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"Being the bridge and the beacon': A qualitative study of the characteristics and functions of the liaison role in child and family health services in Australia

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ABSTRACT

Aims and objectives: This paper explores the characteristics and functions of the liaison role in child and family health services in Australia.

Background: Liaison roles are increasingly being used to improve communication between health services and professionals and to facilitate access to support for families in need. Nurses are commonly, although not always, the professional who undertakes these roles. Research on the role of liaison positions in child and family health services is limited in Australia and internationally.

Design: A qualitative interpretive design informed this study. Interviews and focus groups were conducted with 40 liaison and other health professionals, primarily nurses, working with families with young children in two Australian States. Data were analysed thematically.

Results: Three major themes were identified that characterised these roles: building bridges between services and professionals, supporting families during transition between services and supporting clinicians. Several facilitators and barriers including concerns about sustainability of the roles were identified.

Conclusions: Professionals working in a liaison role in child and family health services, emphasise these positions have potential to link services and professionals thereby, facilitating effective pathways for children and families with complex needs. While a few child and family health services in Australia provide liaison services, the extent of liaison support and the outcomes for families in Australia are unknown.

Relevance to clinical practice: Nurses working with children and families are the most likely health professional to undertake a liaison role. In many nursing contexts, liaison roles are relatively new and those in the role have the responsibility to define the key purpose of their role. Liaison roles are multifaceted, requiring nurses to have excellent communication and negotiation skills to effectively link diverse professionals and services, while simultaneously engaging with and supporting vulnerable families and children. Nurses in these roles also support and educate clinical colleagues.

'What does this paper contribute to the wider global clinical community?'

- Liaison roles are increasingly being used to improve communication between health services and professionals and to facilitate access to support for individuals and families in need. Little is known about these roles in community-based child and family health services in Australia or internationally.

- There are three key components to the liaison role in child and family health services in Australia: 1/ '*b*eing a bridge' - building links between services and professionals dedicated to caring for children and families ; 2/ 'untangling and holding'- providing direct support to the child and family while they are linked to appropriate services; and 3/ providing support for clinicians. Better coordination of services and linkage between professionals should improve outcomes for children and families.

- The liaison role in child and family health services is limited by skills and training

of the nurse and other professionals; resistance from other professionals and limited security of access to ongoing, dedicated funding. Further research is needed to determine the efficacy of the CHoRUS roles.

Keywords: liaison nurse; service coordination; children, family health, health visiting, health services research, community, collaboration

INTRODUCTION

Advancing research in neuroscience and epigenetics demonstrates the importance of fetal life and the early childhood years for long-term health and wellbeing (Hochberg *et al.* 2011). Consequently, health policy and services promote early identification of children and families who would benefit from additional support and early intervention during pregnancy and the preschool years. Government policies in Australia and overseas advocate service delivery through a system of 'proportionate universalism' (Oberklaid *et al.* 2013), which comprises universal, targeted, and specialist secondary and tertiary services. A universal service means that all children and their families have access to services that as a starting point are focused on the identification of children and families who require further assessment, intervention, referral and/or support. Universal child and family health services work alongside targeted or specialist (e.g. sustained nurse home visiting programmes) and intensive services (e.g. child protection services) for vulnerable families or for those children where a health or development need is identified (AHMC, 2011.

In Australia, universal health services for children and families are delivered by child and family health (CFH) nurses and general practitioners (GPs). Child and family health nurses provide assessment, health promotion and support services for families and children from birth to school entry. General practitioners (GPs) also provide significant primary care services for children and families however these are often at a financial cost to families (AHMC, 2011). Despite long-standing government commitment to universal CFH services, administrative data and research (Brinkman *et al.* 2009) indicate varying availability and utilisation of CFH services across jurisdictions with significant service fragmentation and gaps (Schmied *et al.* 2015).

Some maternity and CFH services have implemented liaison roles, to improve formal and informal communication between services and professionals, and to facilitate access to support, particularly for children and families with complex needs. However, research on the role and outcomes of liaison positions in CFH services is limited in Australia and internationally. This paper explores the liaison role in CFH services in Australia.

BACKGROUND

Since the 1960s, healthcare services have utilised the liaison role to achieve holistic, patient-centred care. The liaison role is defined and understood in various ways, however one definition states, "liaison is communication or cooperation which facilitates a close working relationship between people or organizations" (Oxford dictionary 2015). The liaison role features in acute care and community settings including intensive care units, emergency departments and mental health services, supporting specific population groups such as adults with mental illness, children with chronic conditions or disabilities, women with breast cancer and Indigenous Australians (Wand & Schaecken 2006, Wild 2014). For example, Manderson et al report the effectiveness of liaison or navigation roles in facilitating transition of clients with chronic healthcare needs across healthcare settings (Manderson *et al.* 2012). The liaison role is known variously as Patient Advice and Liaison Service, nurse care coordinator, nurse navigator, liaison nurse and discharge coordinator (Buchanan *et al.* 2005, Nutt & Hungerford 2010). The varied names, role settings and responsibilities mean that liaison positions are not clearly defined or delineated regarding required training (Nutt & Hungerford 2010). Most liaison roles involve facilitating information transfer and the transition of care between two healthcare settings, while some provide direct patient/client care (Chaboyer *et al.* 2005).

Formal liaison roles are not common in health care in Australia or internationally in maternity or CFH service settings. In Australia, some services have been established to liaise between hospital-based maternity services (funded by State governments) and GPs providing antenatal care to women, funded by the national health insurance scheme (Medicare). In these models of antenatal shared care, liaison professionals (often midwives) facilitate communication between GPs and acute care services, ensure GPs are informed of policy and practice developments, and attend multi-disciplinary meetings at local maternity units (Schmied *et al.* 2010).

Homer and colleagues studied transition of care from hospital-based maternity services to community-based CFH nursing services in NSW (Homer *et al.* 2009). This survey of 67 services identified 17 that reported using liaison positions to help facilitate the transition of care. The midwife or CFH nurse in the liaison role was reported to review women's records and meet them prior to discharge from maternity services to ascertain needs, then communicate these to ongoing services or professionals (Homer *et al.* 2009). In NSW, the HealthOne model employs GP Liaison Nurses to support children and families with high care needs. The liaison nurse has been described as the "the linchpin of this model, increasing the capacity of the workforce to more effectively identify clients needing care coordination and linking GPs, community health and other service providers to improve health outcomes" (NSW Health 2011 p. 11).

Another model is care coordination. Whittaker and colleagues described the role of Health Coordinators in north-west England (Whittaker *et al.* 2011), who were Health Visitors specifically trained and employed to improve communication between acute and community services and to develop communication pathways. Health Coordinators worked in specified

geographical locations, allowing them to consider services at various levels and develop a consistent approach to service delivery in that area. The evaluation identified system improvements, noting that Health Coordinators mobilised action for children and families through demonstrating expertise, collegial and solution-focused practices (Whittaker *et al.* 2011). No outcomes for children and families were reported.

This paper draws on a three-phase study of universal CFH services in Australia. The Child Health Researching Universal Services (CHoRUS) study investigated the feasibility of implementing a national approach to universal CFH services (authors). The third phase focused on service innovation and identified several exemplars of the liaison role. The aim of this paper was to explore the liaison role in Australian CFH services, specifically the key components of the role and the benefits and obstacles associated with implementing these positions.

METHODS

The overall CHoRUS study used a sequential mixed-methods design. Data for phase three were collected between July 2012 and October 2013 and included focus groups and interviews with CFH service professionals involved in practice innovations in 21 sites in five Australian States and Territories (Western Australia, Queensland, New South Wales, Victoria, ACT). This paper reports data collected about liaison services in eight sites in two Australian states (New South Wales and Western Australia).

The study received ethics approval from University Human Research Ethics Committee (approval number H8244).

Participants and Recruitment

During phases one and two of this national study, participants identified 21 sites where innovation in maternity and CFH services had occurred. Most of the innovations aimed to provide continuity of care and/or carer to support families across key transition points such as the transition from maternity to CFH services. These strategies or innovations included 'streamlining information exchange processes'; 'roles supporting co-ordination of care such as liaison roles; using funding and resources in innovative ways to employ staff across services; joint working, and co-locating services. Participants at several sites reported using a combination of strategies to engage families and to improve continuity of care or carer.

This paper focuses on sites that had implemented a liaison role as a model of care or strategy to improve service delivery. Sites were selected because the innovation or strategy implemented (in this case the liaison position) was considered to be successful based on either internal or external evaluations of the services; or were judged to be 'successful' by policy makers and service leaders in that jurisdiction but had not yet been formally evaluated (Psaila et al 2014). Health professionals at these sites were invited to participate initially via an email to the service manager. Following their response to the email invitation, a follow-up phone call was arranged to determine their willingness to participate. The participating health professionals varied dependent on their involvement in the design and implementation of the strategy or model. None of the professionals invited to participate declined to do so.

Forty CFH health professionals contributed to this component of the CHoRUS study. Twelve were employed in full-time or part-time liaison positions, usually the only position at their workplace. Of the 12 participants in liaison roles, eight were CFH nurses, one was a

registered nurse without CFH qualifications, one was an allied health professional and two were GPs. The remainder worked with or were supported by liaison professionals, including 19 CFH nurses, three GPs and six allied health professionals. Table 1 summarises participants at each site.

Insert Table 1 about here

Data collection:

Four focus groups (five to ten participants each), nine face-to-face interviews, three phone interviews and two small group interviews (two people each) were conducted. Focus groups and interviews were 40 to 90 minutes in duration. Using key prompts, discussions examined the origins and vision of each service; target population; key elements contributing to better outcomes; and factors that facilitate or hinder service sustainability.

Data Analysis

All interviews and focus groups were transcribed verbatim and participants and sites were de-identified. The first, second and last author read all the transcripts and together discussed the broad themes that were emerging from the data. The first author then organised all the preliminary themes in NVivo. Following this, the first and last author read all the data in each theme and compared these data across themes, confirming the three major themes and sub themes. This was an iterative and interpretive process. guided by Braun and Clark's six-step process (Braun & Clarke 2006). These authors then discussed these themes with the full team to confirm relationships between themes and finalise the analysis.

RESULTS

At the start of each interview or focus group, participants were asked to explain the concern or problem that their service wanted to address through the liaison position. All eight liaison roles were established to improve transition of care for women from hospital-based maternity services to community-based CFH nursing and general practice services. These services also aimed to improve uptake of community-based universal, targeted and specialist services by families who were vulnerable to poor outcomes and may fall through service gaps. Specific target groups included pregnant and postpartum women with identified mental health risk factors (sites 1, 5 and 8) children with chronic health care needs (sites 5,6 and 7), and families with significant social and emotional needs such as refugees (sites 6 and 7).

Participants described the liaison roles in CFH services as 'evolving'; the eight positions had existed for between 12 months and three years. Participants explained that these positions were established as a response to diverse situations and needs such as and included ensuring communication between GPs and acute or community-based health services; coordinating support for women with mental health problems; addressing the needs of children with chronic health care issues. Six positions were community-based; the two GPs in liaison positions were hospital-based. Typically referrals came directly from maternity units or CFH nursing services. Four sites supported women during pregnancy as well as postnatally or during early childhood (see Table 1).

Three major themes emerged from the data analysis: 1) 'Gaining Role Clarity'; 2) 'Constructing the liaison role ' which comprised three sub themes: 'b*eing the bridge and the beacon';* '*untangling and holding*'; and '*supporting clinicians*' and 3) 'Making it work:

facilitators and barriers to the liaison role'. In the third theme, the barriers to the liaison role were captured in two sub themes: '*Challenges to the liaison rol*e' and '*Challenges to sustainability*'.

Gaining role clarity

A key issue for participants was clarifying the liaison role. As one participant stated, "*It's a new role. Who is this…what does she do? That's hard when you're not quite sure yourself"* (Site 5 liaison CFH nurse). This often meant establishing the scope of the role, conducting a community needs assessment, and articulating the role clearly to other professionals and services, to prevent confusion and subsequent tensions:

> *I think also being **clear**, so that clarity of your role in your own definition is really important for collaboration.… to communicate clearly the parameters of your role.… putting out there true expectations.* (Site 6 liaison CFH nurse)

For some participants, liaison was only part of their role: two GP participants were employed in liaison positions one day a week. Some nurse participants combined clinical and liaison roles and described the difficulty of changing roles: *'I sort of have two hats here, so it's a bit confusing at times'.* (Site1 liaison CFH nurse)

Constructing the liaison role

The liaison roles studied had three main goals: 1) facilitating links between professionals, services and sectors; 2) facilitating continuity of care and advocating for pregnant women, children and families (sometimes providing clinical care); and 3) supporting and educating other healthcare professionals.

Being the bridge and the beacon: linking services

The liaison role involved identifying local services available to support pregnant women, children and families, communicating information, and linking them to each other. As all participants were the first to hold the liaison position in their respective sites, they needed to establish effective connections between services and across sectors.

> *… it's been like a bridge-building...role. I felt like a bridge at times, between different services.* (Site 1 liaison CFH nurse)

Participants personally liaised between services through telephone calls and case conferences, until a relationship was established and the health professionals were confident to communicate with other services. Liaison professionals often met individually with practitioners, particularly GPs, to discuss how best to link them and the women or families to appropriate services. Participants required considerable *'leg work'* to identify the availability and scope of services, how to access them, and how to link them together. Some participants reported being initially ill-equipped for this task, simply lacking information about local services and resorting to compiling their own lists:

> *…when we first came into the role, we really didn't have the tools I suppose, to do our jobs. We didn't have local GP lists and we struggled to gain those lists.* (Site 5 liaison CFH nurse)

Over time, liaison professionals became repositories of service information:

> *You know everything comes through here and we will disseminate that information to the appropriate source* (Site 3 coordinator).

*S*ome participants described themselves as '*the beacon*', the '*go-to*' point for clinicians requiring the best service pathways for families, making it essential to have in-depth, current knowledge of hospital systems, local community services and the wider community, '[you] *have to have a really good knowledge... a really good handle on…this community'.* (Site 6 liaison CFH nurse)

> *It was really important in the role that you understood very clearly the eligibility criteria of each of the services within community health.* (Site 5 liaison CFH nurse)

> *The services change, the way they operate changes and you need someone to know that* (Site 7 liaison CFH nurse)

'Untangling' and 'holding': the liaison role with families

Liaison services aim to facilitate continuity of care, particularly for families moving between services and professionals. Of the 12 participants in liaison roles, only the CFH nurses described having a small clinical role as part of the liaison position. Figure 1 illustrates their description of the cyclical process of client care.

Insert Figure 1

Liaison professionals support, or '*hold*' the family while identifying and establishing the best service pathways:

> *One of the key outcomes of our role of 'holding' is to achieve a level of continuity for the family or client.* (Site 6 liaison CFH nurse)

Participants highlighted that liaison professionals may be the client's first contact with community-based CFH services. They make regular contact with families, particularly while linking them to services, facilitating continuity of care and preventing families from '*falling through the gap*'. They reported the benefits of regular contact during a critical time.

> *Some of the mums that get referred to me...are the ones that have just felt quite fragmented. And all they need is one person that's just been... two or three times to her, and it's just like, "Oh, I feel a lot better…" I think it's just seeing the same person.* (Site 1 liaison CFH nurse)

> *It's around coordinating the care …I don't need to be up on every single clinical thing but I need to be up on who is taking care of that particular thing and who to go to for information about it, rather than actually doing it.* (Site 7 liaison CFH nurse)

Sometimes liaison professionals have to '*untangle*' the array of diverse and sometimes overlapping services connected to each family, '*Some of that's untangling because on the surface that looked like there's so many people involved'*. (Site 7 liaison CFH nurse).

CFH nurses working in liaison roles identify and link-in appropriate services and advocate for families. They may also undertake clinical activities such as screening for depression or child health checks. To effectively '*untangle*' and link services, participants often organise case conferences with service providers and clients. Thus, liaison professionals endeavour to provide holistic, family-centred care working in '*partnership*' with the family:

> *We'd try to put the family at ease and say "this is about you, this is your opportunity where you've got all these people together, what we want to know is what's working and what's not working. Because if it's not working, that's not good. We need to be able to help you"* (Site 5 liaison CFH nurse)

Case conferences, conducted face-to-face or over the telephone, aimed to ensure that all members of the multidisciplinary team involved in caring for the client were aware of what each was providing, to prevent gaps or overlaps in the support offered. This also enabled liaison professionals to introduce services to one another, to establish links and partnerships:

> *The purpose of those case conferences was actually to determine what each service's role was within supporting that family. Every time we had a case conference, it was always done in partnership with the family. So I would always liaise with the family,. ask them where they felt most comfortable.* (Site 5 liaison CFH nurse)

Participants identified that following initial contact and rapport-building between services, formulating care plan with clients is essential. Thereafter, liaison professionals may be bypassed in co-ordinating care for clients as they had fulfilled their role of identifying and linking necessary services.

> *But when we go out and see the GP, I very clearly write what the issues of concern are and who's involved. To me, then, that's okay if –… those two service providers interact without me even knowing. It's around everyone knowing what everyone's doing.* (Site 7 liaison CFH nurse)

Having achieved the main role of care coordination, some liaison professionals remain in the background to support clients if additional issues arise.

> *They have found that just having my phone number or me phoning every couple of months - how are you going?- ..., that **held** them.* (Site 8 liaison CFH nurse)

> *…in the full knowledge that there's someone holding the strings…And they can be confident in knowing that the needs are being addressed, albeit not by the liaison person.* (Site 6 FG allied health professional)

Liaison professionals clearly cannot continue to provide services once families are linked with appropriate services: *'our limited resources [mean] we can't offer …[an] intensely sustained service'* (Site 6 FG liaison CFH nurse). Clients' relationships with liaison professionals may be only one or two meetings or may continue for up to three months.

Supporting clinicians

A liaison service's success depends on its utilisation by other services, requiring regular updates about referring clients for liaison support. It has a crucial role in ongoing education about the pregnant women, children and families who would benefit most:

> *It was offering the opportunity for them* [GP] *to pick up the phone and say "Hi, I've got this family in the surgery at the moment. Mum's got this, and the child's got this. Is that something that you could help me with?"*(Site 5 liaison CFH nurse)

> *I think that these positions have helped...get people looking outside of their own area and … become more aware of the broader service system, and it opened people's eyes to the possibilities of different kinds of help for their clients* (Site 1 liaison CFH nurse)

Participants also provided education and support for health professionals caring for families with complex needs. One liaison nurse described visiting the local hospital's children's ward to discuss liaison and to offer in-service education about services and referral pathways. Others provided formal education about health care:

> *So when I run any event I always ask the GPs to tell me, what do you need? …I've just done the antenatal refresher for this year and on my evaluation form I ask what do you want to hear about next time?* (Site 2 GP)

They aimed to develop clinical skills and confidence amongst clinicians about children and families, '*I see that capacity building as really important and identifying the issues and providing support'*. (Site 6 FG allied health professional).

> *… developing partnerships…there were those CFH nurses, or other clinicians, who felt less confident and needed support to actually … develop relationships with the GP…I've sat with and supported them to actually make telephone calls or write the letters to GPs.* (Site 5 liaison CFH nurse)

Making it work: facilitators and barriers

Several factors facilitated the liaison role or made it effective primarily, attributes and skills of individual liaison professionals,

> *If you had the wrong person in* [the] *role, who was into the old silos, then that would be a disaster. That just would not work.* (Site 2 GP)

Participants believed that liaison professionals required clinical, communication, collaboration and organisation skills, to enact the role. One proposed that nurses were well-equipped:

> *Our (nursing) core training is how to collaborate, how to work in all situations - jack of all trades, master of none.* (Site 7 liaison CFH nurse)

Participants emphasised the importance of effective communication skills in networking, negotiating with services and professionals, organising case conferences and communicating with families. Good communication facilitated relationships and trust between services, and aided supportive counselling:

> *Well, collaboration … has to feature trust... that sense of knowing that … you're going to be able to refer somebody or hold a case conference with somebody that you know is going to be thorough and who works in a way that is going to engage with the family. So I think that trust is really important.* (Site1 CFH nurse)

The ability for liaison professionals to be flexible facilitated an accessible service. As some participants were employed part-time in liaison roles, flexibility with working hours enabled them to retain clinical currency and provide a liaison service responsive to the community.

> *Normally I try and split it, so I'd do Tuesday morning, Wednesday afternoon...because...if you're trying to meet with people...you've got to have more than one day.* (Site 2 GP)

Challenges in the Liaison Role

One major challenge is performing several concurrent roles - being the bridge and beacon, facilitating clinical care, coordinating (untangling and holding) and supporting clinicians

> *we've both had that challenge as we've come into different parts of our role,...coming to a meeting having just come off a phone call with a really complex case, so I've got to get my head into that now, or I'll come here and I haven't read what I'm meant to read, because I've been in a clients' world for a while ... so that's quite hard to juggle…* (Site1 liaison CFH nurse)

Many liaison professionals are solo practitioners, often working in isolation and feeling that, they receive minimal support from other healthcare professionals. This sense was heightened for those working in multiple workplaces or in a part-time capacity.

> *The thing about being a Lone Ranger is that sometimes you just wish you had Tonto there ... not really feeling a sense of belonging in either place. So I think that that's been …difficult at times.* (Site 1 liaison CFH nurse)

Participants also reported resistance by other professionals to the liaison role as potentially reducing their autonomy regarding family care. Some expressed confusion about the necessity for liaison services as they duplicated existing services, such as CFH nursing. Consequently liaison services may be underutilised if not accepted by other clinicians:

> *I understand sometimes if the CFH nurses* [are concerned]*... they've gone through a lot of change over the last several years ... they're losing their autonomy and I think sometimes they think they know the services that are out there... So why do I* [liaison person] *need to go to ... and enrol this client in the liaison service?... So until they get that acceptance and understanding ... it's going to take some time.* (Site 6 FG CFH non-liaison)

Sustainability

Despite its perceived benefits, participants expressed uncertainty about the sustainability of the liaison role. In some sites, ongoing funding was not guaranteed and liaison positions were vulnerable to removal in times of financial difficulties:

> *That's probably what's coming into play now in the whole ... funding thing.… You know, who owns the service and who will pay for it.* (Site 1 liaison CFH nurse)

Unless a woman/family are present, liaison services are currently ineligible for government health insurance (Medicare) rebates. This makes it difficult to organise consultations with GPs or other healthcare professionals who are not paid for time consulting about a patient, sometimes creating difficulty and animosity.

> *the GP doesn't get paid to talk to me if the client's not there either... There's a tension there because ... they have to see the benefit of talking to me without ... financial incentive* (Sit 6 liaison CFH nurse).

DISCUSSION

In this paper we have described the role of liaison positions in community-based child and family health services in Australia. These positions were highlighted by leaders in CFH services across Australia as service innovations, yet little is known about how these roles operate and if they have benefits for children and families. Three major themes emerged from the analysis: 'Gaining Role Clarity'; 'Constructing the liaison role' and Making it work'. The theme "Constructing the role' articulated the role of liaison positions in linking professionals and services, providing support and at times clinical care for children and families and supporting clinicians. In the third theme, the barriers to the liaison role were identified.

The eight liaison roles we examined were established to improve transition of care for women from hospital-based maternity services to community-based CFH nursing and general practice services. They also aimed primarily to improve uptake of community-based universal, targeted and specialist services by families who were vulnerable to poor outcomes and may fall through service gaps. Service gaps are particularly evident in fragmented healthcare systems and impact particularly on families who are at risk of poorer outcomes. In a review of perinatal service integration, Rodriguez and des Riveres-Pigeon determined that strategies to facilitate continuity of care (e.g. multidisciplinary teamwork) helped make services more effective and accessible, although these mechanisms were not required by all women. (Rodríguez & des Rivières-Pigeon 2007). Previous Australian work has reported that healthcare professionals find liaison roles are useful in improving the transition of care from maternity to CFH services for all women and families in varied services and settings (Homer *et al.* 2009).

This study demonstrates that liaison roles can offer much more than information exchange. We found three central elements embedded in liaison roles in Australian CFH services: facilitating collaboration; facilitating continuity of care and supporting other health professionals. These are now discussed in turn.

Facilitating collaboration – being the bridge and the beacon

Previous research has reported the challenges of achieving collaboration between CFH services and professionals. Australian and Swedish research found that health professionals such as midwives, CFH nurses and GPs focus on their own part of the continuum of care, with limited knowledge of other services, and minimal interprofessional collaboration. This results in inadequate information exchange, physical distance between services, time and task territoriality, and opposing definitions of desired outcomes for parents or professionals (Barimani & Hylander 2012, Psaila *et al.* 2014).

Establishing and sustaining collaboration requires effort. The liaison role can facilitate this process by identifying services, introducing professionals to each other and co-ordinating contact until new relationships are established. A systematic review of collaborative networks across several disciplines (Long *et al.* 2012) concluded that bridging, brokering and boundary-spanning roles are crucial for transferring ideas and information , generating innovative ideas for service delivery, and increasing co-operation between groups. Knowledge brokerage across structural service gaps is most productive where disciplines or professionals have previously been isolated or inwardly-focused (Long *et al.* 2012). Liaison roles can facilitate knowledge transfer and access to new resources, and can co-ordinate effort across services.

Previous research highlights the benefits of building bridges and facilitating collaboration, including informational continuity, improved choices for families, trust between professions and agencies, individualised care and improved linkages with families (D'Amour *et al.* 2008, Homer *et al.* 2009, Myors *et al.* 2013). Formal and informal communication are important and liaison roles can build relationships by promoting trust between professionals, identifying common goals and agendas, understanding the services, roles and responsibilities of professional colleagues, and recognising professional boundaries.

Many commentators consider time a principal barrier to collaboration between professionals (Psaila *et al.* 2014). Effective liaison input may save individual professional's time in identifying and connecting with key services in their community. Liaison can connect relevant people in meetings or case conferences. Studies highlight the importance of liaison or coordination roles in more complex situations such as child protection concerns or families linked with numerous agencies (Katz *et al.* 2007, Myors *et al.* 2013).

'Holding families' to facilitate continuity of care

The liaison role ensured that individual women and their families experienced a smooth continuum of care between services. McBryde-Foster and Allen describe this as a series of care events where the patient seeks providers in one or more healthcare environments and yet remains the central focus as transition between settings occurs (McBryde-Foster & Allen 2004).

Participants emphasised their role in 'holding' women and families as they moved between services. This wording may reflect CFH nurses' training in infant mental health adopting Winnicott's concept of holding as the physical and psychological support mothers give their

babies, vital for their initial development (Winnicott 1989). Winnicott later expanded this concept to characterise the work of primary healthcare professionals (Winnicott 1989). Through 'holding', liaison nurses offer psychosocial support and, if needed, clinical service for example breastfeeding support, while simultaneously identifying and linking families to the most appropriate service. In coordinating case conferences, CFH liaison nurses talked of 'walking beside' the woman and family when they attended, as a familiar person to advocate and introduce them personally to other professionals and services.

Supporting the role of other professionals

Participants emphasised their role in educating, training and supporting clinicians, both formally and informally, through telephone support, face-to-face meetings and in-service sessions. The education and training role of liaison professionals has been associated with increased staff satisfaction and retainment (Caffin *et al.* 2007, Nutt & Hungerford 2010).

Challenges to the role

There are challenges to establishing and maintaining liaison roles within the healthcare system. Some dispute the need for such roles (Schmied et al 2010). Many GPs and some CFH nurses including participants in this study see care coordination and collaboration with other services and professionals as a central part of their role. In Australia, GPs can claim government insurance (Medicare rebates) for care coordination activities. Similarly some nurses in the CHoRUS study indicated that they were being deskilled as they now no longer liaise with other professional groups because that is the role of the GPLN. Others also argue that liaison roles facilitating transition from maternity services to community-based child health services are 'ad hoc' measures to 'prop up' a fragmented system of care (Barimani & Hylander 2012, Homer *et al.* 2009, McBride 2003, Psaila *et al.* 2014), simply providing a

safety net for an inadequate universal health system and sometimes lacking management support (Jeyendra *et al.* 2013, Myors *et al.* 2013, Wild 2014). Liaison positions are often established as an 'add on' and, without evaluations of service quality, are vulnerable to budget constraints (Schmied *et al.* 2010). Our findings indicate some perceived resistance or resentment from other healthcare providers who perceive that liaison positions may usurp their own roles. The liaison role may risk further fragmenting health professionals such as midwives, CFH nurses and GPs from each other by limiting direct contact or monopolising information about community services professionals (Schmied *et al.* 2010). Further, as these positions are often 'one off' and part time, they may lack sufficient time and resources, thereby limiting access and increasing waiting times for families.

The literature on outcomes of liaison roles is equivocal. Some report the benefits of the liaison nurse role for patient/family outcomes (Castles *et al.* 2012, Eales *et al.* 2006) ensuring continuity of care, improving communication between patients and health care professionals, and reducing waiting times. However, further research is required (Long *et al.* 2012).

Limitations

This is a small qualitative study and our data are limited by the availability of liaison services in Australia in general, and there are very few GPs who perform this role in particular. A number of sites in this study were designed to form a bridge across Federal and State funded services in Australia. This division of government responsibilities for healthcare may be specific to the Australian context and not generalisable to other countries. However, in each site the liaison role also formed 'bridges' across State government community and acute care services. An important omission is that the study did not include the perspectives of consumer who have been supported by liaison services. Ongoing research needs to address this significant limitation.

Implications for practice

Despite the numerous challenges to establishing and maintaining a liaison role within the health service, it appears that at the current time, these positions offer at least a temporary solution to fragmentation of care and lack of continuity of care for families with young children. If liaison roles are to continue, they require adequate support through clear guidelines and education both for those in the positions and for health professionals who engage with these services. Child and family health services (both Federal and State funded) need to identify the expected outcomes from these roles and then research is required to evaluate these roles and determine if they improve outcomes for children and families. If demonstrated to be beneficial, specific funding allocation is essential to ensure 'buy-in' from government and private health services and professionals. Development of databases of services and community resources would support the liaison role and may ensure some continuity of the liaison role beyond the current professional.

Conclusion

The health professionals interviewed for this study highlighted from their perspective the core elements of a liaison role in Australian CFH services – linking professionals and services; providing support for families while they were linked to an appropriate care coordinator and or services; and offering specialist knowledge and support for clinicians. However, the extent and outcomes of liaison support for families in Australia is unknown. Liaison roles often lack clear definition and may require staff to juggle liaison within substantive clinical roles. Most participants indicated that they were responsible for determining the dimensions of their role without little guidance from their employing organisations. Better linkage and collaboration between professionals and services, has the potential to improve outcomes for children and families. Rigorous evaluations of liaison programs linked to health outcomes and engagement in other services is required.

Declaration of conflict of interest

The Author(s) declare(s) that there is no conflict of interest'

References

Barimani M & Hylander I (2012): Joint action between child health care nurses and midwives leads to continuity of care for expectant and new mothers. *International Journal of Qualitative Studies on Health and Well-being* **7**.

Braun V & Clarke V (2006): Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**, 77-101.

Brinkman K, Hunks D, Bruggencate G & Clelland S (2009): Evaluation of a new mental health liaison role in a rural health centre in Rocky Mountain House, Alberta: A Canadian story. *International Journal of Mental Health Nursing* **18**, 42-52.

Buchanan D, Abbott S, Bentley J, Lanceley A & Meyer J (2005): Let's be PALS: User-driven organizational change in healthcare. *British Journal of Management* **16**, 315-328.

Caffin CL, Linton S & Pellegrini J (2007): Introduction of a liaison nurse role in a tertiary paediatric ICU. *Intensive and Critical Care Nursing* **23**, 226-233.

Castles A, Anne Bailey C, Gates B & Sooben R (2012): Role of liaison nurses in improving communication. *Learning Disability Practice* **15**, 16-19.

Chaboyer W, Gillespie B, Foster M & Kendall M (2005): The impact of an ICU liaison nurse: A case study of ward nurses' perceptions. *Journal of Clinical Nursing* **14**, 766-775.

D'Amour D, Goulet L, Labadie JF, Martín-Rodriguez LS & Pineault R (2008): A model and typology of collaboration between professionals in healthcare organizations. *BMC Health Services Research* **8**.

Eales S, Callaghan P & Johnson B (2006): Service users and other stakeholders' evaluation of a liaison mental health service in an accident and emergency department and a general hospital setting. *Journal of Psychiatric and Mental Health Nursing* **13**, 70-77.

Hochberg Z, Feil R, Constancia M, Fraga M, Junien C, Carel JC, Boileau P, Le Bouc Y, Deal CL, Lillycrop K, Scharfmann R, Sheppard A, Skinner M, Szyf M, Waterland RA, Waxman DJ, Whitelaw E, Ong K & Albertsson-Wikland K (2011): Child health, developmental plasticity, and epigenetic programming. *Endocrine Reviews* **32**, 159-224.

Homer CSE, Henry K, Schmied V, Kemp L, Leap N & Briggs C (2009): 'It looks good on paper': Transitions of care between midwives and child and family health nurses in New South Wales. *Women and Birth* **22**, 64-72.

Jeyendra A, Rajadurai J, Chanmugam J, Trieu A, Nair S, Baskaran R & Schmied V (2013): Australian general practitioners' perspectives on their role in well-child health care. *BMC Family Practice* **14**, 1-7.

Katz L, Ceballos SG, Scott K & Wurm G (2007): Collaborative practice: The critical role of a pediatric nurse practitioner in an early intervention program for children with prenatal drug exposure. *Journal for Specialists in Pediatric Nursing* **12**, 123-127.

Long JC, Cunningham FC & Braithwaite J (2012): Network structure and the role of key players in a translational cancer research network: A study protocol. *BMJ Open* **2**.

Manderson B, McMurray J, Piraino E & Stolee P (2012): Navigation roles support chronically ill older adults through healthcare transitions: A systematic review of the literature. *Health and Social Care in the Community* **20**, 113-127.

McBride LK (2003): Making the link - An impact evaluation of one Dublin hospital's accident & emergency department's liaison nurse service. *Accident and Emergency Nursing* **11**, 39-48.

McBryde-Foster M & Allen T (2004): The continuum of care: a concept development study. Nursing theory and concept development or analysis. *Journal of Advanced Nursing* **506**, 624-632.

Myors KA, Schmied V, Johnson M & Cleary M (2013): Collaboration and integrated services for perinatal mental health: An integrative review. *Child and Adolescent Mental Health* **18**, 1-10.

NSW Health (2011) What is HealthOne NSW? . Available at: http://www.health.nsw.gov.au/initiatives/healthoneNSW/whatis.asp).

Nutt M & Hungerford C (2010): Nurse care coordinators: Definitions and scope of practice. *Contemporary Nurse: A Journal for the Australian Nursing Profession* **36**, 71-81.

Oberklaid F, Baird G, Blair M, Melhuish E & Hall D (2013): Children's health and development: approaches to early identification and intervention. *Arch Dis Child* **22**, 2013-304091.

Oxford dictionary (2015). Oxford University Press. Available at: http://www.oxforddictionaries.com/definition/english/liaison.

Psaila K, Schmied V, Fowler C & Kruske S (2014): Discontinuities between maternity and child and family health services: Health professional's perceptions. *BMC Health Services Research* **14**.

Rodríguez C & des Rivières-Pigeon C (2007): A literature review on integrated perinatal care. *International Journal of Integrated Care* **7**, e28.

Schmied V, Homer C, Fowler C, Psaila K, Barclay L, Wilson I, Kemp L, Fasher M & Kruske S (2015): Implementing a national approach to universal child and family health services in Australia: Professionals' views of the challenges and opportunities. *Health and Social Care in the Community* **23**, 159-170.

Schmied V, Mills A, Kruske S, Kemp L, Fowler C & Homer C (2010): The nature and impact of collaboration and integrated service delivery for pregnant women, children and families. *Journal of Clinical Nursing* **19**, 3516-3526.

Wand T & Schaecken P (2006): Consumer evaluation of a mental health liaison nurse service in the Emergency Department. *Contemporary nurse : a journal for the Australian nursing profession.* **21**, 14-21.

Whittaker K, Mace J, Murphy J, Carter B & Tudor Edwards R (2011) The NHS East Lancashire Health Co-ordinator Role: A Realistic Evaluation of Practice. School of Health, University of Central Lancashire., Preston.

Wild P (2014): A project to improve links between paediatric liaison nurses and school nurse teams. *Community Practitioner* **87**, 42-43.

Winnicott D (1989) The MotherInfant Experience of Mutuality. In *Psycho-Analytic Explorations* (Winnicott C, Shepherd R & Davis M eds.). Karnac Book, London.

Table 1: Study Sites and Service Description		
Site	Brief description of liaison role/service in each site	Participants
Site 1	Perinatal mental health liaison service linking women from State funded maternity service and community CFH service to perinatal mental health services. • community-based; • typically initiated following birth with some women/families linked during pregnancy; • referral processes established within maternity and CFH nursing services	4 CFH nurses – focus group discussion
Site 2	GP liaison service between maternity unit and State government funded community health services and private general practitioner services; • hospital-based; • initiated post birth • referrals to general practice and community CFH services	2 GPs – one-to-one interviews by phone
Site 3	Liaison service between State government funded community health services and private general practitioner services; • community-based; liaison • initiated following birth • referral from maternity service to community health centre	6 participants - 2 CFH nurses; 1 coordinator (liaison), 1 GP, 1 OT, 1 CNC (focus group and 1 phone interview)
Site 4	Liaison service between State government funded community health services and private general practitioner services; • community-based; liaison • initiated following birth • referral from maternity service to community health centre	2 participants - 1 CFH nurse and 1 coordinator liaison
Site 5	Liaison service linking women and children from State funded maternity service and community CFH service to private general practitioner services. • community-based; liaison • initiated either during pregnancy or following birth • referral from maternity service or CFH services to the liaison program	11 participants - one liaison CFH nurse and a focus group with 10 CFH nurse participants
Site 6	Liaison service linking women and children from State funded maternity service and community CFH service to private general practitioner services. • community-based; liaison • initiated either during pregnancy or following birth • referral from maternity service or CFH services to the liaison program	13 participants - 1 focus group with 10 participants including CFH nurses, psychologist, Clinical Nurse Consultant, One-to-one interviews with liaison nurse and two GPs.
Site 7	Liaison service linking women and children from State funded maternity service and community CFH service to private general practitioner services. • community-based; liaison	1 participant – CFH nurse liaison

Table 1: Study Sites and Service Description		
	• initiated either during pregnancy or following birth • referral from maternity service or CFH services to the liaison program	
Site 8	Perinatal mental health liaison service linking women from State funded maternity service and community CFH service to perinatal mental health services. • community-based; • typically initiated following birth with some women/families linked during pregnancy; • referral processes established within maternity and CFH nursing services	1 liaison coordinator – CFH nurse

Olley H, Psaila K, Fowler C, Kruske S, **Homer CSE**, Schmied V. (2017). Being the bridge and the beacon': A qualitative study of the characteristics and functions of the liaison role in child and family health services in Australia. *Journal of Clinical Nursing* 26 (1-2), pp. 91 – 102.

Figure 1- Liaison service process