual subjective experience. This understanding would provide new knowledge about what nurses are currently not doing and about influences and obstacles that impede best nursing practice.

²¹ A code is 'a descriptive or conceptual label that is assigned to excerpts of raw data in a process called coding' (Gale et al., 2013, p. 118).

The content analysis process involved three consecutive stages described as immersion, reduction and interpretation of the data (Forman & Damschroder, 2008). During the immersion stage I became engaged with the whole of the data, transcribing the interviews using pen and paper and transferring the documents into word documents. This initial phase involved reading and re-reading the raw text data and formulating early impressions of what the data were telling me via the use of memos. These memos were to guide the second phase called data reduction. This iterative process is characterised by reorganisation of the data using coding to facilitate the interpretation. The third and final phase consists of interpretation and revision of the coding with deletion, refining, grouping and reorganisation of codes until a conceptual map emerges.

The importance of making the effort to undertake early analysis of each interview as soon as I had recorded it was helpful in identifying a particular assumption that I had made that clearly impacted on my communication with the participants. I had presumed that mothers had a clear understanding of what was meant by the term ‘nurse’. I soon realised that most mothers identified any professional who provided them with support and clinical interventions in the maternity unit and in the community as ‘nurses’. This early realisation helped me to modify my data collection technique. This observation also added new depth of understanding of what good nursing care meant to mothers when they were struggling with issues during the perinatal period.

3.3.6 Ethical Considerations

PSI and Consent Forms given to all mothers prior to the interviews were stored electronically with the interview recordings and transcripts on a password-protected PC. A backup copy was stored on an external drive in a fire-proof safe in the researcher’s home. To ensure confidentiality the real names of parents and children and other identifying characteristics (e.g. home address and interview location) were withheld and ID numbers were used instead. It was emphasised to each participant that she was free to withdraw from the study at any time and that she could ask for the interview to cease at any point.

There was a small possibility that some mothers could become distressed when they spoke of a particularly sensitive experience, particularly if they were exploring highly emotional events that still presented many challenges in their lives. After all, one of the selection criteria was that they were participating in a program for families with complex needs. The following management strategy was put in place to ensure that parents felt able to stop the interview at any time and that immediate support would be available should their distress intensify. I familiarised myself with local services that could be contacted if external professional support was indicated for an issue that may have been pre-existing and remained unresolved. In addition, I am a qualified mental health professional with extensive experience in acute community psychiatry, including the conduct of mental state assessments. I have advanced counselling skills and a robust knowledge of clinical pathways for the

purpose of mental health referral should the need occur. Notwithstanding my background, I did not consider it was appropriate for me to be both interviewer and debriefer, but I did feel that it enabled me to recognise and refer in cases of distress.

3.4 Study 3: Nurses' Experiences of Caring for Families with Complex Needs During the Perinatal Period

The aim of Study 3 was to investigate what professional knowledge, skills and attributes nurses currently working with families with complex needs during the perinatal period considered necessary for them to practise effectively. The nurses were encouraged to reflect on the adequacy and relevance of their own educational preparation for the challenges they experienced. In addition, they were asked to comment on the value of interprofessional learning in the provision of early interventions to families with complex needs. The study's findings were later used to triangulate the level of congruence between the nurses' perception of their professional roles, the mothers' expectations of the quality of care delivered by the nurses and the experts' opinions of what constituted a capable nurse working with families with complex needs.

3.4.1 Method

Non-directive semi-structured interviews were used to explore the participants' thoughts, opinions and judgements related to caring for families with complex needs. As with Study 2, the aim was to elicit detailed stories about the nurses' experiences of working with families with complex needs.

The initial plan was for a series of questions to guide the interview, focusing on issues essential to the research questions. The mode of asking questions was to follow an unstructured, flexible interview process. However several nurses suggested that they would have preferred to read the list of questions prior to the interview, giving them the opportunity to situate themselves in the conversation that was to take place. As a result of this suggestion, six participants were given the interview schedule prior to the start of the conversation. Both methods of conducting the interviews elicited comparable responses. The questions were:

Reflecting on the work that you have been undertaking with families with complex needs:

- Please describe the core knowledge required for RNs to work effectively with those families during the perinatal period?
- What do you think are the core skills required for RNs to work effectively with those families during the perinatal period?

- How relevant are personal characteristics and attributes to define professional competence in this complex field of practice?
- If you believe they are relevant, can you identify them and explain why you think they are relevant?
- Do you believe that the knowledge, skills and attributes that you identified are essential for all RNs delivering the universal health home visiting program in NSW?
- Should RNs working with families with complex needs be advanced practitioners?
- If you believe they should be advanced practitioners, how would you identify those practitioners?
- How comprehensive and effective do you believe the education program was that you received to prepare for your current role?
- If you identified any gaps what were they?
- Families with complex needs often receive interventions from professionals from various disciplines. How appropriate is interprofessional education with a core curriculum?
- If you believe interprofessional education with a core curriculum is appropriate, how might interprofessional education with a core curriculum for all professionals working with families with complex needs be structured?

3.4.2 Sampling and Recruitment

The sampling method used for the study was purposive, meaning that the intent was not to randomly seek a representative participant group but to recruit from a specific pool of nurses able to provide the researcher with a rich source of information (Patton, 2002). Although most nurse participants were recruited following an advertisement in a professional journal (Appendix 16), an unexpected snowball effect occurred when four nurses actively sought to be interviewed following discussion with colleagues who had already been interviewed. This group of nurses worked in services offering extended care to mothers in response to universal psychosocial screening programs and they felt that their professional experience may have relevance to the research. The four nurses practised at consultant level and they were eager to share and reflect on their personal nursing journeys.

Some preliminary planning was undertaken prior to recruiting and interviewing. The NSW CFH Nurses Association (CAFHNA) was identified as the most appropriate professional group to approach CFH nurses who met the inclusion criteria (see below) and who might be willing to participate in the study. A meeting was organised with the CAFHNA chair-person to promote awareness of the study and to seek support for the recruitment process. An advertisement was placed in the CAFHNA Journal in March 2011 seeking “community registered nurses providing extended interventions to families identified with complex needs during the perinatal period”. Inclusion criteria included: working in the field of CFH nursing for at least five years; practising in NSW either in metropolitan

or rural/regional locations; providing extra support and interventions to families identified with complex needs. The advertisement advised potential participants that the average duration of the interview would be 30-45 minutes and would be arranged at a time and place convenient to them.

Following a lack of response to the March 2011 advertisement, permission was sought from the chairperson of the NSW Child and Family Clinical Nurse Consultant (CNC) group for me to attend the May 2011 State meeting at Belmore NSW. The State CNCs were briefed about the aims of the research and its relevance to this professional group and copies of the flyer were made available for distribution. A similar process was used at the NSW CAFHNA monthly meeting held in June at a local NSW community centre.

The first response was from a CFH nurse practising in NSW Northern Rivers. This unexpected response generated the need to consider if interviews in rural areas of NSW should be excluded because of cost and time considerations. After reflecting on the advantages and disadvantages of including the experiences and perceptions of country practitioners in the data collection, I decided that travelling to rural locations would be beneficial. This decision was based on the assumption that the professional experience of rural and metropolitan nurses can be significantly different and may lead to different expectations, challenges, work practices and roles. This decision proved to be beneficial as four rural nurses were interviewed face-to-face but it did cause some delay in the completion of the data collection.

Interviews were held in various locations selected by the participants including Community Health Centres, parks, emergency department staff rooms, and the researcher's office; one nurse requested a visit at her home as she was on leave. The option of a telephone interview had been included in the advertisement, but only one telephone call in fact ensued and that was for purposes of clarification only. Twelve interviews were completed between June 2011 and July 2012. The duration of each interview was 45-90 minutes. All participants had worked in some community early intervention program, except for two senior CFH nurses who were based within a hospital facility but provided follow-up care to parents in their home. Table 3.4 presents a broad profile of the participants.

Table 3.4

CFH Nurses' Professional Characteristics

	CFH nurses working in rural NSW	Professional title	CFH nurses practising in community settings	CFH nurses with CFH nursing qualification	CFH nurses with mental health postgraduate qualification
N1	rural	CNC	yes	yes	yes
N2		CNS	yes	yes	yes
N3		CNS	yes	yes	yes
N4		Manager/clinician		yes	yes
N5		Senior RN	yes		
N6		Nurse practitioner	yes	yes	yes
N7		Senior RN	yes		yes
N8	rural	CNC	yes	yes	yes
N9	rural	CNC	yes	yes	yes
N10		CNC			yes
N11		Senior RN		yes	
N12	rural	CNC	yes	yes	yes
Total	n=4		n=9	n=9	n=10

CNS=Clinical Nurse Specialist, CNC=Clinical Nurse Consultant.

3.4.3 Data Recording and Analysis

The data recording and analysis process was similar to that used in Study 2. The 12 interviews were digitally recorded and some handwritten notes were taken during or after the interview when observations were considered relevant or when specific segments of the conversation were interpreted as meaningful and useful to answer the research questions. On one occasion extensive notes were taken as the interview was conducted in a noisy environment and the clarification of some statements was necessary. This interview was followed by one telephone call to clarify a segment of the conversation. Transcribing of each recording was manually completed within one week of the interview and converted into a word document that was formatted to facilitate data management and analysis.

Qualitative content analysis was used to explore the textual data. In the initial stage of the analysis I created four categories, identified from the research questions, as a way to get into the data. These *a priori* categories included knowledge and skills, attributes, level of nursing practice and interprofessional learning. Engagement with the data was achieved through reading and re-reading the 12 transcripts and associated memos and annotations. This approach helped to expand coding through an iterative process leading to the creation of themes clearly defined to avoid duplication or overlap. The memos were also coded to allow for the identification of unexpected links between cases. Data collection and analysis for Studies 2 and 3 were conducted concurrently to allow for deeper exploration of the data and the emergence of common themes.

3.4.4 Reflexivity

Thorne (2008) warns about the common trap of interpreting data without considering the impact of our own personality, experiences and professional background on the analysis. This trap can be avoided through the process of reflexivity, as discussed below. The impact of my personal background, values and preconceptions on the analysis of Study 2 data raised my awareness about potential bias in my interpretation of the study data.

I had the insider research advantage of a close professional association with the NSW nursing community involved with the delivery of early interventions to families with complex needs. This link was forged several years ago when I was employed by NSW Department of Health as a policy analyst responsible for the development and implementation of the NSW Safe Start program described in Chapter 1. This role included extensive consultation with CFH services throughout NSW, especially with CFH nurses who play a key role in the implementation of the program. This led to the generation several years ago of a reciprocal, respectful and trusting rapport still present with some of the nurses who agreed to participate in the study. This familiarity was initially perceived only as beneficial as it led to in-depth open dialogues. However, it also carried the risk of contaminating the quality and depth of the interview process itself and bringing subjective interpretation into the analysis of the data. Great care was taken to remain objective and focused during the interview; the provision of the question guide prior to the interview to six participants appeared to facilitate the process. Interviewer and interviewees were less likely to divert into familiar grounds where past professional experiences had been shared. Critical reflection recorded in the research diary (discussed below) and undertaken consistently throughout the data analysis was essential to ensure that interpretation of the nurses' stories was not influenced by my assumptions about the meaning of what was said. A rigorous analysis and constant awareness of these risks meant that tacit knowledge based on familiarity with the participants facilitated greater understanding and useful new lines of inquiry.

A reflective journal was used throughout to complement the research process to set the environmental context for each interview. It included thoughts, queries and ideas about the data collected, the

progress of data collection and issues that required urgent interventions (Thorne, 2008). The reflective journal also served the purpose of reflexivity, where self-searching and constant reviewing of “conceptual baggage” (Hsiung, 2010) assisted with the identification of personal biases that could have impacted on the quality of the research (Fade, 2003). Reflective journaling and reflexivity had several benefits. Descriptive field notes and memos allowed the recording of memories of certain events as they were perceived at the time. These included: specific thoughts about the interview itself, including the circumstances of the interview; questions raised about observations; specific comments; observations about factors such as tone of voice; and any content of the narrative that appeared to be incongruent with the mood conveyed through body language. A second layer of journaling occurred during the manual transcribing of interviews into word documents and the analysis of the transcripts, where memos and annotations were used to record analytical notes that later on supported the thematic analysis.

Reflective journaling has an additional benefit of enhancing reflexivity and, more specifically, emotional reflexivity. Emotional reflexivity refers to the recognition and self-examination of personal emotions that may influence knowledge production (Jackson, Backett-Milburn, & Newall, 2013). Reflexivity has been proposed as a method used by qualitative researchers to validate their research practice (Cutcliffe & McKenna, 2002). Reflexivity helps to identify personal assumptions about data, whereby negative emotions such as personal values, beliefs and constructs can lead to judgement based on personal bias. This in turn can impact on the overall quality of the data collection by affecting which questions should be asked and which analytical angle is adopted (Ely, Anzul, Friedman, Garner, & McCormack Steinmetz, 1996; Hsiung, 2010),

Reflexivity has been argued to be essential for the researcher to situate herself in relation to the data (Haynes, 2012; Lambert, Jomeen, & McSherry, 2010). It provided me with the opportunity to consider my personal knowledge and experience in relation to the mothers’ narratives and my thoughts about the research process. A number of factors had to be acknowledged as potential sources of bias affecting the analysis, notably: the existence of close personal links between my professional role and my employment in a local parenting organisation attended by some mothers after the birth of their infant²²; my active partnerships with local organisations, especially with nurses working in local clinics; and my key role in developing and implementing the Safe Start program. I was also once a mother who would have qualified as vulnerable according to the Safe Start criterion of vulnerability and who, for a short period of time, depended on the knowledge, skills and attributes of community nurses to meet my needs. I addressed potential personal biases by writing about and challenging unexpected emotions that arose during data collection and analysis, by exploring their sources, and by

²² The parenting organisation provides nationwide telephone and web-based parenting advice to families with infants; it also delivers day and residential parenting interventions within a primary health care framework.

examining and challenging my personal beliefs and constructs. The process of reflexivity that I exercised throughout the study using reflective journaling supported greater self-awareness and questioning of personal assumptions essential to the data analysis and to the credibility of the research findings (Lambert et al., 2010).

3.4.5 Ethical considerations

PSI and Consent Forms were given to all participants and returned forms were stored electronically with interview recordings and transcripts on a password-protected PC and on an external drive located in a fire-proof safe. Hard copies were stored in a locked filing cabinet. Confidentiality was also ensured by de-identifying the participants using codes instead of names. No potential risk to the participants was identified in the ethics proposal.

3.5 Triangulation of the Data from the Three Studies

Triangulation was used to combine and compare the information obtained from the three sources of data. Portney and Watkins (1993) define triangulation as the process by which concepts are confirmed using at least three different sources of data to document phenomena. This method is also called data (source) triangulation (Kimchi, Polivka, & Sabol Stevenson, 1991; Shih, 1998) or person (data) triangulation (Fenech Adami & Kiger, 2005). The purpose of data/source/person triangulation is to reveal different perspectives from multiple sources, thus contributing to a richer and more complete picture of the topic being investigated.

Triangulation was used to strengthen the research design. It allowed for a complete picture of the nature of CFH nursing knowledge, skills and attributes explored in this research, enhancing the overall validity of its findings (Casey & Murphy, 2009). It bolstered the strength of the research findings as representing the true experiences of the participants who had agreed to be part of the research (Ely et al., 1996; Fenech Adami & Kiger, 2005) .

The type of triangulation used here is known as ‘within-method’ triangulation (Kimchi et al., 1991). Two qualitative approaches (Delphi technique and semi-structured interviewing) were used to add depth and breadth to the exploration of the nursing knowledge, skills and attributes required to meet the complex parenting needs of mothers in families with complex needs during the perinatal period. It provided an opportunity to look at the phenomenon of nursing knowledge, skills and attributes in their completeness from the three combined perspectives. These findings are presented in Chapter 7. The results of the individual studies are presented in the following three chapters.

3.6 Conclusion

This chapter 3 has described the overall research strategy used to address the three research questions using the three-pronged approach of seeking views from experts, consumers and nurses. Expert

consensus was sought using the Delphi technique and data on mothers' and nurses' experiences were collected using semi-structured interviews. The research design, the ethical considerations and the processes adopted for data collection and analysis of the three studies have been presented.

Chapter 4: Results Study 1: Seeking Expert Consensus

This chapter presents the results of Study 1, whose purpose was to solicit expert consensus using a Delphi technique. The aim of the study in answering the research question was threefold: to draw an expert consensus on the core knowledge, skills and personal attributes expected from nurses working with families with complex needs during the perinatal period; to determine if there was an expectation that these nurses were practising at an advanced level; and to seek the opinion of experts on whether interprofessional education might best meet the educational requirements of health professionals working with families with complex needs. The results of the three rounds of the Delphi study are presented below, followed by a discussion of the final themes representing consensus.

4.1 Round One Results

The first round focussed on element generation by asking seven open-ended questions that addressed the overarching research questions. Table 4.1 shows the research questions and corresponding interview questions that were sent to the 12 participants.

Prior to analysis of Round One data the decision was made to accept a minimum of 50% (at least six participants) as the lowest level of agreement that would be accepted as consensus on the identified element.

Table 4.1

Round One Questions

Research Question	Open-ended Questions
1. What are the core knowledge, skills and attributes required and demonstrated by nurses caring for families with complex needs during the perinatal period?	What are the core knowledge and skills nurses require working with families with complex needs during the perinatal period? To what extent do personal attributes influence the successful practice of the registered nurse working in the field of early childhood? If you believe personal characteristics and attributes are important, what are they?
2. Do nurses working with families with complex needs	Should nurses providing long term follow up to families with complex needs, be advanced practitioners? If you believe this how would you identify those practitioners?

	practise at an advanced level?	
3.	Is there a role for and are there any benefits in interprofessional education for registered nurses working with families with complex needs?	How appropriate is interprofessional education with a core curriculum for early childhood interventions? If you believe it is appropriate how might interprofessional education with a core curriculum be structured?

4.1.1 Research Question 1

As shown in Table 4.1 above, members of the expert panel were asked:

- What are the core knowledge and skills nurses require working with families with complex needs during the perinatal period?
- To what extent do personal attributes influence the successful practice of the registered nurse working in the field of early childhood?
- If you believe personal characteristics and attributes are important, what are they?

Some elements (e.g. reflective capacity, communication, engagement) were identified by participants in both the skill and attribute response categories. Ambiguous classification elements were re-categorised during the data analysis and each element was reassigned to the category with the larger number of mentions.

4.1.1.1 Core knowledge category

Twenty-one elements were identified for the core knowledge category of which 11 elements reached the agreed consensus of 50% (see Table 4.2).

Table 4.2

Knowledge category responses

Majority agreement elements	No. of responses (N=12)
Adult mental health	9
Professional knowledge (with credential) in the field of Child Family Health (including sleep settling, feeding, crying, motor development, toddlers' behaviour)	8
Public health (including primary health care, social determinants of health, health promotion. Sudden Infant Death Syndrome (SIDS), obesity prevention, child safety, community development, capacity building were specifically mentioned)	8
Infant growth and development (including brain development)	8

Ecological model of human development	7
Child protection	7
Knowledge of various legislative frameworks (including ethics, service systems, children's rights, privacy, rights & responsibilities, Mental Health Act, child protection)	7
Psychodynamics of family relationships	7
Domestic violence	7
Infant mental health	7
Cultural competence & sensitivity	6
Minority agreement elements	
Professional knowledge (credential) in the field of midwifery	5
Drug and alcohol	5
Transition to parenthood	5
Early interventions in parenting skills and early relationships formation	4
Motivational interviewing	1
Self-efficacy theory	1
Grief and loss	1
Quality assurance and practice development	1
Men's health	1
Women's health	1

4.1.1.2 Core skills category

Eighteen elements were identified in the core skills category, with only four elements meeting the agreed consensus (see Table 4.3). While a majority of participants agreed that the ability to conduct an assessment was essential, agreement was not reached about specific assessment areas or sub elements comprising psychosocial risks, parent-infant relationship, risk and protective factors and parenting capacity. The parenting capacity assessment skills sub-element was the only one to reach consensus.

Table 4.3

Skills Category

Majority Agreement Elements	No. of responses (N=12)
Reflective capacity	10
Advanced communication skills	7
Engagement skills	6
Assessment skills (four separate elements):	
<i>Psychosocial assessment skills</i>	3
<i>Parent infant relationship assessment skills</i>	3
<i>Risks and protective factors assessment skills</i>	1
<i>Parenting capacity assessment skills</i>	6
Minority agreement elements	
Working within interprofessional and interagency frameworks	5
Effective referrals based on knowledge of community services & resources	5
Problem solving, negotiating & challenging skills for effective care planning	5
Counselling skills for individuals & couples	3
Working from a strength-based solution-focused approach	3
Father-inclusive practice	2
Group work	2
Ability to apply research findings to practice	1
How to work therapeutically with parent-child using play	1
Comprehensive documentation reflective of family complexities	1

4.1.1.3 Core attributes category

All twelve participants agreed that personal attributes were important. However one participant suggested that:

They are necessary but not sufficient alone.....The ‘necessary but not sufficient’ message is important, because otherwise we get the suggestion that someone is just ‘a born nurse’, or you only need to be a ‘sensible mother’ to be a health visitor etc..., and the professional knowledge and skills get downgraded (P9).

Eighteen elements were identified in the core attributes category; no element reached the agreed consensus (see Table 4.4).

Table 4.4

Attributes Category

Element	No. of responses (N=12)
Empathy	5
Respect	5
Flexibility	5
Genuineness	5
Integrity	5
Emotional intelligence	4
Optimism	4
Honesty	4
Friendliness	3
Humility	2
Good listener	2
Trust	2
Tolerant of differences and uncertainty (non-judgemental)	2
Responsiveness	1
Professional maturity	1
Courage	1
Personal resilience	1

Six participants made reference to the Family Partnership Model²³ (Davis, (2009) in which respect, empathy, genuineness, personal integrity, humility, and quiet enthusiasm are identified as essential qualities of clinicians working with families. The list of qualities identified by Davis has similarities with the list of elements proposed by the participants. This finding is discussed in Chapter 7.

4.1.2 Research Question 2

Research question 2 was: *Do registered nurses working with families with complex needs practise at an advanced level?* The participants were asked:

- Should nurses providing long term follow-up be advanced practitioners?

²³ The Family Partnership Model (Davis, Day, & Bidmead, 2002) is identified by NSW Health as key training for primary health staff including nurses and midwives supporting parents during the perinatal period (NSW Health, 2010a).

If you believe this, how would you identify those practitioners?

Nine participants strongly agreed that nurses providing long term follow-up to families with complex needs should practise at an advanced level. For example:

‘Advanced’ includes knowledge but also experience (or success in working) with the population of concern (P6).

If the concern is about perinatal mental health....considerable skills are required (p9).

The complexities of being engaged in long term sustained relationships while supporting vulnerable families require advanced knowledge and skills (P11).

One participant was doubtful that current education programs in Australia adequately prepared nurses for the level of practice indicated to care for families with complex needs:

As the education programs now stand in Australia, all nurses are not currently able to provide effective care to vulnerable families. BUT if the education preparation was sufficient, perhaps they could be (P7).

Two participants were doubtful about the need for advanced nursing practice because

all CFHNS will be working with some families who are vulnerable and in need of extra support (P10)

One participant, who did not agree that advanced practice was essential, commented on elements of practice that were important:

The important aspect is that workers are supervised, understand relationship boundaries and have access to supervision (P5).

4.1.2.1 Characteristics of advanced nurse practitioners

There were few areas of agreement on the question “How would you identify advanced practitioners?” Several participants agreed that they would look for a nurse with effective engagement techniques and robust communication skills. One participant called attention to the fact that the nurse may not need considerable mental health knowledge but could instead

continue to work with the parent on the skills related to developing parenting knowledge and then work in collaboration with the mental health nurse or the social worker or the psychologist (P10).

One participant, who identified advocacy as an important characteristic of nurses who would be expected to support families’ rights, cautioned that the complexity of the concept of advocacy may not be within the realm of a novice practitioner:

It is important for the clinician to be knowledgeable of the child and parents' rights and be able to mobilise resources (and or take a stand) to ensure that rights are upheld in the interests of the parent and child in the event that there are bureaucratic rules that may be enforced at the expense of the child or parents. This is not easily done by a novice practitioner (P9).

4.1.3 Research Question 3

This question explored the potential role and benefits of professional education for nurses working with families with complex needs. The participants were asked:

- How appropriate is interprofessional education with a core curriculum for early childhood interventions?
- How might interprofessional education with a core curriculum be structured?

4.1.3.1 Support for interprofessional education

Nine participants supported interprofessional education with a core curriculum for professionals working with families with complex needs. For example:

The knowledge and skills required for early childhood work are not specific to anyone profession and while there are some profession-specific skills, most of the knowledge and skills required can be taught in an interprofessional setting (P1).

Several potential gains from interprofessional education were suggested:

It would change the current culture of silo and autonomous practice (P2).

It would support good decision making and referral pathways determination... It would help with siloed thinking and professional tribalism (P6).

Different disciplines would be better able to communicate with each other as it would foster a core understanding and language around working with vulnerable families (P9).

This is vital given the need to draw upon the knowledge and skills of a diverse range of health professionals to address the complex needs of vulnerable families... It supports gaining a truly comprehensive picture of the needs of families and the development of appropriate management plans to address those needs (P11).

One participant identified the benefits of a shared curriculum using case-study learning in this way:

interprofessional groups working together to enrich the others' understanding of the aetiology of a particular problem and the resources or approaches that could be apply to modify or enrich the family's environment....[It would also]...help each discipline including nursing to articulate its unique component or skill set (P6)

Two experts, however, disagreed with the broad idea of a core curriculum, suggesting that some subjects could be open to relevant disciplines:

If well thought out, I think this could be both appropriate and realistic....While the 'health' knowledge and skills of nurses is important to recognise and maintain, there are some areas where the skills are generic to all who work with children and families and who do interventions (P10).

I think it can potentially confuse the role of the relevant discipline.....I probably support shared subjects but not shared core curriculum (P8).

One expert did not support the promotion of interprofessional education, citing the example of countries such as Canada where an interprofessional approach did not bring about predicted positive outcomes. The expert did not elaborate on those outcomes.

4.1.3.2 Components of a common curriculum

The following topics were identified as potential key subjects/units in a common curriculum:

- Articulation of key models/theories and approaches that inform early parenting and early childhood development;
- Primary health care principles;
- Leadership and critical analysis skills;
- Mental health (adult, infant, perinatal) and drug and alcohol issues in the family context;
- Working in partnership with families.

The experts' responses to the Round One questions were distilled into a series of statements to which the participants were asked to respond in round two.

4.2 Round Two Results

The round two questionnaire contained a series of statements distilled from the elements that drew strong consensual agreements in Round One. A glossary of terms was also included to prevent any ambiguity about a descriptor. It clarified statements made by participants or briefly explained concepts drawn from participants' responses. The questionnaire used a combination of Likert scales and yes/no response boxes. Participants were also asked to respond to 13 specific questions.

The second round of the Delphi study was divided into four sections:

- The elements that the majority thought were important. This section used mainly Likert scales with options indicating three levels of importance (medium, high, very high);
- Specific elements listed by fewer than six participants using a combination of Likert scales and yes/no response boxes. The elements were selected because it was felt that participants may have overlooked

them rather than deliberately omitted them and some further discussion would inform the research questions;

- The issue of formal nursing qualifications commented on by several experts. A Likert scale was used for the second level of exploration;
- Participants' feedback on interprofessional education and the content of a potential curriculum. The participants were asked to agree or disagree on seven elements.

4.2.1 Elements that Reached Consensus

This section examines the elements that reached consensus in the knowledge, skills and attributes' categories.

4.2.1.1 Knowledge category

This category includes the knowledge elements that a majority of respondents considered important. The respondents were asked to identify the level of importance attached to each element without ranking them. All nine elements were scored in the 'very high' category. However not all results were consistent with the Round One results. This discrepancy might reflect the complexity of some elements such as knowledge about mental health and domestic violence. Table 4.5 identifies the nine important knowledge elements and the number of participants who ascribed medium, high or very high levels of importance to them.

Table 4.5

Importance of Knowledge Elements

Knowledge element	Med.	High	Very High
Professional knowledge in the field of child and family health		1	11
Understanding of psychodynamics of family relationships including transition to parenthood	1	2	9
Infant mental health		3	9
Knowledge of Child Protection Legal Framework including relevant legislations	3	1	8
Understanding of public health principles	1	4	7
Knowledge of fetal and infant growth and development		5	7
Knowledge of the ecological model of human development	1	4	7
Domestic violence	1	5	6
Adult mental health	2	5	5

All participants agreed that professional knowledge in the field of child and family health was of high or very high importance, and 11 participants rated understanding of psychodynamics of family relationships, including transition to parenthood, as of high or very high importance.

Adult mental health had achieved the highest consensus score (n=9) in Round One but only five participants believed it to be very important in Round Two. In contrast six participants agreed on the importance of infant mental health in Round One, but nine attributed a very high level of importance to it in Round Two.

One participant commented on the lack of clarity about the concepts of adult and infant mental health:

This does need some defining because some people may think of it as mental ill-health and pathology - i.e. working with parents with mental health diagnoses, whereas I define it as social and emotional wellbeing and being able to be emotionally available to their children (P7).

The lack of consistency and clarity about the concept of mental health is discussed in Chapter 7.

The same participant also suggested placing domestic violence within a broader violence and trauma element that would integrate the experience of violence in multiple settings within and outside of a domestic context:

I would broaden this to be under the heading of ‘violence and trauma’ and its effect on child development – domestic or family violence would then be only one component with other violence and trauma being relevant, particularly for refugee populations plus short term trauma for families - flood, cyclone, death of a parent etc. (P7)

Opinion about the importance of knowledge of the child protection legal framework, including relevant legislation, was divided, with three participants rating the element as of moderate importance only. This finding was consistent with Round One responses. It also supports the skills category findings presented in Table 4.6 in the next section.

4.2.1.2 Skills category

The participants were asked to rank skills elements by level of importance. Table 4.6 shows a strong consensus on five elements but divided opinions on the element of assessment and management of child abuse.

Table 4.6

Importance of Skills Elements

Element	Med.	High	Very High
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Reflective capacity	2	10	
Engagement skills		12	
Communication skills		12	
Assessment of risks and protective factors		12	
Cultural sensitivity	2	10	
Assessment and management of child abuse	2	4	6

One participant commented further on the assessment and management of the child abuse element:

- (a) A strength-based approach: more work with protective factors rather than assessment, use of strength based approaches etc.[this is] easy to teach, hard to do in practice, particularly with nurses coming from a medical model of care ;
- (b) Use of appropriate language: I would not call it this - but working with vulnerable families and understanding why abuse occurs and working to prevent it (P7).

Another suggested that, while the six skills were essential, they should be expected as prerequisites to entering the field of CFH since they were core nursing competencies.

13 questions were included in the Round Two questionnaire with the purpose of clarifying some individual responses and comments that may or may not have reached consensus but were considered of relevance to the research questions. Responses to two of these questions are discussed below.

Question 1

The panel was asked if engagement and communication should be considered as two different skill sets. While eight participants agreed that the two skills were different, one participant commented:

They are probably not really different; I would say that engagement skills are a subset of communication skills (P10).

Question 2

Participants were asked if they agreed with the observation that the current educational preparation for RNs planning to work with these families was not adequate. Ten participants agreed; one overseas participant agreed from a UK perspective and one participant commented that the situation was not ‘universal across Australia’ (P5).

4.2.2 Elements of Relevance that did not Reach Consensus

This section brought specific elements listed by less than 50% of participants in Round One to the attention of the panel for further consideration in Round Two, using a combination of Likert scales and yes/no response boxes.

4.2.2.1 Core knowledge elements that did not reach consensus in Round One

Question 3

In Round Two, participants were asked how important they believed knowledge about drug and alcohol misuse to be. Three of them believed it was very important, six believed it to be highly important and three judged it to be of medium importance. One participant suggested that drug and alcohol misuse should be integrated with adult mental health knowledge and skills:

better to link it into adult mental health and getting them to understand WHY parents use alcohol and drugs and when it is harmful. Loads of parents use it recreationally and are very capable parents (P7).

Question 4

In Round One four experts identified Sudden Infant Death Syndrome (SIDS), obesity prevention, child safety, community development and capacity building as areas of health promotion within the broader context of public health that required particular consideration. Participants were asked if they agreed that each of the five areas should be core elements within a proposed curriculum. All 12 respondents agreed that knowledge about SIDS, child safety and capacity building were essential; one disagreed with the inclusion of obesity prevention and two with community development.

Participants were encouraged, if they answered negatively to any of the elements, to explain why they thought that the element should not be included. Consequently valuable comments were provided by participants who may or may not have agreed with the statements. One participant agreed with the inclusion of the five proposed health promotion areas but commented:

I do not think that these are all of the same order. I would expect for example that SIDS could be integrated into an example of prevention education strategies; while community development is a much more complex content area, often under-developed and poorly taught as there are few models in practice, yet essential for work with and within vulnerable communities...Similarly obesity is priority; however, it is often reduced to nutrition and or activity programs without attention being paid to the social determinants of health that make it more likely for some children to have diets high in carbohydrates and low exposure to healthy activities (P 6).

Another commented in relation to child safety and community development that it is:

better to understand why some families don't do it [child safety], and look...at harm minimisation...it needs to be presented while challenging western values...Nurses and

midwives need to stop judging families based on what is accepted behaviour to them as health professionals... [Community development] depends on how it is done. Just telling people what it is does little to change anything. (P7)

Several participants suggested that, while it would be essential to prioritise key elements when considering the content of a proposed curriculum, it was difficult for them to elaborate on the issue in the current study:

Some of the questions are difficult to answer without knowing what type of education program is being developed (P10).

It would depend on how much time is available. I would choose to do essential things really well and compromise on some things so that the course doesn't end up being too generic (P9).

Question 5

Five core knowledge elements were mentioned only once in Round One's responses. However it was felt that further exploration of each element would be beneficial to the study. The participants were asked to reconsider whether any of the elements were of importance. They were prompted to comment on the elements that they felt should not be included.

Eight participants agreed on the importance of motivational interviewing, self-efficacy, and grief and loss counselling, but a majority pointed out the risk of an overloaded curriculum that would be too broad; hence there was a need to focus on essential learning priorities. P7 commented on the importance of self-efficacy and grief and loss counselling as educational elements:

There are lots of theories [about self-efficacy] and so unless it is embedded and actually applied to practice, I am not sure that it would be that useful...[Grief and loss] I would prefer to include stress and trauma and their influence on child development (P7).

Specific knowledge of men's and women's health was not identified as important for nurses working with families with complex needs. P1's comment reflects other participants' views that, while men's and women's health are two specialist knowledge areas, they are not essential to the practice of nurses working with families with complex needs:

For both areas the health of men and women should be covered but not in depth, i.e. it is more about preparing the health care worker to identify when referral is required rather than addressing the health specifically in regard to men and women's health...I would assume that an advanced practitioner has knowledge of this basic education (P1).

4.2.2.2 Core skills elements that did not reach consensus in Round One

Question 6

In Round One a minority of experts identified a series of elements in the skills category that they considered important. In Round Two the panel was asked to reconsider those elements and reflect on their level of importance (see Table 4.7).

Table 4.7

Round 2 Core Skills Elements Reconsidered

Skills element	Not important	How important?		
		Med	High	Very High
Working within an interprofessional and interagency framework		1	3	8
Refer effectively through sound knowledge of community services and resources			1	11
Assessment of the parent-infant relationship		1	2	9
Psychosocial assessment of the parent			4	8
Working from a strength-based, solution-focused approach		1		11
Father-inclusive approach			3	9
Group work	2	2	6	2

The majority of participants agreed that the following elements were of high or very high importance: working within an interprofessional and interagency framework; referring effectively through sound knowledge of community services and resources; assessment of the parent infant relationship; psychosocial assessment of the parent; working from a strength-based, solution-focused approach and working from a father-inclusive approach. These results demonstrated the benefit of investigating further elements that were not identified by the majority of respondents in Round One. Only three participants listed strength-based, solution-focused practice as a core skill in Round One. However, when the element was brought to the panel's attention in Round Two, a majority agreed that this skill was essential. A similar outcome was reached for the 'sound knowledge of community resources' element. Notwithstanding that a majority of participants did not believe that knowledge in men's health was essential, nine agreed that a father-inclusive approach was of very high importance.

Question 7

In Round One four elements received only one mention each. However I needed to know if the other participants would rate them as important if prompted. While consensus was reached for the four elements, 12 agreed that comprehensive documentation reflective of family complexity was essential and 9 recognised the importance of being able to apply research findings into practice. Nonetheless

opinions were divided about the importance of the ability to work therapeutically with parent-child using play (n=7) and having the capacity to supervise and mentor (n=6).

4.2.2.3 Core attributes elements that did not reach consensus in Round One

Question 8

In Round One the participants identified **17** important personal attributes but consensus was not reached for any of these. For that reason the panel was asked to reconsider the elements and score them for importance. Most participants agreed that the 17 elements were highly or very highly important (see Table 4.8).

Empathy, respect, flexibility, genuineness, integrity, emotional intelligence, optimism, trust, honesty, humility, good listener, friendliness, professional maturity, courage, responsiveness and tolerance of differences were rated as being of high or very high importance by all respondents. P1 pointed out that most of the listed attributes were identified in the Family Partnership model as essential to support families with complex needs. This finding will be discussed in Chapter 7.

Table 4.8

Importance of Nurses' Attributes

Attribute elements	Not important	Important			Total: high/very high
		medium	high	very high	
Empathy		3	9		12
Respect			2	10	12
Flexibility		1	4	7	11
Genuineness			3	9	12
Integrity			3	9	12
Emotional intelligence		1	3	8	11
Optimism	1		5	6	11
Honesty	1		3	8	11
Friendliness		1	6	5	11
Humility		2	4	6	11
Good listener		1	3	8	11
Trust			2	10	12
Tolerant of differences			2	9	11
Responsive		1	3	7	10

Table 4.8

Importance of Nurses' Attributes

Attribute elements	Not important	Important			Total: high/very high
		medium	high	very high	
Professional maturity	1		5	5	10
Courage	1		7	4	11
Personal resilience			7	4	11

4.2.2.4 Advanced nursing practice elements that did not reach consensus in Round One*Question 9*

The panel was asked about specific criteria that would support the recognition of advanced practice in nurses working with families with complex needs. A majority of respondents agreed that the following criteria indicated an advanced level of nursing practice: decision making, reflective practice and critical thinking; commitment to ongoing professional development combined with awareness of new evidence in the field of early childhood; understanding and advocacy of children's rights and partnership with community services and resources.

4.2.3 Postgraduate Nursing Education

Although not specifically requested to do so, a number of experts in Round One made reference to the issue of professional qualifications. Three participants identified both midwifery and child and family health nursing as essential; one believed that child and family health nursing was the only essential postgraduate qualification and one identified paediatric nursing as adequate. In Round Two the issue of essential clinical postgraduate courses for nurses working with families with complex needs was explored further.

Question 10

In Round One several participants identified three formal postgraduate qualifications (child and family health nursing, midwifery and paediatric nursing) for nurses working with families with complex needs but consensus was not achieved. In Round Two the panel was asked to reconsider the importance of the three nursing qualifications and to score each one in order of importance. Postgraduate infant and adult mental health qualifications were not specifically identified in Round One, therefore they were not included in this list. Agreement about the three listed postgraduate nursing qualifications was not reached. However ten participants agreed that the importance of a postgraduate nursing qualification in child and family health was high or very high. Both midwifery

and paediatric nursing were identified as moderately important. Participant 10 felt that direct entry Midwifery should be included as an essential qualification.

Question 11

In Round One, one expert stated that current Australian nursing qualifications did not adequately equip nurses to practise according to expected professional practice standards (NSW Health, 2010a, 2011) when caring for families with complex needs. In Round Two the participants were asked if they agreed with this statement. Eleven participants answered the question; one strongly disagreed, two agreed, four strongly agreed and four stated that they did not know. Two were international experts who did not feel sufficiently familiar with the Australian nursing education system to respond. Participant 11 commented on her response of 'I don't know':

I believe the content of these courses [Postgraduate child and family health nursing] have been strengthened in recent years and prepared the RN to care for vulnerable families. This is however difficult as there are differences in course content and I do not have a thorough knowledge of courses outside those offered in NSW (P11).

Question 12

The participants were asked if they thought that a different postgraduate nursing course was required for RNs working with families with complex needs during the perinatal period and at what level the qualification should be. Six participants agreed that a postgraduate diploma was a viable option and four believed that a Clinical Masters would be the best option. P7 did not believe that a new course was indicated:

It does not have to be a new post graduate course... [W]e just have to improve the content of the current undergraduate and post graduate programs (P7).

P10 suggested the articulation of the postgraduate course with a Master's program:

It would be feasible to have a graduate diploma in child and family health and potentially it could be possible to build on this with a Masters level qualification to develop advanced knowledge and skills (P10).

4.2.4 Interprofessional Education

Round Two sought the participants' opinions about the appropriateness of interprofessional education with a core curriculum for professionals working with families with complex needs.

Participants were asked whether they agreed or disagreed with interprofessional education; they were also asked to select between the two options of (a) a generic postgraduate course or (b) a series of generic subjects available to relevant disciplines. Nine participants agreed about the relevance of interprofessional education; three agreed with (a) and six chose option (b).

Question 13

In Round One seven elements were identified as potential core components of an interprofessional course. Results of Round Two feedback are shown in Table 4.9.

Participant 1 cautioned about potential risks when contemplating the development of interprofessional education programs:

I would caution that it is possible to have too much, as well as too little, interdisciplinarity' in education. If a program is designed to have some meaning for everyone, it can end with the level and extent of that meaning being limited – a good balance between 'core' and 'specialist' is required. I would suggest that not less than 50% should be specific to the professional qualification being studied (P1).

Participant 6, who disagreed with interprofessional education, felt that the capacity to work within an interprofessional model should instead be achieved through nursing practice modelling.

Findings from Round Two were analysed and reported in the final (round three) feedback sent to the twelve experts for comment and clarification. The results of Study 1 are summarised in the following section.

Table 4.9

Key Elements in an Interprofessional Course

Element	Agree	Disagree
Articulation of key models/theories and approaches that inform early parenting and early childhood interventions	12	
Working in partnership with families (deviation from expert model)	12	
A subject framework is based on the primary health care principles of physical needs (early intervention programs), psychosocial needs (adversity/social determinants of health) and environment needs (equity of access)	12	
Leadership and critical analysis	11	1
Perinatal Mental Health that includes the adult and the infant within a family context	12	
Child growth and development within a social context and that includes the development of optimal relationships	12	

4.3 Summary of Study 1 Results

Several consistent themes emerged from analysis of the responses across Rounds One and Two. These are summarised below in relation to each of the research questions.

4.3.1 Core Knowledge, Skills and Attributes for Nurses Caring for Families With Complex Needs

Consensus was achieved for the following core knowledge elements:

- Professional knowledge in child and family health
- Public health principles with attention to four specific elements of essential health promotion knowledge within the broader context of public health:
- SIDS
- Obesity prevention
- Child safety
- Capacity building
- Foetal and infant growth and development
- Ecological model of human development
- Psychodynamics of family relationships including transition to parenthood
- Child protection legal framework including relevant legislation
- Adult mental health
- Infant mental health
- Domestic violence

Consensus was achieved for the following core skills elements:

- Engagement
- Communication
- Assessment skills divided into five domains:
- Assessment of risks and protective factors
- Assessment and management of child abuse
- Assessment of parent-infant relationship
- Assessment of parenting capacity
- Psychosocial assessment of parents
- Reflective capacity
- Cultural sensitivity

- Ability to work therapeutically with parent-child using play
- Working from a strength-based, solution-focused approach
- Working within an interprofessional and interagency framework
- Effective referrals through sound knowledge of community services and resources
- Ability to apply research findings into practice
- Comprehensive documentation reflective of family complexities
- Capacity to supervise and mentor other professionals.

The following attributes were identified as having a high or very high level of importance:

- Empathy
- Respect
- Flexibility
- Genuineness
- Integrity
- Optimism
- Emotional intelligence
- Honesty
- Humility
- Good listener
- Trust
- Tolerant of differences
- Responsiveness

4.3.2 Nurses' Indicated Level of Practice

Experts agreed that nurses providing long term follow-up to families with complex needs should practise at an advanced level. They also agreed that the current educational preparation for nurses planning to work with complex families was not adequate.

Experts listed the following characteristics that they believed indicated that nurses were working at an advanced level with families with complex needs during the perinatal period:

- Demonstration of excellent decision-making, reflective practice and critical thinking
- Commitment to ongoing professional development
- Keeping abreast of research in the field of early childhood
- Advocacy for children's rights

- Working in partnership with community services and resources
- Working successfully with families with complex needs.

Experts agreed that interprofessional education with a core curriculum for early childhood interventions was highly appropriate and consensus was reached for a series of core subjects or units believed to be relevant to an interprofessional curriculum. Elements that reached consensus were:

- Articulation of key models/theories and approaches that inform early parenting and early childhood interventions
- Working in partnership with families (deviation from expert model)
- Leadership and critical analysis
- Perinatal mental health that includes the adult and the infant within a family context
- Child growth and development within a social context that includes the development of optimal relationships.

Ten of the twelve experts acknowledged receiving the Round Three feedback letter and agreed that the study's findings reflected their responses throughout the three rounds. Participant 7 offered the following final suggestion:

In the final table of your feedback there was consensus that perinatal mental health includes the adult and the infant within the family context. I am wondering if the term perinatal and infant mental health describes it better and as expert that term should always be used when including the infant (P7).

4.4 Conclusion

Study 1 used the Delphi technique to draw an expert consensus on the core knowledge, skills and personal attributes expected from nurses working with families with complex needs during the perinatal period. It aimed to determine if there was an expectation that these nurses were practising at an advanced level and it sought experts' opinions on whether interprofessional education might best meet the educational requirements of health professionals working with families with complex needs.

This chapter reported the findings of the Delphi study. While participants agreed on the importance of several elements of knowledge, skills and attributes, individual participants highlighted the lack of clarity and definition of some of those elements. Both child protection and mental health are examples of such broad, complex elements that are difficult to translate into well-defined nursing knowledge and skills. Similar ambiguity was noted in relation to the concepts of health promotion and public health in relation to CFH nurses' knowledge and skills. Those issues will be discussed in Chapter 7.

The findings from this study provided a platform that guided the inquiry in Studies 2 and 3. The findings of these studies are presented in the following two chapters.

Chapter 5: Results Study 2: Mothers' Experiences of Nursing Support

This chapter presents the findings from in-depth interviews with ten mothers who had infants under the age of two years. This study addressed the three research questions but had particular focus on Question1: What knowledge, skills and attributes are required for registered nurses to provide adequate support to families with complex needs?

Although exemplars of best practice were sought in the interviews, mothers had little to say about good nursing practice, often preferring to talk about how the care they received was actually the antithesis of what best practice might look like. This unexpected issue was discussed in Chapter 3 and will be examined further in Chapter 7. The accounts of the mothers varied widely, with descriptions of both positive and negative experiences. Key emerging themes related to their breastfeeding experiences and alternative sources of support.

Section one of this chapter describes mothers' characteristics. Section two discusses the categories of staff who cared for them and presents mothers' accounts of positive and negative experiences of this care. Subsequent sections report on mothers' perceptions of nursing work, accounts of their breastfeeding experiences and alternate sources of support and guidance.

5.1 Characteristics of Participants

Table 5.1 shows the following health-related characteristics of the participating mothers: vaginal birth (VB) or Caesarean section (CS); location of the birth in the private or public sector; the complex needs identified by health services; and the involvement of specific community agencies (NGOs) that delivered early intervention (EI) to the families once they had been identified as having potential risk factors²⁴.

²⁴ In the context of this thesis early intervention refers to strategies focused on the early years of life that are put in place with families identified as at risk of or having complex needs (NSW Health, 2010a).

Table 5.1
Mothers' Health Characteristics

	Delivery type Public or private sector		Complex needs identified by health services	Targeted early interventions
M1	VB	Public		Nil
M2	CS	Private	Physical problems Social and emotional isolation	Nil
M3	VB	Private		Nil
M4	CS	Private		Nil
M5	VB	Public	Single mother Grieving for her late mother Twin birth Premature birth Homeless Social Isolation Past refugee status Diabetes Limited English	Yes (NGOs)
M6	VB	Private		Nil
M7	CS	Public	Significant breastfeeding issues with first child Childhood abuse Limited social and emotional support Recent emigration	Yes (NGO)
M8	VB	Public	Social issues: 4 children under 6 including twins 2 bedroom apartment Husband unemployed Financial difficulties Limited family support. Gestational hypertension	Yes (NGO)
M9	VB	Public	Limited emotional support Significant geographical move in past 4 months Four children including twins Older child diagnosed with Attention Deficit Disorder	Yes (NGO)
M10	VB	Public	Social isolation Moved house Financial difficulties	

Three mothers (M3, M4, M6) were not identified in table 5.1 as having complex needs according to the NSW Safe Start psychosocial assessment of risk factors that include: lack of support; major stressors in the past months; low self-esteem; history of anxiety, depression or other mental health problems; couple's relationship problems; adverse childhood experiences; and domestic violence (p. 20). However, because they self-selected, they were not turned away. While they did not fit official criteria set by health services, they had interesting stories to tell.

5.2 Staff Status and Experiences of Care

When mothers recounted their stories they referred to four distinct periods of time during which they received care from midwives and CFH nurses: the antenatal and delivery period (time period 1); the postnatal hospital period (time period 2); the early postnatal period following discharge from hospital (time period 3); and the long-term postnatal community clinic period (time period 4).

Within these time periods the mothers identified different groups of staff who cared for them, usually describing them as nurses or midwives. In time period 1, most women stated that they only saw midwives; in time period 2, the women indicated that they were cared for by midwives and nurses; in time period 3 they were also cared for by midwives and nurses. In time period 4, CFH nurses attended to their needs, mainly in early childhood clinics, but some mothers also received community-based early interventions delivered by non-government organisation (NGO) workers, including volunteers. Early Intervention programs were available to the families for up to two years following the birth.

This section presents the mothers' accounts of their positive, negative and mixed experiences with staff across these time periods.

5.2.1 Staff Status

The mothers were not certain whether their care was received from nurses or midwives and were unable to identify with confidence the professional background of the staff, either in hospital or in the community. Some mothers simply referred to the clinicians who cared for them as 'ladies':

[She was] a nice lady who was really helpful (M2).

M2 was talking about her nursing experience in the postnatal ward of the private hospital where she gave birth. The "lady" could have been a midwife, a registered nurse, an enrolled nurse or an assistant in nursing. Similarly:

The ladies that I had I found very good (M4).

Mothers reported some confusion in time periods 2 and 3 when multiple health professionals were involved at once. M5 had a particularly difficult time identifying the various staff involved in her care and the care of her twins, who were born 12 weeks premature. The infants were unwell and remained in hospital for three months. The mother presented with complex risk factors (see Table 5.1) that required multiple interventions delivered by professionals from various backgrounds. When asked about nursing care following the children's discharge from hospital she said:

Yes the hospital nurse then the clinic nurse they came to my home. They check what I am doing and they write something in my papers but I did not know...I don't know if some nurse at the hospital called DoCS [NSW Department of Community Services] (M5).

Confusion about professional background did not automatically generate negative experiences. When asked about hardship and feeling sad, M5 remembered the name of the clinician who cared for her and recalled her positive attitude:

Many times they say K is going to die I must come. I cried, the nurse was nice, she gave me tissues. The nurse was called Mary, she is always very nice. She helps me to go to a nice hostel (M5).

It was sometimes hard to determine whether the mothers were using different terms to describe the same person. M6 told of her experience during the postnatal period when she was still in hospital, struggling with breastfeeding. In consecutive statements she refers to the midwife and the nurse, who may or may not have been the same person:

There was a good experience with the midwife before my discharge. Any anxiety that I may have had before leaving the hospital was alleviated by having a long discussion with the nurse. Then another woman came on day four to bring a nipple shield (M6).

M9 had been concerned while she was pregnant about psychosocial issues that she felt could have compromised her family stability. She sought help from her local early childhood clinic. She was unaware of the professional background of the person who helped her but this did not concern her as she was able to receive the help that she sought:

Paula who was a social worker or a nurse said 'Look at services in your area and say that you could not find vacancies' (M9).

In contrast most mothers who attended the local clinic during time period 4 were aware that they were dealing with child and family health nurses, as reported by one mother:

When I see a GP he is a male, he is always in a rush...The early childhood nurses don't rush you, they allow you to take your time...After the birth I was glad that I could see an early childhood nurse (M8).

Although mothers' lack of awareness of their caregivers' professional background was not of great significance to them, they were highly sensitive to the quality of care that they received throughout the perinatal period.

5.2.2 Positive and Negative Experiences with Nursing and Midwifery Care

Mothers expressed a range of positive, negative and mixed feelings about the care that they received (Table 5.2). As can be seen in Table 5.3, however, mothers identified only positive or negative experiences during time periods 1 and 3 and mixed experiences only during time periods 2 and 4.

Table 5.2

Mothers' Positive, Negative and Mixed Experiences of Care

	Time period 1 Midwives	Time period 2 Midwives/nurses	Time period 3 Midwives/CFH nurses	Time period 4 CFH nurses
M10	positive	negative	negative	mixed
M9				mixed
M8				positive
M7	positive		positive	mixed
M6	negative	mixed	positive	positive
M5		mixed	negative	positive
M4		mixed		positive
M3	negative			mixed
M2		mixed		mixed
M1	positive	negative	Positive	

Table 5.3

Number of Mothers who had Positive, Negative or Mixed Experiences

Time period	Positive experiences	Negative experiences	Mixed experiences
1	3	2	0
2	0	2	4
3	3	2	0
4	4	0	5

Those findings are discussed in Chapter 7.

5.3 Mothers' Accounts of what Nurses Do

Three themes emerged from mothers' accounts of the work activities that CFH nurses performed during their meetings: attending to the needs of infants by assessing and monitoring their developmental growth, both formally and informally; assisting mothers with parentcraft skills; and assessing the mothers' emotional needs and screening for depression.

5.3.1 Assessment of Infant Growth and Development

Ten mothers reported that nurses from the local early childhood clinic checked and monitored the growth and development of their infants; six of these specifically mentioned that the nurses conducted formal comprehensive assessments using the Blue Book²⁵ (Child Personal Health Record). The other four mothers referred to informal assessment of the child's progress or check-up by the nurse. One mother reported an informal assessment by the community midwife in the early postnatal period and a further formal assessment using the Blue Book by the child and family health nurse. The women's straightforward narratives about infants' check-ups indicated an expectation that they would take place, but also a sense of trust and confidence that the nurse would perform the task correctly.

One mother recounts her reliance on the clinic nurses who conducted comprehensive checks of her infant:

²⁵ The Child Personal Health Record (known as the 'Blue Book') is an important book for parents and their child. It records the child's health, illnesses, injuries, and growth and development and contains valuable health information that parents and their child may need throughout their life. Local child and family health nurses offer developmental checks at the following recommended ages: 1-4 weeks, 6-8 weeks, 6 months, 12 months, 18 months, 2, 3 and 4 years (NSW Ministry of Health, 2013)

I went there just for the weekly/monthly check-up just to make sure that P was developing well, feeding, sleeping well, and growing, thriving and later on to check that he was growing appropriately...I found the nurses at the local clinic to be open, easy to talk, friendly and knowledgeable (M4).

M8, a mother of four children including twin infants, described various activities undertaken by the nurse who visited her at home shortly after the birth of the twins and her satisfaction with the care that she received:

She brought the necessary equipment with her to check the babies like weighing them...After the weighing, the checking out...she helped by giving the bottle to one of them and helped me to put them to sleep. She brought the paperwork, the Blue Book that she filled in. She fed him and nursed him and this is how we started talking. I told her that I had a bad disagreement with my sister...I was quite happy that she was checking them all around. I was totally happy with what she did. She told me that I was going in the right direction; I was OK...After the birth I am glad that I could see early childhood nurses.

M9, a mother of four, was matter of fact about the 'stuff' that nurses do:

The ladies from the health centre they came out a couple of weeks after they (twins) were born and they did the weighing and all that sort of stuff.

Other mothers described similar activities:

Things were to be done...things like weigh, measure, filling in the Blue Book (M3).

The nurses they weigh, measure, write the health book (M5).

The nurse completed it [the Blue Book] each time we go to the clinic. She ticked all the boxes (M7).

5.3.2 Parentcraft Education

In addition to infant assessment, three mothers of twins commented on the support nurses provided to enhance their parentcraft²⁶ skills. M5 experienced difficulties caring for her premature twins and her ability to parent safely was questioned by DoCS. She described how the nurses provided her with education and guidance to ensure that she would not be separated from her infants.

When the case goes to court [mother had to attend court following child protection issues] the nurse comes to my house, weighs the babies, tells me how to stroke the babies, how to sleep

²⁶ The term 'parentcraft' refers to the skills and knowledge used by parents in raising children.

the babies—that is the nurse from the health centre...The babies cry, I learn to feed, clean the babies and put babies to bed...They teach me how to play with babies.

M8 related her positive experience when she expressed some concerns about her babies to the nurse who visited her at home:

She helped by giving the bottle to one of them and helped me to put them to sleep [M5 had noticed that the babies' stomach was wobbling when they were fed]. She explained that it was normal because they had just drunk their milk. I did ask questions about their eyes. She explained everything to me.

M9, a mother of two older children, recounted how the early childhood nurse assisted her when she visited the clinic for the first time with the twins:

She knew we were new, she was really thorough, she gave me some CDs and DVDs on various stages for the twins, how to help them to speak, she also gave me pamphlets that teach us on how to encourage children to speak at the right time and all that stuff. She was great despite the fact that I had kids.

Mothers acknowledged the nurses' skills in assessing their infants' growth and development and the encouragement they received with their parenting skills through face to face education and access to valuable information. They also recognised that most nurses inquired about their emotional and mental health. The next section explores the mothers' perceptions of the formal and informal strategies nurses used to inquire about their psychosocial wellbeing.

5.3.3 Assessment of Maternal Psychosocial Risk Factors

When mothers spoke about the nurses' and midwives' inquiries about their emotional wellbeing they mentioned both informal conversations and the use of formal questionnaires. M6 shared her experience of an informal assessment where the nurse explored relevant questions with her:

The nurse who visited...she went through the questions with me, asked added questions. I felt they were obvious questions; I was not surprised...she approached the issue of depression but all was OK. She also rang me later on to see if I was still OK. I could have taken up the offer of help if I had problems at the time (M6).

M1 did not remember completing any questionnaire but when asked 'When the midwife visited you at home what sort of things did she do?' she recalled the midwife enquiring about her emotional state:

As well I did get emotional support to see how I was, how I was feeling about things (M1).

The formal psychosocial questionnaires referred to by mothers are tools recommended to identify families' strengths and vulnerabilities early in order to plan coordinated effective health care²⁷.

M10 commented on her experience with psychosocial screening while she was pregnant:

In the antenatal period I attended the Birth Centre. In one of my first visits, they went through a questionnaire where they asked about how you are feeling, all emotional things and they assess your risk obviously about PND [perinatal depression].

When asked 'How did you find the intervention?' M10 answered:

That was fine, I was a little surprised because I had not realised that they went into that at the time. They asked if your partner is supportive and all that. I found it fine (M10).

Seven mothers said that they completed the questionnaires; six of them did so with nurses during the postnatal period and one mother did so with a midwife during the antenatal period. M7 was assessed antenatally by midwives and postnatally by the nurse who made home visits to her. Her account of the assessments indicated that she completed several Edinburgh Depression Scales (EDS) but it was not specific enough to assume that a formal questionnaire was used to assess psychosocial risk factors. Some nurses and midwives preferred the option of a dialogue with the mother rather than the use of a formal questionnaire.

She [the nurse] came to our place asking gentle questions 'Who lives here? How are you coping? Do you have enough help?' She asked about psychological issues; she talked about depression and gave me the questionnaire with ten questions [i.e. the Edinburgh Depression Scale]. I knew the questions by heart because I completed several questionnaires during my pregnancy at the antenatal classes (M7).

In their narratives about the work that they believed nurses did, they also commented on *how* nurses did their work. The following section presents their accounts of how nurses and midwives cared for them, what they appreciated and what they missed.

5.4 Perceptions of How Nurses and Midwives do their Work

Although mothers acknowledged the skills of nurses in their surveillance and screening roles there were mixed descriptions of their interpersonal skills, with both positive and negative experiences

²⁷ Screening for psychosocial risk factors includes questions about: lack of support; recent major stressors in the past 12 months; low self-esteem; history of anxiety, depression or other mental health problems; couple's relationship problems; adverse childhood experiences; domestic violence ((NSW Health, 2010a). The screening also includes the administration of the Edinburgh Depression Scale that is used ante- and postnatally (Cox et al., 1987b) to help identify current emotional distress and potential depression.

being mentioned. Some mothers referred to inconsistency of information and advice and a small number referred to family-centred care and cultural sensitivity.

5.4.1 Interpersonal Skills and Attitudes of Nurses

Table 5.4 presents, in their own words, the mothers' views of how well nurses used interpersonal skills to promote engagement and effective communication. Several mothers did not specifically define the nurses' skills but, rather, described the outcomes of the care nurses provided them. Hence the table documents both skills and outcomes reported by the mothers.

Table 5.4

Mothers' Descriptors of Nurses' Positive and Negative Interpersonal Skills and Outcomes

	Interpersonal skills	Outcomes
Positive	Able to show empathy	Emotional support; Calming; Approachable Supportive
	Thoughtful	Catered for my needs; Recognise when someone needs extra help and how much to say—try to balance both
	Flexible	
	Patient	Time for me; Allow you to take time; Time to build relationship
	Non judgemental	Always able to contact
	I had trust in them	I talked to them a lot
	She informed me; Explained without fussing; Explained everything; Informative	Anxiety alleviated by having a long discussion; Advice if requested
		Instilling confidence
		She knew the answers
		Knew how to relate
	Listen to	Practical; Down to earth
		She did not just move me she talked to me about the move and she explained why it had to happen

	Proactive	Proposed ideas and options
Negative	Unreliable	They forgot about me
	I felt much judged	Nurse told me I was doing the wrong thing
		I was so scared
	I did not have enough information	Lost all confidence
		They did not care

Several mothers identified some nurses' attitudes that led to positive experiences such as: "she was just a stranger so tender, kind, able" (M7); "pleasant, personable, friendly" (M4); "upbeat, flexible"(M8). They also commented on negative attitudes that brought them pain or discomfort such as: "Nurses were rude, shitty, upset with me, cranky" (M2); "rough" (M1)'.

Mothers told of circumstances where the quality of the nurses' communication skills made an impact on their personal experience of events. Some mothers described effective interactions with midwives and nurses based on sensitive, responsive and respectful sharing of information that led to better understanding and acceptance of situations or events. For example:

I had two midwives, they always informed me about everything. If I ever wanted anything during the pregnancy I was always able to contact one. I had the time to build a relationship with them over time (M1).

M6 shared her hospital experience in which the nurse, in order to reassure her and contain her anxieties, explained what she was going to do and why she had to do it:

The nurse seemed to be very senior. Someone had twins so she said that they would have to move me to another room at the end of the ward. She did not just move me, she talked to me about the move, explained why it had to happen (M6).

M8 provided a detailed account of one of her experiences with a nurse who effectively communicated with her:

She told me ahead about everything she was going to do before hand, always explaining herself first, then did it. After all the weighing, the checking out...I give you a good example. She had to touch their balls and she said 'Before I did this could you give me your permission to touch your children?' (M8).

M9, a mother of four young children, explained how child protection issues were raised truthfully and honestly without unnecessarily alarming her:

She was very good with her language and her ability to express herself; this made a difference to why you have to put a risk of harm form and at first when she told me that I thought ‘Am I going to have my children taken off me?’ and I talked to her about this, I said “Hey there may be moments when I may not have my eyes on my children that may be a risk but not neglect or harm”. I think that she worded it in a way so that I did not look like a crap Mum that did not look after my kids or could not cope looking after four children, there is going to be moments when you cannot.... you know (M9).

Mothers also recalled situations where poor involvement in decision-making, mainly due to what they perceived as midwives’ and nurses’ coercive and authoritarian approaches, led to negative experiences. Several mothers gave detailed accounts of situations where they had a general feeling of having lost control and they did not feel able to respond assertively. They described feeling disempowered, vulnerable, and judged by the staff. M9 recalled the action of the midwife who visited her at home following her discharge from hospital:

She grabbed my daughter and did that... all kind of forcing onto the breast that they do and I did not know better to say ‘Don’t do that’. Now I would just say it (M9).

M1 looked back on a negative experience in the postnatal ward following the birth of her son:

On the second day they said they had to move me to another room because they had someone who needed my room. I was tired; I was grumpy. No one cared, I was crying and I wanted to go home and that second night was a nightmare because I was too tired and he was crying (M1).

M5 remembered the hospital nurse and the clinic nurse visiting her at home following the discharge of her premature twins:

They came to my home. They checked what I was doing and what I was not doing and they write something in my papers but I did not know. They complain to DoCS. DoCS says we take the babies to foster care. I cried and cried a lot (M5).

Three mothers who attended the local CFH clinic felt that they were coerced into attending without being aware of the purpose of their visit:

There was no benefit for me to go there; I only went because I thought I had no choice. I had to go (M2).

Following two unpleasant visits she described as “teary”, M3 asked her husband to escort her to further appointments.

M6, who described herself as generally strong and assertive, summarised her feelings:

I felt that I did not have enough information. I felt that I was not empowered to make decisions (M6).

5.4.2 Inconsistency of Information and Advice

Some mothers encountered fragmented care during the perinatal period. Four mothers commented on the negative impact of having several clinicians looking after them, resulting in inconsistency of information and advice. M10 provided a detailed account of her experience:

I saw a lot of different nurses. I saw probably ten midwives and nurses and they all had opinions to a large extent and they gave different information...I got different advice from a number of midwives. I understand why, but it did not necessarily help if you get differing advice...You get that feeling of 'What am I going to get next?' if you are going to be told something different (M10).

M10's concerns about inconsistent advice indicate a provision of care that lacks continuity. The issue of fragmented care is discussed in Chapter 7.

5.4.3 Family-centred Care

NSW child and family health nurses are expected, according to their professional practice framework, to deliver family-centred care (NSW Health, 2011). Study 2 results were expected to reflect this approach. Ten mothers reported that nurses paid attention to their infant through routine checkups and seven indicated that the nurse's attention was focused on them (as opposed to the children) when a psychosocial assessment was conducted. Only two mothers, however, indicated that the nurses had a wider family focus.

M8, a mother of four including twins, described this approach when the nurse provided postnatal follow up:

At the first visit she brought the necessary equipment with her to check the babies...The second visit was about my wellbeing, the third was about the babies when she checked them a second time...She also looked at our older daughter E, not to check her out formally. She asked how old she was and when she was due for her next visit to the clinic. I mentioned to her that she was not good with her speech; she referred us to a speech pathologist (M8).

5.4.4 Cultural Sensitivity

Five mothers spoke a language other than English at home but only one commented on the need for nurses to be culturally aware:

Culturally some people do things a certain way and then like I was born Greek, brought up the Greek way and I am sure that it would be different from the way other parents raise their children...It is important for the nurse to be aware of the culture so that she is not advising against something that is culturally important to the mum (M4).

5.5 Mothers' Breastfeeding Experiences

Mothers were keen to talk about their experiences of breastfeeding and provided lengthy accounts of what some of them considered to be a gruelling experience. Except for M5, who did not have the opportunity to breastfeed her very premature infants, most mothers' narratives included their experiences with breastfeeding mainly during the first three time periods. Two mothers extended their comments about their breastfeeding experience to the fourth time period when they visited child and family health nurses. For M9, a mother of four, breastfeeding was not an issue:

I don't think I bothered [mother was asked about her visits to the early childhood clinic]; you know when you breastfeed and everything is OK...so I did not bother to take them to the clinic (M9).

Other mothers recounted feeding experiences associated with significant difficulties:

They [the midwives] were going to stop visiting on Friday but because I had so many problems with breastfeeding they extended it for a couple of days (M10).

Eight mothers said they initially wanted to breastfeed but only two were successful. The other six described how they struggled with various complications such as pain from damaged nipples, unsatisfactory milk supply and mouth to nipple attachment issues. Two acknowledged feeling distressed when they were faced with the decision to persevere or cease breastfeeding:

My biggest problem was the failure of breastfeeding (M6)

I am having breastfeeding difficulties with K so I probably need to bottle feed...For one month she was great, now she goes on one breast, cries and starts again for five minutes. I went to the breastfeeding clinic, it did not help. ...If I keep on holding her in my arms she is very happy for hours, when I feed her she cries the whole time. I feel that I am competent at breastfeeding in spite of the fact that she does not deal with my breast (M7).

Some mothers who experienced breastfeeding difficulties also recalled negative interactions with staff caring for them. Three women felt that they were coerced into breastfeeding, and if they chose bottle feeding they were judged and were made to feel guilty. They found this particularly distressing:

I tried to breastfeed but I was still covered with calamine lotion and it was uncomfortable I wanted to stop breastfeeding and felt so guilty about it when the nurse told me that I was doing the wrong thing by switching to bottle feeding (M2).

M6 recalled her postnatal hospital experience:

There were different levels of perception of what I was going through. I was pumping a lot. A couple of times I tried to breastfeed, it did not work out. I asked to get a bottle. Sometimes it would take 20 minutes to bring the bottle. I felt that they were punishing me because I could

not breastfeed. They took the longest time to make up the bottle. Sometimes S was screaming and screaming. 20 minutes is a long time to wait for a bottle. That is after we had tried for a long time to breastfeed prior to going to the bottle. They would just wander in. They did not allow me to prepare my own formula. The messages were different: 'You have chosen to breastfeed therefore we treat you in a certain way' but I wanted to say 'But I did try and it did not work out' (M6).

One mother, who had a particularly traumatic encounter with a community midwife during the early postnatal period, used the interview to debrief about the incident that took place 12 months earlier. Her outburst had not been planned but the opportunity to tell about her journey as a new parent unleashed memories that she had not revisited:

I had lost all confidence with the breastfeeding and I had little confidence to start with. I had to work out how to use the breast pump on my own, I was bleeding, baby had not been fed, it was really quite dramatic...She [the midwife] came in she made the situation so much worse and she swanned off. I am left with a bleeding breast, a baby who has not been fed, no way to feed her...I wanted to breastfeed, I was determined to (M10).

Although mothers were specifically asked about the support provided to them by nurses, several of them described experiences with other support people or services. These were sufficiently common to warrant discussion in the following section.

5.6 Other Sources of Support and Guidance

Nine mothers mentioned several other sources of guidance, support and information that they relied on in addition to nursing support or, in some cases, because they felt that nursing support was not available. Table 5.5 identifies three categories of support:

- Formal sources: health professionals, including lactation consultants, GPs (mostly for check-ups and immunisation), paediatricians, gynaecologists and social workers;
- Informal sources: mainly husbands and other close family members (mothers, mothers-in-law, fathers-in-law), neighbours and friends;
- Four families received long term support from local early intervention teams (NGOs) staffed mainly by volunteers; three of these families also accessed a local parenting centre (also an NGO). None of these four families reported other sources of support.

These findings are discussed in Chapter 7.

Table 5.5

Sources of Support other than Nursing

	Formal	Informal	Other
M1		Mother	
		Mother-in-law	
		Husband	
M2		Husband	
M3		Mother	
M4	Lactation consultant	Mother	
	Paediatrician	Best friend	
		Husband	
M5			Early intervention volunteer service
			Parenting Centre
M6	GP	Next door neighbour	
	Obstetrician	Friends	
	Lactation consultant	Father-in-law	
		Mother-in-law	
		Husband	
M7	Social worker		Early intervention volunteer service
	GP for check-up and immunisations		Parenting Centre
M8	GP for children's check-up		Early intervention volunteer service
M9	Social worker at early childhood clinic		Early intervention volunteer service
	Obstetrician		Parenting Centre
M10	Lactation consultant	Husband	

5.7 Conclusion

This chapter has presented the results from ten in-depth interviews with mothers who had infants under the age of two. A key finding was the limited number of examples of good nursing care that mothers were able to recount. They reported positive, negative and mixed experiences over the four time periods from pregnancy to two years postnatally. The mothers' narratives also revealed lack of

understanding of different staffing roles, especially in relation to midwives, maternity and child and family health nurses.

Mothers were clear about what they perceived as roles that nurses performed well. This included assessing and monitoring the developmental growth of infants, screening for potential or existing emotional distress, including depression, and assistance with parentcraft skills. They were less definite about the way they perceived nurses' and midwives' interactions with them.

Mothers had mixed feelings about the way nurses and midwives performed their roles. They commented on their positive and negative interpersonal skills and on inconsistent information and advice. Other themes discussed in this chapter related to a family-centred approach to care, the importance of cultural sensitivity, maternal experiences of breastfeeding and alternate sources of support and guidance.

The following chapter presents the results of Study 3, which involved in-depth interviews with 12 registered nurses who deliver specialist community interventions to families with complex needs during the perinatal period.

Chapter 6: Results Study 3: CFH Nurses' Experiences of their Role

This chapter presents the findings from a series of in-depth-semi structured interviews with 12 CFH nurses. The aim of this study was to address the following three research questions:

- What knowledge, skills and attributes are required from registered nurses to provide adequate support to families with complex needs?
- Should registered nurses working with families with complex needs practise at an advanced level?
- Are there any benefits in interprofessional education for registered nurses working with families with complex needs during the perinatal period?

The chapter begins with an overview of the characteristics of the nurse participants. In the subsequent sections, data of relevance to each of the research questions is presented and analysed.

6.1 Characteristics of the Participants

Table 6.1 shows the following professional characteristics of the nurses involved in the study: the extent of their nursing experience, the location of their practice, their professional title at the time of interview and their postgraduate qualifications in child and family health (CFH) nursing and/or mental health²⁸. The twelve nurses included five clinical nurse consultants (CNC), two clinical nurse specialists (CNS), one nurse practitioner (NP), one nurse unit manager (NUM), and three senior registered nurses (Senior RN), each of whom had more than eight years of nursing experience; nine of them had experience spanning over 20 years.

²⁸ Mental health qualifications included postgraduate adult, infant, perinatal and child and adolescent mental health courses.

Table 6.1

Professional Characteristics of the Participants

Years of nursing experience		Professional title	RNs working in rural NSW	RNs providing care mostly in home settings	RNs with Child Family Health Nursing qualification	RNs with Mental Health postgraduate qualification/s
N1	22	CNC	rural	yes	yes	yes
N2	25	CNS		yes	yes	yes
N3	5	CNS		yes	yes	yes
N4	20	NUM			yes	yes
N5	6	Senior RN		yes		
N6	22	NP		yes	yes	yes
N7	18	Senior RN		yes		yes
N8	8	CNC	rural	yes		yes
N9	22	CNC	rural	yes	yes	yes
N10	6	CNC				yes
N11	5	Senior RN		yes	yes	
N12	20	CNC	rural	yes	yes	Yes

The 12 nurses all met the inclusion criteria of a minimum of five years' experience working with families with complex needs. Seven had between 15 and 25 years' experience in that field. They were employed at various industrial levels of clinical nursing—senior RN (3), CNS (2), CNC (6) and NP (1). N4 was a NUM who also carried a clinical load. Years of experience were not automatically reflected in the nurses' employment status, as is demonstrated in the comparison between N2 and N3; both were employed at CNS level in an early intervention team, despite N2 having 25 years of experience compared to N3's 5 years. In their narratives they reflected on their professional experience, qualifications and knowledge development.

N2 had over 25 years of experience, mostly as an isolated clinician working in rural NSW. Over the years she complemented her basic nursing training with several courses. She had undertaken these when she believed she was lacking knowledge and skills in particular specialist areas of practice:

I consider myself to be the person and the clinician that I am because of my clinical experience. I worked in an early intervention program for years in a very isolated rural area and I worked with different health professionals. I like the team approach but most of my life I have worked in isolation...I did community audiometry, infant mental health, adult mental health, lactation and other training along the way. The reason I went down that path is that my first certificates only gave me a basis, a platform to work with vulnerable families (N2).

In contrast N3, who works in the same early intervention team as N2, became CNS after practising for five years. She completed a Master of Nursing, received regular clinical supervision and relied on opportunities to enhance her skills and knowledge:

I went to see the mental health liaison CNC at the hospital and spent some time with her, learning to document, learning to do a mental state assessment. (N3)

Four nurses working in rural NSW were employed as CNCs; three of them had 20 or more years of experience.

N 12 practised as both a midwife and a CFH nurse, providing long term interventions to families that she described as 'high risk' in a rural area of NSW. In her interview she spoke about her extended role, her relationship with Aboriginal families and her approach to new learning:

My role is in the rural community. I meet women in the antenatal period, I run the antenatal classes and then I see the mother in hospital when she has the baby then I home visit postnatally when I follow the family through.' . I cover three towns: one has nearly 10,000 people, the other has around 2,000 and one of the towns has mainly Aboriginal people...Sometimes it takes several pregnancies before I am accepted. You move from one child to another...I work closely with an Aboriginal health worker and I am learning from her how to communicate with the community members (N12).

While ten nurses were solely involved in providing care to families in their homes, N 4 managed a mood disorder unit in a parenting centre and N 10 was a liaison psychiatry CNC, responsible for the acute care of women presenting at the local emergency department during the perinatal period. She also coordinated the follow-up care of mothers and their families in the community. N10's antenatal role included the assessment of pregnant women referred to her because of emotional distress identified through the use of the Edinburgh Depression Scale (EDS):

The last thing many women want is another baby or it brings out a lot of tougher things ...but by the time the woman comes back at the next antenatal visit the crisis is resolved and the woman does not score so high on the EDS as they initially did (N10).

N10 believed that midwives and nurses who routinely screen women would benefit from more robust mental health skills to enable them to respond effectively to elevated EDS scores:

It would be helpful if they had knowledge and understanding of mental health issues including depression and anxiety...They should be able to explore further why they are getting the response that they do in the EDS (N10).

The nurses were asked about their formal qualifications in CFH and in mental health nursing. While all 12 nurses were directly involved in the care of infants and their parents, only eight had completed a specialist postgraduate CFH nursing program. On the other hand, ten nurses held postgraduate mental health qualifications. Although N5 had worked for the past six years with families with drug and alcohol issues, she did not see the relevance of available CFH nursing or mental health courses. She commented on her own experience in accessing knowledge:

You should specialise in drug and alcohol but there is no real formal education. Drug health is a strange undefined field with limited onsite education. I received most of my information from the CNC who mentored me. The culture is funny, you are a stranger at first then you slowly integrate and they become your friends and then they share their knowledge with you (N5).

N10 had no formal mental health qualification but she had completed a Master of Nursing with an elective subject in adult mental health and was enrolled in a social work course. N9 had a strong adult mental health background that she consolidated with a degree in psychology. These unexpected findings on the nurses' CFH and mental health specialist education are comprehensively discussed in Chapter 7 section 7.1.1.3.

6.2 Knowledge, Skills and Attributes

This section presents the study's findings in relation to the first research question. The three elements of nursing knowledge, skills and attributes are examined separately.

6.2.1 Knowledge for Effective Practice

The nurses identified a range of nursing knowledge elements that were grouped through content analysis into three core knowledge categories: mental health; concepts, working models and frameworks relevant to healthcare practices; and parentcraft.

6.2.1.1 Mental health knowledge

Participants identified four areas of mental health knowledge that were essential to their clinical practice: infant mental health (IMH); adult mental health (AMH); therapeutic interventions; and child protection. In addition N5 commented on drug and alcohol knowledge and N1 raised the complexity of perinatal mental health within the area of adult mental health.

Infant mental health.

All 12 nurses emphasised the need for a robust understanding of infant mental health including emotional attachment, early relationship formation and the impact of psychosocial issues on the overall growth and development of the infant, especially brain development.

N8, a CNC in rural NSW, described some of the difficulties experienced by nurses attending her supervision sessions:

You need to know about attachment, brain development, normal trajectories...how to manage families that present with complex needs; the group of nurses I supervise, some of the issues that come up, they are shocked because it is not what they are meant to do, they need to have at least some kind of understanding of how things can go, they need a spectrum of normal, they need some knowledge of what can be seen as a variation from the norm...They need to have a basic understanding of mental health concepts and this is what I mean when I talk about moving out of the norm, understanding how mental illness presents (N8).

Adult mental health

Understanding of adult mental health, the consequences of mental illness on early parenting and the process of recovery were proposed as important knowledge topics. Knowledge of relevant mental health policies, practice guidelines and referral pathways were suggested, supported by related skills sets such as the ability to respond appropriately to mental health crises, conduct mental health assessments, use screening tools effectively and access local resources.

Several mental health knowledge and skill areas essential for nursing practice were identified. For example:

You need to have finely tuned assessment and observation skills that allow you to gather data without questioning; something that I have learnt to do being able to assess what parents are not telling you rather than what they are telling you...In that also comes the knowledge of postnatal depression, how to interpret the EDS so...those are the assessment tools, being able to use them and to react to them appropriately...You may have a resistant family, they don't even want to fill in the form but you are able to do a good mental state assessment. It involves working through the points of the MSA through developing your relationship with them...So you are not even questioning, you are assessing while they blab to you...You also need to be able to use mindfulness strategies (N3).

They have to be able to assess mental state at all times, they have to be able to manage basic anxiety, depression and know what is normal... They need to know the impact of anxiety on the baby, depression from the antenatal period to long into the postnatal period. More understanding in these matters may change the way some of our programmes work (N9).

We need to have knowledge of who are the local mental health teams who provide mental health responses in the area, who do we use for emergencies, who do we go [to] for ongoing therapy... We should have knowledge about the concept of recovery, what does recovery mean, what steps does it entail, how best to support the mothers? We should have knowledge about medications, what their effects are, their side effects, we should know how long they take to work, be aware of the gap before effect, we should be aware of adverse effects. We should also be aware of other therapies, the ones that are evidence-based and how they can be accessed in the community (N11).

N10 (liaison CNC) assessed mothers referred to the emergency department with depression:

I must admit depression can be a very subjective expression of how someone is feeling in the context of [antenatal] booking so I think it would be helpful if they [midwives and CFH nurses] had some knowledge and understanding of mental health issues including depression and anxiety and there is certainly a deficit in that area (N10).

In NSW psychosocial assessments are routinely conducted, usually using a screening tool that the woman completes on her own or with the help of a midwife or a nurse. Three nurses were worried about the practice of administering screening questionnaires without a background of robust mental health knowledge and skills:

I would like to see people doing it receiving more training as they are opening a big can of worms and they leave it open. They ask intrusive and insensitive questions which are part of psychosocial screening... There is a big responsibility that goes with the screening (N9).

Nurses need to have knowledge and skills about screening tools that they use such as the EDS [Edinburgh Depression Scale] and the PNRQ [Perinatal Risk Questionnaire]: knowledge about what these questionnaires were developed for, how they are rolled out, how they should be used, what they tell us, how to react accordingly to the responses that they get (N11).

I know of midwives who go around and administer psychosocial screening and EDS without any training; this is scary but they feel comfortable about it because they have completed the check list as it is expected from them (N12).

N1 identified perinatal mental health knowledge, which is a sub-specialty within the broad field of adult mental health, as important but commented on its complexity:

I think that there is reluctance for adult services to take on this population group [mothers with mental illness] and there is reluctance for child and adolescent mental health services to take on perinatal mental health, so in the country we have this no man's land called perinatal mental health (N1).

N5 commented on drug and alcohol (D&A) knowledge, which is another sub-specialty of adult mental health. When she joined a perinatal drug and alcohol service she believed that she had limited relevant skills and knowledge. She unsuccessfully sought a postgraduate course that would provide her with drug and alcohol expertise:

You should specialise in Drug and Alcohol but there is no formal education. Drug health is a strange undefined field with limited onsite education (N5).

Therapeutic interventions

Some nurses identified knowledge of therapeutic interventions for anxiety management as useful to enhance their ability to respond effectively to presenting mental health issues. For example:

Whether it is sleep settling, feeding ...if the mother is requiring help but she is displaying extreme anxiety she is not going to be able to follow through with the information that you are giving (N7).

Several nurses expressed concern about what they frequently perceived as a lack of nursing knowledge of pharmacology and the impact of medications on maternal wellbeing and breastfeeding safety. N1 expanded on the importance of pharmacology knowledge when working with mentally ill mothers:

The baby is born and you are trying to do early relationship counselling, education, looking at what mum and baby can do together... We know a lot about drug interaction in the perinatal period and the fight that you have over convincing her to stay on her medications that kept her well because of the fear that the medications may do something to the baby... We all have the capacity to give pills but if we don't have the knowledge about the pills and if you don't know how it is going to affect the pregnancy you may do more harm than good... In CFH nursing there is a fear of parents with a mental illness, a fear of medication, the fear of the whole complexity— 'this family has this issue so it should be dealt with by mental health service' (N1).

N6 is a nurse practitioner engaged in the supervision of nurses working with families with complex needs. She pondered on the importance of pharmacology as a particular area of knowledge that should be given more attention:

I wonder if nurses should have pharmacological education. Not that it is essential but, if you are going to work in the field of perinatal mental health, you are going to need knowledge

about medications used during pregnancy and during the postnatal period. How do you get that...at the moment? It is still ad hoc from the family's perspective, from the woman's perspective, the information and advice; evidence based information available is often very confusing and it depends who nurses talk to as to what the information is, so if you are working with those families pharmacology should be included (N6).

N9 shared similar concerns within the context of mental health knowledge:

Formal mental health knowledge and skills are essential...Some knowledge of infant development, especially brain development, understanding infant cues... The client's mental state is often much linked with lactation and breastfeeding issues. Should she or not breastfeed? Do medications impact on the baby and to what extent does it affect the baby? (N9).

Child protection

Throughout the interviews nurses alluded to the importance of child safety, the importance of risk assessment and their precarious relationships with parents who may not care for their children adequately. Four participants expanded on the challenge of recognising and sensitively managing situations where the carer-child relationship is compromised and child protection issues are identified. The nurses reflected on their own feelings when they had to be at once proactive in ensuring the child's safety and wellbeing and protective and supportive of the parent:

We need to know about emotional and social development, which is hard to track, so that is why parents and professionals get focused on the physical stuff because it is easy to track whereas emotional and social, it is much harder but that can have a far greater impact so I think we need to have these skills that is a reflection of the quality of the relationship that the child is having in the home with all its carers (N3).

We need to know when the red flags are appearing when there are child protection issues, when the child is not developing according to norms (N4).

I work with mums who have drug and alcohol issues. Whenever I am judging them I am judging myself but then there is always that child protection issue so it is a really fine line—you don't want to judge the parents but you also want the children to grow up healthy and have a beautiful life so you ask yourself, how do I do it? It is difficult. Sometimes it makes you feel very sad and you don't know how to do it (N5).

You have to be so careful not to be judgmental towards the mother because you want to nurture her. You need to act appropriately when your gut tells you something is wrong, that baby is at risk if you are not diligent (N7).

N6 offered a broad perspective on the management of family's risk without referring directly to child protection issues. She believed that knowledge of adult and infant mental health is essential to determine and manage risk:

You need specific mental health training that includes adult and infant mental health knowledge... Then you would hopefully have developed these skills to be able to identify families that fall within different ranges of risk to be able to do risk assessment effectively and know how to work collaboratively with a number of agencies (N6).

6.2.1.2 Theoretical knowledge

Chapters 1 and 2 identified several theoretical frameworks that underpin the evidence-based clinical practice of professionals working in the field of early childhood. The most important of these are socio-ecological theory (Bronfenbrenner & Evans, 2000) and attachment theory (Bowlby, 1982). Socio-ecological theory provides a framework for understanding the impact of parental circumstances on families' wellbeing, while attachment theory, in combination with child development science, establishes a foundation for the prevention of child abuse and neglect, which is a core element of CFH nursing practice. This section sets out three main theoretical constructs that emerged from analysis of the interview data as essential when working with families with complex needs: primary health care within a socio ecological conceptual framework; child and family wellbeing; and working in partnership with families.

Primary health care within a socio-ecological conceptual framework

The socio-ecological conceptual framework, also referred to as the human ecology model, captures the influence of social, behavioural and ecological factors on health and ill-health, especially on healthy growth and development during the early years of life. Six nurses reflected on the quality of their interactions with families when they adopted a socio-ecological framework to help them negotiate families' multiple health challenges. Such a framework gave them a context within which to understand families, assess their needs, recognise their strengths and develop responses that were consistent with their cultural beliefs. As the NP in rural NSW, N6 was expected to lead, supervise and mentor community nurses working with families with complex needs. She was convinced of the importance of theory guiding practice, the importance of working from a primary health care approach (Australian Research Alliance for Children & Youth, 2008) and the significance of a biopsychosocial model:

You need to know the complexities in which families live, based on several models like the biopsychosocial model, cultural models to look at many domains of risk impacting on the family... You have to see families as a whole: you have to have some knowledge of some theories including system theory, narrative theory... Whatever your nursing background is,

you have to have that community experience. It is a big leap to take on working with families in the community and then move into complex families. If you never worked in the community...the change to community focus would be very difficult (N6).

Understanding the concept of primary health care was identified by four participants as the optimal first level of care delivered by community-based nurses. This knowledge enables them to engage in health promotion activities, including family empowerment to access services of their choice and prevention of health risks. N4 was particularly uneasy about risks to family safety if nurses were not pro-active in their practice. N11 remarked on the advocacy role of nurses for families who, because of their life situation, may not have had their concerns heard properly or sympathetically in the past:

Every family has a right to access all that is available to them, to make the choice on how their care should go, so you need to know about things that are available in the community to help your families, right down from government-directed things to local things like libraries, playgroups, mothers' groups... You need to have knowledge about how primary health care works because it is what we are trying to do... so that is knowledge about how individuals operate, how communities operate knowing your communities well, from a population health perspective... You need to have a good world view of how everything works right from the World Health Organisation to government policies down to how we practise. To be able to see yourself in the big picture is important for all nurses, but ever so for nurses working with vulnerable families, because if we are going to learn on how to help them and change things we need to understand how everything works (N3).

It is about an understanding of the social spheres that families come from. Nurses need to be aware of how the big picture impacts on the family—the environment, the population, the community—and how they can be pro-active in preventing some issues from occurring (N4).

They need to know about the support systems and the multiple resources that are out there for the families, thorough knowledge and understanding of current policies and practice guidelines...and the family practices that will keep the family safe (N10).

Families who have often not been heard properly by the health system need to be given the opportunity to be heard (N11).

N12 highlighted the importance of a population health framework (Butchart et al., 2006a) underpinning her practice as a nurse working in rural NSW:

Knowledge about environmental events, for example, recognising the impact the drought had on our local community and how it can affect parenting (N12).

Several participants also referred to the strengths-based model (Gottlieb, 2014) which is based on an ecological perspective that recognises environmental impact, the resilience of families, the capacity of parents to nurture and protect their children and the belief that parents can learn and grow. Several

nurses commented on the relevance of a strengths-based model of practice for families during the perinatal period. Some believed that current nursing training programs and reliance on routine screening tools did not promote the strength-based approach:

You need to know the complexities in which families live and understand the many domains of risk impacting on families; [for this] you need to have that community experience. I believe that education that focuses on hospital care does not expose you to those skills (N6)

They [the nurses] need a real level of expertise to screen for protective factors as well and if I was looking at ways to improve the training I would look at ways to balance vulnerabilities with protective factors. If a person has all these vulnerabilities what stops them from falling apart, is there a protective factor there and how do we screen for protective factors? (N9).

Nurses need skills to recognise strengths when strengths are not always obvious...Change is incremental; it can be very slow and we need to work with families, building on their strengths and accept that these strengths are not always obvious. We need to respect the concept that everybody has strengths and no matter where they come from, they all have strengths to bring to the table (N11).

You need to recognise their [the families] strengths and be positive about them...I have noticed that there are many more so called tools and tick lists. I am scared that this approach will replace our ability to think. I know of midwives who administer psychosocial screening and EDs without any training; this is scary but they feel comfortable about it because they have completed the check list as expected from them (N12)

Chapters 1 and 2 documented compelling evidence of the importance of early intervention during the first years to reduce the incidence of abuse and neglect and to promote optimal early childhood development. N8 commented on her positive experience working within an early intervention approach, noting that this involved her in an advocacy role:

I work holistically with families...For example I have two mums at the moment, one has an 8 months old and one a 4 months old baby and I have been working with them since they are 5 months pregnant, so I will be involved for another 18 months which is awesome...It is not acute work it is early intervention, it is really early intervention...I have to be prepared to be the advocate for the family but I am also the advocate for the baby; it is a parallel process for me (M8).

Early interventions during the perinatal period are mostly home based. N12 highlighted the complexity of working with families in their home:

We cannot just enter a house, quickly assess, do an EDS, exit; we need to consider environmental factors, how they impact on families...Filling forms is easier when the woman goes to the clinic but it is different when you visit the family at home. What is going to

happen is led by the family rather than by you. In a clinic situation you take control; this is different, we don't have total control (N12).

Child and family wellbeing

A second group of theoretical constructs that emerged from the nurses' narratives related to the wellbeing of children and their families. Participants spoke about the concept of early childhood development, the impact of family dynamics on early relationships and the benefits of enhancing parenting practices through self-efficacy, motivation and behaviour-changing approaches in order to promote optimal child health and wellbeing (McCain & Mustard, 2002; National Scientific Council on the Developing Child, 2007) (see Chapters 1 and 2 for more detail):

We are looking at good relationships—nurturing, loving the infant; we are looking at what is nutrition, good health, social-emotional development of babies and young children; we are looking at developmental advances, stages that children are going through to become independent, well-adjusted human beings and that is just a total package... It is basic that we look at social-emotional aspects of health... You need to understand where people are at... You need to hear their stories, their pain. You need to understand their background, the transgenerational issues that have brought them where they are today (N2).

You need to know where they come from, what they have been through... what may be reasonable goals for that mother to achieve (N3).

N11 described her role in motivating parental behavioural changes and identified factors that influenced such changes:

We cannot do this work if we do not understand our own beliefs and constructs... Parents need to be able to tell their stories, be able to put narratives to their situation as their past is absolutely essential for us to help them to move on... We don't only hold the mother/parent in mind when we are interacting with them. We also hold the baby, so this aspect of nursing is all about the relationship and the parent as the family will change based on the relationship and the trust that we build together. It is definitely work based on relationships ... Taking a bit of a risk ourselves [we] then invite parents to come along on the journey where they also take a risk. That is how we promote and facilitate change with families because they have one another to hold them whilst they take the challenge (N11).

N8 gave the example of the Circle of Security (Hoffman, Marvin, Cooper, & Powell, 2006), a relationship-based early intervention program that guided her practice with families with complex needs:

What helped me the most is the Circle of Security. It is a relational model and I don't think that there is any model that matches it (M8).

A third theoretical construct that nurses believed provided them with a solid base for their clinical practice was the concept of working in partnership with families, which represents an alternative to the expert model from which they had previously operated.

Working in partnership with families

A majority of nurses implementing the NSW Safe Start program, which provides direction for the provision of coordinated care to families identified with complex needs during the perinatal period, completed a face-to-face training program called the Family Partnership Model (Davis & Day, 2010). This training equipped them with a framework for engaging and communicating effectively with parents. Several nurses offered positive feedback on the benefits of working in partnership with parents and some referred directly to the Family Partnership model:

Working in partnership. I know that this is talked about a lot but...you need a good understanding and knowledge about motherhood and the difficulties that can be experienced if there are a lot of family issues (N2).

You need to be working in partnership so it means to build a rapport and to know what is working or not and to know what the family expects from you. You need to be on the same page (N7).

Working in partnership with the family and understanding family relationships and engagement is essential. These things don't come naturally, you need to be taught (N8).

Families have specific individual knowledge about their own babies and we need to respect that (N11).

Then you need your communication skills, your ability to develop a relationship with the family and in that comes your partnership, family partnership skills (N3).

Building on the relationship is a very important skill that we cannot assume that people have, regardless of what disciplinary background they are from...whether it is the Hilton Davis [author of the Family Partnership Model] partnership model to start back from (N4).

In summary, most interviewees were supportive of theoretical knowledge underpinning their practice, although not all of them referred explicitly to specific theories or frameworks.

6.2.1.3 Child growth and development and parentcraft

Traditional domains of CFH nursing practice such as health surveillance conducted at regular intervals, comprehensive health history assessments and parentcraft knowledge (e.g. nutrition and sleep and settling techniques) would be regarded as core knowledge for CFH nurses. However, only six of these experienced nurses actually referred to this knowledge area. N6 may have provided an

explanation for this lacuna when she contrasted the specialist role of nurses working with families with complex needs to that of clinic CFH nurses:

You know how to work collaboratively with a number of agencies possibly looking at the primary carer role because I think that you may need to be able to be the person that takes that role because the other services [CFH nurses in clinics] may not be able to work in that capacity (N6).

Four nurses referred to the core knowledge of child growth and development within normal range that helps to identify deviations from the norm:

You have to have that underlying knowledge of...normal development, ages and stages (N1).

A lot of our training looks at the normal growth and development, everything that is about the normal range. We are looking at nurturing and loving the infant, what is nutrition, what is good health. We are looking at developmental advances, the stages that children are going through to become independent, well-adjusted human being ...but we need to focus a little more on how we work with people that are not in the normal range (N2).

You need to know your developmental stuff, it would be normal behaviour of the child, then you need to know about the mother, things that can go wrong for her, this is core development for everybody. We have to know about developmental...what we expect the child to do but also the mother (N3).

You need childhood development understanding and the basic knowledge like childhood illnesses (N5).

N9 identified her lack of postgraduate midwifery qualification as a gap in her knowledge:

I would include midwifery knowledge; I did a one day workshop on lactation and I learnt so much from that that I could pass on to my clients (N9).

N7 described how she taught parentcraft to mothers who had difficulty understanding their infants' cues because they were depressed. She used the example of children becoming tired, contrasting her practice with the traditional 'expert' approach of teaching rigid routines to parents:

I don't tell her it is better to do things this way...wrap the baby this way; it is too early to put your baby down. Instead I tell her 'Look at the tired signs; what is baby trying to tell you, is baby ready to go down? If baby is ready I will help you with it' (N7).

N12 explained how she teaches nutrition to families and some of the challenges that she meets:

I give explanations to the family—breastfeeding, introducing solids, teaching good nutrition principles is important...I may need to talk to them about their food intake, the importance of

fresh vegetables and then find out that fresh vegetables are out of their reach, then I encourage them to eat some meat because their iron level is low but they cannot afford to eat meat or they are vegetarians (N12).

6.2.2 Core Skills for Effective Practice

The discussion of core knowledge areas presented above showed that, in some instances, participants conflated their accounts of knowledge and skills, especially in relation to mental health. This section accordingly focuses on the range of skills the nurses identified as essential for their clinical practice that have not previously been examined. Overall, five broad skills categories were identified: rapport-building that supports engagement and change; family-focused practice; reflective practice; advanced communication skills; and application of theory into intervention practice. Table 6.2 shows the number of participants who commented on each of these categories.

Table 6.2

Core Skills Required for Effective Practice

Category	No. of nurses
Rapport/relationship-building that supports engagement and change	11
Family-focused practice	10
• Work in partnership with parents • Family advocacy, empowerment • Practise from a strengths-based model • Set goals with families • Allow family to lead • Enhance family capacity-building • Provide guidance not advice	
Reflective practice	10
• Boundary setting • Safe risk-taking supporting personal and parental growth • Journaling • Reflexivity • Self-care • Critical thinking	
Advanced communication skills	10
• Listening • Organise/lead multidisciplinary case review • Collaborative practice with professionals	

• Comprehensive documentation that reflects complexities • Develop comprehensive care plans with families • Resource person including awareness and use of local community resources	
Application of theory into specific interventions	7
• Counselling • Refer appropriately • Group facilitation • MH interventions for depression/anxiety • Parental education • Uses relevant tools and interprets findings • Apply child protection knowledge • Conduct informed assessments	

6.2.2.1 Rapport/relationship-building that supports engagement and change

Most nurses agreed that the ability to build strong relationships with parents was essential to support engagement and behaviour change. This skill was discussed in Chapter 1 in relationship to the broader concept of working in partnership with families and working from a strengths-based approach. N2 and N3 focused on rapport building and engagement:

If you understand what they have been through, where they are trying or wanting to go...you are developing a rapport. Then you can move together forward (N2).

How do you go about engaging with the families or at least offer support and give them choices if they want to take them on? Can the nurse develop a relationship with that family that will break down the walls and support them? (N3).

6.2.2.2 Family-focused practice

A majority of participants believed that a family-focused approach was essential. Ten nurses described activities that exemplified effective family-focused practice, including the ability to work with parents, to empower them by being their advocate and by allowing them to lead, hence enhancing their parenting capacity. They also mentioned the ability to set reachable family goals based on the recognition of their strengths rather than their deficits. Family-focused practice was also mentioned in relation to theoretical models, as discussed in the previous section.

We need to know how the family functions, how we are going to engage them, how we are going to develop that relationship, how we are going to sustain their needs and how we are going to plan the discharge (N4).

You have to advocate for your families as they often fall through the gaps... You have to see them as a whole (N6).

When discussing her work with mothers, N3 commented:

You need to know where they come from...what may be reasonable goals for that mother to achieve ...and the family too if the father wants to engage with you and other carers or siblings (N3).

N11 proposed that:

We don't only hold the mother in mind when we are interacting with them; we also hold the baby in mind, so this type of nursing is about the relationships and the parents as the family will change based on the relationship (N11).

At the same time, reflective practice was identified as crucial to supporting and strengthening effective engagement and interventions with parents.

6.2.2.3 Reflective practice

Ten nurses identified reflective practice as a core skill category comprising several component skills including critical thinking, boundary-setting, safe risk-taking and supporting personal and parental growth. Nurses commented on the benefits of journaling and reflexivity and the capacity to self-care. N3 offered a personal example of her ability to reflect on her engagement with parents:

In my heart I ask is this working? What is happening for them? What are they doing? That [reflection] is a definite skill. In fact I am working with a family that I don't like a lot and I am having personal struggles with working out my interventions and my visits in a creative way. I need to find meaningful ways to engage them (N3).

N4 summarises what she identifies as reflective practice:

The skills are about implementing knowledge into practice, what are some issues about the way you work, what do you require to be more efficient, proficient, competent and a safe practitioner who knows when things are outside of the realm of their core practice, know when to refer, know when to discuss cases in a collaborative way, know when you need more professional development and know if the process is truly reflective (N4).

N5 reflected on potential dangers of not reflecting on one's practice:

You must have the ability to step back and come back later because you are the nurse, you are not the family friend; if you become mixed up you lose your objectivity and you endanger the family because your boundaries become blurred (N5).

N8 encouraged the nurses who attend her supervision sessions to engage in journaling as a practical reflective activity:

I suggested that they all may start a journal because to keep a journal is about reflection and it is a core skill; I don't think that you can do this work without reflection (N8).

6.2.2.4 Advanced communication skills

Several nurses referred to the importance of advanced communication skills, citing listening, organisation of multidisciplinary case reviews, comprehensive documentation reflecting complexities, development of collaborative care plans and resourcing families as essential:

The skill is to know where people are at, being honest, non-judgmental, working on the issues that are important for them, not for us as clinicians, because we may think that we need to address three issues and none of them being what the client wants to address so you won't get very far (N2).

N11 suggested strategies underpinned by reflective practice and advanced communication skills to enhance families' health outcomes:

Complex cases should be brought forward and a group of clinicians across the teams and across the disciplines come together and look at how the case was managed and how it could have been managed differently or it could be ongoing cases where clinicians offer their thought about where the intervention should go (N11).

6.2.2.5 Application of theory into practice

As previously discussed, theoretical knowledge was identified by CFH nurses as an essential component of their overall knowledge. Several of them commented on the importance of translating that theoretical knowledge into their everyday practice. They identified some specific clinical activities that they believed required a sound understanding of theories and concepts. They argued that CFH nurses should be able to comprehensively assess situations, including family dynamics, build relationships, promote child protection and safety, counsel parents and refer appropriately. They should also be able to conduct group activities, deliver evidence-based mental health interventions for common problems such as perinatal depression and anxiety, educate parents, use relevant tools such as screening tools and interpret findings appropriately:

The ability to be creative in practice, the ability to get the evidence, to read it, to use that in practice with the family, because often we get the research but we don't know how to apply it in practice... You may have a resistant family, they don't even want to fill in the form but you are able to do a good mental state assessment. It involves working through the points of the MSA through developing your relationship with them... So you are not even questioning you are assessing while they blab to you (N3).

N2 reflected on how a better understanding of families' dynamics enhanced her referral skills:

You find that a lot of people... I have come from that... felt better when they referred... I thought that I was helping the families but now I know that too many fingers in the pie

actually fragments them even more and it does not help. They feel absolutely under the spotlight and more vulnerable (N2).

N11 referred to the relevance of knowledge of mental health to CFH nurses' practice:

The nurses need to know how the issues impact on the baby and family relationships and what sort of outcome there are (N11).

N12 illustrated the application of the ecological model in her daily practice:

It is so hard to unpack what we exactly do...this is about good assessment skills, assessing interactions, assessing what is in their lives. What is in their cupboard to eat? They may not have anything to eat; assessing their financial situation (N12).

N5 commented that, while it was essential to ensure that her practice was based on evidence, it was also difficult to apply:

Theoretical knowledge acquired through studies is different from the knowledge that you acquire through your peers. It helps you to know exactly what you are talking about. Nurses have a long history of telling each other about facts, then when you check you find out that it is not true, it is not based on evidence...We need skills to apply the theory that we are taught formally and that is difficult (N5).

In addition to the five main skills categories, individual nurses commented on the importance of flexibility in response to changing complexities, cultural sensitivity, undertaking effective evaluation and having advanced information technology (IT) skills:

I think that you have to have an open mind about the function of different interventions and how they suit particular families. One intervention will not automatically suit all families (N6).

How to find relevant, accurate information about something? IT skills are essential. I cannot imagine an RN in 2012 who does not have advanced IT skills. How do they function, how do they find new information quickly? (N12).

6.2.3 Core attributes for Effective Nursing Practice

Participants identified eight core attributes as essential for nurses working with families with complex needs: empathy; a non-judgmental attitude; patience; a special personality; passion; respect; genuineness; and positivity. . Table 6.3 shows the number of nurses who referred to each core element.

Table 6.3

Core Attributes Required for Effective Practice

Attribute	No. of nurses
Empathy (compassion, understanding, open-mindedness, sensitivity)	10
Non-judgmental (acceptance, objectivity)	9
Patience (slow pace, small gains, limited short-term rewards)	7
Special personality	6
Passion	6
Respect	5
Genuineness (credibility, honesty, sincerity, humility)	5
Optimism (commitment, stamina, perseverance, sense of humour)	4

N3 considered the concept of personal attributes within her construct of nursing. She proposed that it might be easier for a person who has a specific view of the world to work with families with complex needs. She grouped acceptance, non-judgmental behaviour, patience, trust and nurturing as key characteristics; she also provided a clinical example that she felt would describe best what she meant:

I believe that you have to be very accepting, non-judgmental and very in the moment with these families...It is about one step at a time, you learn to be paced by the family, gently raise the bar and I don't think you can do that if you don't have a trusting almost non-professional nurturing relationship and I cannot think how you could develop that without a degree of acceptance and a feeling of hope as well. It is my understanding those personal characteristics that some people have, it is their view of the world, they come with that personal framework then it probably makes it easier for them to engage with those vulnerable families... The nurse turns up half an hour earlier because she knows the mother always tries to dip out of the appointment so she will walk with her to the baby health centre. The nurse who cares more has that forgiving attitude and she gets the person to their appointment (N3).

N7 shared N3's perspective on personality characteristics that assist effective work with families with complex needs:

I have been nursing for 22 years and I think that you have to be a particular type of person to work with families with complex needs because you have to be patient, empathic, and you have to be a good listener (N6).

Several nurses used the term 'passion' to define a key attribute they believed to be essential to engage with families. This perspective is discussed further in Chapter7. N1 associated passion with a positive attitude made up of stamina and perseverance:

They have to have a passion to want to work with families and they have the stamina to stay long-term... The thing that is unique is someone who has the passion to be there with the family regardless of the complexities... If you get a novice nurse linked with an experienced practitioner and they already have that passion they will do well (N1).

You need to ask, does that nurse have the passion for it? (N7).

Oh yes you have to be different. This is my personal opinion but what I think works is passion. In terms of engaging with the woman, unless you have a level of passion even when you are engaging normally with eye contact, body, posture, hand language; unless you are interested in them you fail the engagement process (N9).

N11 added the need to “have a sense of humour to be able to lighten up difficult situations”.

In summary, participants identified a broad range of knowledge, skills and attributes that they believed nurses required in order to work effectively with families with complex needs. The following section addresses the study’s findings in relation to the second research question relating to CFH nurses’ indicated level of practice.

6.3 Advanced Level Practice

This section addresses the research question: Do nurses working with families with complex needs practise at an advanced level? It presents the interviewees’ perspectives based on their personal experience and observations, with particular focus on mentoring and supervision, which were identified by participants as crucial to practice enhancement. In the final section, nurses describe the range of roles they undertake, from routine clinical work and universal home visiting to expert nursing, practising at an advanced level and providing sustained care to families with complex needs.

Each of the participants had a minimum of five years working in the field of early childhood with families identified with complex needs. This criterion was established to ensure that the views the nurses articulated would be based on sound experience. Not all nurses who practise in this field, however, have this level of experience, so this question was important from a curriculum perspective. Nine participants said that they were already able to practise at an advanced level when they started working with these families because they had extensive previous nursing experience and had undertaken relevant postgraduate studies.

While having difficulties articulating what they understood by advanced practice level, all were adamant that advanced nursing practice gained through experience and specialist training was indicated for work with families with complex needs. N2, for instance, stated explicitly that “nurses

working with vulnerable families should be advanced practitioners”. Several nurses, however, commented on the existence of barriers to this ideal situation and explored potential solutions:

As a choice I would prefer to see a blend where less experienced nurses are supported by experienced practitioners. That way they get the exposure, they know where they want to be...and for the less experienced nurses they can assess what they need to enhance their performance (N1).

Ideally the nurses working with the most complex families are distinct from the nurses who do universal home visits. They are more skilled but in practice it does not work that way because there is not enough staff. People do not like working with these families so they cannot recruit...Where I am our manager chooses to look after the very highly vulnerable families (N5).

N6 questioned the capacity of some nurses working in the field of CFH to work with families with complex needs;

I don't believe that all RNs can do it. I believe that they need to operate at an advanced level; they should have completed further training, they should have undertaken some specialist studies in a particular field (N6).

While most participants agreed that nurses working with complex families should practise at an advanced level, some conceded that in reality employment-related issues such as remuneration could impede effective recruitment.

6.3.2 Mentoring and Supervision to Enhance Nursing Practice

Nine nurses discussed ways of enhancing the practice of less experienced nurses. A mentoring model in which the experienced nurse coaches and supervises the nurse entering the specialist field was proposed.

N6 reflected on issues impacting on the current CFH nursing workforce. She believed that working with families with complex needs was challenging and that relevant specialist education and experience were essential. To this end she proposed mentoring and supervision of less experienced nurses as a potential answer to the problem of an ageing workforce to help them develop their capabilities:

Considering the current workforce we need to bring on younger nurses with less experience...but we cannot expect them to collect that level of experience in the milieu that is currently available, the positions and the nature of employment, so we are not going to get that level of experience so that may be a sign that we need to compromise and we may need to look at that level of support and what capacity of support that experienced people can provide

and that brings me to supervision; people with experience need to be able to impart that back and I think that the infrastructure for that is missing (N6).

It is something that is developed over time with more and more experiences, trials and failures...Having mentors and clinical supervision is very important (N12).

N3 talked about her personal experience of having poor knowledge of mental health nursing when she joined an early intervention team in community CFH. She was asked how she improved her practice:

The hard way. Here is what I was doing. I went to see the CNC at []Hospital [referring to the liaison psychiatry CNC who was responsible for the midwifery perinatal mental health program] and spent some time with her learning to document not in a way that is too long, learning to do a mental state examination (N3).

N11 shared N3's concern when she commenced work in an early intervention program for mothers with complex needs. She had relevant postgraduate qualifications but little experience:

We need to have a system of mentoring in this type of nursing. Having had the privilege to have mentors since I started working in the program I realise the benefits of having nurses mentoring nurses. In the residential (in-patient) area some skills were quite basic and task-oriented. Now I use complex skills at a much more advanced level (N11).

Some participants commented on the multiple levels at which nurses practise when caring for families with complex needs and proposed a tier framework for nursing interventions depending on the family's complexities. This is discussed in the next section and is examined in more detail in Chapter 7.

6.3.3 Tier Framework for Nursing Practice

Four nurses raised the different levels of expectation between nurses working in clinics and conducting universal home visiting and those who provide extended support to families with complex needs, commonly described as sustained home visiting:

Ideally the nurses working with the most complex families are distinct from the nurses who do universal home visits (N5).

N6 reflected on the level of practice of nurses implementing the NSW Safe Start policy:

I don't believe that all registered nurses can do it. I believe that they need to operate at an advanced level...If you are talking about screening or you are talking about identifying this is very different to managing or becoming a resource for the family to access appropriate services. I think that you are moving into different levels. So where you talk about the different stages, the targeted levels, you are talking about different ways of working... If you

are actually managing those families such as in sustained health home visiting then you certainly need to work at advanced level (N6).

N8 concurred with N6's perspective, highlighting the unique position of rural nurses who need to practise at advanced level:

I think that they all need to be at a certain level of expertise. It is almost tiered so even if they are going to do universal home visiting they will have to ask all these questions about vulnerabilities for the psychosocial assessment...As for those who are going to do sustained work with vulnerable families, that is an extra level that requires a higher level of practice...Then if you are going to be doing the rural work you need someone who has advanced practice (N8).

N3 argued, on economic grounds, that "We cannot spend a fortune on being totally skilled up for a population that does not need all those skills all the time". In contrast, N11 proposed that if all nurses working in the field of CFH were capable of working at expert level:

That means that as far as universal home visiting is concerned there would be better screening and early identification of issues because the nurses would have advanced skills, observational skills and ideas and understanding about complex families' needs (N11).

6.4 Interprofessional Education

In relation to the third research question, participants were asked about the potential benefits of interprofessional education for CFH nurses working with families with complex needs during the perinatal period and what specific components of a core curriculum would be relevant. Most nurses were receptive to the concept of interprofessional education. They identified role commonality among early childhood professionals working with families with complex needs and the opportunity to share a common language as compelling advantages. They put forward advanced communication skills and primary health care as fundamental components of interprofessional education.

6.4.1 Nurses' Perspectives on Interprofessional Education

Nine nurses agreed that interprofessional education was beneficial. Three did not respond to the question.

Six nurses had undertaken generic postgraduate courses in the past and they described the experience as positive and valuable. N4 and N6 shared their experiences:

I was fortunate enough to do my Master in Health Sciences Education and that was a multidisciplinary course. We did lots of group work activities...It was just sensational and all

my experience in multidisciplinary supervision has really expanded my personal clinical supervision. So the model of an interprofessional curriculum is an exciting prospect (N4).

I think that that is what is happening with a course like the infant mental health. I see a lot of professionals moving to that and it seems to fit well with many disciplines—social workers, psychologists, nurses (N6).

N3 pointed out the economic advantage of interprofessional education:

We are trying to do primary health care but we are also trying to save funds, we are trying to make our care concise and light so why not overlap education? (N3).

N11, however, cautioned about the introduction of interprofessional education because she feared that it might have a negative impact on the nursing profession:

My feeling is that if we identify a common core learning we may lose our uniqueness. I have seen that eroded over time where some people believe that nurses can only give out pills and cannot do anything else...I don't know that a first year of common education would break off that belief because those things happen when people believe that what they do is more important than what others do. This would not change with interprofessional education (N11).

The relevance of N11's argument to interprofessional curriculum development is discussed in Chapter 7.

Five nurses commented on the professional commonalities between social workers, psychologists and nurses who care for these families. For example:

I think that it is a great concept; nurses and social workers share the same group of women. I think that perinatal mental health is a subject that is easily shared between several disciplines (N10).

There is a lot of overlap between the role of various professionals who work with complex families and this can be quite confusing for the families (N12).

N11 agreed with a core education program that would include medical students as well as nurses, social workers and psychologists:

It would be beneficial, it would be unifying and we would have a common foundation and common understanding if there was some aspects of our education that would be the same. This would mean better collaboration between services...I would suggest that even medical students be part of the interprofessional curriculum to ensure that we are on the same page (N11).

Three nurses pointed out the benefits of a common language for professionals with similar or complementary roles:

I think that it would be excellent because it would help us, it would cement us more, help us speak the same language. My concern is that often parents and families feel overwhelmed but so many professionals and sometimes we talk a different language but mean the same stuff (N2).

I think that we speak the same language...Some people are so wrapped up in their knowledge that they believe in their own terminology or language but we are saying the same thing...I think that speaking the same language is very important and sharing that language (N4).

In the rural area you cannot be the only expert. We need to have common knowledge. The other significant problem is the various languages that we use to interact with families. This can be quite confusing for the families especially when everyone is using different words to mean the same thing This confuses them and leads to poor outcomes; instead we could be on the same page (N12).

Nurses who believed that an interprofessional curriculum would be beneficial were asked to draw on their professional experience to identify potential components of such a curriculum.

6.4.2 Components of an Interprofessional Curriculum

While in principle, most nurses supported the concept of interprofessional education, they had difficulty outlining its benefit to nurses. They identified (a) advanced communication skills; (b) primary health care; (c) advanced information technology (IT) skills; (d) knowledge of maternal and child health supported by midwifery and parentcraft knowledge, as potential core subjects for a common curriculum.

6.4.2.1 Advanced communication skills

Two nurses recommended that the Family Partnership Model described in Chapter 1 be offered as a component of interprofessional education. This training, introduced to enhance the communication skills of clinicians implementing the *NSW Supporting Families Early* initiative, was originally intended for all early childhood professionals working with families. However it only reached CFH nurses and a limited number of midwives and NGO staff. The education program is based on an advanced communication skills framework to support optimal parent-nurse and parent-infant relationships. Relationship building, reflective practice and critical thinking, which are identified in the training as core skills, were mentioned by several nurses.

6.4.2.2 Primary health care

Although nurses were unsure about core learning components of a common interprofessional curriculum, they identified a list of knowledge and skills similar to those they had previously

spoken of as essential to their nursing practice and which reflected a primary health care approach.

The primary health care category contained eight elements: early identification of families at risk; child protection knowledge and skills; mental health and drug and alcohol knowledge relevant to the perinatal period; knowledge of relevant front-line interventions; recovery model of care for parents with a mental illness; concept of safe risk-taking when planning the care of the family and the child; concepts of infant mental health including attachment theory, brain development, socio-emotional growth and development and formation of early relationships; comprehensive assessments, documentation and formulation of family-focused care plans within a multidisciplinary context using tools; and a language common to all professionals.

6.5 Conclusion

This chapter has presented the findings from Study 3, in which 12 nurses working with families with complex needs during the perinatal period provided rich narratives about their current practice. They identified the knowledge, skills and attributes that they believed were essential to work effectively with these families, the optimal practice level required for this challenging nursing specialty and the potential benefits of interprofessional education. The key findings are summarised below in relation to the three research questions.

Research question 1. There was agreement that mental health knowledge was essential to assess and respond effectively to parents with complex needs. The area included sound understanding of infant mental health, adult mental health, front-line therapeutic responses and child protection. Nurses also believed that theoretical knowledge underpinning their clinical practice was critical to understand social contexts and relationship formation which, in turn, strengthened their interactions with parents. Three key concepts emerged from analysis of the nurses' responses: primary health care within a socio-ecological conceptual framework; child and family wellbeing; and working in partnership with families. The third knowledge area identified by the nurses as core to their clinical practice embraced child growth and development and parentcraft; this ranged from universal home visiting to long term early interventions to families with complex needs.

The nurses identified five groups of skills as core to their practice: rapport/relationship building, family focused practice, reflective practice, advanced communication skills and the application of knowledge into specific interventions.

The nurses proposed empathy, a non-judgmental approach, patience, respect and genuineness as essential attributes to support a practice based on relationship formation. Some nurses referred to

specific personality characteristics without which, they believed, nurses could not work effectively with the families. They talked about special personality, passion and optimism.

Research question 2. Nurses were asked if an advanced level of practice was required to work effectively with families with complex needs. All 12 participants observed that, although advanced practice gained through experience and specialist training was recommended, its implementation would face significant obstacles because of education gaps and workforce issues. This question was an important one from a curriculum perspective. The nurses suggested mentoring and supervision and a tier framework for nursing practice as potential responses to existing gaps in nursing knowledge and skills.

Research question 3. Nurses were asked about their perspectives on interprofessional education for practitioners involved in the care of families with complex needs during the early childhood period. Role commonalities and language standardisation were identified as potential benefits. Advanced communication skills and primary health care were proposed as core elements of a common curriculum.

The key findings from all three studies are integrated and discussed in the following chapter.

Chapter 7: Discussion and Conclusion

This chapter examines the key findings from the three studies in relation to each other and to the international literature. The strengths and limitations of the studies are identified, and implications for CFH nurses' clinical practice and education are discussed.

The findings indicate that there is a need for CFH nurses, who play a pivotal role in the implementation of early child health and child protection services reforms, to be adequately prepared for the broad changes in knowledge and skills required for their roles in working with families with complex needs. It seems that some of them might lack sufficient preparation. The nurses in Study 3 were able to enhance their understanding of relevant mental health theoretical frameworks and corresponding skills through a broad range of professional development activities in addition to traditional CFH nursing education programs. The mothers' responses in Study 2 revealed some discrepancies between nurses' perceptions of their own clinical practice and their assumptions about what mothers need and expect, and those of the mothers themselves. Successful implementation of the reforms discussed in Chapter 2 may have been compromised by this discrepancy.

The research was designed in part to explore the knowledge, skills and attributes of nurses who care for families with complex needs during the perinatal period. The investigation was conducted from three different perspectives: an expert panel in the field of early childhood; mothers who identified themselves as having complex needs and who believed they had been cared for by these nurses; and CFH nurses who had delivered or were currently delivering early interventions to families with complex needs.

Results were triangulated to demonstrate the extent to which the findings converged. Core knowledge, skills and attributes for nurses working with families with complex needs during the perinatal period were examined. Table 7.1 summarises the findings, identifying key themes that were generally congruent across the three studies as well as the partly discrepant results from Study 2. In column 2, verbatim mothers' expressions are shown in italics.

Table 7.1

Summary of Findings for Research Question 1: Nurses' Core Knowledge, Skills And Attributes

Study 1: Panel consensus	Study 2: Mothers' interviews*	Study 3: Nurses' interviews
Core Nursing Knowledge		
Mental health (adult & infant) • Psycho-dynamics of family relationships including transition to parenthood • Child protection legal framework including relevant legislation • Domestic violence Public health approach with attention to health promotion items • SIDS • Obesity prevention • Child safety • Capacity building • Ecological model of human development Principles of CFH nursing Fetal & infant growth & development	Parentcraft knowledge The CFH nurse checks the baby, measures & weights, enquires about sleep & settling & writes in the Blue Book	Mental health • Concepts of mental health/illness • <i>Adult MH</i>: impact of mental illness on parenting during the perinatal period • Theories & models underpinning psychosocial assessments, acute & long-term responses including crisis management, treatment & recovery within a perinatal context • <i>Infant MH</i>: emotional attachment, brain development, social-emotional development, impact of psycho-social issues on developing infant, early relationship formation Child protection including risk assessment, knowledge of relevant policies & evidence-based models of practice Key concepts & theories • Primary health care within a socio-ecological conceptual framework • Child development science • Strength-based partnership model of care • Relationships theories Child growth & development & parentcraft • Health surveillance (norms & deviations) • Assessment: Family health history • Nutrition, sleep, settling
Core Nursing Skills		

Advanced communication skills • interpersonal skills (engagement/relationships formation) • written documentation that reflects family complexities Assessment (4domains) • risks & protective factors • child maltreatment • parent-infant relations • psychosocial issues Elements of nursing practice that reflect a public health approach • work from a strengths-based, solution-focused approach • work within an interprofessional & interagency framework. • effective referrals through knowledge of community services & resources • capacity to supervise & mentor other professionals. • reflective capacity • cultural sensitivity Translation of knowledge into practice	Communication skills/interpersonal skills <i>They check what I am doing & they write something in my papers but I did not know what</i> Emotional support <i>She approached the issue of depression but all was OK</i> Education skills <i>She taught me how to stroke the twins, how to put them to sleep, how to feed them, clean them, how to play with them</i> Health promotion skills <i>She gave me CDs, DVDs, pamphlets</i>	Advanced communication skills • listening • interprofessional collaborative practice • comprehensive documentation that reflects complexities • rapport/relationship building that supports engagement & change Use of assessment tools • mental state (MSA), • psychosocial screening (PNRQ, EDS) • child/family health status (ages & stages) Elements of nursing practice that reflect a public health approach • family-focused • relational partnership with parent led decision making • family advocacy • empowerment, • strength-based practice • capacity building (family/community) • reflective practice including safe risk taking while supporting personal & parental growth • reflexivity • critical thinking • awareness & use of local community resources Translation of knowledge into practice
Core Nursing Attributes		
Empathy Respect Flexibility Genuineness Integrity	<i>They say K is going to die. The nurse was nice, she gave me tissues</i> <i>She listen to me, allowed me to talk</i> <i>She had time for me, time to build a relationship</i> <i>She was calming</i>	Empathy (compassion, understanding, open-mindedness, sensitivity) Non-judgmental (acceptance, objectivity)

Optimism Emotional intelligence Honesty Humility Good listener Trust Tolerant of differences Responsiveness	The nurse was • <i>approachable,</i> • <i>supportive,</i> • <i>thoughtful</i> • <i>patient</i> • <i>accessible</i> • <i>non-judgmental</i> • <i>informative</i> • <i>practical, down to earth, proactive</i> • <i>explaining 'without fussing'</i> • <i>empathetic</i>	Patient (acceptance of slow pace, small gains, limited short term rewards) Special personality Passion Respect Genuineness (credibility, honesty, sincerity, humility) Optimism (commitment, stamina, perseverance, sense of humour)
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7.1 Core Knowledge, Skills and Attributes

The expert panel, the nurses and, to a lesser extent, the mothers agreed on the core knowledge, skills and attributes identified in the nursing literature (Kemp et al., 2005; Moules et al., 2010; NSW Health, 2011; Paton et al., 2013; Shepherd, 2011). Although the mothers expressed confidence in the knowledge of the nurses and saw them as experts in their field, their stories also showed that the care they received was at times suboptimal, and some of them reported feeling disempowered by the nurses.

Core sets of knowledge, skills and attributes that were required for optimal care emerged from the accounts of all three groups. Mental health, public health and child growth and development were deemed essential knowledge domains. The expert panel and the nurses identified four essential skill domains: advanced communication, assessment skills, elements of nursing practice reflecting principles of public health, and the translation of knowledge into practice. Common skills and qualities of nurses were identified as particularly important when working with families with complex needs. These attributes can be compared directly to the work of Davis and Day (2010) which informs the family partnership training that is recommended for nurses implementing the *Supporting Families Early* initiative (Appendix 17).

7.1.1 Mental Health and Care

Taken together, the findings identified skilful attention and response to the psychosocial needs of families during the perinatal period as essential. The panel and nurses agreed that a robust understanding of the concept of mental health was imperative for the delivery of effective mental health care. Mothers described their experiences of their new parenting role, the emotional issues that came with it and the type of support they expected from their carers during the perinatal period. Importantly, participants from the three studies identified optimal child development and wellbeing as a main purpose of effective parental mental health care. This is consistent with findings from previous studies that have examined the interconnecting concepts of complex needs and mental illness as parental risk factors for child maltreatment, as discussed in Chapter 2 (Huntsman, 2008; Jordan & Sketchley, 2009; Mayberry, Goodyear, & Reupert, 2012).

7.1.1.1 Expert panel

Findings from Study 1 highlighted the links between adult and infant mental health, domestic violence and child protection. The participants drew a distinction between adult mental health knowledge linked to psychosocial screening and referral to specialist services and infant mental health knowledge that focused on early infant-carer relationship formation and attachment. Several participants noted the benefits of motivational interviewing (MI), which is a directive counselling approach originally developed to encourage behaviour change in patients with addictive behaviours (Miller & Rollnick, 1991). More recently, health professionals working with families with complex needs have adopted

this approach to deal with a range of behaviours that are potentially harmful to the child, such as smoking and harsh parenting practices (Iannos & Antcliff, 2013).

Despite general agreement about core adult and infant mental health knowledge and skills, some differences in the responses between rounds one and two of the Delphi study indicated a lack of consistency in the use of the term 'mental health'. According to one participant, it could apply to the prevention of mental illness and the promotion of maternal mental wellbeing or it could be used to describe individuals with a diagnosis of mental illness; in the latter case, preventive perinatal interventions aim to prevent maternal relapse and promote the infant's emotional health and wellbeing. These interpretations, while not mutually exclusive, are significantly different and suggest the need for separate nursing roles and distinct skill sets. Researchers, policy makers and clinicians have been reluctant to use the term 'mental illness', preferring instead to refer to 'mental health issues, emotional problems or emotional distress'. This may have contributed to the uncertainty that exists around the diagnosis and management of high incidence perinatal mental illnesses such as depression and anxiety within a primary health care setting (beyondblue Perinatal Mental Health Consortium, 2008). Both depression and anxiety have significant negative impact on parenting capacity and early relationship formation (ARACY, 2009; M. Austin & Highet, 2011; R. Austin & Farlinger, 2015; Glover, 2011; Woodhouse et al., 2009).

7.1.1.2 Mothers

The mothers in Study 2 supported the finding that assessment and referral for mental health issues was an important role for nurses. When nurses asked them about their past and present emotional state using structured questionnaires, they said this was surprising, but not unacceptable to them. Most mothers had been asked to complete the Edinburgh Depression Scale (EDS) and they were aware that the questionnaire was a screening tool for depression. The mothers did trust the nurses to be able to identify if they were not coping and recognised that the nurse's role was to refer them to relevant specialist services. It is worth noting that mothers did not acknowledge having a mental illness, but did report experiencing extended periods of sadness, anxiety and stress. They described emotional distress as an adjustment to motherhood which, at the time, impaired their ability to function effectively. Commenting on reluctance to disclose psychosocial issues, one mother hinted at the stigma associated with mental illness:

Your main priority is self-preservation. You try to project to the world that you are coping. The nurse needs to be very intuitive to realise that the mother is not telling the truth because she thinks, 'If I tell the truth what they are going to do?' (M6)

This obstacle to disclosure is well documented in the literature (Myors, Johnson, Cleary, & Schmied, 2014; Reupert & Mayberry, 2007; Woodhouse et al., 2009). This finding, consistent with those from

other studies (Shepherd, 2011; Woodhouse et al., 2009), suggests that, while the women may have cooperated with routine psychosocial screenings, they may also have minimised their symptoms.

Despite such apprehensions among some mothers, successful previous experiences with CFH services may have encouraged others to seek the support they needed (Marshall, Green, & Spiby, 2012). A mother of four (including newborn twins), who had struggled with mental health problems since early childhood, reported how her self-efficacy and confidence as a parent had been enhanced by accessing CFH services while she was still pregnant. Because of her mental health history, she was well informed about the roles of existing services and about the type of intervention she believed she was likely to require in the postnatal period. She relied on the strong relationship that she had built with CFH services in the past to seek their help in planning specific postnatal interventions that she thought would meet her current mental health needs. The plan included risk assessment of potential child maltreatment resulting from the family's psychosocial complexities. When reflecting on the implication of a child protection assessment and the nurse's sensitive approach, she remarked:

The person's good language and her ability to express herself; this made a difference to why you have to put a risk of harm form...She worded it in a way that I did not look like a crap mum who did not look after my kids or could not cope looking after four children (M9).

This mother's positive experience is consistent with findings from studies that explored the benefits of moral, trusting relationships between nurses and parents (Marcellus, 2005; Shepherd, 2011; World Health Organisation, 1986). Success depends on the credibility of clinicians and on interventions that are relevant to the parents and tailored to the family's needs (Donetto et al., 2013). Another mother was faced with complex family issues and lack of support. She described the skilled and sensitive response of the CFH nurse who visited her at home following her discharge from maternity care:

The second visit was not about the baby, it was about me. The nurse may have thought that I was depressed; she had sensed that I was unhappy; she wanted to know that I was alright. She said 'I am here for you' (M8).

The interaction that followed resulted in long-term support being instituted for the family. Similar findings were reported by Shepherd (2011), who showed how CFH nurses were able to meet the emotional needs of mothers "hiding behind the mask of motherhood" (2011, p. 145) using the monitoring of the infant to justify their cautious probing of maternal emotions.

7.1.1.3 Nurses

Nurses were invited to participate in the study through the NSW CFH nurses' professional organisation. The 12 nurses who self-selected to be interviewed for Study 3 worked in primary health care settings providing early interventions to families with complex needs during the perinatal period. It was assumed that all 12 nurses would hold a CFH nursing qualification, as this is a recommended (although not essential) condition of employment in their role (NSW Health, 2010a). Eight nurses

held a CFH qualification, ten had postgraduate qualifications in adult and infant mental health, psychology and social work, and seven held both CFH and mental health qualifications. This level of mental health expertise reflects the focus of the service. More speculatively, it might also indicate the capacity of the workforce to deliver mental health expertise.

While the panel in Study 1 adopted a broad view of mental health, paying particular attention to the inconsistencies and lack of clarity in the concept itself, the nurses were more pragmatic in their approach. Findings from Study 3 were consistent with the beyondblue practice guidelines and education program for primary health care workers (beyondblue, 2010; beyondblue Perinatal Mental Health Consortium, 2008). The nurses reflected on their past and current clinical practice, their nursing education and their personal experiences of working with families with complex needs. This enabled them to articulate the competencies they believed were required to deliver the quality mental health care that is necessary for enhancing parenting capacity and child protection. They commented on the dangers associated with supporting the emotional needs of families without understanding the aetiology of mental illnesses, treatment options, care pathways and community resources. The nurses pointed out that, while various postgraduate courses had been useful for building their theoretical knowledge and skills in mental health, ongoing participation in continuing professional development and supervision had been essential to allow them to practise at an advanced level. Nurses practising, often in isolation, in rural and remote areas of NSW were particularly conscious of their mental health knowledge and skills deficits and chose, whenever the opportunity arose, to collaborate closely with local specialist services.

Nurses in the study subscribed to the recommendation in the literature (Cowley et al., 2013; Donetto et al., 2013) that the ability to assess the family's needs comprehensively and to develop acceptable and effective responses was crucial to their practice. They described psychosocial assessments, monitoring of parents' mental state and parenting capacity, assessment of present and potential safety risks and assessment of the parent-infant relationship as essential components of their practice. Several nurses singled out the importance of finely-tuned assessment and observation skills to promote healthy relationships with parents who were reluctant to engage with them:

You gather data without questioning... You become able to assess parents by what they are not telling you rather than what they are telling you (N3).

Several nurses agreed with the literature that, although extensive training in the use of psychosocial risk assessment tools was available to NSW nurses, further education in comprehensive psychosocial assessments of mothers throughout the perinatal period was indicated (National Health & Medical Research Council, 2003; Rollans, Schmied, et al., 2013a, 2013c). In addition to advanced assessment skills, the nurses identified a combination of important clinical skills gained while working with families, notably their ability to use attachment-based interventions to support early relationship

formation and to use supportive non-directive counselling techniques to de-escalate acute maternal distress and manage mild to moderate symptoms of depression and anxiety (Roden, Jarvis, Campbell-Crofts, & Whitehead, 2015). Finally, several nurses agreed with the panel on the importance of behaviour change skills acquired through programs such as Motivational Interviewing to help parents modify potentially harmful behaviours.

7.1.2 Parentcraft Skills

The findings from the three studies indicated a general agreement that improving parenting capacity and self-efficacy is core business for CFH nursing and that, in line with CFH nursing professional guidelines (NSW Department of Health, 2011b), monitoring of infants' growth and assessment of developmental milestones are key nursing functions. As expected, the three groups explored the nurses' parentcraft competence from very different perspectives.

7.1.2.1 Expert panel

The participants in Study 1 referred to competencies in infants' sleep and settling, feeding, crying, motor development and toddlers' behaviour as CFH professional knowledge. They also identified as essential knowledge an understanding of the psychodynamics of family relationships, especially during the transition to parenthood, complemented by advanced communication skills to guide the family through those life changes.

7.1.2.2 Mothers

The mothers in Study 2 mainly focused on assessment and monitoring of their infant's growth and development as the main role of CFH nurses. Most of them regularly attended the clinic where nurses wrote in the Blue Book, a child personal health record issued to all new mothers in NSW following the birth of their baby (NSW Kids and Families, 2013). The purpose of the Blue Book is to ensure that parents have an up-to-date record of their child's progress, providing accurate information to various health professionals caring for the child throughout the preschool years. Most mothers commented on the importance of the information contained in the Blue Book and they trusted nurses to keep reliable data about their children:

The nurse completes it each time we go to the clinic. She ticks all the boxes (M7).

I went there just for the weekly and monthly check up, just to make sure baby was developing well, sleeping well, growing, he was thriving and later on to check that he was growing appropriately (M4).

Although first-time mothers regularly visited their local health clinic, their narratives indicated a sense of disconnection between the personal health record and the opportunity to discuss the information with the nurse or seek advice about related parenting issues. This finding was surprising but may have resulted from the study design, in which mothers were able to choose the particular experiences of nursing care that they wanted to talk about. Moreover, a number of mothers who believed that CFH

nurses had the *knowledge* to support them with their parenting skills suggested that the nurses may not always have had the *opportunity* to help because of the structure of local health services. One mother, for instance, commented: “I get the feeling that they were doing the best that they could under the circumstances that they work under”. This issue, which is also raised in the literature (Kruske et al., 2006), is discussed in more detail in the next section.

The mothers reported that interactions with health professionals were more positive when the interventions took place at home. The practice of using routine baby checks strategically to engage with mothers and address parenting issues is well documented in the nursing literature (Browne et al., 2010; Marshall et al., 2012; Myors et al., 2014; Shepherd, 2011). One example of opportunistic teaching was reported by a mother of four children under the age of six. She was struggling with feeding distressed twins. The nurse, after seeking her permission, joined in the tasks of feeding, playing with and soothing the infants to sleep while they discussed the activities taking place.

Some mothers had been referred to early intervention programs run by NGOs when antenatal psychosocial screening identified them as ‘vulnerable’. Although they received and appreciated intensive parenting support over an extended period of time (up to two years), it is important to point out that the home visitors were mostly volunteers and family workers. One mother described how the workers taught her to “bath, feed, put the babies to bed, how to handle them and hold them”. This clearly indicates that, while parents welcomed support and guidance with parenting, they did not necessarily expect nurses to be involved. Some of the mothers who did not access early intervention programs sought alternate sources of guidance, mainly from family members, neighbours and best friends who were parents themselves. Nevertheless, most of them conscientiously continued to attend the clinic for routine baby checks recorded in the Blue Book. This finding suggests that, although mothers’ attention is focused on the Blue Book, CFH nurses have the opportunity to build rapport and engage in important prevention and early intervention activities.

7.1.2.3 Nurses

The nurses in Study 3 identified a surveillance role, based on advanced observation skills, sound judgement and a robust knowledge of child developmental milestones, as a key element of their core practice. They reflected on their day-to-day work to illustrate how engagement with mothers allowed for transfer of essential information. They gave examples of how they used routine interactions with mothers about ‘baby stuff’ to develop trusting, respectful relationships. According to the nurses, this initial engagement encouraged mothers to ask questions, express doubts and seek reassurance about their parenting practices. One nurse, talking about her engagement with a depressed mother, described how she purposefully focused on an interactive dialogue to enhance the mother’s self-esteem and reduce her self-doubt:

I don't tell her it is better to do it that way I say: can you see the tired signs? What do you think baby is telling you? If you think he is ready to go to sleep then I can help you putting him down (N7).

One nurse, who was first employed in an early intervention team as a novice, spoke about her first experiences of telling mothers how to care for their baby. She described how years of experience combined with ongoing supervision and reflection transformed her task-oriented practice into a model of interaction in which she encouraged mothers to explore their parenting skills through the use of visual feedback. This approach, known as Steps Towards Effective Enjoyable Parenting (STEEP) (Erickson & Kurz-Riemer, 1999), has long been promoted as a means of assisting the development of child-carer attachment. It involves filming daily interactions between the mother and the child, usually in a home situation, followed by a mother-led discussion about the interaction. While STEEP is mostly used by infant mental health therapists, this particular CFH nurse was able to use it creatively to enhance parentcraft knowledge of mothers in a sensitive, respectful and inclusive way. The importance of nurses' creativity in developing opportunistic interventions involving mothers' participation and allowing for experimentation is well documented in the nursing literature ; (Moules et al., 2010; Shepherd, 2011). In its report on the future of nursing, the US Institute of Medicine (IOM, 2011) supports these findings, defining core nursing competencies as

Not task based proficiencies but higher level competencies that represent the ability to demonstrate mastery over care-management knowledge domains (p. 200).

Study 3's findings provide evidence not only of the commitment of CFH nurses to parentcraft knowledge and skills as core elements of their practice, but also of their ability to integrate those elements within a broader, holistic approach to family care that was not reflected in the mothers' experiences in Study 2. Nurses in Study 3 were convinced that the relational quality of their work with parents, combined with home-based interventions, allowed for engagement to be established and trusting relationships to be formed in order to support the enhancement of parenting capacity. For example:

You need an understanding of where people are at; you need to hear their stories, their pain, their background, and the transgenerational issues that have brought them where they are today. If you understand what they have been through...you develop rapport. Then you can move together forward... You are honest with parents, not judgemental, working on the issues that are important for them not for us as clinicians (N2).

It is about one step at a time and you learn to be paced by the family and gently raise the bar... and I think that you cannot do that if you don't have a trusting, almost non- professional nurturing relationship (N3).

Those findings are consistent with those from other studies that explored CFH nurses' practice (Fraser et al., 2014; Munns, Wynaden, Downie, & Hubble, 2003).

7.1.3 Public Health Model for Child and Family Health Nursing

Key elements of a public health model for early childhood were threaded through the three studies' findings, notably early identification of psychosocial risk factors and the need to intervene early to prevent infant maltreatment and to promote the capacity of parents to provide their children with safe and nurturing environments. The panel highlighted the importance of a socio-ecological approach to CFH service models and the role of CFH nurses in prevention. Nurses in Study 3 reflected on the benefits and dangers of universal screening for maternal psychosocial risk factors and on their expanded role in responding effectively to the complex expectations of some families. The mothers were more concerned about the continuity of the care they received from midwives and nurses through a smooth transition between maternity and community services. They also expected nurses to support and guide them using effective communication skills.

The expert panel agreed that CFH nurses had a role to play in health promotion, particularly in the areas of Sudden Infant Death Syndrome (SIDS), obesity prevention, child safety, community development and capacity building. They noted, however, that it was not enough for nurses simply to issue general health messages to parents. To be effective, they needed to consider the various socio-ecological forces that influence parental behaviour in families with complex needs. The nurses in Study 3 indicated that, as primary health care professionals, they had a responsibility to promote health by helping families to make decisions and by providing information. They were unclear, however, about the four other health promotion action areas identified by WHO—namely, healthy public policy, creating supportive environments, strengthening community action and re-orienting health services (Mittelmark et al., 2007; World Health Organisation, 1986).

There is strong evidence that, to be effective, personal skills development must be combined with other strategies, especially with disadvantaged and vulnerable population groups (Jackson et al., 2007). Available research indicates that, although health promotion is a recurrent item in policy documents and reports (Adrian, 2009; NSW Health, 2011), in reality, nurses' contribution is limited (Flinders Media and Communication, 2016). In one Australian study (The Interprofessional Curriculum Renewal Consortium, 2014), community nurses in urban, rural and remote areas of NSW were questioned about their understanding of the five areas of the Ottawa Charter for Health Promotion. Findings indicated that the nurses' limited understanding of health promotion principles was likely to impede their capacity to support the Australian primary health care reform (Australian Institute of Family Studies, 2014; Commonwealth of Australia, 2009b).

While participants in Study 1 emphasised the importance of health promotion, mothers in Study 2 drew attention to the difficulties they experienced when they transitioned from hospital to follow-up in the community. Continuity of care, characterised by pro-active collaborative partnerships between

services and professionals, is a core element of the public health model. Factors that may have contributed to fragmented perinatal care are discussed below.

7.1.4 Continuity of Care

The mothers' narratives indicated a sense of embarking on a life journey that was at once exciting and daunting and which held not only promises of joy but also many unknowns, commencing with pregnancy and finishing with the birth of a baby. Along the way they expected to be cared for and supported by health professionals who would help them in their transition to motherhood. For example:

I was married for about six years when [baby] was born He was very much planned but it was still a rude shock... It changed our whole way of life. I expected changes but not to that extent. People joke about the four-hourly nappy changes, the sickness, but unless you experience it firsthand you cannot imagine what it will be like (M4).

I had no real expectations. I did not plan what I would or not do. I went into it open- minded. It was actually more fun than I expected...The only big mistake, the biggest problem with the care I received is that none of the midwives prepared me for how hard breastfeeding was going to be... I wish I had been prepared for that (M6).

The findings from Study 2 pointed to a sense of disconnection and overlap between maternity and CFH services, hospital and community staff, private and public health care. Unfortunately, this indicates that continuity of care is still problematic, despite significant efforts made by Australian governments to address this in the past 15 years (Commonwealth of Australia, 2008, 2011; NSW Health, 2003, 2010b) . Chronic fragmentation between maternity and CFH services is highlighted in recent literature as an obstacle to professionals' ability to meet the needs of families (Psaila, Kruske, Fowler, Homer, & Schmied, 2014; Psaila, Schmied, Fowler, & Kruske, 2014a; Schmied et al., 2015).

The midwifery Continuity of Carer model (Commonwealth, 2011) was introduced in NSW in order to reduce fragmentation of care through pregnancy, birth and the postnatal period (NSW Health, 2010b). In contrast with the Standard Maternity Care model, in which women are seen by whichever midwife is on duty that day, the Continuity of Carer model promotes the development of relationships with a limited number of midwives throughout the woman's journey through pregnancy and birth (Sandall, Gates, Shennan, & Devane, 2015; S. Tracy et al., 2013). It encourages a strong interface between hospital and community and involves collaboration with various relevant health professionals. The woman receives postnatal care in hospital and is home-visited by a community midwife. This program is found to be particularly effective for women with complex needs (T. Tracy et al., 2013). One important recommendation of the midwifery Continuity of Carer model is that "all women accessing midwifery continuity of carer programs receive midwifery postnatal care at home for at least two weeks after the baby is born" (NSW Health, 2010b, p. 11).

The NSW Supporting Families Early policy on maternal and child health primary health care (NSW Health, 2010a) promotes a parallel, coordinated and integrated approach to the care of women and their families. Postnatal primary health care home visiting by a nurse is one of the key components of the continuum of perinatal care, beginning in pregnancy. According to the policy:

It is mandatory for Area Health Services to provide Universal Home Visiting. This is the offer and the provision of a home visit by a child and family health nurse to families with a new baby within two weeks of the birth of the baby (NSW Health, 2010a, p. 21).

Mothers in Study 2 reported confusion about the handover of their care in the fortnight that followed their discharge from hospital. One woman recalled:

I did stay in hospital for two days then I went home... I had different nurses visiting me. I came home on the Tuesday and they were not going to come until Sunday but because I had so many problems with my breastfeeding they extended it for a couple of days. They were midwives. Then I got a nurse from the health centre, she came out for the initial visit and then told me when my mother's group would be (M10).

Conflicting policy recommendations for community postnatal care are likely to have contributed to this problem. The Midwifery Continuity of Carer Model recommends home follow-up by midwives during the two weeks following hospital discharge and the Maternal and Child Health Care Policy directs CFH nurses to complete the universal home visit during the same period of time. There appear to be no clear guidelines about the potential overlapping of service delivery. Recent Australian studies identified the main causes of problems with the transition of care as ineffectual and inconsistent transfer of information, staff shortages, limited communication between professionals and services and tensions around role boundaries (Psaila, Schmied, et al., 2014a, 2014b).

At this point it is worth remembering that the participating mothers in Study 2 identified themselves as having a complex set of needs in the perinatal period. Those who paid for private maternity care claimed that they had not accessed CFH nor been approached to access the service. Considering that 29% of all mothers in Australia give birth in private hospitals in 2012 (Moore, MacDonald, & Sanjeevan, 2013), a significant number of families potentially miss out entirely on the support of CFH services, including access to more intensive interventions when complex needs are present.

One unexpected observation was the mothers' interpretation of the chain of events that shaped their postnatal experience and brought them acute emotional distress and frustration. Several mothers were angry and disappointed with the care they received. They did not, however, direct their criticism at the nurses' poor performance. Instead, they suggested that external factors at organisational and service level might have impacted negatively on the nurses' individual practice:

The nurses are overstretched and busy, always under some kind of pressure (M6).

I can imagine that the CFH nurse would not have had time to support me...I understand there is limited funding to help families and I know we were not one of the worst, but still it is sad...I get the feeling that they were doing the best that they could under the circumstances that they work under (M9).

I think that the system is such that it is hard. They were people who wanted to help but it is hard with that system (M10).

The constraints which the structure of CFH services can impose on nurses' roles and clinical practice is well documented in the Australian literature (Kruske et al., 2006). The mothers' stories support these reports, suggesting that inflexibility in service delivery may have impacted on the nurses' ability to develop ongoing relationships with families.

7.1.5 Psychosocial Risk Assessment

Although the nurses in Study 3 spoke mainly about their own experience in supporting the families they worked with, they also reflected on the role of CFH nurses who were mostly responsible for the early identification of families requiring extra support. One recurrent topic of discussion was the use of psychosocial screening in primary health care assessment. Most nurses expressed concerns about relying solely on screening tools to identify families with risk factors and to formulate short- and long-term interventions in response to results:

[The CFH nurses] need to have knowledge and skills about the screening tools that we use such as perinatal risk questionnaires and the Edinburgh Depression Scale, knowledge about what the questionnaires were developed for, how they are rolled out, how they should be used as screening tools, what they tell us and how to react according to the responses that we get (N11).

They [CFH nurses] are not mental health nurses and they do not have time to do an extensive assessment but I think that they should be able to explore further why they are getting the responses that they do [when they screen] (N10).

As previously discussed, the nurses pointed out that their ability to assess risk factors comprehensively was underpinned by a sound understanding of perinatal mental illnesses, especially depression and anxiety. In addition they commented on the importance of clinical supervision and reflective practice to enhance their assessment skills and ensure that screening was not limited to a 'ticking boxes' exercise. These observations are consistent with findings from studies by Hayes (2010) and Rollans et al (2013b).

The nurses in Study 3 reflected on the distinction, if any, between the core knowledge and skills indicated for CFH nurses responsible for universal home visits and psychosocial screening and those of nurses providing early interventions to families with complex needs. While some nurses did

support the concept of a two-tiered CFH nursing practice, others advocated broadening CFH nurses' practice rather than dividing it. One nurse summarised the benefits of this model:

A nurse with advanced skills knows the difference between a family having difficulties with the transition to parenting and the family with complex issues. She can rapidly bring in other services to support the family before escalation of the crisis. Having nurses with advanced skills doing the universal home visiting should lead to early recognition of issues and rapid intervention (N11).

This perspective is supported by a number of Australian and international studies pointing out the health benefits of a more advanced, comprehensive child health practice role for all CFH nurses (Borrow et al., 2011; Browne et al., 2010; Kruske et al., 2006).

The next section addresses the role of CFH nurses in promoting and supporting breastfeeding. This issue is discussed separately because it is conspicuously absent from the findings in Studies 1 and 3 despite its importance in the field of CFH.

7.1.6 Breastfeeding

In Australia, breastfeeding is promoted as the biological and social norm for infant feeding (Australian Health Ministers' Conference, 2009). Midwives and CFH nurses are expected to ensure that continuity of support at the transition point between birthing and community services is robust and seamless for all mothers who wish to breastfeed (NSW Department of Health, 2011a). Except for a mother of premature twins, all the women in the study had set themselves the goal of continuing to breastfeed for several months. They were convinced that it would promote their baby's health and they associated it with the notion of good parenting. Contrary to their expectations, only two were successful past one month. The other mothers struggled with cracked and sore nipples, perceived insufficient milk supply and emotional distress. The mothers did not blame health professionals for what some of them perceived as a personal failure; instead they reported having held a naïve assumption that breastfeeding was going to be easy and uneventful. One mother observed:

I went into it open minded; I was not prepared for how hard breastfeeding was going to be. No one told me how difficult it was (M6).

In 2008 the rate of breastfeeding was 92% at birth and 71% at one month; at six months only 14 % of infants were fully breastfed (Australian Health Ministers' Conference, 2009). This is well below the level of 80% at six months recommended by the National Health and Research Council (NHMRC) to ensure an optimal nutritional start for the infant (National Health & Medical Research Council, 2003). Only 20% of mothers in Study 2 continued breastfeeding after one month. It was presumed that, when mothers talked in interview about their inability to breastfeed, they would also comment on the advocacy and supportive roles of nurses (and, before them, of midwives) (McLelland, Hall, Gilmour, & Cant, 2014). It was also assumed that the promotion and support of breastfeeding would have been identified as a key nursing area of parenting knowledge and skills.

Australian policies and guidelines (Australian Health Ministers' Conference, 2009; NSW Department of Health, 2011a) emphasise the key role of CFH services in the promotion, protection and support of breastfeeding. In contrast, the mothers in Study 2 believed that successful breastfeeding was the luck of the draw and that professional intervention, even from lactation consultants, could not have changed outcomes. These findings indicate a dissonance between breastfeeding policy directives and the expectation that nurses would actively encourage breastfeeding. A possible explanation is that CFH nurses focus their attention on specific parenting issues that they believe take priority over feeding problems. It could also be hypothesised that the nurses' first postnatal contact with mothers comes too late, that is, when difficulties were so acute that the decision to cease breastfeeding had already been made. One mother certainly indicated this possibility: ‘

The nurse asked about feeding. I told her it drove me crazy I was in so much pain. I told her that I was switching to the bottle and she was OK about it. If I had decided to keep on trying I probably would have talked to her but I had given up (M6).

Interestingly, findings from Study 2 are consistent with data on breastfeeding outcomes from the NSW Sustaining NSW Families (SNF) (KPMG, 2015) and the Maternal Early Childhood Sustained Home Visiting (MECSH) (Kemp et al., 2012) programs, both of which are early intervention nursing programs for families requiring extra support. In spite of extensive nursing support, evaluations of the two programs reported breastfeeding rates below the national average at one month postnatally.

The supportive role of CFH nurses to improve breastfeeding rates may well be clearly defined in the Child and Family Health Nursing Professional Practice Framework (NSW Department of Health, 2011b), but findings from the three studies possibly reflect a poor commitment from community nurses. They might also indicate that the transitional process from maternity to CFH services has failed and that mothers who are experiencing early breastfeeding difficulties are not flagged at this point. This suggestion is supported in Barimani's and Hylander's study (2012) of continuity of care for pregnant and new mothers. The researchers found that, while shared policies and protocols and supportive management were important to promote continuity of care, ‘joint action’ between midwives and CFH nurses at a professional level was an essential relational element for success, especially in the area of breastfeeding.

The next section discusses the findings about core attributes of CFH nurses.

7.1.7 Core Attributes of CFH Nurses

Findings from the three studies indicated agreement on a series of attributes required to work effectively with parents. Most panel participants and nurses made reference to the list of skills and attributes identified in the Family Partnership (FP) training program recommended by the NSW

Ministry of Health (Davis & Day, 2010). The program lists respect, genuineness, humility, empathy, quiet enthusiasm and integrity as key attributes necessary to develop a partnership with parents, combined with core communication skills such as listening skills. The nurses in Study 3 also commented on the importance of clinical supervision as a means of enhancing their communication and interpersonal skills, decision-making, and clinical judgement, all of which are benefits documented in the nursing literature (Borrow et al., 2011).

7.1.7.1 Communication and interpersonal skills

The mothers in Study 2 were appreciative of nurses who were able to communicate effectively with them. Several mothers described instances where the quality of the communication resulted in either a positive acceptance of a potentially unpleasant situation or extreme distress and trauma. The following narratives illustrate both the powerful effect of good communication skills and the negative effect of poor communication skills on the mothers' experiences. The first mother with multiple health issues was told she had to give up her single room while in hospital:

The nurse seemed to be very senior. Someone had twins so she said that they would have to move me to another room at the end of the ward. She did not just move me, she talked to me about the move, explained why it had to happen (M6).

A second mother, in a similar situation, described her less than helpful interaction with the staff:

On the second day they said they had to move me to another room because they had someone who needed my room. I was tired, I was grumpy. No one cared. I was crying and I wanted to go home and that second night was a nightmare; my son cried the whole night (M1).

The findings from the three studies confirmed the importance of specific core attributes required to support engagement and rapport with parents. While the list of attributes provided by participants in Studies 1 and 3 may well have been directly drawn from the FP program, mothers in Study 2 were able to articulate the same skills and attributes that they expected from CFH nurses. Findings from Study 2 also contained examples of negative patient outcomes in situations where nurses did not display those attributes.

7.1.7.2 Working in partnership

In Australia, the Family Partnership model of care is embedded in most postgraduate education programs and employers' professional development courses. Nurses are strongly encouraged to shift from their traditional "expert" model of practice to one of engagement and reciprocity, to support parents to reach the goals that they set for themselves (Davis, 2009; NSW Department of Health, 2011b).

Despite the well-documented benefits of supporting parents to self-care, to develop their own solutions and to problem solve (Kemp et al., 2005), the findings from Study 2 suggested that partnership did not always occur during the mothers' interactions with nurses. Several mothers reported being coerced by some nurses whom they perceived as authoritarian and judgemental. Consequently they felt disempowered, vulnerable and judged. Even regular attendance at the clinic was understood by some mothers to be out of their control: "There was no benefit for me to go there; I only went because I thought I had no choice. I had to go". One mother, who described herself as generally strong and assertive, summarised this perspective:

If I ever have another baby, I will know better, I will be more assertive. I will not let the nurse make me feel guilty (M2).

Findings from Studies 1 and 2 indicate that a majority of CFH nurses have completed the FP training and are therefore familiar with the concept of working in partnership with families to promote best health outcomes. Findings from Study 2, however, suggest that not all nurses apply the principles of partnership into practice. Kruske, Barclay & Schmied (2006), in their study of contemporary CFH nursing practice, propose that those difficulties may be linked to rigid health service structures rather than nursing competence. The complex factors that might have contributed to the unexpected findings from Study 2 are discussed below.

7.2 Comment on Study 2 Results

Findings from Study 2 indicated that, while most of the mothers had limited contact with CFH nurses, probably because of their local health services' structure, some of them were consistently critical of the quality of the nursing care they received. The study's findings highlighted several complex factors that may have triggered the mothers' negative responses. These included the type of extra support mothers received, the effect of the transition to motherhood on their emotional wellbeing, their transition from hospital to community care and their interpersonal relationships with carers.

During pregnancy and the postnatal period, midwives and CFH nurses routinely ask mothers questions about psychosocial issues that might be affecting their wellbeing, such as stressful events, loss of a loved one, type of parenting received, childhood trauma, lack of support and depression. The recruitment pamphlet used in Study 2 (Appendix 11) reminded potential participants that they would have been asked such questions as part of their routine psychosocial screening and that the study was seeking to include mothers who had received extra nursing support in response to the identification of any of these risk factors. Two groups of women self-selected to participate in the study.

One group received a range of targeted early interventions over a two year period from a local non-government organisation (NGO). The interventions included home visits from volunteers and access to a supported playgroup facilitated by trained early childhood educators (Commerford & Robinson,

2016). The women had limited contact with CFH nursing services and, when they did, it was mostly through the universal post-natal home visit and at the clinic where the child's growth and development were monitored. These mothers reported being satisfied with the nursing care they received and also reflected on their positive experiences of interventions from a range of people who were not necessarily health professionals.

The second group of women, who reported more negative experiences, also attended the playgroups. Rather than describing how nurses had made their experience a positive one, these mothers took the opportunity to recount lengthy stories about negative experiences associated with a health facility or with professional care during or following the birth of their child. Those negative experiences coincided with the midwifery and nursing care they received at the time, and several participants indicated that they had avoided further contact with CFH services as a result.

Although the mothers' motivations for seeking an interview were undoubtedly complex, the findings that resulted from this unforeseen course of events nonetheless highlighted what new mothers expect from care-givers.

Becoming a mother is in itself a major life event and professional care can influence women's emotional adjustment to this dramatic change in their lives (Ball, 1987; Luthar & Ciciolla, 2015). In interview, women told of particularly stressful experiences both in maternity units and after they had returned home with their infants. They described being suddenly faced with challenging situations that were out of their control and which had outcomes that they often did not anticipate or comprehend. As one mother put it: "In hindsight now and for my second baby I would be much more in control but you don't know what you are doing".

Participants reported a widely varying quality of care throughout their perinatal journey (see Table 5.2) but they were particularly confused and distressed during two specific periods: when they were in hospital following the birth of their infant and after they had returned home, when the excitement of becoming a parent subsided and they were left alone, sleepless, exhausted and facing the demanding and unpredictable behaviour of a newborn. In interview, the women chose to revisit these disquieting periods in their lives, when they felt most vulnerable, powerless and unprepared for their new role and relied heavily on the support of midwives and nurses to help them manage the transition to motherhood (Luthar & Ciciolla, 2015; Seefat-van Teeffelen, Nieuwenhuijze, & Korstjens, 2011):

It was horrible, the whole experience was so horrible...It was my first baby (M2).

It was a rude shock. It changed our whole way of life. I expected changes but not to that extent... Unless you experience it firsthand you cannot imagine what it will be like (M4).

The women indicated that they had expected that they would be able to navigate maternity and CFH services confidently and seamlessly and assumed that these services would respond sensitively to their needs and support them in their new parenting role. Instead, they reported, the interventions were delivered by clinicians who did not understand their experiences and struggled to meet their needs. This is consistent with findings from an earlier study of women's experiences of early motherhood where a sense of loss and hopelessness was exacerbated by rough or insensitive care (Barclay, Everitt, Rogan, Schmied & Wyllie, (1997). Similarly, a more recent Australian study (Brown, Davey, & Bruinsma, 2004) showed that the quality of interactions with health professionals was a key determinant of new mothers' overall satisfaction rating of postnatal care.

A complicating factor in the data analysis was the mothers' inability to identify the professional background of staff, either in hospital or in the community. This included the NGOs' early intervention staff, some of whom were volunteers and who supported them during the extended postnatal period. Consequently, the mothers' positive or negative experiences could only be confidently examined from the quality of care perspective, irrespective of who the caregiver was. The women might not have been interested in, or remembered, the titles and status of their caregivers and/or might just have assumed that they were being cared for by nurses. Alternatively, the nurses or midwives might not have said who they were or might not have worn identity badges. In any case, this uncertainty is likely to have added to maternal confusion and distress.

Communication breakdown and poor patient outcomes resulting from lack of identification of staff status was highlighted in the report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals (Garling, 2008). Its recommendations for urgent changes, however, might not have been implemented in maternity hospitals and community services by the time this research was conducted.

7.3 Strengths and Limitations of the Research

One of the strengths of the study was its use of a mixed-methods design in which the research questions were investigated from different perspectives— experts, consumers and nurses. The Delphi study (Study 1) provided a platform for Studies 2 and 3 by identifying priorities and core elements in the research inquiry, resulting in the production of rich data. Even when unexpected circumstances arose early in the recruitment stage of Study 2, the findings added strength to the research, in that they generated a deeper understanding of mothers' experiences at a time when many women, irrespective of psychosocial factors, perceive themselves as alone, unprepared and helpless (Barclay et al., 1997).

The triangulation of findings from the three studies identified a broad agreement about CFH nurses' core competencies that supported findings from previous international and Australian research

(Cowley et al., 2013; Kemp et al., 2005; Kemp et al., 2011; Kruske & Grant, 2012). There is, however, a paucity of research on nursing interventions for families with a mental illness during the perinatal period. The available evidence suggests a general lack of parenting knowledge and skills among adult mental health case-managers (Maybery & Reupert, 2006, 2009) (Maybery et al., 2006). One of the strengths of the present study is that it has provided an opportunity to explore the specific mental health issues faced by families who have been identified as having complex needs. It approached the enquiry from a primary health care perspective, focusing on the parenting element rather than the diagnosis. It was successful in generating comprehensive information on the mental health nursing competencies required to care successfully for those families. Nonetheless, Study 3 is limited by its small sample size and by the recruitment strategy that resulted in the self-selection of highly experienced nurses who identified themselves as practising at an advanced level.

One important finding from Studies 2 and 3 was the indication that CFH nurses did not belong to a homogenous professional group with common qualifications and roles. Rather, there appeared to be a two-tiered CFH nursing structure within primary health care settings. One group of nurses engaged with mothers while they conducted universal home visiting and psychosocial screening under the NSW Maternal and Child Health Care Policy. Additional interactions took place at local health clinics; these were brief and focused on the infant's needs. A second group of nurses, practising at an advanced level, provided extra support to families identified as having complex needs.

The research was strengthened by the opportunity to conduct face-to-face interviews with nurses who were working in rural and remote areas of NSW. These data generated a unique insight into the challenges of isolation, limited access to resources and the responsibility of caring for a large number of families as a sole practitioner. They also highlighted the creative strategies these nurses deployed to enhance their knowledge and skills.

Several important limitations should also be mentioned. Study 2's sampling bias is likely to have impacted on the study's findings. Prior to recruitment, assumptions were made about how women would identify themselves as having complex needs and about the characteristics of CFH nurses who responded to their needs. It was not envisaged that mothers would mainly report negative experiences with a range of health workers during the birth of their baby or soon after. Nor was it anticipated that some mothers who had been identified with complex needs would be referred to NGOs' extended home care programs that were delivered by generic staff, including volunteers. Nonetheless the data added to existing knowledge of the core attributes required from all nurses working with families (Davis & Day, 2010). The interviews provided mothers with an opportunity to articulate the type of care they would have liked to receive when they felt particularly vulnerable and were facing seemingly unsurmountable challenges. The mothers' narratives highlighted the negative impact of

poor interpersonal skills and negative nursing attitudes on their future relationships with CFH services.

The ambiguity around the role of CFH nurses in supporting breastfeeding was an unexpected finding which, unfortunately, could not be further explored because it fell outside the scope and methodology of the research inquiry. While mothers expressed their strong commitment to breastfeeding during pregnancy, only two out of ten were successful. The women did not appear to have received extra nursing support, despite (or perhaps because of) their identification as having complex needs. Furthermore, neither experts nor nurses identified breastfeeding support as core business of CFH nurses, despite government concern about the decline in breastfeeding rates after one month (Australian Health Ministers' Conference, 2009; NSW Department of Health, 2011a). While this finding was unexpected, it does not necessarily imply that they saw the role as irrelevant. It is more likely that the method of inquiry in Studies 1 and 3 contributed to this result since participants were not specifically asked about breastfeeding.

Nurses were invited to participate in study 3 through the NSW CFH nurses' professional organisation to ensure that the sample would be representative of all nurses working with families with complex needs within a primary health care setting. However, the study's findings indicate an overrepresentation of nurses with postgraduate mental health qualifications. As discussed in section 3.4.2 (p.7), an unexpected snowball effect in recruitment led to four nurses practising at consultant level self-selecting. This may have resulted in a sample not necessarily representative of CFH nurses in general. The sample bias, therefore, limits the generaliability of the findings to a wider group of nurses. The literature review highlighted the limited capacity of health professionals to recognise and respond to the specific needs of mentally ill parents (Maybery & Reupert, 2006). While further research is strongly indicated, this study provides valuable information for academic staff and educators responsible for the review, development and delivery of relevant education programs that would enhance the preparedness of all professionals working with families with complex needs.

The findings from studies 1 and 3 did not provide significant evidence about experts' and nurses' awareness of or interest in interprofessional education. Most participants agreed with the international and national literature in identifying interprofessional collaborative practice as a key element in improving the care of families with complex needs (Allen Consulting Group, 2009; ARACY, 2010; Moore & Skinner, 2010). Nonetheless, they were largely noncommittal in their support for the concept of a common curriculum and leant instead towards interprofessional units within courses and enhanced shared professional learning. While the study design did not allow for a more extensive investigation of the concept, this finding suggests the need for further exploration of the meaning, relevance and benefits of the term "interprofessional" in the context of developing more comprehensive and relevant curricula. This is particularly important because the successful

implementation of early childhood and child protection reforms is highly dependent on the quality of the interprofessional practice of CFH nurses in a primary health care model.

7.4 Implications for Clinical Practice and Education

One aim of the study was to provide insight into the level of expertise at which CFH nurses practise when they work with families with complex needs during the perinatal period. Two further objectives were to examine the benefit of interprofessional education and to inform future curriculum development. This section considers the implications of the research findings for CFH nursing practice and education.

7.4.1 CFH Nurses Practising at Advanced Level

As explained in Chapter 1, it was decided to use the term Child Family Health (CFH) nurses to refer to all registered nurses working with families with complex needs during the perinatal period. I had expected that the investigation would identify a single professional group of nurses with CFH nursing qualifications and specific knowledge, skills and attributes that equipped them to work with all families on a continuum of complexity. Nurses in Study 3 provided information about their qualifications, years of experience and current employment status, including their roles and functions in the particular health service in which they were employed. In Study 2, mothers spoke about ‘nurses’ who visited them once at home and enquired about psychosocial issues and depression through the use of questionnaires. According to the women’s accounts, those nurses competently assessed and monitored their children’s growth and development and entered information in the Blue Book at the local clinic, which is indicative of a traditional CFH nursing role. Findings from the two studies, however, suggest the existence of two different nursing roles that may not have been related to nursing competence but to the work structures and expectations of specific services.

Nurses in Study 3 spoke very little about traditional elements of their CFH practice. They focused instead on the complex health issues faced by some families and the practice areas they had to improve in order to respond effectively to parents’ complex needs. Like the participants in Kemp et al.’s (2005) study of nurses’ competencies for sustained home visiting, these nurses emphasised their understanding of health determinants and their ability to apply this public health knowledge to their clinical practice. As one nurse working in rural NSW commented: “You need knowledge about environmental events, for example recognising the impact the drought had on our local community and how it can affect parenting”. The nurses indicated that they incorporated the whole family, its social system and its environment in comprehensive psychosocial assessments and interventions. In doing so they described the development of active collaboration, not only with parents, but also with various agencies involved in the care of the family. Furthermore, the nurses indicated that they adopted strengths-based, proactive strategies that were flexible and responsive to the parents’ expectations.

Echoing criticisms found in the literature (Peters & Barlow, 2003), the nurses particularly disapproved of the increasing use of tool-based assessments in place of highly developed engagement, inquiry and observation skills supported by advanced communication skills. Other studies (Gillingham, 2011; Taylor et al., 2008) have suggested that the use of screening tools risks undermining professional development of assessment skills by oversimplifying and limiting nurses' clinical practice. Further research is needed to clarify the role of CFH nurses in the early identification of families with complex needs as a core competency of primary health care nursing.

Nurses in Study 3 reported that they were confident in their ability to case-manage families who would otherwise have been referred to specialist services. Their optimism and eagerness to engage with the local community and take part in capacity-building activities was in contrast to the findings of another exploratory study of CFH nurses' new practice domains (Borrow et al., 2011) which reported that nurses experienced difficulties in meeting the challenges of an expanded CFH nursing role, especially when they were expected to practise from a population health approach. Findings from Study 3 might indicate that CFH nurses have gained confidence since the previous study was undertaken.

7.4.2 Pathways of Care for Early Intervention

There are well-documented risks associated with screening if quality pathways of care for follow-up support are not in place (M. Austin et al., 2010). Findings from Studies 2 and 3 indicated significant inconsistencies in referral pathways of care. The NSW Maternal Child Health Primary Health Care policy (NSW Health, 2010a) outlines the nursing sustained health home visiting (SHHV) service model for families that are categorised as 'at moderate risk' and therefore require additional support and guidance.

The nurses in Study 3 were employed in early intervention programs run by local CFH services. They reported a significant level of flexibility in the admission criteria for the program as well as in their clinical decision-making; this was encouraged by their employers, who facilitated their professional development and clinical supervision. Some of the parents in the program had experienced mental illness and/or drug and alcohol misuse. In Study 2, several families who had been identified as having complex needs were not followed up by CFH nurses. Instead, they were referred to NGO early intervention programs delivered by family support workers, some of whom were volunteers. It was beyond the scope of this study to explore the nature or effectiveness of the interventions delivered by these workers. It is important to note, however, that the mothers expressed appreciation for the parenting support they were still receiving at the time of interview.

These findings suggest that, while the NSW policy promotes a consistent, integrated approach to the care of all families, its implementation in relation to families with complex needs is inconsistent. Furthermore, while the pivotal role of CFH nurses is highlighted in the policy, the present study's

findings suggest that the responsibility of providing long-term support to those families does not automatically belong to CFH services; rather, service models are varied and compliance with policy directives is not consistent throughout NSW. A rigorous evaluation of the international Nurse-Family Partnership (NFP) program for vulnerable families showed that nurses produced larger and more consistent effects on child and maternal health than did paraprofessionals (Olds et al., 2014; Olds et al., 2004). This signals a need for further research into the relative benefits of employing CFH nurses rather than generic family workers or volunteers in Australian early intervention programs.

7.4.3 Primary Health Care Nursing for Families with Mental Illness

The findings drew attention to the respective roles of CFH and adult mental health services in intervening early with families with mental illness during the perinatal period. Parental mental illness is associated with a range of negative outcomes, such as reduced parenting capacity, poor family dynamics and child ill health, yet there is little research on early parenting interventions for this vulnerable population (Mayberry et al., 2012). In addition, most of the studies that are available target adult mental health workers responsible for case-managing families with children of school-age. Adult mental health services focus on parents, whereas perinatal and infant mental health (PIMH) services concentrate on the child and the quality of the attachment with the carer (Reupert & Mayberry, 2007).

Research has shown that collaborative practice between those services is minimal and that health workers remain in silos (Myors, Cleary, Johnson, & Schmied, 2015). In a review of the capacity of the mental health workforce to respond to the needs of children of mentally ill parents, Mayberry and Reupert (2006) argue that a lack of knowledge, skills and resources, organisational and role constraints and ineffective collaboration between agencies prevented the delivery of comprehensive interventions. A study involving 294 mentally ill mothers found that when parenting stress—usually associated with common contextual risks such as lack of support—is reduced and favourable environmental changes are implemented, symptoms are also reduced (Kahng, Oyserman, Bybee, & Mowbray, 2008). Consequently, mothers are able to parent positively and effectively.

There is also a paucity of studies exploring effective collaborative practice between primary health care and specialist services to enhance the parenting capacity of mothers with mental illness and/or drug and alcohol issues. While this population group is excluded from most structured Sustained Home Visiting programs (Commonwealth Department of Health and Ageing, 2012; KPMG, 2015; Olds, 2012), nurses in Study 3 provided important information on the delivery of effective, comprehensive nursing interventions to those families, particularly in rural CFH services where somewhat difficult working conditions were reported. At the same time, these participants explained how they enhanced their expertise and self-confidence by collaborating with specialist services and ‘buddying up’ with Aboriginal, mental health and drug and alcohol workers while maintaining their

role as the primary worker for the families. Despite the limitations of Study 3 discussed above, its findings provide a rich account of the particular challenges faced by families with complex needs and highlight the need for further investigation of this largely unexplored area.

The introduction of new models of care and nursing practice for families with complex needs has important implications for nursing education as part of the new directions in workforce development (Bower, Gilbody, Richards, Fletcher, & Sutton, 2006). These are discussed in the next section.

7.4.4 Implications for Nursing Education

Several studies of the preparedness of nurses caring for families with complex needs (Fraser et al., 2014; Kemp et al., 2005; Kruske et al., 2006; Kruske & Grant, 2012) argue that published CFH nursing competencies (CAFHNA, 2000; NSW Health, 2011) are no longer adequate for the implementation of reforms in early childhood and child protection. The nurses in Study 3, while acknowledging that parentcraft skills underpinned their clinical practice, echoed the literature by identifying a range of new core knowledge and skills in the areas of mental health and public health that were essential for effective interventions with families with complex needs. When faced with new expectations and challenges, the nurses enhanced their knowledge by undertaking a variety of courses in areas where they had identified knowledge gaps. Their life-long learning included the enhancement of essential skills in critical thinking, decision-making, problem-solving and relationship formation, supported by flexibility and creativity and underpinned by a partnership approach.

The findings indicated a possible division between CFH nurses working in universal services and the nurses who deliver specific early interventions to families identified as having complex needs. The first group of nurses, responsible for universal home visiting, focus on child surveillance, screening and the promotion of health and wellbeing and usually operate from local health centres. The second group of nurses practise at an advanced level to deliver highly skilled support to families with complex needs. It could be argued that all CFH nurses require new knowledge and skills sets that equip them to work with a wide range of families during the perinatal period. This model has been adopted by UK health visitors (Cowley et al., 2013; Watts, 2011). It enables nurses to practise on a care continuum that takes into consideration the fact that health status of most families is not static. In this model, the CFH nurses can fine-tune their intervention according to the family's specific level of need at the time of the intervention. One participant in the present study commented that this approach would support the early identification of families with risk factors that are not recognised through routine screening.

What emerged clearly from all three studies was a shared view among experts, nurses and even mothers that nurses require advanced knowledge and skills to support their work with families with complex needs. This highlights the importance of educational preparedness and the need to identify the components of an ideal CFH nursing curriculum. Currently RNs become CFH nurses by following

up their undergraduate nursing degree with a postgraduate CFH nursing skill set program that mainly concentrates on parenting skills. Nurses choosing to work with families with complex needs are encouraged to build on their existing knowledge through a series of courses available to anyone working with those families. A review of current Australian programs would help to identify gaps and provide a foundation on which to incorporate new knowledge and skills in key areas such as mental health, public health and advanced communication skills.

Although the thesis did not intend to focus on parenting needs of mentally ill parents and parents with drug and alcohol issues, its findings have highlighted the circumstances of those families. The study was initially motivated by concern about the limited nursing support provided by primary health care services to mentally ill parents during the perinatal period. As discussed previously (see Chapter 2), these families are likely to be excluded from universal and targeted CFH services (NSW Health, 2010c). In addition, the specialist mental health services responsible for the care of such families are poorly equipped to enhance the parenting capacity of their clients and prevent child maltreatment (Maybery & Reupert, 2009; Reupert, Maybery, & Kowalenko, 2012).

Interprofessional education is described in the literature as a key element in successful collaborative practice dealing with complex issues in primary health care settings (Burton et al., 2010). An interprofessional studies program structured around key areas of learning essential for professionals supporting families with complex needs, in particular CFH nurses and MH case-managers, would be worth considering. It would define the theoretical framework and common vision on which Australian reforms in CFH and child protection are based. This thesis has identified a wide range of core knowledge and skills areas, notably in mental health, public health, and relational, reflective and advanced communication, which are shared across academic disciplines and inform all work with families with complex needs. An interprofessional curriculum would not dilute the professional identity of nurses but would enhance CFH nurses' ability to develop their critical and reflective thinking, which are crucial elements of collaborative family-centred practice (D'Amour & Oandasan, 2005). Such an educational program would allow CFH nurses to engage in sustained learning activities directly related to their unique nursing role, thereby helping them to position themselves firmly within the complex early childhood tapestry.

This chapter has discussed the key themes that emerged from triangulation of the findings from the three studies. Core sets of knowledge and skills in the areas of mental health, parentcraft and a public health model for CFH nursing were identified. The findings also indicated that CFH nursing roles varied greatly depending on the CFH service model. Nurses who administer the universal psychosocial screening during the universal home visiting have a role that is vastly different from that of the nurses who provide early interventions to families with complex needs. Implications of these findings for clinical practice and nursing education were discussed.

7.5 Conclusion

This thesis described a mixed methods study that explored the core knowledge, skills and attributes required by CFH nurses caring for families with complex needs during the perinatal period. The level of expertise at which the nurses practised was investigated and the benefits for nurses of interprofessional education were examined. Three complementary studies investigated the research questions from the perspectives of international experts in the field of early childhood, mothers who received support from early childhood services, including CFH services, and CFH nurses who identified themselves as providing support to families with complex needs.

Table 7.2 summarises the recommendations for practice, education and further research arising from the findings

Table 7.2 <i>Study's Finding: Summary of Recommendations For Practice Education And Research</i>	
Practice & education	Research
	A scoping review of current Australian postgraduate CFH nursing courses is indicated to identify gaps in curriculum and provide a foundation on which to incorporate new nursing knowledge and skills in key areas such as mental health, public health and advanced communication skills.
CFH nurses require advanced knowledge and skills to support families with complex needs. This highlights the urgent need for educational preparedness	Further research is needed to clarify the role of CFH nurses in the early identification and management of families with complex needs as a core competency of primary health care nursing.
Nursing education programs need to reflect the separate roles and distinct skill sets required from nurses caring for families with complex needs in regard to: • <i>universal prevention of mental illness and promotion of maternal mental wellbeing</i> • <i>targeted perinatal interventions to prevent maternal relapse and promote the infant's emotional health and wellbeing</i>	Further research is indicated to address the lack of clarity and consistency in the use of the term 'mental health' within the context of CFH nursing practice.
	Further investigation of the largely unexplored area of effective collaborative practice between primary health care and specialist services to enhance the parenting capacity of mothers with mental illness and/or drug and alcohol issues is indicated.
Continuing professional development and supervision are essential to ensure that nurses supporting families' emotional needs understand the aetiology of mental illness, risk assessment and management, treatment options, care pathways and community resources	Research exploring the benefits and negative impact of nurses and midwives using screening tools for risk identification and formulation of early intervention is recommended

Flexible, supportive CFH services are essential to assist all CFH nurses with rapport building and successful engagement strategies and early intervention activities A 'relational joint action' model of practice between midwives and CFH nurses is recommended to assist effective transition from hospital to community care and promote successful breastfeeding	Investigate the impact of service models and expectations on CFH nurses' ability to intervene effectively with families with complex needs
	Evaluation research into the relative benefits of employing CFH nurses rather than generic family workers or volunteers in Australian early intervention programs would be valuable
An interprofessional studies program structured around key areas of learning essential for professionals supporting families with complex needs is worth considering	Investigate the likely benefits of interprofessional practice and education

The results showed that CFH nurses did not belong to one homogenous professional group. Instead they assumed various roles ranging from universal health home visiting and psychosocial screening to more advanced roles in the care of families with complex needs. The nurses practising at an advanced level were confident in their abilities to support parents with a range of complex issues including mental illness and/or substance misuse. The ability of all CFH nurses to practise across the broad spectrum of care, from health promotion and prevention to the more complex area of early intervention according to parents' identified needs, was reported to be optimal but this could not be directly explored in depth. The service model in which the nurses were employed was particularly significant since it partly determined the scope of their practice.

Mental health competencies, combined with the ability to practise within a public health framework, were identified as essential to achieve optimal health outcomes for families with complex needs. A robust understanding of socio-ecological theory, a commitment to principles of prevention and early intervention, strengths-based approaches and collaborative practice were put forward as core knowledge and skills of contemporary CFH nurses.

Poor continuity of care during the important transition from hospital to community was identified by some mothers as a significant factor that impacted negatively on their experience of nursing care. Nonetheless, nurses with advanced communication skills indicated an ability to build robust collaborative partnerships with other professionals and develop successful interpersonal relationships with families with complex needs. Those nurses reported being regularly involved in interprofessional activities that help them build new knowledge and critically reflect on their clinical practice with the ultimate goal of supporting their most vulnerable families to optimise their parenting capacity and keep their children safe.

Finally, a combination of comprehensive postgraduate education programs combined with professional development and ongoing reflective activities are essential to prepare contemporary CFH nurses to face new expectations and role expansion. A scoping review of current Australian postgraduate CFH nursing curricula is indicated to identify the strengths and gaps in those programs in relation to meeting the educational needs of nurses working with families with complex needs. CFH nurses are partners within a broad group of professionals caring for those families during the perinatal period. They share a common goal of promoting families' health and wellbeing, enhancing parenting capacity and preventing child maltreatment. Hence, particular attention should be given to the likely benefits of interprofessional education and practice to foster learning and knowledge exchange for effective early intervention programs during the perinatal period.

« Bebe, qui que tu sois, tu es le bienvenu! Je t'accueillerai toujours comme celui qu'on attendait!

Bebe, dis-moi qui tu es »

“Baby, whoever you are, I will welcome you. I will always embrace you like Nature's greatest gift

Baby tell me who you are”

(Grandsenne, 1996)

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Appendices

Appendix 1: Key Developments in Early Childhood Research and Policy

Timeline	1950-1998	1998-2002	2003-2005	2006-2008
International research	The battered child syndrome USA (1962). Nurse Family Partnership (NFP) USA (1986).	Early Years Study (EYS) Reversing the Brain Drain. Canada (1999). Early Years Study - 3 years later (2002).	Early Childhood Interventions: Proven results, future promise. RAND Corporation report. USA (2005).	
International policy				
National research		Child behaviour problems: A literature review (1999). Longitudinal Study of Australian Children (LSAC) (2001). Children of parents affected by a mental illness: Scoping project report. AICAFMHA (2001). Australian Research Alliance for Children and Youth (2002).		
National policy				beyondblue's National Action Plan for Perinatal Mental Health (2008).
NSW research				Report of the Special Commission of Inquiry into Child Protection Services in NSW (The Wood Report) (2008).
NSW policy				

Appendix 1 (cont.)

Timeline	2009-2010	2011-2012	2013-2014	2015-2016
International research	Review of health inequities in England post 2010(The Marmot Report).	Early Years Study: Decision Making	Why health visiting? Review of the	

	WHO Framework for Action on Interprofessional Education and Collaborative Practice (2010).	and Action (Canada).	literature UK (2013). Health visiting: The voice of service users UK (2013).	
International policy				
National research	LSAC Protecting children: A common approach to identifying children & families in needs. ARACY(2010). Clinical practice guidelines for depression and related disorders - anxiety, bipolar disorder and puerperal psychosis - in the perinatal period: Literature review (2009).	LSAC Sustained home visiting for vulnerable families and children: A literature review of effective programs. The early childhood development workforce Productivity Commission report (2011).	LSAC	LSAC Better systems, better chances: A review of research and practice for prevention & early intervention. ARACY (2015).
National policy	Protecting children is everyone's business: A national framework for protecting Australian's children 2009-2020 (2009). National Early Childhood Development Strategy - Investing in the Early Years. The beyondblue Clinical Practice Guidelines for Depression and Related Disorders Documents.	Protecting children is everyone's business: A National framework for protecting Australian's children 2009-2020. Second Action Plan (2012). National framework for universal CFH services. Clinical practice guidelines for depression and related disorders - anxiety, bipolar and puerperal psychosis - in the perinatal period.		Development of Healthy, Safe & Thriving: National Strategic Framework for Child & Youth Health. Twenty years on: Measuring progress in child & youth health since 1992. COAG (2015). National framework for child and family health services - secondary and tertiary services (2016).
NSW research				
NSW policy	Maternal & child health primary health care policy (2010).		Child wellbeing & child protection	

	Improving mental health outcomes for parents and infants: Safe Start guidelines (2010). Safe Start strategic policy (2010).		policy and procedure for NSW Health.	
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Appendix 2: Literature review. Manuscripts graded as highly relevant

Articles	Content	Research question(s)	Origin
(A. Gardner et al., 2007)	Competence to capability. Nurse practitioners	Q1 Q2	Australia
(Chiarella et al., 2008)	Overview of the competency movement in nursing and midwifery. Development of advanced competency standards-definitions-impact on practice and professional development. Link with APN	Q1 Q2	Australia
(Eraut, 1998) Literature review	Seminal article-concept of competence Conceptual framework and definitions for health & caring professions	Q1 Q2	UK
(Fraser et al., 2014) Literature review	Role experience of CFH nurses in developed countries including Australia	Q1	Australia
(Feeley & Gottlieb, 2000)	Nursing approaches for working with family strengths and resources Knowledge & Skills. Expert nursing practice. Major conceptual shift for Partnership approach	Q1 Q2	Canada
(Kemp et al., 2005)	Exploring Australian Nursing competencies	Q1 Q2	Australia
(Kemp et al., 2012)	Benefits of psychosocial intervention (SHV program) & continuity of care	Q1 Q2	Australia
(Borrow et al., 2011)	Community-based child health nurses: exploration of current practice	Q1	Australia
(Schmied et al., 2008) Literature review	Role nature of universal health services for pregnant women, children and families in Australia	Q1	Australia
(Hutchinson, East, Stasa, & Jackson, 2014) Meta-summary of 2 decades of research	Deriving consensus on characteristics of APN	Q2	Australia
(R. Watson et al., 2002) Literature review	Clinical competence assessment in nursing	Q2	UK

(Kruske & Grant, 2012)	Educational preparation for maternal child and family health nurses	Q1 Q2	Australia
(Pijl-Zieber et al., 2013)	Competence & competency-based nursing education	Q3	Canada
(Cowan et al., 2007) Literature review	Competence/Competency in nursing practice: controversial concept	Q1	USA
(Browne et al., 2010)	Public health nursing practices with high priority families The significance of conceptualizing risk The focus of paper is Foetal Alcohol Syndrome but relevant to the role of nurses working with high priority families	Q2	Canada
(Benner, 1982) Seminal article	Novice to expert	Q1 Q2	USA
(Dowling et al., 2013)	APN a concept analysis Identification of AP attributes	Q2	USA Ireland
(Delamaire & Lafortune, 2010) OECD health working papers No 54	Nurses in advanced roles (12 developed countries including Australia)	Q2	OECD
(Morrison & Symes, 2011) Literature review	Expert nursing practice	Q2	USA
(Tucker et al., 2002)	The construction of an interdisciplinary framework for working with children and young people	Q3	UK
(Moore, 2008a)	Working with vulnerable families Early childhood intervention: core knowledge & skills	Q3	Australia
(D'Amour et al., 2005) Literature review	Core concepts theoretical frameworks for interprofessional collaboration	Q3	Canada
(Kitto, Goldman, Schmitt, & Olson, 2014)	Intersections between continuing education interprofessional education and workplace learning	Q3	Canada
(Travaglia et al., 2011)	Diffusion of interprofessionalism across the health system	Q3	Australia
(Mendez, Armayor, Diaz Navarraz, & Wakefield, 2008)	Advantages and disadvantages of interprofessional education in healthcare curricula	Q3	Spain
(Christensen, 2011)	Advancing nursing practice: theoretical and practical integration of knowledge	Q2	UK
(Bainbridge, 2012)	Interprofessional education for interprofessional practice Collaborative practice to improve quality of care	Q3	Canada

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Grey literature-reports	Content	Research question(s)	Origin
(Joel, 2013)	Advanced practice nursing Essentials for role development	Q2	USA
(Watts, 2011) Report	Educating health visitors for a transformed service. Areas of theory, knowledge skills for practice	Q1 Q2	UK
(Moore, 2008b) Report	Families with complex needs. Rethinking universal and targeted services.	Q1 Q2	Australia
(Australian Government Department of Health and Ageing, 2011)	National Framework for Universal Child and Family Health Services	Q1 Q2	Australia
(NSW Health, 2010a, 2010c, 2010d) Maternal and Child Health Primary Health Care Policy; SAFE START Guidelines: Improving mental health outcomes for parents and infants; Safe Start Strategic Policy	Supporting families early strategy	Q1	Australia
(NSW Health, 2011) CFH nursing practice framework	Child & Family Health Nursing-professional Practice Framework 2011-2016 linked to the ANMC framework recommendations and the CFHN Association competency standards (2009) currently under review	Q1	Australia NSW
(World Health Organisation, 2010) Health professions networks Nursing & Midwifery	Framework for action on interprofessional education & collaborative practice	Q3	WHO

Appendix 3: Ethics Committee Approval



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RESEARCH INTEGRITY
Human Research Ethics Committee
Web: <http://sydney.edu.au/ethics/>
Email: ro.humanethics@sydney.edu.au

Address for all correspondence:
Level 6, Jane Foss Russell Building - G02
The University of Sydney
NSW 2006 AUSTRALIA

Ref: PB/00

17th December 2010

Professor Mary Chiarella
Sydney Nursing School
Mallet Street Campus M02
The University of Sydney
Email: mary.chiarella@sydney.edu.au

Dear Mary

Thank you for your correspondence dated 5th December 2010 addressing comments made by the Human Research Ethics Committee (HREC). The Executive Committee of the HREC, at its meeting of 17th December 2010, considered this information and approved the protocol entitled **"Core knowledge, skills and attitudes of registered nurses working with families identified with psychosocial vulnerabilities during the perinatal period under the NSW Safe Start framework"**.

Details of the approval are as follows:

Protocol No.:	13243
Approval Period:	December 2010 to December 2011
Authorised Personnel:	Professor Mary Chiarella Professor Catherine Fowler Ms Anne-Lyse De Guio
Documents approved:	Participant Information Statement Study 1 (v4 5/12/10) Participant Information Statement Study 2 (v4 5/12/10) Participant Information Statement Study 3 (v4 5/12/10) Participant Consent Form Study 1 (v4 5/12/10) Participant Consent Form Study 2 (v4 26/09/10) Participant Consent Form Study 3 (v1 27/09/10) Invitation to Participate (v4 5/12/10) Advert (v4 5/12/10)

The HREC is a fully constituted Ethics Committee in accordance with the National Statement on Ethical Conduct in Research Involving Humans-March 2007 under Section 5.1.29.

The approval of this project is conditional upon your continuing compliance with the National Statement on Ethical Conduct in Research Involving Humans. N.B. A report on this research must be submitted every 12 months from the date of the approval, or on completion of the project, whichever occurs first. Failure to submit reports will result in the withdrawal of consent for the project to proceed. Your report will be due on **31st December 2011**, please put this in your diary.

Chief Investigator / Supervisor's responsibilities to ensure that:

1. All serious and unexpected adverse events should be reported to the HREC within 72 hours for clinical trials/interventional research.

Human Ethics Secretariat:
Ms Patricia Engelmann T: +61 2 8627 8172 E: patricia.engelmann@sydney.edu.au
Ms Kala Retnam T: +61 2 8627 8173 E: kala.retnam@sydney.edu.au

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CRICOS 00026A



THE UNIVERSITY OF
SYDNEY

2. All unforeseen events that might affect continued ethical conduct of the project should be reported to the HREC as soon as possible.
3. Any changes to the protocol must be approved by the HREC before the research project can proceed.
4. All research participants are to be provided with a Participant Information Statement and Consent Form, unless otherwise agreed by the Committee. The following statement must appear on the bottom of the Participant Information Statement: *Any person with concerns or complaints about the conduct of a research study can contact the Deputy Manager, Research Integrity (Human Ethics), University of Sydney on +61 2 8627 8176 (Telephone); + 61 2 8627 8177 (Facsimile) or ro.humanethics@sydney.edu.au (Email).*
5. Copies of all signed Consent Forms must be retained and made available to the HREC on request.
6. It is your responsibility to provide a copy of this letter to any internal/external granting agencies if requested.
7. The HREC approval is valid for four (4) years from the Approval Period stated in this letter. Investigators are requested to submit a progress report annually.
8. A report and a copy of any published material should be provided at the completion of the Project.

Please do not hesitate to contact Research Integrity (Human Ethics) should you require further information or clarification.

Yours sincerely

Associate Professor Philip Beale
Chair
Human Research Ethics Committee

Copy: Anne-Lyse De Guio adeguio@uni.sydney.edu.au

Appendix 4: Study 1 Participant Information Statement

PARTICIPANT INFORMATION STATEMENT Study No 1

(1) What is the study about?

This research investigates a range of perceptions of the core knowledge, skills and attitudes required by registered nurses working with emotionally distressed families with complex needs during the first postnatal year. The research was motivated by the introduction of the Safe Start initiative in NSW and the potential challenges that this program may place on clinicians, especially the community registered nurses responsible for its successful implementation. For the past decade the knowledge, skills and attitudes required by health workers to care for families facing challenging circumstances have been debated by policy makers and service providers who formulate position descriptions and employ staff to assume these new roles. For the purpose of this study I am seeking your input as a professional who is an expert or an informed advocate in child and family health.

(2) Who is carrying out the study?

My name is Anne-Lyse De Guio and this study will contribute to the completion of a PhD at the University of Sydney under the supervision of Professor Mary Chiarella.

(3) What does the study involve?

The study will use the Delphi technique that will consist of several iterations of questions sent to you electronically that will be progressively built upon as information is collated from the statements of experts in the study. Major themes will be drawn from initial questions selected to formulate a survey instrument. Feedback from this will be collated to send to you through an iterative process until consensus is reached.

(4) How much time will the study take?

It is anticipated that the each iteration of questions will take about 30 minutes of your time to complete. The usual number of iterations before consensus is reached is 3 but it may be more. These will be sent out to you at intervals over a period of 6 months.

(5) Can I withdraw from the study?

Yes. Being in this study is completely voluntary and you are under no obligation to continue your participation in any of the study's rounds of questions. Completion and return of responses will confirm your willingness to continue your participation throughout the study

(6) Will anyone else know the results?

No This research will be reported using de-identified data and any data that may lead to your identification will be removed.

(7) Will the study benefit me?

It is anticipated that the findings will contribute to the development of nursing education programs that will support a child and family health nursing workforce that is competent and responsible for the delivery of early interventions to highly vulnerable families.

(8) Can I tell other people about the study?

Yes. You can tell anyone about the study

(9) What if I require further information?

Please don't hesitate to contact Anne-Lyse De Guio who will discuss this information with you further and answer any questions you may have. If you would like to know more at

any later stage, please feel free to contact Anne-Lyse De Guio research student again adequio@uni.sydney.edu.au

(10) What if I have a complaint or concerns?

If you have concerns or a complaint please feel free to contact Professor Mary Chiarella on 02 93510904 Email: mary.chiarella@sydney.edu.au

Any person with concerns or complaints about the conduct of a research study can contact The Manager, Human Ethics Administration, University of Sydney on +61 2 8627 8176 (Telephone); +61 2 8627 8177 (Facsimile) or ro.humanethics@sydney.edu.au (Email).

This information sheet is for you to keep

Appendix 5: Study 2 Participant Information Statement

PARTICIPANT INFORMATION STATEMENT Study No 2

(1) What is the study about?

In the past twenty years major social and technological changes in the Australian society has placed significant strain on families with young children. The NSW Safe Start program is a government initiative to ensure that all parents can access the right support at the right time when they face unexpected difficulties. To help recognise parents who may need extra help early, women are asked a series of questions about their past and present social and emotional history. Extra support and sometimes treatment are offered by registered nurses who will travel the journey with the family to ensure that parenting becomes a joyful rewarding experience.

The purpose of the study is to find out from parents who received extra help and support from nurses what the nurse did that made the intervention a successful one and what aspects of the interventions were most helpful. Finding out about those skills, behaviours and attitudes will help ensuring that all parents receive similar quality support by providing adequate education and support to nurses.

(2) Who is carrying out the study?

My name is Anne-Lyse De Guio and this study will contribute to the completion of a PhD at the University of Sydney under the supervision of Professor Mary Chiarella.

(3) What does the study involve?

I will interview you at playgroup unless you prefer a different location that is more suitable to you at a time that is most convenient to you. I will ask you several questions related to your experience of becoming a parent and our conversation will be audio taped. You are welcome to invite your partner should you wish to do so.

(4) How much time will the study take?

A period of 30 minutes is anticipated to complete the interview. However the duration will be flexible and guided by the amount of information that you will be prepared to share with me.

(5) Can I withdraw from the study?

Being in this study is completely voluntary - you are not under any obligation to consent.

You may stop the interview at any time if you do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

Being in this study is completely voluntary and you are under no obligation to consent to be interviewed. Accepting to be interviewed is an indication of your consent to participate in the study. You can withdraw any time during the interview.

(6) Will anyone else know the results?

All personal details identifying you will be strictly confidential and only the researcher will have access to information on participants. A report of the study may be submitted for publication but individual participants will not be identifiable in such a report.

(7) Will the study benefit me?

The study will help to develop the education provided for registered nurses who support parents following the birth of their baby so that they are highly knowledgeable and skilled. This is particularly

important if the family requires extra support when unexpected challenges occur. All families should benefit including yourself should you plan another pregnancy.

(8) Can I tell other people about the study?

You can tell anyone about the study, including other parents that you know who like you have had positive experiences and would be prepared to share their experience

(9) What if I require further information?

When you have read this information, Anne-Lyse De Guio will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Anne-Lyse De Guio, research student 042524989 adeguio@uni.sydney.edu.au

(10) What if I have a complaint or concerns?

If you have concerns or a complaint please feel free to contact Professor Mary Chiarella on 02 93510904 Email: mary.chiarella@sydney.edu.au

Any person with concerns or complaints about the conduct of a research study can contact The Manager, Human Ethics Administration, University of Sydney on +61 2 8627 8176 (Telephone); +61 2 8627 8177 (Facsimile) or ro.humanethics@sydney.edu.au (Email).
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This information sheet is for you to keep

Appendix 6: Study 3 Participant Information Statement

PARTICIPANT INFORMATION STATEMENT

Study 3

1. What is the study about?

In the past twenty years major social and technological changes in the Australian society has placed significant strain on families with young children. The NSW Safe Start program is a government initiative that ensures that parents are receiving appropriate interventions in a timely fashion when they face challenges that may impact negatively on their parenting capacity. For the past century registered nurses working with those families have successfully provided support, guidance, information and education to new parents. This study seeks the opinion of registered nurses who are currently working with families identified as vulnerable and requiring extended support, about the knowledge, skills and attitudes that they believe are necessary to achieve positive outcomes

2. Who is carrying out the study?

My name is Anne-Lyse De Guio and this study will contribute to the completion of a PhD at the University of Sydney under the supervision of Professor Mary Chiarella.

3. What does the study involve?

I will interview you at a location that is suitable and at a time that is most convenient to you. I will ask you a few broad questions related to your experience as a registered nurse working with families with complex needs and our conversation will be audio taped.

If you wish to participate in the study but are unable to meet with me, a telephone interview with audio taping of the conversation is possible.

4. How much time will the study take?

A period of maximum 60 minutes is anticipated to complete the interview. However the duration will be flexible and guided by the amount of information that you will be prepared to share with me.

5. Can I withdraw from the study?

Being in this study is completely voluntary - you are not under any obligation to consent and - if you do consent - you can withdraw at any time

You may stop the interview at any time if you do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

6. Will anyone else know the results?

The results of the study will be reported in the PhD thesis and a report of the study may be submitted for publication but individual participants will be de identified.

7. Will the study benefit me?

The study will contribute to the development of new knowledge in relation to the increasingly complex demands placed upon registered nurses working with families identified as vulnerable during the perinatal period.

8. Can I tell other people about the study?

You can tell other people about the study

9. What if I require further information?

When you have read this information, Anne-Lyse De Guio will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Anne-Lyse De Guio, research student 042524989.

10. What if I have a complaint or concerns?

If you have concerns or a complaint please feel free to contact Professor Mary Chiarella on +61 2 93510904 Email: mary.chiarella@sydney.edu.au

Any person with concerns or complaints about the conduct of a research study can contact The Manager, Human Ethics Administration, University of Sydney on +61 2 8627 8176 (Telephone); +61 2 8627 8177 (Facsimile) or ro.humanethics@sydney.edu.au (Email).

This information sheet is for you to keep

1



ABN 15 211 513 464

CHIEF INVESTIGATOR:
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Telephone: +61 2 93520904
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I, _____[PRINT NAME], give consent to my participation in the research project _____

TITLE: Investigation of core knowledge skills and attitudes of registered nurses working with families with vulnerabilities during the perinatal period

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
3. I understand that I can withdraw from the study at any time.
4. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.
5. I understand that being in this study is completely voluntary – I am not under any obligation to consent.
6. I understand that I can stop participating in the study at any time if I do not wish to continue, my responses will be destroyed and the information provided will not be included in the study.

Study 1 consent March 11

7. I consent to:

- i) Audio-taping YES ☐ NO
- ii) Receiving Feedback YES ☐ NO
- If you answered YES to the "Receiving Feedback Question (iii)", please provide your details i.e. mailing address, email address.

Feedback Option

Address: _____

Email: _____

Signed: _____

Name: Professor Sarah C. Gray
Date: 15th March 2011

Appendix 8: Study 2 Consent Form

PARTICIPANT CONSENT FORM

Study No 2

I, ...[PRINT NAME], give consent to my participation in the research project

TITLE: Investigation of core knowledge skills and attitudes of registered nurses working with families with vulnerabilities during the perinatal period

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
3. I understand that I can withdraw from the study at any time.
4. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.
5. I understand that being in this study is completely voluntary – I am not under any obligation to consent.
6. I understand that I can stop the interview at any time if I do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

I consent to:

- | | | | |
|------------------------|-----|--------------------------|----|
| i) Audio-taping | YES | ☐ | NO |
| ii) Receiving Feedback | YES | ☐ | NO |

If you answered YES to the "Receiving Feedback Question (iii)", please provide your details i.e. mailing address, email address.

Feedback Option

Address: _____

Email: _____

Signed:

Name:

Date:

Appendix 9: Study 3 Consent Form

PARTICIPANT CONSENT FORM

Study No 3

I, ...[PRINT NAME], give consent to my participation in the research project

TITLE: Investigation of core knowledge skills and attitudes of registered nurses working with families with vulnerabilities during the perinatal period

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
3. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher(s) or the University of Sydney now or in the future.
4. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.
5. I understand that being in this study is completely voluntary – I am not under any obligation to consent.
6. I understand that I can stop the interview at any time if I do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.
7. I consent to:

- | | | | | |
|------|--------------------|-----|--------------------------|----|
| i) | Audio-taping | YES | ☐ | NO |
| iii) | Receiving Feedback | YES | ☐ | NO |

If you answered YES to the "Receiving Feedback Question (iii)", please provide your details i.e. mailing address, email address.

Feedback Option

Address: _____

Email: _____

Signed:

Name

Witness:

Name:

Date:

Appendix 10: Study 1: Round 1 Questionnaire

Invitation to Participate in Research

Dear.....

I would like to invite you to participate in a Delphi study, a component of my PhD research at the University of Sydney under the supervision of Professors Mary Chiarella and Cathrine Fowler. This research investigates a range of perceptions of the core knowledge, skills and attitudes required by registered nurses working with emotionally distressed families with complex needs during the first postnatal year. The research was motivated by the introduction of the Safe Start initiative in NSW and the potential challenges that this program may place on clinicians, especially the community registered nurses responsible for its successful implementation. Safe Start recommends a broad range of activities delivered by nurses and other health professionals that include parental behavioural changes and environmental modifications to optimise the health and wellbeing of the child and its family and ultimately the community to which they belong.

For the past decade the skills and knowledge required by health workers to care for families facing challenging circumstances have been debated by policy makers and service providers who formulate position descriptions and employ staff to assume these new roles. For the purpose of this study I am seeking your input as a professional who is an expert in or an informed advocate for the substantive areas of child and family health (pregnancy to 2 years) and who is willing to participate. It is anticipated that the findings will contribute to the progress of nursing education programs that will support the development of a child and family health nursing workforce competent and responsible for the delivery of early interventions to families that are highly vulnerable.

The Delphi study will consist of several rounds of questions that will be progressively built upon as information is received from the experts and distilled. Your information will not be identifiable. Major themes will be drawn from the initial questions overleaf selected to formulate a survey instrument. Feedback from this will be collated to send to you as participants through an ongoing and iterative process until consensus is reached. Participation is voluntary and completion and return of the first responses will be taken as an indicator of consent. This research will be reported using de-identified data and any data that may lead to your identification will be removed.

A list of the experts consulted is normally included as an appendix in the Thesis. Inclusion in the list of experts does not mean that any data will be attributable. However if you do not wish your name to be included in the list of experts please advise Professor Chiarella and your name will be omitted.

If you have any questions about this research please feel free to contact Professor Mary Chiarella 0400421568/ mary.chiarella@sydney.edu.au

Yours sincerely

Anne-lyse De Guio

Please respond in a much detail as you wish to the following questions. You may write in dot points or sentences

What are the core knowledge and skills nurses require to work with vulnerable families during the perinatal period?

How relevant are personal characteristics attributes and attitudes when examining professional competence in the field of early childhood?

If you believe personal characteristics and attributes are important, what are they?

Should nurses providing long term follow up be advanced practitioners? If you believe this how would you identify those practitioners?

How appropriate is interdisciplinary education with a core curriculum for early childhood interventions?

How might interdisciplinary education with a core curriculum be structured?

Appendix 11: Study 1 Round 2 Questionnaire

Thank you very much for being involved in the second round of our Delphi study, which is a component of my PhD research. As I explained in Round One, the purpose of this research is to inform the content of a curriculum relating to caring for vulnerable families and their children that may or may not be multidisciplinary. A total of 12 international experts, including yourself, have generously provided their comprehensive invaluable opinions on the series of questions I posed in round one. Whilst a majority of participants agreed on key issues, there was no unanimity (N=12) on any of the issues. However there was strong consensual agreement by a majority of experts on a number of elements. In the feedback below, the number of participants who agreed with each particular element is indicated as (N=). From the responses received, we have further distilled the questions into a series of statements, to which we would like you to respond using a Likert scale.

The second round of this Delphi study contains 4 sections.

- Section 1 will address the elements that a majority (N=6-9) thought were important
- Section 2 will address the elements that less than 50% of you mentioned. We are asking you to consider these elements now that we have brought them to your attention.
- Section 3 will report on the issue of formal nursing qualifications commented on by several experts.
- Section 4 will discuss your feedback on interdisciplinary education.

Where there might be ambiguity about a descriptor, this will be highlighted by the word Glossary. The glossary section will clarify statements made by experts or briefly explain recent concepts.

We apologize for the length of this second round but to have shortened it would not have done justice to the rich and informative nature of the responses provided in Round One.

Section 1

These are the elements that a majority ($\geq$ 50% or N=6-9) thought were important to include in a curriculum. We would now like you to identify the level of importance you would attach to each. There is no requirement to rank the elements. Each is to be considered on its merits.

Core knowledge

Please select your level of importance

N=9 Adult mental health	medium	high	very high
N=8 Professional knowledge in the field of child and family health (Glossary)	medium	high	very high
N= 8 Understanding of public health principles (Glossary) ²⁹	medium	high	very high
N=8 Knowledge of fetal and infant growth and development	medium	high	very high
N=7 Knowledge of the ecological model of human development (Glossary)	medium	high	very high
N=7 Understanding of psychodynamics of family relationships including transition to parenthood	medium	high	very high
N=7 Knowledge of Child Protection Legal Framework including relevant legislations	medium	high	very high
N=6 Infant mental health	medium	high	very high

²⁹ Subcategories of public health identified by N=4 will be presented in section 2

N= 6 Domestic violence	medium	high	very high
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Core Skills

Please select your level of importance

N=9 Reflective capacity	medium high	high	very
N=8 Engagement skills	medium	high	very high
N=7 Communication skills	medium high	high	very
N=6 Assessment of risks and protective factors	medium high	high	very
N=6 Cultural sensitivity	medium high	high	very
N=6 Assessment and management of child abuse	medium	high	very high

Question1

Whilst 8 experts identified engagement skills as essential and 7 experts identified communication skills as essential 5 experts listed the 2 skills separately indicating that engagement and communication skills are different.

Do you believe that engagement and communication should be considered as 2 different skill sets?

Yes ☐ No ☐

Personal attributes and characteristics

N=9 experts strongly agreed that personal characteristics and attributes are essential for successful practice However experts have different opinion about what these attributes are. None of these attributes were endorsed by a majority of respondents and therefore the results will be discussed in Section 2 (Minority elements)

RNs providing long term follow up should be advanced practitioners (Glossary)? How do you identify advanced nursing practice?

Whilst N=9 experts believe that an advanced nursing practice level should be expected from RNs working with families with complex needs an expert majority was not reached for the identification of advanced nursing practice therefore the results will be discussed in section 2

Question 2

One expert expressed concern that whilst advanced nursing practice should be expected, the current educational preparation for RNs planning to work with these families was not adequate.

Do you agree with this observation? Yes ☐ No ☐

Section 2

A small number of experts identified some elements as important (less than 50% or N=5-1). Now that these elements have been mentioned we would be grateful if you would also give them some consideration

Knowledge

Question 3

How important do you believe knowledge about drug and alcohol misuse to be?

N=5 Drug & Alcohol	medium high	high	very
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Question 4

N=4 experts identified Sudden Infant Death Syndrome (SIDS), Obesity prevention, Child Safety, Community Development and Capacity Building as specific areas of essential health promotion knowledge within the broader context of public health. Do you agree/disagree that each of the 5 areas should be core elements within the curriculum?

SIDS	yes []	no []
Obesity prevention	yes []	no []
Child safety	yes []	no []
Community development	yes []	no []
Capacity building	yes []	no []

If you answer no to any of the elements why do you think that the element should not be included?

SIDS-----

Obesity -----

Child safety-----

Community development-----

Capacity building-----

Question 5 The following five elements received only one mention each. However we are interested, now that they have been mentioned to know if you consider any of these elements to be of importance

Motivational interviewing (Glossary).	yes []	no []
Self-efficacy theory (Glossary)	yes []	no []
Grief and loss	yes []	no []
Men's health	yes []	no []
Women's health	yes []	no []

If you answered no to any of the elements why do you think that the element **should not** be included?

Motivational interviewing-----

Self-efficacy-----

Grief and loss-----

Men's health-----

Women's health-----

Core skills

Question 6

A minority of experts considered the following elements to be important. If you do not think that the element is important tick the **not important** box. If, on reflection, you consider them to be important, please identify how important you think they are.

	Not important	How important?		
N= 5 Working within an interdisciplinary and interagency framework		medium	high	very high
N=5 Refer effectively through sound knowledge of community services and resources		medium	high	very high
N=4 Assessment of the parent infant relationship (Glossary)		medium high	high	very
N=3 Psychosocial assessment of the parent		medium	high	very high
N=3 Working from a strength-base, solution focused approach		medium	high	very high
N=2 Father-inclusive approach (Glossary)		medium high	high	very
N=2 Group work		medium high	high	very

Question 7

The following four elements received only one mention each. However we are interested to know if you consider them to be of importance

Ability to apply research findings into practice	yes []	no []
Ability to work therapeutically with parent-child using play	yes []	no []
Skills in comprehensive documentation reflective of family complexities	yes []	no []
Capacity to supervise and mentor other professionals	yes []	no []

Personal knowledge and attributes

Question 8

The following personal attributes were identified by a minority of respondents but we would like you to rate them in order of importance. If you do not consider them to be important please tick not important

	Not important	Important: medium	high	very high
N=5 Empathy		[]	[]	[]
N=5 Respect		[]	[]	[]
N=5 Flexibility		[]	[]	[]
N=5 Genuineness		[]	[]	[]
N=5 Integrity		[]	[]	[]
N=4 Emotional intelligence		[]	[]	[]
N=4 Optimism		[]	[]	[]
N=4 Honesty		[]	[]	[]
N=4 Friendliness		[]	[]	[]
N=2 Humility		[]	[]	[]
N=2 Good listener		[]	[]	[]
N=2 Trust		[]	[]	[]
N=2 Tolerant of differences		[]	[]	[]
N=2 Responsive		[]	[]	[]
N=2 Professional maturity		[]	[]	[]
N=1 Courage		[]	[]	[]
N=1 Personal resilience		[]	[]	[]

Advanced nursing practice

Question 9

A minority of experts gave the following examples to describe how advanced practice can be identified. Do you agree with their examples?

	Agree	Disagree
N=5 RN seeks supervision on an ongoing basis	[]	[]
N=4 RN demonstrates excellent decision making, reflective practice and critical thinking	[]	[]
N=4 RN demonstrates commitment to ongoing professional development	[]	[]
N=4 RN keeps abreast of research in the field of early childhood	[]	[]
N=4 RN understands and advocates for children's rights	[]	[]
N=4 RN is able to connect and work in partnership with community services and resources	[]	[]
N=4 RN demonstrates experiences of success in working with vulnerable families	[]	[]

Comment ?-----

Section 3

Whilst not specifically requested to do so, a number of experts made reference to the issue of qualifications. We would like to obtain your opinion in relation to nursing qualifications that you believe would support competency development for RNs caring for vulnerable families during the perinatal period.

N=3 believed that that both midwifery and child family health nursing were essential

N=1 believed that child family health nursing only was essential

N=1 identified paediatric nursing mental health nursing as two nursing qualifications likely to be adequate

Question 10

How important do you believe the following nursing qualifications to be? Please score each one in order of importance

	medium	high	very high
N=4 Formal qualification in the field of child and family	[]	[]	[]
N=3 Midwifery qualification	[]	[]	[]
N=1 Pediatric nursing	[]	[]	[]

Question 11

One expert stated that current Australian nursing qualifications did not adequately equip RNs to practice according to expected standards when caring for vulnerable families. Do you agree with this statement?

Strongly disagree	disagree	agree	strongly agree	don' know
[]	[]	[]	[]	[]

Question 12

If you believe that that a different postgraduate nursing course is required for RNs working with vulnerable families during the perinatal period, at what level should this qualification be:

Postgraduate certificate	Yes []	no []
Postgraduate diploma	Yes []	no []
Clinical Master	Yes []	no []

For the purpose of the study we would be most grateful if you advised us of your qualifications. These will be included in a table as part of the study but it will not be attributed to any responses or identifiable people

Section 4

Interdisciplinary education with a core curriculum for early childhood interventions

N=9 experts believe that interdisciplinary education with a core curriculum for early childhood interventions was highly appropriate

Two options were identified

N=3 Option 1: A generic postgraduate course (level to be determined)

N=6 Option 2 Common subjects/units

Question 13

In addition to responses relating to core knowledge and skills that have already been discussed, the following elements were identified as core components of interdisciplinary subjects. Please state whether you agree or disagree with these modules. If you do not agree with interdisciplinary education at all, please tick the box below

I do not agree with interdisciplinary education	[]
---	-----

Core subjects/units	Agree	Disagree
Articulation of key models/theories and approaches that inform early parenting and early childhood interventions	[]	[]
Working in partnership with families (deviation from expert model)	[]	[]
A subject framework is based on the primary health care principles of physical needs (early intervention programs), psychosocial needs (adversity/social determinants of health) and environment needs (equity of access)	[]	[]
Leadership and critical analysis	[]	[]
Perinatal Mental Health that includes the adult and the infant within a family context	[]	[]
Child growth and development within a social context and that includes the development of optimal relationships	[]	[]
The mode of delivery for the education content includes experiential learning and practical assessments	[]	[]

Thank you for agreeing to participate in the second round of this Delphi Study

Appendix 12: Study 1 Round 3 Final Feedback to Experts

Dear Ms

Thank you very much for having continued involvement in the third round of the Delphi study component of my PhD. The research sought to explore the core knowledge, skills and attributes required by registered nurses working with families with complex needs during the perinatal period. The aim was to provide insight into the level of expertise at which these registered nurses practise. The objectives of the research were to inform future curriculum development for registered nurses who are caring for families with complex needs during the perinatal period and to examine the role and benefits for nurses of interdisciplinary education.

We are now pleased to provide you with the final results of the consensus study. Note that the threshold for consensus on each theme was reached when six or more of the twelve participants agreed with the element.

Once again, thank you for generously giving your time and providing your invaluable opinion. We welcome comments should you have any further thoughts on this.

In round one of the Delphi study your expert opinion was sought using a series of five questions. Only elements that reached consensus are presented.

Question 1

In question 1 you were asked: *What are the core knowledge and skills nurses require to work with families with complex needs during the perinatal period?*

The following table identifies the elements that reached consensus for question 1

Question 1 core knowledge elements:
Professional knowledge in child and family health
Public health principles with attention to four specific elements of essential health promotion knowledge within the broader context of public health:
SIDS
Obesity prevention
Child safety
Capacity building
Foetal and infant growth and development
Ecological model of human development
Psychodynamics of family relationships including transition to parenthood
Child protection legal framework including relevant legislation
Adult mental health
Infant mental health
Domestic violence
Question 1 core skills elements:
Engagement
Communication
Assessment skills divided into four domains:
Assessment of risks and protective factors
Assessment of parent-infant relationship
Assessment of parenting capacity
Psychosocial assessment of parents
Reflective capacity
Cultural sensitivity

Assessment and management of child abuse
 Working within an interdisciplinary and interagency framework
 Effective referrals through sound knowledge of community services and resources
 Working from a strength-based, solution-focused approach
 Ability to apply research findings into practice
 Ability to work therapeutically with parent-child using play
 Comprehensive documentation reflective of family complexities
 Capacity to supervise and mentor other professionals.

Question 2

In Question 2 you were asked the following:

2a. To what extent do personal characteristics and attributes influence the successful practice of the registered nurse working in the field of early childhood?

2b. If you believe personal characteristics and attitudes are important, what are they?

2a. Nine participants strongly agreed that personal characteristics and attributes are essential for successful practice.

2b. The following table identifies the elements that experts agreed were of high or very high level of importance:

Core characteristic and attribute elements:

Empathy
 Respect
 Flexibility
 Genuineness
 Integrity
 Emotional intelligence
 Optimism
 Honesty
 Humility
 Good listener
 Trust
 Tolerant of differences
 Responsiveness.

Question 3

In question 3 you were asked if nurses providing long term follow up to families with complex needs should be advanced practitioners. You were also asked how you would identify those practitioners.

Consensus (nine participants out of twelve) was reached about the expectation that an advance level of practice is required from nurses providing long term follow up to families with complex needs. Consensus was also reached about the current educational preparation for registered nurses planning to work with complex families not being adequate.

A series of elements were given as examples of demonstration of advanced nursing practice. You were asked if you agreed or disagreed with those elements. Elements that reached consensus included:

Demonstration of excellent decision making , reflective practice and critical thinking
 Commitment to ongoing professional development
 Keeping abreast of research in the field of early childhood
 Advocacy for children's rights
 Working in partnership with community services and resources

Working successfully with families with complex needs

Although several participants commented on seeking ongoing clinical supervision as an essential element for nurses working at an advanced level with families with complex needs, agreement was that supervision was required for all nurses; it did not demonstrate advanced practice. Demonstrable outcomes such as reflective practice, high capacity for critical thinking and effective decision making assisted by ongoing supervision were indicators of advanced nursing practice.

Questions 4 and 5

In question 4 and 5 you were asked *how appropriate interdisciplinary education with a core curriculum might be for early childhood interventions and how you would structure the curriculum.*

Nine experts agreed that interdisciplinary education with a core curriculum for early childhood interventions was highly appropriate; consensus was reached for a series of core subjects or units believed to be relevant to an interdisciplinary curriculum. Elements that reached consensus are listed below.

Articulation of key models/theories and approaches that inform early parenting and early childhood interventions
--

Working in partnership with families (deviation from expert model)
--

Leadership and critical analysis

Perinatal mental health that includes the adult and the infant within a family context
--

Child growth and development within a social context that includes the development of optimal relationships

The mode of delivery for the education content includes experiential learning and practical assessments

Once again thank you for having agreed to participate in the third and final round of the Delphi study.

Appendix 13: Study 1 Round 1 Glossary

Advance practitioner

Specialist knowledge including knowledge of specific interventions and programs that are effective with the population group, skills in the implementation of such interventions, advanced communication skills; abreast of relevant research and clinical practice development; nurses practising in rural and regional areas in autonomous positions

Professional knowledge in the field of child and family health

Sleep and settling, nutrition including breast feeding, crying, developmental stages, toddler behaviour

Public health

Includes primary health care and social determinants of health and health promotion

Ecological model

The model refers to the societal approach to child health practice to keep children and families safe and enhance their wellbeing by considering the important roles of the extended family, the neighbourhood and the community context in which the child grows

Pro-active early intervention for child protection

Evidence based early parenting interventions demonstrated to reduce the risk of child abuse that were identified by some experts included Triple p, Circle of Security, NCAST

Motivational interviewing

Client-centred counselling to promote change through semi directive, non-judgemental, non-confrontational strategies

Reflective Capacity

This descriptor was used interchangeably with self-awareness and self-care skills

Parent infant relationship

This descriptor was used interchangeably with parent capacity assessment

Father inclusive practice

Understanding of the role and impact of fathers and their importance as a social group in the life of their infants has been identified in the literature as essential for the infant's healthy development

Appendix 14: Study 2 Original Mothers' Recruitment Pamphlet

Seeking mothers of children under 2 for nursing research

Did you give birth in the past 2 years?

When you were assessed by your midwife or your child and family health nurse were you asked a series of questions about stressful events in your past? These might have included questions about the recent loss of a loved one, the type of parenting you received, including whether you had any childhood trauma, if you suffered from depression prior to falling pregnant and the kind of support that you currently have.

If you answered yes to any of those questions, did you receive extra support from a midwife or child and family health nurse during the first year after you had given birth?

If you did, I would like to speak with you for a period of approximately 30 minutes as I am conducting a research study exploring what skills midwives and nurses need to best provide that help and support to new mothers.

Becoming a mother is usually a great experience but sometimes (often unexpectedly) problems of social or psychological origin impact on the pleasure of being new mothers. Nurses working in early childhood try their hardest to recognise when things are not going well. They are also committed to work with parents to sort out the problems and if necessary they guide parents towards specialist support or professionals.

My name is Anne-Lyse De Guio. I have been a registered nurse and midwife for the past 42 years and I am now responsible for the education of nurses working with children and families. I am also a PhD student at the University of Sydney. Through my research I wish to try to understand how and why nurses understand parents and what special skills they use to provide the right help at the right time in a way that is agreeable to them.

The findings of this study will help to prepare nurses better for their roles and responsibilities when they care for families.

I would like to meet with you with or without your partner (or anyone else that you would like by your side) at the playgroup that you attend with your child.

If you wish to contact me prior to consenting to a meeting my contact details are

0425249897

Email: adeguio@uni.sydney.edu.au

Thank you for taking the time to consider this request

Anne-Lyse De Guio

Appendix 15: Study 2 Simplified recruitment pamphlet

Seeking mothers of children under 2 for nursing research

Did you give birth in the past 2 years?

Having a new baby meant that you may have had lots of contacts with midwives until the birth of your baby and with clinic nurses afterwards. Some of them gave you extra support and advice when things were complicated for you, your partner or your family.

My name is Anne-Lyse De Guio. I have been a registered nurse and midwife for the past 42 years and a mother since 1982. I am now responsible for the education of nurses working with children and families. I am also a PhD student at the University of Sydney.

I am studying the way midwives and nurses help mothers when they struggle with being parents whilst enduring difficult times. I would like to find out why some nurses do it so well that mothers trust them, seek their help and manage to make problems go away. I want to know if it is what they learnt during their training, their long experience working with families, some special qualities maybe it is, like a good soup, a combination of many ingredients.

If you have experienced difficult times during pregnancy and after the birth of your baby and you received the support of helpful midwives and nurses, I would be grateful if you could speak with me for approximately 30 minutes. I am happy to meet with you wherever you prefer at a time that is best for you. You can speak to me with your partner or someone else close to you including your baby if babysitting is problematic.

My contact details are:

Home telephone after hours 02 95559805 Mobile 0425249897

Email: adeguio@uni.sydney.edu.au

Thank you for taking time to consider this request

Anne-Lyse De Guio

Appendix 16: Nurses' Recruitment Pamphlet

Seeking Community Registered Nurses providing extended interventions to families identified as vulnerable within the NSW Safe Start program

My name is Anne-Lyse De Guio. I am a registered nurse and midwife practising in NSW for the past 42 years. I am a PhD student at the University of Sydney and the topic of my research is the knowledge, skills and attitudes required by registered nurses delivering extended support and care in the community, to families with complex needs.

After much anticipation the NSW Safe Start policy underpinning the Safe Start program was officially released in March 2010. For the past 10 years many midwives and child and family nurses have already been exposed to an intervention model that advocates the early identification of families at risk of or already experiencing difficulties during the perinatal period. This is achieved through effective psychosocial assessment and screening for depression that commences during the antenatal and continues in the postnatal period. This process allows midwives and community nurses working in the field of child and family health to provide extra support and interventions that will strengthen mothers' resilience during the transition to parenthood.

My research has ethics approval from the University of Sydney.

I would like to interview you if you are:

- A community registered nurse working in the field of child and family health
- If you are practising in NSW either in a city or rural/isolated (rural/outback) location
- If you provide extra support and interventions using the Safe Start guidelines and If
- you have practised in this field for at least 5 years.

I expect the interview to take between 30 to 45 minutes and I am happy to negotiate an interview time and place that suits you. If you prefer a telephone interview I am happy to adopt this method. This interview will be totally confidential and all information collected will be de-identified. You can also cancel the appointment or stop the interview at any time.

Should you agree to talk to me, you will help with the definition of advanced practice in this important field of nursing and will inform future nursing education programs and curricula development. My contact details are:

0425249897 adeguio@uni.sydney.edu.au

I thank you for your support

Anne-lyse De Guio

Appendix 17: Skills and Attributes: Comparison between Davis’s family partnership model and expert panel’s opinions

Panel: Personal Attitudes	Davis: Helper Qualities	Panel: Skills	Davis: Helper Skills (also called Helper Communication Skills)
Respect	Respectful (belief in the abilities of parents to be effective)	Reflective capacity	
Empathy	Empathy	Engagement skills	
Genuineness	Genuineness	Communication skills	Negotiating
Tolerant of differences		Assessment of risks and protective factors	Prompting and exploration
Trust			
Integrity	Personal integrity	Assessment and management of child abuse	
Emotional intelligence			Problem solving
Honesty		Cultural sensitivity	
Good listener			Concentration/active listening
Flexibility			Enabling change
Responsive			Empathic responding
Humility	Humility		
Optimism	Quiet enthusiasm		Summarising