POLICY AND PRACTICE: THE IMPACT OF THE NSW GOVERNMENT'S FAMILIES FIRST STRATEGY ON CHILD AND FAMILY HEALTH NURSING

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CERTIFICATE OF AUTHORSHIP/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 sources and literature used are indicated in the thesis.

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ACKNOWLEDGEMENTS

PREFACE

This Dissertation is centred around the more recent events that have brought changes to the community child health service and which eventually have had an impact on child and family health nursing. It is the result of a long period of reflection on the contemporary state of child and family health nursing in Australia, and New South Wales in particular. In thirty years of involvement with child and family health nursing services in NSW I have witnessed many changes.

I began my involvement with child and family health nursing as a clinician, and then moved into nurse education and latterly into research. In 1977 I was employed by the Northern Sydney Area Health Service as a Mothercraft nurse and worked in the Baby Health Centres in the Ryde/Hunters Hill area. This was my first appointment to the Early Childhood Health service, and I was a neophyte in the clinical area as I had only completed my Mothercraft Nursing Certificate the previous year. I was fortunate to spend my apprenticeship, because that was what it was, with an experienced nurse, who taught me more than any book learning could do. I went on to spend a happy six years working as a clinician, before leaving the then Early Childhood Health Nursing service in 1983.

In 1986 I moved out of clinical practice and into nurse education. The previous year had seen the inauguration of the move in NSW of nursing education from the State funded hospital sector into the federally funded higher education sector and I took a position as a lecturer in one of the very recently formed Schools of Nursing.

My new career direction opened up possibilities for me that may not have been available if I had remained in clinical practice. The most dramatic was the broadening of my personal perspective on health care and the role of nursing, from that of a clinician delivering services to that of an observer of the bigger picture of the health care system within Australia. I became interested in aspects such as service organisation, funding mechanisms, and political processes in health care in Australia, and particularly the apparent lack of power and influence of the nursing profession in health policy.

My personal growth in professional issues was slow, but by the end of the 1980s I had formed an alliance with several other like minded child and family health nurses, who believed that the voice of child and family health nurses was not being heard in the formation of policy that had an impact on their work and conditions of practice. They had watched the changes occurring in the service with some consternation and felt that the service was undervalued by health managers and at risk of being debilitated by the ever expanding needs of the acute care sector. Although lip service is frequently given to the importance of the family in Australian society, mothers and babies do not appear to rate highly on health planners' priorities, apart from the provision of obstetric services.

Our small group met to discuss the possibility of setting up a professional nursing association to represent child and family health nurses, with the intention of becoming more involved in the political process in NSW. In 1989 we called other interested child and family health nurses together to a meeting, where the Child and Family Health Nurses (NSW) Association was formed (CAFHNA). There were ten of us at that first meeting, and enthusiasm and hopes for the infant Association were high. We were fortunate to have within the initial group several members who had experience in filling senior nursing management positions, but by and large we were inexperienced in the world of big P policy. Certainly I had very little experience in health politics, and like many nurses of my generation had previously had little interest in the broader health issues of the day.

In 1991 I attended a seminar held in Sydney where Margretta Madden Styles from the International Council of Nurses spoke about identifying and developing nursing specialisations. This meeting was an eye opener, because I became aware that many of the problems that the committee had been grappling with were experienced by other nursing specialty organisations. At the Sydney seminar nursing speciality organisations were invited by the Australian Nursing Federation to attend a meeting in Melbourne to form a new group to be called the National Nursing Organisations, now known as the Coalition of National Nursing Organisations.

At the NNO meetings I met delegates from the Maternal and Child Health Nurses Special Interest Group, an organisation with similar aims to CAFHNA, based in

Victoria. In our conversations at the NNO meeting it became apparent that a more united front was required. We were becoming aware that to be active in the politics of health required a national presence, and the power and influence of the group was determined by the weight of its numbers. This led eventually led to the inauguration in 1996 of the national group, the Australian Association of Maternal Child and Family Health Nurses.

As a member of CAFHNA I have represented the Association on NSW Department of Health committees and other meetings, such as the meeting in Canberra in March 1999 to the set up of national lobby group for family and child health and welfare, the National Initiative for the Early Years, which later became the National Investment for the Early Years, known by its acronym as NIFTeY. From these activities my interest has grown in health policy per se, and in particular the effects of health policy on child and family health nursing services and the nurses who practice within them.

I have maintained my interest and membership of the CAFHNA Committee until the present day. Throughout my tenure as a member of the Committee I have been privileged to work with many committed and highly motivated child and family health nurses, who gave their time generously to firstly ensure that the Association was viable, and secondly to represent the views of child and family health nurses in as many forums as necessary. The furthering and strengthening of organisations representing child and family health nurses, such as CAFHNA and the AAMCFHN, remains a personal goal.

It is not usual for somebody to take on the arduous task of a doctoral research project at this stage of their career, but for me it is the culmination of all those earlier experiences as a child and family health nurse. The research project found in this Dissertation is my small contribution to the body of scholarship that Australian nurses have been slowly building up over the past several decades, as we began to document our practice and theorise about our discipline. I hope it prompts nurses working in child and family health to think more deeply about their practice and their contribution to nursing.

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ABSTRACT

Child and family health services in NSW are a well established component of community health services. Child and family health nurses provide parenting support, health surveillance and early intervention for families with infants and young children.

Contemporary child and family health services have been influenced by international research and trends in delivery of services to families with young children. The NSW Government introduced a comprehensive social program known as the Families First Strategy in 1999. This large State wide policy involved a whole of government approach to providing coordinated services to children and families. As a part of the Families First Strategy, NSW Health introduced Health Home Visiting for families with new babies, to be implemented through the community child and family health nursing network.

This research study describes the development and implementation of the Families First Strategy and related health policies in child and family health nursing services in NSW from a nursing perspective. It provides a baseline description of contemporary child and family health nursing in NSW and examines the impact of the health policies on nursing practice in two Area Health Services.

The research study explores the potential of child and family health nurses to influence health policy in respect of children and families and proposes recommendations and further research to inform the development of nursing leadership in child and family health nursing practice, education and policy.

INTRODUCTION TO PORTFOLIO

Introduction

Maternal and child health services are recognised as essential primary health care services by the World Health Organisation (WHO, 1978) and in Australia have become an established component of health care services. Infant welfare services were first set up in New South Wales (NSW) in the early 1900s with the introduction of a home visiting service in the city of Sydney, and have grown since then into a comprehensive State wide network of specialist services. Over the past 100 years the structure of the original maternal and child health service evolved into the contemporary child and family health service, but the goal of the service, to improve the health and wellbeing of children and families, remains the same (Keleher, 2007a).

As the child and family health services grew, the role and function of the nurses who worked within the service was developed and refined. Within two decades of the inauguration of the first nurse home visiting service in Sydney, Registered Nurses were being educated for practice within this clinical specialty area (Armstrong, 1939). The primary health care role of the nurse in supporting families with infants and young children has now been well established.

In the past decade changes have occurred in NSW that have the potential to alter the structure of the child and family health nursing services. New policies have been introduced which have required service managers to rethink service delivery and these changes have had an impact on the role and function of the nursing workforce. Consequently, child and family health nurses have been challenged to rethink and refashion their role and practice.

Despite the long history of child and family health nursing in NSW and community child health services in other States of Australia, the service and the practice of the nurses has until recently attracted little attention from researchers. In 1989, at the 75th anniversary of the introduction of maternal and child health services in NSW, the NSW Department of Health published a history of baby health services (O'Connor, 1989), and other authors documented innovations in service provision in NSW (Rissel & Vaughan, 1989). There were some social analyses of the infant welfare movement in general (Deacon, 1985: Reiger, 1986a) as well as historical accounts (Flood, 1998; Smith, 1991) and the occasional feminist critique (Knapman, 1993).

More recently there has been an increased interest in researching child and family health nursing services and aspects of child and family health nursing practice. Henderson, Downie, Juliff, Borrow, Waddell & Muns (2007) have described the practice of child health nurses in Western Australia. In Victoria Edgecombe and Ploeger (2006) described a model of service provision for maternal and child health nurses dealing with family violence. Kemp, Anderson, Travaglia and Harris (2005) investigated a nurse sustained home visiting program in NSW. Kruske, Schmied and Cooke (2007) explored the effect on breastfeeding of attendance at a mothers' group. In her doctoral thesis and subsequent publications, Kruske (2005; Kruske, Barclay & Schmied, 2006) undertook an investigation of child and family health nursing services and practice in NSW, prompted by the introduction of new State health policies, particularly the NSW Government's Families First Strategy. Using a case study approach, Kruske (2005) investigated the effect of the implementation of Families First in two Area Health Services in NSW and concluded that the child and family health nurses in her case studies were struggling to cope within a changed context of practice. The nurses were carrying heavier work loads and had difficulty adjusting to the demands of the service management to implement the new home visiting schedule. Kruske (2005) found that, whilst the nurses in her study were excellent clinicians, they had poorly developed skills in research or policy development. This resulted in a limited ability to promote their unique practice or to engage health management in their professional concerns. The work I have undertaken in this Professional Doctorate complements Kruske's (2005) research findings by continuing the investigation into the impact of Families First and related health policies on child and family health nursing services in NSW.

History of Child and Family Health Nursing

There is a long and distinguished history in New South Wales of services for maternal and infant welfare, beginning in the early part of the twentieth century. Nurses have been the backbone of the infant welfare service since its introduction in 1904, shortly after Federation. At that time there was consternation in government circles about the high infant mortality rate, which in the latter half of the 19th Century had reached the unheard of levels of 174 deaths in every 1000 live births, reportedly higher than the infant mortality rates in London at the time and as high as that in many European cities (Armstrong, 1939). Of the surviving infants, only 800 would live to the age of five

years (O'Connor, 1989). Federation had recently occurred in 1901, and the founding fathers were worried about the long term viability of 'Britannia under Southern Skies' if the Anglo-Australian population did not adequately grow (Withers, 1991). There followed a Royal Commission on the Birth-Rate in 1903, which identified 'summer diarrhoea' as a major health risk for infants. The Medical Officer of Health to the metropolitan combined district of Sydney and City Health Office was Dr W.G. Armstrong, who had been impressed by the work of the English and French pioneers in infant welfare. As a public health advocate, Armstrong recognised that infant gastro-enteritis was linked to the filthy conditions in the homes of many of the poorer citizens of Sydney. He began a campaign to improve hygiene practices in the home by educating the mothers in mothercraft and advocating breast feeding, of which he was a passionate supporter (Armstrong, 1939). To this end Armstrong had a pamphlet, which he himself had authored and titled 'Advice to Mothers', sent to every address at which a new birth had been registered. He prevailed upon the City Council of Sydney to employ a trained health visitor to visit the homes of all newborns and personally instruct the mothers on infant feeding and correct hygiene practices, and in May 1904 Miss Margaret Ferguson took up her duties (O'Connor, 1989). Armstrong lists Miss Ferguson's duties thus:

> ...within a day or two after registration (of the birth) the house of each child was visited by the health visitor, who interviewed the mother, talked to her confidentially on the management of the child, and advised her as to the methods she should follow. The principal points impressed upon the mother were the great importance of breast feeding and its superiority to any other form of feeding...The conditions as to cleanliness and the general sanitary state if the dwelling were noted and reported at my office for necessary action...in cases of poverty, the household was referred to the appropriate charitable institutions...a simply worded pamphlet, setting forth the dangers of infantile diarrhoea and giving instructions as to the feeding and management of infants was handed to the mother. If the child was found sick or ailing by the health visitor the only advice was to get the child to the doctor at once...
> (Armstrong, 1939, p.643).

I have set out this long quote because, whilst it describes the nurse's work in 1904, there are clear parallels to the work of child and family health nurses today. It is easy to recognise the same key nursing topics as infant feeding, care of the child, parent education, the home environment, documenting care and referral to medical care. Of course, over the following decades the service grew and developed, but in general the focus of the nurses' work remained on assisting parents to care for their children. From

that initial emphasis on hygiene to combat the dreaded 'summer diarrhoea', the scope of the nurses' practice has enlarged, although it still includes the clinical activities listed by Armstrong (1939).

Each decade brought new ideas and changes in service organisation. There appear to be three distinct phases in the development of child and family health nursing: from the early 1900's to the beginning of World War Two, and from then until the late1980s, and the present-day era (Knapman, 1993). These phases were influenced by prevailing social conditions, contemporary political pressures and developing health care services.

At the turn of the century, the infant welfare movement, of which nurse visiting was only one aspect, evolved from the concerns of politicians and community minded citizens for the conditions in which children were reared, and concentrated on their mothers' perceived ignorance of correct mothercraft. There is a strident feminist critique of the seemingly benign aims of the infant welfare movement as a front to denigrate mothers' knowledge as a means of social control over the mothers (Knapman, 1993: Reiger, 1986a). This is linked to the high value given to the 'scientific mothering' promoted by the health professionals and charitable bodies that instituted the baby health clinics and mothercraft homes. This critique includes the role of the infant welfare nurse, who was even then the health professional who had the most direct and ongoing contact with the mothers. This is an important critique of the child and family health nursing role and function and it remains pertinent to contemporary practice.

The first Baby Health Clinics were begun by the Benevolent Society in conjunction with the opening of the new hospital, The Royal Hospital for Women, Paddington. The Society provided a Consultation for Mothers as part of the Outpatients Department, and it grew steadily in popularity, eventually moving into rooms in the local suburban area (O'Connor, 1989). The Alice Rawson School for Mothers opened in 1908 in premises in Darlinghurst, providing clinic and home visiting services. The Royal Society for the Welfare of Mothers and Babies (known as Tresillian) was established in 1918 (Royal Society for the Welfare of Mothers and Babies, 1918). Tresillian immediately established their own Baby Health Clinics, which by 1919 were jointly managed by a Baby Clinics Board and not the Health Department at that time. In 1921 the Tresillian Infant Welfare Training School was opened at the Society's premises at Petersham for

general or midwifery trained nurses. Truby King opened the Australian Mothercraft Society (known as Karitane) in 1923 with the same constitution and model as the New Zealand Karitane Society (Van Krieken, 1991) and the first mothercraft training school began in 1924. A course for untrained girls to prepare them as 'mother's helps', later called mothercraft nurses, was also begun. The major focus of the nursing training was to prepare the 'nursing aide' to attend to the mother during the lying in period and to instruct the mothers on 'proper methods of nursing, feeding, bathing and dressing the child, and generally looking after' (Royal Society for the Welfare of Mothers and Babies, 1918). The two Mothercraft Societies formed the cradle of child and family health nursing education and are still active in educating child and family health nurses today.

Although the first visitors in child health were nurses, and the mothercraft societies were charitable institutions organised by concerned citizens, the medical profession soon become interested in issues to do with infant mortality and child health. There was an early struggle over medical dominance of the clinic, which was resolved when the Department of Public Health took formal control of the clinics. As a result of the transfer to the health authority, the trained nurses in the clinics were restricted in their capacity to treat illness without the authority of a medical officer (O'Connor, 1989). The number of the clinics grew and by 1927 there were 35 clinics established in the metropolitan area. The clinics were open to all mothers, but the poor and uneducated mothers were less likely to attend (O'Connor, 1989, p60).

Up until the end of the 1930s the principal focus of the maternal and child health service had been on instructing mothers about hygienic methods of child care to combat the scourge of the 'summer diarrhoea'. By the end of the Second World War there was an improvement in the mortality rate from infectious diseases, especially gastroenteritis, and the infant mortality rate was dropping significantly (Gandevia, 1978). The proponents of the infant welfare movement have always claimed credit for the significant decline in the infant mortality rate, but that claim has been questioned (Smith, 1991; Stanley, 2001). It is argued that the epidemiological evidence suggests that improved social and living factors had an influence on the decline in infant mortality, following McKeown's thesis. Smith's (1991) claim is supported by evidence (Nurses Registration Board, 1998) that suggests the decline in the infant mortality rate

predates the beginning of the infant welfare movement, which in her opinion is 'more likely a beneficiary than the instigator of the downward trend in the infant death rate' (Smith, 1991, p28).

From the late 1930s onwards the emphasis changed to providing mothers with professional advice, and to addressing the causal factors of neonatal mortality (Stanley, 2001). The second era begins during the years of World War Two, with increasing recognition of the dual needs for both preventive health services and education of mothers to maintain the health of their children. With medical advances post war, children were much more likely to survive, and the work of the maternal and child health nurses moved away from concerns about the immediate survival of children, to ensuring that they would grow up into strong and healthy citizens. There was an interest also in healthy minds, and the encouragement of children's intellectual development, which all took place within the old framework of monitoring growth and development and screening of children (Knapman, 1993). There was also concern now for the health and wellbeing of the preschool child and the introduction of regular screening tests. The popularity of the Baby Health Centres continued to grow and in the post war period it became routine for mothers to attend the Centres.

A survey conducted by the Health Districts in 1961 compared total births in the State to attendance figures and indicated that overall 70.4% of mothers, and 86.2% of new mothers attended the Centres, with attendance being even higher in some metropolitan areas (O'Connor, 1989). Home visiting was available to those mothers who needed extra assistance, or who did not attend the Centre. The work of the Baby Health Centre nurse included advising mothers on all aspects of infant and child care, monitoring growth and development, conducting screening tests and referring infants and children with health concerns for medical advice. There was still an emphasis on the benefits of routine and discipline, epitomised by the strict daily schedules advised by Truby King, but by the mid 1960s there were the beginnings of a change in attitude towards a more relaxed style of child care and the recognition of the need to grow confidence and independence in the mothers (Knapman, 1993; O'Connor, 1989). During the 1970s there was a move to broaden the scope of the baby health service by making the Centres available to other services, such as immunisation clinics, Community Aid, adolescent services, and health education programs for community groups.

The modern era begins with the shift in emphasis towards the psychological and emotional needs of the child as the research in child development began to influence child rearing practices. The Baby Health Nurses' role by the late 1970s is reported as being that of a 'health educator and health supervisor', with the aim of 'supporting, guiding and advising parents to be confident and competent in their parenting role' (Degeling, 1979, p.20-21, cited by O'Connor, 1989). By the 1980s child health practice was increasingly influenced by the principles of primary health care and the social model of health, in which attention is given to the social, economic and environmental context of health (Keleher, 2007a). Changes in health promotion policies from this time reflect the primary health care influence (Wass, 2000). This translated into an emphasis on parent education and social support for the mother and a more family oriented approach (Knapman, 1993). A Baby Health Activity Survey undertaken in 1984 confirmed that the role of the nurse had moved away from a procedure oriented role to that of a counselling and support role (O'Connor, 1989).

Today we are seeing the introduction of other approaches and ideas and child and family health nurses are again being challenged to work within new models of practice that require them to rethink their professional approaches for working with parents and their young children.

Changes in Community Child Health Service Organisation

Services to children and families have changed greatly in their organisation and structure since their introduction. In 1925, Dr E. Sydney Morris, the Senior Medical Officer in the Health Department, added into his duties those of the Director of Maternal and Baby Welfare, and so begins the formal involvement of the health bureaucracy. In 1926 the Baby Health Centres administered by the charitable organisations were transferred to the direct control of the Director-General of Public Health and by 1934 a fulltime Director of Maternal and Infant Welfare was appointed. The Division of Maternal and Baby Welfare would continue to be the major administrative unit for infant welfare services until 1965, when it combined with the School Medical Service to form the Bureau of Maternal and Child Health. The Bureau continued to function as a separate entity until 1973 (O'Connor, 1989).

Following the Second World War the government encouraged local councils and other organisations to become involved in infant welfare services by entering into a cost sharing arrangement with the Department of Health. The councils built and maintained the local Baby Health Centres, whilst the Department provided the nurses who staffed the Centres. This arrangement has continued in some local government areas almost to the present day.

In 1973 the NSW Health Commission was established. This brought hospital and community services under the same central administration (NSW Health, 2000), although clinical directorates such as the Division of Maternal and Child Health were maintained. Also in 1973 the federal Whitlam Labour Government introduced legislation to initiate generalist community health services in Australia known as the Community Health Program (Keleher, 2007a). Originally funded by the federal government, the Community Health Program services were eventually transferred by the Fraser Coalition Government to the control of the States. Baby Health Centres and School Health Services were now incorporated into the community health services and a review of the services undertaken in 1984 reported that the diversity of service arrangements necessitated a reassessment of the management structure (O'Connor, 1989).

When the NSW Health Department was established in 1982, decentralisation of health services commenced to regional health services and the Bureau of Maternal and Child Health ceased to function. By 1986 the responsibility for service provision in community health had passed to the newly appointed Area Health Services (NSW Health, 2000) with a senior specialist as policy advisor in the Department of Health (O'Connor, 1989). In 1987 the Baby Health Centres were renamed as Early Childhood Health Centres and the title of the nurse changed accordingly to that of Early Childhood Nurse. The name change was intended to signal to the community the breadth of the service for children from birth to four years of age to encourage attendance of preschool children. The nurses' title changed again in 2002, from Early Childhood Nurse to Child and Family Health Nurse (NSW Health Circular 2002/54), again to signal a change in service orientation.

By the close of the 1980s the service organisation of the Early Childhood Health Services differed according to its regional location, as Area Health Service management shaped the service to suit local priorities. In some metropolitan areas and also in some rural areas the original structure of a stand alone Early Childhood Health Centre remained, whilst in others the child health service was incorporated into a generalist community health service. The title of the nurse could also vary, as could the qualifications required for employment, and in some Area Health Services the nurse was required to take on a case load of clients across the age span. The situation is exemplified by the diversity of service structures found within the Sydney metropolitan area. Those metropolitan Area Health Services that had inherited the remnants of the Baby Health Centres tended to maintain the separation of the Early Childhood Health services from other community services. Those suburbs of Sydney which had been developed since the introduction of the 1973 Whitlam Community Health Program were more likely to have the child health service incorporated into the generalist community health organisational structure. Whichever service model prevailed, the management of the child health service was combined with hospital administrations, which accelerated the tendency to view community health services as an extension of hospital services.

Child health services appear to have been working under conditions of fiscal restraint for decades: funding shortages were reported in the late 1950s (O'Connor, 1989), but by the late 1980s health costs were again under pressure. In an atmosphere of severe fiscal restraint, providing services to the well child seemed frankly extravagant. Therefore there was an increasing tendency to view universal community child health services in particular, as areas for review. Community child health nursing services were particularly vulnerable. The decade of the 1990s began with concern expressed by medical officers that there would be no growth in funding or new child health services (V. Nosser, personal communication, May, 2002) and this concern was shared by senior nursing management (personal communication M. Belansky, August, 2003). By the mid 1990's there was discussion in the Child and Family Health Unit in the NSW Department of Health that community child health services should not be concerned about the 'worried well' (B. Wellesley, personal communication, January, 2003) and should begin to target their services towards those families considered to be in an 'at risk' category. This contrasts, however, with an infant welfare movement built on the premise of a universal service, that is, all mothers should have access to a free, locally

available advisory service that did not discriminate amongst nor stigmatise those who used it, so such a change would create a very different kind of service model.

It was into this atmosphere of confusion and uncertainty for the Early Childhood Health service that the NSW Government introduced new policy developments that nominated the child and family health nurse as either the key health worker or an important health worker in the policy implementation. This change in policy motivated me to look more carefully at the effects of the new policy direction on the child and family health nursing services.

Contemporary Practice in Child and Family Health

Contemporary child and family health services have been heavily influenced by policy and practices developed outside of Australia. These international initiatives are sometimes introduced formally into Australian practice by government policies, and sometimes are notions and practice improvements taken up by clinicians as part of their practice development. For example, child and family health services in NSW are guided by the philosophy of Primary Health Care as set out by the World Health Organisation and formally recognised in policy documents. Whilst nursing practice within the services has long been based in the principles of primary health care, more recently it has been heavily influenced by other practice approaches, such as the Family Partnership Model (Davis, Day & Bidmead, 2002) and the 'strengths based approach' (Blundo, 2001) applied to nursing care. The tradition of adopting and adapting international initiatives continues, so this section includes a discussion of the international influences that have prompted changes in service delivery in the past decade and the local response.

Primary Health Care and Health Promotion

Primary health care has been a major policy of the World Health Organisation since 1977 when it was first articulated in the Declaration of Alma Ata. In the following two decades, the WHO continued to elucidate the principles of primary health care and expanded the notion of health promotion as a method of systematically practising primary health care. There were a series of five international conferences, beginning with the Ottowa Charter in 1986 through to the Mexico Ministerial Statement for the

Promotion of Health in 2000 that oversaw the development of the contemporary approach (Talbot & Verrinder, 2005).

Primary health care was initially intended to provide both a philosophy for change in health care and a method of service delivery. In its most radical form it challenges the health care system and forms the rationale for a reconfiguration of health care service delivery. The philosophy of primary health care strongly supports a health care system based on the principle of social justice, demonstrated through policies of equity and access of clients to the health care services (WHO, 2003). As a description of ideal service delivery it endorses primary, or first level services, as the leading sector in the health care system and emphasises the importance of preventive health and health promotion. The WHO identifies maternal and child care services as a vital part of the primary health care system, and it is from this that child and family health services gain their legitimacy. Indeed, it can be argued that the national and international health policies initiated by the WHO on primary health care and health promotion underpin community child health services in NSW. Community child health services are the quintessential example of a primary health service as they reflect the principles of the primary health care philosophy of providing equitable health promotion services that are affordable and appropriate to local needs (Talbot & Verrinder, 2005). Child and family health nurses provide a free service through locally based centres that is seen as appropriate by the users and is very acceptable to the community (Ochiltree, 1991). One of the roles of the nurse is to assist clients to access the health care system by acting as a conduit to secondary and tertiary services. The health practitioner is the knowledgeable insider who assists clients to access the services and this is an important part of the role for many child and family health nurses, as they refer clients on to other service providers.

Child and family health nurses identify health promotion as a major component of their work. Health promotion is a broad term that is recognised as incorporating a wide range of measures, most of which are outside of the ambit of the health care system. The theory and practice of health promotion has its origins in public health, and its antecedents are found in the concerns for clean water and proper disposal of waste that dominated public health one hundred years ago, as well as other actions to contain and control the spread of infectious diseases (Fleming & Parker, 2007). Over the past three

decades the interest in public health turned towards the control of modern epidemics such as cardiovascular disease, and so the emphasis in health promotion was on the so called 'lifestyle' diseases. More recently attention has turned to the health determinants approach and social and environmental explanations of health inequality (Keleher & Murphy, 2004).

Within medicine and nursing practice, the biomedical approach to 'preventative health care' is by far the most dominant health promotion model, with its familiar sectors of primary, secondary and tertiary prevention (Talbot & Verrinder, 2005). Most nurses would recognise this model and identify it as the model that guides their practice. This sits well with child and family health nurses, who can readily identify with the preventive health practices of health surveillance and screening, and immunisation carried out at the primary prevention level. Another aspect of health promotion with which child and family health nurses can identify is health education, both individualised health teaching and group health education (Kiger, 2004; Rankin, Stallings & London, 2005).

Whilst medical and nursing practice has maintained a biomedical perspective (Robinson, & Hill, 1998; Whitehead, 2001), elsewhere in the field of health promotion the social-ecological model of health promotion has gained prominence, particularly as the influence of the social environment on the development of the individual has been demonstrated in research (Wilkinson & Marmot, 2003). The influence of the social model of health promotion should be particularly noticeable in child and family health nursing, where the nursing practice is said to be more aligned with social explanations of behaviour than biomedical models of health care. The daily observations of the nurses could lead them to conclude that the life circumstances and social disadvantage of their clients would have a significant influence on their health and on family life.

Whilst health promotion is seen by child and family health nurses as an essential part of their work, their professional nursing association, the Child and Family Health Nurses Association (CAFHNA), claims a health promotion role for the nurse in their Competency Standards (CAFHNA, 2000). Further, CAFHNA claims that this extends beyond the preventive health activities nominated above to a broader community development role. The competency standards were devised with the assistance of an

expert group of child and family health nurses, but they have not been tested in the field as to the extent of the practice. This is of special note in terms of the nurses' health promotion role, especially if community child health services move to reposition themselves within the social model of health promotion.

Nossar (1998), a medical practitioner, has put forward a model for community paediatrics that endorses such a move. Nossar's Integrated Model of Healthcare acknowledges the need to expand health promotion and population care in community child health service delivery alongside the more traditional biomedical response to individual client's presenting health problems. Using a four quadrant model he presents a 'map' of contemporary services and suggests that activity in the upper quadrants should be increased, if necessary at the expense of the more traditional biomedical services.

Health Promotion/Health Protection

Response to health problem
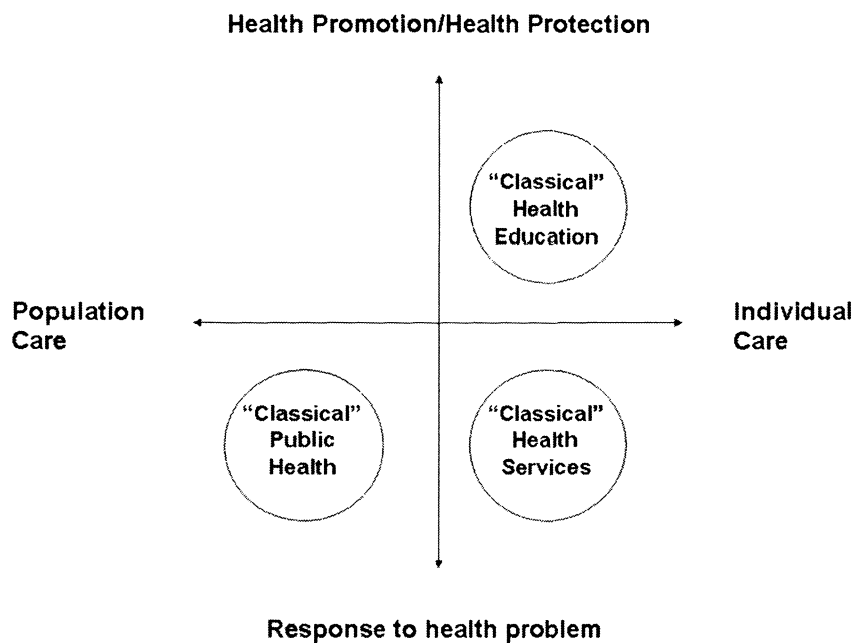
Figure 1: Integrated Model of Healthcare: Mapping of Health Services

The Strengths Based Perspective

The principles of practice in the 'strengths based perspective' originated in the discipline of social work. This approach to working with clients criticises and rejects the traditional paradigm based in scientific medical techniques of identifying pathologies and problems in the client leading to diagnosis and treatment (Blundo, 2001). Instead it purports a new technique in which an egalitarian relationship is

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fostered between the helper and the client to increase the client's sense of self efficacy by building on the client's resiliency, strengths and problem solving skills (Green, Lee & Hoffpauir, 2005). The strengths based approach assumes an alteration in the expert-client relationship which is empowering for the client (Graybeal, 2001). The strengths based perspective has been suggested as a suitable application for family and community support programs (Green, McAllister & Tarte, 2004; Leon, 1999), but it has its most salient application in child and family health nursing as a mechanism for changing existing practice. It is a concept that has been discussed at NSW Child and Family Health conferences (Briggs & Fowler, 2000; Davis, 2003) and appears in government policy documents and is becoming more accepted in child and family health nursing practice.

The differences in approach to the client can be best demonstrated by a comparison between the strengths based perspective and the more familiar needs based approach to patient assessment found in traditional models such as that of Dorothea Orem (Fawcett, 2000), and expressed in the Nursing Process. The first stage in the nursing process is problem identification and the objective is to uncover and describe the patient's 'health need' or to discover where dysfunction occurs. A reductionist model is used, that is, the person is seen to be made up of functioning parts and the identification of pathology allows investigation of causes or antecedents of underlying causes. Intervention includes removing, reducing or modifying to allow correct function to return. The model assumes the practitioner has more knowledge and insights than the 'patient' and the objective gaze of the clinician is the accepted professional stance where the client has a passive role, and is reliant on the expert for diagnosis and construction of the solution (or intervention). This model holds true across biomedicine and is the basis of professional practice in contexts where biomedicine dominates, such as acute care services.

Practising from a strengths based perspective requires the clinician to relinquish the assumptions of the professional. In contrast to the accepted professional stance in which the professional is seen as the expert, an egalitarian relationship is formed with the client. A major issue is then the exercise of power, and particularly the power of expertise (Green, Lee & Hoffpauir, 2005), as the parent is accepted as bringing to the relationship legitimate expertise in their knowledge of their own child. The discussions

that the clinician has with the parent are therefore more about sharing of information and joint decision making than has occurred in the traditional clinical relationship. Furthermore, the clinician is focused not on diagnosing and remedying deficits in the parent, but in identifying and encouraging positives or strengths in parental behaviour and the family environment (De Jong & Miller, 1995). Blundo (2001, p5.) points out that this seemingly innocuous practice is harder than expected, and can become diluted and overshadowed by the familiar paradigms of clinical practice.

> Students and practitioners assume that because they 'think about' strength, add strengths questions to their assessment battery, or use the words, that they have understood the significance these ideas might bring to their practice and to the profession.
> (Blundo, 2001, p.5).

Doing things differently is often met with resistance and adherence to existing practice models. Some professionals will want to maintain the dominant and entrenched and legitimated and familiar clinical practice and just attach a 'modification' (Blundo, 2001). This may work well when the new knowledge is congruent with the principles on which the existing practice is based, so the new knowledge becomes an extension or even a refinement of the present practice knowledge, but Blundo (2001) warns that the danger is that the new model of practice eventually becomes diluted and overshadowed by the familiar paradigm.

Blundo (2001) uses Goffman's (1974) concept of 'frames' to explain the need for social workers to question the taken-for-granted nature of much professional practice. As such, he critiques standard social work practices as being controlling and intrusive. He argues that clinical practice is disempowering if the clinician requires the client to follow her/his rules and manipulates the client situation to enhance compliance with professional decisions or to align the client with accepted attitudes and behaviours. Blundo (2001), citing Margolin (1997), sees this as a central paradox where the client has to 'absorb' the clinician's definitions, interpretations and prescriptions. A good example is the notion of empowerment, which is a practice concept that many nurses espouse. There is much discussion in the nursing literature about empowerment, but the term appears to be poorly understood, although it is frequently cited as a key nursing role (Whitehead, 2001).

Concerted efforts have been made by child and family health managers to change the climate of practice to reflect the strengths based perspective. The most vigorous is the introduction by NSW Health of the Family Partnerships Training, based on the model described by Hilton Davis (Davis et al, 2002). The model targets the 'expert' view of clinical practice and the intention of the training is to challenge clinicians' professional values and beliefs about their practice to force a cognitive shift.

Family Partnership Training

The Family Partnership Model was developed by Professor Hilton Davis, a clinical psychologist at Guy's, King's and St Thomas's School of Medicine and the South London and Maudsley NHS Trust, London. Originally named the Parent Advisor Model, it was developed for family workers without a mental health background to give them basic helping skills in communicating with client families.

The training program in the model developed by Davis and his team was introduced in Australia, firstly in Western Australia and then from 2002-2006 in NSW. The program was re-named Family Partnership Training and consists of a counselling and communication course of ten sessions presented by a specially trained facilitator. The Australian program was in the form of a train-the-trainer program with the intention that those trained by Professor Davis would build capacity in the workforce by training other facilitators, thus enabling the program to reach a wide audience.

The aim of the program was to refresh or encourage the development of interpersonal communication skills in child and family health nurses as practice development. The program was overseen by an Organising Committee, chaired by a senior clinician and comprised of representatives from the then Area Health Services of Hunter and South Western Sydney, the University of Newcastle, the University of Technology Sydney and NSW Department of Health (Vimpani, 2002). The pilot Family Partnership Training program conducted by Professor Hilton Davis in 2002 had sixteen participants drawn from a variety of health disciplines, who were then to act as trainers for further training programs in their respective areas. A second train the trainer program was conducted by Professor Davis, and then the program was contracted to Tresillian Family

Care Centres to be rolled out throughout the State. The pilot program was evaluated and the findings published (Keatinge, Fowler & Briggs, 2007) but further evaluation has not yet occurred.

International Influences

The Ecological Approach in Community Child Health

A major influence on the development of child health policy in NSW is the ecological approach to health care, based on the concepts first proposed by Bronfenbrenner (1972). Such an approach includes an appreciation of the interdependence of the person with their social group and their environment and proposes that health is an outcome of the interaction of a myriad of factors (Scott, 2000). Support for the ecological approach comes from many quarters: economics, environmental science, developmental psychology, epidemiology, sociology and anthropology, epidemiology, medical science and neuroscience (Mustard, 1999) and has influenced government policy development.

From the ecological perspective promoting the health of children begins with supporting parents in their parenting role, so that they can provide the love, warmth and nurture required for the physical, emotional and psychological growth and development of children within a functional family environment. This translates into providing appropriate health care services for maternal and infant health, and strengthening the family to withstand the normal crises of family life. Healthy families are sustained by healthy communities rich in social capital, which support families with opportunities for social interaction and growth, maintain the physical infrastructure for a safe community, and provide children with education for participation in adult society. Healthy communities are, in turn, sustained by healthy environments that promote health through safe water, clean air, food and shelter, supported by healthy public policy, within a society where there is consensus on the conduct of civic affairs for the wellbeing of the citizens (McMurray, 2007). Such an approach recognises the interrelationship between family, community and society in the promotion of individual health and wellbeing. The role of the Government resides in providing the public infrastructure that supports and promotes the health and welfare of citizens. However, health departments do not have direct responsibility for many aspects of community and environmental health, so a whole of government approach is required.

There has developed a view in NSW Health that child health services should not operate in isolation from other service organisations involved with a given community and this is acknowledged in the NSW Child Health Policy (NSW Health, 1999). Child health programs put into place in the past decade, such as Health Promoting Schools, Schools as Community Centres and the Families First Strategy have reflected this view. Such programs are intended to address the determinants of health and build social capital within the communities in which they are placed.

The Early Years and Early Intervention

Research into growth and development in childhood has been slowly putting together the picture of the physical, social and emotional determinants of health over the past 100 years, so that today we are more knowledgeable about the experience of the growing child than we have ever been in history. Recent improvements in medical technology have allowed intimate investigations of the human body and nowhere has this been better demonstrated than in the new imaging techniques that pictured the working of the human brain (Hoon & Melhem, 2000). This area had previously been difficult to investigate, and much of the information was inferential, from animal studies, or from autopsy specimens. Now brain imaging has allowed scientists to clearly see the functioning and developing brain. The result has been a stimulus to child development research in the effects of early experiences on the development of the infant and child. Interest in the physiology of the developing brain and the effects of negative and traumatic experiences were promoted by the work of neuroscientists, such as Bruce Perry, (CITIVIS Foundation, 1996) using advanced imaging techniques that enabled the functioning brain to be examined. These studies provide a neurodevelopmental/neuropsychiatric explanation for the way in which social deprivation and exposure to adverse circumstances in early life have an impact on children's learning and behaviour (Vimpani, 1999).

The brain during early life is known to be malleable, and has the capacity to constantly change its structure and function in response to experiences. The brain is now thought to have high 'plasticity' during early childhood, that is, an ability to adapt and change and grow new cells (Di Pietro, 2000). Although the newborn baby has 100 billion neurones

at birth, the neural pathways that connect areas of the brain are laid down in early childhood, when myelinisation of the dendrites occurs and synapses grow and connect: the brain is said to be 'wired'. The most rapid growth and development occurs in the first three years of life, with brain weight tripling in this time. It is important to remember that synapse formation occurs in response to stimulation. Therefore the everyday experience of the infant of being touched and comforted, and the infant's interaction with his/her caregiver, provides the stimulus that encourages the development of the emotions, the capacity to communicate and the growth of intelligence as the neural pathways are laid down. Lack of stimulation, however, results in fewer or poorer neural connections and leads to deficits in brain development.

The work of Bruce Perry with the Romanian orphans indicated that severe deprivation results in brains up to 30% smaller and lighter than children who had been raised in normal environments (CITIVIS Foundation, 1996). When the infant's experiences are detrimental, such as the effects of living in a violent family or being physically, emotionally or sexually abused, the body responds with raised levels of adrenalin and other stress hormones, bathing the brain in a neurochemical cocktail (Kotulak, 1998). Perry (2001) suggests that when fear arousals are constant, the brain is tuned to a high alert, becoming sensitised and overreactive when new threats are presented. These children have been found to have high resting heart rates, high levels of stress hormones in their blood, and problematic sleep patterns, suggesting that the experience of early trauma has long lasting effects (CITIVIS Foundation, 1996).

The research on brain development has rekindled interest in the effects on the developing child of social deprivation in early childhood and particularly on attachment theory. This work began many decades ago with Renee Spitz's reports in the 1940s of marasmus in war orphans, John Bowlby's early studies on deprivation, Mary Ainsworth's work on secure and insecure attachment and Kennel and Klaus's investigations in the 1960s on infant bonding (Berger, 2006). More recent publications re-emphasise the effects of a deprived environment on the development of primary attachments with caregivers and the effects of this on the psychological and emotional wellbeing of the child (Dowling, 1998; Keating & Mustard, 1999; Erikson & Kurz-Riemer, 1999; Davis, 2000). Linked to brain development theory it makes a powerful case for early intervention.

Fonagy (1998 & 2001) is a strong advocate, and his work highlights the effect of social factors such as poverty, poor home environments, family violence and aversive parenting styles on the quality of the relationship between the parent and the child. He believes that child rearing practices have a significant influence on child behaviour, and that nurturant parenting has a protective influence against the development of antisocial behaviours in children. He supports the view that the mental health status of the mother has a significant effect on the child. Fonagy subscribes to the model which ties the attachment classification system to the development of emotional regulation (1998 & 2001), and claims that securely attached infants tend to grow up to be healthier emotionally and socially and have a more positive self image. In contrast he links insecure or disorganised attachment with increased likelihood of substantial social problems, increased aggression and a variety of psychiatric disorders. He argues that poor attachment makes these children doubly vulnerable, and compounds the load already presented by adverse social and environmental factors. Fonagy's opinion has been publicly supported by the NSW Institute of Psychiatry (Newman, 2000), and has been influential in policy development.

There are many other researchers interested in the effects of poor parent-child relationships and social deprivation. Ross Homel reported in 1999 to the Commonwealth Government on the criminal justice system and made clear connections between criminal behaviour and identified social risk factors, such as family violence, child neglect and cultural discrimination (National Crime Prevention, 1999). United States research has also demonstrated a link between family factors such as poverty, parental rejection and poor parent child attachment and criminal activity (Salmelainen, 1996). Homel (National Crime Prevention, 1999) has also made the argument for providing social and family support as a means of reducing criminal behaviour in children from socially deprived communities. The work of David Olds in the Elmira Project (Olds, 1999, 2005) has been cited as evidence of the efficacy of supporting family functioning to decrease the likelihood of criminal activity in adolescence and early adulthood.

Critics of Brain Development Research and Early Years Agenda

Most of the research findings cited above make a clear case for intervening early in the child's life, and the consensus of opinion is for intervention before the age of three years. There has been such a clamour from advocates for early intervention, that some writers are now cautioning against their evangelistic fervour (di Pietro, 2000), but at this stage the critics appear muted and few in number.

The major criticism of the case for early intervention is that the research base in brain development is not convincing: there is only strong evidence of critical periods in early childhood for vision and language development (Bruer, 1998). Furthermore, the findings of detrimental effects in brain development come from research primarily conducted on abused children and may so not be generalisable to the whole population (Wilson, 2002). It is therefore problematic, argue these two authors, to assume that early intervention in the general population will have the same positive effect as it does in abused children.

Wilson (2002) raises further concerns about the use of brain development research to condone unwarranted intervention in families who do not meet standards of socially approved parenting. These families are labelled as being 'at risk' for reasons that are often beyond their control, such as living in poverty, or for being members of minority cultural groups, and because they may not uphold the approved middle class view of parenting. She argues that the focus on brain development implies the problem lies with the parenting and leads to advocating for individualistic solutions, and as such is similar to the discourse on scientific mothering that dominated the early part of the twentieth century. This detracts from a consideration of the very real social conditions that affect the lives of families and which are beyond the control of the individual.

In summary, the evidence from neuroscience on brain development in the early years is not compelling and therefore the case for early intervention, or privileging this time of childhood above other stages of development, is flawed. Finally, Wilson (2002) notes that 'although neuroscience may be useful for professionals working with child abuse, it has little specific to offer parents beyond the general advice found in parenting manuals' (2002, p.198).

The Political Response

The Early Years Agenda and Lobby Groups

There is now a high level of interest in children's psychological and social welfare from government policy makers, medicine, education, welfare services, criminologists and social commentators. Many of these people have come together to form powerful lobby groups to ensure their message gets to its political target. Internationally lobbyists are sometimes drawn from very eminent bodies such as the Canadian Institute for Advanced Research (CIAR) and the Carnegie Corporation in the United States. The CIAR as a lobby group was influential in persuading the government of Ontario Province, Canada, in promoting a comprehensive agenda centred on the early years which has become internationally acclaimed (Norrie McCain & Mustard, 1999). This program was firmly based on the research into the early years of life which emerged from the research programs of the CIAR (Keating & Hertzman, 1999).

In Australia the principal lobby groups are the National Investment for the Early Years (NIFTeY), and the National Council for Community Child Health (NCCCH), both of which are a consortium of medical, welfare and education groups, but where nurses are poorly represented. Many of the group members are deeply committed to their work and have developed powerful networks with each other, which ensure they are an influential and effective lobby group. Their message is that children should be considered as an investment for society, and they advocate for change across a broad spectrum from social policy, legislation and research through to encouraging new service directions. The Commonwealth and State Governments have responded to the pressure groups with initiatives such as the Longitudinal Study of Australian School Children (by the Commonwealth Government) and in NSW the creation of the Office for Children and Young People.

In NSW the State Government was convinced enough by the evidence on early intervention to embark on a new initiative for children's services that would concentrate on providing quality interventions for families with young children. The whole of government program known as the Families First Strategy included the NSW Department of Health, whose major contribution was to provide a conduit to families through their use of maternal and child health services. To ensure that health staff was

able to access child bearing families and direct them to the broad range of services offered by the Families First program, the NSW Department implemented a raft of health policies. These policies included the introduction of a comprehensive assessment schedule for families to identify those deemed 'at risk', and the setting up of a home visiting program for new parents. These policies had a direct effect on health staff working in maternity and child and family health services, including child and family health nurses.

Potential Effects on Child and Family Health Nursing

Many of the practice concepts described above were introduced with the specific aim of changing practice. For example, the social model of health promotion redirected practice from individual health education to community development and political activism, whilst the strengths based perspective in child and family health nursing and the Family Partnership Model promoted a change in the relationship between clinician and client.

The current policy direction of the NSW Government, influenced by international programs built around the Early Years Agenda and exemplified in the Families First Strategy, has the capacity to change service direction. There is an assumption that there will be a commensurate change in service provision to allow for the new practice approaches to be implemented. There is also an assumption that the clinicians will adopt and adjust their current practices to accommodate the changes.

Following this line of reasoning implies the need for a significant rethinking of existing nursing practice. Such an exercise is hampered by a lack of research. Although child and family health nurses have set down descriptions of their practice (CAFHNA, 2000), there is no supporting research to confirm or deny their claims. It may well be that existing nursing practices are already achieving the aims of the new policy direction, or conversely, that practice has not changed at all.

The impetus for this Professional Doctorate is the necessity for researching contemporary nursing practice in child and family health and for documenting the effect of the introduction of new policy directions on nursing practice. There is a clear need

for nursing research that describes and defines changes to practice, and in doing so to make a positive contribution to best practice in child and family health nursing. This would seem an opportune time to take a searching look at the role of the child and family health nurse in community child health services.

The research study

Goals and Objectives of the Research Study

The stated goal of the research study was to

1. Investigate contemporary nursing practice and service delivery in child and family health, and

2. To explore the impact of recent policies on child and family health services in NSW and the nursing practice of nurses working in the services.

As the study progressed it coalesced into two distinct projects: firstly, an enquiry into the introduction of the major health policies driving change and the effects on nursing practice, and secondly, an examination of the components of contemporary practice in child and family health nursing to understand the extent of the changes that resulted from the new policies. These projects are contained within the Portfolio as discrete monographs, titled separately as the Policy Study and the Nurses Study.

The objectives for the Policy Study were:

1. To investigate the formation and implementation of the Families First Strategy and related health policies in NSW.

2. To explore the effect of the policies on child and family health nursing services and nursing practice.

The objectives for the Nurses Study were:

1. To observe nursing practice in the clinical setting to investigate the nature of contemporary child and family health nursing practice.

2. To explore whether there have been changes to child and family health nursing practices as a result of the introduction of the Families First Strategy and subsequent NSW Health policies.

The Nurses Study was undertaken in two Area Health Services of NSW, one of which was a rural setting, and the other within a large city. One of the Area Health Services had been included in the original pilot program for Families First, and the other was not yet formally involved in Families First at the time of beginning the study.

The Portfolio that contains the dissertation is structured as follows:

This **Introduction** gives an overview of child and family health nursing in NSW and introduces the reader to the components of the Portfolio. It begins with a history of child and family health nursing that traces the development of the maternal and child health service from its early beginnings to contemporary times. For those readers unfamiliar with health services in NSW, it provides the context to the present situation. The history is followed by an exploration of the contemporary influences on nursing practice arising from international research and health care practice. It concludes with a description of the impact of the international evidence in prompting policy activity.

Section 1 contains the Policy Study. A Preface introduces the Study. Chapter One provides the review of the literature taken from political science studies of policymaking. Chapter Two introduces the reader to the context of the Australian political system in which policymaking occurs, and describes the major policies that will be investigated in the Study. Chapter Three outlines the methodology for the study. Chapter Four describes and discusses the research findings. Chapter Five focuses on the contribution of the professional nursing association for child and family health nurses in NSW to the policymaking process. Chapter Six summarises the findings and identifies key issues for further investigation and discussion.

Section 2 contains the Nurses Study. A Preface introduces the Study and Chapters One and Two provide the literature review of child health services. Chapter Two is an extension of the literature review on child health nursing practice published as a paper in the refereed journal *Contemporary Nurse*. Chapter Three describes the methodology used for the Nurses Study, Chapter Four reports the findings and Chapter Five is the discussion of the findings.

The **Exegesis** brings the Portfolio to a close. This is an essay beginning with a synopsis of the major findings of the two Studies outlined above that lead to a discussion of the issue of developing leadership in child and family health nursing practice, education and political activism.

To assist this research project a concept map was constructed to identify the various influences on contemporary child and family health policy and practice. The ideas generated then were formed into a diagrammatic representation to inform the research study. This is reproduced below:

International Research on
• child development in the early years of life
•social & economic determinants of health
•effects of adverse circumstances on brain development
•effects of poor parenting relationships on children's growth and development

Development of New Child & Family Health Services in UK, US & Canada
•Parenting education
•Volunteer home visiting
•Emphasis on intervention in early years of life (1-3 years)
•Nurse home visiting
•Partnerships with other agencies

Development of Health Policy in NSW
•Families First strategy
•Guidelines for Nurse Health Home Visiting
•Child Health Policy
•Integrated Perinatal and infant Care

Political Influences
Prevailing political ideology underpinning decision making
•Health care funding for community child health services
•Pressure on gov't to respond to social problems & social change

THE ROLE AND NURSING PRACTICE OF THE CHILD & FAMILY HEALTH NURSE

Area Health Service response to development of new policy and implementation of NSW Health policies

Historical Influences
•Development of mothercraft services & Baby Health Nurse role
•Dominance of medical model of community paediatrics

Contemporary Influences on Nursing Practice
•Challenge to clinical/medical approach by social model of care
•Challenge to contemporary health promotion practices
•Challenge to revise communication practice to a family partnership model

Figure 2: Concept Map

The central theme of the research study is the investigation of the contemporary role and practice of child and family health nurses, and this is represented in the red square in the centre of the diagram. Although the nursing role has existed since the beginnings of the infant welfare service in Sydney, it has undergone considerable changes, and this is described in the chapter on the history of child and family health nursing in NSW. The research study for this Professional Doctorate is founded on the premise that the

evolution of the child and family health nursing service is again in a dynamic phase when changes are occurring that are likely to have an effect on nursing practice in child and family health. These service changes have been influenced by the developments in research, policy and early intervention programs for infants and young children described in the international literature. This literature is drawn from a large number of disciplines and, when viewed as a whole, represents a new and emerging consensus about the importance of the experiences of the early years of life, specifically from birth to three years of age, on the lifestyle, behaviour and health status of the individual in adulthood.

The map begins in the top left hand corner of the page. The green box in the top left hand corner indicates the range of the research that has influenced policy makers and child health service providers internationally and discussed further in this Section of the Portfolio. There has been great interest in the effects of adverse family circumstances on the development of the infant brain and subsequent life chances for the child. Policy development in child health in the United Kingdom, and Canada in particular, has led the way by developing new service initiatives as outlined in the second green box. Many of the new programs involved nurses working with families with young children in the community setting. The effect has been to stimulate health policy in New South Wales to also develop new service initiatives, as evidenced by the health policy directives in the yellow box.

The NSW government has made a substantial investment in services for families with young children. The major service initiative that had an impact on child and family health nurses was the Families First Strategy and this stimulated the development of a range of health policies addressed at health staff working with children and families, as outlined in the yellow box. The development of these policies has taken place within a political context, and therefore cannot be isolated from the influence of the dominant political ideology of the day, as indicated in the orange box. This theme will be revisited in Section Two of the Portfolio.

In NSW health care services are organised by regional Area Health Services. The structure of the health care system in NSW is described in Section Two of the Portfolio. Area Health Services are expected to implement official policy, as represented by the

second yellow box. Each Area Health Service decides how these policies will affect the structure and function of their specific nursing service providing services to families with young children.

The history of child and family nursing services, and the Mothercraft Hospitals that preceded them, contributes to the work practices and ethic of service to mothers and babies still evident today. This is represented in the blue box on the left of the diagram. There have, however, been recent pressures to change work practices. These new pressures include the promotion of a social model of care in child and family health nursing services and the challenge to established nursing practice. They are indicated in the second blue box and form part of the investigation into nursing practice in this research study and documented in Section Three of the Portfolio.

The Portfolio

The Professional Doctorate and the Portfolio

The aim of the Professional Doctorate program is the development of professional practice, and the dissertation should make particular reference to policy development, leadership and international practice (Faculty of Nursing Midwifery and Health, University of Technology, Sydney, 2007). In this dissertation an analysis of contemporary practice in child and family health nursing is situated within the examination of the development and implementation of NSW government policy. The changes to existing service models required by the introduction of the policies had the potential to trigger changes in nursing practice, but there was little research evidence to suggest how the nurses had responded, and whether leaders emerged to guide a change process. Therefore, the focus of this study is on the impact of significant policies of the NSW Government and Department of Health on child and family health nursing practice.

The final product of the Professional Doctorate Program is a body of work that may be presented in the form of a Portfolio that contains 'artefacts' and an Exegesis that demonstrates how the artefacts contribute to the dissertation (Faculty of Nursing Midwifery and Health, UTS, 2007). This Portfolio has been structured around three artefacts: the introduction that describes the influences on contemporary nursing

practice in child and family health, and two independent but related research studies presented in the form of monographs. The Exegesis addresses the issue highlighted in the conclusions from the monographs of the importance of developing nursing leadership. It explores the necessary conditions that encourage the development of nurse leaders in policy and practice to meet the demands of the changed workplace and to move child and family health nursing forward.

The Portfolio may be represented diagrammatically as follows:
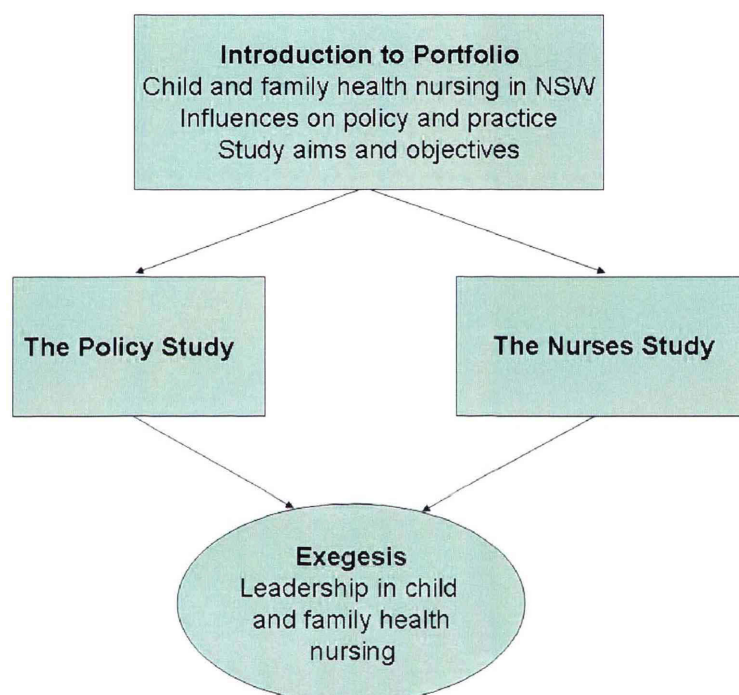
Figure 3: Portfolio Components

Concluding Remarks

In this introduction to the Portfolio I have set out the background, history and contemporary pressures on child and family health nursing in NSW as an introduction to the field under study in the Professional Doctorate. The next section (Section 1) moves on to investigate those aspects of the study related to the implementation of the Families First Strategy and related NSW Department of Health policies.

SECTION 1: POLICY STUDY

PREFACE

For some readers, policy is not a neutral term. It is made controversial because of its connections to politics and politics often arouses contrary views and forceful emotions. For others, policy sounds dry as dust, and the mere mention of health policy may evoke a glazed reaction, particularly if it is viewed as an activity far distant from the realities of everyday work. Health policy, however, is the conduit through which decisions made by the government are conveyed to the public. Australia has a federal system of government so this occurs at two levels, and policy decisions made by the Commonwealth and State Governments are put into action through their respective health departments (Pollard, 1992). Hence, the role of the NSW Department of Health is to make State government decisions explicit to its health workers. Policy therefore is an integral part of the work environment in health care, so it was axiomatic to me that, in investigating nursing practice in child and family health services, the policies that guided service direction and potentially had an influence on nursing practice were also relevant to the research study. Indeed, this research study began with the hypothesis that new directions in health policy in the previous decade had a major impact on nursing practice in child and family health. Further, that the impetus for the emerging policy had come from international policy development and had been influenced by the values and actions of key stakeholders at both a national and state level. All of this necessitated a closer examination of both the policy making process and the policies that emerged to test the hypothesis and to investigate if and how nursing practice had been changed. Consequently key policies were identified that appeared to have had an impact on nursing practice in child and family health services, and ten key stakeholders were interviewed about their views of the formation and implementation of these policies and their own contribution to the policy process.

The Portfolio contains a companion study which should be considered in parallel with this Policy Study. The Nurses Study examines the clinical setting of child and family health nursing, the scope of the nurses' work with their client families and their understandings and perceptions of their role. In the interviews conducted with the child and family health nurses I was interested in the nurses' views of the impact of health policy on their work. Although they rarely voiced it in this way, it is apparent that they were aware of the effect of at least seminal policies on their everyday working life.

Therefore an examination of the health policies that led to a change in the work climate was essential if I was to understand the changes in practice described by the nurses. That is the link between the examination of health policy in this monograph and the Nurses' Study.

This section of the Portfolio contains the Policy Study, which is divided into five chapters. Chapter One provides a review of the theoretical frameworks that support the analysis of policymaking, drawn principally from the political science literature with particular reference to the Australian context. Chapter Two identifies health policies seen as central to child and family health nursing and provides necessary background knowledge for the examination of the selected NSW State health policies in Chapter Four. As the political context within which health policy is made is particular to the Australian system of government Chapter Two also contains a description of the Australian parliamentary system and the structure of the NSW health care system. Chapter Three discusses the theoretical framework for the policy analysis. Chapter Four provides an analysis, discussion and critique of the formation, planning and implementation of the NSW Government's Families First Strategy. Chapter Five describes the role of the professional nursing association and critiques its contribution to the policy making process. A summary to the Policy Study is found in Chapter Six.

CHAPTER 1: HEALTH POLICY – LITERATURE REVIEW.

Introduction

In 1984 Sydney Sax, a noted Australian political analyst, described the making of health policy as 'a strife of interests' (Lin & Gibson, 2003). Policy analysts have taken up the challenge of exploring the controversy involved in policy by asking Sax's three main questions: what is policy, how does it come about and what is the evidence for this claim? In terms of this research project I have reframed the questions as: what is the policy most relevant to this study of child and family health nursing practice, how is the policy-making process explained by those involved and what evidence is used to inform policy? This chapter begins with a discussion of the various forms of policy and the meanings attached to them. I then draw upon the academic literature on social policy as health policy falls within this descriptor. Various models of policy analysis are presented and the factors that impinge on policy making discussed, including the use of evidence from research. From this discussion the methodology that will support the policy analysis in later chapters is identified and described. As such the review provides the basis for the analysis and discussion of the policy making process that produced the NSW Health policies reviewed in this section of the Portfolio.

There has been a growing literature on policy and policy development over the past thirty years. Key contributors to the academic policy literature were identified and their authoritative texts reviewed to introduce the field of study. The most recent editions of most texts were accessed but it was clear that there had been a burst of publishing in the Australian policy literature in the early 1990s and this is reflected in the citations. These authors provided an overview of the major concepts and debates within the policy literature in the Australian context. The literature was then searched using databases such as EBSCOHost and Academic Search Elite to locate journal articles that could contribute to the specific topics of interest that arose out of the literature and were relevant to this study. The database was searched for journal articles, government reports and other items of interest published between 1985 and 2006.

Literature Review

Historical Perspective

The term *policy* derives from the Greek *polis*. Here it was understood as decisions made by the citizens of the state that improved the lives of the people, who lived in the polis, or town or city state, and which contributed to a state of good order (Bessant, Watts Dalton and Smyth, 2006; Colebatch, 2002). Hence, Aristotle, in his work *The Politics,* defined the Greek conception of policy as a positive function of the State that enables the people to live the 'good life' in harmony with the moral and intellectual virtues, and thus live in happiness (Copelston, 1962). Good policy therefore existed for the good of the people. The same notion of policy serving the people and enabling the 'good life' is expressed in more modern terms by Hartley (2006)who identifies enjoyment of good health, freely participating in society and being able to think for oneself as key attributes. Bessant et al (2006) remind us that the same root word *polis* also gives the word 'politics' and that today 'policy' and 'politics' retain their controversial nature since there are major differences among social groups and cultures as to what is defined as the nature of the 'good'.

This view of the end purpose of policy, as delivering the practical good of a happy life, was further developed by thinkers from the European traditions. In 16th century England the term 'policy' was synonymous with improvements in the lives of the population. A century later Adam Smith used the term to refer to the efforts of government to regulate the social order to enable the greatest good for the population of the society. The priority given to the development of civil liberties and rights in the 18th century advanced the notion of all citizens as participants in the political process. This was emphasised by the granting of the voting franchise in the 19th Century (Dean, 2006). Finally the notion of social rights was developed, in which citizens are accorded rights to state welfare provision. So in 19th century England it was accepted that the role of government was to advance 'the greatest happiness of the greatest number' (Bessant et al, 2006, p. 36) and this was done through the formulation of public policy and legislation. This utilitarian philosophy laid the foundations for the modern welfare state with its educational, health and welfare institutions, constructed by social policy.

Social welfare provision in Australia is now a responsibility of both federal and state levels of government. It was originally a state only responsibility as the Constitution only permitted the Commonwealth to legislate in one social policy field, that of invalid and old-age pensions. In 1946 an Amendment allowed power to make laws for maternity allowances, widow's pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services, benefits to students and family allowances (Fenna, 1998).

The family has been central to the politics of the Australian welfare state and the recipient of many social policies including the Family Allowance Scheme (introduced as a child endowment benefit in 1941), the Supporting Parent Allowance (introduced by the Whitlam Government of 1973), the Family Income Supplement (introduced by the Hawke Government of 1983), and more recently the 'Family Package' introduced by the Howard Government in 1996. Indeed, Fenna (1998) considers that family policy has been a growth industry. The NSW State Government has also been active in legislating child health and protection policies, such as those to be considered here.

Definitions of Policy

The contemporary meaning of the term 'policy' has various interpretations, so much so that many of the writers on political studies begin with an attempt to define 'policy' (Bridgman & Davis, 2003; Colebatch, 2002; Davis, Wanna, Warhurst & Weller, 1993; Levin, 1997: Lin & Gibson, 2003). There are three central elements in the use of the term: order, authority and expertise (Colebatch, 2002). Hence, policy is not arbitrary but has a purposive element with some end goal in mind, that is, it is intended to achieve a particular outcome (Bridgman & Davis, 2003). Policy becomes Public Policy when it provides legitimate force for others to act, as, for example, when government legislates and this is applied in law (Fenna, 1998); policy comes into existence by the efforts of those with policy knowledge of the problem area and what might be done about it. Colebatch (2002) points out that these attributes are not all present equally and may in fact operate against one another, so that in the development and implementation of policy there may be a continuing tension between them.

Policy may be described as the expression of the values and aspirations of Government as a whole, which Stewart (1999) characterises as big P policy concerned with politicians and the media. It can also be viewed as the outcomes and activities of various public agencies, the level at which all players, including public servants, are active and shaping public policy. Or the term can refer to the intention to commit resources to a program (Considine, 1994). It may describe major decisions of government to commit to various actions, documents and particular decisions as well as to political and bureaucratic processes. So the term could be as easily applied to a formal written document as to a set of ideological positions that drive actions, and in government both forms may be used.

Levin (1997) emphasises the importance of policy as a commitment to future action. That is, it is not just an expression of aspirations or isolated action but an intention by politicians and officials to commit to a course of action and actively proceed.

> The measures by which this is done include legislative (Acts of Parliament and delegated legislation), public expenditure (allocating funds among departments and categories of expenditure) organisational restructuring (abolishing or modifying structures) and a variety of management activities (making appointments to positions, setting performance targets, prescribing organisational practices and supervising the activities of provider, purchaser and executive organisations).
> (Levin, 1997, p.20)

Social Policy

Social policy is the term applied to those actions of the State that are concerned with the welfare of its citizens (Hill, 2006). Distinctions can be made between social and general public policy (Colebatch, 2002) such as those between public policy, economic policy and social policy (Pollard, 1992), although social policies are regarded as being interlinked with the other types of policy (Hill, 1997). Social policy requires resources to meet social needs, so it is seen as an integral part of economic policy, which in turn is embedded within public policy. Social policy may be defined by its fields – health, housing, education, social security and personal social services. Levin (1997) also includes industrial and workplace relations, noting that this field brings the world of work and the private and personal life of the citizen into the remit of social policy. The purpose of social policy is promoting social welfare and it is especially concerned with

the welfare of the most vulnerable citizens (McClelland & Smyth, 2006). Social policy may be used by governments to modify the uneven social impact of the market economy (Fenna, 1998) and there is much controversy about the appropriate role of the state in relation to its citizens (Hill, 2006).

An alternate view of social policy suggests that not all policy arises from altruistic motives. Hill (1997) points out that welfare policies are not necessarily formed from humanitarian concerns to meet need, but prompted as a response to social unrest and that this is particularly true of social security policies. Although the good of the citizens is often the driving force mixed motives exist for some policy-makers and therefore social policies should not be interpreted as being only altruistic with the welfare of the public in mind.

In summary, social policy addresses social needs, issues or problems and has a direct impact on the lives of citizens and as such is highly political. It is best understood as an activity of government that involves the attempts by policy makers, interest groups and other stakeholders to define given social problems and to construct solutions to address them.

Models and Approaches to Policy Making

The study of policy as a separate discipline distinct from government or public administration first emerged in Australia three decades ago as a way of analysing the decisions of government and the effects of those decisions (Davis et al, 1993). Australian researchers have drawn on the development of social policy as a discipline in the U.K., particularly the work of Richard Titmuss (McClelland & Smyth, 2006). Since the 1960s there has been a shift in the emphasis of the studies from public administration to public policy, principally about what constitutes public policy and the analytical tools to examine it. Public policy as a field of study is considered to be more political than the study of public administration.

One of the first Australian academics to study the field was Forward (1974) who noted this tendency of social policy analysis to expand into a discussion of politics and social values. Forward and his contemporaries identified three important areas of study within

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public policy analysis: models of decision making at a macro level, examination of policy content, and the development of techniques to evaluate and improve the content and process of government (Forward, 1974). Three decades later McClelland and Smyth, (2006) described the study of policy as being an examination of the policies themselves, how the policies were conceived, planned and implemented and the subsequent impact of the given policy.

Whilst early researchers adopted mostly a structural functional analysis of the process of policy making, other research approaches have developed. For example, policy researchers may use comparative studies of actual cases, or analyse the process and outcome in an interpretive approach (Colebatch, 2002). The study of policy may be viewed from a theoretical perspective, drawing on political and social theory to explain the complexity of the policy making process and the relationships between the people that contribute to the process (Palmer & Short, 1994).

Colebatch (2006, p7.) is an important Australian author on policy, who identifies three main approaches to policy analysis in the literature: policy as authoritative choice, policy as structured interaction and policy as social construction. In policy analysis that takes the authoritative choice view, policy is seen as a decision making activity usually involving authorised decision makers such as ministers and senior officials who work with them. This is best exemplified by the Bridgman and Davis (1993) model in which policy officials' move around the policy cycle and which will be described below. The aim of research using this model is to identify and describe the policy players and the decision making process. It is the dominant paradigm in that most writers implicitly or explicitly adopt this mode of policy analysis (Colebatch, 2006). This analysis aligns with a structural-functional approach in that it is linear, frequently top down and does not specifically critique the influence of policy actors and values.

In the structured interaction approach, government is an arena in which a variety of different actors interact with one another. This perspective takes into account the large number of people beyond the formal lines of authority that may be involved in policy making, and is focused on analysing the manner in which their different agendas and concerns are incorporated into policy. The various players may include many outside of the formal policy circle and this 'policy community' (Richardson & Jordon, 1979) is

described as 'a relatively small number of regular players linked by a shared interest in the problem, mutual recognition and mutual dependence' (Colebatch, 2006, p13) as well as a shared understanding of the policy issue that maintains them. The attention of this research activity is focused on identifying the various players, the interaction between them and the manner in which they interact to arrive at a mutually acceptable outcome.

The third perspective centres on policy making as an exercise in social construction, that is, the manner in which social problems are conceptualised and how the proposed solutions are framed. Research interest here is on the construction of meaning, on what knowledge is identified as valid and relevant, and how participants make sense of the world. This approach is more informed by critical social theory and is described as:

> The focus is on the underlying processes that shape social action; along the way that practice is described and recorded, knowledge is assembled, expertise is recognised and certified, forms of reporting and accounting are devised, problems are identified, and ways of governing practice discovered.
> (Colebatch, 2006, p9).

Rational Comprehensive Models

The first attempts by policy researchers to describe the policy making process were known as rational models. The 'rational comprehensive model' was developed as an idealised model of decision making. It follows a logical, ordered sequence that considers and compares all options available to the policy maker to ensure a 'rational' outcome by selecting the most effective means of achieving an end.

The model has six basic steps:
1. a problem must be defined;
2. the values, goals and objectives of the decision-maker must be determined and ranked in order of priority;
3. all the options for achieving the goal must be identified;
4. the costs and benefits of each option must be determined;
5. costs an benefits must be compared;

6. on the basis of this comparison, the rational decision-maker selects the course of action which maximised the outcome in line with the value, goals and objectives identified in step 2.

(Davis et al, 1993, p. 161.)

This model has been criticised as unrealistic (Davis et al, 1993). There were early doubts about the efficacy of the model for not taking into account numerous factors that may upset the process, such as difficulties with defining the problem, making known the values of all participants, conflict between values and goals, lack of resources for the solution reached and so on. The model works as if an individual were making the choice when in reality the process of policy making involves many groups. It is arguable whether this model works at all in practice. As a response to criticism, Herbert Simon developed the concept of 'satisficing' to explain why policy makers chose to relax the criteria of strict rationality in order to satisfy these other demands (Simon, 1957 cited in Davis et al, 1993).

Alternative Models

Responding to criticism of rational models, an alternative was proposed by Lindblom (1980), who claimed that his model was a more realistic description of how governments and officials make decisions. This model, known as 'incrementalism', acknowledges the difficulties of the rational comprehensive model and instead proposes that if problems are contingent, and information limited, then approximations is all that is possible. Decision-makers, when faced with a problem in the process tend to fall back on familiar alternatives until an acceptable compromise is achieved and the block in the decision making process removed so decision making is more a series of incremental decisions that are reviewed and modified. Lindblom (1980) contended that this method, which he called 'muddling through', is closer to the usual problem solving methods that people employ.

These two models dominated early work on policy making. Later theorists attempted to combine the best aspects of these two models. The 'mixed scanning' model proposed by Etzioni offered a process using the comprehensive overview but acknowledging that policy details were determined incrementally. Dror suggested a refinement to the

rational model by taking into account intuitive components in the process (Davis et al, 1993). However, the same criticisms that applied to the rational model also apply here.

Other policy research critiqued the linear or rational actor view as being static and rule bound. Systems theory is one such, where the policy making process is viewed from the perspective of systems analysis, using the language of inputs, outputs and feedback loops to describe the cause and effect of policy development (Considine, 1994). Easton (1965, cited in Considine, 1994) pioneered the application of systems theory to the study of policy. He viewed policy making as a process that interacted with the political and social environment by responding to demand (inputs) and outputs (programs). In this analysis policy making is a much more dynamic process, capable of responding to change and being informed by feedback from other actors in the environment (Lin & Gibson, 2003).

Still others have argued that policy making is irrational and turn to explanations such as the 'garbage can' solution proposed by Cohen, March and Olsen in 1972 (cited by Davis et al, 1993: Levin, 1997; Mason, Leavitt & Chaffee, 2002). This model of policy making is the antithesis of logical decision making. It proposes that when a crisis arises that needs an immediate or definitive response politicians and officials seize the opportunity to put forward an existing proposal, and often one that they personally favour. This is not so much a reasoned response to the situation but the promotion of solutions that were waiting for the right problem to appear; 'it is as though a decision-maker reaches into the garbage can to pull out a problem with one hand, a policy proposal with the other, joins the two together and proclaims a resolution. A garbage can contains 'answers in search of a suitable problem' (Davis et al, 1993, p 172). Lin and Gibson (2003) suggest that Cohen et al's 'garbage can' model may be the more accurate description of real life practice as there is a reservoir of ideas and choices in organisations that may be discovered as preferences when the right decisional situation arises. Utilising Cohen et al's notion of solutions waiting for the right opportunity, Kingdon (1995) described three spheres (he referred to streams) of activity in which 'garbage can' options operate: the problem stream, policy stream and political stream. When any two of these streams coincide their shared needs opens the window of opportunity for possible solutions to emerge (Mason et al, 2002).

Public choice models offer another view of the policy making process, suggesting that policy can be influenced by the lobbying of organised groups. Thus, groups of individuals, or businesses or those representing industries organise into 'distributional coalitions' (Olsen, 1965, cited in Davis et al, 1996) to secure benefits for themselves or their representatives and to further their interests and influence. Public choice theories remind us of the importance of considering the use of power in the policy making process and of the dangers of allowing policy making to be overly influenced by organised lobby groups. However, public choice models have also been criticised as too narrow and not fully taking into account the dynamic nature of the interaction between the political process and the organised groups that seek to influence it (Colebatch, 2002).

A critique of the staged rational view of policy making is offered by Sabatier and Jenkins-Smith (1993), who contend that the model fails to provide a clear basis for empirical testing as it is descriptive rather than analytical. As an alternative they propose the Advocacy Coalition Framework (ACF) as the basis for analysis of policy. The basic premise of the ACF is that policy is driven by a policy subsystem of policy actors who may come from a variety of public and private organisations, and who share normative and causal values and beliefs that ensure they usually act in concert (Sabatier & Jenkins-Smith, 1993). They include administrators, legislators and policy makers from all levels of government as well as interest groups, journalists and researchers. It appears that they do not need to be known to each other as members of a coalition, because their shared beliefs form the core set of values that result in them supporting similar policy solutions. This core set of values develops over a long period of time, usually a decade, and reflects accepted knowledge at the time. The collective view of the policy actors is informed but may be challenged by research and other new knowledge and thus develop new directions. The ACF challenges the rational comprehensive model and offers policy analysts an alternative methodology with which to critique policy making. It is a truly comprehensive model, requiring the analyst to take into account social, legal and resource features of the society as well as the policy subsystem in which overt policy making takes place (Sabatier & Jenkins Smith, 1993).

The Policy Cycle

The 'stage' or 'policy cycle' approach arises from the rational comprehensive model and views policy making as a logical progression through a cycle of decision making and implementation which can be identified and analysed (Colebatch, 2002). Anderson (1979) offers a simple organising framework that follows the policy cycle model. This framework identifies the key stages in the policy making process as follows

> Agenda setting
>
> Policy formation
>
> Policy adoption
>
> Implementation
>
> Evaluation

This is an orderly progression of events that assumes there is a logic and structure to the policy making process and that policy makers are orientated to objective knowledge and comprehensive analysis (McClelland & Smyth, 2006). Hence attention will be paid to the identification of the key stages of the process and the consequences of the proposed policy.

Bridgman and Davis (2003) are acknowledged as the authors of the leading text on Australian policy (Colebatch, 2006). They propose a more complicated version of this model of policy making, which they contend fits the Australian political context. The authors recognise that such a model is by nature simplistic, but gives an indication of the steps that policy makers should at least include at some stage of their policy making process. Further, it provides a basis for analysing case studies of policy, as is demonstrated by McClelland and Smyth (2006), who adapted the Bridgman and Davis model in their analysis of contemporary Australian policies.

Bridgman and Davis describe the policy cycle thus:
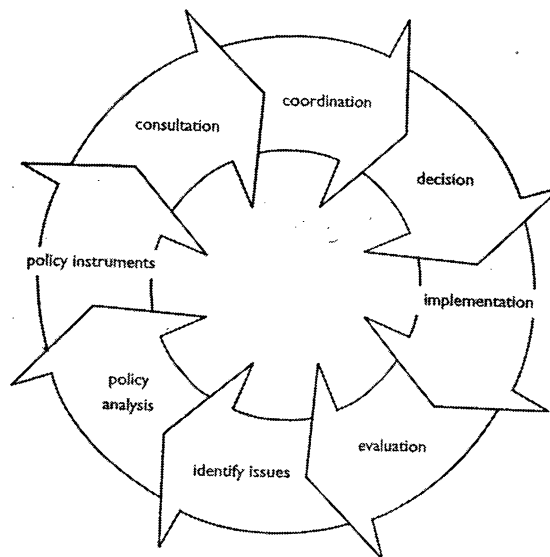
Figure 4: The Australian Policy Cycle

Source: Bridgman, P. & Davis, G. (2003). *Australian policy handbook.* (Ed. 3). St. Leonards, NSW: Allen & Unwin.

The process begins with the *identification of issues*. This is sometimes described as agenda setting and usually involves a number of stakeholders, including those wishing to influence the government to act on social issues for which they are campaigning. Agenda setting is when the norms are defined that determine how the problem is to be viewed or even what problem will be considered whilst others will be disregarded. It includes questions of power and influence over agenda setting and how social norms shape the problem. Fenna (1998) cites a substantial body of literature that considers agenda setting as the most significant phase. The emergence of an 'issue' becomes a matter for public policy when concerned interests and actors manage to get that issue placed on the political agenda. It often is followed by an investigative government response such as a Green Paper and the government's position is then shaped up and published as a White Paper spelling out policy intentions (Fenna, 1998).

Once an issue has been given prominence *policy analysis* begins. This stage is intended to provide policy makers with information about the social problem that leads to an informed judgment. It typically takes the form of briefing papers for officials and ministers.

If it appears that a decision to act is likely, then appropriate *policy instruments* must be identified. The intervention may be through legislation, or the introduction of a new program, or the modification of existing services. It is at this stage that appropriate policy responses are identified. Policy instruments are forms of intervention that include exhortation (advertising), economic incentives and disincentives, provision (when governments step in and undertake desired activity), regulation (legislation). The policy mix means that more than one instrument will be used at a time.

The introduction of a new policy may involve many agencies and other government departments, which will have to be consulted, and their views and requirements taken into consideration in the planning process. At this stage non-government interests and external expertise will be consulted. *Consultation* leads to ideas being tested, proposals improved and support gathered for the emerging policy.

When the policy has developed to the point where it is being considered by the government, then necessary *coordination* between various central agencies and other instrumentalities must be addressed so that agreement is reached on the policy strategy.

Once the groundwork described above is in place, then the submission goes to Cabinet where the government must make a *decision* on whether or not to proceed. Policy making is often not a single decision but a web of decisions taken over time.

Policy is also non-decision or a process of succession. As Bridgman and Davis (2003) point out, a non decision is still a policy decision and inaction is also policy making. Sometimes government chooses not to act and the lack of formal policy means that the problem stays submerged, making them less accountable (Fenna, 1998).

If approval is given, then the *implementation* phase begins. 'An individual, institution or government can only be said to have a policy when clear measures have been taken to make the intention a reality' (Fenna, 1998, p5) so some attempt at implementation is required, but as Fenna notes, it is a long way from making policy decisions to making policy work. Implementation is a complicated process and one that is frequently fraught with difficulty (Hancock, 1999).

The final phase in the cycle is *evaluation*. The results of the evaluation may lead to a reconsideration of decisions made and prompt a fresh cycle of policy making.

The Bridgman and Davis model recognises the three spheres of activity in the Australian political system through which the policy cycle must travel as the political, policy and administrative sphere. The political domain includes members or groups in the community with an interest in the social problem and the elected politicians; the policy domain includes all agencies and departments involved with policy planning and implementation and the administrative domain includes line agencies supporting the process. Although much of the work of policy making occurs in the policy and administrative domains where the public service and other government instrumentalities reside, the three domains have an impact on each other. Social policy progressing through the policy domain with officials in government departments may be subject to pressure from the political domain and influenced by the activities of senior officials and ministers in the administrative domain. Crucially, Jamrozik (2005) has recognised the importance of the service personnel who put the policy into practice. He also proposes a three level model that differs from Bridgman and Davis by nominating the three spheres of activity as political, administrative and operational. It is in the latter sphere of activity that policy planned at the upper levels is interpreted at a local level and put into practice by service providers such as child and family health nurses and their managers. Implementation of policy as it may have been conceived and intended at the upper levels is not necessarily assured. There are many factors involved, such as local issues, the complexity of the service organisation/s involved and the values and interests of the service providers that determine how the designated policy is interpreted and finally put into practice (Jamrozik, 2005).

The policy cycle approach, as exemplified in the Bridgman and Davis model, provides a structural functional analysis of policy making. This has also been called the rational actor viewpoint (Levin, 1997) in that it assumes the procedures for decision making will result in order and efficiency and take into account expert knowledge. As such, the process of policy making is coherent and hierarchical, embodies authority and is instrumental in pursuing particular purposes (Colebatch, 2002; Lin & Gibson, 2003). Rationality has benefits, and according to Dalton, Draper, Weekes and Wiseman (1996)

these include attention to information about the consequences of policies, the identification of key stages and the bringing of order to a complex process. However, Dalton et al (1996) criticise this model as too simplistic and not reflecting real life situations where the influence of power and politics, the role of values and the need to compromise interferes with the objectivity of the process. Bridgman and Davis are aware of these critiques, recognising that 'policy making is not a strictly logical pursuit, but a complex and fascinating matrix of politics, policy and administration' (2006, p23).

Colebatch (2002) recognises the usefulness of the policy cycle approach but critiques it as being a one dimensional view of policy making. Policy making is seen as primarily the business of politicians and senior officials, in which decisions progress from the top and down the line, are referred to as the vertical dimension, where policy is seen as authorised decisions to be put into action. Policy is also formed through the actions of other participants, such as interest groups, advisors and lobbyists so policy making has another dimension outside of the line hierarchical authority – the horizontal dimension - concerned with the understandings, commitments and actions of the many participants outside of the authorised decision making stream.
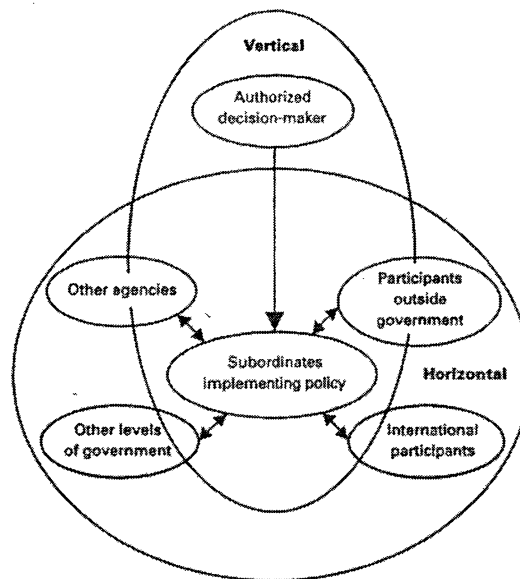
Figure 5: The Vertical and Horizontal Dimensions of Policy

Source: Colebatch, H.K. (2002). *Policy* (2nd ed.). Buckingham, U.K.: Open University Press.

In this view policy development is a complex process that involves many stakeholders and players and a convoluted intermeshing of values and interests within the exercise of power. Considine places emphasis on the actions of 'policy actors', whom he describes as individuals or groups able to take action on a public issue and who 'use the available public institutions to articulate and express the things they value' (1994, p4). The policy actors seek to influence the policy makers, such as key politicians and bureaucrats within the government departments who have the power to make and approve policy decisions. Policy analysis must therefore include considerations of who has influence and who is excluded. Policymaking may then be considered as a kind of game, in which policy actors seek to persuade policy makers to convert their values into real programs. However, Considine (1994) cautions against the game analogy with its emphasis on strategy alone, and argues for a consideration of the social environment and contexts in which policy making takes place.

The ideas and values held by the various players have a considerable influence on policy direction. Whether explicitly acknowledged or not, the political philosophies held by the policy players underpin their actions. Dalton et al (1996) identify four major philosophical traditions: libertarian, social liberal, egalitarian and communitarian. The libertarian tradition accepts the dominance of individual self-interest and places a high value on the market place as an economic regulator, asserting the citizen's right to act free from (government) coercion. It is reflected in neo-liberal economics and expressed as new-Right political ideas. The social liberal tradition, whilst holding individual freedom highly, sees this as the means for individuals to achieve certain goals, again through the marketplace. It is reflected in social liberalism. The egalitarian tradition reflects a social democratic philosophy that emphasises the equal rights of citizens, including social rights, and favours redistribution as a mechanism to allow citizens the freedom to achieve their goals. Lastly, the communitarian tradition places high value on cooperation and the promotion of the ideal of the community as mechanism to allow citizens to develop to their full potential. In this view some restrictions on individual freedom are acceptable if they provide a benefit to the community.

McClelland and Smyth (2006) add a fifth, the conservative tradition, which they see as the political philosophy behind the Australian Liberal Party policies. In this view high respect is accorded to social institutions such as the family, community, religion and

private property together with an emphasis on order and authority (2006, p23). The key difference in each of these traditions is the view of the person as having and asserting individual freedoms versus the more socialist ideology of social equality and the value of community action. If social policy is essentially about meeting social needs, then the ideals held by policy actors will influence their value orientation to social needs of citizens, their rights to have these needs fulfilled and whether or not they are deserving of claims on the state (2006, p28). Hill (2006) points out that there is a difference between 'needs' and 'wants' and part of the policy process is distinguishing between those two terms.

The policy making process requires decisions about how to define the problem and how to officially respond to it, who to listen to and who does not hold a place at the table, and what evidence should be taken into consideration. To treat social policy as impartial service provision ignores the contested nature of policy making. Institutional structures in government are complex and individual actors may have more difficulty in being heard. Collective interests are often expressed through political actors such as interest groups and political parties and some interest groups manage to insinuate themselves into the decision making process or become part of the policy making network (Considine, 1994). Various interest groups represent a view on a given problem and seek to have their definition of the problem and perhaps solution accepted as the best course of action (Fenna, 1998).

Policy communities are formed when key members of pressure groups build up working relationships with officials in relevant government departments (Davis et al, 1993). Over time they get to know each other and pressure group leaders may serve on advisory committees or be invited to make submissions. Davis et al (1993) describe a phenomenon called the 'circulation of elites', whereby members of pressure groups may be appointed to government departments or government officials may be employed by pressure groups. These people may have common interests and may have a common professional and educational background, as is found in health where '…health department officials, the AMA, general practitioners and specialists may all work within the values of a medical training. This common background can be reinforced by a professional association which holds conferences and regular meetings' (Davis et al, 1993, p 143).

A probing analysis of policy is advocated by Levin (1997), using a heuristic technique. Levin's approach is to explore the phenomenon under discussion using sets of questions to 'interrogate' the policy making process (1997, p.31). Each set of questions arises from a conceptual framework that shapes and colours the interrogators' perceptions of the phenomenon under study. By approaching the phenomena from these different perspectives, a more complex analysis is obtained that provides a multidimensional perspective of policy making. There are four such frameworks, as described below.

The first conceptual framework views policy as the product of a rationale, and interprets it as though it was a consequence of a set of rational actions based on clearly defined aims, goals or objectives that are intended to produce desired consequences. As Levin describes it "the conceptual framework is one of perceived 'means and ends', logically connected and hence mutually consistent (1997, p33). This approach assumes the policy maker is designing goals and actions on a rational basis, after taking into consideration the means and ends to do so. The questions are designed to probe the logic behind a proposal or policy rather than taking it on face value. Levin (1997) poses questions that probe the particular perceptions, theories, ideas or value judgements that dominate the rationale and consider whether they correspond to the views of any particular person or group. He asks questions about the extent to which perceptions conform to what might be called 'reality', that is, the situation in the real world.

The second conceptual framework identified by Levin (1997) turns from examining policy making as an ordered, rational mechanism and attempts to identify political considerations that may have influenced policy makers or at least were part of their conscious thinking in developing the policy. The conceptual framework is that of 'interest', that is, who stands to gain or benefit from the proposed policy. Levin distinguishes between political/institutional interests and consumer interests and notes that while the advocates of consumer interests may emphasise this effect of the proposed policy, there is rarely an open acknowledgement of the perceived benefits to themselves in terms of careers, personal aspirations and reputation of the policy makers. Here Levin (1997) is probing whose interests made a mark on the policy, in the sense that they stood to gain from it. That includes stakeholders whose personal position, reputation, self esteem or careers are at stake. Interest may also include that of the

consumers, and whether they stood to lose or gain, and asks whether the documentation suggests that an attempt was made to identify potential gainers and losers.

The third framework takes into account the events and activities that took place in the course of the policy's formation and implementation. It looks at the matters that first prompted interest in the issue that led to the policy's development, how the policy was brought to the attention of the policy decision makers, and the events that took place as the policy was formed, published and formally instituted. The questions that arise from this perspective include defining the motives and the actions of the policy actors involved. Consideration should be given to the chronology and the landmark events that occurred, as well as the key actors in the policy making process, their actions and the effect that had on the progress of the policy.

The fourth approach views policy as a reflection of the existing power structure, that is, those institutions and formal positions in government and the bureaucracy, as well as the people who occupy those positions. The administrative structures have a profound effect on the way policy is conceptualised and formulated, so that, for example, policy originating from within a given department will almost certainly reflect the orientation, values, and concerns of that department of government. The problem and the policy solution correlate with the position of the department. It is possible for outside interest groups to persuade the government or department to consider their point of view, but the dominant interest will be that of the existing power structure. The capacity to exert pressure includes the 'power to do', as well as 'power over' persons, actions and events and also the 'power to achieve', as in have the means to enact the policy. Levin suggests policy analysis should consider how power can be asserted by applying pressure or influence, and the communication channels used by powerbrokers, such as access to the policymakers.

The four approaches used by Levin (1997) highlights the human psychology of policy making:

> When we view policy as a reflection of the power structure, we encounter the propensities of some people to see the world of government and politics primarily in terms of territories, or networks... The mechanisms encountered when we view them as the product of a rationale are essentially intellectual ones, to do with ways of thinking and reasoning. .... Those encountered when we view them as a selective response to interests are essentially to do with feeling as opposed to reasoning. The policy maker is implicitly seen as an 'emotional actor' rather than a 'rational actor' and the interests of different individuals and groups make their mark on policies and measures via 'personal' mechanisms, such as empathising or making moral judgements.
> (Levin, 1997, p62).

The Use of Evidence to Inform Health Policy Making

Policy makers draw on many sources of evidence, such as expert knowledge, existing statistics, stakeholder consultations as well as scholarly research (Edwards, 2004). Although good quality policy making depends on sound evidence commentators have acknowledged the nexus between policy making and research is fraught with difficulty. This section will look at the debate about the use of research in policy making and consider some solutions to bridging the divide.

It has been suggested that researchers and policy makers operate in different contexts and are motivated and constrained by dissimilar expectations and priorities, sometimes described as the 'two communities' model (Edwards, 2004). In this view, they 'speak different languages, have different motives, face different organisational constraints and incentives and have different world views' (Lin & Gibson, 2003. p.102). For instance, research findings by their very nature often address narrowly defined research questions, whereas policy makers may be grappling with complicated social problems and require a broader approach to the problem (Gold & Fries Taylor, 2007). Hence the results of pure research, particularly based on positivist, reductionist empiricism are likely to be insufficient input for policy development (Lin & Gibson, 2003). Policy makers may have goals other than clinical effectiveness and the research evidence may not be seen as relevant, or its applicability may not be evident. Factors such as lack of

consensus amongst researchers or competing evidence may discourage policy makers to utilise research findings. Such is the nature of the cultural divide between them.

An alternative to the 'two communities' hypothesis can be found in the work of Sabatier and Jenkins-Smith (1993) and the advocacy coalition framework (ACF). They do not envision researchers as a separate community, but as members of 'advocacy coalitions', which are groups of policy actors who share similar beliefs and values and who seek to influence policy formation. From this view, Lin and Gibson (2003) suggest the point of resistance to research is not between researchers and policy makers per se, but between advocacy groups seeking to influence policy, and which would include researchers and policy makers as well as others who seek to influence policy. Coming together in 'advocacy coalitions' such groups work from shared value systems including values and beliefs about research activity, worth and applicability to social problems. Advocacy coalitions may hold conflicting belief systems and researchers may find themselves on opposing sides, depending on their affinity to one or more advocacy coalitions (Lin & Gibson, 2003). The advocacy coalition framework also holds that research has an educative effect on members of the coalitions by providing them with alternative views and solutions to problems. Although research may not have an immediate or primary effect it can contribute to the values and goals of the coalition group, described as an 'enlightenment function' (Sabatier & Jenkins-Smith, 1993, p5).

The impact of social science research on health policy has been examined in the sociological literature. There are four models that are said to explain differences in the attitudes to and use of research in policy making and these will be briefly explained as described by Short (1997). The *engineering* or knowledge driven model assumes that good research will be disseminated, recognised for its intrinsic worth and then taken up and acted upon. This is grounded in the academic belief in the intrinsic worth of the research process itself, a view which is not necessarily shared by policy makers (Edwards, 2004). The *enlightenment* model suggests that research findings will gradually infiltrate into the many channels that inform the world of policy makers through a slow process of diffusion. The obvious difficulty is that there is little or no direct influence on policy decisions, as the model relies on the ideas generated by research becoming part of the values system of the policy makers. On the other hand, the *materialist* model, suggests that the influence of research in health policy is

exaggerated and that pragmatic matters such as economic considerations have far more influence. The final model and the one which Short (1997) favours, is the *elective affinity* model. This model suggests that a direct relationship between research and policy outcomes is unlikely except where the research fits with the values and needs of the policy community. Thus, some research may be advanced, whilst other is ignored. This model views research as 'one piece of the complex jigsaw of policy making' (Short, 1997, p71), contributing to, but not a single driving force, in the policy making process.

There is no guarantee that research evidence will guide policy planning and implementation. The reality of the policy making process is often a response to perceived problems whose definition is highly dependent on contexts (Lin & Gibson, 2003). It may owe more to economic constraints, political expediency, changes in ideology and the organisational imperatives operating within the existing systems than to any clear evidence that change was required. Social values, the political will at the time and the practicalities of policy implementation are among other factors that may have a greater influence on decisions of policy makers than research.

There are recognised examples of policy making in Australia where the relationship between health policies and research evidence is not obvious (Lin & Gibson, 2003). One such example is the introduction of a new administrative health framework in 1986 that broke the previously centralised NSW State health service into decentralised, relatively autonomous Area Health Services, the administrative pattern which still holds true today. The authors cite the work of Lawson and Davis (1992) as follows:

> In 1986, the NSW health system was characterised by the media as in crisis. A new health minister needed to present the public with the solution to the system's ills and demanded that the bureaucracy come up with some immediate solutions. It so happened that the evaluation of four pilot area health boards was nearing completion, along with another study of a range of models to improve coordination of health delivery. These became the basis for the policy announcement by the Department of Health.
> (Lin & Gibson, 2003, p 12).

Another example involves the introduction of casemix funding in Victoria:

> For some years, policy makers had been amassing information about hospital performance and efficiency but policy makers had been reluctant to commit to radical reform. It was when the political opportunity emerged, with a new reform-oriented government looking for an acceptable way to pass on severe budget cuts, that casemix analyses provided the evidence base and emerged as a logical solution.
> (Lin & Gibson, 2003, p 12).

Research results are only one small force amongst the many that influence decisions of policy makers. Although researchers may consider themselves as having special status, there are many interest groups trying to catch the attention of the policymakers (Trostle, Bronfman & Langer, 1999). It is known that policy makers will be much more favorable to research findings if they themselves participate in the research, or if the research findings support their preferred policy positions, and especially so when the research results are compatible with their own values (Short, 1997). It has been suggested that part of the problem lies in the ineffective transmission of research knowledge by researchers, and researchers have been encouraged to 'champion' their research studies by making them more accessible to policy makers (Short, 1997).

There are considerations to observe for researchers wanting to influence policy making. Trostle et al (1999) confirm that policymaking and research are different processes but there are places in the policy making process that provide opportunities for policy makers and researchers to learn from each other. When these occur, researchers must recognise such opportunities and maximise them. How the research is presented is important. Policy makers need information to help them make a decision, and Briss, Gostin, Gottfried and Snide (2005) urge researchers to consider the needs of policy makers, what information is most useful and how this can best be presented to the policy makers. Researchers can assist policy makers to choose from amongst the large amounts of research evidence available to them by presenting the most credible evidence in an acceptable format. Gold and Fries Taylor (2007) suggest that there is an advantage when the researcher is part of the system, that is, an 'insider', as it gives them knowledge of the corporate systems and encourages ease of communication and inclusion in decision making. Researchers working from a position outside of the service need to develop a strong working relationship with service participants for the

best advantage. They would do better if there was an 'internal champion' who could advance their case and foster the research relationship with insiders and who acts as a bridge between the outside researchers and the service managers and clinicians.

This short discussion confirms that the use of evidence from research in policy making can be fraught with difficulties. Researchers who are keen to have their work considered would be advised to become knowledgeable about the policy making process and to seek active ways to become an accepted partner in the policy making process. Those with the interest and the energy to engage in the politics of policy making may succeed in having their research, or their values about certain research, acknowledged and included.

In this chapter I have laid out the theoretical issues that will form the foundation for the examination of the activity and interests of those policy actors, activists and researchers who became part of the policy communities and advocacy coalitions during the period of policy making considered in this dissertation.

Investigating Social Policy

My attention in this section of the Portfolio is concentrated on an analysis of the social policies adopted from 1999 to the present by the NSW Department of Health and which had an impact on community health services for families with infants and young children and the nursing practices of child and family health nurses.

There are several interlinked policies which together have affected health service delivery and nursing practice in community child health and these have been considered as a whole rather than as separate policies. By examining these policies I hope to, firstly, reveal the processes of policy formation, and secondly, to probe factors surrounding the planning and implementation of the policies. This work will then inform the investigation of the nurses' practice that is contained in the Nurses' Study.

It is necessary to note that it is not my intention to trace in detail the intricacies of policy development through the NSW Cabinet and other government departments. To do so requires a larger study design that includes as many as possible of the actors involved

and invites a critical analysis of the policy making procedure on a much larger scale. Such a project is outside of the scope of this Dissertation. Instead my intention is to provide insights into the events and actions that occurred in The Cabinet Office and principally in the NSW Department of Health that had a subsequent effect on the health services and the practice of child and family health nurses delivering those services to families with young children in the community.

Concluding Remarks

This chapter has set out the literature review that informs the Policy Study. As this study was centred on the process of policy making that led to the formation of the health policies for children and families in NSW, the literature reviewed describes the considerable scholarly activity in the political science literature regarding the genesis, formation and implementation of social policy. As such, it provides the rationale for the policy analysis set out in Chapters Three and Four.

The next chapter (Chapter Two) will provide background information for the policy analysis undertaken in Chapter Four. It will identify the relevant health policies and describe them in chronological order of development. The chapter also provides the reader with an appreciation of the structure of the government and health system in which the policies were formed and implemented.

CHAPTER 2: THE AUSTRALIAN POLICY CONTEXT AND NSW GOVERNMENT HEALTH POLICIES FOR FAMILIES WITH YOUNG CHILDREN

This chapter presents the context for the policy analysis that follows in subsequent chapters. Australian public policy is shaped by the particular characteristics of our political institutions (Davis et al, 1993). Therefore, an analysis of the political process in which policy is nurtured requires knowledge of the structure of the Australian political system, with its distinctive brand of federalism and representative government. The first section will provide a background to the Australian political system to enable the reader to make sense of the description and discussion of the health policies to follow. The second section identifies and describes the major health policies that are of interest in this study. It is intended to support the analysis of the NSW Families First Strategy and subsequent policy activity that took place within the NSW Department of Health that is discussed in Chapter Four by giving an overview of the relevant policies.

The Australian Policy Context

Australia as we know it today is a federation of six States: Queensland, New South Wales, Victoria, South Australia and Western Australia on the mainland, plus the island of Tasmania. There are three Territories: the Northern Territory in the far north of the mainland, the Australian Capital Territory (ACT) in the south east corner and Norfolk Island off the east coast of the Australian mainland in the South Pacific Ocean.

The Australian Government

The Australian system of government is modeled on the Westminster system of responsible government but adopted key elements of the Canadian federalism model (Parliament of Australia, 2007a) Bridgman and Davis (2004) described it thus:

> The Australian system of government melds notions of ministerial responsibility, drawn from the House of Commons in the Palace of Westminster in London, with a federal Senate modeled on (North) American practice. It includes a governor-general, as the representative of the Queen, and a powerful executive that reflects party domination of the parliament. This unique system, given expression in the Commonwealth Constitution of 1900, combines parliamentary government with federal institutions.
> (2004, p8.).

Under this system of government powers are distributed between the Commonwealth Government and the six states. The three territories have individual self government arrangements with the Commonwealth Government (Parliament of Australia 2007).

The federal Parliament is bicameral, comprised of the House of Representatives (lower house) and the Senate. Essentially Australia has a two party system and the Government is formed by the political party which wins the majority of votes in a preferential voting system in which voters rank all candidates in order of preference (Parliament of Australia, 2007b). The leader of the government is the Prime Minister and he/she is chosen by the Party and is located in the Lower House.

The federal government has responsibility for the defense of the realm, collecting income tax, immigration, currency and coinage, trade and commerce with other countries. It also has jurisdiction over matters that are connected to the social rights of citizens. Through the Family Law Court it regulates divorce and related issues including custody and guardianship of infants, and social security arrangements such as pensions and allowances for old age, widows, maternity and child endowment, sickness and unemployment benefits. (Parliament of Australia, 2007c). The federal government administers the universal health insurance system (Medicare), the Pharmaceutical Benefits Scheme (PBS) and some aged care and mental health programs. Funding for State administered health services is provided by the Federal government to the State governments from the taxation base and annual amounts to be allocated to the State Governments are decided at the meeting of the Council of Australian Governments (COAG).

The Federal Minister for Health presides over the Commonwealth Department of Health and Ageing. Policy originating in this Department is concerned with giving direction on national health issues and these decisions potentially have an impact on the State and Territory governments. So, for example, the national child health policy of 1995 was the impetus for the development of the child health policy of 1999 in NSW. More recently, the National Strategic Health Framework for Children 2005-2008 has outlined the federal government's blueprint for the strategic direction of child health services that are the responsibility of the States and Territories. The implementation of these directions

will be overseen by the National Public Health Partnership that reports to the Australian Health Ministers' Advisory Council and thence to COAG.

The NSW State Government

The NSW state government has a structure based on the same principle of parliamentary government as the Commonwealth government. The two houses of parliament are the Legislative Council (lower house) and Legislative Assembly respectively. The Governor is the Queen's representative in the State and has similar powers to the Governor General. The leader of the government is the Premier, chosen by the members of the party which wins the election but appointed by the Governor. The Cabinet is the executive decision making forum, comprised of the senior ministers of the Government and assisted by officials of the Public Service. (Parliament of NSW, 2007)

As Davis et al (1993, p89) describe it:

> Cabinet is the place around which the political, bureaucratic, economic, social and international interests all pivot... It has the potential to wield tremendous power as it determines the general strategy of government. It decides what legislation to introduce and which programs or policies will be adopted. It arbitrates between ministers and between departments, and provides a ministerial perspective on departmental submissions....it is the arena where the criteria of politicians, rather than a set of administratively rational precepts, operate. This central decision making body is surrounded by an air of mystery. The weight given to its pronouncements is enhanced by the secrecy of its processes.

The agenda for Cabinet is officially drawn up by the Premier, acting with the advice of officials from their department. What is finally discussed by Cabinet depends, in part, on what the leader wishes to discuss, and in part by how far other ministers need the support of Cabinet for their decisions. Decisions may be made elsewhere but Cabinet gives the final check on decisions giving formal authority to decisions made elsewhere. Hence, the health policy that became the Families First Strategy (Office of Children & Young People, 1999) was promoted by senior policy officials but the major decision was made by Cabinet.

The NSW Health Care System

The health care system in New South Wales is a large and complex institution. Like all government instrumentalities it is guided by policy decisions initially formed in the Cabinet and Parliament and disseminated through the web of the Public Service (Pollard, 1992). An understanding of the organisation and management of the state health care system in NSW is necessary to understand the role and function of policy within the system and its relevance to this research project.

The entity known as NSW Health is comprised of 8 Area Health Services, the Ambulance Service of NSW, the Children's Hospital at Westmead, Justice Health and a number of other statutory and affiliated health organisations and at its apex is the NSW Department of Health (NSW Health, 2006a). The NSW Department of Health is the bureaucratic arm of government that interfaces with The Cabinet Office and receives and disperses funding from the Government Treasury to the Area Health Services. It is the NSW Department of Health that decides State policy which the Area Health Services must implement.

The NSW Minister for Health presides over the Department and, as a member of the Government and Cabinet, holds the Portfolio and is responsible to Parliament, as in similar Westminster systems (Davis et al, 1993). The NSW Department of Health supports the Minister for Health, and provides assistance to the Minister and the Director General in responding to the NSW Parliament, Cabinet and other government agencies. The NSW Department of Health has responsibility for advice to government through the office of the Director General.

The Corporate Plan published on the NSW Health website describes the role of the NSW Department of Health as leading system wide health policy, planning and response (NSW Health, 2006b, p.1). In this role the Department provides statewide strategic planning and policy development. One of the four main divisions of the Department is the Strategic Development Division, which lists amongst its responsibilities Primary Health Care and Community Partnerships Branch. It is in this Branch that policy development and planning for child and family health services principally originate. Stakeholders or policy actors who wish to contribute to the policy making usually direct their attention and effort to officials of this Branch. Policy makers

according to Colebatch (2006) also include professional associations. The professional association representing child and family health nurses is the Child and Family Health Nurses Association (NSW), known as CAFHNA. The role of CAFHNA in the policy process will be discussed in Chapter 4.

The Department also allocates resources and monitors and manages performance (NSW Health, 2006b). Although the responsibility for provision of health services to the population resides within the Area Health Services, the Department of Health is the policy making body that directs and, more importantly, funds the Area Health Services. Health policy, variously constituted as directives, guidelines or targets, is the driving force and one of the mechanisms of control. The organisational model is that of a decentralised system, with the Area Health Services having autonomous control of their affairs but reporting to the Director General of the NSW Department of Health. The Executive Officers of the Area Health Services are directly responsible to the Department of Health for the implementation of Departmental policy and, indeed, the Area Health Executive Directors are often tied by service contracts to the implementation of set policy. Within the Area Health Services there is a complex web of health service provision, and health services for children and families constitute only one facet of a large number of intersecting institutions, services and programs. Acute care and community health services have traditionally been separate streams but there has been a convergence of these services under single administrations. Consequently child and family health services are frequently managed by hospital administrations as part of the network of hospital services.

It can be deduced from this complex network that the implementation of policy at the workface is effected by a top-down flow segmented by the many layers of the system. Nevertheless, the nurses who work in child and family health services are, whether they know it or not, directly affected by health polices decided at Departmental level and above.

NSW Health Policy for Families with Young Children

The health and wellbeing of children is given a high priority by Australian governments that have responded by putting into place a wide range of services to support and sustain child rearing families in the community (Fenna, 1998). Within the last fifteen years there have been a large number of health policies that address health and wellbeing of children and families at both federal and state levels.

This section will begin by briefly outlining the national health policies for children and families and then move to a description of the suite of policies developed by the State government of New South Wales. The information for this section was sourced from federal, state and NSW Health policy documents.

Child Health Policy in the 1990s

In 1992 the federal government published National Health Goals and Targets for Children and Youth (Australian Health Ministers Advisory Council, 1992). This was in line with the series of health policies prompted by the World Health Organisation's primary health initiative Health for All by the Year 2000. The publication of such health goals was seen as a mechanism to stimulate the development of appropriate primary health care services for children and families. Whilst the child health goals and targets supported well established clinical practices, such as the importance of reducing vaccine preventable disease, they also flagged a less well developed goal addressing the effects of the social and family environment on children's health and wellbeing. In many ways, the Health Goals and Targets was a forerunner to child health policy development within Australian in the following decade.

Following the publication of the national health goals and targets, in 1995 the Commonwealth government published, under the auspices of the Australian Health Ministers Annual Conference (AHMAC), a National Health Policy for Children and Youth that was intended to act as a blueprint for policy and service development within each state. The role of the federal government is to set the overall health service direction, to which the State governments were expected to respond. The Federal

Government exhorted each State government to produce a child health policy that would detail their government's commitment to child health service provision. Between 1993 and 1999 every state reviewed child health service provision and published state child health policies.

NSW Health was among the last to publish a State child health policy. Work on the policy had begun in the early 1990s but the publication of the document was delayed until 1999. The policy was named The Start of Good Health and had four goals:

- To improve the health and wellbeing of children
- To improve the accessibility and appropriateness of health services for children
- To improve the quality of health services provided for children
- To promote partnerships within the health system and with other public and community based agencies which impact on the health of children.

The child health policy sought to complement recent national and international initiatives relating to the health of children and its content was influenced by the international research on children and children's services. It used the framework of the national health goals and targets for Australian children and youth to provide direction and guidance for the NSW health system to address the needs of children. Importantly, it supported the NSW Government's initiative known as the Families First Strategy.

The following section will describe the features of the NSW Government's Families First Strategy and subsequent child health policies developed by the NSW Department of Health that were linked to Families First.

Families First Strategy

In the seminal document released by The Office of Children and Young People in 1999, Families First is described as 'a coordinated strategy sponsored by the NSW Government to increase the effectiveness of early intervention and prevention services in helping families to raise healthy, well adjusted children' (Office of Children and Young People, 1999, p.1). The overall aim was to create a coordinated network of services that support child rearing families within their communities. The use of the term 'strategy' is deliberate to emphasise the nature of the government's intention.

Although $52M was originally allocated to set up the Strategy, the policy is not to be interpreted as a method of funding new programs; it is instead a mechanism for identifying and integrating existing government services and non-government programs within a given geographical or population community to provide a coordinated response. The service networks developed by Families First are expected to reflect the differing needs of each area, with the community being serviced defined geographically or by population group. It was expected that the result would be improved services and easier identification of service gaps to families.

The Families First document names the five Human Services agencies participating in the Families First Strategy as the Department of Community Services (DoCS) responsible for child protection, Department of Ageing, Disability and Home Care (DADHC), Department of Education and Training (DET), Department of Housing and NSW Health through Area Health Services. As well the Strategy includes non government or community agencies, General Practitioners, and childcare and disability services for families. This is a disparate group that have historically been isolated within their separate administrations, and between which communication and case sharing have been more incidental than planned. Families First is based on the concept of a 'whole of government' approach, where social policy is enacted by a coalition of involved agencies working together to contribute their specialised talents towards common goals. Proponents of this approach to policy implementation argue that when government bureaucracies operate in isolation from one another (the so called 'silos') they restrict their capacity to respond to complex social problems that require multifaceted solutions. This view had been circulating in government departments for most of the previous decade and in the case of NSW Health has led to cooperation with the Department of Education and Training (DET) on the Health Promoting Schools and Schools as Community Centres programs (DET, 1998). These two successful programs stand as good evidence of the effectiveness of an integrated approach to community health and serve as excellent examples where 'building on and broadening existing service structures' (The Office of the Cabinet of NSW Govt., 1999, p.1) can be achieved.

The range of the Families First Strategy was ambitious, covering parents, children, communities and service networks. The target group was families with children up to eight years of age, with a special emphasis on the early years of life 0-3 years. The rationale for the Strategy was that assisting and supporting parents and building support networks in their local community would make a difference to their children's health and wellbeing (OCYP, 1999). The primary objective of the Strategy was the establishment of a network of universal and targeted services supporting families, with home visiting as a core component and incorporating the activities of professional service staff as well as volunteer groups. The Strategy was concentrated on four defined Fields of Activity, built on the research evidence for early intervention and support for families. These were:

1. early identification of problems and support for expectant parents and those with a newborn child

2. ongoing support for childrearing families in the community, especially families with infants and young children

3. targeted services for families whose difficulties indicated they needed more intensive support.

4. community development that linked local community networks to families with young children and provided early intervention strategies.

The principles of practice espoused by the Strategy were based on concepts of holism and empowerment of parents, consumer involvement and integration of services, and strengths based professional practice (OCYP, 1999, p. 15).

The Families First Strategy was implemented in three pilot areas whose population had high levels of disadvantage, commencing in 1998, 2000 and 2002 respectively. The first designated Area Health Service comprised a very diverse multicultural community in a densely populated suburban area of Sydney, the second was a geographically large rural Area Health Service with an isolated population, and the third was an area to the south of Sydney with a mix of urban and rural densities (Valentine, Fisher & Thomson, 2006). Following evaluation of the implementation in the three pilot areas the Families First Strategy was sequentially rolled out across the state, with the last Area Health Service receiving funding in 2004.

The Strategy had an impact on policy development in all the involved government departments, but the flow on effect in NSW Health will now be documented.

Health Home Visiting

Within the Families First Strategy the major task assigned to NSW Health services was to provide universal access to families through a home visiting program for parents of all new babies. This meant child and family health services were in the forefront of the Strategy's implementation. The NSW Department of Health responded by developing a policy that would direct and protect service providers, and the draft policy was published in 2002.

The document also gave expression to the Department of Health's view of the expected role of the child and family health nurse as one that empowered parents to make decisions about their child, viewed parents as experts and took their views into consideration, and worked to link parents to appropriate services. The nurses were to be flexible in making the service convenient to parents. Visits could take place in homes, parks, clinic or coffee shop (NSW Department of Health, 2002, p.9) or by telephone. The document points out that the nurses 'must go further than providing a professional (clinical) service to a passive recipient of care' (NSW Department of Health, 2002, p.22). A health promoting framework was required that recognised parent's strengths and helped them to problem solve, within a trusting relationship with the family that enabled the nurse to work with the family to facilitate change. In this sense the Department of Health document was true to the spirit of the Families First Strategy.

The nurses were required to carry out a prescribed universal assessment of the family which is described as a bio-psycho-social assessment. The form of the assessment tool is not specified but should include information from antenatal and postnatal sources as well as screening such as the Edinburgh Postnatal Depression Scale and the Integrated Perinatal and infant Care (IPC) scale which was then under development. The level of care for the family is determined on the result of the primary assessment as:

Level 1: Universal - Routine health care offered in the antenatal and postnatal period.

Level 2: Universal - As above plus further support such as more intensive home visiting and Volunteer Home Visiting Services.

Level 3: Targeted - Requires a coordinated individualised support plan devised by the nurse with the family. Families at this level have an identified case coordinator and the family can expect targeted medium to long-term support.

Level 4: Targeted - If family refuses care then an assessment of child protection risks is done and referral made to Department of Community Services if appropriate.

The document also includes information on concerns related to occupational health and safety of the nurse, such as travel, point of entry to the home and potential threats from the home's occupants.

Integrated Perinatal and Infant Mental Health

Work on this policy was undertaken within the Centre for Mental Health in the NSW Department of Health and began around 1998, although the final draft was not published until April, 2006. The policy has two parts: a Strategic Framework for Mental Health, and Guidelines for Improving Mental Health Outcomes.

The Framework is essentially directed at mental health practitioners, but also provides direction for all primary health care practitioners involved in mental health responses to families at risk of mental health problems. It is built on the body of evidence of postnatal depression and other mental health problems in the perinatal period, noted as being from up to 2 years following the birth of the child. This period is seen as a window of opportunity for early identification and intervention with mental health problems, and the opportunity to provide sustained support to vulnerable families (Norrie McCain & Mustard, 1999). The policy takes a population health model of health promotion and advocates a comprehensive psychosocial risk assessment of all new families. As such, it provides the rationale for the bio-psycho-social assessment performed antenatally by midwives and by child and family health nurses at the universal first home visit and again at the 8-9 months infant check. Importantly, the framework identifies the specific role of mental health services in the IPC model and outlines a model of care.

The Guidelines provide the rationale for the advocated psychosocial assessment and early interventions, drawing on research findings on brain development in early childhood, attachment theory, and the adverse effect of perinatal mood disorders on child development and family life (NSW Health, 2006b). The guidelines give a recommended schedule of questions for use by midwives and nurses in the assessment process and advocate the inclusion of the Edinburgh Depression Scale. It describes clinical pathways and clinical responses to the bio-psychosocial assessment results and is very specific in setting out the roles of all primary care practitioners, including private medical practitioners. It is clear the scope includes all clinicians who come into contact with the family, including neonatal services. The specific role and function of the mental health services is set out as providing consultation for other health practitioners and direct intervention when required. Adult mental health and child and adolescent mental health services are identified as essential services in the perinatal period. Finally, the guidelines advocate for the use of clinical supervision for all staff working with high needs families.

Supporting Families Early

It had become clear that the Health Home Visiting and Integrated Perinatal and Infant Mental Health had compatible goals under Families First, and in 2005 moves were made by policy staff in the Centre for Mental Health to combine their documents with those produced by Primary Care and Partnerships Branch into one policy document that could speak to the initiatives the Department of Health was taking under Families First and the new direction of primary health care services to families with young children. Consequently the two policies were combined in a new document titled 'Supporting Families Early'. The new policy document had been revised and expanded and now contained an emphasis on primary health care, and included both the Health Home Visiting Manual and the Integrated Perinatal and Infant Mental Health Manual.
The assessment process has been defined and there is a clear indication of the data to be collected and from which sources it will collected. The role of the midwife and the child and family health nurse is clarified. The three levels of care and risk factors are revised and the pathways of care/model of care spelled out.

The draft of Supporting Families Early (which included the Health Home Visiting Guidelines of 2002) was sent out for comment in 2005 and revised in 2006. The policy was finally released for general dissemination by the NSW Department of Health in May 2008. There is no indication from the NSW Department of Health as to why the policy took so long to be released. The long delay in formal publication meant that child and family health nursing services in NSW had been operating within Families First mostly on the basis of health policies that were only in draft and not formally endorsed until very recently.

The final document released as Supporting Families Early officially mandates the Universal Health Home Visit by the child and family health nurse within two weeks of the infant's birth. It requires the Area Health Services to ensure the comprehensive assessment process is in place and conducted at the first visit, and again at 6-8 weeks and 6-8 months. The method of determining the level of care to be assigned to the family is described, along with a continuity of care model of practice that is to ensure the family's needs are met. Sustained home visiting to families in level 2 or 3 is not mandated. The instructions for implementation of the policy include recommendations for meeting appropriate staffing needs and levels of training required. The document provides a comprehensive description of the NSW Department of Health's nurse home visiting policy but there is very little content included about other services delivered by the nurses, such as centre based activities.

With this document in place Area Health Services now have a clear instruction about nurse home visiting.

Implementation Education Program for Supporting Families Early

This program is the educational accompaniment to the policy document. It was released in July 2007 in draft form. The document contains a complete educational package and includes educational guidelines, learning objectives, lesson plans, suggested learning tools and an evaluation questionnaire. The program was prepared for distribution to Area Health Services and is intended for child and family health nursing services and other education opportunities for new and existing staff. The program is supported and funded jointly by Primary Health and Community Partnerships Branch and the Centre

for Mental Health in the NSW Department of Health. There is no indication at present when the final program will be released, but it was expected to be released at the same time as the Supporting Families Early documents.

NSW Department of Health Child and Family Health Nurse Practice Standards Framework

In 2004 senior policy staff in the Primary and Community Partnerships Branch in the Department of Health approached the Nursing and Midwifery Office to discuss the possible development of a continuing professional education and practice support package for child and family health nurses that incorporated practice standards. A Working Group was set up in February 2005 under the auspices of the Nursing and Midwifery Office (NaMO) to oversee the development. The intention was to build on work that had been carried out by the Child and Family Health Nursing Clinical Practice Development Working Group in the Hunter/New England Area Health Service to meet staff education and professional development goals and the work of CAFHNA in developing Competency Standards for Practice. It was suggested that the resulting practice development program could form the basis of a state wide program for child and family health nurses.

The impetus was a felt need amongst senior departmental staff for a unifying statement on the scope of practice and standards for practice required for successful implementation of the Supporting Families Early policy. That policy had indicated the general requirements for practice as a child and family health nurse but had not specified essential skills and knowledge. There was no recognised credentialing process in place. The new Practice Development Framework provided the means to assess required skills, such as those inherent in the bio-psycho- social primary assessment of the family. It also encouraged professional behaviours using a mentoring process. The elements of the framework were
   1. self assessment
   2. practice consultancy
   3. clinical skills assessment
   4. professional portfolio presentation
   5. clinical supervision

The core knowledge and skills of the child and family health nurse were identified as:

1. primary health care, including health promotion and preventative health strategies
2. community development and partnerships
3. working in partnership with families
4. skills in managing continuous care
5. management of the health environment

The framework developed a list of skill sets built around the following key areas

1. comprehensive primary health care assessment (included psychosocial screening, identification of maternal depression, domestic violence and substance abuse)
2. maternal and infant clinical skills assessment (included breastfeeding, observation of mother and infant, and safe sleeping practices)
3. bio-psycho-social infant/child health clinical skills assessment (included normal growth and development, routine screening tests, immunisation and child protection)
4. community development and partnerships (included group facilitation processes).

The knowledge and skills assessments were to be completed over a period of three years by each nurse together with the compilation of a Professional Portfolio that enabled the nurse to verify her/his level of competency and professional development. Each skill set had a self directed education package and assessment was by observation of practice by a skilled assessor.

The development of the framework continued over 2005/6 and in early 2007 the draft framework was piloted in the Hunter/New England Area Health Service. The pilot was completed and the researcher reported to the Nursing and Midwifery Office in June 2007 (Guest, 2007). There have been discussions to date but no decision has been taken on how and when the Practice Standards Framework will be implemented in NSW. There is a possibility that child and family health nurses' professional nursing association, CAFHNA, will be given permission to oversee parts of the Framework with

a Steering Committee convened by NaMO. If this occurs it will become a form of credentialing for child and family health nurses.

There is no indication at present when the final Framework document will be officially released.

Integrated Primary and Community Health Policy

Released in December 2006 with a five year plan this policy document describes the NSW Health services as a three sector model: primary and community health care, population health and acute care hospitals. The document notes that around 20 different professions work in about 60 different types of service within this sector, and community child and family health services obviously fall within this sector, along with general medical practice, dental practice, community pharmacies and non-profit organisations. The purpose of the policy is to provide 'an overarching vision for the delivery of primary and community health services in NSW (NSW Health, 2006c, p.5). It articulates values and operating statements as a vision for change and identifies six priorities for action. These are:

1. integrated service planning
2. integrated service delivery
3. improved models of care
4. stronger partnerships
5. improved workforce capability
6. enhanced information management and research.

The importance of this document lies in the recognition of primary and community health as deserving of an equal place in the health pantheon. It acknowledges that changing demographics and health care characteristics will rely on a stronger and larger primary health care and community health service to reduce health inequalities and deliver lower costs to support the health care system in the future.

Other Recent Policy Announcements

The NSW Action Plan for Early Childhood and Child Care, released in April 2007 (COAG, 2007) announces that the Integrated Perinatal and Infant Care Program will henceforth be known as SAFE START. There does not appear to be any change to the content of the program. The SAFE START documentation is now included in the Supporting Families Early policy.

In July 2007 the Department of Community Services notified the Department of Health of the renaming of the Families First Strategy as 'Families NSW'. This was in response to concerns that a political party of the same name would become confused in the minds of the general public with the Strategy.

Concluding Remarks

This chapter has described the policies of the NSW Government directed at child and family health nursing services to provide background material for the analysis of the Families First Strategy and related health policies. The next chapter will outline the methods used to investigate the formation and implementation of the policies in NSW.

CHAPTER 3: POLICY STUDY: METHODS

Introduction

This study investigates the policy context within which major health policies for families with young children were developed in NSW, and the eventual impact of these policies on child and family health nursing services and on the nurses working in these services. The approach taken is grounded in health services research, which is defined as 'scientific inquiry to produce knowledge about the resources, provisions, organising, financing and policies of health services at the population level' (Shi, 1997, p15). Fulop, Allen, Clarke and Black (2001) note that health services research concentrates more on the study of the health services rather than on the health status of the population, which is usually the remit of the broader category of health research per se. Health services research studies 'the provision, effectiveness and use of health services' (Bowling, 2002, p3) and as such tends to be eclectic, utilising a range of research methods across both quantitative and qualitative paradigms. Hence research approaches include organisational studies, epidemiology, economic evaluations and policy analysis (Fulop et al, 2001).

Using the insights from policy analysis I set out to probe the 'story' behind and around the development of health policies for children and families between 1995 and 2007 in NSW, and in particular the introduction of the Families First Strategy and the health policies which followed to support the implementation of the Strategy. As such, it is an attempt to present the facts of the 'story' as a comprehensive summary of the events. This is consistent with methods employed in qualitative descriptive studies (Sandelowski, 2000). It is not my intention to critique or evaluate the policies themselves, which I will leave for others to do. My interest lies in the effect these policies had on the child and family health nurses rather than in an analysis of the intrinsic worth of the policies themselves.

The Policy Study is informed by discussions with stakeholders and health personnel connected to NSW Health. It reflects the view of the Family First Strategy and other related policies from the perspective of health personnel and their informants. There may well be dissenting views, but for my purposes the collective view that I am presenting here tells the story as viewed by NSW Health personnel, and they were the

very people who influenced, formed and implemented the health policies that had a direct bearing on the role and function of child and family health nurses.

Sabatier and Jenkins-Smith (1993) caution researchers undertaking policy analysis that they should recognise the implicit assumptions from which they view the phenomena under study. In this study of Australian policy I have taken the perspective that examining the views and actions of people involved in the policy making process gives the best insight into understanding the phenomena, as they exercised the power and were involved in the decision making. This section of the Portfolio describes and examines the relevant health policies as they had meaning for the policy stakeholders who helped form them and for the nurses who were given the task of implementing them. Therefore I have accepted their interpretation of the events and outcomes as having most authenticity. It is possible for other researchers using other perspectives to reach different conclusions.

Rationale for Study Design

In my search for a suitable methodology to guide this policy examination, I read widely, including the work of policy researchers who had published insightful analyses of policy making in the Australian political context, such as Milio (1988), Edwards (2004) and McClelland and Smyth (2006). The work of these authors was salient, because they set their analysis within the Australian political system, with its unique characteristics, and they included in their accounts the influence of local pressures and the actions of key political actors. All of these authors sourced their information from interviews with well placed policy actors, including public service officials and members of interest groups. Edwards in particular also drew on personal papers and recollections as a former member of the public service with close connections to policymakers. They provided me with an example of how I could construct my own examination of policymaking.

I particularly drew on the insights provided by Edwards (2004) and McClelland and Smyth (2006). The method used by these three authors was to embed the analysis within a chronological description of the development of the policy, such as the policy cycle framework developed by Bridgman and Davis (2003). The policy cycle offers a staged analysis of the steps in the policy planning and implementation process and has been

well accepted as suitable within the Australian policy context. McClelland and Smyth (2006) used an abridged version of the policy cycle as part of their analysis of major national policies in Australia, such as social security, housing and education, including the complexities of the Australian health care system. Meredith Edwards in her work refers to the Bridgman and Davis model as the 'policy development framework'. Edwards presents a case study analysis of key policy initiatives, where she draws on her background as a senior public servant with the Commonwealth Government and as a policy advisor to inform her work (Edwards, Howard & Miller, 2001). Edwards believes the framework makes clear the steps of the policy process and allows her to better manage the complexities of the policy case studies she explores.

A more probing investigation of the events surrounding the making of the selected health policies is provided in Chapter Four by the discussion of the interviews with stakeholders and key policy analysts in the Department of Health. It requires an approach that allows a more searching scrutiny, taking into account some of the underlying factors that contributed to the policy making. I have chosen to utilise concepts and techniques suggested by Colebatch (2002) in his analysis of the policy process. This approach gives attention to the horizontal dimension of policy making by considering the influence of policy actors, communities and collectives located outside of the formal line of authority. Levin (1997) provides some of the questions that can be used to discern the use of power and the consequences of decisions and his heuristic technique was used in the gathering of the data and the analysis of the transcripts of interviewees to gain insight into the stories they told.

The methodology used in this study is naturalistic enquiry. That is, it is a qualitative descriptive study that aims to explore the experiences and perspectives of a small number of participants involved in the planning and implementation of the Families First Strategy and selected health policy. Qualitative descriptive research is a respected method of qualitative research (Sandelowski, 2000). The descriptions are as accurate a record as possible of the events, and the meaning assigned to those events, as described by participants. Sandelowski (2000, p.337) notes that 'qualitative description is especially amenable to obtaining straight and largely unadorned answers to questions of special relevance to practitioners and policy makers' that 'are directed towards

discovering the who, what, and where of events or experiences' (2000, p.338). In keeping with this, the research questions that guided this part of the research were:

1. Why and how were the Families First Strategy and related health policies formed and who was involved in the process?

2. What was the effect on child and family health nurses when the policies were implemented?

Study Participants

The participants in the study were key stakeholders in the policy making process during the time that the policies of interest were being formed. They included departmental officials and other members of the policy community involved in the policy formation, and senior health managers who were given the task of implementing the policies in the two Area Health Services. Ten people were approached to participate in the study and all agreed to be interviewed. They were chosen because of their proximity to the policy process as all had extensive involvement with some phase in the development and/or implementation of the Families First Strategy. However, they are only a small group in the large numbers of NSW Health personnel involved in the policy. As such they are not meant to be a representative group, and their stories will not provide a definitive account of the events at the time.

Recruiting participants

Each participant was initially contacted by telephone or email letter and the study objectives explained. An information letter about the study was included. If they agreed to be interviewed an appointment was made for at least one hour at a time and place convenient to them.

Ethical Considerations

Ethics approval for the conduct of this study was gained from the UTS Ethics Committee (Approval Number UTS HREC 03/48A). The Committee required that all participants be given full information about the study and their participation, and that they could withdraw from the interview at any time. All participants gave signed consent to their involvement in the study. An example of the Consent form and

information forms are located in the Appendix. The tapes, field notes and transcripts were stored in a safe location and the confidentiality of the participants respected by use of codes in the reporting of data. Strict confidentiality was maintained in handling material collected to ensure the privacy of all participants was respected.

Data Collection

Most but not all interviewees were interviewed at their worksites and the interview took place in their office or a quiet room on the premises where privacy could be maintained. One participant was interviewed by choice at her private residence as she had since left her position.

Semi-structured interviews were conducted with the interviewees. Prompt questions were given to them on a sheet of paper before the interview began asking them to identify their involvement on the policy making process that had gone into the formation of the policies and for their thoughts about the process. Prompt sheets also contained questions specific to the role of the person being identified. The most common prompts used for the interviews were:

- Can you describe the circumstances and actions that in your opinion resulted in the Families First Strategy becoming formal government policy?
- What role did the NSW Department of Health take in Families First? What did NSW Health consider its obligations in the Strategy?
- Whose interests (in your opinion) were served or made a mark on this policy or measure?
- What were the changes brought about in your service by the introduction of Families First including administration, staffing and nursing practice changes?
- What role did the child and family health nurses or their representatives take in all this?

The semi structured interview format was chosen to allow the pursuit of leads or notions that the participants brought up that were not amongst the original prompt questions.

Open ended questions were designed to encourage participants and to elicit their perspectives. It was considered best to interview participants individually to provide confidentiality and to allow them freedom to express their opinion. As each participant's views came from their own perspective it was not anticipated that consensus would be achieved or even that it was desirable.

All interviews were tape recorded with permission of the participants. A small number of field notes were taken during the interview or immediately after the interview had ended and the interviewee had departed to aid in transcription of the tapes and to add context to the transcribed interview data.

Analysis

The tapes were transcribed by the researcher as soon as possible after the interview was conducted, usually within days. This meant my memory of the interview was still fresh. Transcribing the interviews myself gave me an opportunity to become immersed in the data from the beginning. The transcriptions were then printed and read several times for gist. For each transcript the narrative was then searched more carefully for topics using a content analysis process. I was searching for factual information about the policy making process and also their thoughts and ideas on the circumstances surrounding the initiation, formation and implementation of the policies, as per the framework suggested by Bridgman and Davis (2003). The transcripts were read in conjunction with listening to the tapes. As key events, actions or ideas were identified they built up a picture in my mind of the sequence of events and also the intentions of the actors. Similarities and differences in the various accounts helped to confirm or question the history of the events and each interviewee contributed a personal perspective. This was a useful process because it allowed for a comparison of events and policy actions across the 'stories' of each participant.

Where possible the information given by the participants was validated for the chronological order of events and for correctness of facts recalled by cross checking the 'story' given about the policy formation against other participant's recollection. A key informant was interviewed twice – once very early in the study and then again late in

the study because other interviews collected up to that time indicated that a second interview of this person was required to clarify and expand on original interview content. The transcript from the first interview was sent to the person to read before the second interview took place.

Key Considerations

Reflexivity

A particular difficulty in this part of the study was my personal involvement in the rather small world of child and family health. Each of the interviewees was personally known to me and I had sat on various committees with many of them, including departmental committees related to the policy development. Some of the history that they were relating was also my history. However, their perspective was different, allowing me to see the same event through different eyes, like looking into a room through different windows of the house. In fact I found it quite refreshing to hear a new version of familiar events; also some of the events recounted were unknown to me and helped fill the gaps in the narrative. I needed, however, to make a conscious effort not to colour the participants' reports by imposing my own views. Indeed, the raising of awareness of the influence of our personal experiences and values is considered good practice in the conduct of qualitative research (Bradbury Jones, 2007). So in the interviews I allowed the interviewees to tell their story without comment, and when reading the transcripts I was mindful of the need to recognise my subjective reactions to some of the events being described. Clearly I was not a neutral observer to these events, because of my close identification with child and family health nursing. This led to a consideration of my contact with the policy community through my connections with the Child and Family Health Nurses Association, and this is explored in Chapter Four.

Limitations of the study

This study can in no way be considered a definitive account of the events and actions that occurred around the policy making during this time. There are only a small number of interviews with a limited number of participants in a major policy making process that involved many people in the Department of Health and The Cabinet Office. Missing from the account are some of the personnel in The Cabinet Office, government departments other than Health and non-government agencies involved with the

formation of the Families First Strategy in the early days and its later implementation. This was a deliberate decision. The Families First Strategy was not the primary focus of the study but it had to be considered as it was the genesis of the policies formed in the Department of Health that had an impact on child and family health nursing practice, which is the primary focus of this Dissertation. A thorough examination of the Families First Strategy is beyond the scope of this study and must wait to be undertaken by others.

CHAPTER 4: POLICY ANALYSIS AND DISCUSSION: The Development of the NSW Government's Families First Strategy and Subsequent Impact on Child and Family Health Nursing Services

Policy comes into being through a long and sometimes convoluted gestation and involves large numbers of people across diverse organisations. The circumstances and development of the health policies I am interested in are just such a case. This chapter will attempt to unravel the complex story behind the actors, actions and contexts in which the health policies described were incubated, born and grown into reality. I will use the theoretical framework identified in Chapter One to analyse the events and actions that took place around the development and implementation of the Families First Strategy and the ensuing NSW Department of Health policies prompted by the introduction of the Strategy.

Although a linear or chronological explanation of policy development has been criticised, the rational model has some merit as an organising framework. Frameworks such as this help to clarify the policy process and provide information that assists in understanding the policy (McClelland & Smyth, 2006). For the purposes of this analysis, I will use the policy cycle framework suggested by Anderson (1979) and later expanded by Bridgman and Davis (2004) to describe and critique the policy making process. This identifies the key stages in the policy making process as follows

         Agenda setting

         Identification of issues

         Policy formation

         Policy analysis

         Policy instruments

         Policy adoption

         Consultation

         Coordination

         Implementation

         Decision

         Evaluation

If 'all policy has a history' (Dalton et al, 1996, p.4) then the telling of the policy making history forms part of this story, but not all of it. This chapter also seeks to reveal the social and political context in which the policy making occurred. As Levin (1997) points out, a singular analysis is always deepened by a consideration of issues of power and influence, the actions of the policy actors in the policy community and political events. These considerations must be taken into account in any recounting of the events of the policy cycle and will inform the analysis.

It should be noted, however, that the linear presentation may disguise to some extent the inherent irrationality of the policy process. When I re-interviewed a stakeholder for this study, several years after the first interview, I sent a summary of the earlier interview as preparation. The comment I received was that the orderly progression of events that I had presented was misleading in that it did not catch the circular process that accompanies policy making. Such an orderly progression suggested that the policy proceeded to a clearly mapped plan, which was not the case. The development of policy is contingent on many factors and may be subject to influences beyond the control of the officials who are responsible for formulating it (Colebatch, 2002).

Agenda setting

Identification of Issues

Whilst at any given time there are many social problems and issues that could demand political attention, there are four conditions that must be satisfied for any one issue to rise above the others and demand attention of policy makers (Bridgman & Davis, 2004). There must be agreement about what constitutes a problem and the issue identified. More importantly, there must be some prospect of a solution for the identified issue. Thirdly, the issue must be of enough significant political importance to gain political support. And lastly, the solution must be compatible with the ideology of the party that holds office.

As McClelland and Smyth (2006, p. 57) point out, it is not easy to get an issue onto the policy agenda. There are many social problems demanding attention at any one time, so why did early childhood become an issue, and what is the story around how this happened? The answer seems to be a confluence of events that brought the issue into

prominence at this particular time. There was research evidence on the effects of adverse conditions during early childhood on later health and wellbeing of children, there was agreement among the child health community on the need for a new approach to health care for families with young children and a growing consensus on how that might be envisioned, and this occurred at an opportune time politically. Together these factors appear to have contributed to the identification of early childhood as an issue (interview with PS8) and will be discussed within the following section.

Research Evidence

The 1990s saw a rise in interest in brain development during the perinatal period and early childhood, largely as a result of the research studies presented in that decade. Projects such as the Perry Preschool (CITIVIS Foundation, 1996) had clearly shown that planned intervention at an early age for children and families had a positive effect on practically all aspects of child development, physical, social, and emotional, and led to better outcomes for the children educationally. Furthermore, that these benefits were evident into adulthood and reduced the likelihood of adverse social impacts such as unemployment, family breakdown and criminality. There was much published material on brain development and the plasticity of the brain during early childhood that suggested that interventions could improve cognitive functioning overall (Norrie McCain & Mustard, 1999). Early intervention programs introduced in northern America had indicated positive improvements in children and family welfare (Izzo, Eckenrode, Smith, Henderson, Cole, Kitzman & Olds, 2005; Norrie McCain & Mustard, 1999). Other commentators were suggesting that there were considerable cost savings in the long term (Heckman, 2006; Vimpani, 2005). The story was told by one interviewee of his astonishment that this information was not as well known in Australia as it apparently was known internationally and he made it his business to see that the information was distributed widely amongst key stakeholders (interview with PS5). Medical academics attended international conferences and heard presentations of research work being done by Fraser Mustard in Canada (Norrie McCain & Mustard, 1999), Bruce Perry in the USA (CITIVS, 1996) and David Olds (Olds, Henderson, Kitzman, Eckenrode, Cole & Tatelbaum, 1999) in early intervention and home visitation programs. The research evidence activated interest amongst child health academics, who introduced the international research on early intervention during early

childhood, eventually named the Early Years Agenda, to policy makers and officials in the government.

Problems in Existing Service Delivery

There was agreement amongst senior medical clinicians and health managers that child health services were not being accessed by those families most in need of the service. In the Sydney metropolitan area medical and nursing services staff in community child health were grappling with the difficulties of delivering a suitable child health service to a diverse and often underprivileged population within the constraints of limited funding (Alperstein, Thomson & Crawford, 1997). In two of the Sydney Area Health Services, senior medical clinicians and health managers were actively exploring other solutions (Interview with PS1). They were convinced of the efficacy of the population health approach, in which effort is put into moving the whole population on key indicators, and they identified three areas of vulnerability which were likely to become more urgent in the future and which would need a response because of political or community pressure. These areas were child protection, immunisation and Aboriginal child health (Interview with PS1). In 1996 senior officials and community paediatricians instigated the Report on the Health Status of Children and Youth in which the local epidemiology studies together with Australian Bureau of Statistics evidence were used to outline the social and health status of child rearing families and articulate health needs. The child health 'Report Card' was initiated, which was a list of major indicators of children's health for that community (O'Sullivan, Alperstein & Mahmic, 2000). This report was the first of its kind in NSW and became a common reporting method. Another initiative was the Child Health Plan, which gave a detailed, planned program of early intervention in child and family health (Alperstein & Nossar, 1998). It was reported the senior clinicians and managers worked together, looking for health measures and interventions for which there was good evidence of efficacy, and other publications and conference presentations followed (Interview with PS1). Informants claim the Health Plan was influential in detailing the evidence for effective early intervention programs and child health service delivery, and raised questions about the efficacy of many of the current activities in child health services, whilst its strong evidence base made it a powerful tool.

In early 1998 a group of community paediatricians collaborated with policy officials in the NSW Department of Health to prepare an internal Department of Health discussion paper that addressed child development (Wraith, Kakakios, Alperstein, Nossar & Wolfenden, 1998). The paper outlined the research evidence for early intervention and advocated a population health approach and engaged the interest of the departmental Director, who was impressed by its content and initiated discussions with Cabinet Office. The discussion paper was circulated amongst the Directors of other human service agencies and non-government organisations and generated great interest. This paper would prove to be a catalyst, as following its dissemination informal meetings were set up between Directors of the human services departments and received their support for its proposals. Further, the Director Generals of each department endorsed a common bid to the Treasury and Cabinet for a program initiative which eventually became known as Families First (Interviews with PS1, PS2 & PS8).

Several of the health personnel interviewed for this study believed that NSW Health had a major role to play in setting the policy agenda for the government. It was mainly health personnel who had provided supporting research and other evidence that acted as an engine for change. Whilst there was already a trend to bring human services together (the 'whole of government' approach) and the government had already proposed moves to coordinate health, education and welfare services, the position paper written by the senior clinicians and managers in 1998 had prompted policy officials to consider the successful social programs outlined in the international evidence and pushed the impetus for change. Informants claim there was also an element of political astuteness in the dealings of the policy actors with the government bureaucracy that helped advance the proposal.

In many respects the people involved were 'policy entrepreneurs' (Dalton et al, 1996), whose activities were directed towards 1) recognition of the problem from the social and epidemiological research, as evidenced by the two reports; 2) generation of policy proposals in that they were aware of the evidence of what was working elsewhere; and 3) they were linking in to the political event and the readiness of the bureaucracy to listen. This analysis also coincides with Kingdon's (1995) agenda setting theory of the convergence of the three policy streams of policy recognition, the proffering of workable proposals and favourable political factors.

At this time discussions were progressing with policy officials in the NSW Department of Health about the notions of improved service delivery (Interview with PS8). The issue was now more clearly identified, and better than that, a possible solution was in the offing. The evidence from programs such as the Canadian Early Years Study (Norrie McCain & Mustard, 1999) plus the population health approach to early childhood health services that had been trialled in two Sydney Area Health Services suggested a way forward.

Political Timing

Policy issues may be identified, and there may be a clear reason for them to be acted upon, but the ingredient that is now necessary is political will. Kingdon (1995) suggests that it is when the problem stream and the political stream intersect, as appears to have happened in this case, action is likely to occur. Davis et al (1993, p15) remind us that politics is the final arbiter of public policy choices: 'policy and politics are not easily separated, since each informs the other.'

There are some social problems that appear intractable. Bridgman and Davis (2004) call them 'wicked' problems that do not have easy solutions and therefore are not amenable to policy action. They will not get on the policy agenda until they become 'open to a solution' (McClelland & Smyth, 2006). Drug abuse in the community is one such problem and in 1999 the NSW government held a Drug Summit to canvass possible solutions. An invitation to speak was extended to a child health academic, who presented the research evidence on the effect of negative parenting experiences in early childhood in front of the Premier of the State.

> I think the drug issue was quite critical in getting an expansion of Families First going. I know Bob Carr (the Premier) was very impressed with what I had to say at the Drug Summit just around the histories of these people as poor attachment and disturbed early childhood. You know that one of the strategies for dealing with preventing later drug and alcohol issues was investing resources in the front end to ensure better parenting. …So there was an idea that came together with a political imperative – like we need to be doing something about drugs, what's some novel things that we can do about that…?
> (Interview with PS5).

The possibility of a new direction in family policy fitted well into the government's political agenda as the Labour Government had identified youth, families and children

as a major policy area for the forthcoming election. The government was also concerned about countering the bad press that the government had been receiving following a highly publicised series of child abuse cases apparently mishandled by the Department responsible for child protection (DoCS). When a new Director General of the Department was appointed, following the retirement of the previous Director General, he was given the opportunity 'to go (into the position) with funding that he argued would get (the Department) off the front page' (Interview with PS5). There was information available to the government from their own internal departmental reviews that the large scale social issues were not adequately addressed. That gave attention to how in an election year the government could be portrayed as proactive with a workable solution that had the full support of academics, health clinicians and department heads and with international research to back it up. Although research alone would not have gotten this issue onto the agenda it was used to give weight to political solutions.

The Policy Community and the Policy Actors Involved

There are many groups and individuals who play their part in setting the agenda. The development of the Families First Strategy is indeed dominated by key 'policy actors' (Considine, 1994) whose values were a driving force. The policy community which surrounded the development of these policies was comprised of community paediatricians, senior officials and policy officers within the Department of Health and Cabinet Office, academics and members of non-government agencies involved in early childhood services. Nurses are noticeably absent from this group.

When like minded persons act together to influence the political process they are called pressure groups, or interest groups. The medical profession is seen as a major interest group in health policy because of its dominance in the health sphere (Palmer & Short, 1994) and the development of the child health policy throughout the 1990s was heavily influenced by medical practitioners closely involved with community child health. As a group of health practitioners they shared a similar ethics and value system and they also had access to the same international research that was transforming child health services internationally. The medical profession, however, is only one of a number of groups with an interest in family life and child health and who seek to also act as pressure

groups. Others include family welfare organisations and child advocacy groups, but many of them do not have the status or political power of medical lobbyists.

The policy actors mentioned above were part of the network of child health opinion makers in NSW and nationally. They formed a key lobby group working through the auspices of the National Council for Community Child Health (NCCCH), which was set up in the early 1990's to inform policy development and service implementation in community child health at a national level. The membership of this group, at least in the early stages, was mainly comprised of senior medical academics and community paediatricians from Queensland, NSW, Victoria, Tasmania and Western Australia. It did, however, include two highly regarded senior nurses considered to be influential in their respective State bureaucracies. It was later widened to include representation from other, mostly non-government, organisations.

The NCCCH is an example of a policy collective, whose members are known to each other and who share an interest in common problems and who have the expertise and connections to play a part in the policy making process (Colebatch, 2002, p33). As the numbers of medical personnel specialising in the field of community paediatrics is small, they tend to form a close knit network. All of the medical academics knew each other's work well and exchanged ideas and views freely. They were supported by community paediatricians in the health services, most of who are in senior management positions. This was the group that had encouraged the federal government to develop the 1995 national Child Health Policy for Children and Youth, and was instrumental in the writing of the Health Goals and Targets for Children and Youth in 1992 (Interview with PS5). Their role is central to the development of the Families First Strategy, as they produced the publications and provoked the discussions within NSW Health that supported Families First. They were key advisers to policy makers, introducing new ideas and informing the policy officials in NSW Health and the Cabinet Office (Interview with PS8).

What should also be noted at this point is that child and family health nurses are not strategically involved at this stage. Although senior nurse managers or academics may have been personally known to the members of the lobby groups named above, only a very few were actively involved within the policy community in NSW at this stage.

The notion of the policy community can be contrasted with that of the Advocacy Coalition Framework (Sabatier and Jenkins-Smith, 1993). They define an advocacy coalition as consisting of policy actors from a wider range of institutions than just interest groups as it includes officials from all levels of government, journalists and researchers. This disparate group acts as a 'coalition' because they share a set of basic beliefs and policy goals and seek to influence policy direction. From the information supplied at interviews, it does seem that there existed an advocacy coalition in child and family health, informed by similar research and other knowledge, bound by a core set of values around the notion of family and child development in early life, and dedicated to similar policy goals. Some of the advocacy activities of this 'coalition' and the policy community are described below.

Keeping the Issue Prominent

Activities to influence the agenda by maintaining interest in the issue continued to operate even after the Families First Strategy had been launched in 1998. A large meeting was organised by members of the NCCCH in Canberra in March 1999 to which senior personnel from State services in child health, early childhood education and family welfare were invited, as well as academics in health and social sciences, senior policy officials from federal and State governments, representatives of professional associations and sympathetic journalists. In short, they were members of the Advocacy Coalition. I was a first hand witness as I was invited to attend as the representative for the Child and Family Health Nurses Association (CAFHNA). The research evidence on early intervention was presented to the meeting to put the case for lobbying both national and state governments for policies to support intervention in early childhood. Discussion at the time ranged around persuading governments of the desirability of early intervention as a means of attacking larger social problems, such as reducing the incidence of crime, domestic violence and child abuse.

Dalton et al (1996) suggest that a successful move on the part of agenda setters is to use the policy strategy of citing objectives within a broader agenda that is appealing to policy makers and therefore likely to attract wider support. In this instance, social policies were put forward as a means of addressing wider social problems that have beset governments and been difficult to ameliorate. At the meeting, a senior policy

official from the federal government commented that the government, which had been heavily focused on the needs of an aging population, perhaps now needed to rethink the need for increasing support in early childhood. The group that organised the meeting was predominantly composed of members of the child health policy community. They saw an opportunity to promote a set of programs that they were convinced by the international research evidence could substantially contribute to their goal of a coordinated welfare and health system for families, and which was consistent with their own values and professional beliefs. In this respect, they were 'using public institutions to articulate and express the things they value' (Considine, 1994, p.5).

From this meeting a formal lobby organisation was formed, the National Initiative for the Early Years, known by its acronym of NIFTeY. Within three months the journalist Adele Horin had published several major articles in the Sydney Morning Herald syndicate on early intervention, and the federal government indicated a raised interest in the child health agenda (Interview with PS5). NIFTeY continued to evolve, forming a governing committee representative of the broad coalition of interests represented at the Canberra meeting. It began to actively lobby both federal and state governments such that both political parties in the 2001 federal elections produced family policies that echoed some of the central tenets of the lobby group.

This coalition of interested professionals and academics had links to international researchers and policy actors through many of its distinguished members. In the following years members used their contacts and influence to recruit a number of distinguished international academics to undertake lecture tours of Australia to maintain interest in the early childhood intervention agenda. These included David Olds to speak about the Elmira Project (in 1999), Fraser Mustard from the Canadian Institute for Advanced Research (in 2000), and Peter Fonagy, Freudian Chair in London University on the link between mental health and infant attachment theory (in 2001) and Hilton Davis from the University of London in 2002 to introduce Family Partnership Training to NSW. These lecture tours included most major cities and attracted enormous interest from a range of professionals in health, welfare, and early childhood education. The policy actors were not about to let the issue flag and activities such as this served to keep the debate alive and the policy makers interested. They also acted as a means of

informing the child health workforce, principally the nurses, about the research evidence and policy development.

The story given by those involved in the policy formation is an excellent example of the use of political skills and processes. The policy actors were able to advance their cause by linking this into political ideology. In NSW there was a Labour government in power, with a tradition of social liberalism (Dalton et al, 1996) and the values of the key players coincided with the government's views on the necessity for supporting families. The notion of 'supporting families' is really a motherhood statement: one can hardly argue about such a populist sentiment. It is the kind of rhetoric that governments frequently espouse in political campaigns and there were political events surrounding the time of the policy development that could have influenced it. Nineteen ninety eight was an election year and the government had a spotlight on children's services, so there were proposals put forward for funding of children's programs (Interview with PS1). The concept of Families First provided an opportunity for the government to be seen as putting into place a truly innovative policy that had the support of a broad base of health, welfare and educational professionals. The policy makers in the bureaucracy are generally sensitive to the prevailing ideology of the political party in power and therefore more likely to provide policy advice that is compatible with prevailing political views, so the bureaucracy was willing to support the new policy direction. There is some suggestion that the Australian public service bureaucracy is highly politicised, and very much in tune with their political masters (Editorial, Sydney Morning Herald, June 14, 2007; Gourley, 2007), as would appear to be the case here.

Policy Formation

In the Australian parliamentary system, whether or not an emergent policy passes from being a good idea to actual formation can sometimes depend on the level of support it gains in the Cabinet room. A well placed and influential policy official or member of the senior bureaucracy may pick up and protect and grow the new ideas into a document that begins to attract attention and gather support. Such 'champions' (McClelland & Smyth, 2006) may be pivotal.

In 1996 the Office for Children and Young People (OCYP) was set up within the Cabinet Office with a Commissioner for Children and Youth. The newly appointed

Commissioner had a good understanding of social services for families and had previously held a senior position in the Director General's office as Ministerial Advisor to the Cabinet Office. It was reported that this person was known to be 'scanning the environment' for quality projects for the newly created office, and it seemed an opportune time to introduce a coordinated family policy (Interview with PS2). A Cabinet Minute was drafted and the Directors of the human services departments agreed that the OCYP would be given carriage of the new proposal.

As it was reported

> So the government was looking for something, new initiatives in the area of child health and the OCYP felt that ....the Cabinet Minute would actually come out of the Cabinet Office itself, so we would allow the Cabinet Office to submit it and then all the other human services departments would support it. So it was at that stage that we handed over all the information that we had, the paper, plus the Cabinet Minute that we drafted to the OYCP and they redrafted the Cabinet Minute, added to it, and gave it a title and it became Families First. So it gave it a nice catchy title and one cannot underestimate the importance of doing something like that.
> (Interview with PS8).

Experienced policy officials have the strategic ability to present evidence to ministerial staff in a manner that will gain their interest and support, and so it was in this way that the concept of Families First appeared on the Cabinet agenda (Interview with PS2). It matched the political imperative to do something about youth and family problems and as there was a State election due it offered a solution to troublesome social problems. The government was keen to be seen to be active in social policy and Families First was now seen as a new and innovative move by the Carr Government.

By this stage the policy instruments that would implement the new policy were decided. This was to be through provision and coordination of services involving a range of human services departments and non-government organisations, in a whole of government approach, with four main fields of activity. These were respectively, early identification of problems and support for expectant parents and those with a newborn child; ongoing support for childrearing families in the community, especially families with infants and young children; targeted services for families whose difficulties indicated they needed more intensive support, and community development that linked

local community networks to families with young children and provided early intervention strategies. The range of services was broad, from maternal and child health services provided by NSW Health, through to community programs for families such as volunteer home visiting, child care and preschool education services and specialised services for families with complex needs. Although five government departments were to be involved, it was reported that the government had a major interest in and commitment to the Department of Community Services. Families First would provide that Department with a different entry point with families, giving it an opportunity to broaden its agenda and thus reshape its public image.

> I think in part that there was a political decision to direct most of their new resources to the Dept of Community Services because politically they wanted to bolster DoCs... and this is with the benefit of hindsight I have seen what has happened in subsequent years... this was kind of a first move to give DoCS a different public image and a different entry point with families. So particularly they decided well before the launch of the Strategy (inaudible) there were decisions that the bulk of the money would go through the Dept. of Community Services and if the bulk of the money is going through the Dept of Community Services, they don't run universal child health systems they fund non government organisations to do a variety of things so I think it was kind of tied up in wanting to bolster DoCs give it a new image so most of the funds were going there for that purpose...
> (Interview with PS2).

By and large this appears to be what has happened, and the Department has since developed a profile as a large stakeholder in the field of early intervention, as a visit to the Department's website will confirm.

It is at this point in the policy making process consideration needs to be given to who will be affected by the new policy. In the context of Families First, this would include parents and other caregivers, providers of early childhood education, family care services including non government organisations, and health clinicians. Consultation may occur with representatives of these key groups, experts and interest groups, proposals may be circulated for comment and advisory committees convened (Colebatch, 2002). It was reported that consultation occurred between the human services departments and key experts and interest groups (interview with PS8). The setting up of the Statewide Families First Committee to oversee the new policy was another avenue for consultation with stakeholders, as this committee included

representatives from the government departments, non-government agencies and interest groups. It was to this committee that representatives of the health clinicians who would be most affected by the initiatives proposed in the new policy, such as the child and family health nurses' professional association (CAFHNA) was invited. It is reported that the presence of the nurses' representative at the newly convened State wide committee was not particularly welcome (Interview with PS6). From my own recollection of this particular time, confirmed by interview with PS6, there were a series of earlier meetings that predated the Statewide Families First Committee, to which representatives from key clinical organisations were invited, including CAFHNA. These meetings were held in the NSW Government offices in the city centre, were chaired by Cabinet Office officials, and were set up to introduce the new policy to clinicians. How well CAFHNA responded to the consultation process will be discussed in Chapter 5.

Policy Adoption

When Cabinet approved the policy direction, things moved quickly. In March 1998 the Premier announced the Families First Strategy and an initial funding of $27M at a media launch at the Masonic Centre. At that point staff could be recruited for senior positions to begin the policy development and implementation. Initially there were three staff members involved; a Program Manager, and a senior policy officer in The Cabinet Office, who was appointed Policy Adviser, with the assistance of an administrative clerk. They were located within The Cabinet Office, which was a deliberate move to emphasise and maintain the transdepartmental nature of the policy.

Once the government makes a public commitment the progress is even more rapid. Money was allocated from Treasury for the three pilot areas and a regional officer was employed at the pilot sites whose brief was to pull together human agencies to work out gaps in service delivery and to make plans to begin the change in service direction (Interview with PS2). The first pilot began by late 1998 and in the 1999/2000 Budget money was allocated at regional level. The Cabinet Office employed two consultants to develop the framework for the policy and this document was sent to the regions by the end of 1998. The Statewide Families First Committee was set up to oversee the policy implementation in the three pilot areas.

Home Visiting

Families First has four fields of activity, of which the first two are providing universal services to women during pregnancy and the early parenting period, and home visiting and other support for families with infants and young children. These two fields of activity were to become the main fields for NSW Health services.

From the first stages of the development of Families First it appears that home visiting was seen as a major component of the policy. In the beginning there was excitement around the notion of volunteer home visiting in a model similar to that of the Community Mothers Program in Dublin, Ireland (Molloy, 2002). The UK home visitation programs Newpin and Homestart had begun several programs in the greater Sydney and Newcastle region, and evaluations of their program showed high levels of acceptance (Vimpani, Frederico, Barclay & Davis, 1996). In these programs volunteers usually receive a short orientation or training program and, with the support of a program manager (who is often a suitably qualified health professional), they visit families on a regular basis to assist the new parents to adjust to the demands of infant care and changes in family life. Volunteer home visiting programs are funded by the Department of Community Services, and the early budget went to this department. This was an important decision, because several years later when the NSW Department of Health was keen to fund sustained home visiting programs by nurses, the money was not available as the major budgeting allocations had already been made.

> Health got a certain amount of money much less than they actually needed to be able to deliver in the first field of activity which is basically the universal home visiting. And Health got no money for sustained home visiting it is still unfunded to this day apart from a couple of programs.
> (Interview with PS2)

Although the first interest was on volunteer home visiting, it soon became apparent that volunteer home visiting as it was originally envisioned was not a reality. Volunteers were not easy to recruit, and they tended not to stay long term, which interrupted the capacity of the program to deliver its long term outcomes. It seemed that the volunteer visitor model was not practical because there would not be enough volunteers able to be recruited and maintained to support the demand from new births. More crucially, Families First needed universal, non stigmatising access to families with new babies and

it was argued by health personnel that this could best be obtained through the maternal and child health services offered to all families by NSW Health services.

> ...even though the focus initially might have been on volunteer home visiting.... Health was always considered to be the central platform to the Families First Strategy because it was via the health system that people were universally accessed. So the whole Families First Strategy was always contingent on Health being the main access point but I guess the politics around the Families First announcement was to focus on volunteers but I think people quickly kind of realised that volunteer home visiting was not going to get a universal reach and what underpinned Families First was the universality of it for the population, it was a population strategy, so yeah...
> (Interview with PS2)

NSW Health policy officials put forward the evidence to The Cabinet Office for the efficacy of nurse based home visiting, such as that provided by the Elmira Projects (Olds et al, 1999). This, together with the existence of an already well organised and extensive network of community nursing services, made nurse visiting a more feasible option. Community health nurses working in child and family health services were to provide universal home visiting for families with new babies. Initially they were also designated as home visitors for families with more complex needs requiring sustained home visiting programs as suggested by the Elmira Project.

The decision of the Families First planners to institute universal home visiting was a watershed for child and family health nurses. To be implemented fully it would require nothing less than a reorientation of the community child health program. From a clinic based service where mothers could opt to attend or not, it would have to become a more proactive service in which the nurses actively sought out parents for that first mandated home visit. With the introduction of the obligatory psychosocial assessment at the first visit the emphasis of the service swings away from traditional public health measures such as health surveillance towards psychological care, particularly of the infant and mother. If regular (sustained) home visiting was to be implemented for those families who were identified through the psychosocial assessment as needing further support, then appropriate service adjustments would be necessary to implement the program and

the nurses prepared and supported to meet the increased demands. Looking back, an interviewee close to the situation at the time commented on the tasks set for the nurses:

> Oh they would have struggled to do it because we didn't have the...I mean there were a lot of changes...we would probably struggle less now because we've had seven or eight years of re-orienting the child and family health nurse workforce to the kind of more broader principles, broader things underpinning Families First and the broader way of working that child and family health nurse have had to learn to work under Families First.
> (Interview with PS2)

This stakeholder was not the only interviewee to express this opinion. The particular issues that arose for the nursing service in re-orientating to universal home visiting under Families First principles will be addressed further in the implementation section of this chapter.

Further Policy Development within NSW Department of Health

— Health Home Visiting Guidelines

When NSW Health took up the challenge of Families First in 1999 it soon became apparent in the pilot areas that it was necessary to develop policy documents that would guide health managers struggling to implement the new strategies (Interview with PS1). The NSW Child Health Policy had been released in 1999 and had provided a formal departmental policy to set the direction, but further more detailed direction, particularly for health home visiting, was required. There was an expectation that Area Health Services would achieve universal health home visiting to new babies and sustained home visiting for needy families. However, there were no guidelines to assist health managers and so, in the first year of Families First, a decision was made at Departmental level to write policy guidelines to direct Area Health Services and to provide health managers with information and support. A proposal was put to Families First staff in The Cabinet Office and money allocated to write the guidelines (Interview with PS2). The policy making unit within the Department of Health that was to be responsible for this document was at that time named the Family and Child Health Unit and later renamed Primary Care and Partnerships Unit. The policy officers in the Unit were members of the Families First State wide Committee and closely involved with the development of the Families First Strategy so the Health Home Visiting policy was

devised to support NSW Health's role in the Strategy. The new Health Home Visiting Guidelines were released in draft for comment in early 2002.

The 2002 draft document made it clear that this was a change in service direction. This was not to be a transfer of a medical service from a clinic into the home, but a new style of service. It describes the necessity for a reorientation of existing child and family health services to become part of a 'comprehensive, coordinated and integrated framework of services that provide a mix of clinical, targeted and universal programs to support parents' (NSW Department of Health, 2002, p.9). This included antenatal, postnatal and other programs within NSW Health that serviced families and was a move away from the traditional service view of child and family health in a separate clinical stream distinct from other services. Health Home Visiting forms part of a continuum of care for families throughout the first three years of the child's life and requires greater cooperation between health care streams, particularly between midwifery and child and family health services.

The draft was widely disseminated and, despite its status as a draft, was reported to be used by AHS health managers in establishing some congruence in nurse home visiting in the early implementation phase (PS10). The Health Home Visiting Guidelines document was revised in 2006 and remained in draft form until its recent release in May, 2008 as part of the Supporting Families Early policy. Effectively, the AHSs have been implementing nurse home visiting, which is a key plank of the Families First Strategy, since 2002 on the basis of the draft document. The Department of Health has not explained why this policy took so long to formalise.

— *Integrated Perinatal and Infant Care and Family Partnership Training*

At the same time as the Health Home Visiting Guidelines were being written by the Family and Child Health Unit, the Centre for Mental Health within the Department of Health was writing the Integrated Perinatal and infant Care (IPC) initiative. There was consultation between the two policy branches in the Department and as a result the IPC policy became part of the package of new health policies being developed for child and family health nurses (Interview with PS7). The revised IPC remained in draft form until

2007 when it was renamed as SAFE START and announced by the Premier (NSW Health, June, 2007a).

The staff members in the Centre for Mental Health were aware of the research around early intervention during pregnancy and the postnatal period and the work of The Cabinet Office with the Families First Strategy. In 1998/9 they started to move towards an ecological model of perinatal mental health. There was support from important clinical stakeholders for change in mental health services and commitment from senior management in the Centre for Mental Health (PS7).

In 1999 pilot programs were begun in six Area Health Services with a new clinical role of perinatal mental health coordinator. The coordinators would be responsible for organising and implementing strategies to encourage early identification of pregnant women with personal or family histories or risk factors that indicated they were likely to need more intensive support in the early postnatal period and to mobilise existing services to move to a more integrated service delivery model. Funding was provided in 2000 to a senior clinician to develop an ideal model, but the pilot programs resulted in different implementation strategies. In one Area Health Service the funding was given to a dedicated perinatal mental health position that was funded for three years, in other Area Health Services existing staff were utilised in the new positions because of lack of funding.

The Centre also encouraged the development of a psychosocial assessment questionnaire and funded in 2002 an education and training package for clinicians that would be rolled out across the state in every Area Health Service (Interview with PS3). The psychosocial assessment questionnaire was developed and validated, but the education and training package was only partially implemented. It was replaced with another training package known as Family Partnership Training, designed by Professor

Hilton Davis and his team, in London University. The reason for the change in direction was explained as:

> ...the Centre for Mental Health ...produced a (IPC) training package which was made of fifteen modules. Now that money came from Cabinet Office ...and that money was going to be used for all child and family health nurses for all midwives and a big chunk of it was for mental health so an adult mental health worker could also learn about the principles and the way to work in the perinatal period. There was some money put aside to educate managers, to advertise etc. it took two years and then Cabinet Office decided in the usual political way of doing things to pass everything to DoCS where it actually went into a melt down... Another twist came along... (name of person) went to a conference in England in 2001 and he met a man who literally amazed him and that was Hilton Davis. He heard about the training that Hilton was doing and he thought that it was fantastic. So when he arrived back ...he actually wrote to us in Primary Health and the Centre for Mental Health and said 'this is a fantastic training would you like to take part in this and then you can see if it is suitable for the state'.
> (Interview with PS7).

The Family Partnership Training program emphasised counselling and communication skills and was introduced with the specific intention of improving the proficiency of the health professionals involved with the implementation of the Health Home Visiting Guidelines and the Integrated Perinatal and Infant Care Program. Its major target audience was therefore child and family health nurses who were involved in home visiting. NSW Health supported and subsidised the Family Partnership Training Program, privileging it above the Integrated Perinatal and Infant Care Program (Interview with PS3).

Funding the Service

An important consideration at this stage of the policy process is the allocation of funding for the new policy. There was a consistent criticism from all the stakeholders interviewed for this study about the paucity of funding that NSW Health received to implement its role in the Families First Strategy, and particularly in comparison to the large amount of funding that was given to other government departments. The critics maintain that the funding to NSW Health was not generous enough to sustain the Department's commitment to Families First for Health Home Visiting. Several informants alleged that lack of funding was the main reason for the delayed release of

the Health Home Visiting Guidelines, as the Department was reluctant to ratify a policy which had clear funding implications without the funding to support it.

There is a similar rationale for the slowness in implementing sustained nurse home visiting, which to this day is largely inactive in the two Area Health Services that participated in this study. Sustained nurse home visiting as a strategy missed out on the first round of funding in 1999 and health managers who wished to implement it had to rely on money available through the regions to fund their programs. By and large this was not forthcoming, sometimes due to competing priorities in the regions, but also it is alleged due to interdepartmental jealousies that prevented money controlled by one department to be dispensed to Health.

> ...like all of the decisions had been made quite early in regards to Families First funding in regards to how that money was to be apportioned and where it was to be used and while some of the regions could have chosen to use some of their money for sustained home visiting the problem with that was as well that the regions in the most parts were not allowed to give money to Health because it was considered to be DoCS money...
> (Interview with PS2.)

For whatever reason, it is clear that some personnel in NSW Health felt at the time of the Strategy implementation in 1999 that their programs were under funded by Families First money and this belief still persists today. If funding from the Families First coffers was not available, there was still the possibility of funding for health home visiting within NSW Health itself. However, as one of the stakeholders interviewed knowingly commented, 'child and family health to the health system is a very small part of the health system, and attention is on the bigger things' (Interview with PS2).

So it seems that at the point of policy implementation there were real difficulties for NSW Health personnel in the implementation of their obligations under the Families First Strategy. Whilst money issues may have been prominent, there were also staffing and service change issues. These will be discussed in the next section.

Implementation

Policy commentators have long suggested that policy implementation is fraught with difficulties (Hancock, 1999). There are any number of actors and stakeholders, changing

contexts and unforeseen problems that may affect the implementation of any policy as it travels through the execution phase. Indeed, Hancock (1999) notes that some policy analysts consider policy to be an evolving concept, which only clearly emerges in the implementation phase as the original intentions of the policy writers are interpreted and changed to suit local conditions.

This discussion of the implementation phase is not intended to be a comprehensive account of the full implementation of the Families First Strategy throughout NSW. A more complete account of the implementation experience is recorded in the process evaluation studies undertaken by the NSW Consortium engaged by the government to evaluate the Families First Strategy (see Fisher, Thomson & Valentine, 2006: Valentine, Fisher & Thomson, 2006).

The discussion in this paper covers only the implementation experience of the stakeholders who agreed to be interviewed by me for this study. It does, however, highlight the particular problems experienced by health managers in the two Area Health Services involved in this study. One of the Area Health Services had begun to implement Families First well before this study began, and the other Area Health Service commenced to formally implement Families First as this study progressed. Although at different points of the implementation cycle, the reported experiences were similar and, where necessary, the comments of informants interviewed for this study are aggregated here.

Health managers are the personnel expected to translate policy directives into services on the ground. For this study a total of five health managers in either of the two Area Health Services involved were interviewed about their experience of the implementation process. They reported that, to varying degrees, the policy ideals were difficult to implement in the real world of service delivery. Their experiences of the implementation process, together with some of their criticisms, are described below.

Implementation Committee Structures in the Area Health Services

A complex committee structure was put into place to implement Families First, headed up by the State level committees that consisted of the Statewide Expert Group chaired

by the Commissioner for Children and Young People together with three sub group committees, and supported by the Directors-General of each of the five human services departments. The Cabinet Office retained responsibility for daily management from 1997 to 2003, when it was handed to the Department of Community Services (Fisher, Thomson & Valentine, 2006).

Beneath the State structure was the Area Health Service committee structure. The common response in the Area Health Services reviewed for this study was to put into place layers of new committees to manage the implementation process. These committees involved personnel from participating government and non-government organisations, most of who had not worked together before, although they may have been known to each other. As the committee structure differed between the two Area Health Services they are described separately.

In Area Health Service 1 there was a complex committee arrangement. At the apex of the management structure there was a senior officers committee comprised of chief executive officers of all the relevant government and non-government organisations, including Health. This committee devised the Area Plan, set priorities and allocated the budget. A subcommittee of the senior officers committee, chaired by the Department of Community Services Director, was convened with senior management from all involved organisations to approve and oversee the Area Plan, and this committee was advised by an area wide Steering Committee. There was a senior nurse manager on both of these committees. As the Area Health Service covered a large rural territory divided into sub regions, regional implementation committees were convened to implement the Area Plan, and beneath them were working parties of the implementation committee that developed local networks. Health managers and senior clinicians charged with implementing the new policy in this Area Health Service reported the complex committee structure resulted in many meetings and an increased workload for them: 'as you can imagine there is a whole lot more meetings...(my workload has increased) hugely, absolutely hugely...' (Interview with PS3 & PS10). Local managers reported that despite the cumbersome structure the working parties were able to work well together, although it was acknowledged that this was not a universal experience.

I think it went reasonably well and I really think that was because the girls
already had great networks created. I think in other areas it hasn't been quite so
smooth. I know that the FF implementation groups in some areas are just
fighting, the whole time.
(Interview with PS4).

In the second Area Health Service the reported committee structure was much flatter,
with a Senior Officer's Group, again with representation from all government and non-
government agencies, with the responsibility of setting the Area Plan and allocating the
budget. Beneath the Senior Officer's Group were sector implementation committees
with middle managers of local service organisations, departmental managers,
representatives from the municipal council and consumers, to take decisions around
implementation projects for their local area. These committees included a nurse
representative. It was reported that there was not always agreement between this group
and the Senior Officer's Group about what projects should be funded. As an informant
expressed it: 'There was a lot of angst because it was seen that the Senior Officers
Group chose to fund projects that were not what the grassroots felt was needed'
(Interview with PS6). The sector committees were responsible for developing local
networks, which they did with varying success, depending on the level of commitment
from group members.

It appears that not all government departments were interested in being involved or keen
to participate in the committees. Interviewees from both Area Health Services reported
that certain organisations did not actively participate although they were specifically
invited, and this was thought to be due to a perceived reluctance on their part to move to
the new structures required by Families First (interview with PS3, PS4 and PS6). In
some instances, there was a difficulty in maintaining continuity, with departmental
representatives constantly changing.

So I think that the NGOs we work with have been fantastic (but) I think there
has been reluctance on the part of some government departments to move to a
new structure)....(name of department) has been involved in two or three re-
structures since Families First came in is a classic example of that, and they
simply don't attend the meetings - they have funding for children's early
intervention etc and yet most of the time we can't get them to the table or engage
them or if you do you find you are dealing with a different manager every three
months.
(Interview with PS3)

It was noted that the non-departmental organisations displayed greater commitment to the process, and several interviewees gave examples of successful cooperative efforts between the child and family health nursing services and local non-government organisations. For example, one interviewee reported 'We have a yearly plan for our local FF group and all the services get together and we plan that.' (Interview with PS4).

A significant issue reported by health managers in both Area Health Services was the difficulty of the localised implementation groups in maintaining momentum. Many of the people involved were busy clinicians or managers taking on this responsibility over and above their usual workload, so that

> ...what that means is the people who are already in jobs have to do something extra and that has been a hard push to maintain things, ... (named sector) is having great difficulty in actually engaging or starting again because the people are not there to put in the time.
> (Interview with PS6)

However, despite these difficulties, there appears to be a willingness on the part of a large number of people to work towards meeting the vision of the Strategy. It was reported from one of the three pilot Area Health Services involved in Families First that considerable effort was made on the part of the diverse service agencies to work together under the Families First principles (Interview with PS1). Interviewees for this study commented that the reward for participating organisations was a greater knowledge and understanding of each others services, the formation of personal and professional networks and consequently greater likelihood of planning service initiatives together, and ease of referrals between services (PS 4 & PS 6).

> we organised a joint community consultation where a guest speaker came as the little carrot and we actually had a template about service gaps and what people needed and what was working for them and what wasn't working for them and it was a cross service thing so it included all of the services that are in the Families First network and we got some valuable information from that then went into our planning and we could see what the other services were planning - the whole of the Families First group are involved in the drawing up of position descriptions and any changes we make in the description of the position – I suppose that's the type of planning...so it has worked well for us.
> (Interview with PS4).

Funding Decisions

Decisions had to be made on what services could be allocated extra funding with the limited amount of funding available. This sometimes meant that some services received money whilst others missed out. In one of the Area Health Services involved in this study the decision was made to put most of the money into bolstering Early Childhood Nursing services to set up universal home visiting, which led to some dissatisfaction amongst allied health staff, who felt their needs for extra funding to meet bulging caseloads were being ignored. Commonly health managers reported that expectations were greater than the actual amount of money allocated would allow, resulting on pressure on them

> The (Area Health Service) plan contains a whole lot of performance indicators that Health have to meet as part of the funding agreement for Families First and when the actual program was implemented it was really a very small amount of money to do a whole lot of things.
> (Interview with PS3).

Staffing the Service

To complicate matters further, there could also be a disparity between nursing services in sub regions of the area in question. Local or historical factors may have left some sub regions inadequately staffed to meet the ramped up requirements of Families First and had to be addressed. In one of the Area Health Services in this study, there was funding made available for extra nurses, which usually translated into between 0.4 to 2 extra full time positions in the selected sub regions. It was estimated by one interviewee that this roughly translated into less than a 25% increase across the board, with some regions getting more staff than others (PS4). In the second Area Health Service there was no real increase in nursing staff and the area was expected to redeploy existing nursing staff to implement the health home visiting program and other service changes.

It was reported by both Area Health Services that funding was most often used to employ a Families First Coordinator, who had no role in actual service delivery. In many instances the limited number of nursing staff available made it difficult for areas to meet their obligations for universal home visits and they struggled to implement the second level sustained home visiting program. Whilst the targets for universal home visiting was generally met, with most, if not all, of new parents receiving a home visit,

the requirement for instigating the second level sustained home visiting program was usually not met, mainly because of funding and staffing issues (interview with PS4, PS6 & PS9).

> At the moment the nurses....I suppose this is the same sort of thing as the difference between what you do and then when you supposedly implement Families First. What we do is the nurse makes an assessment and then she decides whether to see the family at home on any more visits. In Families First if you are doing the Sustained Home Visiting program you do your assessment and then you put them into level 1, 2 or 3 and then you do so many home visits on them for the period of time, OK. So if we were to implement the whole Families First level of care strategies and give extended home visiting or Sustained Home Visiting to everyone we should we could not do that because we don't have the resources. So at the moment the nurse makes the assessment, 'can I possibly get back to this family at home? If I can I will try to do that'.
> (Interview with PS6).

Data Collection Requirements

The funding arrangements implemented by The Cabinet Office required participating agencies to report on Families First progress and activities, built into the Area Plan as performance indicators. Area Health Services had to meet these requirements, as part of their funding agreement for Families First, and data now had to be collected to address these performance indicators. Sometimes this data was already being routinely collected, but where it was not new systems had to be put into place. Requests for data on items that had not be routinely collected meant the data had to be researched retrospectively, leading to time consuming activities such as file searches. Health managers also reported that one of the issues for them was the reporting required 'was a constantly changing feast' (Interview with PS3).

The child and family health nurses themselves reported an increase in data collection activities. The introduction of health home visiting brought with it new paperwork, that 'increased remarkably' (Interview with PS10), such as that associated with the comprehensive psychosocial assessment of the parents carried out during the initial home visit. The nurses' perceptions may also have been influenced by attempts in one of the Area Health Service to bring about upgraded reporting facilities by introducing a comprehensive statistical proforma to service the new database (Interview with PS4). Some of the added paperwork came from the new requirements around occupational

health and safety issues for the nurses who were home visiting: 'categorising the risk so that you actually are able to inform your practice in terms of home visiting based on what the risk level is that you assess' (Interview with PS3). The risk assessments were to be made before nurses went out to visit families, particularly on isolated rural properties, and most particularly if they went alone. Nurses were now required to fill in a security log with the names of clients to be visited and their addresses.

Changes in the Organisation of the Nursing Service

The reported experience of policy stakeholders and the nurses indicates that there were regional differences in the organisation of the nursing service and subsequently the changes that the introduction of the Families First Strategy required also differed. In some Area Health Services the once cohesive and extensive Early Childhood Health Centre network had been partially dismantled over the past twenty years, and the specialist skills of the child and family health nurse had been degenerated by dispersing the nurses into more generalist community nursing work. Thus the task here was to re-create an integrated child and family health nursing service by re-educating the workforce and refocussing the service only to maternal and child health. To meet these requirements community nursing teams reformed into child and family health teams and an area education program was put into place to support them. It has now been eight years since these reforms and more recent reports suggest that there are now groups of child and family health nurses who work predominantly with families with young children and that is accepted within the area (Interview with PS9).

In other Area Health Services, including the two where this study was undertaken, the remnants of the old state wide dedicated Baby Health Service had been maintained, although the spread was not even. At least in this instance the framework for the introduction of universal home visiting was in place, although this did not guarantee a problem free transition to operating under the principles of Families First. The major difficulty revolved around the introduction of the Health Home Visiting program. The move to universal home visiting had required a reorganisation of service programming to allow for the time now spent in the home visit. Each of the two Area Health Services made local adaptations to their services, such as restricting access at the Centre to provide home visiting time for the nurses, or moving mothers into parent education

groups to reduce the amount of time spent in one-to-one interviews (Interview with PS4). Where funding was available extra staff were employed (Interview with PS3) and single nurse centres closed to congregate nurses into group practices for efficiency (Interview with PS6). One of the health managers described how she had coped with the increased requirements for nursing staff:

> ...what we did here we did things like, although hopefully I think it is the form everywhere, we took the scales out of the nurse's room and put them in the waiting room and along with our philosophy of less visits we put in place parenting groups to empower the parents to make their own decisions and to come to us as professionals to assist them in making a decision about an issue they have rather than come every week and we tell the parent how to.
> (Interview with PS6)

In the same sector the traditional health screening check for primary school children was reduced and eventually ceased, and regular appointments for developmental checks reduced. There was consideration given to a further reduction of services to preschool age children to allow the nurses to concentrate services on parents with infants aged 0-18 months, although at time of writing this had not occurred.

The organisational changes that occurred as a result of the introduction of the Families First Strategy and the Health Home Visiting Policy pushed the health managers into rethinking service provision and management of their nursing staff in order to meet departmental directives. This process was expressed by a health manager as:

> How can we change our service using the philosophy of FF? So we over a period of years we refocussed to early years. How did we do that? We looked at what the important issues around the early years, the FF strategy, what did we need to do to run that or provide that service. So that involved nurse education, so part of that was doing things like Tripe P, universal home visiting training, Family Partnership training, so a progressive process. Part of that was getting a Clinical Nurse Consultant as a support and mentor for the team and part of that was restructuring the service to facilitate the nurses being able to do it.
> (Interview with PS6).

Terminology Troubles

The traditional separation of services into service silos has resulted in differences between service providers in their understanding of the purpose of early intervention services. The increased interaction between the various government agents during the implementation process brought out this unforeseen difficulty. Theorising about early intervention strategies assumes there is a shared language and understanding of the concept. In reality, health service managers found that their definition of 'early intervention' differed from that used by a major player, the Department of Community Services. This linguistic difference was mentioned by several interviewees (PS2, PS4 & PS6), and apparently came to the fore because of discussions around the introduction of second level support services for clients assessed by the nurse as requiring extra services. It was explained by one interviewee as:

> But they have reached a few barriers and one of them is the DoCs understanding of early intervention compared to our understanding of early intervention. Our understanding of early intervention is the traditional getting to the problems before they become problems. DoCs' definition is once someone's been notified, intervening before they become (worse).
> (interview with PS4).

This apparently innocuous definitional difference caused conflict between child and family health nurses and the DoCs early intervention teams over when it was appropriate to intervene. The child and family health nurses thought it appropriate to refer clients for sustained home visiting support when they assessed that problems in the household were likely to lead to greater difficulties for the parents, but this was not acceptable to the DoCs staff, who applied a different interpretation of early intervention. DoCs required families to be formally assessed as having a problem before sustained home visiting services were made available to them. So the only way of obtaining further assistance for families the child and family health nurses considered vulnerable and in need of support was by notifying them to the local DoCs service.

> My understanding, and we did have some discussion about this, was that the only way you could put them in this (DoCs early intervention) program was to ring the help line and the help line would decide.
> (Interview with PS6).

This left the nurses with the dilemma of either formally placing parents within the DoCs reporting system - a move which the nurses resisted because of wider implications for the family - or of leaving the parents to cope with minimal support. Furthermore, if the child and family health nurse did notify a family to the DoCs agency, there were difficulties in communication between the two agencies, leading to some confusion about the ongoing responsibility to the family expected from the child and family health nurse by the DoCs workers (PS6).

Changes in Nursing Practice

The introduction of Families First principles into a child and family health nursing team was expected to precipitate changes in practice. On the reporting of the health managers, the nursing teams responded according to factors such as the level of adjustment required to current practice, the previous experience of the individual nurse and local conditions. Some of these are described below.

The Department of Health had made it clear that home visiting of new mothers was to become a priority, which resulted in an increase in the numbers of home visits to be carried out in the local area. Indeed, the rate of home visits in an area was used by the implementation committees as a performance indicator, so pressure was applied to the nurses to visit (PS4). All of the nursing teams surveyed for this study were already scheduling home visiting in the daily routine, mostly for mothers who were unable to come to the clinic or who were seen to have special circumstances needing further support, such as the birth of twins. As such the home visits were an extension of routine clinic services into the mother's home. Although most of the nurses had had experience with home visiting, this was not a universal experience. For those nurses who did not regularly carry out home visits there were some anxieties attached to the change, especially around security concerns and they needed support to build up skills and confidence to go into people's homes (PS4).

There was also a qualitative change to the requirements of the home visit. These were now first contact visits where a set of in depth assessments would be carried out, and where the nurse could be confronted by a whole lot of other issues that had not been part of standard practice in the past (PS3). There was also recognition that entering the

home gave the nurse a different perspective on the family, and the opportunity to observe home conditions. This may have given the nurse a deeper appreciation of the family's circumstances.

> Yeah I think the other thing they don't realise completely when they look at the level of information that they can pick up in somebody's home…I think a whole lot of that clinic stuff gets done in one or two home visits because you are entering the person's territory you are not in your own territory…you are more likely to see the rough husband or the cat climbing all over the baby. I don't think as a group they have quite reached that level (of saying) 'oh, yeah, I do get different things out of a home visit than I do out of a clinic visit'.
> (Interview with PS4)

At the conclusion of the initial home visit, and based on the data gathered in the comprehensive assessments undertaken at that visit, the nurse made a clinical decision on the level of care to be given to that family according to their need, using the four categories described in the Families First documentation as a guide. For example, the nurse may assess the family as managing well and offer only Level 1 or routine care. Families assessed as having more difficulty were to be assigned for further support and increased services on a sliding scale according to need. Theoretically, the system was predicated on informed nursing judgement of the level of care required and the formation of a plan of care for the family. This differed from previous practice where, although the nurses were no doubt very aware of needy families, no formal assessment of level of need was required to inform the nursing care plan. It was reported that, in practice, the services available to help such families were not always available, leaving the nurses and families to cope as best they could with limited resources (PS 6 & 10).

The philosophy of Families First was on supporting the parents, developing family strengths and early intervention for detected health problems (NSW Government, 1999). This required a more holistic approach, focussing on psychosocial issues in the family and consequently attempts were made to move the nurses' practice away from the growth and development screening and infant care that had been the mainstay of the child health service for some decades. Some nurses welcomed the change because it

> …gave them permission to spend more time in what would previously have been called the 'fuzzy areas' rather than the developmental ones.
> (Interview with PS6).

The change from health surveillance processes to psychosocial processes did not suit all nurses, some of whom felt threatened by the changes. These nurses were less enthusiastic about the change in routines and more reluctant to leave the clinic to home visit, with the result that they often left the service rather than adapt to the changed routine (PS6).

Other nurses contended that Families First heralded very little difference to their existing practices.

> …what you have been hearing from the nurses is that not a lot has changed….and I think that if they take a little step backwards they are doing this a little bit differently…and even though the nurses say we do things exactly as we have always done it, I think there has been a change of focus. (Interview with PS4)

This statement may be truer in some areas than others, as on her own reporting this interviewee acknowledged that the nurses known to her had been particularly innovative in their practice and therefore had voluntarily initiated practices compatible with the proposed changes. It may be that these nurses were not recognising the change in practice because it was part of a gradual move or swing to psychosocial work in child and family health nursing that has been occurring for some time. This very gradual change may have occurred as the result of the practice philosophy of individual nurses and in this sense would have occurred independently of the managerial changes instituted by the introduction of Families First. There were, however, instances when the gradual change occurred as the deliberate intent of innovative health managers, who prepared their nursing team for the coming changes through education and leadership. As the Strategy was rolled out across the State incrementally and over a period of years, there was plenty of time for informed health managers to become aware of departmental policy and to begin to implement changes that would assist in the smooth transition to the operating principles of Families First (PS6).

The local Families First network groups required the nurses to interact with other agencies in their local area. As the local networks began to function, the various members came to understand and appreciate each others services and the contributions that could be made. Working with staff from other agencies exposed the work of the nurses to others in the group, which helped establish partnerships with other agencies.

This led to innovations such as the Department of Education representative on the local implementation committee organising with the child and family health nurses in the local Centre to provide special care for three teenage girls with new babies in Year 10 at the local High School (PS4). The network partnership also extended to jointly developing an annual plan for the local area, thus widening the sphere of activity of the child and family health nurses.

There were also new practice requirements for nurses around the change in services. Before a home visit could take place a risk assessment was carried out and nurses had to fill in a security log listing the names and addresses of clients they were visiting that day. The Occupational Health and Safety checklist asked if there was a gun in the house, which raised issues for rural areas where gun ownership was high. This was a real concern in rural areas that had no satellite phone service and where the nurse would be unable to call for assistance if there was a need. City based nurses, who had previously conducted mostly clinic based services, were now more mobile with home visiting, so such things as transport and car pooling had to be factored into the daily routine.

Education Requirements

In both of the Area Health Services surveyed for this study there was effort put into education programs, both formal and in-service, to accompany the introduction of Families First. It was recognised that disparities existed in the nurses' knowledge and skills, particularly around the introduction of the health home visiting program and the comprehensive psychosocial assessments. Formal education programs for nurses included the Triple P parenting education program, and counselling and communication programs such as the Family Partnership training (FPT) program. FPT was a state wide program funded by the NSW Department of Health and based on a train the trainer implementation model, in which the two initial groups of health professionals trained in the program in 2002 were to take a role in rolling out the program across the State (Vimpani, 2002). All Area Health Services were expected to participate and to include ongoing Family Partnership Training within their area budgets when the subsidised program ceased in 2005.

The NSW Department of Health has also introduced additional assessment requirements with the revision of the Personal Health Record (or Blue Book) in 2006, which means retraining for some staff in the new screening tests. Consequently much effort has been put into education packages for the nurses, with short courses and in-service workshops. It was suggested that much of this material could be incorporated into one package, thus reducing the massive overlap in the education programs (interview with PS10) and also reducing the burden of the education time adding to their already busy schedule.

The education needs of the nurses addressed by the NSW Department of Health at the time had one notable omission: there was no connection to the education that provided the postgraduate programs to prepare registered nurses for practice in child and family health nursing. Course coordinators in the three major education providers in the State were left to rely on their own network connections to keep informed of the changes occurring in the child and family health nursing services. Whilst the professional association published articles in the journal sent to members, and included relevant topics in the seminars, unless the educators were members they would not have received this information. In early 2008 this issue was addressed by the Working Group for the NSW Department of Health Child and Family Health Nurses Practice Development Program by formally advising educators of the Program's requirements for pre-practice education.

Losing Momentum

Several interviewees reported concerns that the Families First Strategy was in danger of slowing down, or even being watered down. It was reported in one Area Health Service that pressure had been exerted on child and family health service managers to fit into the Area's Clinical Services Plan by requiring the child and family health nurses to take on acute care paediatric cases in the community setting to reduce pressure on the hospitals.

> …so the whole thrust is on acute services. We have lost the agenda I think in terms of early intervention, which is what child and family health is about. (Interview with PS3)

Part of this was due to health managers responding to increased demand on the health care services, and Department of Health directives that gave priority to acute care services. The perception that senior health management was wavering in their commitment to the child and family health policies was reinforced by knowledge that the AHS Chief Executive Officer's individual performance agreement with the Department of Health no longer included Families First.

At this time of writing it is more than eight years since the Families First Strategy began so it is not surprising that in that time some enthusiasm for the Strategy has dissipated. As Hancock (1999) suggests, policy implementation requires adaptation of the initial concept to local conditions, and this carries with it the risk of losing sight of original objectives. The real danger occurs if the frittering away of policy objectives results in policy death, even if the policy name remains.

Harrison (2001) in his discussion of policy implementation models draws on the work of Gunn (1978) to propose an ideal type with six conditions. The first two relate to the availability of sufficient resources (both material and non-material) and in the appropriate combination of resources. For example, material resources would include funding, but also adequate supplies of materials, staff with relevant skills and non-material resources such as sufficient time to implement the policy. He also asserts that the theoretical basis of the policy must be valid and that the intervening links between the policy theory and the policy expression in the real world during actual implementation are kept to a minimum. That is, the more levels of administration required, the greater the probability of a breakdown in the chain of implementation. Finally, he notes that if there are a number of organisations involved in the policy implementation, the same conditions of cooperation and communication apply. By considering Harrison's ideal model in the context of the reported experience of the stakeholders, it can be seen that the factors which he identified are evident here. There were difficulties with resource allocations, both material and non-material and the chain of implementation committees was long enough to provide opportunities for breakdown. Indeed, it would appear to be remarkable that the local implementations went as well as reported, for in summarising their experiences the stakeholders interviewed remained committed to the principles of the Strategy and convinced that the benefits were evident or would eventually flow.

Change in Lead Agency

In 2004 the overall responsibility for the Families First Strategy was transferred from The Cabinet Office to the Department of Community Services. The informants interviewed for this study reported that the transfer in 2004 was not universally acclaimed.

> When it went across to DoCs OK everybody opposed that. We were asked to comment on it and we said like every other department we commented and said we don't think this is a good idea. It was sent across to DoCs anyway. Why? I think it is purely political. I think that in some point in time somebody in the government made a decision that DoCs needed to have some positive stories. (Interview with PS8).

Families First is now one of a number of programs administered by DoCs for families with children in NSW. It is part of a continuum of integrated service provision that includes preventative (which is where Families First sits), early intervention (after family is notified to DoCs), child protection services and out-of-home care (DoCS, 2007a). According to the Annual Report of 2006/7 (DoCS, 2007b) funding for the Families NSW program was distributed to specialist and general family worker projects, supported playgroups, volunteer home visiting services, and the Triple P parenting education program, among others. There is no mention of nurse home visiting.

For NSW Health employees, and particularly for the nurses, the lasting legacy from Families First is the Health Home Visiting Program. The NSW Department of Health has continued to develop Health Home Visiting and to cement it as the central plank in child and family health nursing services, as expressed in the Supporting Families Early (2008) policy. Regardless of the direction in which the Department of Community Services takes Families First (or Families NSW as it is named now), it is apparent that Health Home Visiting will remain a significant service requirement in child and family health.

Evaluation

The Cabinet Office, which at that time was leading the Families First Strategy, awarded in 2001 the contract for evaluating Families First to a consortium led by the Social Policy Research Centre, University of New South Wales. The UNSW Evaluation Consortium has since conducted Area Reviews and delivered seven reports to The Cabinet Office. The Consortium published the following:

1. Outcomes Evaluation Framework, 2004
2. Area Review Methodology
3. Area Review South West Sydney
4. Area Review Orana Far West
5. Area Review Illawarra
6. State Level Review
7. Final Summary Report published in 2006, included Area Reviews together with findings of the State Level Review

(Fisher, Thomson & Valentine, 2006).

The Area Reviews were process evaluations of the implementation of Families First in the three pilot Area Health Services (Valentine, Fisher & Thomson, 2006). They evaluated the capacity of the services involved in Families First to achieve the goals of the Strategy by examining the different organisations' responses, the networks they set up, and the staffing and resources allocated as well as their leadership activities. In general, the reported implementation experiences of the stakeholders interviewed for this study echo the findings of the Consortium research team. The Consortium reviews note that the success of the policy implementation was built on the historical strengths of the service communities, that is, on whether or not the existing service networks were utilised and strengthened. The importance of services incorporating Family First principles into their organisation's core business is noted, together with the introduction of management processes that facilitate relationship building between service partners. The role of champions for Families First to sustain momentum is also noted. Commentary on the need for adequate resources including staffing supports the assertions of stakeholders reported above. The evaluation report notes the challenge presented by Families First in bringing together government departments and non-government agencies with sometimes significant differences in structure, organisation

and value beliefs and this is also reflected in the reports of stakeholders interviewed for this study.

The area reviews included a component for interviews with fieldworkers (Fisher, Thomson and Valentine, 2006), however, specific occupational groups were not indicated, so it is unknown whether nurses were included. Amongst the complex sets of data collection methods there appears to be little reported on the direct effect of the implementation of Families First on workers at the implementation coalface, which includes child and family health nurses. The value of this Policy Study is that it gives some insight into the impact on the nurses and the other agents with whom they came into contact in the local implementation committees.

The reviews listed above are the only published evaluations of the NSW Families First Strategy to date (Lynn Kemp, UNSW, personal communication, November 15, 2007). The Consortium proposed a full outcomes evaluation with a complex dataset around the three central domains of child, family and community outcomes (Fisher, Kemp and Tudball, 2002). In the evaluation framework proposed for Families First, it is noted that the expected timelines for outcomes, as assessed by indicators, is as follows:

- Two to five years before a decrease in priority risk factors;
- Five to ten years before an enhancement in positive and healthy development;
- Ten to fifteen years before a vision for a health community is embedded in the social contexts and institutions of a community.'

(Griffiths et al, 2001, cited in Fisher, Kemp and Tudball, 2002, p29.).

On that timeframe, the outcome evaluation of the Families First Strategy is a long way from completion. The Department of Community Services published an outcomes framework data report in 2005, but that report is not available in the public domain. I await with interest further evaluation reports.

Conclusion

The Families First Strategy is an ambitious social policy that owes its genesis as much to the altruism of its supporters as it does to political expediency. It has had and will continue to have an enormous influence on the conduct and organisation of health and welfare service agencies in NSW. It has also begun to make rapid changes to child and

family health services, and ultimately to the work of child and family health nurses. This analysis has displayed the intricate structures that inaugurated, supported and defined the social policy known as the Families First Strategy during the time period 1998 to 2007.

It is apparent from the examination of the policy cycle, that child health nurses were silent witnesses and minor players in the policy making process. Yet the introduction of Families First had a huge impact on child and family health nurses. Given the organisational changes that were occurring around the nurses, it is to be expected that this would lead to changes in practice and this was reported as occurring. Whilst it clearly increased their workload, it provided them with recognition of a unique role in health care, and the opportunity to develop the clinical specialty of child and family health nursing. Because of the emphasis on psychosocial aspects of family functioning, they were given permission to redirect their nursing practice to spend time on family issues that had previously been seen as secondary issues. The question now arises: did they make use of the opportunities presented to them?

Concluding Remarks

Some of the issues raised in this chapter relate to the role of the nurses professional organisation, CAFHNA, in the policy process. The next chapter will address the role and function of the professional nursing organisation and critique the association's ability to participate in policy making.

CHAPTER 5: THE POLICY ROLE OF THE CHILD AND FAMILY HEALTH NURSES ASSOCIATION

Introduction

The nursing profession in Australia has developed mechanisms for interacting with the political domain in health care through professional nursing organisations. Such organisations may influence the policy making process by acting as pressure or interest groups, or their officers and members may become influential as part of the policy community (Davis et al, 1993). This chapter will describe and discuss the role and function of professional nursing organisations and consider the influence of the association that represents child and family health nurses in NSW as a policy actor in health care policy. I have argued in Chapter Four that child and family health nurses were not primarily involved in the development of the Families First Strategy and only secondarily involved in policy implementation. By examining the professional association's role and actions some insight may be gained into the political base from which the nurses operated.

Professional Nursing Organisations in Australia

There are three major nursing organisations that are large and well organised enough to interact with the government at both national and state or territory level. The Royal College of Nursing, Australia was established 50 years ago and has a membership of more than 8,000 (RCNA, 2003). The College is situated in Canberra, the seat of the federal government, to denote its perceived national political role. The RCNA also officially represents Australian nursing interests at the International Council of Nurses. The College of Nursing (formerly the NSW College of Nursing) is smaller at 4,000 but active in NSW health politics. The College sees itself as a nursing leader in NSW and has sought to widen its sphere of influence within the State and beyond (Walker, 1999). Both of these organisations claim a position representing the profession of nursing in Australia nationally and internationally. The third organisation is the Australian Nursing Federation (ANF) which has a dual role of industrial and professional representation. The ANF is the oldest, established in 1924, and by far the largest organisation with more than 150,000 members, and participates in development of policy in nursing, nursing regulation and industrial matters (ANF, 2008). The mission statements of these

three organisations clearly indicate their role and function as promoting the profession of nursing and supporting their membership.

The practice of nursing is fragmented into clinical specialty areas, and there are a plethora of smaller nursing associations that claim to represent the nurses working within the particular clinical specialty area. This state of affairs is also true for community child health nurses, where there are separate, small organisations in each state and territory. These state based organisations come together at the national level to form the Australian Association of Maternal, Child and Family Health Nurses (AAMCFHN) that interacts with federal government agencies and other national bodies such as the RCNA and the ANF. Child and family health nurses in New South Wales are represented by the Child and Family Health Nurses Association (NSW) (CAFHNA). CAFHNA is a state based association with its activities confined to within NSW, however its sphere of influence extends beyond the state borders through its membership of the AAMCFHN.

The role, function and reach of professional nursing organisations was analysed by Hamlin (2005) who examined the aims and objectives, structure, membership, activities of nursing organisations and their ability to influence health policy and practice. This framework will be used to describe and analyse the purpose and activities of CAFHNA with particular reference to its political ambitions. Although a small organisation, the Association sees itself as a player in health policy making for child and family health nurses. Therefore an examination of the Association's actions and contributions to health policy assists in the policy analysis undertaken in this study.

Aims and Objectives of the Association

From its inception in 1989 CAFHNA was set up as the conduit for child and family health nurses through to the policy making process in the NSW Department of Health. Representation to policy officials and senior health service management was considered essential to put forward the nurses' interests and thus provide another view to that given by other stakeholders.

The aims of the Association were set out as follows:

- to promote the concept of child and family health nursing,
- to provide a forum for professional support,
- to provide continuing education to facilitate professional development,
- to set and monitor minimum standards of nursing practice by acting in an advisory capacity on matters relating to child and family health nursing,
- to be involved at the policy development level within the Department of Health and Area Health Boards on matters affecting child and family health nursing practice and education,
- to encourage the development of nursing research within the area of child and family health,
- to provide communication to members through papers, articles and journals.

Mission statements or aims are important as they set out the goals of the organisation. The CAFHNA aims are principally about promoting/developing the clinical specialty and supporting members and therefore are similar to other nursing organisations (Hamlin, 2005). Since its inauguration CAFHNA has striven to meet its overall goal of providing a voice for child and family health nurses. Its success can be measured against the range of education, communication, and policy development activities that it has undertaken to meet its stated objectives. The CAFHNA aims have not been revised since 1989 and a review of the fit between the organisation's present activities and its stated aims suggests that whilst most aims have been and continue to be met there are some that are less well established. Hamlin (2005) notes that whilst identifying organisational aspirations is necessary there is a need for constant review to ensure continued relevance of the organisation and this may even be necessary for the organisation's survival.

Structure

CAFHNA is an incorporated entity with the Office of Fair Trading in the NSW Department of Commerce and is administered according to the CAFHNA Constitution. There is an honorary board, which includes representation of rural as well as urban members that is elected by association members for a term of one year. The board, known as the Committee of the Association, meets at regular intervals of once per

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month to conduct its business. Committee members may meet face to face or by teleconference. Revenue is mostly generated through membership fees although small profits may be made on Association activities such as seminars. Similar to most small associations the organisation operates principally with voluntary labour.

The work of the Committee of the Association is supported by sub-committees that are involved in education, standards review, publications and marketing activities. Each subcommittee is chaired by a member of the Committee of the Association and reports to the Committee. Typically about twenty members are involved with the work of the Association at any one time (CAFHNA Minutes of meeting 18/10/05).

Membership

Membership is open to registered nurses with a further qualification in child and family health nursing. Associate membership is available to any nurse with an interest in child and family health nursing. From an initial membership of ten, the association has grown to a membership of approximately 420 most of whom live and work in NSW with small number (less than 30) members from other states and territories (CAFHNA Minutes of Meeting held December 11, 2007). Estimates of the numbers of nurses who are working in child and family health nursing positions vary, but the Australian Institute of Health (2005) in a workplace survey conducted in 2003 reported that 1,048 nurses (both RN and EN) were employed in child and family health positions in NSW and that 54.5% of these were working part time. This is consistent with anecdotal reports. Taken on these figures, the Association represents 40% of child and family health nurses in NSW. This compares favourably with other organisations in clinical specialties that have larger numbers but smaller representation. The Australian College of Critical Care Nurses has 2,500 members, that represent approximately 12% of nurses eligible for membership, and the Australian College of Operating Room Nurses covers approximately 20% of their possible membership (Hamlin, 2005).

Hamlin (2005) suggests that the level of coverage of available prospective members is an indicator that they are relevant and adaptable and on this analysis the Association can be seen as moderately successful. Nevertheless, it remains a relatively small association. Increasing the membership is an obvious target, but DeLeskey (2003) reports barriers to recruitment, including cost of membership fees, a lack of information about the

organisation and lack of time to participate in association interests and activities. Of these three, lack of information is probably the most amenable to change and CAFHNA has made efforts to increase its profile amongst clinicians through its seminars, and more recently, the commissioning of a more interactive and enlarged website.

Activities

The Association's activities are intended to meet the needs of its members as well as to enhance the profile and influence of the organisation. The range of activities is typical of clinical specialty organisations (Hamlin, 2005).

Standards Setting .

The setting of standards for practice specific to the clinical specialty is a chief concern. Indeed, the first major work that the newly formed committee undertook was to address the need for specialty specific standards for practice that would set the parameters of competent practice and also define child and family health nursing as a clinical nursing specialty. At that time there was great interest amongst a number of professional nursing organisations in the development of nursing standards. The Australian Nursing Federation, operating as a professional association, had created and published standards for nursing practice in 1984 and 1989, but these were considered generic in nature and therefore presented difficulties when used as the basis for appraisal of nursing practice in child and family health. It was therefore seen as important that CAFHNA should determine the standard of nursing practice required for competent practice in child and family health nursing. Subsequently a sub-committee of the Association was formed to begin the work of developing and validating the child and family health nursing standards for practice, chaired by a member of the Committee of the Association. The sub-committee published the first edition of the Standards in 1993, and the Chair reported the research study that developed the Standards at the State Child Health Conference of that year. The Standards of Practice for Child and Family Health Nurses were accepted by the NSW Department of Health, although not officially endorsed, and subsequently adopted by the majority of nurse managers in child and family health services. A second edition of the Standards was published in 2000. By that time the federal government had initiated a competency based framework and subsequently the Australian Nursing Council had researched and published Competency Standards for

Nurses in general nursing practice, replacing the Australian Nursing Federation document. The second edition of the CAFHNA standards was written in the competency based framework but even at its publication in 2000 it was clear that child and family health nursing practice was subject to change under the policy direction from the Families First Strategy. A new subcommittee formed in 2003 to completely review the Competency Standards and to bring them into line with new directions in nursing practice in child and family health. The revised edition of the Competency Standards was originally scheduled for completion by 2005, but was deferred. In that year the Department of Health established the Working Group for the NSW Child and Family Health Nurse Practice Development Program and the CAFHNA competency standards were acknowledged as the basis for the Program. It was realised that the CAFHNA standards needed to be written in a format that was compatible with the CFHN Practice Development Program and published together with the Program.

The Association has also responded to a felt need in the child and family health nursing community for guidance on clinical supervision, which became an issue following the directive from the NSW Department of Health for nurses to undertake health home visiting as part of the implementation of the Families First Strategy. Clinical supervision is the term used to describe a psychological support and counselling process for clinicians to enable them to debrief about difficult or stressful clinical issues with an independent qualified counsellor. In 2004 the Association published the guidelines to assist nurses and managers in the implementation of clinical supervision in the workplace (CAFHNA, 2004).

Publications

Communication with members through journals, newsletters and more recently, electronic means, is a vital activity in servicing members (Corcoran, 2000). The newly formed association immediately began publishing a newsletter, and eventually this developed into a format more consistent with a nursing journal with the inclusion of papers and editorial comment on professional issues. The President's column reports on Association activities with the Department of Health, but generally refrains from political commentary. The journal is published periodically and is well received by the members and regarded as providing a targeted source of information to child and family

health nurses. The Association is considering convening an Editorial Board to peer review submitted articles to increase the journal's status, and consequently the prestige of the Association.

The Association also interacts with members via the Association website. The site was originally set up to allow members to access their membership details and pay their annual subscription. There is the potential for direct communication with members with the use of online discussion forums to gauge members' views. This is as yet an unexplored avenue but one that has the means to enhance the Association's ability to communicate and interact with the membership.

Communication of the aims of the organisation to the general public is another way to raise the awareness of the work of the clinical specialty and thereby the profile of the organisation. In an electronic age the general public, or at least interested members of it, increasingly use the Internet to access information. Providing information on the practice and education of child and family health nurses on the webpage is another unexplored avenue to raise the profile of the association and one that the Association needs to consider.

Professional Development Activities

Professional development is a typical goal of nursing organisations (Hamlin, 2005). This may include conferences and seminars, scholarships and grants, and a credentialing service. This range of activity is not seen in CAFHNA, which mostly confines itself to the holding of face to face seminars for its members. There are two seminars per year, of which one must be in a rural setting to meet the requirements of the Constitution. These seminars provide continuing professional education for members and interested others.

Credentialing involves the setting up of processes to formally examine clinical competence, as judged against the professional association's published standards of practice, leading to formal recognition by the professional association and endorsement of the members' expertise. Proposals to introduce a credentialing system through the professional associations was first discussed in Australia in the early 1990s by the

National Nursing Organisations and supported by a study commissioned by the RCNA (RCNA, 2003). The notion has generally received a lukewarm reception because the process is considered unnecessary in the Australian context as it appears to duplicate existing State regulatory functions (National Review of Nursing Education, 2002). The Association considered the credentialing of its members, but made a decision not to proceed because of the costs, both fiscal and human, involved in the process. In reality, only larger and well resourced nursing organisations, such as the Australian College of Critical Care Nurses (Gill, 1999), have been able to instigate a credentialing process.

More recently, the Association has considered becoming directly involved in more intensive professional development activities. The Australian College of Midwives offers its members a professional development program, named MidPLUS, that incorporates a three yearly midwifery practice review (ACMI, 2006). There is now a possibility opening up for the Association to be involved in a similar process, with the implementation of the NSW Child and Family Health Nurses' Practice Development Program. In March 2008 discussions took place with the Nursing and Midwifery Office in the Department of Health about the role the Association may take in assisting members to carry out sections of the program, and in formally recognising members who have successfully completed it. The exact form this will take is yet to be worked out and will not be made public until after the NSW Department of Health officially releases the Practice Development Program, projected for mid 2008.

CAFHNA could consider instituting scholarships and grants for members, but as Hamlin (2005) points out, using resources to assist individual members helps only a few. Given the resources of the Association are limited it is likely that emphasis will be placed on ensuring benefits are shared by the majority of members.

Ability to Influence Health Policy and Practice

From the beginning the Association recognised the necessity for engaging influential and well placed individuals in health service management, academia and within the Department. The inaugural committee included the Directors of Nursing of both Karitane and Tresillian and the work of the Association was openly supported by their respective Boards. The President was a mid level nurse manager in an Area Health Service, as were several others members, so there was a reasonable level of knowledge

of the health care system in NSW, but not with the NSW Department of Health. The committee's first interest was on issues around clinical practice, nursing education and the like. It could be said that the committee was politically inexperienced and, at least in the beginning, not well informed about the broader health issues of the day. As their main interest was nursing issues, there was little interest in developing bridges or networks with other, non-nursing groups and key individuals. Nevertheless, the Committee of the Association intended to become involved with the policy making process and, as the Association became better established, became more active. Examples of this are given below.

NSW Child Health Policy

In 1996 the Department of Health called together a committee to write the NSW Child Health policy and CAFHNA was represented on the committee. The child health policy was published by the Department in 1999 and sets out the policy direction for all paediatric and child health services to be implemented by each Area Health Service. The policy gives overall service direction to Area Health Services and Area management is required to implement its key recommendations.

Families First and the Health Home Visiting Guidelines

When the association was made aware of the planned implementation of the Families First Strategy, CAFHNA sought and was granted a position on the NSW Statewide Committee that oversaw the implementation of the Strategy. Representation on the committee continued from 1999 until the committee was disbanded and reconstituted in 2003. Although the Association was represented at this level, and Minutes of the meeting were available to the Association, there was no formal involvement of its delegates in the decisions about implementation at Area Health Service level. The only way the Committee of the Association was kept informed of progress in the Area Health Services was through child and family health nurses who were members of the Association and who could report on local activity. The Association was not directly involved in the implementation of Families First in the Area Health Services, because there was no provision for representation offered by the Area Health Services, but it also did not seek involvement.

During this time the NSW Department of Health was writing the Health Home Visiting Guidelines for child and family health nurses working in the Families First framework and the Association's views were sought by policy analysts involved with the policy's formation. The final draft of the Health Home Visiting Guidelines was issued in 2002, and a revised version was released for comment in November 2005. CAFHNA officially responded, as did many individual members.

Family Partnership Training

When health home visiting was rolled out in NSW the Department of Health introduced the Family Partnership Training for child health nurses to increase the nurses' skills and support the new policy. Professor Hilton Davis and his team from Kings College, London were invited to introduce the Family Partnerships Model (Davis, Day & Bidmead, 2002) in New South Wales.

The training program was overseen by a committee, chaired by a prominent medical academic, and CAFHNA was asked to represent the interests of child and family health nurses. The committee was initiated in 2002 and functioned until 2004 (G. Vimpani, personal communication, January 31, 2006), and by that time the Family Partnership Training Program was fully incorporated into Area Health Services with funding from the Department, managed by Tresillian Family Care.

NSW Health Policy on Breastfeeding for all Staff Involved with Mothers and Babies.
The committee to develop the State wide policy was formed in 2004 and reported in November 2005. CAFHNA provided a representative on the committee for child and family health nurses. The policy, titled, 'Breastfeeding in NSW: promotion, protection and support' was endorsed by the Department in April 2006 and affects all staff working with breastfeeding mothers. A recommendation from the report of the committee was for the development of competency standards for supporting breastfeeding and a committee was convened but CAFHNA did not send a representative to this committee as there was no member available to represent the

Association. The breastfeeding clinical competencies were not published separately but later incorporated into the NSW Child and Family Health Nursing Practice Development Program.

NSW Child and Family Health Nursing Practice Development Program

The Nursing and Midwifery Office in the NSW Department of Health set up a Working Group in early 2006 to develop the framework for a professional development program for child and family health nurses. Together with the CAFHNA Competency Standards, the framework will clearly set out the scope of practice of child and family health nurses in NSW and define the beginning and continuing requirement for practice in the clinical nursing specialty. A pilot of the professional development program was carried out in early 2007 (Guest, 2007) and resulted in some modifications to the Program. The Practice Development Program is due for publication in mid 2008 and the three documents (CAFHNA Competency Standards, Practice Development Program and the Supporting Families Early policy) are the Department's response to the political momentum generated by Families First and are now a key plank of the NSW State Plan. The Association has invested heavily in this Program, through representation on the Working Party and the revision of the CAFHNA Competency Standards to fit within the Program.

Representation at the National Level

CAFHNA was also involved from the early days in the formation of the National Nursing Organisations, an umbrella group initiated by the Australian Nursing Federation. The ANF had realised the necessity for bringing together the many professional associations representing Australian clinical nursing specialties and invited Margretta Styles, a prominent activist in the International Council of Nursing to speak at a seminar held in Sydney in November, 1991. Subsequently the ANF convened a meeting in Melbourne of the professional nursing organisations with the intention of uniting the disparate groups (there were at that time more than 40) into a strong representative voice for nursing. The group became known as the National Nursing Organisations (NNO) and was set up as an informal meeting where information could be exchanged and support provided for group members. The ANF continued to sponsor the NNO and chair the meetings. During that time agreement was reached on the

definition of the role and level of practice of a registered nurse working at a clinical specialty level and the educational requirements necessary to support that role (NNO, 1999). The question of nurse credentialing was investigated and agreement reached on minimum requirements to be met by professional nursing organisations intending to credential their members (NNO, 1999). The NNO also lobbied the federal government for funding for a study into nurse credentialing in Australia and was successful in obtaining a grant. Subsequently the RCNA took responsibility for the study and final report, published in 2001 (RCNA, 2001). The NNO enjoyed the support of both the ANF, which acts as Secretariat, and the RCNA, which acts as Chair of the meetings, and the NNO meetings continue to be held biannually. The NNO has enabled its members to gain a national perspective and encouraged small and separate organisations to work together for a common cause, but appears to restrict its sphere of activity to professional issues. This is confirmed by a visit to the NNO homepage on the ANF website, which shows a list of publications on professional issues (ANF, 2008).

The NNOs had agreed early in their formation that their membership would comprise nation wide professional nursing organisations and defined such organisations as having members in at least four states or territories of the Commonwealth. Strictly speaking, as a state based group CAFHNA did not meet that criteria. The NNO meetings provided an opportunity for CAFHNA representatives to meet with representatives from similar organisations in other States. It became apparent that other states and territories had nurses working in community child health positions that shared similar concerns to CAFHNA and who were largely unrepresented at the national level. Consequently discussions began with a Victorian group, the ANF Maternal and Child Health Nurses Special Interest Group (MCHNSIG) and with interested nurses from Queensland and Tasmania to enable the formation of a national body to represent all community child health nurses nationally. As a result new professional nursing organisations were begun in Queensland and Tasmania and together with CAFHNA and the MCHNSIG became the founding members of a national group named, after much debate, the Australian Association of Maternal, Child and Family Health Nurses (AAMCHN) in 1996. The AAMCHN was now eligible to sit as a full member of the NNO and has represented its state group members since 1996. The original membership of four state groups (Queensland, NSW, Victoria and Tasmania) has increased and now includes associations from Northern Territory, Western Australia and South Australia. Child

health nurses in the Australian Capital Territory have formed a Chapter of CAFHNA, completing the national coverage. At the AAMCHN committee meetings, which are held by teleconference, representatives from Plunkett nursing in New Zealand (the equivalent practice area to child and family health nursing in NSW) are invited to attend, leading to trans Tasman cooperation between the New Zealand and Australian nurses. In a short ten years the AAMCHN has grown in both membership now publishes a national journal. The inaugural national conference, held in Melbourne in April 2005 attracted 600 delegates from Australia and New Zealand, and the second national conference held in Sydney in May 2007 was equally successful, bringing together 750 nurses with an interest in child and family health nursing. As with the NNO, the AAMCHN concentrates on professional issues and has little involvement in the political sphere or in policy making. It has been most successful in meeting professional development obligations, through the two national conferences and membership of the NNO, but appears to have little enthusiasm for interacting with external partners. For example, it has not sought representation on the NCCCH, or participation in the activities of lobbyists such as NIFTeY.

Critique of CAFHNA's Performance as a Professional Association

Becoming Known and Gaining Credibility

The limits of a volunteer association such as CAFHNA are obvious. The numbers of nurses who are willing to participate in the workings of professional organisations such as these remain small, yet the association is reliant on their good will for its continuance.

Some of the reasons given for non-participation by nurses have been reported by De Leskey (2003) as being time constraints and difficulties attending meetings. Although her findings were not specific to committee work they are still relevant, as does her suggested solution of moving to computer technology for online conferencing and setting up virtual offices. CAFHNA has already instigated teleconferencing facilities to enable rural committee members to participate and has put into place the website to enable a virtual office where committee members can access agenda papers. The technology also opens possibilities for increased services to members, thus encouraging new members to join from amongst those who feel alienated by time and distance. The

website also allows interaction with the membership with posting of notices and association activities and the Committee of the Association is currently investigating use of online surveys to inform the association's efforts.

Improving the Association's credibility and influence in the policy arena is another priority area. This, however, is dependent on the acceptance of nurses as political actors, and the willingness of nurses to be involved in the policy making process. Antrobus and Brown (1997) document nurses' historical reluctance to become involved in the political process and their lack of awareness of policy issues. There is a suggestion that the policy process is not well understood by nurses (Antrobus & Kitson, 1999) contributing to their lack of involvement. It is in this regard that CAFHNA has a responsibility to take a leadership role and it could take as an example the midwives' association. The Australian College of Midwives Inc (AMCI) has been remarkably successful in progressing its political agenda for national recognition of midwifery as a profession distinct from nursing, and in encouraging its members to lobby for this cause (Brodie, 2003). Midwifery leaders became skilled at constructing supportive networks and using the political process to promote their aims.

A consideration is whether the Association adequately used all the conduits available to it. Certainly lack of sophistication in dealing with bureaucrats and opinion makers may be a factor here, although the committee has included at various times nurse leaders with some understanding of the political process. It is CAFHNA's responsibility to develop the political skills and to foster a working relationship with the Department of Health and other opinion makers. Advice from professional lobbyists suggest that representatives of organisations that seek involvement in the policy making process should begin by building credible relationships with policy makers and their staff (Ferman, 1999). This can be achieved by setting up contact with the officials in regular visits during the year and establishing the representative as a source of information about the needs of the organisation so they will seek the organisation's comments. However, opinions given must be offered candidly, thoughtfully and without bias. Networking with like minded health professionals is a vital activity in politics and a discussion on the association's success or otherwise follows. It is, therefore, in the Association's interests to seek out and make links with influential members of the policy network.

Networking

Child and family health as a clinical specialty area tends to be well networked, probably because the numbers of senior clinicians, academics and bureaucrats involved is small enough to be able to maintain personal contacts and they share an undoubted commitment to improving the health of children and families. This commitment became apparent with the publication of the Health Targets for Children and Youth (AHMAC, 1992) and continued through the production of the national (Commonwealth Department of Health & Human Services, 1997) and State (NSW Health, 1999) child health policies and into the introduction of the Families First Strategy. They have interacted with each other on the various State wide and local committees (such as the various Families First committees) and formed lobby groups to bring their views to the notice of government and the health bureaucracy. Although CAFHNA has contact with most of these network members, the affiliations are not strong and sometimes based on personal acquaintance. Whilst the Association has supported the actions of network members in promoting child and family health per se, it has not sought to make use of the wider child health network in putting forward and promoting nursing goals, except where they are compatible with the overall goals of the network members.

Developing expertise in managing the bureaucratic process is essential and includes knowledge of the internal structure and workings of the department and in setting up relationships with key personnel. CAFHNA has been more active in establishing networks within the NSW Department of Health with policy analysts and management in the departmental unit concerned with child and family health. More recently bi-annual visits have begun to the Chief Nursing Officer, and links established to personnel in the Nursing and Midwifery Office that she heads. CAFHNA members are part of the committee that brings senior health managers in child and family health nursing together on a regular basis (known as the State Managers Group). Although the Association has no formal place on the committee, the State Managers will seek the Association's views. CAFHNA members sit in a similar capacity on the committee that brings Clinical Nurse Consultants in child and family health nursing together as a group (known as the CNC Network). Taken as a whole, the Association has been successful in aligning itself with key personnel, although the depth and extent of those relationships has not been tested.

More recently, efforts have been made for CAFHNA to form an alliance with the NSW Midwives Association to lobby the Department of Health on matters of mutual interest. Informal meetings have begun between members of the Executive of both organisations and agreement has been reached on issues that affect the memberships of both organisations. For example, the group identified a difficulty in differentiating the responsibilities of midwives and child and family nurses in handing over care of the mother and baby after the mother and baby are discharged from hospital. Area Health Services that had instituted midwife home visiting in the early postnatal period had widely differing policies on the timing of the handover to the child and family health nurse and there appeared to be different practices in the transfer process. Discussions between the two associations identified the need to clarify the process of transition of care from midwives to child and family health nurse and to consult with the Chief Nursing Officer of NSW in the Department of Health. Consequently a position statement was drafted on the preferred transition process and approved by the Committees of both associations and representation was made to the Chief Nursing Officer. The position statement was presented at the May 2007 Conference by representatives of both associations. The cooperation between the executive of the two associations also has led to ongoing involvement in a research study investigating models of transition between midwifery and child and family health nursing services in NSW.

Similarly, agreement was reached in 2006 with the NSW State branch of the Australian Confederation of Paediatric and Child Health Nurses (ACPCHN) that CAFHNA would be the lead organisation in NSW in matters to do with child and family health nurses. However, the two professional nursing organisations would cooperate to present a united position on matters of mutual interest. This agreement prevents a potential conflict of interest between the two organisations that could weaken the ability of either organisation to contribute to the policy making process. As a result, ACPCHN withdrew from the consultations with the Nursing and Midwifery Office on the development of the NSW Practice Development Framework for Child and Family Health Nurses. Nevertheless, ACPCHN represents a challenge at the national level, where it presents itself as an alternative spokesperson for child and family health nurses in other states and territories. Consequently, the cordial relationship between the two organisations in NSW is not necessarily mirrored elsewhere.

The Association has now been established as the organisation to contact on matters to do with child and family health nursing and has proven its interest and willingness to provide committee delegates and comments on policy and service issues. However, it should be noted that at least in the NSW Department of Health this is at the discretion of the manager or policy analyst, although there is an ethic in the department on gaining wide consultation. Similar conditions surround the relationship with the Chief Nursing Officer of NSW. More importantly, the question remains of how influential these personnel are within the Department and in the wider health workforce. For example, the Chief Nurse acts in an advisory capacity only to the Minister of Health and to the Area Directors of Nursing, and although the Nursing and Midwifery Office monitors policy implementation and has a role in nursing and midwifery initiatives, it does not appear to have direct input into policy development (NSW Health, 2007c).

It has to be said, however, that the association's influence is not strong at Area Health Service management level. A good example of this is the recent instance in Sydney South West Area Health Service (SWSAHS) where senior community health managers were changing service delivery to allow for the introduction of a new case load model of midwifery care in which the midwife followed the mother and child into the community to deliver postnatal care. The association was alerted by members in SWSAHS to their concern that the new area policy resulted in a diminished role for the CFHN. Subsequently the CAFHNA President spoke to the senior community health manager and formally wrote to her. The Association put the case for greater cooperation between midwives and child and family health nurses and reminded the manager that NSW Health policy required the child and family health nurse to visit the family within two weeks of the mother's discharge from hospital to assess the family's need for continuing care. It is fair to say that the Association's ability to influence policy in that particular instance was weakened by the low membership numbers of the Association in that Area Health Service. The community health managers also knew that under the decentralised management system in NSW the Area Health Services had the freedom to devise service delivery to suit their own needs, so that even departmental policy could be interpreted accordingly. The policy the Association referred to did not at that time hold official status, although it was likely that it eventually would, and so the power lay with the Area Health Service to interpret it as they perceived fit.

It was following this incident that it became obvious to the Association that the way forward for the Association was to work at the Department level, which was above the Area Health Service, to ensure that NSW Health policy was properly endorsed, so that Area Health Services would have to take it into account when changing services. The interface between midwives and child and family health nurses was emerging as an important issue for both services and practitioners. The association therefore moved on two fronts: one was to raise the issue with the Chief Nursing Officer of NSW in the Department of Health, the other was to raise the issue with the professional body of the midwives. The issue under discussion was the transition of the care of the mother and infant between the midwife responsible for the delivery and postnatal care of the mother and the community based child and family health nurse preparing to visit the family at home.

What is clear is that for it to survive the Association needs to take a more proactive stance. Corcoran (2000) suggests that in a continually changing world the most successful associations will be those that are flexible enough to anticipate change and provide leadership. Analysing, interpreting and sharing knowledge is part of that process, but also is collaboration with other organisations and government.

CAFHNA's Interaction with the Policy Process

Success in influencing health policy depends on the Association's profile. This is a small organisation with a low profile and this tempers its ability to act in the political domain. Because of the acknowledgement by the relevant staff in the NSW Department of Health of the Association's representation of the clinical specialty the Association has had some success in being involved in the policy making process, although it is doubtful if it has been able to significantly influence the direction of health policy. Examples of Australian organisations that are successful politically, such as the Australian Medical Association (AMA), have a larger membership and the resources to employ media personnel and professional lobbyists (Hamlin, 2005). Nevertheless, in comparison to similar clinical specialty organisations the Association's achievements are commendable.

There is, however, room for improvement. The Association could take the example of the AMA and become more proactive in targeting policy makers they wish to influence. Similarly, they could learn from the success of the Midwives Association in developing political skills to put forward and support their views. In either case, it is necessary to have the confidence and support of the membership and this can be gained by listening to the concerns voiced by the membership and developing relevant political actions that meet those needs. The Association, therefore, needs to increase its efforts to interact with its members by keeping membership informed of new developments and encouraging members to put forward their views and concerns.

One criticism of the Association is that it remains insular and does not engage in larger public health issues, probably because of its limited size and resources. Georges (1993) suggests that small professional organisations still have a role to play in wider public health issues when they are brought together by a common purpose to join with other organisations and the resulting coalition provides the status, strategies and resources to achieve such goals. To date CAFHNA does not appear active in public health issues, although it does have similar views and purposes to existing lobby groups for child and family health, such as NIFTeY. When in 2006 NIFTeY established the NSW Branch, CAFHNA was invited to be a part of the new branch. NIFTeY includes amongst its NSW membership influential persons in pivotal positions. Thus CAFHNA was linked to a number of key persons in children's services in NSW and potentially could play a larger role in influencing policy directions. To date the Association has not sought to exploit those links. Another likely coalition partner is the National Council for Community Child Health (NCCCH), an organisation that has strong links to NIFTEY. Although CAFHNA provides a delegate to the NCCCH, the Association has not sought to influence the agenda of the NCCCH by presenting its specific concerns. Potentially this is another avenue in which CAFHNA could become more actively engaged in larger public health issues. As I have argued elsewhere in this Dissertation, the promptings of lobby groups such as NIFTeY have been influential in directing the Department's attention to community child health issues and the Association has benefited from the efforts of these lobby groups in maintaining a momentum for change.

Nevertheless, CAFHNA's activities and ambitions are likely to remain limited by its small resources. Its power and success in achieving aims will be compromised by the small number of members that are willing to become involved in policy and politics. The small membership base also limits its ability to influence and that is unlikely to increase significantly given that it already has attracted a sizeable proportion of the available market. The most logical way to increase both its resource base and ability to influence decision makers would be to combine with other like minded organisations, either through aligning with a large organisation such as the ANF or the RCNA. The Victorian state group, MCHNSIG is an affiliate of the ANF, and the RCNA also offers associate status to groups. The disadvantage, however, is that the ANF and RCNA are national organisations that are unlikely to become involved in local issues and may have less success in meeting the local needs of NSW members. Another alternative is to amalgamate with another specialty organisation, such as the ACPCHN to form a larger bloc within the State. To date such a move has been resisted on the basis that such an alliance combines two distinct nursing specialty groups whose common interest, the health needs of the child and family is served in two very different modes of practice. That is, paediatric nursing is concentrated on the sick child and family, whereas child and family health nursing is focussed on the well child and family and the models of care differ significantly enough to raise concerns that the needs of child and family health nurses will not be served as well in such an alliance.

I note that the National Nursing and Nursing Education Taskforce (2006), reported on the development of the clinical specialty nursing groups and located the practice of child and family health nurses within the general category of Family Nursing, together with women's, men's and adolescent nursing specialties. This confirms the general belief within the maternal, child and family health State and national nursing groups that the practice area is distinct from other child focussed nursing care, but does not satisfy the expressed need for separate recognition. It remains to be seen whether the categories developed by the National Nursing and Nursing Education Taskforce become widely accepted, for example, by the new registering authority to be created by the federal government to oversee the development of national registration for nurses.

Conclusion

This chapter has outlined the work of CAFHNA over the past decade and half, a time when much of the impetus built up for the changes that have occurred in child and family health nursing. It is more than an account of the achievements of the Association; it is also a record of the success or otherwise of clinical specialty organisations in the political arena.

The chapter has demonstrated the necessity for nurses to be represented in those parts of the political process that contribute to the making of health policy. This may take the form of joining with likeminded organisations in a lobbying process, participation in invited committees and other working groups within the bureaucracy, or advocacy at the individual level. If nurses are not politically active in these spheres they risk being omitted from the decision making forums that ultimately have an impact on the healthcare workplace and upon their practice. To do so, they and/or their representatives must become familiar with the policy making process and learn the skills of effective networking.

There are, however, limits to the ability of small professional organisations to make an impact in health politics. It is not just their finite resources but a limited appreciation of the world of politics and policy making that restricts their vision and thus their impact. If, however, the energies that are channelled into the specialty organisations are harnessed effectively, then the possibilities of working productively with government and policy makers are operationalised.

CHAPTER 6: SYNOPSIS AND CONCLUSION

It is usual in the reporting of research studies to leave the discussion of the findings of the research until the final chapter. As was explained in the methodology for this study, the research process adopted here has differed from the usual reporting, in that Chapter Four presents both the findings of the study together with a discussion of the literature that informs the findings. Therefore, in this final chapter of the Policy Study it is left to provide a synopsis of the major findings, and further, to identify from the findings those issues which have emerged that require further exploration.

Synopsis

The previous chapters have described and discussed the chronology of events that led to the introduction of the Families First Strategy in 1999 and its subsequent implementation. As described, the policy was intended to support families with children 0-8 years of age, and involved five human services government departments (Department of Community Services, Ageing Disability and Home Care, Education and Training, Housing, NSW Department of Health) and numerous non government agencies providing services to families in the target group. Carriage for the policy was with the Premier's Department from 1998 to 2004, and then was passed to the Department of Community Services as lead agency. The policy was primarily intended to strengthen the network of existing service providers, and secondarily to provide new services, but only where deficiencies in the network were identified. Families First concentrated on four defined Fields of Activity, built on the research evidence for early intervention and support for families. Of the four fields of activity the first, (early identification of problems and support for expectant parents and those with a newborn child) and the second, (providing ongoing support for childrearing families in the community, especially families with infants and young children), were seen as primarily NSW Health responsibilities. As such, they fell within the ambit of the child and family health nurses, who found themselves with a new direction and an increased role in service provision. The contact with the family was ideally to begin in the antenatal period, where midwives had the primary role, with a seamless follow through to the community health nursing services during the postnatal period, where the ongoing contact with the child and family health nurse would continue for the first 3 years of child's life, at least. The main concern of the child and family health nurse was to

support the parents in their parenting role, and to be alert to the signals of family distress that required early intervention.

I have argued in the Policy Study that the introduction of the Families First Strategy satisfied the need for action to a number of social problems and the wish of the government of the day to be seen to be 'doing something' in the lead up to the State election campaign. Support services for families with young children built around the notion of early intervention had been trialed internationally well enough to provide an evidence base that satisfied the government's advisors (Norrie McCain & Mustard, 1999; Elkan, Kendrick, Hewitt, Robinson, Tolley, Blair, Dewey, Williams & Brummell, 2000). It fitted with the ideology of the political party that held office and it had the support of a wide number of lobbyists who had persuaded senior health management in the NSW Department of Health. It fits with Kingdon's (1995) theory of three policy streams: problem recognition, appearance of workable solutions, and favourable political factors. There was an impetus for change and the political will to implement it.

The effect on child and family health nursing services and the nurses was not immediate but had long lasting effects. From a community health service that had rolled in the doldrums since 1980 and had experienced a crisis of confidence (Knapman, 1993) the child and family health nursing service was thrust into prominence by being given the new role of assessing families at a Universal Health Home Visit to identify factors that could place the family at risk and in need of early intervention. The nurses were to provide the conduit for these families to a range of children's and family welfare services united under the umbrella of Families First. For this to occur changes were required to the existing service structure.

The setting up of Area implementation committees with other service providers, government and non-government, brought the nurses and their managers into contact with other service groups and widened their view of services to children and families. Nursing managers reported that changes were made to service organisation to accommodate the government's mandate that every newborn child would be home visited. The response of the Area Health Services observed in the Policy Study was not uniform, and there were various combinations of Universal Health Home Visiting, clinic based services and group work, but Universal Home Visiting was given priority.

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The effect was a major change in service delivery that is still having knock-on effects today.

Informants reported that little new money came to NSW Health and the Area Health Services to support the nurses' increased activities. A constant complaint from health personnel interviewed for the Policy Study was that lack of funding made it difficult to implement the Families First Strategy as it was originally envisioned. Indeed, Area Health Services have been slow to implement sustained nurse home visiting programs because of lack of funding and resources. Kruske (2005) has argued that the provision of a one off universal home visit is inadequate in meeting the needs of client families, especially when resources do not allow for follow on services for those clients identified as being in need. In her study of child and family health nursing services Kruske (2005) found funding difficulties at the service level resulted in restricted services beyond the universal home visit, and services had inadequate funding to provide services to mothers identified in need of further support beyond the minimal level.

During the early introductory period a series of State wide child health conferences and seminars were held, to which prominent international guest speakers were invited to speak about the international research on the Early Years Agenda and infant mental health. The intention was to inform a broad range of child health practitioners, including child and family health nurses, to change the climate in which services were provided. The State wide conferences introduced the nurses to unfamiliar practice concepts such as strengths based practice and working in partnership, and the NSW Department of Health funded a training program in the Family Partnership Model of communication and parent counselling. The nurses were guided towards nurturing parent–child interactions, with the aim of fostering positive and functional parenting.

Family Support or Undue Interference?

Families First and the companion NSW Department of Health policies is a health promotion program that intends to optimise health and wellbeing through developing parenting skills to encourage optimal development in children.   It is firmly based in the social model of health promotion and addresses the social and economic determinants of health. As such, it is a social change program that intends to improve parenting skills

and behaviours to provide an optimal environment for child development, and to intervene to ameliorate the effects of adverse social and family circumstances. Therefore it is based in the moral principles of beneficence (maximising good) and non-maleficence, or preventing harm.

There are implicit values within the document. Children are viewed as inherently good and deserving of the protection of the larger society and there is a high value placed on children and their rights (UNICEF, 1989). The notion that children's experiences of family life and caregiving have an effect on their life chances is accepted and that early intervention leads to improved outcomes and life chances for children. The policy is built on the premise parents, or some parents, need assistance with child rearing as they may lack parenting knowledge and skill, and it is assumed that parents will welcome and appreciate assistance. It is within the role of the State to intervene to ensure healthy and psychologically well adjusted future citizens, and the power of the State may be used to legislate to allow intervention. The State has a responsibility to ensure that public funds are spent cost effectively.

In the main, Families First supports parenting education programs as the means of improving family functioning. Child and family health nurses have been given training to conduct parenting education programs, such as the Triple P Program endorsed by NSW Health (Zubrick, Silburn, Lawence, Williams, Blair, Robertson & Sanders, 2005). The Family Partnership training programs are designed to encourage empathetic parenting and foster good parent-child relationships (Vimpani, 2000). Almost without exception, the parenting programs uphold middle class values in the parenting styles that they support. For example, parents are encouraged to use verbal communication techniques when disciplining their children, and physical techniques, such as smacking, are discouraged (Zubrick et al, 2005). Within these parenting classes, parents are informed of the benefit of providing their children with high levels of interaction and an enriched environment of educationally approved toys or activities to enhance their development. Not all social classes have the economic means, the family support or even the motivation to meet these requirements. Fonagy (1998) has pointed out the harsh effects of poverty on family life, and the difficulty that some parents have in meeting the minimal physical and emotional needs of their children under the stress of poverty.

The relationships and life events within the family have traditionally been viewed as a private sphere, beyond the reach and influence of the State. The question is posed of whether there exists strong enough justification to allow the State, through the implementation of Families First, to intrude into the private sphere of the family, and to what extent the State may intervene. Civil libertarians may express some disquiet over the targeting of nonconforming families, as these families may belong to minority social groups and their nonconformity nothing more sinister than the expression of ethnic values and behaviours. In this context, the policy provides a mechanism for the surveillance of parents in their own homes (Ling & Luker, 2000; Peckover, 2002; Wilson, 2003).

If the policy is viewed primarily as a method of providing efficiency in service delivery, then the awkward considerations of the role of the State in family life are avoided. The government does justifiably have a role in ensuring cost effectiveness of service provision, and certainly a goal of the Families First Strategy was to maximise existing service delivery through coordination and cooperation. It would appear that this in taking this position, the State is on stronger moral ground. However, it may not be the primary intention of the actions of many of the personnel involved in the implementation of the policy.

Changes to Nursing Practice
The four fields of activity in Families First included two that helped define the nurses' work, as described above. The policy effectively spelt out for the nurses a clear scope of practice in activity fields one and two. Whilst these may have been within the familiar parameters of the nurses' work, the policy gave form and legitimacy to the nurses' role in Families First.

The introduction of Health Home Visiting prompted the child and family health nurses to become more proactive in their practice rather than simply reactive. They were now required to contact the mothers to set up the universal home visit, rather than wait for the mothers to turn up at the clinic. The mother may or may not have been aware of services available in the area, so this first contact, usually be telephone, became the opportunity to 'sell' the service (Briggs, 2007). In effect, they now promoted the child and family health service to the parent. The necessity for refashioning practice to take

into account the dynamics of the changed context has been discussed in previous research with health visitors (Baggaley & Kean, 1999), who have long had a service requirement to be proactive in following up mothers at home. For child and family health nurses in NSW, however, this apparently small change could, potentially, have a large impact on their practice. There is now an obligation to seek out client families and to do so the child and family health nursing services will have to be made aware of the family. This requires a reliable handover process between midwives and nurses to be put into place that enables a seamless transition (Homer, Kendry, Schmeid, Kemp, Leap & Briggs, 2008). It requires the development of good working relationships between midwifery and community nursing services that historically have been located in separate hospital administrative streams (NSW Health, 2008). It requires a rethinking of the duty of care of the child and family health nurse to families within her/his local area to families who do not respond to the offer of a first home visit. It has the potential to alter the practice of many clinicians involved with the care of the family.

The new requirement to move out of the centre clinics and universally home visit was reported as changing the daily routine for some of the nurses. The first visit now included a psychosocial assessment of the parents, such as domestic violence screening and a compulsory screen of the mother for depression, using the Edinburgh Depression Scale. The nurses reported they did less routine health surveillance to accommodate the increased need for psychosocial screening. The move away from growth and development screening to psychosocial screening was a change in focus of nursing care, but it did depend on the orientation and expertise of individual nurses. Some nurses reported that it gave them permission to redirect nursing care to psychosocial aspects that were previously seen as secondary issues.

There was a qualitative change in the first contact with the mother, whether it took place in the home or in the clinic. The new policies made it clear that, whilst the health and wellbeing of the infant were important, equal emphasis was to be given to the wellbeing of the mother, as the primary caregiver for the child. A battery of assessments was introduced to ensure that the home was a safe place for both mother and child (NSW Health, 2008). The opportunity to observe the mother at home was said by informants to give the nurse a different perspective on the family and an opportunity to observe home conditions at first hand. Some of the nurses, however, believed the location in which

the mother is seen is immaterial. They contended that the same outcomes could have been achieved without the move to universal home visiting.

The nurses were now required to make a clinical decision about the level of care that they were assigning to the mother, according to the Families First guidelines, so that appropriate resources could be activated. Previously any planned nursing actions only involved other health personnel, now the level of care assigned to the family had the potential to involve clinicians outside of the health care sector.

Indeed, the intersectoral nature of Families First gave some of the nurses who were interviewed an opportunity to interact with other community groups and helped to establish community partnerships. This appeared to be most successful when the disparate groups had an opportunity to meet regularly and plan together. The outcomes of this joint planning were not of interest in this study, but would make an interesting future study. Recently the Collaboration for Research into Universal Health Services for Mothers and Children commissioned a literature review that included a discussion of the role of universal health services in collaborative and integrated models of service delivery. The report demonstrated the benefits of collaboration and integration but made it clear that this ideal was not easy to achieve (Schmied, Homer, Kemp, Thomas, Fowler & Kruske, 2008). Of the four criteria identified as contributing significantly to effective collaboration, one was demonstration of leadership, and this theme will be revisited in the Exegesis.

Families First had other hidden effects on the nurses' work. There were increased Occupational Health and Safety requirements before the nurse could home visit (NSW Health 2008). In some instances, concerns have been raised about the safety of nurses visiting outlying farms in isolated rural areas, particularly if they were visiting hostile families. Although home visiting has a long tradition, for better or worse there are heightened fears in contemporary society. Some health managers have reported that they use occupational health techniques, such as sending two visitors to the home, and maintain communication through mobile phones. Most of this was strange ground for the child and family health nurses, who had been mostly insulated inside their Centres until the introduction of the new home visiting protocol. This is a new and developing aspect of home health visiting.

The policy focus on the universal home visit appears to have been a mixed blessing for the child and family health nurses. The emphasis on home visiting overshadowed the clinic based services offered through the community centres, which were sometimes reduced as a result. The changes in centre based services do not appear to be uniform, with some areas reporting a greater reduction in clinic services to accommodate health home visiting than others. Some of the nurses interviewed were concerned that there was little continuity of care when centre based drop-in clinics were reduced as this provided little opportunity for mothers to follow on from the first home visit.

Families First did, however, force nurses to look at their own practice, examine their reasons for organising their work in any particular fashion, why they do it, and the value of their work. There was a general feeling that if child and family health nurses could not articulate their practice, either to themselves, or anyone else, then they were at a loss to describe and defend their specialty area of practice. The introduction of Families First and subsequent attention on the child and family health nursing service has forced them to reconsider and raises the issue of the nurses' capacity to promote their views and defend their practice. The theme is examined further in the Exegesis.

The changes in policy and service delivery presented the nurses with an opportunity to change their practice. The question which arises and which will be addressed in the Nurses Study, is whether there was a discernible effect on the nurses' practice.

Nurses' Involvement in Policy

The analysis of the interview data provided in the Policy Study concludes that, although the introduction of the Families First Strategy would directly affect them, as a group the child and family health nurses were not politically active in the policy process and largely silent throughout the implementation process. Most of discussion and activity about the planning and implementation of Families First took place at the highest level in government, in The Cabinet Office initially, and later in the senior management of the NSW Department of Health, and generally at a level to which the nurses did not have access. Although the key players included senior Area Health Service management and community paediatricians, usually it did not extend to include nursing representatives.

One way in which they could have kept themselves informed was through their professional association, CAFHNA. A major aim of the Association was to be active in policy development, but, at least in the early development stages of the Families First Strategy, the Association had not developed strong links to the NSW Department of Health. Nor did the Association have strong links to any of the informal practitioner networks that formed around child health services in NSW. Networks are useful in ensuring access to the policy makers and promoting the desired policy agenda, and both the National Council for Community Child Health and NIFTeY had been formed to fulfill this purpose. They were effectively lobby groups, and many of their members were also individually active within the policy departments of their respective States. As the nurses' association, CAFHNA was not a part of these networks and it did not participate in the lobbying activities. Therefore, the professional association was not cognisant of policy activity occurring at senior levels of the Department of Health. Its officers did not anticipate the Families First Strategy, and when they were made aware, which was only at the implementation phase, they did not recognise its likely impact. They were, in fact, reactive and not proactive, and as such, did not offer leadership.

The suggested reasons for the failure of CAFHNA to effectively participate in the policy making process are found in the nursing literature on the lack of nurses' participation in politics. As reported in the analysis of the association's activities in Chapter Four, the major focus of their activity was around providing information and education to the membership through the journal, seminars and national conferences. There is a certain naivety in keeping the focus of their activity at the service level, in that the forces that influence service delivery are found at other, higher levels of the Department and the Government. As CAFHNA had few contacts at those levels, they had little foreknowledge of events that would have an impact on their members at the service level.

The ability of policy actors to influence policy and service direction is dependent on their status and access to policy makers. Medical practitioners have an accepted advisory role in policy and the position of the community paediatricians in child health policy formation is well established. Medical practitioners are also in senior Area Health Service management positions, where they are able to directly influence service delivery. In contrast, child and family health nursing does not yet have a strong

presence in academia, and nursing research is limited. The nurses tended not to hold senior management positions but middle management positions. Therefore their ability to influence top level decisions in policy or service direction is limited because their sphere of influence is limited, but they can influence nursing practice because they are dealing directly with the nurses.

Both of these aims (policy formation and service direction) are important for CAFHNA, yet the Association is not very proactive in promoting these aims. The Association does respond to invitations by the NSW Department Health to participate on departmental committees and this is an achievement that should be recognised – at least the Department acknowledges the Association as a legitimate representative of the child and family health nurses. In terms of having an impact on service direction, the Association does not hold a strong position because their legitimacy is not always recognised by the service management and Area Health Service management is under no compulsion to take notice of the Association's views.

There are some major themes that have emerged from the Policy Study that require further discussion. These themes centre on the issue of leadership in child and family health nursing. The over riding conclusion from the Policy Study is the necessity for the development of political skills by nurse leaders and the professional association, CAFHNA. The discussion around political leadership is found in the Exegesis.

SECTION 2: NURSES STUDY

PREFACE

The previous section has documented the health policy developments that occurred in NSW from the mid 1990s onwards. NSW Government policies such as Families First and the NSW Department of Health's Health Home Visiting program were gradually introduced into the publicly funded child and family health services and began to have an impact on the service direction. At the same time other events occurred that were intended to directly influence prevailing notions about service provision and indirectly would have an impact on nursing practice. There was a series of international speakers invited to speak at child health conferences on the Early Years Agenda, including Fraser Mustard (Canada) and Peter Fonagy (U.K.). The Family Partnership Model was introduced to NSW by Professor Hilton Davis from the UK and a training program for nurses begun. These two events, promoted by the NSW Department of Health, were designed to create an atmosphere in which established practice would be questioned and opened to changes. This begs the question 'what was the established practice at the time and how did it change as a result of the introduction of the new health policy?' This section, which is the companion study to the Policy Study, will describe and discuss the findings of a qualitative study of nursing practice in child and family health services in two Area Health Services in NSW.

The number of Australian studies describing the role and scope of practice of the child and family health nurse is small and consequently gives a limited understanding of child and family health nursing services and nursing practice. The reasons for this are historical: although child health nursing began in NSW more than a century ago, it is only recently that child and family health nurses have been interested in documenting and exploring their own practice. It takes time and the specialised effort of dedicated researchers to develop a critical body of research evidence, and few child and family health nurses have been interested in research. Most of the initial interest has been shown by researchers who are not themselves nurses and not overly interested in nursing work. For example, Ochiltree's (1991) report was part of an early childhood study conducted by the Australian Institute of Family Studies and only incidentally reported on nursing work, and Rissel was a health education officer evaluating a family care centre (Rissel &.Vaughan, 1989). Later studies (Hanna, Edgecombe, Jackson & Newman, 2002: Barnes, Courtney, Pratt & Walsh, 2003; Kruske, 2005) were undertaken by nurses, but there is not a large research infrastructure to support

investigation in child and family health nursing. I would estimate the number of nurse researchers with an active interest in child and family health nursing to number less than ten nationally. This miserable state of affairs was my impetus to undertake this research project in an attempt to explain and explore the uniqueness of nursing practice in child and family health. I was aware that other nurse researchers have documented the philosophies, roles and scope of practice of the child health nurse in their own countries and thus I understood the value of recording the unique characteristics of child and family health nursing. This professional doctorate is positioned as a contribution to the continuing research that seeks to explain and record child and family health nursing in NSW.

This section of the Portfolio contains the Nurses Study, which is divided into five chapters. Chapter One describes the role and scope of practice of the child and family health nurse in NSW and compares it with international models of child health nursing. The literature identifies the necessity for child health nurses to be able to engage with their client and to develop a working relationship and Chapter Two draws on this body of work to review the particular features of the nurse- client relationship. Chapter Three introduces the research study and documents the methodology used. Chapter Four summarises the results and findings from the interviews and observations conducted with child and family health nurses and chapter Five discusses the implications of the research findings.

CHAPTER 1: LITERATURE REVIEW FOR NURSES STUDY

The Nurses' Study examines the nature of nursing practice in child and family health and begins from the premise that there is a clearly identifiable role and scope of practice in child and family health nursing. The review of the literature was undertaken to explore the evidence for a distinctive nursing practice. Although child and family health nurses themselves may have a strong sense of identity, it is not uncommon to find other health practitioners confusing the area of practice with related nursing specialties such as paediatric or neonatal nursing. Indeed, community paediatric medicine, melds the care of sick children with ambulatory care of well children, so it is not surprising when nurses working in paediatric settings claim to be also practising child health (see for example, Barnes, et al, 2003). The NSW Department of Health has added to this confusion by changing the nomenclature of the position title twice in the past twenty years, from 'baby health nurse' to 'early childhood nurse' in 1987 and then finally to 'child and family health nurse' in 2002. The 2002 official circular (2002/54) clarified the position title and indicated the role of the nurse was to support the Families First Strategy of early intervention, prevention and supporting families to raise their children. That was the state of affairs when this study began.

The limited Australian literature on the role and scope of practice of child and family health nurses spurred a search for information on similar nursing roles in other countries. The range of nursing databases searched included CINAHL, Medline, Academic Search Elite, Nursing and health sciences, and Science Direct. Reference lists in selected articles were scrutinised for relevant items. The keywords used were nursing practice, child health nursing, health visiting, public health nursing, paediatrics and home visiting. This chapter reports on the results of the first part of the literature review. The review provides a description of relevant international nursing roles and allowed for a beginning comparison with the largely anecdotal description of the child and family health nurse in NSW.

International Comparison of Role and Scope of Practice of Child Health Nurses
The international literature throws some insights into the work and nursing practices of child health nurses, whose role and function appears to be comparable to that of the child and family health nurse in New South Wales. The literature search was limited to

English titles only, so the accounts described here are taken from studies of nurses in the United Kingdom, northern America and Scandinavia. Although most health workers with children and families in the community are nurses, or have a nursing background, the title of the position varies from country to country, which has the potential to confuse the comparison between various nursing positions. The nurses' titles - variously health visitors in the United Kingdom, child health nurses in Sweden and Norway and public health nurses in Canada – and work description tend to reflect the history of the health care service. From another perspective, they give some indications of the dominant model of service delivery in which the nurses worked.

The most extensive studies were those on health visitors in the United Kingdom and appear to stem from a perceived need amongst health visitors to investigate and document their own practice. The Council for the Education and Training of Health Visitors published twice on the principles of health visiting practice (in 1967 and 1977) and other early studies used survey methods to describe activities of health visitors (Luker & Chalmers, 1989). In later studies nurse scholars are investigating health visiting from a theoretical perspective with a series of masters and doctoral theses that employed qualitative research methods, mostly grounded theory, to examine the nature of health visiting practice and uncover the underlying processes (Sefi, 1985; Chalmers, 1992; Luker & Chalmers, 1990; de La Cuesta, 1994a). Cowley is a consistent and important contributor to the British research and her work gives an example of the transition from descriptive to theoretical studies in describing and interpreting the health visiting practice. Other British studies focus on health visitor's practice from the point of view of the client, raising ethical concerns about undue interference in private domains (Robinson, 2004; Twinn, 1991; Peckover, 2002). More recently there has been an interest in child health nursing from a policy perspective. Elkan et al (2001) in an official report on Health Visiting for the United Kingdom government reviewed 102 studies covering 86 home visiting programs involving a postnatal home visit and noted implications for practice and future research. The UK Government commissioned a wide reaching review of Health Visiting to make recommendations for the future role of health visitors (Health Visitor Review Group, 2007) and responded to it (Department of Health, 2007). This was accompanied by commentary from the profession that both prompted and responded to the Government's investigation of Health Visiting (UKPHA, 2007a). There seems to have been a crisis in confidence in health visiting and

the government report set new directions for practice, education and policy. The United Kingdom Public Health Association held a Symposium in the House of Commons in 2007 and called for a revitalisation of the health visiting service with increased employment and training opportunities, and more government recognition and support (UKHPA Press Release, 2007b).

Research into child health nursing in Sweden and Norway is another source of information. These studies begin in the 1970s and again provide a description of the child health nurses' role and function (Fagerskiold & Ek, 2003). The authors are either child health nurses or academics with an interest in child health. Later works investigate the responses of clients of the service to the work of the nurses (Aborelius & Bremberg, 2003).

In northern America the pattern for child health services differs to that in the UK and Scandinavia and there appears to be a difference in service delivery between Canada and the United States of America (USA) (Kuo, Inkelas, Lotstein, Samson, Schor & Halfon, 2006). The predominant nursing model is that of the public health nurse, where the nurse is responsible for delivering care to a range of clients and age groups, including mothers and children.

Health Visiting in the United Kingdom.

In the United Kingdom the health worker responsible for maternal and infant health care is the health visitor. Health visitors in the UK have a long history beginning in the public health movement of the mid nineteenth century. The first practitioner was a public health official and not a nurse (Davies, 1988) and the non nursing tradition of health visiting is reflected in the title. The transition of the health visitor from a lay worker into a health professional took many years, but eventually it was accepted that health visitors should have a nursing educational preparation and from 1962 to 1983 the Council for Education and Training of Health Visitors (CETHV) registered and regulated health visiting practice (Cowley, 1995). Since 1974 health visitors have been part of the National Health Service (UKHPA, 2007a). In contemporary practice there seems to be a variety of entry points to health visitors' qualifications, but most health

visitors hold specialist qualifications in health visiting obtained post registration (NHS Careers, n.d.).

Health visitors operate within a defined geographical area within a Primary Care Trust, where they may be attached to general medical practices in the locality or to Children's Centres or other organisations (Health Visitor Review Group, 2007). Case loads tend to be large, with reporting of health visitors carrying case loads of 500 clients (UKHPA, 2007a). The goal of care has traditionally been to improve the health of the local population, including the elderly and other vulnerable groups within the area, with a particular brief for services to mothers and young children 0-6 years. Although health visitors have no legal right of access, they are expected to home visit all families with children in their locality. However, parents' participation is voluntary and they have the right to refuse the service.

The 2007 review of health visitor services, *Facing the Future* (Health Visitor Review Group, 2007) identified core elements of practice as being health promotion for children and families, with early intervention and prevention and parenting support forming an important component of the health visitors' work. Health promotion activities for families with children are to be given within the context of the official government Child Health Promotion Program. There is also a wider target group of disadvantaged and marginalised groups for whom population health programs are provided. The service is expected to meet the requirements of 'progressive universalism' (Health Visitor Review Group, 2007). That is, all citizens have the right of access to the service, but interventions will be targeted towards those individuals, families or social groups that demonstrate greater need.

Home visiting is identified as the cornerstone of the service (Cowley, Caan, Dowling & Weir, 2007), with visits being offered to all new babies. Centre based services in which group or community activities were carried out provided another significant component of the health visiting service. The balance between home visiting and centre based services appear to differ according to regional circumstances, and some health visitors offered a range of other services (Cowley et al, 2007). Cody (1999) notes a trend to move away from the traditional home visitation in the UK and towards more clinic

contact with client families and suggests that it is connected to management efficiency concerns.

Health visitors have been identified as the health worker with the primary role in leading multi-skilled teams, where they work in conjunction with other health professionals and paraprofessionals, such as nursery nurses, to deliver the range of services. Health visitors have the responsibility for identifying and engaging with 'at risk' families and leading the team response. They may also deliver child health services in general medical practices or hold individual caseloads (Health Visitor Review Group, 2007).

Health visitors operate within a health education, health promotion and disease prevention framework (Cowley, 1995). Their work is directed towards enhancing an individual's resources for health (Cowley, 1991), as in the provision of health and nutrition counselling to parents (Chalmers, 1992). Indeed, health visitor's descriptions of their work tend to focus on health improvement through encouraging healthy behaviours. So, when de la Cuesta (1994a) interviewed health visitors they tended to cite activities such as diet and nutrition, dental health and surveillance activities. A more recent survey of the pattern of service provision indicated that health promotion activities range from individualised biomedical activities, such as developmental checks of infants, through to community development. (Cowley et al, 2007).

Child Health Nursing in Norway and Sweden

It appears all Scandinavian countries offer child health services but articles located related mostly to Norway and Sweden. In Norway maternal and child health services are primary health care services offered to all pregnant women and parents free of charge. The public health nurse visits the newborn baby and mother at home within weeks of the infant's birth and further visits to the Mother/Child Clinic are scheduled at regular intervals for immunisations and routine health checks. The service is well attended with close to 100% of all children in Norway attending the service (Andrews, 1999).

The largest number of reports in the literature search related to child health nursing in Sweden. The Swedish child health nurse is employed in a Child Health Clinic located in

a primary health care service in the community setting. The nurse is qualified as a registered nurse in general nursing, with a further year of specialist training in public health nursing or paediatric nursing (Fagerskiold & Ek, 2003). The nurse may work solely in child health or in a combined role of child health and generalist nursing providing care to sick people across the age span (Fagerkiold, Timpka & Ek, 2003). Each nurse is responsible for a caseload of 400 children and takes on about 60 new cases per year (Arborelius & Bremberg, 2003). Although parent's involvement with the service is voluntary, attendance is well established, with 99.5% of parents accessing the child health clinic for advice, examination of the infant and immunisations (Arborelius & Bremberg, 2003) and studies report a high degree of satisfaction with the service (Fagerskiold, Timpka and Ek, 2003). First contact occurs at a nurse home visit, and subsequently parents visit the nurse or physician at the child health centre. Up to fifteen visits take place within the child's first year and then continue for about five visits during the preschool period. A physician is also available at the child health centre and parents pay an average of four visits to the physician in the first year of the child's life (Arborelius & Bremberg, 2003). In Sweden social insurance provides generous paid parental leave of up to 450 days, which is usually taken by the mother in the first six months of the baby's life (Fagerskiold, Wahlberg and Ek, 2001). Fagerskiold, Timpka and Ek (2003) report that the service has the dual role of supporting new parents as well as identifying possible misconduct, which gives it a policing role.

The Public Health Nurse Role in North America

In northern America the service model appears to be dominated by the physician role and heavily influenced by the medical model (Kuo et al, 2006). For example, well child care in Canada is provided through general practice physicians, and in the USA this service is provided by family physicians as well as paediatricians. According to Freed, Nahra and Wheeler (2004) less than 12% of primary care well child visits occur in community health centres or hospital clinics. Falk Rafael (1999) gives an account of the historical development of the public health nurses' role in Canada and the United States which indicates that much of the maternal and child health work, such as well baby clinics, infant immunisations and comprehensive postnatal follow-up examinations that was initially nursing work was transferred to community physicians between 1972 and

1995 (1999, p.32), although there is a suggestion that there are differences between services offered in various locations.

The community health role is known as public health nursing in both Canada and the USA and includes maternal and infant health, although the scope of practice does not appear to be uniform (Kuo et al, 2006). Public health nursing is based on principles of primary health care and is directed at promoting the health of individuals, families and population groups (American Public Health Association, n.d.). Bradley and Bray (2003) compare the differences between the British health visitor model and USA maternal and child health nursing and note that the closest equivalent role would be a public health nurse working in a specific geographical area with an interest in maternal child health.

In the past twenty years there has been a rising interest in early intervention programs, such as that introduced in the Province of Ontario (Norrie McCain &Mustard, 1999) and which employed public health nurses as home visitors. Similarly, Olds (Olds et al, 1999) work in the United States on home visiting programs also employed registered nurses, although whether they had specific training in maternal and infant health is unclear. Jack, DiCenso and Lohfeld (2004) report that the goal of the public health nurses work in the Ontario home visiting programs was to encourage healthy child development by working with families to change parental attitudes, knowledge and behaviours.

The Role and Scope of Practice of Child and Family Health Nurses in NSW

The nurses' role as reported in the international literature appears to be similar to that of the community child and family health nurse in New South Wales. Child and family health nurses commonly see families with children up to the age when formal schooling begins, although some services offer contact through to age 15 years. With rare exceptions, Australian mothers give birth in a hospital setting, and on discharge from hospital they are given information about the local community child health service, and the service may also be routinely notified. The method by which the mother's transition from hospital to community setting may vary: some services offer liaison or community midwives to follow up the mother post discharge, others do not (Homer, Henry, Schmied, Kemp, Leap & Briggs, 2008). As in the UK and Sweden, the initial contact

with the mother is usually through a home visit by the child and family health nurse. The mothers are invited to visit the child health centre located in the community, where they may attend a mother's group or seek individual consultations with the nurse. (NSW Department of Health, 2006a).

The parent's participation in the service is voluntary. Parents may refuse the offer of the initial home visit by the child and family health nurse, who has no mandated right of entry to the family home. The nurse does have a mandatory reporting requirement for child protection but this is in keeping with all other health workers.

This is a primary health care service and the mainstay of the nurses' work is the public health role of child health and health surveillance. The health promotion role is centred on providing anticipatory guidance for parents and promoting health through primary immunisation programs. The nurses' responsibility for maternal health mainly concerns the psychosocial wellbeing of the mother and her adjustment to motherhood, detecting postnatal depression and breastfeeding support. There is a developing psychosocial support role for other family members, particularly fathers, during the early parenting period and some nurses take on more intensive support for families deemed to be in a risk category (Barnes et al, 2003).

Child and Family Health Nursing Services in NSW

The description of child and family health nursing services which follows is derived from my observations of the service structure in the two Area Health Services included in the Nurses Study, from my own experience as a practising child and family health nurse and from professional contacts with child and family health nurses. The description is thus a generalisation of the structure of the NSW state child and family health nursing service.

Child and family health services in NSW are provided by Area Health Services, which differ in their size, population characteristics and the human resources available to them. Community child health services are expected to be responsive to the needs of the local population, hence not all Area Health Services have exactly the same type of service design, but it is true to say that they have many features in common. In most parts of

NSW community services for families with young children is exclusively a child health service. There is no requirement on the part of the nurse to service the needs of any other age group and it is recognised as a specialised nursing strand. In some areas, because of local conditions, the service model is more like that of a generalist community nurse and the nurse may provide services to all clients across the lifespan. NSW Health has now made it clear that the preferred service model is the specialist one (NSW Health, 2008), so generalist roles are becoming less common. All child and family health nurses in NSW are employees of the Area Health Service and therefore a part of NSW Health.

Child and family heath services are staffed by registered (level 1) nurses with additional training in child and family health beyond the undergraduate degree required for registration as a nurse. However with the chronic nursing shortage in NSW there have been suggestions from health managers for level 2 nurses to fill positions. This has been resisted by nurse managers and opposed by the professional association (Briggs, 2005)

The nurses work in teams servicing the population within the geographical sub-areas of the Area Health Services. The nurses are located in community centres which may be single purpose child health centres known as Early Childhood Health Centres, or multidisciplinary community health centres. The centres are distributed throughout the local area and are usually located in prominent and easily accessed positions, such as adjacent to shopping centres or within local schools. Most centres are staffed by two or more nurses and isolated centres with a single nurse are becoming less common. The nurses work as a team to provide the mix of services and to meet staffing contingencies. The client caseload is shared between the nurses at the centre. Each sub-area has a nurse manager, who in turn reports to an area manager.

The child and family health service is primarily a nursing service with links to other health professionals within the local health service, such as Well Baby clinics conducted by a physician, speech therapy and other ancillary services. The nurses act as a source of referral to other community agencies and will direct the family to their General Practitioner for medical assistance. The child and family health service often includes secondary services such as Day Stay nursing centres, known as Family Care Cottages,

where mothers may attend for more intensive assistance with common problems such as breastfeeding or unsettled infants.

Although this is mostly a primary health care service there is a tertiary level service offered across the State by Tresillian Family Centres and Karitane. These organisations have a unique place within child and family health services as specialist providers of both residential and outreach services for families with complex needs. Child and family health nurses can refer families to Tresillian and Karitane for more intensive care.

Comparison with International Literature

There are similarities and some differences between the four (UK, Scandinavia, Northern America & NSW) child health roles and scope of practice examined, but it is clear that the similarities outweigh the differences. The major categories will be discussed below:

Location of Service, Population and Services Provided

In the UK and Scandinavia and to some extent in the USA and Canada the child health services in which the nurses were employed were primary health care services providing first line health care to the local community. The target group in the population was families with children up to school entry age and parents voluntarily attended the service. The nurses' services were provided free of charge at the point of service in the publicly funded primary health care model of service, but some cost sharing was suggested in Northern American services when services occurred in physician's offices (Kuo, 2006). The nurses were centrally located where they could be easily accessed by the target population, in General Practice surgeries, local shopping centres, and neighbourhood centres. The more common method of work distribution was allocation of a caseload of clients whom the nurse continued to see until either client or nurse terminated the case, however in NSW individual caseloads was not usual.

Promoting Health

Although it is not always openly expressed there is a tacit assumption that the aim of the child health nurse is health improvement for the child and family in care and this provides the impetus for the service. Child health nurses are concerned with the welfare of the parent, particularly the mother, and this is a constant theme in the accounts of the nurses' role in the literature. All of the four child health roles claim health promotion as the major goal of the service and standard health promotion activities occupied the nurses' practice (Baggens, 2001; Cowley et al, 2007; Fagerskiold et al, 2003). Historically the work of the child health nurse has been primarily concerned with infant welfare and as a result has been concerned with public health activities that are largely about health improvement and disease prevention. The new public health movement has been influential in changing the emphasis of child health services towards a social model of health care and this is evident in the international reports of child health practices. There are also reports of difficulties arising from the application of health promotion concepts of empowerment and partnership (Baggens, 2002; Andrews, 1999: Mitcheson & Cowley, 2003). The notions are found in NSW Health policies and the extent and effectiveness of these concepts in health promotion activities in child and family health in NSW requires further exploration.

Gender

The literature implies but does not always state that the overwhelming majority of the child health workers are women. Fagerskiold, Timpka and Ek (2003) note that this is the case in Sweden, and this situation appears to be replicated in Britain and northern America. In Australian nursing the gender inequality is well documented, but in maternal and child health it is even more exaggerated. For example, in New South Wales only 0.6% of the child and family health nursing workforce position is male, compared to 2.8% in pediatrics and 28.8% in mental health nursing (AIHW Survey, 2005). The lack of involvement of male nurses probably reflects social roles of infant care being women's business. I personally know two child and family health nurses who are males working in a vocation that is considered to be a female role and providing care to mothers and babies, which is often typified as 'women's business'.

They enjoy their work; see themselves as pioneers and have each created a unique role for themselves in the community where they are accepted. One of them is an interviewee in this study.

Ambiguities in the Nursing Role

A theme that emerges mostly in the British literature but which rings true for all community child health services is a perceived ambiguity in the nursing role. Nursing has traditionally been associated with care of the sick patient in a hospital setting. In community child health, the nurses' role is obviously very different to that of hospital nurses, and sometimes even to that of other nurses working in the community. The clients of the child health nurse are not ill: they are independent and competent adults seeking assistance with a new life task, that of parenting their child. Secondly, they are free to choose whether or not to attend the child health centre. So their autonomy and their right to determine what is best for their child must be respected. Child health nursing is unique in that contact with clients occurs before a health problem or health need becomes apparent. The British studies describe the role of the health visitor's work in helping the client to identify potential needs (Cowley, 1991) and the purpose of nursing as identifying and enhancing the family's resources for health (Cowley, 1988). In essence this means that the child health nurse is working from a different basis to that of the hospital nurse. The service is based not on meeting patient's needs to regain their health, but in meeting client's needs to maintain their health. This is described by Chalmers (1992) as being based upon a mutual need in which the child health nurse seeks to provide a health promotion service and the clients want to fulfil their own personal health needs or goals. This subtle difference is vital to understand as without a grasp of its significance the role of the child health nurse is likely to be misunderstood.

Ambiguities Around the Client

A further complication is the confusion that sometimes exists around the question of exactly who is the recipient of care in child health nursing. In NSW the case notes are written about the baby, but it is acknowledged that the child and family health nurse is in reality interacting with the parent on behalf of the infant. It remains unclear whether the nurse is acting on behalf of the child or whether her/his duty of care is to the parents

and the family as a whole. Many nurses will identify the infant as the primary object of care, yet the policy documents require them to consider the mother at least, if not the whole family, as part of the nurses' duty of care. This muddled position is alluded to in the UK studies, where the move to a more family oriented service has also occurred. It was not always clear from descriptions of the nurses' work who within the family caseload should be considered the client 'or even whose responsibility it should be to determine that' (Cowley, 1995, p278). This situation potentially exists with child and family health nurses. There is ambiguity in the formal documents over exactly who constitutes their client, and whether they would be seen as stepping outside their jurisdiction if they provide care to other family members.

Conclusion

This chapter has served as an introduction to the role and scope of practice of the child health nurse. Reviewing and comparing the international literature with what is known to date about the role and scope of practice of child and family health nurses in NSW raises questions about the nature of nursing practice and informs the research questions for this study. The following chapters detail the interviews with child and family health nurses in which they describe their view of their nursing practice and identify that which they believe makes it unique. This allows an informed comparison and discussion of how practice in NSW accords with the international literature.

Concluding Remarks

The following chapter takes up the theme of the special relationship that must develop between the child health nurse and the client parent for the nurse's work to progress and reviews the literature on this aspect of child health nursing. The chapter was accepted for publication by a refereed journal and is presented here in the Portfolio as a journal publication.

CHAPTER 2: PUBLISHED ARTICLE.

Nursing Practice in Community Child Health: Developing the nurse-client relationship

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ABSTRACT

Community nursing services to parents with young children have been an established part of child health services in Australia for more than a century. Although the titles vary within states, community child health nurses provide support services for parents with infants and young children and typically their scope of practice includes public health functions such as health surveillance of the developing infant and child up to the age of 5 years and early intervention. More recently state health policies have instituted universal home visiting and emphasised the primacy of psychosocial support for parents. These policies are accompanied by education programs that propose a change in nursing practice to a more egalitarian partnership model of practice. As a consequence greater attention now has to be paid to the processes used in developing a working relationship with the client in the community setting. Whilst there has been little published in the Australian nursing literature on the methods used by community child health nurses to engage their clients, the international literature offers some insights into the nurses' practice.

This paper describes the practices of community child health nurses in engaging the parent and developing a complementary and therapeutic relationship that enables the nurse to promote the health of the child and family. Published accounts of community

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child health nursing practice in the United Kingdom, Scandinavia and northern America are described and compared to the Australian context.

KEY WORDS: Nursing practice; Child health nursing; Community child health; Health Visiting; Public Health Nursing; Paediatrics; Home visiting

DATABASES REVIEWED

CINAHL; Health Source; Medline; Academic Search Elite; Nursing and health sciences; Science direct; English titles only.

Introduction

Infant welfare services in the community for parents with infants and young children were first instituted in most states of Australia in the early decades of the twentieth century. Since then they have become an established part of health services for children and families and are among the most used of all community health services (Ochiltree 1991). In Australia, the work of the nurses within the community child health service has not been well researched. There are accounts of the scope of practice (Barnes et al 2003; CAFHNA 2001) but a deeper analysis of the nurses' practice is missing from the Australian literature. However, the international literature provides insights into the practice of nurses whose role and function appears to be comparable to that of the community child health nurse in Australia. The literature reviewed describes the nature of the nursing work in community child health and highlights the processes involved in engaging the client and developing the nurse-client relationship.

Aim of the review

The aim of this paper is to describe and compare the practices of community child health nurses when engaging with their clients as depicted in the international literature. This will provide a baseline against which comparisons can be made to the context of Australian community child health nursing.

The accounts in this review are mostly taken from studies of community child health nurses in the United Kingdom, northern America and Scandinavia as these accounts were dominant in the literature. The nursing practice of British health visitors, whose role includes community child health, has been extensively explored with particular reference to the processes used to engage the client. Scandinavia have established and well accepted community child health nursing services, and the literature describes service provision and the community child health nurse's role and practice. Studies carried out in northern America contribute a different point of view. Canadian studies describe and discuss the work of public health nurses attached to community programs for mothers and babies (Jack, DiCenso & Lohfeld 2005). The US studies report on early intervention programs mostly but not always provided by nurses (Olds et al 1999; Barnes-Boyd, Fordham Norr & Nacion 2001).

For the purpose of this paper, community child health nurses are taken to be registered (or level 1 nurses) who work with families with children under five years of age providing primary health care services to those families in the community setting. There is no consistent title for these nurses within Australia. They are variously described as child health nurses (Western Australia, Queensland and the Northern Territory), child and family health nurses (New South Wales), maternal and child health nurses (Victoria), family and child health nurses (Tasmania) and child and youth health nurses (South Australia).

The literature was accessed through computer databases such as CINAHL and Medline, meshing the terms nursing practice and variants of child health nursing/ community child health/public health nursing and home visiting. Articles were also retrieved from reference lists, focussing on those studies which reported the nature of the work of community child health nurses. Both research and scholarship articles were accessed from refereed and non-refereed journals and books spanning two decades of reporting from 1985 to 2005. Only articles written in English were retrieved, which could possibly have limited the range of the review.

The articles reported here were selected because they described the characteristics of the community child health nurse and the strategies utilised to facilitate the nurse-client relationship.

Attributes of the community child health nurse

Personal qualities

There is recognition in the literature of the importance of the personal qualities which the nurse brings to the relationship with the client. Value is placed on an empathetic and caring health professional, able to understand and appreciate the client (usually the mother's) point of view. Davies (1988) notes that the British health visitor was very early described as the 'mother's friend'.

The skills and qualities of the community child health nurse are crucial in determining the degree of acceptability of the service to the client (Normandale 2001). Jack et al. (2005) record that reliability, genuineness, warmth and ability to be caring and empathetic was cited by participants in their study as being of paramount importance. These mothers preferred a professional demeanour which was not overly bureaucratic, and which respected the mother's confidentiality. The mothers in a study by Fagerskiol, Timpka & Ek (2003) wanted the nurse to be sensitive to their emotional needs, to take their voiced concerns seriously and to see things from their perspective. They valued nurses in whose knowledge and nursing experience they could feel secure.

Flexibility

Flexibility, or moving with the client, is seen as a positive attribute of the nurse. Being flexible enables the nurse to shift the focus when a more important or immediate problem arose unexpectedly (Cowley 1995a). The nature of the practice is such that the nurse has to be prepared to attend to whatever is identified by the client as important, rather than rigidly stick to a pre-set agenda. According to Cowley's (1995a) study, this was so commonplace in health visiting practice that they were not necessarily consciously aware that they were shifting focus, rather it was explained in terms of remaining responsive to client needs.

Being prepared to seize the moment was another example of flexibility. In her study de la Cuesta (1994b) identified health visitors' willingness to shift their agendas in response to a perceived need. The nurses' ability to step out of the structured schedule or the formal policy agenda to consider other issues allows them to address issues or matters that may have more relevance to the family than the formal agenda set by the health authority.

Whilst these attributes may be seen as relevant to all nursing roles, they have particular relevance in community health nursing. In this type of nursing work, conducted in the largely informal setting of a community clinic or the client's home, the literature suggests that personal qualities that engender a strong nurse-client relationship and the ability to respond to rapidly shifting demands are most suitable to the community nursing role.

Goals and purposes of nursing practice

Historically the work of the community child health nurse has been divided between activities that originate in public health with a disease prevention focus and parent education to assist parents to care for their child. These activities are still seen as an important part of the nurse's practice. For example, the goal of the child health service in Sweden follows traditional public health goals of the prevention of mortality, morbidity and handicap in preschool children and to encourage healthy development of the children (Fagerskiold & Ek 2003). There is also a clear acknowledgement of the psychosocial needs of parents, and a major goal of community child health nursing practice is now described as reducing parental distress, increasing parenting capacity and offering social support for families (Bloomfield et al 2005; Sparrow et al 2005). Parent education remains a frequent activity of child health nursing practice although since the introduction of the concept of health promotion (WHO, 1996) the literature tends to describe the nurse's practice as being centred in health promotion (Cowley 1995b; Ellefson 2001).

Health promoting nursing practice aims to provide an optimal health environment to prevent the occurrence of health problems, which makes its purposes different to that of sick care nursing practice (Robinson & Hill 1998). Hence Cowley (1988) describes the purpose of the health visitors' work as identifying and enhancing the family's resources for health and part of their work is in helping the client to identify potential needs (Cowley 1991). Difficulties may arise when the nurse's intervention begins before a health problem is identified. In most hospital nursing work, where there is an explicitly stated health problem, the purpose of the nurse's intervention is clear from the outset and there is no question as to the legitimacy of the nurse's work (Cowley 1995a). Unlike hospital nursing, community child health nurses may not have automatic right of

access to the client. In this situation, engaging the client and establishing the validity of the nursing relationship are critical aspects of the nurse's work.

Strategies used to engage clients and establish a working relationship

The conditions and the methods used by community child health nurses in engaging clients have been well described. This next section will describe the processes used by the nurses to invite and establish a working relationship with the client.

Attracting the client to the community child health service

Where the first encounter is likely to occur in a community clinic, the community child health nurse must set up conditions that attract the client to the clinic. If the health service in which the nurse is located is well known and accepted in the community this is noted as a pivotal means of gaining access to clients. In Sweden the child health clinics are well accepted and Swedish parents are encouraged to come regularly during the infant's first six months to facilitate the development of the relationship between the nurse and the parents (Fagerskiold & Ek 2003). In the UK the health visiting service is well established and it is known that health visitors attend the mother at home, beginning in the antenatal period. However parental obligations alone may not be enough to entice clients into the service. The interpersonal aspects of the engagement process have an enormous impact on the outcome of the first meeting between the child health nurse and the client.

Entry work

Community child health nurses must gain entry to the house and to the family if they are to undertake the work of improving the family health and 'entry work' is the process which obtains access to the client and the home. British studies have described the processes health visitors use to gain access and engage with their clients.

De la Cuesta (1994a) explored the tactics used by health visitors to gain entry to the family, and characterised this as a marketing exercise. Health visitors use a combination of commercial techniques to make their services accessible, acceptable and relevant to their clients, such as promoting the service to the prospective client, adjusting the delivery of the service to suit the client and tailoring the 'product' of health promotion to the client's needs. Chalmers (1992) suggests that the entry work continues through

the presentation of 'offers' of assistance to the client. In this manner the nurse has an opportunity to present the service and her health promotion 'product'.

In home visiting the community child health nurses may contact the client even before a request to visit is made, in a tactic that sales personnel describe as 'cold calling'. Therefore they must in the first instance convince the client of the legitimacy of the contact and get them to agree to continue with the contact. For example, one of the tactics used by health visitors to gain access to families with new babies was to present the service as a routine or expected requirement (Chalmers 1992).

Luker and Chalmers (1990) identified women as the 'gatekeepers' to the family for health visiting services. They identified factors that either facilitated or blocked entry to the client and thereby the nurses' work. Entry was facilitated when the health visitor had met the mother antenatally, there was an identified need or problem needing to be addressed and the client's previous experience with health visitors had been positive. Entry was more difficult if the clients did not value the health visiting service or perceived they did not need such a service. The health visitors were aware their behaviour had an effect in determining their entry to the house, so they consciously presented in a non authoritarian manner respectful of the client's needs and their position as a guest in the client's home. The nurses also consciously modified their speech and behaviour to suit the situation in an attempt to make themselves more acceptable to the client.

Getting to know the client

Cowley (1991) uses symbolic interactionism to explain the process of 'getting to know' each other that opens the interaction between the client and the health visitors in her study. The client is not passive in the interaction and will establish his or her own grounds for the interaction so the nurse must identify the position and basic beliefs of the client. By doing so the nurse may avoid dissonance and make suggestions or negotiate situations in a way that is compatible with the perceptions and values of the client. A second and parallel process of 'getting known' occurs, in which the nurse explains her role, assuming that to do so would encourage clients to accept the service. Cowley postulates that if clients could predict a helpful response from the health visitor they might 'open out and express needs, especially about sensitive or private concerns'

(1991: 653). A high value was placed on respecting the rights, needs and explicit wishes of the client expressed as 'not imposing' (1991: 654). Cowley concludes that the health visitors' tolerance of diversity in their clients, acceptance of individual client values and receptiveness to a broad range of perceived needs were important in establishing the relationship.

Settling in the relationship

Once access has been established, and the two participants have gone some way to establishing the ground rules of the interaction, then the next phase of settling in the relationship begins.

Cowley (1991) identified three conditions; legitimacy (convincing the client that the continuing contact is warranted), normalcy (agreement on basic concepts and values) and activity (agreement on how the actions will proceed) as central to the process of setting up the relationship. That is, unless these conditions are met, the relationship is unlikely to grow. The nurse and client get to know each other so that sufficient common ground is established to enable the building of trust. Trust is seen as central to the relationship before the client would be able to open up and express their needs. This was particularly important if the topics were sensitive or deeply personal.

Developing mutual trust and creating connectedness

For a mutually respectful relationship to grow and develop the nurse must demonstrate to the parent her trustworthiness. Jack et al (2005: 190) found that for the mothers, the most important outcome of the interaction with the nurse 'was the development of a connected relationship' with the home visiting nurse built on a foundation of trust. The mothers 'tested' the nurse to see if they were trustworthy. The mother's decision to trust the nurse and the extent of the trust was influenced by the personal characteristics of both the mother and the nurse. Mothers judged the nurse's trustworthiness according to whether they perceived the nurse as reliable, maintained confidentiality and was accepting. How rapidly it was established differed with whether the mother was willing to discuss more personal and sensitive issues. If they did not trust the nurse then the mothers limited the nurses work by keeping the relationship at a superficial level, 'playing along with the nurse' (2005: 187), not openly sharing.

Nurses who were perceived as being disconnected were those who 'mechanically collected family assessment data' (Jack 2005: 188) or behaved in a bureaucratic or paternalistic manner, lecturing the mothers. Jack concludes that the creation of a connected mother-client relationship was most likely when the nurse treated the mother first as a person, and only secondly as a client. This included the nurse entering into a mutual exchange of information with the mother, which allows the mother to see them as an individual person. Jack (2005) notes that mothers felt more connected when they perceived the nurse as having had similar personal experiences. The development of a rapport with the mother allows the formation of a more egalitarian relationship that Jack characterises as mutuality.

The use of power and persuasion

The purpose of the relationship building is to enable the community child health nurse to carry out health promotion activities with the family. However, health promotion is not a value free activity. Seedhouse (1997) argues that persuasion and coercion are intrinsic to health promotion practice, although frequently unacknowledged. The community child health nurse may not be consciously exerting power over the client but none the less it is present in the nurse-client relationship.

Part of the exercise of power lies in the ability of the community child health nurse to control the direction and depth of the interaction. Control can be exercised in many ways: by ignoring questions, by deflecting the conversation into selected topics, or by imposing strict guidelines on what is acceptable or not acceptable in the conversation. De la Cuesta (1994b) typifies this as 'controlling talk'. In an analysis of the dissonance that can occur in the health visitor-client conversation, she relates an observation in a clinic in which the health visitor appeared to work through a memorised schedule of questions, actively discouraging the mother's attempts to introduce other topics. Other researchers have recorded parent's dissatisfaction with such interview techniques (Cowley & Houston 2003; Mitcheson & Cowley 2003).

Persuasion may be used to induce clients to change lifestyle or simple health habits, to accept a referral to another health service or to take up preventive health actions such as immunisation. For example, the health visitors in de la Cuesta's (1994a) study persuaded clients to take up immunisations by commenting in positive terms about the

benefits of the immunisation and the professional expertise of the immunisers. Similar tactics were used to persuade clients to join a group (1994a).

There are hints of the exercise of social control in the nurses' practices. Chalmers (1992) suggests that in offering assistance to parents the nurses are able to disguise their role in ensuring compliance with socially determined adequate mothering. Arborelius & Bremberg (2003) report that mothers in their study felt pressured to accept certain social norms of child care. These mothers perceived the child health nurse as disapproving of the mothers' efforts and insistent on the mothers following the nurses' view of appropriate mothering behaviour. Such behaviour is viewed as a form of 'policing' of the family, with the nurse acting as an agent of the state (Abbott and Sapsford 1990; Robinson 2004). Other studies have supported the view that health visitors in the UK are perceived by parents as a form of welfare police in which the parents are obliged to present their child caring practices for approval (Mayall 1990; Peckover 2002). Parents may actively resist the nurse by challenging the nurse's claims to superior or professional expertise about child care (Peckover 2002). Or they may be non compliant, ignoring advice and concealing practices such as early weaning; they may also actively avoid the service (Peckover 2002). The perception of policing is strengthened by the official role that community child health nurses have in child protection. In both the UK and Australia nurses are themselves subject to legislation and required to report instances, actions or circumstances where they believe the child's safety is in doubt (NSW Health 2006; Peckover 2000; Senate Community Affairs Committee 2005).

Relevance to community child health nursing practice in Australia
The studies reviewed identify many issues that parallel with the largely anecdotal reports of the experiences of Australian nurses working in community child health nursing services. The description of the nurses' work is consistent with that described in Australian child health policy documents as being principally centred on a public health model of family support (NPHP 2005; NSW Department of Health, 1999; Department Human Services, Victoria 2002). Barnes et al (2003) clearly document the public health role of the child health nurse in Queensland by describing the primary, secondary and tertiary health promotion activities undertaken by the nurses. As well, these authors note the transition that appears to be underway in all states from a traditional screening and

surveillance model to a practice model that focuses more on psychological support for parents and addressing the family's social needs. This movement towards a psychosocial support model is consistent with the international experience and reflected in family support policies in state and territory child health policy documents (Department of Human Services, Victoria 2002; Queensland Health 2002; NSW Department of Health 1999)

With the change to a more psychosocial model of practice there have been recent policy directives in NSW to provide support and education for community child health nurses to increase their capacity to work in a psychosocial model (Fowler 2005). These include the introduction of Family Partnership Training (Davis, Day and Bidmead 2002) that emphasises the skills necessary to support a respectful and supportive working relationship with the parent. Concurrent with Family Partnership Training is the move to a strengths based approach to nursing practice in which the nurses' focus is on enhancing parental strengths as apposed to compensating for parental deficits (Blundo 2001). In this approach a more egalitarian relationship with the client is encouraged so that the parent will gain confidence in their parenting role.

Recent policy directives in most states in Australia have included the introduction of nurse home visiting for all parents with newborns (NSW Health 2005; Queensland Govt. 2006, Govt of Victoria 2006). The increase in the extent of home visiting has changed the context of nursing practice from the community health clinic to the client's home. The community child health nurse is now required to be more pro-active in contacting clients and initiating the first home visit, even before the client voluntarily approaches the service. The introduction of universal home visiting has made the process of entry work more explicit. It is therefore important that the nurse is more consciously aware of factors that will help or hinder the entry into the home and the building of a connected relationship with the client. Health policy now also supports extended home visiting to clients who may not wish to voluntarily access the nurse's services. In this situation a more deliberate use by the community child health nurse of strategies to initiate and maintain a working relationship with the client may be required.

The psychosocial model of nursing practice advocated by the health policy documents includes psychological support of the parent. A number of British authors acknowledge the psychological work of the health visitor (Chalmers 1992; Cowley 1995b; de la Cuesta 1994b; Twinn 1991), but they note that not all health visitors are willing to include psychological support, including therapeutic interventions, in their work. Instead, they choose to manage their work by adhering to public health aspects of health visiting work such as immunisation, screening for health problems and monitoring of child development. The extent to which the nurse becomes involved in therapeutic encounters may depend on the personal style of the nurse and her or his perception of their ability to deal with emotional work (Cody 1999).

Normandale (2001) describes the personal qualities deemed as necessary for health visitors to work in a social support model of health visiting but, interestingly, she thinks the psychosocial model is not always achievable in practice as not all aspirants to health visiting practice exhibit the necessary empathetic skills. Consequently, she suggests changing the recruitment and selection process of health visitors and reviewing their training needs to ensure that these qualities are enhanced.

In a recent article Kruske, Barclay and Schmied (2006) made similar observations about community child health nursing practice within the Australian context and pointed to the necessity to review contemporary nursing practice and education to include adequate support for the psychosocial nursing role.

Conclusion

The principal interest in these studies is the insights they offer on the underlying processes involved in providing nursing care in community child health. They raise issues to do with the creation of the therapeutic relationship between the nurse and client family and the intended and unintended consequences of the nurses' actions. There are moral dilemmas implicit in the nurses' work that requires further investigation, such as the policing role of the nurse. A thoughtful examination of child health nursing practice within the Australian context may lead to a deeper analysis of the effect of contemporary Australian child health policy in terms of what the nurses are being asked to do and the impact on the families with whom they come into contact. With the introduction of health policy documents that direct community child health

nursing practice to concentrate on the psychosocial care of the family, it seems timely to review the relevance of current preparation for practice as a community child health nurse and support for nursing practice development.

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CHAPTER 3: RESEARCH METHOD

Introduction

The Nurses' Study is informed by a small research project that examines contemporary nursing practice in NSW Health funded child and family health services. The literature review in the previous two chapters has yielded international studies on the nursing practices of child health nurses in the U.K., Scandinavia and the U.S.A., but the scant evidence of similar studies in Australia at the time of commencement of the study suggested that there was a gap in our knowledge of child and family health nursing, and thus a study of contemporary nursing practice was justified.

More specifically, the study was intended to respond to the questions raised by the Policy Study about the effects of the introduction of the Families First policy in child and family health nursing services. The Policy Study had hypothesised that, if Families First and its supporting policies had an effect on the structure and delivery of the nursing service, there would, consequently, be an impact on the practices of the child and family health nurses. The purpose of the Nurses' Study, which is the companion to the Policy Study, was to investigate whether or not this hypothesis could be substantiated.

The goal of the study was, firstly, to describe the nursing practice of child and family health nurses, and then to explore whether or not the nurses considered their practice to have changed as a result of the policy initiatives.

Thus the study addressed two research questions:

1. What is the nature of nursing practice in child and family health nursing?
2. Do child and family health nurses perceive their nursing practice to have changed as a result of the introduction of Families First and subsequent NSW Health policies, and if so, how has it changed?

Rationale for the Study Design

The study was designed to describe and critique the nurses' day to day practice as they understood and experienced it. It was situated within an interpretive framework as I was aiming to research the nurses' understanding of their own world by observing them in the natural setting and can be described as a naturalistic study.

The qualitative framework used in the study was suggested by Sandelowski (2000). She argued that a legitimate expression of qualitative enquiry was qualitative description, which, as its name implies, is descriptive in nature. This is a less complex form of qualitative research, when compared to grounded theory for example, but still a valid research method. It is not as highly interpretive as other forms of qualitative research in that it does not require researchers to give a highly abstract rendering of the data. Nevertheless there should be an accurate rendering of the sequence and meaning of the data: 'the description in qualitative descriptive studies entails the presentation of the facts of the case in everyday language' (2000, p336). Qualitative descriptive studies 'offer a comprehensive summary of an event in the everyday terms of those events... An accurate accounting of events and the meanings attributed to those events' (2000, p 336). Researchers conducting qualitative descriptive studies stay 'closer to the surface' of words and events than researchers using more complex forms of qualitative research such as grounded theory and phenomenology. In qualitative description language is a 'vehicle of communication, not itself an interpretive structure that must be read' (2000, p336). The aim is to elicit the facts and the meanings participants give to those facts and then convey them in a coherent and useful manner. Qualitative descriptive designs are compatible with naturalistic inquiry, in which the target phenomenon is allowed to present itself so 'there is no a priori commitment to any one theoretical view of a target phenomena' (2000, p. 337). Data collection may include open-ended interviews and observations of events and the examination of documents.

Polit and Beck (2006) describe the ability of naturalistic methods of enquiry to capture the human experience through the collection of narrative and subjective materials over an extended period of time. This allows the researcher to gain insights that lead to an understanding and explanation of the processes under observation. In keeping with accepted naturalistic methods the study design included interviews of the nurses about their perceptions and beliefs of their practice as well as observation of the nurses'

interactions with their client mothers in the community health centre or during home visits.

Comparable studies in the United Kingdom had also used a qualitative research design, often using grounded theory or action research as the methodology of choice. Both of these methodologies were considered but I did not intend to build theory, as occurs as an outcome in grounded theory, or to initiate a process of change which is found in action research. Rather, I was asking nursing participants their views and opinions about their practice and the change process they had experienced. This study was not based on a specific intervention in which I and the nurses were concurrently involved but was a study of the effects of a number of actions carried out by others, such as policy makers and health managers. I have been in a position of facilitator of change through my committee work with the NSW Department of Health and CAFHNA but in this study I was an observer of change, not an agent of change as in action research.

In some respects the methods chosen have drawn on methods from ethnography, and Sandelowski (2000, p337) notes that qualitative descriptive studies may have 'overtones' of ethnography as researchers may employ similar techniques. I used semi-structured interviews, observation and field notes, which are common to ethnography. Ethnography describes 'general' patterns and regularities within the social system under study and by using inductive logic generalises them to others sharing the same culture and activities (Knapp, 1999). My intention was to observe general patterns within the nurses' work: not just to generalise to the practice of other nurses, but to explain any possible changes in the nurses' practice brought about by the policy implementation.

Ethnographic studies require close contact with a social group for a long period of time and also that the researcher participates in the same kinds of activity as the people in the study (Maggs-Rapport, 2000). The ethnographer may be a peripheral member of the group, where the researcher interacts sufficiently to be considered an insider but does not participate in the group's activities, or an active member of the group, where the researcher may participate in some of the group's core activities, or a complete member of the group where the researcher is entirely involved with the group's activities and experiences (Burton & Steane, 2004; Parker, 2004).

I considered myself to be a peripheral member of the group, that is, I was not actively participating in the day to day activities of the nurses' I interviewed and observed. I had, however, an intimate knowledge of the practices and world of work of the nurses and a continuing connection with many through my position on the executive of the professional nursing organisation. Furthermore, I also personally knew many of them and had worked with them either in clinical practice or on various committees. So in the eyes of the nurses I interviewed I would have been close enough to their everyday world to be considered an insider. These close connections to the clinical setting and to the clinicians involved have enabled me to gain access to the everyday world of child and family health nursing in NSW. They have allowed me to observe the behaviour, language and interactions of the actors within their familiar setting. In some respects my close association with the clinical field could have caused some difficulties. If the nurses saw me as an insider it may have made it more difficult for me in reporting adverse findings: they may have viewed this as a betrayal of trust.

Participant observation is frequently the chosen method of ethnographers because it allows the participant to see the world through another's eyes. My prolonged immersion in the world of child and family health nursing made it easy to study in one way because it was so familiar, but harder in another in that its very familiarity could mean that I simply would not see the phenomena I was looking at in the same way as a new observer may. Preston (1997) encourages health care professionals to practice ethnography in their own cultural health care settings, arguing that their familiarity with the context contributes to the reliability and validity of the research, so long as consideration is given to insider bias when being an observer in their own cultural setting. I needed to differentiate between myself as a previous practitioner in child and family health and as a researcher. The perceptions, understandings and assumptions that underlie the actors behaviours and interactions could have been so indistinguishable from my own that I could fail to see the significance of what I was observing.

The 'taken for granted' is more likely to emerge in participant observation than in interview (Bryman, 2004) but there were special circumstances here that made participant observation difficult. Firstly, I was not employed by the Area Health Service and so had no legitimate role in the service. My observations of the nurses would have to be done as an occasional visitor to the service. Secondly, the nurses conducted a one-

to-one session with their client in a private consultation room, so even if I had gained employment in the service, which was possible, I would still be unable to participate in the very interactions that I wished to observe. Also, while my visitor status would give me entry to the consultation room, there was little opportunity for participation of a third person, especially a stranger, in the interaction, because of the exclusiveness of the one-to-one interaction between the nurse and the client mother.

I was keen to include observation of the nurse's practice within the study as a balance to the interview data. McKenna, Hasson and Keeney (2006) caution that data collected via questionnaires or interviews may be inaccurate, reflecting intention rather than actual practice, and that observation of practice may provide a truer picture of the situation. I knew the nurses were used to having observers in the room, such as student nurses, so I hypothesised that they would not be unduly concerned with the presence of another observer who did not participate in the interview process, hence non-participant observation seemed a logical choice.

Non-participant observation has been critiqued as a method coming out of the positivist tradition (Watson & Whyte, 2006). It is accepted as a method in qualitative research with the knowledge that pure observation without the researcher in some way influencing the situation is impossible. So I would have to take into consideration just how my presence as an observer in the consultation room may have had an impact on the participants and influenced or biased the data I collected. There was a possibility that the nurse would try to display acceptable nursing behaviours for my specific benefit, or that the mother would be reluctant to discuss deeply private issues with a stranger present. The former I hoped to address by catching three interactions for each nurse to minimise the risk. The latter I could do little about, but by aggregating the content of all the nurse-client interviews the risk would be minimised. I intended to position myself in the room outside the line of sight of the client and sufficiently distanced to not be able to participate in the conversation between the nurse and the mother. Bryman (2004) suggests that in reality observers in the situation are drawn into a participant role if they are invited or required by circumstances to become involved in the action. Accordingly, I had some difficulties in maintaining the strict observer role. In at least one incident the toddler with the mother approached me directly and attempted to engage me in her play, which caught the attention of the mother. It was

also hard not to become attracted by the direct gaze of a friendly and curious baby and enmeshed in a smiley game, as this also would attract the attention of the mother and nurse.

The Study

Setting

The participants in the study were drawn from two Area Health Services in NSW. The two Area Health Services no longer exist in the same form, following a major structural re-organisation by the NSW Department of Health in 2005. The rationale for choosing these particular two health services for the Nurses Study was that while they had comparable child and family health nursing services they would be sufficiently unalike to allow for differences to be detected.

Area Health Service One was located in a rural area of NSW. The estimated population in 2001 was in excess of 350,000 and the greatest population density was in the eastern regions. The age profile showed that the proportion of children 0-14 years in the population was slightly above the State average, as was the proportion of people over the age of 65 years. In comparison to the State average the area had a larger proportion of residents of high need due to low socio-economic status. There was a significant Aboriginal population, descendants of the Aboriginal nation that had originally inhabited the area. There was a lower than State average number of people from non English speaking backgrounds living in the districts. The Area Health Service had four major base hospitals, supported by small, localised hospitals and community health services, although the isolated western regions had community health services only. There were dedicated Aboriginal health services. The child and family health nursing services were part of the community health services and the nurses held post registration qualifications in child and family health. The larger towns had well established and dedicated community child health centres, but the isolated regions were serviced by visiting nurses, who also held clinics in community venues. I spent the day with the child and family health nurse as we drove 400 kms on country roads to visit mothers on isolated farm properties. At the end of the 'run' we opened the clinic room in a tiny inland town, where about six mothers brought their children in from outlying properties to see the nurse. There were several secondary level referral Family Care Cottages in

the Area Health Service offering day stay services, but any major difficulty requiring tertiary level referral needed to be sent out of area to Sydney hospitals. Area Health Service 1 had been participating in Families First for more than five years and so had progressed some way into the changes initiated by the Families First Strategy at the time data was collected.

Area Health Service Two was situated in a large metropolitan city and was comprised of eleven local government areas. The population was in excess of one million people, with a higher than usual State average of elderly people over 75 years of age. More than 18% of the population was not born in Australia, and there were three local government areas with significant numbers of non English speaking people residing in them. The area was extensively developed for residential use, with commercial and shopping districts interspersed amongst the suburbs. The health care service was subdivided into four local areas for administrative reasons. The whole area was serviced by several level 1 hospitals with highly specialised health care services (both public and private), with more localised level two hospitals feeding into the level one hospital, and supported by extensive community health services. The child and family health nursing service was a specialised strand of the community health service with dedicated stand alone community health centres staffed by nurses with post registration qualifications in child and family health nursing. A secondary level referral Family Care Cottage operated in each of the four local areas, offering day stay options for mothers requiring more intensive assistance. The two State tertiary level referral services (Tresillian and Karitane) offered residential and specialist services within easy driving distance. Where possible the nurses worked in teams of three or four nurses to a community health centre, but there were still a number of single nurse centres in the region. Area Health Service Two was not at that time formally involved in the Families First implementation, so was officially still working under service conditions that had been seen as the normal service prior to the introduction of the Families First policy. It is a fact, however, that because of its city location the staff had easy access to the State conferences and educational seminars that accompanied the introduction of the policy. It is possible that they also observed and learnt from the experiences of nurses working in other Area Health Services where Families First had been implemented. For example, although funding for the NSW Department of Health's policy of Health Home Visiting

was not officially available, the nurse managers recognised the necessity to prepare their services for the introduction of universal home visiting.

Ethical Considerations

In preparing applications for ethics approval for the study from the relevant authorities I had to consider how the nurses and their client would be protected from harm, whether my actions would compromise them in any way and if there would be any long term effects from the interview.

Ethics approval for the nurses' study was gained from the UTS Ethics committee in 2003 (Approval Number UTS HREC 03/48A). Application for ethics approval was submitted to both Area Health Services and obtained before the interviews were arranged and was contingent on my meeting certain conditions. The requirements were that the nurses' were to be fully informed of the reasons for the study and any risks attached to the study for them through a letter which they sighted before signing the consent form. They were to be informed that they could withdraw from the study at any time and that their participation in the study would not compromise their employment status. They were verbally assured that their right to privacy of identity would be respected and any data obtained would be de-identified so that they could not personally be identified as a participant in the study in either the study report or any subsequent publication arising from the study. Information obtained from the interviews would not be given to their managers and participation in the study did not have an impact on their employment status. Ethics approval was granted by each Area Health Services in 2003 and 2004 respectively.

Ethics approval for the nurse-parent interviews included conditions to be met to safeguard both the nurses and their client mothers. Before I could visit any given Centre, the clients of the Centre were to be notified two weeks prior to my visit that I would be present on set days in the centre. A notice was displayed in the waiting room with a photo of me and description of the study written in plain English. Thus if they did not wish to participate they could avoid attending the centre on the days that I would be present. Recruitment for the interviews took place in the waiting room on the day. Parents were approached, their attention drawn to the displayed notice and a brief

description of the study given). If they wished to proceed they were given an explanatory letter together with the consent form (see Appendices). The parents were informed their participation was voluntary and their decision to participate or not would not jeopardise their care. They were informed of their right to refuse or to stop the interview. They were given explanations of how their confidentiality would be maintained. Consideration was given to their protection from harm and long term effects of the study and the letter contained the name and contact details of a neutral person at the university and in the Area Health Service (this was the Research Officer in both cases) who could be contacted with complaints or queries. The separateness of the study to their ongoing relationship with the nurse or the child and family health service was emphasised.

Although not included in the formal ethics approval process there was a possible ethical issue that could arise in the course of the study. The issue was to do with the difficult situation of observation of poor nursing practice that had the potential to cause harm to clients. In this case I would be under a moral obligation to notify managers, but the decision to do so would be taken on the basis of the severity of the outcome of the incident.

Participants

The participants in this study were nurses employed by the Area Health Service as child and family health nurses in primary health care positions in community nursing services. Child and family health nurses working in tertiary referral services such as Tresillian and Karitane were not included in this study so it only refers to primary health care services. The nurses were invited to participate so this was a self selecting sample. All those invited accepted. There were fifteen study participants, with almost equal participation from each Area Health Service: eight and seven respectively. One of the fifteen nurses was a male and all were Anglo-Australian. The two nurse cohorts are identified as A and B in the discussion of the results in Chapter Four to distinguish between their locations. All fifteen nurses were interviewed for the study and the interviews recorded. All the nurses were employed in a full time position, which is unusual, as the clinical area of family and child health has a high proportion (up to 54.4%) of nurses working in part-time positions (AIHW, 2005). It is noted that this was

an experienced and well qualified group of nurses with between five and 16 years experience as a child and family health nurse. The majority of the nurses had achieved qualifications beyond the minimum usually required for employment in the position, such as certification in Lactation Counselling or other further postgraduate study. This may have positively influenced their willingness to participate in the research study as they could be considered an expert group. The age range was 35-55 years, and reflects the socio-demographics of child and family health nurses in the State generally where the average age is 45.7 years (AIHW, 2005).

Each nurse was to be interviewed about her/his views on the nature of child and family health nursing practice and the effects of contemporary policy on her/his work. For each nurse interviewed in the study I would observe her/him interacting with client/s on three occasions of service. It was not possible to complete three observations of practice in several cases, so the final number of nurse-client interviews was 43. From these nurse-client interactions, the longest of the three audiotapes for each nurse was chosen as the representative sample for analysis.

Recruiting Participants

Nursing unit managers in the two area health services were formally approached for permission to access their staff. As each AHS is subdivided into three or four local areas I requested that participants be drawn from at least two separate local areas to spread the load and to obtain diversity.

The Nursing Unit Managers (NUM) invited me to the nurses' meeting where I was introduced and given an opportunity to briefly outline the research and to invite the nurses to participate. NUMs then gave me list of nurses who had expressed an interest in being interviewed and their contact numbers. In one area health service I was already well known to the nurses who were familiar with my role as a nurse academic and also knew me through the professional association. This could potentially affect the acceptance of the study and influenced the nurses' willingness to volunteer to participate, either postively or negatively. In the other AHS I had a collegial relationship with a key senior child and family health nurse in the area who smoothed my path and introduced me to the NUM. The nurses in this AHS were also asked to volunteer and I

am aware that the support of the key senior child and family health nurse was of assistance in encouraging some nurses to do so, but could also have dissuaded others to volunteer.

I was cognisant of the influence that my professional standing might have exerted on the participants and in the first contact with the nurses I made it quite clear that their participation was entirely voluntary and they could withdraw at any time. I had decided to present myself to the nurse as a colleague but not one in active practice. We therefore had an expectation of a shared vocabulary and that I would come with some knowledge of the service and the routine at the clinic. This shared understanding made it easier for me to fit in with the centre because I was familiar with the setting, with the rhythm of the day and with the type of client I was likely to meet. It had been many years since I had worked in the child and family health nursing service myself, but it struck me that the setting and the clients were familiar. I enjoyed being back amongst the mothers and babies again. Looking around at many of the centres I visited there appeared to be very little change in the building and contents from the last time I had worked in the service, more than 20 years previously. In reflecting on this feeling of familiarity, of being a part of the service again, almost as if I had never left, it was a very comfortable feeling and I felt quite relaxed. While this relaxed stance may have contributed to the success of the interviewing, nevertheless I had to remain aware that this may have made the process more difficult. My subjectivity was a factor that could not be ignored and I used field and diary notes to note my reactions as an attempt at balance.

Data Collection

The Interviews with the Nurses

The interviews with the nurses were conducted in the clinical setting. Typically I visited the clinic where the nurse was located and the interview was conducted in the nurses' consultation room or an office room in the clinic. The meeting was arranged at a time convenient to the nurse when we could talk without the expectation of being interrupted by a client. In several cases the nurses wrote me in as an appointment in their clinic appointment book. On some occasions the visit was an all day visit where the interview with the nurse and the three occasions of service with the clients were recorded on the same day. In other instances the nurses' interviews and the occasions of service were

separated visits. The interviews were tape recorded, with the permission of the nurse. The length of the interview with the nurse was typically about 45 minutes to one hour. The nurses' interviews were semi-structured, and usually began with the request to 'tell me how you would describe your work to someone who was not familiar with it'. A schedule of questions was drawn up as prompts for discussion that included requests to describe a typical day, and asked for the nurse's views on the introduction of recent policies. As the interview progressed the interviewee was encouraged to expand on any interesting ideas or emerging themes. This flexible approach to interviewing is consistent with practice in naturalistic research.

The Nurse-Client Consultations

The majority of the observed discussions between the nurse and the client mother took place in the nurses' consulting room in the community health centre and only a small number of home visits were attended. When permission for the visits was sought from health managers I did not specifically request home visits, and whether or not I observed clinic or home visits depended on the nurse's schedule for the day of the arranged visit. When home visits were attended they were not necessarily newborn first visits. The consultations observed in the community health centre were a mixture of previously organised appointments and drop-in visits, where mothers and babies were seen as they arrived at the centre. The babies attending with their mothers were all under the age of 15 months, with eight babies being less than six months old, of which four were newborns. The sessions were tape recorded with the permission of both nurse and mother. The tape recorder was placed on the nurses' desk or in a position to best capture the conversation between the nurse and the mother, as per the practical recommendations in ten Have's (2007) article. If the pair moved to another position in the room or the centre I picked up the tape recorder and followed. I usually sat at a point in the room where I could see the expressions on the faces of both participants but removed far enough not to be drawn into the conversation. The aim was to tape record three interactions with every nurse in the study but this did not occur with several of the nurses so that in all 43 interactions were collected. The interview with the mother varied in length from 10-40 minutes, depending on the mother's need and the number of child health assessments carried out at the time.

During the consultation I took notes to supplement the tape recordings. My notes were taken as unstructured observations in keeping with traditions of qualitative research and an ethnographic approach. That is, no framework was developed for data collection prior to the interview. Fieldwork notes included comments about critical incidents that occurred during the consultation to expand on the taped conversation and further conversation or nonverbal actions not captured on tape, comments on location or environment and on my personal impressions of the nurse and the setting. Ideas for the analysis were noted.

Most, but not all, observations of the nurse-client interactions occurred on the same day as the interview with the nurse and this was particularly true for the visits to the rural Area Health Service, where I had limited time. There was no set order and the nurse interviews sometimes preceded the nurse-mother observations, but sometimes they did not, dependant on when the nurse had free time in her daily schedule for the interview to be conducted. The city Area Health Service was more accessible and observations and nurse interviews were more likely to be spread out over several days.

Analysis

This is a procedural account of the process of analysis explaining how I used the data collected to reach my main conclusions. The interviews with the nurses are reported here first.

Analysis of Tapes of Nurses' Interviews

As soon as practicable after the interview I transcribed the tapes into word documents. Recording and analysing the tapes myself gave immediate immersion in the data, a process which is considered essential to good data analysis (Lathlean, 2006). The tapes were recorded verbatim including laughter, long pauses and hesitations, exclamations and such, but the record was not nearly as detailed as that used in discourse and narrative analyses (Silverman, 2000), or in conversation analysis (Liddicoat, 2007; ten Have, 2007).

The next step was the analysis of the transcripts. I had the option to use statistical software packages, but preferred in this instance not to do so. I discovered that it was easy for me to manage the data in the hard copy transcripts by hand. The transcripts

were printed in hard copy 1.5 line spaces for ease of reading. As I read and re-read the transcripts codes that emerged from the data were written in the margins. Coding is a means of categorising to classify word/phrases, ideas and beliefs presented by the participants. Data are broken down into 'basic descriptive units' (Maggs-Rapport, 2000) and sorted according to common themes or patterns. Initially I had multiple categories and as the data analysis progressed preliminary themes emerged, which were eventually collapsed into major themes. I used highlighter pens with a different colour for each major theme. These key themes were checked by listening again to several tapes for correct narrative and to get a feel for the nurses' affect. The naming of the themes was prompted either by my reading or by a phrase or expression that the nurses' used. I was not consciously looking for metaphors, just descriptive labels.

Lathlean (2006) notes the importance of being aware of your own personal feelings and professional experiences during the analysis process.

> meaning of a text arises from the interaction of the mind (including personal history) of the reader with the content of the text (which in turn arose from the mind and personal history of the interview respondent). (2006, p597).

Reflection on the content of the interview transcripts was ongoing across the many weeks this process took and eventually early themes were either confirmed or subsumed into the main themes. During this process I kept an e-diary of thoughts and ideas that I thought might be useful when writing up the study.

Analysis of Tapes of Nurse-Client Interactions

The purpose of taping the nurse-client interactions was to supplement the nurses' interviews by observing actual practice. Initially, I intended to compare each nurse's interactions with their clients, with their descriptions of practice obtained from their individual interviews. That is, compare what they actually did to what they said they did. It soon became apparent that this was not possible: it would have required numerous recordings of each nurse's interactions to capture a true picture of their individual practice. Therefore one interaction for each nurse was chosen from the sample and the data aggregated to give an overall picture of nursing practice. The nurse-client interaction was selected on the basis of the length of the interview. Each of the

recorded interactions for each nurse was timed and the longest interaction selected for further analysis.

The tapes were not transcribed verbatim, and this decision was taken on the basis of evidence that suggests that alternatives to transcriptions are acceptable in handling data analysis (Lapadat & Lindsay, 1999). The tapes were listened to and notes made of their content, and episodes of interactions that related to themes that had emerged from the analysis of the nurses' interviews were transcribed. Content analysis is classifying words in text to a few categories chosen because of their theoretical importance (Silverman, 2000). Categories are sequences of related talk and in this case, three categories were chosen as likely to be of significance: greetings, communication and listening behaviours, and topics of conversation. Content analysis uses a systematic means of measuring the frequency, order or intensity of words, phrases and sentences (Silverman, 2000). For the first two categories, characteristic examples of the nurses' behaviour were noted where they confirmed or disconfirmed the themes that emerged from the analysis of the nurses' interviews. That is, where what they said was congruent or not with what they did in practice. Topics of conversation were only counted for frequency.

As each tape was played I made extensive hand written notes capturing the interactions on the tape and when necessary actual spoken phrases. Most tapes were listened to at least twice to confirm the note taking. The interview was then divided into sections of related talk. The greetings and introductions were noted with attention to who was present. The manner of the goodbyes was also noted including who said goodbye to whom. The body of the interview was categorised into topics of conversation with attention as to whether the nurse or mother initiated the topics. Sometimes the conversation returned to previous topics but this was counted as if it were a new topic.

For the content analysis of the nurse-client interactions I was guided by the work of Baggens (2001), who, in a Swedish study of child health nurses and client mothers, recorded the topics discussed and their frequency during consultations in the community child health A table was constructed using Baggens' topics as a guide. Each nurse-client interview was scrutinised and the interactions tallied. New topics were added as they arose with the final number of topics reaching 35. Similar topics were then collapsed to reach a final number of 15 categories. Field notes were consulted during

the analysis to supplement and support the data on the tapes. Although it is customary to check the reliability of the categorisation procedure by using independent raters this was not considered in this case because it was not a stand alone study. Rather, it is a small part of the main study and intended to be used to inform the thematic analysis of the nurses' interviews.

Key Processes in Qualitative Research that were used to Inform the Method of Data Collection and Analysis

Confirmability

This relates to the neutrality and reliability of the data in terms of accuracy, relevance and meaning (Polit & Beck, 2006). This can be enhanced by making explicit the decision rules established during the analysis process to form an audit trail. The specific decision rules described above for categorising data were established so that there would be consistency in the handling of the data and as one way to establish the trustworthiness of the data. To enhance auditability, the data has been stored so that it can be produced if requested.

Reflexivity

Simultaneous with the data analysis was the need to address relationships between the study participants and myself as the observer of their interaction. Burns and Grove (2001) note that the researcher needs to reflect on the meanings obtained from the data and the manner in which they are becoming involved in the subject's experience. Further, the researcher must recognise that their own social identity and background may have an impact on the research and they are therefore under an obligation to explain this in the study report.

Taking the concept of 'participant' to also include myself, I needed to consider the influence that my professional background might have had on the process and the outcomes of the study. This was especially relevant because of my previous practice in child and family health nursing and continuing involvement with the clinical field. There was a danger that this may have influenced study participants and the data

collection, or that my personal feelings and experiences may have biased the interpretation of the research findings.

A well recognised method to manage this difficulty is to 'reflexivity bracket' my experiences to minimise the bias in the research process (Burns & Grove, 2001). 'Bracketing' is suspending or laying aside what is known about the experience being studied. I could, however, not easily do this as I was deeply involved in child and family health nursing and had been for a long period of time. Most of this practice knowledge and skill had entered my subconscious and become intuitive (Benner, 1996) and could not easily be set aside. So instead I chose to use a different process that required me to consciously identify my beliefs, assumptions and preconceptions about the research topic (Burns & Grove, 2001). I wrote a reflective essay about my experiences as a child and family health nurse in an attempt to facilitate openness and provide insight. (The essay is not included in this Dissertation). For example, I entered the study with the assumption that most nurses are competent practitioners with a high level of expertise, that good is intended from their interactions with their client mothers and that good outcomes ensue from good practice. I may have been unconsciously directed to those nurses that epitomised those qualities, so the participants may not be representative of all child and family health nurses.

Validity and Reliability of Process

Validation refers to the extent to which the research findings are congruent with reality. External validity implies that the abstractions and concepts developed during the data analysis can be applied to other settings and internal validity requires that they are authentic (Watson & Whyte, 2006).

In this study several methods were used to ensure the research findings had validity. Firstly, feedback was sought from interviewees as to the extent to which they thought I had captured their ideas and thoughts. I made formal presentations at both Area Health Services of the thematic analysis of the nurses' interviews. The presentations were made to the group of nurses involved in the interviews and their colleagues at staff in-service days. This gave the nurses an opportunity to clarify and confirm or otherwise whether I had successfully encapsulated their ideas. Secondly, the self report data from the

nurses' interviews was checked against the interactions with mothers obtained through the observation of the nurse-client interviews. The nurse-client observations allowed me to access the context in which the nurses were practising and this could also be compared to my own experience as a child and family health nurse for authenticity. In this way the reliability, validity and trustworthiness of the study was enhanced.

Concluding Remarks

The following chapter of the Nurses Study reports the findings of the research study to investigate contemporary practice in child and family health nursing.

CHAPTER 4: ANALYSIS OF NURSING PRACTICE IN CHILD AND FAMILY HEALTH

The aim of the Nurses Study was to describe the nature of the nurses' practice and to enquire into perceived changes in nursing practice flowing from recently introduced health policies. To this end, two sets of data were collected for the study: interviews with fifteen child and family health nurses on their views of contemporary practice, and observations and recordings of the nurses' interactions with their client families. The analysis of the two data sets are combined and reported here.

This chapter begins with a description of the interaction between the nurse and the client parent in either the community health centre clinic or in the client mother's home. In the presentation of these findings, I have interwoven reference to the work of other authors, as I found it useful to support assertions I have made. The process of the interview is described as well as topics of conversation that occurred during the progress of the interview. This description gives an understanding of the setting in which the nurses' practise, the daily work of the nurses and examples of their interactions with their client mothers.

The thematic analysis of the transcribed tapes from the interviews with the nurses follows. The themes which emerged are described and discussed. These interviews elicited the nurses' attitudes and values about their practice as child and family health nurses. As the interviews progressed the nurses began to voluntarily describe the underlying reasoning and philosophical basis of their practice. They explained the processes they used to obtain the intended outcomes for the child and family and shed some light on the purposes behind their actions within the observed nurse-client interviews.

Observations and Recordings of Nurses' Interactions with Client Families

During this part of the study observations and tape recordings were taken of the nurses interacting with their client parents in either the home or the community health centre. For each nurse up to three interviews with the parents were audiotaped and field notes taken of the interaction. From the taped interviews one was chosen for further analysis. The purpose was to try to capture the fundamental nature of the nurses' practice by

examining what actually happens when the parent and the mother talk. Of the fifteen interviews described the majority (13) took place in the community health centre, with only two occurring in the mother's home. This ratio of 6:1 clinic versus home visits is roughly in proportion to that in the total number of tape recorded interactions (36 clinic vs seven home visits). The two home visits both took place in the rural Area Health Service, which offered home visits to families who were living in isolated towns or who for some other reason could not attend the community health centre.

When Nurse Meets Mother...

The interview usually took place with the mother of the infant. In some instances there was another parent or family member present: in three interviews the father was with the mother, and on three other occasions the grandmother accompanied the mother. On two occasions there were other children in the family present, one of which was a home visit where it could be expected to find other children in the family. For ease of description I will refer to the mother as the other person in the interview.

The interview rooms in the Centres and clinics were set up to encourage the interaction between the nurse and mother. Although the quality of the facilities varied considerably, the furniture in the room was usually arranged in a similar style, to facilitate conversation. The nurses' desk was pushed against the wall, so that the nurse and mother sat facing each openly and at a conversational distance. If another family member was present, the circle was enlarged. The babies and small children were often positioned on the mother's lap, or in carry cots placed on the floor at the mother's feet. Older, more ambulant children were often sat at the small children's table and chair set and encouraged to play with the toys under the watchful eyes of the nurse and mother. The nurses turned their chair to face the mother during the conversation, only returning to the desk to make notes in the health record. If the baby needed to be physically examined, then both nurse and mother would move to the examination table and the conversation would continue standing side by side. The tone of the conversation was low, the room was quiet and the atmosphere encouraging to the mother.

Home visits to the parent's home were also observed. When the nurse arrived she would be greeted at the front door and waited until she was invited inside by the parent. The discussion with the parent usually took place in the kitchen/living room of the house

around a kitchen table. The nurse would set up the weigh scales and measures on the table and any other equipment that she had brought with her. Baby examinations were carried out on the table or with the baby on the mother's lap. On some occasions other family members were present, or the baby's siblings were noisily apparent. The atmosphere was informal and relaxed. The nurse's visits were apparently very welcome and cups of tea or coffee, together with biscuits and cake, were offered to the nurse as expressions of hospitality.

Progress of the Nurse-Mother Interaction

The consultation followed the standard structural model of an interview in that there was an introduction where greetings occurred and the discussion was opened, the body, where the business of the interview was conducted, and then a closure where the interview closed and goodbyes were said (Sommers-Flanagan & Sommers-Flanagan, 2003; Sully & Dallas, 2005). This corresponds to the three categories I have previously identified as of significance for content analysis viz. Greetings and leave-taking, topics of conversation that occurred in the body of the interview, and the communication and listening behaviours of the nurses.

In the community health centre the nurse usually went out into the waiting room to meet the mother and while they were walking back into the nurse's office civil courtesies were extended, so that if the mother had not previously met this particular nurse, the nurse introduced herself appropriately and enquired after the mother's and baby's names. In the home visit, the civil courtesies were also in evidence. The nurse introduced herself and stated the purpose of the visit at the front door, did not enter the house until invited, and if other family members were present then introductions were made before the nurse turned her attention to the business at hand. All of these actions were intended to put the mother at ease and set up the conditions for the discussion.

The style of the interaction reflected the characteristics and personality of the nurse: some were more formal than others, some smiled and laughed more, others less so. The nurses were without exception pleasant and welcoming, and the exchange of small talk began as the small group of nurse, mother, baby, and occasionally another family member moved from the public rooms to the relatively more private domain of the nurse's office. This polite introduction to the interview was extended if the nurse and

mother knew each other well enough to sustain a conversation about personal events, such as a recent holiday, family occasions, or even time honoured introductory comments about the inclement/hot/fair weather. The chatting continued as the nurse and mother settled down in the nurses' room. The nurses frequently made positive comments about the baby's appearance, or some other aspect of the baby and when everybody was settled, including the baby, the interview proper began.

The serious discussion between the nurse and the mother was usually opened by the nurse. In twelve of the fifteen interviews the nurse indicated that the conversation was beginning by asking the opening question. This opening statement to the interview proper invites the mother to tell her story and ideally should be nondirective (Sommers-Flanagan & Sommers-Flanagan, 2003). Most of the nurses began with an indirect question, such as

> So how is it all going? (Nurse A4)
> So how are you today, Mrs X? (Nurse B5)
> How are you today? (Nurse B6)
> So how are you going? (Nurse A8)

On one occasion, after the nurse and mother had settled themselves the nurse opened the conversation with one softly spoken word: 'So...?' the mother was clearly agitated and this gentle invitation encouraged her to talk about her distress with the nurse.

Using open questions that invite detailed responses is consistent with good counselling practice (Braun, Davis & Mansfield, 2006). Here the nurses were able to skilfully encourage the mother to describe and explain in her own words the purpose of the visit. Communication strategies such as this reward the mother's initiative and do not limit the interaction.

Some times it was a more direct question, such as

> How is she? (referring to the baby) (Nurse A2)
> And what's he doing now? (Nurse A5)
> You say she's been in hospital? (Nurse B4)

Yet even in this more direct line the nurse is expecting the mother to take the initiative and begin the discussion.

Sometimes the nurse used humour, as in this example, where the nurse is joking with the baby's two brothers and the mother as she and the three children entered the nurses' room.

> Where's your sister? Where is the object of your visit? Here we go, boys, in here!

And then a little later:

> So what can your sister do, boys?
> (Nurse B1).

In this example, the nurse and mother were well acquainted and it was apparent that the visit to the community health centre was a family occasion. The older children obviously knew the routine quite well, as following a noisy greeting they immediately turned their attention to playing with the toys available in the nurses' office as the nurse and the mother settled down to talk.

In a first visit, however, where the nurse and the mother do not yet know each other, it is during this initial greeting phase that the nurse and mother are sizing each other up and making judgements about each other (Sommers-Flanagan & Sommers-Flanagan, 2003), so first impressions are important and may colour the interview process.

Following the greetings and opening statements, the interview now moved on to the next stage of addressing the purpose of the meeting. On two occasions the mother initiated the discussion by clearly stating the purpose of the interview: 'I've got some feeding questions today' (Nurse A4). In the second example: 'I want a weigh and measure as (child's name) is 14 months today' and the mother continues straight on to say she 'wants a bit of a chat as he is out of sorts' which turns out to be difficulty with sleep and settling routines (Nurse A1).

These mothers had come to the nurse with a clear agenda of their own. They apparently saw the nurse as a source of information, and by their behaviour acknowledged her/his expertise. On both of these occasions the visit took place in a community health centre located in a well-to-do middle class suburb, and the two mothers were well educated, articulate and confident enough to take control of the interview. Nurses in other locations also reported that some mothers came to the interview with 'a little wish list of questions they want to ask you' (Nurse B3). This assertive behaviour was not seen in all mothers, some of whom adopted a passive stance typical of clinical encounters (Strong, 2001). They waited for the nurse to direct the interview and observed the conventions of the clinical interview, particularly if this was a first visit. It was noticeable, however, that when nurse and mother knew each other better, then the interaction was more egalitarian in nature.

Sometimes the mothers did not state the purpose of the visit at first, but let it become apparent as the interview progressed.

> Mother: She's now 14 months
>
> Nurse: 14 months…
>
> Mother: I've just really come up because um, I just wanted to have, I wanted to weigh her and measure her. And also to sort of have a bit of a chat because she's just trying to…she's really out of sorts, she's just not herself. She's been the easiest baby and a great little sleeper and now she's not sleeping well and…
>
> (Mother goes on to describe problem in detail).

Two very different interview structures were observed. One was the scheduled developmental assessments, where the format of the screening tool structured the interview. The other was the drop-in session where the mother came to the centre to seek a consultation with the nurse for her own reasons and purposes, not for the scheduled 'baby check'. The interaction in the drop-in session was less structured and for my purposes yielded much richer data. Of the fifteen nurse-mother interviews analysed, four were scheduled baby checks, two were home visits (but not first home visits) and nine were drop-in visits.

The scheduled developmental screening was for some nurses so dominant that they found it difficult to divert from the examination process. In one observation, the nurse was examining the baby and running through the standard questions and did not appear to notice comments from the mother that could have been taken as an indication she needed to discuss further.

> Nurse: Sometimes they don't like rolling but that's great.
>
> Mother: But he's not a very active baby…
>
> Nurse: No you're happy just to look, aren't you, lie in bed and look. He's pretty cute though isn't he? That's great all right so he has a 1.30(am) bottle?
>
> (Nurse A5)

In the drop-in sessions the progress of the interview depended more on the interviewing style adopted by the nurse and the personal characteristics of the mother. Some nurses took charge of the interview, asking most of the questions, and other nurses were much more relaxed, allowing the mother to lead the conversation.

> Mother: We're having some sleeping problems…
>
> Nurse: Tell me about that what was it like?
>
> (Nurse A1)

The mother then went on to tell the story and nurse asked open questions to encourage her.

There were some exemplary examples of good counselling technique in which the principles of empathy and active listening were evident.

> Nurse: (noticing mother seems a little quiet): You been feeling OK?
>
> Mother: Yeah, alright… (mother sounds uncertain)
>
> Nurse: A bit off?
>
> Mother: Yeah.
>
> Nurse: It's hard when you've got, you know, a baby who's physically quite busy.
>
> Mother: Oh yeah.

Nurse: I think when you are feeling a bit off and tired with the early pregnancy... (mother says something inaudible) ... you can't often do that when you've got a busy toddler.

(Nurse A3)

In others there was evidence of mutual respect and shared decision making.

Mother: She's going to be immunised this afternoon at the GP. Should I give her panadol before just in case she..., you know?

Nurse: Well, often babies don't react or have a reaction and most GP's feel that you don't in case nothing happens. What do you think?

Mother: I was sort of in two minds, I wasn't really sure...um...yeah I wasn't really sure how much Panadol (inaudible).

Nurse: How about if you have the panadol and then you've got it there?

(Nurse A1)

Where it worked well, the nurse and the mother appeared to settle into a two way flow of interaction that was much more a conversation than an interview, with either party initiating discussion.

It was apparent from some of the interactions that the nurse and mother knew each other well enough to establish a friendly relationship. Depending on the personality of the nurse, it could be quite informal. In one observation, the mother came sweeping into the room, sat straight down into the chair near the nurse's desk and began:

Nurse: How is it going?

Mother: Oh, terrible.

Nurse: what's happening?

Mother (leaning forward): Is it possible that she is going through a growth spurt?

Nurse: yep, yep, yep.

Mother (in an exasperated tone): What are the signs? Feeding a lot? Screaming like (indecipherable), sleeping all over the place? (Nurse's name), I'm having a nervous breakdown, I tell you!

(Nurse A6).

A friendly relationship between the nurse and mother inspired confidences, and some of the topics raised by the mothers were quite personal. I witnessed a long discussion between a nurse and the mother, initiated by the mother when she volunteered that she was thinking of having a third baby. It was a respectful conversation between two women, and although there was some information giving from the nurse, she refrained from offering advice as the mother worked through her options. The nurses told me that it was not unusual for the mothers to confide in them quite sensitive matters, and on another occasion I observed a long discussion between the nurse and a young mother in which the mother confided her fears for her younger sister, who she thought was being sexually abused. On this occasion the nurse took more of a formal counselling role, as it was clear that the issue was not going to be easily resolved.

There were, unfortunately, also examples of dominant and disrespectful behaviour. In one observed incident, the mother's response suggested some resistance to the nurse's advice, and the nurse, who had been sitting, stood and moved to the centre of the room as she spoke to the mother, who remained seated. It appeared to be an attempt by the nurse to dominate the discussion and was an unconscious display of power.

Sometimes the nurse was not as perceptive as she could have been. The ability to listen and respond appropriately to cues (both verbal and nonverbal) is a crucial part of nurse-client interaction (Freshwater, 2003). In this interaction the nurse is concentrating on the mother's physical status and is not as alert to the cues the mother was giving out as she could have been:

> Nurse: So once you started bottle-feeding do you think you've been different yourself?
> Mother: Yeah I was sad, really sad.
> Nurse: Sad but did you feel that your iron stores got better. Did you feel less tired?
> (Nurse A7)

During the observations of the nurses and mothers I became aware that the baby, who was usually placed close to the nurse and mother, was frequently acknowledged in the discussion. Indeed, there was a high incidence of the nurses talking directly to the

young baby. At some point in the conversation with the mother the nurse directly addresses the child. Sometimes it was joking as follows:

> (baby gurgles loudly)
> Nurse to baby: Oh what do *you* think, have you got an opinion, have you?!
> (laughs)
> Mother (laughing): She sure has!
> (Nurse A4)

Sometimes during the physical examination the nurse would play with the child, tickling the tummy, or clapping the baby's hands whilst talking to the child. It became so common an occurrence that I began to record the incidence. In 13 of the 15 interviews recorded, the nurse directly addresses the baby, and in four of the interviews on between six and eight occasions during the conversation with the mother. When this behaviour was brought to the nurses' attention they explained:

> I think it is part of observation and everything, checking out what the baby's development is…and it's looking at mum's interaction too, that's something I am looking at too. (Nurse B3).

Content of Interview: Topics of Discussion

A large range of topics were discussed in the interviews. Content analysis was used to gain an appreciation of the number of the topics and they were listed and as per Baggens' (2001) study. The frequency of topics is shown in Table 1. If the nurse or mother returned to the same topic later in the interview it was counted as a new topic because it reflected a new perspective on the topic, so the total represents all subject matter introduced into the conversation.

Topics of conversation n= 19	Frequency
Breastfeeding	23
Sleep and settling	23
Solid food	17
Development	17
Skin/ rashes	16
Growth/weight gains	12
Milk feeds	11
Mother's physical health	11
Immunisation	8
Baby hygiene	7
Baby exercise	6
Mother's mental health	6
Social factors in family	5
Family health	4
Baby behaviour	4
Baby's health/sickness	4
Family issues	3
Weaning	3
Return to work for mother	2

Table 1: Topics discussed and frequency

The three most frequent topics of conversation were, not surprising, to do with infant feeding and sleep and settling issues. These have historically been the major concerns of mothers attending well child health services. The age of all of the babies was less than 14 months, with four of the fifteen being less than one month of age (Table 2). It is therefore likely that the mothers would be occupied with feeding issues, and in the case of the younger babies less than one month, would still be establishing breastfeeding. Weaning from the breast to solid food was specifically discussed on three occasions, with the broader topic of solid foods scoring highly. Indeed, four of the top scoring six categories are to do with infant feeding and weight gain.

Age of baby	Frequency
< one month	4
Between one & two months	1
Between two & three months	1
Between three & six months	2
Between six & nine months	2
Between nine & twelve months	3
Between twelve & fifteen months	1

Table 2: Age range of babies seen in interviews

The interviews did not always proceed in a linear fashion, but had a circularity where the nurse and the mother frequently returned to the same topic, picked up the topic again and advanced it. This was taken as a signal that either party still had unfinished business with that topic. In each interview observed the nurse or mother returned to the same topic up to seven times, with an average of three returns. The number of separate topics discussed varied but did not fall below five for the interviews observed. Overall, a surprisingly large number of topics were raised by either the nurse or mother: an average of eight per interview, with a top of fourteen in one interview. The large number of topics discussed indicates the density of the interviews, most of which were packed with discussion with very little idle chatting, although sometimes chatting was used as a break between topics. Sometimes the flow of the interview was interrupted by a child or when an outsider entered the room, but mostly it was an intense and concentrated discussion.

Table 3 sets out the main categories of items discussed in the nurses' conversations with the mother. The 19 topics identified in the content analysis have been sorted into five major categories: infant feeding, infant health care, maternal and family health and wellbeing, infant growth and development, and parentcraft.

Topics and categories discussed	Percentage of total
Infant feeding - breastfeeding/weaning - solid foods - milk fees	29.6%
Infant health care - rashes/skin problems - baby hygiene - baby health/sickness - baby exercise - immunisation	22.1%
The family - mother's physical and mental health - social factors affecting family - family health - family issues - return to work	16.7%
Growth and development of infant	15.6%
Parentcraft skills - sleep and settling - infant/child behaviour	14.5%

Table 3: Topics of conversation collapsed into major categories

Infant feeding is a topic of great concern to mothers, who seek reassurance the infant is growing well and thriving. It is the topic most cited by mothers as their reason for using the community child health service and the time honoured practice of weighing the infant is ingrained in the mind of the general public, who often associate the child and family health services with 'weighing the baby'. The mothers use the infant weight gain as a concrete indicator of the baby's wellbeing. When the baby is growing and appears content, the mother takes this as a visible sign that their mothering skills are adequate (Lauritzen, 1997; Sachs, Dykes & Carter, 2006). Hence the topic of the infant's weight gain also ranks highly.

The category of infant care and management includes those aspects of parenting that involve the learning of parentcraft skills. Hence, sleep and settling issues are included here as these involve the parent understanding their child's behaviour and learning appropriate settling techniques. Discussion of sleep and setting issues scored almost as highly as infant feeding which indicates it is a serious parental concern. Parentcraft skills have also traditionally included physical care of the infant and are reflected here as well.

The high incidence of topics to do with infant development may be viewed as an artefact of the scheduled infant checks that occur at the first visit, eight weeks and three, six, nine and twelve months of age in the first year of life and less frequently thereafter. However, aside from this the topic was also raised independently by mothers who asked questions about their infant's developmental progress.

Health promotion as part of the nurses' discussion

Health promotion as a child and family health nursing activity features prominently in the data. The nurses interviewed for this study claimed health promotion as a fundamental precept in child and family health nursing. They described a number of activities and topics of discussion with the mothers that they identified as being part of their health promotion practice.

Activity	Examples of topics discussed
One-to-one health teaching	— Physical care of the infant and young child — Infant settling techniques by recognition of tired signs — Breastfeeding techniques and positioning — Preparation of infant formula feeds — Management of child behaviours
Group education	— Parenting skills — Normal patterns of infant growth and development — Accident prevention and child safety — Protecting infants through immunisation
Primary prevention and early intervention	— Monitoring of normal growth and development patterns — Detection of deviations from normal — Primary immunisation . — Emotional support for parents — Detection of child abuse — Detection of postnatal depression

Table 4: Health promoting activities nominated by the nurses

Identification of health problems that required treatment and/or referral to another health practitioner was not considered health promotion but a clinical nursing action. It is important to separate these activities for the purposes of this discussion.

The above table suggests that most activities fall into two main categories, education and primary prevention. They are consistent with the principles of the Ottowa Charter of 1986 in increasing personal skills and knowledge, and with preventive health practices. A comparison with list of topics discussed with the mothers (Table 3) indicates that direct client teaching occupies a significant proportion of the nurse's time. If the time spent on group education activities such as the mothers' groups is included, then health education would constitute a major part of the nurse's work. Primary prevention activities, such as discussions about immunisation, were also identified in the content analysis. This supports the nurses' claim that health promotion was a fundamental part of their work

A major tenet of health promotion practice is that of empowerment (Keleher, 2007b; Talbot & Verrinder, 2005: Whitehead, 2001). Particular claims were made by the nurses to the practice of supporting and 'empowering' mothers. Concepts such as this are notoriously difficult to explain (Gilbert, 1995; MacDonald, 1998) and the nurses

interviewed had similar difficulties. In this interview with the nurse, the term 'empower' was used three times, as follows:

> What we are doing is trying to educate parents to be empowered, to be good parents to value their role of how important being a parent is and having, I guess, having the skills to work through the challenges that there are....
> And my philosophy is empowering parents to be as good as you get, sort of thing, and I think the other things that goes with that is telling parents that they don't have to be perfect....Following the WHO code helping people empowering them and giving them actual factual advice.
> (Nurse A5).

It would appear that the nurse is trying to express the importance of giving parents life skills and health information, both of which are identified as health promotion activities by the Ottowa declaration (Wass, 2000). A closer examination of the nurses' description suggests some tension in the way in which health promotion may be understood and appreciated. For example, in the first part of the quote the nurse describes how she 'educates', which she then describes as 'giving them actual factual advice'. It appears, that to this nurse at least, 'education' equates to 'empowerment', but if this involves little more than telling the mothers what to do, it is, in fact, more disempowering.

There is an official health promotion schedule that NSW Health requires the nurses to carry out and which provides the format for the baby health checks carried out by the nurses. This is more akin to the public health function of the nurse. The official schedule is best exemplified in the contents of the 'Blue Book' that every child receives at birth. The Blue Book includes a schedule of the required developmental checks and examinations, as well as a record for the primary immunisation and information for parents. All health professionals who have dealings with the child are encouraged to record their contact so that the book is a true record of the child's health. Parents are always keen to have the child's weights and measures recorded in their Blue Book.

During the interaction with parents the traditional weigh and measure holds a prominent place. Table 5 shows the centrality of the baby weigh and measure in the nurses' work

Actions	Occurrence (no of visits)
Baby weigh	In 13 of 15
Baby measure	In 10 of 15
Baby examination	In 7 of 15
Other (vision & hearing)	In 1 of 15

Table 5: Frequency of common nursing actions

The nurses considered the weighing of the baby to be both an indication of the baby's health and also a device to draw the mother to the service. They indicated that they did not attach great importance to the record of weight gains but that they recognised that it was important for the mothers. A record of a weight loss, however, was noted for further checking.

Concluding the Interview

The termination phase of an interview is considered to be just as important as the earlier phases of the interview (Sommers-Flanagan & Sommers-Flanagan, 2003). It is when both partners acknowledge that the interview is over, summations may be given to reiterate agreed actions and the parties say farewell.

The nurse-mother interviews appeared to conclude when they reached a natural end. In the developmental assessment interviews that usually occurred when the checklist was completed. These interviews were also time limited as they were built around appointments, so it was likely that another mother was waiting to come in but there was usually ample time to conclude the business of the interview. If the mother had come to a drop-in session the length of the interview was more flexible and directed by when all topics of discussion were exhausted.

The mother was not rushed to end the interview. Sometimes it was the nurse who signalled the interview was closing, at other times it was the mother who began to pack up in readiness to leave. Some nurses used the device of summing up the agreed actions,

reinforcing what had been decided during the discussion or important points that the nurse wanted the mother to remember.

> ...when you've thought that the conversation has finished and you hear its finished then you bring them back and just go over again what you might have thought were the best points, you know, recapping...to see if she really thought it was a good idea.
> (Nurse B5).

Leave taking is another ritual of the interview and formally ends the encounter. The nurses farewelled the mother, and if the child was old enough to notice also said goodbye to the children. This was a continuation of the recognition of the child that occurred throughout the interview.

Interviews with the Nurses

In this section the analysis of the tape recordings of the nurses' interviews is documented. The nurses describe the philosophy that guides their practice and in a sense give their rationale for their observed behaviour.

The thematic analysis yielded six themes. They are:
1. The importance of the conversation with the mother
2. Forming a relationship with the mother
3. Opening up
4. Affirming the mother's mothering
5. Normalising the situation for the mother/anticipating
6. Walking beside the mother as a guide or mentor

These are discussed in detail below.

The Importance of the 'Conversation' with the Mother

The interview is commonly seen as the vehicle for the interaction between the health professional and client within the clinical context. The purpose of the interview is for the clinician to gather information about the client and the client's health needs to enable an assessment to be carried out that will guide the subsequent care plan for the client (Sommers- Flanagan & Sommers-Flanagan, 2003). The conduct of the interview

may vary depending on the purposes for which it is set up, but it usually reflects the dominant role of the clinical expert, who directs and controls the exchange (Strong, 2001).

The child and family health nurses clearly considered the interaction with their client mothers was not a formal clinical interview, although they still used the term 'interview'. Rather, they used the interview with the mother as the vehicle for the main form of intervention practised by the nurses, which was the discussion between the nurse and the mother. It was clear from the manner in which the interviews were conducted, and the nurses' explanations of their intended outcomes for the interviews, that the better description would be that of a 'conversation' between the nurse and the mother or other family member. In Baggens (2001) study with Swedish child health nurses, the conversation was identified as the main instrument of the nurses' work.

The nurses' conversation with the mother formed the therapeutic component of their work. The nurses sat with the mothers and talked with them about infant behaviours, care of the baby, parenting and family life and whatever else the mothers had on their minds at that time, but it was not idle chatting. The key skill of the nurses' practice was the ability to listen, and to listen with that special ear that develops from experience, allowing the nurse to hear not only the words but the implicit meanings behind them. This was expressed by the nurses as: 'It's really about having a conversation with someone and using skills to hear something that you need to respond to...(Nurse B5). And again: 'Sometimes she just wants to talk things over, so you've got to be a good listener.' (Nurse B6).

In identifying the central importance of listening skills the nurses are in agreement with standard counselling theories, in which the comment element is sensitive and effective listening (Sommers-Flanagan & Sommers-Flanagan, 2003). While counselling practice usually requires a psychological intervention by the therapist, active listening can also be seen as the intervention. The nurses identified active listening as the key component of their work: 'In a hospital...you are doing practical things, like giving a drug...whereas in this job it is very much about communicating, it really is the big thing, trying to listen.' (Nurse A1).

In the simple act of listening the nurse connects and communicates with the mother and this helps in forming the relationship with the mother. The nurses recognised the centrality to their practice of good listening skills and most of the nurses in my study considered knowledge of communication skills to be an essential requirement for the work. In their interactions with the mothers they said it was important to respect the mother's autonomy, to follow the mother's direction during the flow of the conversation, to be non-judgemental and to demonstrate empathy for the mother's feelings. They were aware that the level of language used should be matched to the mother's capacity to understand, particularly so if the woman belonged to a social group identified as having special needs, such as Aboriginal mothers, or adolescents. The nurses discussed how they made efforts to match their language with that of the client (vocabulary and syntax, particularly sentence structure) and refrained from using medical jargon to facilitate ease of understanding.

The conversation observed between the nurse and the mother appeared to be a mutual interaction where both parties were free to contribute. When a problem was outlined, the solution was reached after a discussion in which ideas put forward by the mother were treated respectfully. Chalmers' (1992) study with British health visitors identified the egalitarian nature of the communication and considered the mutuality of the interaction to be a feature of the health visitor's practice. It is the reciprocity of the interaction that is important, because it underlines the participatory nature of the relationship that the nurse is building with the mother, where the mother is recognised as an active contributor with something valuable to bring to the conversation. In the family partnership model in which most of the nurses had received some training, the interaction is intended to be reciprocal, with the nurse facilitating and supporting the parent's decision making rather than taking the role of the expert advisor. The core communication skills identified by the model include attending behaviours and cues that give the parent the confidence the nurse is actively listening to them (Davis, Day & Bidmead, 2002).

Chalmers and Luker (1992) described the interaction between the nurse and mother as being a mutual exchange, based on presentation and acceptance of offers from both the client and the nurse. The conversation is not entirely random, it can be guided by the nurse into topics that she wishes to discuss, but the nurse also follows the mother's

direction, taking her cue from the mother (Cowley, 1995). So the nurse must be aware of the subtext and be very open to what she is hearing and respond appropriately.

Forming a Relationship with the Mother

The conversations with the mothers facilitated the development of the nurse-mother relationship. There was a consensus of opinion that developing a rapport with a mother took some time, with some nurses suggesting that it was weeks (Nurse A3), or even months (Nurse A8) before the nurse and mother had settled into a friendly and reciprocal relationship. 'It could be by the end of 8 weeks that you feel really comfortable with that particular person but for others it will be a lot longer'. (Nurse B1).

Maintaining a regular contact with the mother meant the nurse got to know the mother as an individual and helped to develop the relationship. In a few cases the nurses were involved with the mothers antenatally and considered that to be an advantage as the nurse and mother got to know each other before the mothers came to the clinic with the baby.

> …you know you see them the first week you do hospital visits so you meet them in hospital and you…offer them a home visit…and then the following week…they come to the clinic so that is continuity for the parent as well. (Nurse B5).

Some new mothers were customarily seen by the nurse four or five times in the first eight weeks of the baby's life (Nurse B2), although this was not necessarily universal practice. If the mother was invited to attend a New Mothers' Group, then her contact with the nurse was weekly for the next six weeks, so that within the first six months there may be ten or so contacts with the nurse.

The nurses talked about the development of a trusting relationship between the nurse and the mother and they considered the development of trust essential if the mother is to feel comfortable enough to disclose deeper worries or personal problems. The professional relationship that characterised the nurse-mother interactions was a form of 'friendship' in which the nurse and mother had gotten to know one another and clearly had a mutual liking and respect for each other. As one nurse commented: 'I'd like to think that we didn't stay strangers for very long' (Nurse A5).

The professional relationship described above was based on a respect for the mother as a person and her place as the mother of the child. As they pointed out, she was the person with primary responsibility for the baby's care, whereas they had a supporting role only. The nurses related how important it was to be aware of sensitivities, and to keep in mind the mother's feelings and emotions. In the transition period in which new parents are settling into their new parenting role, there are many potentially sensitive topics. In particular, they refrained from openly criticising the mother's care of the child or her parenting style. One nurse described it as: '...you know the part about them being really sensitive as to how they bring up their children: no one likes to be criticised about how they bring up their kids.' (Nurse B5). So during the conversation the nurses were assessing the mother's emotional level and making decisions about what to say to the mother. They related how they needed to judge the mother's emotional state so that they did not 'push the mother too hard'. 'Never be critical of them (the mothers) always try and make that into a positive. So I just sort of said "yes, it's not recommended" but I wasn't going to come down really hard on her and say you can't do this.' (Nurse B3).

The nurses suggested they preferred to hold back rather than risk offending and hampering the developing relationship. 'If you don't know the person well I sometimes think there is some things that can wait...I can hold back until I've built a bit more rapport.' (Nurse A1). There is certain pragmatism in this, as the mothers attended voluntarily and to risk offending a mother was to risk losing contact with her. As a nurse (B5) commented: 'I don't like to do anything that will make the mother go away and not come back again'.

The risk of offending was most apparent when the mother's opinion differed to that of the nurse. If the matter was not vital the nurses said they would respect the mother's point of view and refrain from open criticism on the basis that there would most likely be another opportunity to discuss it. However, if there was a point where the nurses felt the matter could not be ignored, then they were quite prepared to intervene. Therefore where it was a matter that, if not addressed, would contravene the standards of professional nursing practice, such as the possibility of harm arising to the baby or some other family members, they would act, even if it risked the developing relationship. As one nurse put it: 'If there is a risk with the child, then that takes precedence.' (Nurse B5). They recognised that as registered nurses there were legal and statutory

requirements and obligations to uphold, such as mandatory reporting of suspected instances of child abuse. The possible threat to the developing nurse-mother relationship from their reporting role was recognised by the nurses. They reported that they tried to minimise the possible negative effects by telling the mothers at the first visit that they were mandatory reporters.

Several of the interviewees related instances of needing to exercise professional judgement. Sometimes the health problem was obvious, as, for example, with the nurse who identified a baby was failing to thrive, or another nurse who detected an abnormality on a routine physical examination of the baby. In both instances, the nurse intervened appropriately by informing the mother and referring the baby for immediate medical attention. Other nurses described instances when they were required to make clinical decisions about the health care of parent or child or to interpret clinical signs.

> I had a mum yesterday, a young mum with a toddler just going crazy and I produced the Edinburgh Scale because I knew this mum had other issues. Her mother died in December just before the baby was born and she had a sister who got married the weekend before and she was the martyr doing everything for everybody. And every time I asked her how she was, she was 'fine' and I'd talk about grief issues 'no, I'm OK' and so I brought out the Edinburgh Scale and OK she scored fine – she was too fine. I wondered if she was telling me the truth. She just looked totally exhausted yesterday and I just thought 'you're scoring well on the end of the Edinburgh scale but you're not really like that.' (Nurse A8)

The mothers were also making judgements about the nurses. The nurses described how the mothers 'sussed them out' and as the mothers became more confident in the nurse they felt safe enough in the relationship to open up the conversation to difficult or upsetting topics. So it was the mother's decision whether the conversation moved to the next level.

They will come in and they will be this, this, and this and then they get up and you'll almost see a physical transformation and then they say "while I'm here' because what they have done is sussed you out to make sure you're OK and a safe person to talk to and the real problem comes out then.
(Nurse A1)

The phenomenon of interviewees waiting until almost the last moment to disclose the real reason for their visit is well recognised in counselling theory. It is known as 'doorknob conversations' (Sommers-Flanagan & Sommers-Flanagan, 2003). This disclosure by the mother can be disconcerting and leaves the nurse with the dilemma of whether to handle the issue immediately, which would mean continuing on with interview although it may be ostensibly ended and keeps another mother waiting, or whether to suggest the topic should be deferred to another day.

As disclosure of sensitive matters was discussed by the nurses at length, it forms a separate theme. The nurses suggested that in forming the relationship with the mother both parties may have built up enough trust for the mother to feel able to discuss matters which she may not have broached previously.

Opening up

The nurses recognised that there were times when the conversation moved onto sensitive ground. They implied that they knew the mothers well enough to be able to detect the nuances in the conversation when the topic under discussion became emotionally charged.

> Often they will tell you things that are not necessarily related to the reason they were initially coming in for, or the first reason they give you for being here. So often you uncover things that might have been troubling them or bothering them or they are worried about, in the course of the interview. Often the clues appear or they will tell you something directly or they will not tell you something, maybe something nonverbal that you pick up or they will refer to other things that give you an indication of something they are actually worried about.
> (Nurse A2)

The nature of the disclosures could be surprisingly frank.

> They can tell you very personal things. Sometimes around the relationship with their own mother that may not have been that good. Maybe about some real deep feelings around their own relationship and their own partnership in their own lives…and they will tell you a lot about their emotions about their feelings but that won't come until they have worked out that they can trust you, that they can share that information confidentially.' (Nurse A3)

The nurses described how important it was to be open to what they might hear: they may suspect there was something more the mother wanted to say, but they waited for the mother to choose the moment to disclose.

> sometimes you can go into a room and you know there's something on her mind and you can start probing but you don't always get that…they sit there for three quarters of an hour and all of sudden it comes out'.
> (Nurse B4)
> Sometimes they don't even…there's nothing and then all of a sudden you start to get – they tell you something that is important to them.'
> (Nurse A6)
> I just find that over the weeks they eventually open up to you how things really are'.
> (Nurse A8)

There is an indication that when they suspected there were underlying issues that they used gentle probing to open up the discussion:

> If it doesn't work one way you go and do it another way…you could ask direct or indirect questions and then go somewhere else if that didn't really work'
> (Nurse B4)

They related with humour the time honoured device of 'popping in for a quick weigh' that often turned into a lengthy session as the mother related what was really on her mind.

They recognised that it took time to establish the level of trust in a relationship where the mother would be prepared to take the conversation into less safe territory, but they were prepared to wait for the right moment. They saw their responsibility as providing a 'safe place' for the mother to disclose.

> This is a safe place for them to come – know they can talk to you. Part of it is that…we have the time to be able to sit and listen. I make a conscious effort to make the centre a safe, comfortable, happy place.'
> (Nurse A4)

The nurse went on to describe how she felt that some of the mothers felt safe to talk to the nurse because she was so separate from the mother's other connections.
As these nurses customarily had extended contact with the families, sometimes lasting over long periods of time, they were very aware of family issues. Where they had been living or working in the same neighbourhood area they combined this with knowledge of social problems in the community, providing them with considerable insights into social and personal issues that had an impact on the welfare of the mother and child.

> You get to know people over time because they keep coming back to you and if you're not moved around or whatever you get to know them and their history and you can build on that as time goes by.
> (Nurse A4).

For the mothers to be confident enough to broach intimate topics clearly suggests there was a trusting relationship between the mother and the nurse. It is possible, however, that the presence of an observer had a muting effect, so that what was said in any particular interview did not always capture the depth of the nurse's knowledge of and relationship with the mother. Many times after the mother had left, the nurse would turn to me and explain the significance of a phrase or a question used in the interview. Sometimes she would comment that the interview had been atypical, because of my presence, and that she had followed the mother's lead in leaving many issues unsaid, but it was likely the mother would come back to discuss them at a later date.

Affirming the Mother's Mothering

Many of the nurses commented on how important it was to help the new parent, and particularly the mother, through the early parenting phase. As one nurse put it: 'a lot of holding in the first twelve months, especially the first couple of weeks … a lot of reaffirming about who they are and what they are doing.' (Nurse A1). This raises again the image of keeping the mother safe and secure and of supporting her while she learns to mother. They spoke of the importance of the mother building confidence in her own mothering skills (Nurses A1 & B2).

Helping the mother to trust her own judgement was seen as an important aspect of confidence building.

> I would see a mum on a first visit, when they say 'the midwife said this or the doctor said this or I read this'. You know, I would say - what does this say (puts hands over abdomen) – what does your gut say?
> (Nurse A1).

Providing support was expressed as more than verbally reassuring the mother, as the nurse was prepared to give direct assistance if necessary. Sometimes the nurse taught the mother a practical skill, such as how to wrap the young baby to help them settle, or to recognise tired signs, so that the mothers could become more confident in their own mothering skills (Nurse B2).

The nurses sought to boost the mother's confidence by praising successes, and not criticising things that did not go so well.

> I always try and find something that they are doing really well because I just think parenting is so hard these days – so I really try to encourage them that they are doing a great job and I, yeah, usually always tell them 'you are doing a wonderful job this baby looks fantastic' and even if the baby is not gaining weight or whatever you can usually find something to praise the mother on.
> (Nurse A8).

Praising the baby was another way of helping the mother feel good about herself.

(by praising the baby) it reflects in the mother and the mother feels good about herself because I've actually praised her indirectly...which makes her feel good. You might make some comment about how she looks that boosts her self esteem'.

(Nurse A3)

Confidence building also included encouraging the mother to take the lead and propose the course of action or solution to a problem. The nurse could then support the mother's decision by agreeing with her. In effect it was giving the mother 'permission', after she had 'checked it out' with the nurse, so the nurse was actually confirming or affirming the mother's decision making.

The mother feeling good about her own mothering and feeling confident and knowing that she's doing a reasonable job, and she may not be doing it the same as everybody else but she's feeling pretty good about how she is doing it. You know, be able to make decisions that suit her.

(Nurse A1)

Normalising the Situation for the Mother/Anticipating

The anxieties of new parents as they learn the parenting role have been well documented, so unsurprisingly a great deal of the nurses' effort went to activities to reassure the parent the child was well and thriving, or the child's behaviour was within expected norms. Allowing mother to meet other mothers in similar circumstances so they can share common experiences was one such activity, and the nurses reported that the mother's groups gave the women the opportunity to exchange stories and to observe other babies, which they found reassuring. As one nurse put it: 'seeing other mothers doing the same thing helps them learn from each other.' (Nurse A9)

Another mechanism the nurses used was to anticipate new developments so that the mother is not surprised by them and can plan ahead. So typically they would talk with the mother about the expected behaviours in the next stage of the baby's development, or common problems that may arise. By giving realistic expectations of baby behaviour

and needs they hoped to normalise the baby's behaviour and give accurate feedback so the parent would gain a sense of control.

> The most common things would be issues around breastfeeding or adjusting to being a parent and developing a routine or pattern with the baby, trying to gauge some realistic expectations of what is going to be happening to them on a daily basis.
>
> (Nurse A2).

Another related activity, which was also designed to increase the mother's caring behaviours, was that of modelling expected behaviour. When the nurses interacted with the baby or child, they did so knowing that the mother was observing. Sometimes interactions with the baby or child were initiated specifically to illustrate the desired behaviour, such as initiating lalling conversations with the baby to demonstrate turn taking.

> Well, it's just a natural thing to look at the babies. I mean, I often just talk to them and they will talk back…and then I'll talk to the mother about 'look we are having a conversation'. Some young mother's don't realise that their babies do converse with you in that manner.
>
> (Nurse B4).

Walking Beside the Mother as a Guide or Mentor

There was a very real awareness amongst the nurses that their role was that of a guide or mentor to the mother. In this respect they were true to the spirit of the family partnership model, which was introduced as part of the implementation of the Families First strategy, and in which NSW Health has provided further training for child and family health nurses in counseling and interpersonal skills since 2002. One of the aims of the Family Partnership Model is to re-orientate clinicians in the way they interact with their clients from adopting the expert role to that of a more egalitarian helping role, and it seems that this lesson has been well learnt. Therefore the nurses talked about guiding their clients, rather that telling, directing or advising them.

It's not telling people what to do anymore. Parents like to be given choices and have some discussion around making their choice with the support of the expert person.

(Nurse A3).

Partly this was recognition of the prominent role of the mother in caring for the child and partly it was around the rhetoric of giving choices. So the nurse's role was to inform the mother of the available alternatives, thus allowing the mother to make the final decision. Hence the mother's problem solving abilities would be enhanced. The tactic the nurses often used would be letting the mother talk it through and, if necessary, pointing her towards the preferred behaviour or option, rather than instructing her. 'It's important not to tell people what to do… I think our role is to give them options, give them confidence to make the decision'. (Nurse A3).

The mother, however, was not afforded total freedom. Whilst the nurses tried to refrain from directly instructing the mother, in the event that the mother did not take up the preferred option, the nurse reserved the right to intervene as necessary. The nurse would then guide the mother towards an acceptable decision. 'You've got to lead them in the right path to that answer'. (Nurse A5).

The nurses argued that some mothers preferred direct advice or instruction and this was offered when that was seen as appropriate.

On the other hand they sometimes want good direction.
(Nurse B6).
Sometimes it's more helpful to give them something concrete to go home with, point them in the right direction.
(Nurse A1).
I'm directive if I need to be.
(Nurse B1).

In the main the nurses described a practice philosophy that had moved away from the notion of 'telling mothers what to do' to one where the nurses' task was to help the mothers find their own path. The principles of the family partnership model of practice

with parents, where the role of the clinical expert is challenged, were frequently re-iterated by the nurses.

> Yeah and I think the thinking now is changing with the family partnership model, it's letting the parents lead it because, and I certainly have experienced that, most of the parents have the answers within themselves. You've just got to lead them in the right path towards that answer. And most of them have the answers within themselves. They might still ask you direct questions about what to do for this, but a lot of it they actually have the knowledge there themselves. (Nurse A3).

The shift to a mother-centred view of nursing practice is a constant theme in many of the interviews. The nurses saw their role as supporting the mothers to mother, and 'part of good practice is to explore with the mother where she is at, what does she want to do?' (Nurse B6). 'Family centred practice' is a practice philosophy promoted in other nursing contexts, most notably in paediatric nursing, although there is some controversy about how well the philosophy is incorporated into nursing care (Franck & Callery, 2004). In the context of child and family health nursing the emphasis appears to be on the recognition of the parent's right to make decisions for their child, hence the mother is allowed greater freedom in deciding health practices and outcomes for her child.

This shift in perspective is one of the most noticeable changes in nursing practice in child and family health nursing in the past decade. Some of the nurses thought the change in perspective to be a direct outcome of the Families First Strategy and Family Partnership Training, but others noted that there had been changes occurring for more than ten years. This was consistent with historical accounts that suggest the move to a counselling style of consultation within the child and family health service began in the early 1980s and continued at a slow pace until the introduction of Families First.

The Nursing Care Role
The nursing care role, as described by the nurses, included many activities that are easily identified as conventional nursing activities. They identified the use of nursing assessment skills to make sure the baby is well and healthy, and other traditional nursing activities, such as opportunistic immunisation and referrals to other family

support services, were also mentioned. Two of the nurses in the rural area health service also undertook adult nursing work such as taking pulse and blood pressure readings on adults, giving of injections other than immunisations, wound dressings, and follow up of mothers being treated for hypertension or gestational diabetes (Nurses B2 and B3). One of these nurses also organised the paediatric clinic in the local community health centre for the visiting paediatrician.

The nurses gave great importance to the activities of health promotion and health education. They cited activities such as health surveillance of the babies and growth and development, assessing the quality of the attachment relationship between infant and caregiver, as examples of early intervention, which they considered to part of health promotion. One of the rural nurses had extended her health promotion role to include exercise groups for mothers, a walking group for the whole of the small town she visited (Nurse B2) and a childhood obesity program. Health education activities were heavily focussed on parent education, either antenatally in preparation for parenthood classes, or postnatally in mother's groups. Meeting the mothers antenatally was considered to be useful in building the nurse-mother relationship, and the benefits flowed into the postnatal period when the mother met the nurse again in the mother's groups (Nurse B3).

All of the nurses considered they had a counselling role, but they were usually careful to classify this as 'first line counselling', by which they meant to limit the extent of the psychosocial work they undertook. There appears to still be some debate about the social welfare role of the nurse. A much clearer view was given of their responsibilities in child protection, where the legislation and health department policy gives clear guidelines for practice.

The extension of the nurses' role into the psychosocial model of healthcare was expressed by a health manager, who also confirms the ongoing importance of the nursing care role:

> I think you have got to be a nurse because the basis of it is the health of the child, but the health of the child also encompasses no longer just the physical health but it covers the emotional health. Originally child and family health

nurses were all about physical health I think our move has been that we are now looking holistically at mother, child and family and that, still from a health focus, but the things we're picking up are health issues. Whether they be mental or physical health, they are still health issues aren't they, they are not…so people who don't have our background don't pick up that sort of stuff.'
(PS5).

All of the nurses interviewed were part of community health services, and were placed in centres located in the community setting. Many of them had developed good working relationships with other primary health care practitioners, and with the general medical practitioners in their local area. One interviewee related how she had been sixteen years in the local centre, and had subsequently become well known in the community. Contact with families attending the child and family health centre were extended when she again met the children during school screening visits in the local primary schools. She lamented how the decrease in school screening that had taken place to accommodate home visiting meant she no longer was able to follow through with babies she first met in the centre into the school environment. The nurses in that particular centre enjoyed a good working relationship with the local medical practices. Whilst the nurses referred mothers and babies to the medical practices, she reported that some of the general medical practitioners also referred mothers to the child and family health nurses for assistance with breastfeeding and similar matters. The collegial respect shown to the nurses was obviously appreciated.

The nurses expressed a high level of satisfaction with their nursing role. They enjoyed the work, but most of all they enjoyed the babies.

> The best thing I suppose is watching the babies gradually getting older and watching their development…watching the mothers begin to develop their relationship with their baby and begin to gain confidence and obviously begin to enjoy their children.
> (Nurse A2).

The relationship they formed with the mother was also a source of satisfaction.

The best thing about the job is the clients, and the relationships that you might have with the clients yourself, professional relationships...yeah, just if they let you know that something turned out well for them subsequent to a plan that you put into action with them, so yeah, that's the best thing, it's the clients. (Nurse B1).

There were instances of complaints being made against the nurses, such as the nurse who related the story about how difficult she had personally found it when a mother had written a letter of complaint. Some mothers were unpleasant to deal with. '(Nurses name) had somebody who said something to her that wasn't particularly nice this morning, um, but you've got to think "where does that come from?' (nurse A1). She went on to discuss how these things were part of professional practice and one had to expect it to happen sometime.

Who is the Client?

There appears to be a lack of clarity around who is the official health service client. In one of the area health services surveyed, the official record was the baby's health record, but in the other it was a family health record. As one nurse commented 'it's a bit of a mess, really' (Nurse B4).

The nurses got around this dilemma by recognising the mother and baby as a dyad: 'When you talk to mother the child doesn't cease to exist' (Nurse A1). The mother (or father) was the person the nurse interacted with because she/he is the carer: 'More the mother because she brings child to clinic and she is the one you converse with' (Nurse B4), although another nurse noted that it depends on need – 'who is the client on any given day may change' (Nurse B1). So even if the client officially is the baby they have to be interested in the whole family, because what happens to the family affects the baby (Nurse B3). 'I think we have to look at the whole family...we actually register a baby but you're actually treating the whole family' (Nurse B3).

Even where the whole family was viewed as the client, the nurses felt they had a responsibility to advocate for the baby. Sometimes that brought the nurse into conflict:

And that's where we have issues when you come to a service that is predominantly advocating for the child and you have to do a care plan or work in partnership with a service that is predominantly advocating for the adults and sometimes that makes for some very interesting discussions.

(Nurse B1).

The lack of clarity around the client records appears to be a result of the evolution of the nurses' role from that of baby health nurse to that of child and family health nurse, and remains to be resolved.

Changes Resulting from Families First

During the interviews the nurses were asked what changes they thought had occurred with the introduction of families first. They indicated that they had experienced changes to health service delivery as a result of the introduction of Families First. They noted the reduction in centre based clinics that followed the introduction of universal home visiting, and some indicated that mothers groups had also been reduced.

When Families First started up they got the whiteboard out and said 'what are your workloads? OK now do you need that clinic or not?' Our whole week was up on the whiteboard and it was decided in consultation between us and our team leader what we would keep up and what we couldn't.

(Nurse A8).

This nurse had a sustained home visiting caseload and identified the need for more training that arose because of Families First.

It used to come up at nurses' meetings a lot that we felt very underskilled as far as helping mothers with DV situations...I felt very much that we were on the front line. We were out there doing things that we didn't feel we had the training to do.

(nurse A8).

When extra training was provided her fears subsided, and she was also offered clinical supervision which she found most helpful. However, some nurses were said to have

struggled with new demands. 'There was one nurse who was older but she adjusted. I mean she struggled with change, but she adjusted' (Nurse A8).

Concluding Remarks

This chapter has described the findings of the Nurses Study. It brings together the two sets of data collected for the study and presents the analysis of the data sets. The observations of the nurses' interactions with the client mothers is supplemented by the interviews with the nurses in which they explained the values and beliefs that underpinned their nursing practice. The description of the nurses' work is compatible with that found in the literature on nurses undertaking similar roles in the UK, Sweden and Norway. The nurses' philosophy of practice is built around the value placed in developing a cooperative relationship with the mother to enable the nurse to work in partnership with the mother. The recorded practices of the nurses may or may not support that practice value. The next chapter provides a synopsis of the study results and discusses the implications of the findings.

CHAPTER 5: DISCUSSION

The previous section has described the results of the analysis of the taped interactions between the mothers and the nurses and the interviews conducted with the nurse. In this section the findings will be discussed with particular reference to the major conclusions from the study and in the context of the literature.

The role and function of the nurses observed in this study is consistent with that described in similar roles in the literature, such as those of the health visitor in the U.K. and the child health nurse in Scandinavian countries. Nursing activities occurred in a range of contexts, including home visits, individual consultations and parenting groups that reflect contemporary practice in Australia. The nurses offered these modes of service delivery to parents with children up to five years of age, although they were more likely to see children in the 0-2 year age range than older children, unless the children accompanied their mother on visits for the new baby. This was primarily a universal service and as such was considered to be non-stigmatising, although the nurses described how some families were targeted for increased contact. The mothers were able to access the service voluntarily, but there was provision for the nurse to be contacted by the midwife in the immediate postpartum period to refer needy families.

The nurses in this study were well settled in their nursing roles. Some of them had many years of service as child and family health nurses and had been employed in the same locality for more than four years. Consequently, they became familiar with the regular clients and knowledgeable about the women and their children, because they had ongoing contact with the mothers/parents over an extended period of time, sometimes several years. The continuity of care provided by the nurses appeared to contribute positively to the development of the nurse-mother relationship. The nurse, or small group of nurses in the Centre, became familiar to the mothers, and this helped develop trust and confidence in the nurse. The nurses reciprocated with genuine concern for the welfare of the families they saw, and some of them spontaneously spoke about their professional commitment to the women and babies. There was a sense that as the mother and the nurses got to know one another better that they appreciated and respected each other more. The effect of lack of stability in the nursing role has been commented on in other work in Australia. Kruske (2005) suggests that service models that frequently move nursing staff between centres may limit the opportunity of nurses

to know families and to provide ongoing support and continuity of care. Further, the imperative to meet Area Health Service targets, such as the number of Health Home Visits to new families, may compromise the ability of nurses to continue to see the mothers at regular intervals. The pressure to meet departmental service indicators at the expense of other modes of service delivery was also noted by health managers in the Policy Study.

The consultation with the client mother took the form of an interview, either in the mother's home or in the Centre, where the nurse carried out the official health promotion schedule and talked with the mother about parenting concerns. Listening to the nurses' conversations with their client mothers it was apparent that the nurses' personal style had an impact on the conduct of the interview. Whilst some of the nurses used a formulaic approach to the discussion, others had a style that allowed the interview to be predominantly parent led, where the nurse moved with the mother as she presented ideas or problems for discussion.

During the interview the nurse shifted between various roles, in line with the conversation. Sometimes they were the 'professional befriender' discussed in the early literature (Davies, 1988: Ochiltree, 1991), listening to the mother's story and providing an empathetic ear. At other times they took a more formal clinical role, carrying out the official child health surveillance schedule and performing conventional nursing tasks. Many times they assumed a counselling role in which the helping relationship was foremost.

The Conversational Interaction with the Client Mother

The progress of the nurses' consultation with the mother is consistent with that described in the literature on clinical interviewing (Sommers-Flanagan & Sommers-Flanagan, 2003; Sully & Davis, 2005). That is, it followed the format of introduction, greetings and small talk, opening statements leading to the main body of discussion, and then leave taking.

Greetings are very important as they set up the social atmosphere for the interview. The smiling greeting accompanied by respectful form of address helped put the mother at ease. The nurses exchanged small talk with the mothers and this form of social

conversation appeared to be used as a social lubricant to put the mothers at ease. In a first meeting, where the nurse and the mother do not know each other well, there may be some initial awkwardness and the social greetings give the nurse and the mother an opportunity to settle in and size up each other. The nurses appeared to be aware of this and careful of the impression they created with the mother, using the social chatting to set up a welcoming tone for the interview. Fenwick (2001) suggests that social exchanges, which she termed 'chatting', serve a useful purpose in helping establish the terms of the interaction between the mother and the nurse and may enhance the development of the nurse-mother relationship. The informal conversation invites the mother to participate and signals to the mother that the nurse is willing to connect on a more egalitarian level. The chatting continued until the nurse and the mother were ready to move onto the business of the meeting.

The introductory phase concludes with the opening statement, from either the nurse or mother. What was noticeable here was the opening statement was most often open and non-directive, allowing the mothers to respond as they saw fit. It is during this opening statement that the client's expectations about the purpose of the meeting can be discerned. Whilst some mothers were direct and had a clear expectation for the purpose of the meeting, for others it was less clear and they were there for non-specific help.

The body of the interview contains the purposeful interactions that constitute the therapeutic part of the interview. These were identified by the nurses as providing emotional support, describing norms against which the mother may judge the baby's behaviour and perhaps her own parenting skills, and information giving. They used clinical judgment to assess the health status of the infant, interpret the parent child interactions, and determine the mother's emotional status, parenting capacity, attitudes and knowledge. They discerned the mothers' personal style and functioning and decided how they could best respond to the parent.

Helping behaviours used by the nurses included exploring alternatives, encouraging the mother to problem solve, and providing feedback as to her progress and the baby's growth and development and wellbeing, all of which were important to the mother as she negotiated new parenthood (Fagerskiold, Timpka and Ek, 2003). These helping behaviours were built around principles of establishing trust, maintaining rapport and

building connectedness, exemplified in the Family Partnership Model in which most of the nurses had received training (Davis, Day & Bidmead, 2002). Being trustworthy included respecting confidentiality. Building connectedness with the mother was accomplished by attentively listening to her with consideration, and offering empathetic support. The nurses related how they mostly let the mother set the pace, refrained from pre-judging the mother, and were concerned not to push her too hard. They boosted the mother's self esteem by complimenting her good care of the baby.

The observations of the nurses interacting with their client mothers confirm the actions which they described during their individual interviews. As such they form the basis of the standard counselling interview, and are reflected in the Family Partnership Model in which the nurses were trained (Davis et al, 2002; Davis & Meltzer, 2007). The characteristics of an effective helping partnership are explicated in the model as

- Working closely together with active participation and involvement
- Shared decision-making power
- Complementary expertise
- Agreeing aims and process
- Mutual trust and respect
- Openness and honesty
- Clear communication
- Understanding and flexibility
- Negotiation of all aspects of helping, including the relationship.

(Braun, Davis & Mansfield, 2006, p7.)

It could be said that the nurses, both on self reporting and by observation, were actively endeavoring to put into practice most of the above. Although the extent to which this was accomplished may vary between individuals (as indicated, this is influenced by the nurse's personal style) there was in the main, an understanding that these were the principles upon which they based their nursing practice. The Family Partnership Model also defines the tasks in the process of helping as

- Establishing and building a relationship
- Helping the person explore a current situation

- Helping them formulate a clearer understanding of the situation
- Establishing agreed aims and goals
- Planning strategies
- Supporting parents while the plans are being implemented
- Evaluating or reviewing the results
- Ending

(Braun, Davis & Meltzer, 2007, p8)

The Family Partnership Model is designed to be used by a variety of 'parent helpers' and has as its foundation a helping model based on the work of Carl Rogers (1959, cited in Davis & Meltzer, 2007). The model prepares the 'parent helper' to 'explore any difficulties identified by the parents' (2007, p9) and then to take the parent through the process of goal setting and implementing agreed strategies to address the mutually identified problem. Goal setting is identified as crucial to the helping process and a pre-requisite for working together with the parent to plan strategies. The goals are to be specific, defining the behaviour targeted, the expected outcome and setting the time frame within which this is to be achieved.

The observations of the nurses' interactions with their client mothers included many illustrations of the first three steps of the above process. What was not always obvious was the inclusion of the following four steps; that is, there was not always evidence of the nurses setting goals and implementing agreed strategies, as it is described in the Family Partnership Model literature. Many of the nurses' conversations were empathetic and supportive, but without the explicit goal setting described as necessary in the model. It may be that the goal is implicit and unspoken: the nurses did identify in interview that their overall goal was to assist the parents to rear a healthy, emotionally stable and happy child. This long term goal is then achieved through a series of meetings with the nurse. Indeed, in this study, the mothers contact with the nurse was continuous rather than episodic, so that each visit was an extension of the previous visit, underpinned by the goal that was assumed, and probably unspoken, at the first meeting. As such, it demonstrates the advantage of stability in the nursing role, as discussed previously.

Setting goals leads on to the next stage of strategy planning (Braun, Davis & Meltzer, 2007, p10) where the parent helper works together with the parent to decide a plan of action. The nurses laid great emphasis on the importance of shared decision making and complementary expertise. It appears the nurses have certainly got the message about not being prescriptive, that is, not to give 'advice' within the expert model. There were examples within the nurse-mother interviews of genuine attempts to help the parents to solve the problem for themselves. This is described as a 'coaching' relationship, where the nurse takes a mentoring role (Hayes & Kalmakis, 2007) to encourage and support decision making.

The Family Partnership Model also lays emphasis on the necessity for understanding the way in which parents make sense of (or 'construct') their personal model of parenting, with the aim of increasing the parent's self efficacy. The flip side is that the parent helper is also obliged to challenge parents whose constructions are not helpful and 'need to be explored and potentially changed' (Braun et al, 2007, p.18). That is, the counsellor must challenge wrong or harmful constructions so that the client can be helped to understand the implications of their behaviour, and to facilitate behaviour change. Although there were incidents of helpful exploring, the observations of the nurses with their client mothers in this study did not include any incidents where the nurses directly challenged the mother's 'constructions', as would be expected in a counselling relationship. It may be that the limited number of observations analysed did not yield illustrations of this type of work of the nurse, or it may be that the nurses customarily did not directly confront their client mothers. There was a voiced reluctance to offend the mother so that she did not return, in which case they may have prioritised continued contact above confronting the mother's perceptions.

Similar observations to the above have been made elsewhere (Jack, 2005). In this current study, however, the nurse-mother interview data examined was not large enough to make more definitive comments about the nurses' interactions with their client mothers. There is a need for further research, drawing on a larger data set, before these behaviours can be more fully examined. This study does, however, raise the question of whether the nurses were able to fully operationalise the Family Partnership Model.

The introduction of Family Partnership Training in 2002 by NSW Health was intended to give the child and family health nurses an officially sanctioned counselling process, deemed necessary by the implementation of Families First (Vimpani, 2002). It was a belated recognition of the need to provide the nurses with suitable tools for them to work in the social model of health espoused by Families First. Following the introduction of the Family Partnership Training, the ongoing responsibility for training was devolved to the Area Health Services and consigned to continuing professional education. The issue of whether or not sufficient opportunities are available for child and family health nurses in training in the Family Partnership Model needs further examination by ongoing research.

Has Nursing Practice Changed?

This study collected accounts from nurses who have had a long employment history in child and family health nursing and who could clearly set out the changes in service organisation over the past two decades. What is not as clear is whether the nurses' practice has significantly changed. Some of the nurses considered they had made modifications to their practice, others thought that the changed policy environment had merely confirmed their long held practice philosophy. They acknowledged that there have always been some practitioners who, because of their personal qualities, exhibited the characteristics of the helping relationship as set out in the Family Partnership Model. The data analysis suggested that there is indeed raised awareness amongst the nurses of the requirements of working in partnership with parents, and a conscious attempt to implement the model in practice, but with varying success. The overwhelming impression is that for many of the nurses their routine with their client mothers has not changed significantly. This is exemplified by the dominance of time honoured topics of conversation with the mother, as discussed below.

It is difficult to criticise the child and family health nurses for not adhering to ideal practice, because in truth there is little to guide them in what a model of practice for child and family health nurses may hold. Their adherence to trusted elements of past practice is not surprising and their willingness to adopt the Family Partnership Model encouraging. The nurses were taking on new ways of practising but they were still working with a framework informed by past practice. At this time there is no universal acceptance of an ideal model of practice in child and family health nursing. The

documents published by their professional organisation give some indication, but there is little in the way of official publications from their NSW Health employers. This lack of professional and policy guidance will be discussed further in the exegesis.

What the Nurses Talked About with Their Client Mothers

An unsurprising finding is that the topics about which the nurses and mothers talk are, in the main, those which have occupied child health nurses and mothers for decades. As one informant put it, 'during all these (service) changes the mothers are still asking the same questions about feeding, routine and settling' (J. Roberts, retired child and family health nurse, personal communication, May 20, 2004). Whilst much of the talk is about 'feeding, routine and settling' there is a constant underlying sub theme about the development of the relationship between the mother and child, as this is recognised as paramount.

Most of the discussion in the nurse-parent interviews is about baby care and parenting tasks, rather than about family relationships. Even where there is provision in the notes for asking questions about relationships, this is not an important question. The nurses however, said they were aware of the family dynamics, and especially so when they thought that there were family issues affecting the mother and baby.

Where the interview was based around an appointment for the baby health checks, the structure of the interviews, and hence the topics discussed, tended to follow similar lines. These are consistent with the findings of Baggens' (2001) in her study of Swedish child health nurses. That is, they were dominated by the assessment schedule as set out in the official child health record, the Blue Book. The main discussion topics were about the growth and development of the child and related health issues, although some interviews did extend into discussion of other problems as well. The health schedule could be so dominant that it impeded the nurse's ability to pick up on other cues given out by the mother, but this again is dependent on the sensitivity of the nurse and her willingness to deviate from the schedule.

What is Not Talked About with the Mothers

The NSW Health policies for families with infants and children have a strong emphasis on infant mental health, particularly the quality of the baby's attachment relationship to

the primary caregiver. Therefore it is surprising to see that these issues did not arise as topics of conversation between the mother and the nurse. Their absence, however, from the agenda may simply indicate that they are not overtly practised. The policy documents make it clear that the nurse is expected to be observant of the interaction between the infant and the parent, looking for indicators of secure parent-infant attachment as per the infant attachment literature (Child Youth & Women's Health Service, 2007; NSW Department of Health, 2008). In the interviews with the nurses they made it clear that they were aware of the necessity for assessing the progress of the infant's developing attachment relationship with the parent, and of offering assistance and support to encourage the parent. It may well be that they are covertly observing the infant and parent interaction, encouraging when able and actively intervening only when they consider that intervention is warranted.

Considering the importance given in the policy documents to the mother's mental health, there is a low rate of discussion on this topic. Where the topic does arise it is not always discussed in depth, more likely to be a query as to whether or not the mother feels 'all right'. Again, the explanation for an absence of depth in the topic may be similar to the above explanation: that is it is observed, noted, and, where it seems to be working well, goes without further comment.

Similarly the relationship between the two parents is not openly discussed in the interactions observed. The necessity for a quality relationship between the baby's parents is apparently acknowledged but there is little open enquiry. It may be that the nurses feel this is a topic beyond the range of their expertise or outside of their ambit. Again it may be covertly assessed but not commented on unless it is raised by the mother or it is apparent that the parental relationship is impacting negatively in some way. The universality of the mother's presence as primary caregiver of the baby and the relative absence of fathers from the interview room lends itself to an interpretation of the nurses' work as being more concerned with the mother-child dyad than with the family as a whole (Arborelius & Bremberg, 2003). Concern with the parental relationship may be more apparent in first home visits when the psychosocial assessments are routinely sheduled, but this was not observed in this study.

Some of the interaction between the nurse and the mother was very subtle and did not necessarily arise as a topic of conversation. In 13 of the 15 interviews observed, the nurse at some point attended closely to the baby, playing games or 'talking' to the baby in a manner which mimics the ideal of parent-infant interaction. That is, they brought their face closer to the baby to within the desired focal length for the baby's age and stage of development, raised the pitch of their voices, smiled and had direct eye contact and reciprocated in lalling conversations. If the baby broke the gaze to signal the interaction was at an end, the nurse took the cue from the baby. This behaviour is described by interaction theorists as 'engaging' the baby. It is thought to be a key device in the complex building of the emotional ties that bind the baby and the primary caregiver into a love relationship, helping the parent to commit to the time and effort required for early parenting and laying for the infant the foundations of emotional health and wellbeing (Stern, 2002). When asked, the nurses explained that they were modeling parenting behaviours that they wished to encourage in the mothers. There were always a lot of encouraging comments from the nurses about the mother's interactions with the infants, intended to reward the mother for what is seen as worthy behaviour, and the play with the baby was obviously meant to augment that by demonstrating acceptable ways in which the mother could interact with the baby. It provided the mother with a form of observational learning, which is a well established in social learning theory as a teaching model.

Health Promotion as Part of the Nurses' Work.

Almost every health policy document noted in the introduction to the Portfolio describes child and family health nursing as a primary health care service. That is, the nurses offer first line services in the community that are accessed without referral from another health service, and the major focus of the service is the promotion of health rather than the treatment of illness (Talbot & Verrinder, 2005). In the interviews the nurses themselves described their work as primary health care, and saw the major part of this as being health promotion. They were in universal agreement that the principles of health promotion were central to their conceptualisation of child and family health nursing and they identified health promotion practices in which they engaged as being primarily health education and preventative health activities. These are traditional community health nursing activities (St John & Keleher, 2006).

It is no real surprise that health education and preventative health activities dominate in the nurses' day to day practice of health promotion. There is little experience in nursing generally of the breadth of health promotion activities that lie outside of the ambit of health education. This is demonstrated in surveys of nurses' knowledge of health promotion (Whitehead, 2001; Maben & Macleod Clark ,1999), who report that nurses tend to consider health promotion to be mostly education activities, as these nurses did. Nor should it be surprising that the other denominator of their health promoting practice lies in preventative health, as nursing education tends to concentrate on biomedical models of health promotion.

The many forms of health promotion described in the literature can be depicted as falling into three main approaches: biomedical, behavioural and social-environmental (Fleming & Parker, 2007). They differ as to their rationale, the strategies they employ and their intended outcomes. Biomedical models of health promotion are prompted by the presence or incidence of disease or pathology, employ strategies of patient education or instruction, and have as their goal the reduction of disease or disability in the individual or population group. They constitute traditional preventative health models of primary, secondary and tertiary prevention. Behavioural or lifestyle models are based on notions of preventing disease by changing health habits or behaviors through the provision of health education, with the aim of maintaining a healthy lifestyle (Keleher, MacDougall & Murphy, 2007). The social-environmental model addresses the wider socio-economic and environmental determinants of health through policy and legislation to effect and protect the primary conditions of health (Keleher & Murphy, 2004). The social-environmental model of health promotion is a contested notion within nursing, where the prescription of the clinical role does not lend itself easily to activities outside of the clinical sphere, such as policy activism (Whitehead, 2003).

If the health promotion models described above are compared to the description of the nurses' practice in this study, it appears that the nurses were mostly operating within the preventative health model, which is a biomedical model of health promotion. Their authority was derived from their clinical position, the rationale for much of their work was provided by epidemiology or evidence for early intervention, and they were carrying out the policy directives of the NSW Department of Health. Whether the activity took place within the community health centre or during a visit to the mother's

home seemed to have little importance for this part of their work as the encounter followed similar lines and had a common purpose.

This raises the question of how well the nurses' work could incorporate other forms of health promotion outside of the biomedical model, or whether they were confined to the clinical model. For example, health visitors in the United Kingdom include a variety of activities, including lifestyle programs such as smoking cessation programs within their work (Cowley et al, 2007), and there have been calls from time to time for a community development role in child and family health (CAFHNA, 2000). Generally, in the interviews, the nurses appeared to be satisfied with the scope of activities in their current role, and although aware primary health care practice could extend beyond this, they did not express an interest in an enlargement of the nursing role beyond its current boundaries. There are instances of individual nurses taking the initiative in identifying and addressing community issues that had an impact on their clients and they proved to be creative and proactive in motivating support and resources to address these; by and large this was the exception rather than the norm. Most of the nurses confined their activities to the home visiting or the clinic role.

Embedded in the models of health promotion practice is the concept of empowerment and this was cited by several of the nurses as part of their practice. The health promotion literature is rather obscure when referring to empowerment, which has a very sophisticated meaning (Tones & Green, 2004). It was not clear whether the nurses understood the nuances of this very complex concept, which springs from Foucauldian understandings of power as central to the construction of individual identity and social practices, and the supporting discourses of authorities, such as the health professions (Gilbert, 1995). Much of the nursing literature on empowerment interprets the notion as one of the giving of control, or power to the individual to enhance autonomy and the decision making power of the individual (Kendall, 1996; Norton, 1998). This is through providing information and social support to enable individuals lacking personal and social power to 'take control' of their life circumstances, modify their health behaviours if necessary, and thus improve their health. Community empowerment is a much broader notion, where social groups are encouraged to take an activate part in the health decisions affecting their community and to access adequate resources to create health (Keleher, MacDougall & Murphy, 2007). It is enabled through the processes of

community development (St John & Keleher, 2006). The nurses were comfortable with the notion of individual empowerment and with the practices of information giving and social support as the mechanism of empowerment. They were not as familiar with the notion of community empowerment, as development activities within the surrounding community were rarely mentioned, and not obvious within the nurses' reported activities, with one exception. This nurse was far more interested in health promoting activities within the community at large, but it has to be said that she was in a special position within a rural community that had limited health facilities available to it. It is, however, unfair to draw definitive conclusions about the nurses' understanding of health promotion or empowerment from the small numbers examined in this study.

The nursing literature on health promotion includes the notion of the 'health promoting nurse'. First proposed by Maben and McLeod Clark (1995), as practice encompassing information giving, advice, support and skills training, the concept was developed further by Robinson & Hill (1998). They suggest that everyday nursing practice can be imbued with health promoting characteristics, if the nurse retains as the goal a health promotion (as opposed to sickness curing) orientation. The principles of the familiar nursing process are there, together with the customary nursing activities, but they are augmented by strategies that seek to promote self awareness, improve self esteem and encourage the clients to make their own health decisions, thus empowering them. There is awareness within the health promoting nurse of the importance of listening skills and of empathising with the client. These activities fit within the work practices described by nurses in this study.

Other activities of the health promoting nurse are more familiar to the community nursing setting and were included in the nurses' descriptions of their practice. For example, the recognition of the importance of wider community networks in the promotion of health, and in establishing links with community supports. Robinson and Hill (1998) also allude to the notion of place, where the nurse establishes 'a setting conducive to health…a clean and pleasant environment…with good communication and harmonious relationships' (p237). This is reminiscent of comments by nurses in this study, who appreciated the importance of making the community health centre a safe and happy place where the mothers could meet, be listened to, respected and valued for their intrinsic worth as women and mothers.

There is one aspect of health promotion practice that is noticeably absent from the nurses' description of the practice, and that is political activism. There may have been a degree of awareness amongst the nurses of the impact of political processes on the health of children and families and on health care services, but they did not identify socio-political activities as part of their everyday practice. Whitehead (2003) defines socio-political activities as critical consciousness raising in communities, setting up political advocacy networks, and directly influencing policy development by lobbying at various levels of policy making. He believes that it is an is an important aspect of practice, and that for nursing to truly claim health promotion as a nursing practice role, it is one that needs to be properly considered. The reluctance of nurses generally to be involved in socio-political activity is well documented (Antrobus & Kitson, 1999) and child and family health nurses appear to be no exception. Political activism, however, is not necessarily a priority with many people and requires a knowledge of the political system, the development of networks and skills in dealing with policy makers. There is here a place for the child and family health nurses' professional association, CAFHNA, to actively assist its members by setting up mechanisms to develop political skills and encouraging members to become involved in policy making. CAFHNA, I would argue, as an organisation representing child and family health nurses, should be collaborating with stakeholders, and working within the policy community as policy entrepreneurs. This aspect will be further developed in the exegesis.

Wise Women

Taking an anthropological perspective, the nurses' work can be seen as carrying out 'women's business'. Many societies have allocated a special place to older and experienced women to pass on knowledge to the new mother (Lamm, Keller, Yovsi & Chaudhary, 2008). In many respects the nurses were holders of that special mother knowledge and fulfilled the role of wiser older woman to the youngest and newest members of the social group known as parents. In contemporary Australian society the knowledge and assistance of older women in the family may be unavailable to the new mother (Munns, Wynaden, Downie & Hubble, 2004), in which case the nurse stands in the place of the older family women.

Another view is that in the modern social order we have created special categories of health workers to monitor parenting, particularly where it appears to deviate from

prevailing norms (Ling & Luker, 2000; Robinson, 2004). The original impetus for the introduction of an infant welfare nurse in Australia was the observation of medical authorities of the time for the need for regulation and supervision of infant care and particularly infant hygiene. Reiger (1986a) has argued that the attitudes and prejudices of the day around the notions of 'scientific mothering' were instrumental in the development of a web of surveillance of parents to ensure they complied with accepted practices.

As such, good mothering was defined as abiding by the expectations of 'experts' and prevailing psychological theories of parenting (Wilson, 2003). Parenting education programs advocate an authoritative parenting style, based on talking and reasoning with the child, with the use of psychological theories of behaviour management, without resort to physical punishments (Zubrick et al, 2005). These parenting programs may be conducted in child and family health facilities with the assistance of the nurse. The intention of the nurses' actions is assumed to be universally benign and there is little discussion about aspects of the role that could be considered coercive. It has been argued that the parent educator is given the role of educating parents in socially acceptable parenting behaviours (Abbott & Wallace, 1998). This theme of subtle coercion will be revisited in the exegesis.

Health Care Nursing or Psychosocial Care?
The nurses interviewed clearly saw their work as health care, and identified health as the outcome of their care. Health in this context was defined as a well baby, who was thriving physically and emotionally, and with good attachment to the primary caregiver. Although the stated and desired outcome is optimal health status, the question must be posed of whether the work of these nurses is nursing care or whether it has closer links to psychosocial care. The question of most urgency is whether another health or non health worker is more appropriate in this role.

I would argue that there is a clear health role and that the nurses carried out tasks that were identifiably nursing tasks. The activities of health assessment were very evident, and monitoring of the growth and development of the child is clearly a health related task. Some of the nurses carried out standard nursing interventions, such as giving of injections, maternal health checks, and referrals to other health professionals. Health

education featured frequently in the nurses' daily activities. The nurses' health care training allowed them to identify emerging health problems and institute early treatment. Their expertise in health care was valued by the mothers, who looked to them for guidance in health matters. In this respect their nursing background advantaged them. Research in acute care health settings has suggested that an important role of the nurse is to act as an 'early warning system' (McArthur-Rouse, 2001) and that their experience and clinical expertise equips them to identify subtle changes in health status and thus begin intervention early (Cioffi, 2000). Although these studies report from an acute care perspective, the notion of the nurse identifying potential health problems and intervening early has applications in community health nursing. The nursing care role of the generalist community health nurse includes diagnosis and management of illness alongside their health promotion role, and this would appear to hold true in community child and family health nursing as well. Kendrick, Young and Futers (2000) surveyed health visitors, who identified the diagnosis of acute childhood illness, and the advising of families on management, as part of their practice. There seems to be a tension between the expectations of the NSW Department of Health policies, which promote a predominantly psychosocial nursing role for the child and family health nurse, and the expectations of at least one of the Area Health Services included in this study, that the nurse would undertake conventional nursing tasks as well. The issue of the balance between these roles is not addressed in any meaningful way in the Australian literature, and awaits further exploration.

From the observations made in this study, the daily routine work of the child and family health nurse moved along the continuum between conventional nursing practice and psychosocial care, and to some extent it depended on the practice of the individual nurse where the emphasis lay. As recent health policy emphasises the importance of the psychosocial care of the family, child and family health nursing practice has moved more towards the psychosocial end of the continuum, and as such has the potential to blur the distinctions between child and family health nurses and other psychosocial workers, such as volunteer home visitors. There is, however, a major difference between the work of the child and family health nurse and other parent advisors or volunteer home visitors, who visit as 'friendly helpers': the nurses are health professionals with legally enforced responsibilities for practice. They were aware of their professional responsibilities as a registered nurse, including mandatory reporting, intervening to

prevent harm, advocacy for the client (in this case the baby primarily and the family also), and obligations to maintain competency. The nurses in this study talked about developing supportive relationships with their client mothers and participating in joint decision making, but they retained for themselves the right to intervene if necessary. This is consistent with their responsibility as health practitioners, who, in the final analysis, are accountable for their actions. It does, however, present them with a paradox: how to walk the line between acknowledging and encouraging parental autonomy, and their duty of care to the infant/child, who is their chief concern and the person most frequently nominated on the official health record as the recipient of care.

Given the emphasis in the policy documents on parent support and psychosocial care, would another category of home visitor be more appropriate than a nurse? Certainly there are many examples of parenting support services employing paraprofessionals rather than nurses, with validated good outcomes (Woodgate, Heasman, Chalmers & Brown, 2007). In NSW where this study was conducted there are well recognised and successful providers of volunteer home visiting programs. There are difficulties associated with volunteer workers, such as recruiting adequate numbers, and lay workers require specialised training, and ongoing supervision and support, which can be expensive (Barnes-Boyd, Fordham Norr & Nacion, 2001). Lay workers, on the other hand, bring different expertise to professionals (Muns et al, 2004). They may be closer to the target community in characteristics, personal circumstances and life experiences and therefore very acceptable with high credibility. The often cited research studies of David Olds and fellow researchers privileges nurse visitors above paraprofessional visitors (Olds et al, 2004) but there is debate about this assertion (Watson, White, Taplin & Huntsman, 2005) It is also a proposition that remains untested in the Australian context.

Limitations of the Study

This study reports on the interviews and observation of fifteen nurses in two Area Health Services in NSW. As Area Health Services differ in organisation and staffing requirements the nursing practices observed in this study may not be representative of the experience of child health nurses in other child and family health services. The participants were all child and family health nurses with more than five years of practice

and their attitudes and beliefs about their practice may differ from less experienced nurses.

The nurses volunteered to take part in the study and this selection technique may bias the study. It may have been mostly experienced nurses, or nurses who were confident enough to have their practice observed, who volunteered. Some nurses may have been encouraged to volunteer because they knew of me through my connections with the professional association, or conversely this may have discouraged them to do so.

The number of observations of the nurses' interactions with the parent/s was restricted to one per nurse to a total of fifteen in this study. The observations were used to support the analysis of the nurse interviews and the content of the observations was not fully utilised. The content analysis was restricted to a small number of variables, such as the number of topics discussed and the frequency of their occurrence. Other items in the observations were not examined so that it is possible that further analysis of the interactions between the nurse and parent may alter the conclusions reached in this study.

The nurse-mother interactions were mostly observed in a community health centre location and few consultations were observed in the home setting. As a result there were no observations of first home visits observed, as indicated by the health policy. Some of the centre based observations were appointments scheduled for regular baby health checks and these were found to yield very little interaction data of interest. I therefore requested to attend drop-in sessions, where a much broader range of topics was discussed. This may have inadvertently skewed the findings.

This study does not include interviews with the parents who are the recipients of the child and family health nursing service. The decision to exclude parents was made to contain the study size by limiting it to the views of clinicians only. As the goal of the study was the differences in nurses' practice occasioned by the introduction of the Families First Strategy, it was deemed reasonable to restrict the data collection to nurses' interviews. Any further investigation of the nursing practices observed would now have to take into consideration parents' views of the service they receive and their perceptions of their interactions with the nurse.

Future research

The data collection for the Nurses Study yielded many taped interactions between the nurse and mother that were not used in the analysis for this study. Further exploration of this untouched data set would allow the researcher/s to test whether the themes developed from analysis of the nurses' interviews are confirmed in the practice context. It would also allow the researcher/s to test whether the service model outlined in Supporting Families Early (NSW Health 2008) has support in the wider community, and particularly from the perspective of parents using the service. Little attention has been given to parent's perspective and the Nurses Study did not include parents as participants. It is essential that future work seek the opinion and views of parents on the service model most applicable to their needs, and their expectations of the role and function of the child and family health nurse.

Conclusion

This section has discussed key issues identified from the data analysed from the interviews with the nurses and observations of their interactions with their client mothers. I have analysed the conversational interaction that occurred in the mothers' consultations with the nurses, and the major constructs which the nurses used to form their practice. In particular, the counselling or helping relationship has been discussed in context with the Family Partnership Model that directs official policy. The content of the conversations between the nurses and mothers has been examined in terms of what overt and covert topics were inherent in their discussions. Finally, the conditions that support nursing practice of health promotion and parent support were discussed.

From the discussion several topics have emerged that require further scrutiny. They include the need for further exploration of practice issues identified in this discussion, such as those around the nurse's health promotion role, many of which could be addressed if there was a recognised and accepted model of practice for child and family health nurses. Some of the issues raised in the Nurses Study present practice dilemmas, such as the tension between the nurses' expectation of building rapport and cooperative relationships with the mothers versus the service restrictions outlined in the Policy Study that restrict their ability to have a continuing relationship with the mother. There are also moral dilemmas that need to be acknowledged, such as the nurses' role in advocating socially acceptable parenting behaviors.

Consequently, the exegesis will discuss the necessity for strong leadership to advance child and family health nursing. Leadership is called for from NSW Health, and from the professional nursing association, to identify the scope of practice and explicate expectations of the role and practice of child and family health nurses. Leadership is also required from nurse educators in preparing nurses for practice in child and family, with the inclusion of agreed key knowledge and skills within preparation for practice curriculum. And finally, I will address the necessity for political leadership, for child and family health nurses to consider the socio-political environment within which they work, to become involved in the political process and in particular, the development of health policy that has a direct bearing on their role and practice.

EXEGESIS: CONCLUDING DISCUSSION TO THE PORTFOLIO

Introduction

The Dissertation for a professional doctorate is distinct from that of a Doctor of Philosophy degree. With a clear focus on nursing practice, the Dissertation should demonstrate leadership and make a contribution to leadership in practice and policy development. The final essay in a professional doctorate draws together the major findings of the various components of the Portfolio and discusses how they contribute to the Dissertation. In keeping with this requirement, this paper will identify the major conclusions of the policy analysis and research component and explore questions raised in the Dissertation that require further consideration. It begins by discussing the main conclusions from the Policy Study and the Nurses Study that were first identified in the concluding chapters to the two monographs. In keeping with the requirements of the professional doctorate, I will then return to the wider issues of demonstration of leadership in practice and policy development through research, education and political activism.

Policy and practice are the twin focal points around which this Dissertation is constructed. The goal of the study was to discover whether changes had occurred in nursing practice in child and family health due to the implementation of the Families First Strategy and associated health policies. The Policy Study examined the origins and growth of the Families First Strategy from the perspective of NSW Health, the health policies that flowed from the implementation of the Strategy, and the impact on child and family health nursing services. The study concluded that there was a discernible effect on nursing services, and by association, upon the nurses' practice as well. The nurses interviewed for the study were explicit about the service changes that occurred, such as the reorganisation of health services to accommodate the introduction of Health Home Visiting in their Area Health Service. In contrast, there was no real agreement amongst the nurses interviewed as to the extent of the changes to their nursing practice occasioned by the implementation of the Families First Strategy. Whilst some of them identified specific changes in practice, others believed that the changes to the service delivery model had officially confirmed practice modalities that were already in place.

A major conclusion of the Policy Study was that, by and large, the nurses had no part in influencing the formation and direction of the policies, and they had minimal influence on senior management decisions about the implementation processes. They were not

part of the decisions made by the NSW Department of Health and the professional association representing the nurses was not active in the policy process. Their major involvement occurred within the workplace where they were asked to operationalise the decisions made by the NSW Department of Health and their Area Health Service management, and initiated at senior levels of the NSW Government. Whilst they played a minor role in policy development they were the health workforce that was most involved in the policy implementation.

The child and family health nurses' political position could be described as reactive rather than proactive. When the policy decisions were announced they settled down to implement them as best as their particular circumstances would allow. They attended the child health conferences and embraced the notions of early intervention and parenting support advanced by the international experts, and they took up the offers of training in the Family Partnership Model that the NSW Department of Health had instigated and funded.

The Policy Study and the Nurses Study have identified the necessity for strong leadership in both the political sphere and in nursing practice to take child and family health nursing forward. Although leadership ability cannot be defined precisely it is thought to be due to a combination of factors, such as personal qualities and traits and the ability to influence others (Sofarelli & Brown, 1998), excellent communication and people skills (Gebbie, Wakefield & Kerfoot, 2000) and a good understanding of the wider socio-political sphere (Antrobus & Brown, 1997). As the literature demonstrates, the qualities of leadership are complex but they can be developed and new leaders fostered and supported. For the continuing development of child and family health nursing, leadership must be demonstrated. There are a large number of existing issues in contemporary child and family nursing that need to be addressed for the clinical specialty to continue to progress, or indeed, for the nurses to be able to do what is required by policy makers and managers. The following sections will identify and discuss a small number of crucial leadership issues that are relevant to practice, education and political activism in child and family health nursing.

Leadership in child and family health nursing practice

Both the Nurses Study and the Policy Study concluded that the introduction of Families First led to expectations from the NSW Department of Health and Area Health Service managers that the nurses would extend or expand the services they provided to families. The new service requirements were largely drawn from the international literature on contemporary practice in child health services and early intervention in childhood. In doing so, assumptions were made about current practices without research evidence that the international programs fitted with the context of the Australian health and welfare systems. Thes new service requirements are expressed in the health policy documents issued by the NSW Department of Health and now made explicit in the newly released Supporting Families Early policy (NSW Health, 2008). The policy documents point towards the desired service model in child and family health and outline the expected nursing role and function.

The Supporting Families Early policy prescribes a role for the child and family health nurse that is dominated by the Universal Health Home Visiting program. The policy mandates a single home visit to all families with newborns to assess the infant's health and the family circumstances, and makes provision for follow on services. Kruske (2005) has argued that the evidence for home visiting is mainly about sustained home visiting programs, and there is no evidence that provision of a one off home visit is effective. Yet the universal home visit remains the dominant service activity endorsed by the Supporting Families Early policy. The policy gives precedence to home visiting apparently above other service activities, such as centre based consultations, group work and community development activities. There is no indication in the policy of how the other service activities are to be combined with home visiting and it is apparently left to the Area Health Service management to decide which combination of service activities they will endorse. As the nurses interviewed for the Nurses Study noted, the struggle to meet home visiting targets resulted in other services being overshadowed. Kruske (2005) has demonstrated that when the capacity of the child and family health service is compromised many parents receive limited services beyond the first home visit. Consideration now needs to be given to designing the best mix of the various service components so that the service model fits best practice. It may well be that for some Area Health Services universal home visiting is less of a priority than for others, and best practice is achieved with a balanced combination of service activities specifically

designed for the contingencies of the geography and population of the region. The reality is that the NSW Department of Health has mandated the universal first home visit, and services are now obliged to fulfill that mandate. Yet the nurses interviewed for the Nurses Study were in agreement that ongoing contact with the family, and particularly the mother as the primary care giver, was essential. The emphasis given to the first, and for some areas only, home visit does not support this and will remain an inherent contradiction. Child and family health nurses will struggle to maintain the continuing contact with the mother that they so desire.

The Supporting Families Early policy documents describe a service model for child and family health nurses. The policy sets out the clinical practice principles the Area Health Services are expected to support in order to implement the policy and defines the clinician's level of skill, such as the application of the Family Partnership Model and core skills and knowledge for working with children. The Area Health Service's obligations in providing training are clearly stated. These service expectations describe the scope of the nurses' practice. A scope of practice provides the broad boundaries of the nurses' practice according to 'that which the nurse is educated, competent and authorised to perform' (Queensland Nursing Council, 2008, p11). The NSW Department of Health Child and Family Health Nurse Practice Development Program contain relevant statements on the scope of practice and the core knowledge and skills for practice in child and family health nursing. This Program is yet to be released and is currently under embargo, but it provides an opportunity to express in a formal NSW Department of Health document a clear scope of practice for child and family health nurses that could be adopted across the State.

There is, however, no clear description in any of the NSW Department of Health policy documents of a model of nursing practice, as distinct from a service model. Descriptions of the boundaries of the nurses' scope of practice are not synonymous with a conceptual model of nursing practice. There is not at this time a universally accepted model of practice in child and family health nursing across NSW; even service models vary across Area Health Services. The publications of the professional association suggest that CAFHNA has gone some way towards developing a model of nursing practice but it is not explicit and it is not necessarily used by nursing management in the Area Health Services to guide practice. Tresillian Family Care Centres have developed a draft

model of care for the organisation that is in the process of being evaluated, and this could provide some insights and be used as a springboard to develop a more conceptual model when the current project is completed in 2009 (Fowler, 2007).

One of the aims of my research project was to investigate the nature of nursing practice in child and family health nursing. A methodology was adopted located with the interpretive paradigm to allow the nurses to express their personal understanding of nursing practice. The nurses were also observed in the practice situation and the observations helped to confirm or disconfirm the nurses' statements. In this way a picture of the nurses' practice was constructed which expressed the way in which, for these nurses at least, they conceptualised their practice. Pearson, Vaughan and Fitzgerald (1996) indicate that descriptive pictures of nursing practice that adequately express the understandings of the nurses, are in effect a practice model.

The emergence of leaders to defend and promote child and family health nursing presumes there is clear and agreed understanding amongst the leaders of that which defines and constitutes the practice of child and family health nursing. In particular, a clear vision of the concepts and principles of practice that makes child and family health nursing unique as a nursing specialty practice. In short, the articulation of an ideal model of practice that is identifiably child and family health nursing. With a practice model in place, it is then possible to go on to define educational requirements to prepare the nurse to enter practice. A clear model of practice allows nurse leaders to decide how best to defend their perspective to others and to make a difference through advocacy, lobbying and contribution to policy making at senior levels in the NSW Health bureaucracy. Identification of those issues that are the special interest of child and family health nursing leads to cooperation with likeminded others in the policy community. Finally, recognition that others in the broader community hold similar ideals links nurses to other contributors to the wellbeing and welfare of families with young children in NSW, and indeed nationally.

Leadership in child and family health nursing education
Defining an ideal model of practice for child and family health nursing allows child and family health nurses to demand education programs to meet it, and thus to take control of their own practice. Whilst the professional association, CAFHNA, must play its part,

there is also a necessity for strong leadership from NSW Health to identify the expected scope of practice and mandate the educational requirements to fulfill the prescribed service position. The Supporting Families Early policy sets out the expected level of qualifications and training for the child and family health nurse, and the final draft of the NSW Child and Family Health Nurse Practice Development Program contains learning packages for ongoing professional nursing education. What are not addressed by both documents are the requirements in nursing education programs that prepare registered nurses for practice in child and family health nursing. This section proposes principles for designing an educational program that will lead practice and meet the needs of child and family health nurses in the 21st century. Curriculum development requires educators to take notice of the current political climate, to be informed about developments in health care and nursing practice beyond the local situation and to be ready to incorporate new policy directions into practice.

Theoretical content – essential knowledge and skills

The primary purpose of postgraduate programs in child and family health nursing is to prepare nurses for practice in the clinical area. There are some skills and knowledge that are considered essential to child and family health nursing practice and should be mandatory in any program to prepare nurses for beginning practice. It is not my intention to prescribe a definitive list but to give an indication of those components of the education program that differentiates the preparation of child and family health nurses from other clinical specialty areas. Commonly, essential skills and knowledge include such items as:

- Principles and practice of primary health care, health promotion and health education.
- Communication theory and skills in interviewing, counselling, and group work.
- Nursing knowledge of the care of infants and young children, particularly psychological care, that is based on a sound knowledge of child development.
- Breastfeeding and maternal health in the postpartum period.
- The psychosocial context of child and family health nursing.
- Nursing assessment and the planning of care, including psychosocial assessment.

Educators should, however, also aim to prepare nurses for leadership in child and family health nursing. Educating for leadership includes opening up the breadth and extent of health care provision beyond the nursing role and function to students and increasing their awareness about the political process. This is necessary to adequately prepare nurse leaders who will contribute to policy making, take an active role in implementing policy in practice and act as champions for nursing within the political sphere.

Nursing is such an eclectic practice that nursing curriculums have a long history of incorporating theories and models from other disciplines into nursing curricula. These theories are said to inform nursing practice. In child and family health nursing the principal disciplines from which these theories are taken include psychology, developmental psychology, sociology and communication theory. Borrowed theories include primary health care, human attachment theory and theories of child growth and development, family, parenting, interpersonal relationships and counselling theory.

The application of theories borrowed from other disciplines is problematic if they are accepted uncritically, as borrowed theories may change if used outside the context of the discipline for which they were developed (DeKeyser & Medoff-Cooper, 2004). Therefore Fawcett (1995) suggests that theories developed outside of nursing should be scrutinised for their suitability to nursing practice. Fawcett (1995, p.26) gives the example of attribution theory, borrowed from psychology, which, when tested by Lowery and associates in 1987 did not hold up in a nursing context. This example highlights the need for child and family health nurses to be more critical of imported theories and to embark on research that validates the use of theory from other disciplines adapted for nursing practice. Their education should give them the skills and knowledge to make these assessments and their leadership the credibility to promote these judgments at the right levels.

Clinical experience during program

Nurses are commonly not employed in a child and family health position without first obtaining the relevant qualification. That is, health service employers expect the applicant to have already acquired some post registration education in child and family health nursing as a condition of employment. In contrast, nurse managers in other

related areas of specialty clinical practice will accept that the nurse enters the specialty nursing education program whilst holding concurrent employment in the clinical area. Hence, paediatric and neonatal nurses work in paediatric wards and nurseries whilst they undertake postgraduate study in their clinical specialty. Their educational program therefore includes an expectation the nurse will gain practical clinical experience as she/he studies, and the nurse may be supervised by more experienced colleagues in the workplace.

In recognition of the unique situation of child and family health nursing, all the NSW current programs include a clinical experience component, however this is of varying lengths and far less than that required before the move to tertiary education. Principles to be used to guide the formation of a clinical experience program are as follows

- Uniform across the state and preferably nationally
- Of sufficient length to expose the student to a depth of experience in the clinical field
- Supervised by experienced child and family health nurses
- Subject to examination using competency standards

Level of the award

Currently in NSW the education standard for postgraduate programs in child and family health nursing is at graduate certificate level. It is the responsibility of educators to ensure the level of the award and the content of their programs meets industry expectations. A perusal of the current NSW Department of Health documents and the expectations for practice expressed in those documents suggests that the graduate certificate level of award is insufficient to adequately incorporate the necessary and required knowledge and skills for family and child health nursing practice (Kruske, 2005). Kruske (2005) advocates for a minimum postgraduate diploma level of award, which appears to be the more usual level of preparation in other States and Territories. If NSW was also to adopt the graduate diploma as the minimum entry level it would reinforce this as the desired level of award nationally. As the Commonwealth Government moves to set up a national nurse registration and accreditation scheme by 2010 (Australian Peak Nursing & Midwifery Forum, 2008), a uniform level of entry nationally becomes even more desirable.

Leadership in Developing Political Capacity

As identified in the Nurses Study, the development of a socio-political role for child health nurses within their health promoting practice is only one way in which nurses must become alive to the needs of the profession as it seeks to operate in the charged political atmosphere of healthcare. This section of the paper will argue the political necessity for child and family health nurses to become involved in the political process and in particular, the development of health policy that has a direct bearing on their role and practice. It will address a projected role for the child and family health nurses' professional association and discuss ways in which the association can provide leadership and vision for child and family health nursing.

Child and family health nurses are the key clinicians in delivering the health service initiatives presaged in the changes in health policy and discussed in the Policy Study. The success or otherwise of these new initiatives will have more effect on them than any other health professional. It therefore is necessary, and politically astute, for them to be actively involved in the processes surrounding the interpretation of health policy and the implementation of policy directives at the ground. That requires sound leadership and involvement in health politics at a level that nurses have historically avoided, preferring to remain outside the bureaucratic and political process (Antrobus & Brown, 1997). This is compounded by the problem that there is little analysis or critique of policy issues for nurses in the nursing literature (Cheek & Gibson, 1997), perhaps reflecting this lack of interest in policy matters. Certainly there was little attempt to critique the health policies presented to the child and family health nurses by the NSW Department of Health. There is some basis for believing that knowledge of the policy process is not well understood by nurses (Antrobus & Kitson, 1999) and that is demonstrated by the Policy Study. However, if child and family health nurses do not contribute to the decision making at the highest levels of policy development and implementation, they run the risk of having others decide the direction of their service delivery and ultimately their own nursing practice, as the service changes around them. They should be shaping the political agenda, and taking the lead in matters important to them and their client families.

The identification, nurturing and development of new leaders is an ongoing issue and it is the responsibility of those who are in leadership positions now to foster the leaders

for tomorrow. It is clear that new leaders must arise from amongst child and family health nurses themselves, as these nurse leaders will be better able to understand their concerns and thus represent their interests. There is a temptation in the first instance to look to nurse managers, but Courtney, Nash & Thornton (2004) make the very good point that managers are not necessarily leaders. Identifying nurses who have the capacity to lead and who would be acceptable to the clinicians as a leader is not an easy task, but those nurses working in advanced practice roles have an obvious responsibility to demonstrate leadership skills (Bennett, 2004).

Nurse leaders must operate in the disparate nursing domains of academia, clinical practice, nursing management and policy development with each domain having a distinct knowledge base and requiring a particular skill set (Antrobus & Kitson, 1999). Effective nurse leaders have ability to access and move around all four domains, but they find their primary grounding in their clinical practice as it is this which gives them legitimacy. They bring their practice knowledge and skill to bear on their political activities, as when they use the many people skills they gained from clinical practice in their dealings with the policy domain (Gebbie, Wakefield & Kerfoot, 2000). Importantly, successful nurse leaders understand that the ideology and language used by nurses in practice differs significantly to that found in the policy context, leading to a policy/practice divide (Antrobus & Kitson, 1999). Thus, they must have the ability to interpret nursing values and perspectives for non-nurses operating within the policy context so that they understand nursing concerns.

The concept of political leadership is said to be relatively new to nursing (Antrobus, Masterton & Bailey, 2004) or at least less well developed than the other domains. Some commentators suggest that this is an issue of lack of expertise and experience in dealing with political matters and may be addressed through education (Des Jardins, 2001a; Byrd, Costello, Shelton, Thomas & Petrarca, 2004). Other commentators ascribe the problem more to situational factors that inhibit political activism, such as busy nurses being time poor or feeling unsupported by management and thus disempowered to act (Hyett, 2003). In a thoughtful commentary, Davies (2004) suggests that the real issue is not the lack of leadership so much as the inherent disadvantage confronted by nurse leaders in a health system that both patronises and sidelines them culturally and structurally. The power of Davies' critique is acknowledged, and certainly nurses

should be working towards system change, but the thrust of the argument put forward in this paper is that, of the three views described above, the one of immediate interest is the educational preparation of potential leaders.

It is axiomatic the nurses will not be able to develop a socio-political role without adequate preparation and support. Ideally this should begin in the pre-registration phase of nursing, educating nurses about the political system in which they operate, such as has been trialed in pre-registration programs in the U.S. (Byrd et al, 2004). There is a corollary to this, and that is introducing nursing students early to the politics of nursing encourages a more active interest in 'big picture' matters. Hopefully this will foster curiosity about the political context in which health care decisions are made, or interest in a broader view of nursing issues. Such an attitude encourages nurses to look beyond the narrow confines of their discipline and prompts them to recognise the interrelationships inherent in the health care system. Encouraging such interest could continue at the post registration level with programs such as that described by Des Jardins (2001b) in which registered nurses enrolled in a two day continuing education program aimed at empowering nurses to take action on behalf of themselves and their patients. Best of all is the expectation that child and family health nurses would be sufficiently engaged to seek postgraduate education at the masters and doctoral level that would prepare them for a leadership role. In this, university faculties have a responsibility to offer programs to prepare future child and family health nurse leaders.

There is also a place here for professional organisations to become involved. In the U.K. the Royal College of Nursing set up the Nursing Political Leadership Programme in 1999 to prepare nurses for a political leadership role by specifically giving them the necessary political skills (Antrobus et al, 2004). Australian nurses may rightly look for similar direction from our own professional nursing associations, such as the Royal College of Nursing Australia, but there does not appear to be a comparable local program. The College of Nursing located in Sydney, however, has a link on its website to the Australian Health Policy Institute in the University of Sydney, for a postgraduate award course in health policy leading to a graduate diploma, with a Masters degree planned from 2009 (University of Sydney, n.d.). Considering the length and expense associated with postgraduate study, there is still a good case to be made for the

involvement of the large professional nursing organisations in providing affordable, accessible and appropriately focused nursing leadership programs.

Kruske (2005) has criticised the child and family health nurses' professional association, CAFHNA, for not developing political leadership. There is obviously a special role for CAFHNA in providing information and making the political context more relevant and accessible to its members. By doing so, the Association empowers its members to participate, and helps the Association officers to put forward the views and argue the perspective of the members. CAFHNA has been the conduit through which many of its members have gained access to decision making forums in the NSW Department of Health. Once engaged, this facilitates the emergence of those nurses willing to give of their time and energies to take an active part in the political process on behalf of all child and family health nurses. There are various avenues open to the Association to engage its members. Antrobus et al (2004) suggest that the journey towards political leadership has a four stage process, beginning with consciousness raising and continuing on to develop qualities of political astuteness before becoming politically active and transforming into a political leader. CAFHNA has the capacity through its publications and seminars to raise the awareness of its members to the issues and challenges that confront child and family health nurses in contemporary practice and the political context in which they exist. There have been attempts on the part of the Association officers to do so, with editorial comment included in the periodical journal, and with plans to include discussion forums on the website. Consciousness raising may lead to political empowerment (Mason, Backer & Georges, 1991), particularly if it is reinforced with activities that give nurses the confidence and self esteem to be more involved in health policy and politics. Therefore supporting member nurses who volunteer to participate in decision making forums is a major responsibility of the Association. The Association should give consideration to enabling its members to participate in education programs that build the political skills necessary to negotiate within the political system, whether that is financially supporting members to attend formal education programs, or including such content within their own seminars. There is a case to be made for the Association identifying potential political leaders and actively fostering and mentoring them.

Ascribing such a role to the professional association presumes that there is within that group a reasonably high level of political expertise and the willingness to be involved in such matters. Whether they acknowledge it or not, professional associations such as CAFHNA are political bodies, and Association officers need good political skills to represent their members within the health politics arena (Speedy & Jackson, 2004). For CAFHNA to have an influence its leaders need to know how to gain access to the right political networks and to do this they must be knowledgeable about government structures and the political process, lobbying and influencing policy (Antrobus et al, 2004). Association members should be proficient enough in writing and presentation skills to enable them to present the association's views in media interviews and releases, position statements, and have enough political savvy to be able to catch the interest of politicians and senior health bureaucrats. They should be able to construct strong arguments using language that is amenable to policy makers, which implies that they are also knowledgeable about policy priorities. They should be able to critique policy well enough that they can describe the impact of decisions taken at policy level on child and family health services, nursing practice and the families that constitutes the target population.

These skills can be learnt from professional communicators and lobbyists, such as the excellent advice offered on how to be politically active and media savvy by Buresh and Gordon (2006). These authors argue that nurses must articulate their position to those who have influence. Collins (2006,p.16) agrees that 'outsiders will fail to notice' unless nurses define that which makes them special to affirm their identify. Kingdon (1995) argues that one of the most important political skills is being able to present your reality to others. That is, to define the issue from the perspective of child and family health nursing and to present and promote a solution that answers the problem, to be prepared to seize the day and react to windows of opportunity. A contemporary success story exists in the achievement of midwives in defining midwifery practice as separate and unique. Their solution was to separate the conceptual framework, competency standards and midwifery education from nursing (Brodie, 2003). They have won through principally by defining what made midwifery special and then using political skills to convince others of their view of reality.

Nurse leaders require a solid research basis in child and family health nursing practice on which to base their claims and to suggest innovations to policymakers and implementers. For example, new trends and/or research that could be used to inform policy makers or to point to solutions to difficult problems. Knowledge based experts such as academics play an important role in identifying problems and investigating possible solutions (Lethbridge, 2000). The professional associations (either CAFHNA or its national counterpart, the Australian Association for Maternal Child and Family Health Nurses) should consider developing a working relationship with nurse academics in policy research centres, or at the very least strengthen ties to them so that the Association's views can be included in research projects that affect child and family health nurses.

Professional associations have a role as champions of relevant research. It is notoriously difficult to get research into policy development but if brought forward and championed by the professional association, providing the organisation is politically astute, it would have more chance of being attended to. Representatives of the professional association could use such research findings in their political lobbying to validate claims, point towards necessary change or define problems and issues that need to be addressed.

Further Research

Many of the nurses in the Nurses Study reiterated strengths based practice and the Family Partnership Model as theoretical models of care that had been presented to them. There was an uncritical acceptance of these models, neither of which had been developed within nursing, and which had been applied to nursing practice on the assumption that they would be suitable. The strengths based perspective is drawn from social work practice and its critics suggest it is more of a value stance (Staudt, Howard & Drake, 2001) or an alternative service modality (Whitley, White, Kelley & Yorke, 1999) than a practice theory or model. There has been some evaluation of the strength of the application of the model in social work practice (Hwang, Cowger & Saleebey, 1998) and it has been tested in social work programs (Green, McAllister & Tarte, 2004). The efficacy of its application in child and family health nursing, however, remains unevaluated and so until this occurs the model must be included in the curriculum with a cautionary note.

The practice model of partnership is another addition to nursing practice both in child and family health and paediatric nursing. The notion is critiqued for its application in paediatric nursing practice (Coyne & Cowley, 2006) but not in child and family health nursing practice. The notion was introduced in child and family health through the Family Partnership Model (FPM), which is well evaluated and has been applied in many practice contexts. Even so, some child and family health nurses in the Nurses Study appeared to have difficulty with following through with the counselling process advocated by the Family Partnership Model. Whether this is due to difficulties with the nurses applying the theoretical process, or whether it is because the model does not lend itself to the practice situation in child and family health nursing is yet to be explored.

The Nurses Study suggested there were practice dilemmas that needed further exploration, one of which is the tension between the professional responsibilities of the nurse and the nurses' position as 'partner in care' with the parent. There exists for the nurse a practice dilemma of where to draw the 'line in the sand' between professional obligations, some of which are legislated as mandatory, and the partnership collaboration with the parent. The practice dilemma occurs when the nurse has to decide if her/his professional responsibilities require the nurse to act in a way that could be counterproductive to her/his collaborative role with the parent. Clearly, where the nurse has a regulatory or mandatory obligation, that requirement should take precedence over the other. Anecdotal reports suggest that the nurses are aware of this dilemma and take steps to manage it. They use devices such as informing the parent on first contact of their mandatory reporting role. But this practice dilemma is more subtle than legislated child reporting obligations, which may themselves be of difficulty. It is about the day to day decisions on where the boundaries of practice occur and how the relationship is defined. It is about whether the parent's decision will prevail, even though there may be grounds for considering that the parent's actions are potentially harmful.

The nurses in the Nurses Study reported that they held back from criticising, or appearing to be telling the mother what to do, in fear that this would jeopardise the relationship and the mother would not return. It may have been the unspoken reason for their lack of challenge to harmful 'construing' in the counselling relationship, which leads to a preference to stay on the pleasant side of the counselling relationship by never

challenging perceptions and beliefs. But when is the obligation to act greater than the need to hold back?

There is some research on this aspect of child and family health nursing practice. Wilson (2001 & 2003) examined aspects of the power relationship in the nurses' role with New Zealand child health nurses. Other research has been carried out on the notion of nurses 'policing' mothers (Peckover, 2002; Peckover, 2003; Robinson, 2004; Twinn, 1991). Further research could build on Wilson's (2003) findings to specifically scrutinise how the nurses make their decisions. It would investigate the elements in the decision path that leads to the decision to intervene. An exploration of how the nurses calculate the costs and the consequences, and how they inform parents about their professional responsibilities would be particularly important for those nurses involved in providing sustained home visiting for vulnerable families.

Concluding Remarks

This is a study of two intersecting worlds: health policy making and nursing practice. Where they intersect is the world in between and the focus of this study. The Policy Study ventured into the world of health bureaucracy and, in particular, health policy for children and families during the period 1999 to the present. The Nurses Study took the insights from the Policy Study and then examined the world of child and family health nursing practice to see how nursing practice had adjusted to the impact of the new child health policies. In the process a description of contemporary child and family health nursing in NSW was obtained.

It is hoped the findings from this study will enable child and family health nurses to be better informed about their nursing practice and and the mechanisms of health policy making. That, in doing so, they will be encouraged to move between the worlds of health policy and nursing practice and actively promote and defend their unique clinical nursing specialty practice.

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APPENDICES

Participant Information Sheet
Child and Family Health Nurses
Re: Nursing Practice Study

You are being invited to participate in a study being undertaken by the Ms Carolyn Briggs from the Faculty of Nursing Midwifery and Health, University of Technology Sydney, (UTS). The aim of the study is to describe the nature and scope of contemporary nursing practice and the qualities, attributes, knowledge and skill that the nurse demonstrates in the practice context. This study has been approved by the (name of AHS) research ethics committee and the UTS Human research ethics committee (UTS HREC)

If you agree to be part of this study you will be asked to participate in two ways. Firstly you will be asked to have three of the consultations that you conduct in the clinic settings or in the home with parents observed by me as the researcher and audio-tape recorded. This will involve me spending half to one day with you in your workplace. During this time I will observe and audio-tape the interactions that take place during approximately three separate consultations between you and individual women. Secondly, you will be asked to participate in a face to face 'interview' with me. The interview will take approximately one hour and will be organised for a time and place that is private and convenient to you. You will be provided with a schedule of questions, which will be used to guide the discussion but the interview will be informal and relatively unstructured in nature. With your permission the interview will be taped and notes will be taken of the key points. You will be asked to sign a consent form. There may be no direct benefits to you individually but we hope that the results of this study will assist with the planning and development of practices that improve support for parents.

All data will be treated confidentially. The tapes from the interviews and consultations will be transcribed as soon as possible and then destroyed. When the tapes are transcribed they will be de-identified, no names or positions mentioned on the tape will be transcribed. The transcriptions will be stored on a computer in a folder needing a password access. In addition to this, a backup copy will be stored on a disc in a locked cupboard. In the presentation of the results of the study, neither the individual participants nor the area health service will be identified. The study data will be kept in a locked cabinet and on disc in a protected file for 5 years after the completion of the research. The data will be erased and the files shredded at the end of this period. It is anticipated that the final results of this study will be published, but again confidentiality will be preserved and no document will identify you or the area health service individually. The results of the study will be available to you on request at the completion of the study. At no time however, will your individual identity be exposed.

Participation in this study is voluntary and your decision whether or not to participate will not affect your relationship with (name of Area Health Service) now or in the future. If you decide to participate you are free to withdraw your consent and discontinue participation at any time. Any such withdrawal will not affect your relationship with (name of Area Health).

If you have questions about this research you can contact me at the University on 95145136 or my supervisor, Associate Professor Virginia Schmied, at the Centre for Midwifery and Family Health, University of Technology, Sydney, on 9514 2977.

Yours faithfully
Carolyn Briggs

Consent Form for Child and Family Health Nurses:
Nursing Practice Study – <u>Audio-taping of interactions</u>

I,

_____

(name of participant)

of_____

      (street)   (suburb)   (state & postcode)

have been invited to participate in a research project entitled 'Nursing practice in child and family health services'.

In relation to the project I have read the Participant Information Sheet and have been informed of the following points:

1. Approval has been given by the Research Ethics Committee of (name of Area Health Service) and the Human Research Ethics Committee of the University of Technology, Sydney.
2. The aim of this research is to investigate the nature and scope of contemporary child and family health nursing practice in a variety of settings in two NSW area health services.
3. The results of this study may not be of direct benefit to you but will assist with informing clinical practice that may improve professional support given to families.
4. **Participation in this study will be twofold. Firstly a researcher will observe and audio-tape interactions that take place during individual consultations between you and individual women. Secondly you will be asked to participate in a face to face interview with the researcher. <u>You will be provided with a separate consent form for the interactions and interviews.</u>**
5. Should I have any problems or queries about the way in which this study is conducted and I do not feel comfortable contacting the researcher, I am aware that I may contact the representative of the (name of Area Health Service and contact details) or Susanna Davis Research Ethics Officer at the University of Technology, Sydney on 02 9514 1279.
6. I can refuse to take part in this study or withdraw from it at any time without affecting my relationship with (name of Area Health Service).
7. I understand my research data will be coded and stored in a secure office and on a computer with password access and that the researchers will take all precautions to protect my identity.
8. I understand that results from this study will be published but that my identity will not be revealed.
9. I declare that I am over the age of 18 years

After considering all these points, I accept the invitation to participate in this project.

_____(please print name)

Signature: _____   Signature:_____

       (of participant)   (of witness)

Consent Form for Child and Family Health Nurses:
Nursing Practice Study – <u>Interview with the researcher</u>

I,

_____
       (name of participant)

of_____
       (street)   (suburb)   (state & postcode)

have been invited to participate in a research project entitled 'Nursing practice in child and family health services'.

In relation to the project I have read the Participant Information Sheet and have been informed of the following points:

1. Approval has been given by the Research Ethics Committee of (name of Area Health Service) and the Human Research Ethics Committee of the University of Technology, Sydney.
2. The aim of this research is to investigate the nature and scope of contemporary child and family health nursing practice in a variety of settings in two NSW area health services.
3. The results of this study may not be of direct benefit to you but will assist with informing clinical practice that may improve professional support given to families.
4. Participation in this study will be twofold. Firstly a researcher will observe and audio-tape interactions that take place during individual consultations between you and individual women. Secondly you will be asked to participate in a face to face interview with the researcher. <u>**You will be provided with a separate consent form for the interactions and interviews.**</u>
5. Should I have any problems or queries about the way in which this study is conducted and I do not feel comfortable contacting the researcher, I am aware that I may contact the representative of the (name of Area Health Service and contact details) or Susanna Davis Research Ethics Officer at the University of Technology, Sydney on 02 9514 1279.
6. I can refuse to take part in this study or withdraw from it at any time without affecting my relationship with (name of Area Health Service).
7. I understand my research data will be coded and stored in a secure office and on a computer with password access and that the researchers will take all precautions to protect my identity.
8. I understand that results from this study will be published but that my identity will not be revealed.
9. I declare that I am over the age of 18 years

After considering all these points, I accept the invitation to participate in this project.

_____(please print name)

Signature: _____ Signature:_____
       (of participant)   (of witness)

Participant Information Sheet for women:
Nursing Practice Study

You are being invited to participate in a study being undertaken by Carolyn Briggs from the Faculty of Nursing Midwifery and Health, University of Technology Sydney, (UTS) which is exploring ways in which child and family health nurses (CFHN) listen to and talk with parents who visit child health services. It will help the researcher to understand the ways in which nurses may best support parents in caring for their children and learning about parenting. This research will be used to improve the quality of the nursing service. This study has been approved by the (name of Area Health Service research ethics committee and the UTS Human research ethics committee (UTS HREC).

If you agree to participate you will asked to sign a consent form. Participation will involve the researcher being present during a consultation you have with a child and family health nurse. The researcher will observe and audio-tape record the consultation that you have with the nurse. With your permission the consultation will be audio-taped and notes will be taken of the key points. There may be no direct benefits to you individually but we hope that the results of this study will assist with the planning and development of practices that improve support for parents.

Participation in this study is voluntary and your decision whether or not to participate will not affect your relationship with (name of Area Health Service) either now or in the future. If you decide to participate you are free to withdraw your consent and discontinue participation at any time. Any such withdrawal will not affect any future treatment or your relationship with (name of Area Health Service).

All data will be treated confidentially. All audio-tapes and transcripts will be coded and any identifying information such as names will be removed from the transcripts so that they will not be identifiable. Only the researchers will be able to link your name to the coded data. Data will be stored securely and will only be accessed on a computer using a password and only by the researchers. Individual participants will not be identified and there will be no repercussions for customers of (name of Area Health Service) regarding any possible negative comments about services provided by this health service. It is expected that the findings of this study will be published in professional journals, as well being presented at conferences but again confidentiality will be preserved and no document will identify you or the health care service individually.

At the completion of the research, study data will be kept in a locked cabinet and on disc in a protected file for 5 years at the University of Technology Sydney. At the end of this period, data will be erased and the files shredded. At no time however, will your individual identity be exposed.

If you have any questions about this research you are free to contact Ms Carolyn Briggs at the University of Technology Sydney on 02 9514 5136, or her supervisor, Associate Professor Virginia Schmied, at the Centre For Midwifery and Family Health, University of Technology Sydney on 9514 2977.

Yours faithfully
Carolyn Briggs

Consent Form for Women: Nursing Practice Study
Audio-tape recording of interactions

I,

_____
      (name of participant)

of_____
      (street)   (suburb)   (state & postcode)

have been invited to participate in a research project entitled 'Nursing practice in child and family health services'.

In relation to the project I have read the Participant Information Sheet and have been informed of the following points:

1. Approval has been given by the Research Ethics Committee of (name of Area Health Service) and the Human Research Ethics Committee of the University of Technology, Sydney.
2. The aim of this research is to investigate the nature and scope of contemporary child and family health nursing practice in a variety of settings in two NSW area health services.
3. The results of this study may not be of direct benefit to me but will assist with informing clinical practice that may improve professional support given to women.
4. Participation in this study will involve a researcher observing and tape recording the interactions that take place during a consultation between me and the child and family health nurse. I may also be asked to participate in a face to face interview. **I will be provided with a separate consent form for both the interviews and the taping of interactions.**
5. Should I have any problems or queries about the way in which this study is conducted and I do not feel comfortable contacting the researcher, I am aware that I may contact the representative of the (name of Area Health Service and contact details or Susanna Davis Research Ethics Officer at the University of Technology, Sydney on 9514 1279.
6. I can refuse to take part in this study or withdraw from it at any time without affecting my relationship with (name of Area Health Service).
7. I understand my research data will be coded and stored in a secure office and on a computer with password access and that the researchers will take all precautions to protect my identity.
8. I understand that results from this study will be published but that my identity will not be revealed.
9. I declare that I am over the age of 18 years

After considering all these points, I accept the invitation to participate in this project.

_____(please print name)

Signature: _____ Signature:_____
      (of participant)   (of witness)

Participant Information Sheet

Title of Research Project: Nursing Practice in Child and Family Health

Re: Health Policy Study

You are being invited to participate in a study being undertaken by the Ms Carolyn Briggs from the Faculty of Nursing Midwifery and Health, University of Technology Sydney, (UTS). The overall aim of the study is to describe the nature and scope of contemporary nursing practice and the qualities, attributes, knowledge and skill that the nurse demonstrates in the practice context. An objective of the study is to investigate the interaction between health policy and service delivery and you are being asked to comment on this aspect of the study. This study has been approved by the (name of Area Health Service) Human research ethics committee and the UTS Human research ethics committee (UTS HREC)

If you agree to be part of this study you will be asked to participate in this study in two ways. Firstly you may be asked to provide a written description (or tape) of your recollections of the activities of the Child and Family Health Nurses Association (NSW) during the time you were involved with the Association. You will be provided with questions to guide your recollections. Secondly you are asked to participate in a face to face interview with me bout your knowledge of the NSW Government's Families First Strategy. The interview will take approximately one hour and will be organised for a time and place that is private and convenient to you. You will be provided with a schedule of questions, which will be used to guide the discussion but the interview will be informal and relatively unstructured in nature. With your permission the interview will be taped and notes will be taken of the key points. You will be asked to sign a consent form. There may be no direct benefits to you individually but we hope that the results of this study will assist with the planning and development of practices that improve support for parents.

All data will be treated confidentially. The tapes from the interviews and consultations will be transcribed as soon as possible and then destroyed. When the tapes are transcribed they will be de-identified, no names or positions mentioned on the tape will be transcribed. The transcriptions will be stored on a computer in a folder needing a password access. In addition to this, a backup copy will be stored on a disc in a locked cupboard. In the presentation of the results of the study, neither the individual participants nor the area health service will be identified. The study data will be kept in a locked cabinet and on disc in a protected file for 5 years after the completion of the research. The data will be erased and the files shredded at the end of this period. It is anticipated that the final results of this study will be published, but again confidentiality will be preserved and no document will identify you or the area health service individually. The results of the study will be available to you on request at the completion of the study.

Participation in this study is voluntary and your decision whether or not to participate will not affect your relationship with Northern Sydney Health now or in the future. If you decide to participate you are free to withdraw your consent and discontinue participation at any time. Any such withdrawal will not affect your relationship with (name of Area Health Service).

If you have questions about this research you can contact me at the University on 95145136 or my supervisor, Associate Professor Virginia Schmied, at the Centre For Family Health and Midwifery, University of Technology, Sydney, on 9514 2977.

Yours faithfully
Carolyn Briggs

CONSENT FORM

**Title of Research Project: Nursing Practice in Child and Family Health Services
Consent to participate in Health Policy Study - <u>Interview with the researcher</u>**

I, _____
            (name of participant)

of_____
    (street)   (suburb)   (state & postcode)

have been invited to participate in a research project entitled 'Nursing practice in child and family health services'.

In relation to the project I have read the Participant Information Sheet and have been informed of the following points:

1. Approval has been given by the Research Ethics Committee the University of Technology, Sydney.
2. The aim of this research is to investigate contemporary child and family health nursing practice in a variety of settings in two NSW area health services.
3. An objective of this research is to investigate the interaction between health policy and service delivery with reference to the Families First Strategy.
4. The results of this study may not be of direct benefit to you but will assist with informing clinical practice that may improve professional support given to families.
5. Participation in this study will be through a face to face interview with the researcher.
6. Should I have any problems or queries about the way in which this study is conducted and I do not feel comfortable contacting the researcher, I may contact Susanna Davis Research Ethics Officer at the University of Technology, Sydney on 02 9514 1279.
7. I can refuse to take part in this study or withdraw from it at any time.
8. I understand my research data will be coded and stored in a secure office and on a computer with password access and that the researchers will take all precautions to protect my identity.
9. I understand that results from this study will be published but that my identity will not be revealed.
10. I declare that I am over the age of 18 years

After considering all these points, I accept the invitation to participate in this project.

_____(please print name)

Signature: _____ Signature:_____
      (of participant)   (of witness)