An Exploration of the Past, Present and Future of Nursing in Early Parenting Services in Australia

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Chapter 3: The Case

3.1 Introduction

As indicated in Chapter One, EPS within Australia have a key role in providing services to support families with young children in the early years of life. Families present to EPS for a range of issues, including adjustment to parenting and isolation in the parenting role, an infant’s irregular sleep and feeding behaviour, behaviour management strategies, nutrition issues, poor maternal postpartum mental health, parenting assessments for child protection and much more (Fisher & Rowe, 2003; Phillips, et al., 2010; Turner, et al., 2006).

EPS have been in existence for over a century, and throughout this time nursing has been their major discipline. It is timely to focus on these services because a range of factors are influencing the potential national direction of EPS, such as family needs in presenting to services, the impact of government policy, the professional skill mix to meet the needs of today’s families and predictions of future nursing shortages. The case for this study was therefore identified as nursing within EPS in Australia (see Figure 17).

In this project, along with the process of identifying the research questions and the appropriate sources of data, it was necessary to identify an appropriate research design. The researcher identified that a case study using multiple sources of evidence was the approach of choice (Cresswell, 2007; Gangeness & Yurkovich, 2006; Punch, 2005; Yin, 2009). The choice of case study strategy is discussed in Section 2.2.2.
This chapter presents a historical context for EPS, including:

- The development of scientific motherhood;
- The European and NZ experience;
- How the child welfare movement and the rise of public health developed in Australia; and
- The development of EPS in Australia.

This movement simultaneously affected the development of the universal child health centre system and the development of mothercraft homes in each state. The overview of the history of each State is followed by an in-depth history of Ngala. Finally, the current context of national EPS is articulated.

### 3.2 The Development of Scientific Motherhood

As comprehensive, coordinated community interventions supported by social, educational and economic changes throughout Australia led to a dramatic decline in infant mortality, parental education became a significant factor in the improvement of children’s health (Davis, 1983). Dr Truby King from NZ founded the New Zealand Society for the Health of Women and Children (Bryder, 2001), and his book (King, 1923) was soon followed by an abundance of written material advocating that all women, irrespective of their socioeconomic background, could benefit from the guidance of an expert nurse in learning how to parent effectively.
For example, Sister Mary Jacob states:

> By an intelligent study of mothercraft and availing herself of the help and advice of child experts in prenatal, baby, pre-school and child guidance clinics, a mother can do great to make a good job of being a mother. (Jacob, 1957, p. 11)

Ruth Park (1949), the NZ writer who spent most of her adult life in the inner city area of Surrey Hills, used the colourful landscape of Sydney slums to set the scene for the struggles of the fictional Darcy family. When her daughter died giving birth, Mumma Darcy was left to raise the newborn. Park summarises the nurse’s main focus on physical care that remained the role of child health nurses for many years:

> Mumma knew everything about babies, but nothing according to the clinic. Dutifully she listened to the sister’s advice, and painstakingly laboured through the booklet of directions given to her. But to Mumma directions were only for bottles of medicine and tins of condensed milk. You couldn’t bring up a little live baby that way. Mumma knew that what babies need most of all is love. (Park, 1949, p. 138)

From the early 1920s, all centre sisters taught scientific child-rearing during consultation sessions. Surveillance of the infant with a sharp eye on milestones meant that babies were weighed, measured, examined for abnormalities and tested for variances from the norm. Sleep, settling, nutrition, management of toddlers’ behaviour and immunisation were some of the core business of nurses, who continued to strongly advocate for the benefits of breastfeeding and the early implementation of strict routines. All data collected was recorded on cards kept at the clinic. Those practices are still very much in place, supported by a plethora of documents, policies and practice guidelines that dictate what expert knowledge nurses will deliver to new parents, and how they will deliver it. Studies (McCalman, 1985; Mein Smith, 1997; Selby, 1992; Thorley, 2000) using women’s recall of their experience of the ‘centre sister’ during the middle of the twentieth century show mixed feedback due to the rigidity of routines and rules prescribed by Dr Truby

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3 Centre sister/clinic sister was the terminology used for the specialist nurse who worked at the clinic.
King’s methods. Some women found the nurse helpful, and many found the advice unhelpful and felt they were blamed if things went wrong.

The rigid child-rearing teaching and surveillance practices expected from nurses and supported by government publications raised many concerns. Wilson (2003) in her examination of the discourses of scientific mothercraft and the monitoring role of the nurse within a nurse–mother relationship suggested a conflict between the two. She pointed out the potential risk of the mother ignoring the recommendations made by the nurse, rather than challenging or clarifying them. This in turn can impact negatively on health outcomes. Brennan (2007) contests that ‘scientific motherhood, with all that it entailed, was socially constructed, reinforced by philanthropic and professional groups and actively supported by women’ (Brennan, 2007, p. xi). Davis (1988) argues that the emphasis on the home and housewifely tasks was detrimental rather than beneficial to the contemporary status of women. The separation of work and home, and public and private spheres left many women without a stable and constructive niche, making them ‘vulnerable to exploitation by professionals who could claim superior knowledge’ (Davis, 1988, p. 162). Nurses during the first part of the century particularly ‘were reflecting the attitudes and values of their time’ (Brennan, 1998, p. 14).

This next section will detail the child welfare movement in Europe and NZ.

3.3 The European Experience

In 1939, Dr W.G. Armstrong, regarded as the architect of infant welfare in Australia from 1898 until his death in 1941, was compelled to clarify what he identified as many inaccuracies in the perceived origin of the Australian child welfare movement (Armstrong, 1939). His detailed account of the movement informs the following historical section.

For many years, Australia and NZ relied on the health knowledge and education experience of Europe to inform local practice changes. This was applicable to the area of infant welfare, in which mentors from England and more importantly from France, guided the new public health interventions aimed at controlling infant mortality. Dr Pierre Budin Professor of Clinical Obstetrics at the Charity Hospital in Paris in the late nineteenth century established the consultation de nourrissons
establishments (often shortened to consultations). The consultations became schools at which mothers learnt to adequately care for their babies (Armstrong, 1939). The clinics spread throughout England and North America, and were soon followed by the establishment of milk depots, where cow’s milk was modified to resemble breast milk. Mothers unable to breastfeed could purchase the milk at low cost. They were in return expected to bring the infant back on a weekly basis to be examined and weighed. In England, mothers who could not attend clinics were attended at home by health visitors⁴ (Reid, 2001a), who monitored the child’s health and provided health education (Welshman, 1997). These activities provided the foundations for preventive activities in infant welfare around the world, including in Australia and NZ (Bryder, 2003b).

3.4 The Royal New Zealand Plunket Society: Truby King’s Legacy

The review of the birth of the infant welfare movement would not be complete without commenting on the NZ experience.

In 1907 in Dunedin NZ, Dr Truby King, Director of Infant Welfare Services founded the New Zealand Society for the Health of Women and Children⁵ also known as the Plunket Society. King was responsible for the rapid development of a powerful national organisation that spread its teaching across the Tasman. According to Bryder (2001), a social historian at Auckland University (Bryder, 2001), King’s strong leadership shaped a robust model of care for well babies and their mothers that was organised and run by women outside of the medical jurisdiction that was the norm in other Western countries. Unlike Australia, where care was only provided at a low cost to women who deserved it,⁶ or England, where socially disadvantaged women were targeted, the Plunket Services were universal and free to all. The functions of the Society were to provide nurses who had been carefully educated in scientific approaches to nutrition and child care with an emphasis on breastfeeding, to deliver home care to mothers that requested support from Plunket nurses, to run

⁴ According to the Health Visitors’ Association administrative/bibliographical history 1902–1984, the title ‘women sanitary inspectors’ was changed in 1962 to become ‘health visitors’. They came from various professional health backgrounds and the emphasis of their work was public health education. This also involved an element of social intervention.
⁵ In 1980, it officially changed its name to become the Plunket Society.
⁶ Unmarried mothers and working mothers were excluded from welfare services established under the Armstrong leadership.
health clinics for older children, and to provide antenatal care (Bryder, 2003b). The Society owned six Karitane Hospitals, where the establishment of breastfeeding for babies who had feeding difficulties was supported and where nurses received specialist training as Plunket nurses. King’s commitment to educating new mothers, who he believed were fundamentally ignorant in the science of raising children, led him to write *The Expectant Mother and Baby’s First Month* (King, 1923), which was given to all couples applying for a marriage licence. King’s views were essentially to train mothers with fairly simple rules of hygiene and household order. An example of one of King’s rigid regimented parenting schedules is portrayed in Figure 18, taken from Bryder’s (2003b) book on the four-hour feeding clock, which also shows times to sleep, exercise and bath the baby.

![Clock Face for Four-Hour Feeding](image)

**Figure 18. Clock Face for Four-Hour Feeding (Bryder, 2003b, p. 42)**

King’s innovative views of child care and his exceptionally good outcomes for infants who were failing to thrive, crossed the Tasman to Australia, where the first Karitane homes opened in NSW in 1924 (Tresillian) and in Melbourne (Tweddle). In Hobart, the school took the form of a mothercraft home on the Karitane model (Mein Smith, 1997, p. 131). The Plunket Society is still flourishing and leading the care of children in NZ.

In 2007, Plunket celebrated 100 years of operation. An exhibition of archives was held that showed aspects of Truby King’s life and work (Anonymous, 2007, p. 5).

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7 Karitane is a small township north of Duned in where Dr King and his wife owned a house and where they provided care to several malnourished children prior to King setting up the Royal Society for Women and Children in 1907.
Figure 19 is an excerpt from the newspaper article. Plunket (a not-for-profit agency) is the major provider of child and family health services in NZ. They provide both the universal system of child health checks, as well as other community-based parenting services akin to those provided by EPS in Australia. The exception is that they have no residential services in NZ and they have a very solid volunteer program of family support throughout NZ.

Figure 19. Plunket celebrates 100 years (Anonymous, 2007)

The next section will focus on the child welfare movement in Australia.

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8 In 2007, the researcher went to the 100-year celebration of Plunket in Dunedin, NZ.
3.5 The Child Welfare Movement and the Rise of Public Health in Australia

Infant mortality rates indicate the number of deaths of children at less than one year of age per thousand live births in any particular year. It is viewed as a key indicator of a country’s health and is considered to reflect the social development, education and level of wellness of its population. Considering that access to prenatal and postnatal health services and maternal education have contributed significantly to the lowering of infant mortality rates, an examination of the Australian child welfare movement is now described to better understand the developing role of health workers, and especially nurses, in working with families in the last century.

Some of the original reforms emerged in the eastern states of Australia and New Zealand, where the pioneering work of Truby King led NZ to have the world’s lowest infant mortality rate in 1907 (Bryder, 2003a). Originally divided in their approaches to improving infants’ survival rates, Australia and NZ now share a strong collegial partnership and common practices in the field of family and child health.

In researching the historical accounts, there appeared to be some inconsistencies, as the history was informed by original reports and articles that were written by Australian health leaders in the early twentieth century and the work of Australian and NZ historians who researched the development of the child welfare movement in both countries. When faced with apparent contradictions, further information was sought, often revealing the contradictions to be different perceptions of writers who demonstrated great passion and commitment to the improvement of the welfare of children. These authors were faced with multiple challenges and had access to limited scientific evidence. They were also influenced by their professional education9 and had to rely on the European experience to guide them in their fight to achieve necessary social and health reforms.

The first half of the twentieth century continued to be a period in which infants remained a most vulnerable population group, with their chances of survival inseparable from maternal health during pregnancy, childbirth and lactation. According to the NSW Health Department Archives (NSW Health, 1972), the

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9 They came from the diverse fields of public health, obstetrics and even psychiatry.
rapidly increasing urbanisation of Sydney, characterised by lack of sanitary control and sewerage, poor housing and limited and unsafe milk supply, led to an alarming increase in infant mortality. Young children were exposed to malnutrition caused by poor quality or insufficient food and infectious diseases including lung infections and the highly contagious and often fatal summer diarrhoea (Davis, 1988; Featherstone, 2009). Lewis (2003), in his history of public health in Australia, records the infant mortality rate between 1906 to 1910 at 77.6 per thousand births, with a steady reduction to 52 by 1930 (Davis, 1988; Exley, 1932; Lewis, 2003)

The awareness that a great country needed healthy growing children, combined with a significant decline in the NSW birth rate and a high mortality rate led to enough public concern for the establishment of the Royal Commission on the Decline of Birth Rate and on the Mortality of Infants (NSW Parliament, 1904). Several issues of importance were raised by the Commission. Children most at risk came from disadvantaged families, often cared for by mothers who were widowed, disabled through work accidents or unmarried. This last group of women was particularly stigmatised and ostracised, resulting in the abandonment of their infants. The lack of Government family support meant that women worked for low wages with young children left at home to fend for themselves. The Commission also heard about the high rate of abortions, the ill-health of poor mothers, the lack of maternal knowledge and, most of all, the disastrous impact of diarrhoea on infants who were fed with breast milk alternatives, particularly during the harsh summer months (Armstrong, 1939).

The findings of the Royal Commission were disturbing enough to provoke a strong response from various social groups that divided their attention in two broad directions. One group focused on childcare for when the mother was not able or not available to parent the child herself. The day nursery movement is now well established in Australia and is identified as early childhood education. The second group concentrated on the health needs of the mother and the child, which is now the core business of child health nurses. For the purpose of this study, the focus will be
examining the second group only, although Ngala’s origins incorporate both groups.

Various Acts were passed in Parliaments and Public Health departments were set up in Australia so that by the end of the interwar period in 1939 the growth of services included maternal and child health welfare, school health services and venereal disease, tuberculosis and immunisation clinics (O’Hara, 1988).

3.6 Early Parenting Services in Australia

As previously indicated, Truby King established NZ as a model during the 1920s for the training of infant welfare nurses. In three states, the mothercraft homes were modelled on that of Karitane, NZ. The Karitane NSW, Tweddle and Hobart mothercraft homes were adapted to Australian conditions. The nurse trainees were paid a low salary compared to the NZ nurses, and if nurses worked in baby health centres they were paid nothing (Mein Smith, 1997).

By 1920, the infant welfare movement was emerging in most states of Australia, with various Boards and Associations being established to oversee the management of baby health clinics opening in Tasmania, South and WA and Queensland (Kitchens, 2005a). Each state adopted different pathways to establish family and children’s services that reflected their political, health and social requirements, but a detailed examination of each individual state (other than WA) would be beyond the scope of this thesis. A description of the development of EPS in each State will be given and similarities and differences presented where possible.

The traditions of EPS were a part of the early child welfare movement and often a precursor was developed alongside the setting up of infant welfare clinics. Many were driven by women’s or church organisations. Organisations were often labelled ‘Homes’ (Lang; 1992) as was the case for Ngala, commencing as the House of Mercy. In Victoria, there was a ‘Centre’ and ‘House’, ‘Riversdale’ or Hospital; in SA, a ‘House’; and in Tasmania, a ‘mothercraft home’ (Blundell, 2009; Brennan, 2007; Crockett, 2000; Kane, 1980).

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10 The curricula for early childhood education and child health nursing share several fields of knowledge, which indicates a strong overlap in the expected competencies of these professional groups.
Many of these homes were also part of the training of mothercraft and infant welfare sisters (child health nurses) until the transition of nursing training to the tertiary sector during the mid-1970s. Mothercraft training ceased in Victoria in 1978, and ended in WA during 1989.

It is interesting to note that the infant welfare movement was supported very strongly by community advocates, volunteers (mostly women) and fundraising. Queensland was an exception, where voluntary work or financial assistance was discouraged by government (Selby, 1992; Thorley, 2000)

3.7 The NSW Experience

3.7.1 The Organisation of Baby Health Clinics

In 1903, Armstrong was the medical officer to the metropolitan combined district and city of Sydney. He was strongly influenced by Budin’s work but had reservations about the real benefits of milk depots. Armstrong initiated a broad systematic public health campaign that differed from the French model of setting up milk depots. He chose the alternative of educating women in the skills of mothercraft and the importance of breastfeeding. One of his first undertaking as medical officer of health was to develop a broad education campaign for Sydney’s new mothers:

... I had previously (in 1903) issued a brief pamphlet of ‘advice to mothers’, a copy of which I had sent to every address in the city at which a birth had been registered. (1939, p. 642)

In 1904, Armstrong trained the first health home visitor to instruct new mothers about the art of successful breastfeeding or, should breastfeeding not be possible, about the safe preparation of artificial feeds, about personal hygiene and clean environment. Over the following 10 years, he continued his public health campaign and kept meticulous data demonstrating a 50 per cent decrease in infant mortality

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11 Baby health clinics replaced the terms baby clinics or infant consultation centres that were used between 1914 and 1918. This change in terminology coincided with the establishment of a coordinating body responsible for all community clinics attended by mothers and well babies. In 2009, Child and Family Health Clinics (or Child Health Centres) replaced the baby health clinics, reflecting a redirection of health services from child to family. This terminology is not consistent throughout Australia.

12 Historical writings do not indicate whether the health home visitor had a nursing background. All health home visitors are now registered nurses (Gimson, 2007).
rate (110 to 68 per 1000) and an increased breastfeeding rate from 72 to 94 per cent by 1914 (1939, p. 644). As the number of health home visitors increased, the care of mothers and infants became more systematic and organised with a series of complementary programs developing around Sydney.

The NSW infant welfare movement continued to grow and expand. An outpatient department opened at the Royal Hospital for Women, Paddington in 1905. Children born in the hospital could be monitored until two years of age. As new hospitals were built, more outpatient services for mothers and babies opened. This program was followed by the opening of community clinics independent from hospitals. Three ‘Schools for Mothers’ were established solely for the purpose of educating mothers who were perceived as lacking natural instinct. In 1914, the schools were replaced by the first baby clinic at Alexandria followed by clinics in other disadvantaged industrial areas such as Glebe, Newtown and Woolloomooloo. By 1918, 28 clinics were open. Clinics were also opened in Newcastle, a mining city in the Hunter region, in response to its high level of poverty, diseases and consequent high infant mortality rate. Broken Hill was the first country town to see the establishment of a baby clinic in 1918 (O’Connor, 1989b). Soon home visiting became integral to the role of nurses employed in outpatient departments and clinics, as it was noted that mothers from the most disadvantage backgrounds did not attend the clinics following the initial home visit in the first week of delivery. The nurse’s role also expanded to include advice to pregnant women and planning for their oncoming childbirth experience in hospital.

The public health campaign that from its inception had targeted disadvantaged families by 1920 had expanded to include all women irrespective of their socioeconomic background. The NSW Early Notification of Birth Act that took effect in 1915 ensured that the nurses were made aware of all births in their geographical area. The infant welfare movement had mushroomed to become a complex network of clinics, outpatient departments and charitable organisations, all committed to improving the health of babies. Coordination of the network was imperative.

In 1914, after extensive consultation, the Minister of Public Health established the Baby Clinics, Pre-Maternity and Home-Nursing Board. The Board was responsible
for the overseeing of the overall care of the woman and child from pregnancy until two years. The Board determined the structure, the governance, the clinical role of the staff and the definition of referral pathways.

At the 1918 Conference on the Welfare of Mothers and Babies in Sydney, the Minister of Public Health the Honorary J.D. Fitzgerald announced the establishment of the Society for the Welfare of Mothers and Babies.\textsuperscript{13} The society was incorporated in an Act of Parliament in 1919. Its function as a coordinating body also included responsibilities such as seeking public funds, providing direct intervention to mothers and sick children and most importantly managing the postgraduate mothercraft nursing education for NSW. In 1919, the members of the Baby Clinics, pre-Maternity and Home-Nursing Board joined the Council of the Society.

To guide the examination of the movement in both NSW and Victoria, two main texts were used: Our Babies the State’s Best Asset—\textit{A History of 75 Years of Baby Health Services in New South Wales} (O'Connor, 1989b)\textsuperscript{14} and Heather Sheard’s Master’s thesis \textit{All the Little Children—The Story of Victoria’s Baby Health Centres} (Sheard, 2007). While telling a similar story to that of NSW, Sheard gives an account of the slow-to-develop movement because of it limited coordination and the conflict of ideologies.

\subsection*{3.7.2 Tresillian and Karitane in NSW}

\textit{Tresillian} was established in Petersham in 1921 by the Royal Society for the Welfare of Mothers and Babies, with the assistance of government funds (O'Connor, 1989a). Dr Margaret Harper was a Paediatrician committed to the infant welfare movement and wrote the ‘\textit{Parents Book}’ (a standard text in mothercraft) in 1926. Tresillian trained many nurses from around Australia. Tresillian expanded centres in Sydney that would accommodate special wards for premature babies. In 1956, Tresillian became involved in the production of educational films for parents, students, teachers and nurses, the first being ‘\textit{Care of the Premature Baby}’ and ‘\textit{The Natural Feeding of Infants}’. These films received awards from international film associations (O'Connor, 1989a, p. 83). During the 1950s, the nurse’s role broadened to include

\begin{footnotesize}
\textsuperscript{13} In this thesis, the Society for the Welfare of Mothers and Babies is also referred to as the Society. The Society still exists but is commonly referred to as Tresillian Family Care Centres.

\textsuperscript{14} Written at the request of the NSW Health Department to celebrate 75 years of service.
\end{footnotesize}
antenatal care and a look at the family, with more of an emphasis on the education of parents. Over time, the role again broadened to include interactions with the mother and its effect upon child development, emotional development and behaviour patterns in young children (O'Connor, 1989a, p. 84).

Harper was known to have adapted the Truby King Karitane training model in the early days to the ‘conditions and climate of Australia’, which was criticised by Truby King (O'Connor, 1989a, p. 35). The followers of Truby King formed the Australian Mothercraft Society (Karitane) and set up separate establishments in NSW.

Karitane Mothercraft Home was opened in 1923 (Ashton, 2009) and provided mothercraft and infant health training for registered nurses and midwifery nurses. The aim was ‘to help the mothers and save the babies’ (O'Connor, 1989a, p. 37). Reasons for admission included:

- Mothers had been admitted with babies to increase or regulate the flow of breastmilk, and to learn about feeding and mothercraft. Babies were admitted suffering from malnutrition from weaning too early, wrong feeding and management. The Society promoted breastfeeding as the best feeding option. (O'Connor, 1989a, p. 36).

Karitane expanded with clinics around the city and products were also manufactured and sold by the Karitane Products Society. The Australian Mothercraft Society was a voluntary organisation and its income was derived from the fees of mothers and students, donations and annual subscriptions. It did not receive government assistance until the 1970s (O'Connor, 1989a). The educative role of the Society has been well known since its establishment. In the 1930s, the Society gave weekly talks on mothercraft over the radio. The Truby King Clinics grew from just one in 1930 to 10 full-time clinics at their peak of activity in 1948. In the 1960s, Karitane received financial assistance from the state, and since this time has increasingly relied on funding from the government (Ashton, 2009).

In 1976, Tresillian and Karitane developed a joint curriculum for mothercraft nurses. Tresillian and Karitane have been influential centres, both in NSW and around Australia.
3.8 The Victorian Experience

While high infant mortality rates were shared by all states, the infant welfare movement did not expand simultaneously or uniformly around Australia. Victoria’s infant health movement had its origins within both the local councils and the women’s committee, The Victorian Baby Health Centres Association (VBHCA) (Mein Smith, 1997).

Similarly to Sydney, Melbourne experienced a rapid expansion of its working-class suburbs and the infant mortality rate reached 87 per 1000 births in 1912. Babies and children of unwed mothers were most at risk, as they were frequently weaned early. In her account of the infant welfare movement in Victoria, Flood (1998) reports that even though Victoria shared the NSW’s concern of an alarming increase in the infant death rate, it chose a different approach. Whereas Armstrong advocated for the mass education of all mothers about breastfeeding, general hygiene and sanitation, his counterpart in Melbourne, Dr A. Jeffrey Woods, Medical Officer at the Children’s Hospital, focused on the treatment of sick children and the availability of clean safe milk. Following intense lobbying from Woods, the Lady Talbot Milk Institute was established in 1908. However, this initiative was not sufficient to produce the expected far-reaching effect that the provision of mothers’ education generated.

In 1917, the first baby health clinic, staffed by one welfare nurse and supported by women volunteers, was finally opened. By 1918, nine more clinics staffed mainly by volunteers were established in Melbourne’s industrial suburbs. This rapid expansion of welfare services\(^{15}\) required funding and coordination; the VBHCA was formed in 1918, followed by the establishment of a second infant welfare organisation with its own baby health centre in Coburg. The Society for Health of Women and Children of Victoria (SHWCV) was also inspired by the work of Truby King and it followed his strict instructions rigorously. The work and influence of Truby King on child-rearing practices and nursing education has been described in Sections 3.4–3.6. This influence was widely felt throughout Australia and NZ.

\(^{15}\) The original Victorian ‘welfare services’ are now called Maternal and Child Health Services.
3.8.1 Queen Elizabeth Centre, Tweddle and the O’Connell Family Centre

During the early twentieth century, baby health centres were being developed, as were three mothercraft institutions in Victoria. The Carlton Refuge Home 1854–1949 was a refuge for young pregnant girls (Crockett, 2000), similar to the House of Mercy in WA. Due to declining numbers of young women requiring this service, the Home was closed, and transferred in 1950 to the VBHCA, which refurbished the establishment to house the VBHCA training and mothercraft facilities. In 1951, it was named the Queen Elizabeth Maternal and Child Health Centre and later the Queen Elizabeth Hospital for Mothers and Babies (Crockett, 2000). It is now known as the Queen Elizabeth Centre, and moved from Carlton to a newly built site at Noble Park in 1998.

Joseph Thornton Tweddle (1865–1943) financed the establishment of the Tweddle Hospital for Babies and School of Mothercraft as the training centre for Plunket and Primrose nurses. The hospital opened in Footscray in 1920 (Tweddle Child & Family Health Service, 2011). The only historical resource available on Tweddle is a memoir by a mothercraft nurse (Blundell, 2009) who worked on and off at Tweddle from 1945 to 1960. Blundell (2009, p. 3) states that the Society for the Health of Women and Children of Victoria was managing Tweddle when she commenced work there in 1945.

The Mercy O’Connell Centre was established by the ‘Grey Sisters’, particularly Maude O’Connell, a teacher, social worker and nurse, at Daylesford House in 1931. It was established as a training school of social service and mothercraft, and was embedded in the work of the Company of Our Lady of the Blessed Sacrament Grey Sisters (that is, nuns) (Edman, 2010; Kane, 1980). The Grey Sisters trained in mothercraft and advocated for disadvantaged families with young children in the home environment (Kane, 1980). Lectures and demonstrations were conducted by a registered infant welfare sister (Edman, 2010). By 1945, the purpose of the work was in three distinct areas: practical care of mothers and children, training for marriage and motherhood, and extension work in parent education (Edman, 2010, p. 76). In 1975, the centre was registered as a public hospital, and in 1990, the Grey Sisters Mother and Child Centre was incorporated and became the O’Connell Family Centre.
Centre, an EPS. In 1997, the Sisters handed over the management of the Centre to Mercy Health and Aged Care.

3.9 The Queensland Experience

The first baby clinic opened in Queensland in 1913, followed by three further clinics by 1918 resourced by the State Government. Nurse Ellen Barron was a strong advocate of the concept of a mothercraft home, and from 1924, the Valley clinic operated some live-in facilities and training for nurses (H. Murphy, 1963). With the help of other nurses and an Honorary Paediatrician as medical advisor, the growth of clinics continued (McFarlane, 1968). In 1922, Barron undertook the Karitane course in NZ, studying under Dr Truby King. Upon her return to Queensland, she implemented four-month infant welfare training courses twice a year in Fortitude Valley.

McFarlane (1968) notes that the work of the early clinic sisters was subject to a great deal of criticism and general hostility, both from some in the community and from higher profile people. However, important advances were also made, and from 1929 a rail car equipped as a baby clinic with a lecture room and staff accommodation travelled to the West of the State and ‘helped educate mothers in the principles of infant care’. This initiative was supported by the Country Women’s Association (McFarlane, 1968, p. 3). This had the benefit of expanding centres over time through rural areas, until the onset of the Depression. The infant death rate had halved during this period, largely attributable to the work of the Department of Health (McFarlane, 1968).

The purpose of these mothercraft facilities was to provide support for mothers of breast fed babies to be in residence with their babies and learn how to manage them; the average duration for this was three weeks (McFarlane, 1968, p. 9). In 1942, the first Mothercraft Home opened at St. Paul’s Terrace and then in 1943 this was followed by the Home in Riverton Street at Clayfield (Berry, 2012a). Other Homes subsequently opened in Toowoomba (1947), Ipswich (1952) and Rockhampton (1952) (McFarlane, 1968). A Home in Sandgate opened in 1944, specially catering for the care of children up to 12 years of age while their mothers were in hospital. This Home ran until 1961 (McFarlane, 1968).
In 1968, Queensland had 280 clinics (McFarlane, 1968). These mothercraft facilities evolved separately to the Queensland nursing homes that cared for ‘illegitimate children and children of destitute mothers’ in the early twentieth century (Selby, 1992, p. 379). In 1920, there were 78 registered nursing homes caring for 193 children; by 1957, the number of homes registered had fallen to 33 (Selby, 1992, p. 391).

Three main resources were available to describe the history of the infant welfare movement in Queensland. McFarlane (1968) provided a brief account of the historical phases, outlined the achievements of many key nurses and change agents and listed the centre locations up until 1968. Selby’s (1992) thesis studied the period 1915–1957, looking at the impact of legislation and polices on motherhood. Thorley (2000) focused her study on the period 1945–1965 and explored women’s experience of infant feeding advice received from the baby clinic system in the context of the time. In addition, Health Department report documents revealed much about the experiences of Mothercraft Homes over time.

As at 1966, the six mothercraft homes mentioned above (that is, at St Paul’s Terrace, Clayfield, Sandgate, Toowoomba, Ipswich and Rockhampton) continued to operate. It was noted that at the Sandgate Home:

> The problem of caring for children of mothers who are suffering from nervous disorders is becoming difficult owing to the length of time these children have to remain in the Home … average duration of stay … five weeks. (Queensland Department of Health, 1966, p. 31).

As at 1971, a new Clayfield Home was under construction to accommodate more babies. Figure 20 gives the admission statistics for five Homes in Queensland for 1969 and 1970.
As at 1986, three mothercraft homes existed, at St Pauls Terrace (Fortitude Valley), Clayfield and Ipswich, serving the needs of the community in the provision of residential care for families. Reasons for referral included feeding problems, parents seeking assistance in parenting skills, behavioural problems and family dysfunction. These Homes also undertook the training of child health nurses and child health assistants (Queensland Department of Health, 1986, p. 32). By 1991, families throughout Queensland accessed services at two Mothercraft Centres operating at Clayfield and Fortitude Valley, with an average length of stay of 7–14 days (Queensland Department of Health, 1991, p. 22).

From the early 1990s, Health Department reports were unavailable. There appears to be a gap of information in relation to the slow demise of family and children’s health services in Queensland. The mothercraft centre in Riverton St at Clayfield became the Ellen Barron Family Centre when the Riverton operations were moved to a new site in May 2007 (Berry, 2012a). The Ellen Barron Family Centre is now a residential service only. Other services, for example day stay are managed by the government universal community child health service.

### 3.10 The ACT Experience

Although the ACT EPS, the Queen Elizabeth II (QEII) Family Centre, did not participate in this study, a brief outline of their experience is presented here. The Canberra Mothercraft Society (CMS) commenced in 1926 when Canberra was a very young city. The people working within the new national capital often had no support from their extended families. The main focus of the Society in its early days was the

**Figure 20. Admission statistics 1969–1970 (Queensland Department of Health, 1971, p. 31).**
welfare of mothers and babies, but this has since evolved to include all partners, grandparents and other primary carers. Since 1926, CMS has brought Mothercraft Clinics, Home Help, Playgroups and Occasional Care Centres to the families of the ACT. Today CMS operates a diverse range of services including GrandJugglers, Relaxing into Parenting and the QEII Family Centre (Canberra Mothercraft Society Inc., 2012). The QEII Family Centre is classified as a public hospital (Canberra Mothercraft Society Inc., 2012).

3.11 The South Australian Experience

In 1909, Dr Helen Mayo, along with some women who shared a common concern for social problems, established the School for Mothers in Adelaide, which would eventually become Child and Youth Health. This School was instrumental in improving infant nutrition and hygiene. It promoted breastfeeding and instructed mothers who were unable to breastfeed in safe artificial feeding. Mothers also received support and advice in the treatment of minor problems and illnesses (Child and Youth Health, 2011).

The infant welfare movement in SA was advocated for and by women. Baby Health Centres were established in areas of high infant mortality with very little support from government. The first centre was opened in 1913 (Mein Smith, 1997), and by 1926 there were 39 clinics (Child and Youth Health, 2011). The School for Mothers in Adelaide became the Mothers and Babies Health Association in 1927 (Kitchens, 2005b) and set up Torrens House, a residential training school, in 1938 (Mein Smith, 1997). Other milestones were the introduction of the first baby health train servicing country areas (1931), the introduction of a correspondence section to assist isolated mothers (1935) and an ever-expanding preventive health service in the city and country areas. All of these combined to give SA the lowest infant mortality rate in the world in 1937. Over time, the declining birth and infant mortality rates and a reduction in the incidence of serious childhood infectious disease have reorientated services away from survival in childhood, to quality of life, parenting issues, prevention of illness and health promotion. These are the basic concepts of child health services today, with the development of a range of child health and parenting programs (Child and Youth Health, 2011).
3.11.1 Torrens House

A document providing some history of the Mothers and Babies Health Association was printed in 1959 (The Mothers & Babies Health Association Jubilee, 1959). It gives a brief summary of the Association’s key events. This facility initially provided accommodation for ‘five mothers, two premature babies, six babies and one toddler, for five infant welfare trainees and two mothercraft trainees, in addition to a matron, sister and domestic staff’. The establishment and continuation of breastfeeding was the most important part of the teaching at Torrens House, and many mothers were transferred directly to the House from the maternity hospital (The Mothers & Babies Health Association Jubilee, 1959, p. 26).

3.12 The Tasmanian Experience

In Tasmania, the first infant welfare centres commenced in 1918 in Hobart and Launceston and were strongly supported by women’s organisations, particularly the Child Welfare Association (CWA). At its formation in 1917, the CWA’s aim was ‘to provide facilities to help women before and after birth and to reduce the infant death rate’ (Brennan, 2007, p. 17). ‘[T]hrough fundraising, work circles, education and deputations to government, the Association was able to extend its work to projects ranging from the supply of pure milk to the organisation of school classes in mothercraft and infant hygiene’ (Waters, 2006). Photo 23 is of a mother in 1912, followed by the statement of desire of the CWA.

‘A mother and child in 1912: This was the ideal the child welfare movement wished for every baby’ (AOT, PH30/1/4988)

The Government paid for the nurses’ salaries and the CWA worked very closely with the nurses in the centres, supporting the nurses and the providing of material support for mothers (Brennan, 2007, p. 17). Brennan’s book, The Fence on the Precipice: Child Welfare Nursing 1918–1930, provided a rich history of child health nursing during this period, and particularly of the experience of one nurse activist, Myrtle Searle, who worked in Launceston. Brennan describes the role of nurses during this period as follows:

Child welfare nurses reached out to all the women in the areas in which they worked. They tried to reach as many pregnant women as possible and then after babies were born they visited them at home. They taught school-girls and girl guides, a future generation of mothers, as well as women’s groups. They spoke on local radio stations, after these were established in the 1920s, and wrote weekly articles for newspapers for Hobart and Launceston. They maintained a large and apparently growing correspondence with countrywomen and encouraged women to the centres by the provision of pure milk at minimal cost. (Brennan, 2007, p. 37)

3.12.1 Three Parenting Centres

The CWA, with the assistance of government grants, established the Hobart Mothercraft Home in 1925. The purpose of the home was to train nurses in child welfare and to provide a home for the teaching of mothercraft for mothers in residence. The hope was to help mothers to continue breast feeding (Brennan, 2007, p. 19). The State Government in 1947 assumed control of the Mothercraft Home, which had become a financial drain on the CWA (Brennan, 2007). The Government entered into a formal agreement with the CWA of Hobart (known as the Child Health Association since 1951). Like most States in which women in voluntary organisations were supporting child welfare organisations, the CWA’s intent was to work politically for the welfare of mothers and children and to assist in the reduction of infant mortality (although Tasmania’s infant mortality rate was lower than that in other states) and the suffering of women and children as a result of poverty and ignorance (Brennan, 2007).
In 1970, a Child Health nurse in Tasmania (see Figure 21) wrote the following about working mothers in the community in her assignment undertaken as part of the Child Health course at Hobart Mothercraft Home (Ducrow, 2011).

![Figure 21. Child Health Nurse’s Assignment 1970 (Ducrow, 2011)](image)

In 1990, the Beveridge report recommended the coming together of Child Health, School Health Services and the Mothercraft Home in Tasmania. The combined service became known as the Family and Child Health Service. During the early 1990s, the Mothercraft Home was decommissioned and three parenting centres (day stay centres) were established in Hobart, Launceston and Burnie. At the time of decommissioning, the Mothercraft Home provided accommodation (18 beds) and assistance to infants and mothers experiencing difficulties in parenting, as well as to infants requiring emergency crisis accommodation or respite care. There was also a 24-hour state-wide telephone service (Shaw, 2011).

The researcher worked in the Family and Child Health Service (Northern Region) from 1990 to 2004, from the beginning of the changes in Tasmania. In the early 1990s, a feasibility study was undertaken both in the North and Northwest regions, to identify the location of each day stay parenting centre facility and their model of practice. To this day, the Child Health Association remains very active within
Tasmania and works collaboratively with State Government as an advocacy body on behalf of parents with young children in Tasmania (Murphy, 2012, p. 2).

3.13 The West Australian Experience

Ngala was initially named the ‘House of Mercy’. It was established at a time of change in WA history, with the 1890s gold rush creating increased immigration and a subsequent rise in infectious disease, for which the State was unprepared (Hobbs, 1980). Planning commenced in the early part of the next century for the establishment of a maternity hospital by key community members in Perth, including the matron of the House of Mercy. It was noted by Reverend Kench in 1909 that with ‘the good work being done by the House of Mercy amongst single women, we should be conferring with the principals of that Home in regard to the proposed maternity hospital’ (Hobbs, 1980, p. 17).

The Commonwealth introduction of the Maternity Bonus occurred in 1913. This gave young women more choice in where they stayed for their confinement, and the numbers at the House of Mercy fluctuated accordingly (Lang, 1980). The transition of name change from the House of Mercy to the Alexandra Home for Women came at the same time as the opening of the KEMH in Perth. A pattern of interchange between the two facilities soon emerged for the girls for their confinement and then the birth of their baby (Lang, 1980).

During the first two decades of the twentieth century, Dr Roberta Jull was a champion for the infant welfare movement in WA, both at Ngala and with the Infant Health Service in WA. An infant welfare course was initiated at KEMH in 1927 after the then Matron, Agnes Walsh, visited Tresillian in Sydney to undertake the training. The course was recommended by the Infant Welfare Association in a report to the Minister and was approved to run at KEMH and to be incorporated into the Infant Health Clinic for the Subiaco area. It appears that this course was discontinued in 1946 (Hobbs, 1980), leaving a 13-year gap in courses offered in WA until Ngala began offering courses in 1959.

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16 Roberta Jull (1940) undertook a summary of the history of Ngala by writing a précis of the minutes of meetings from 1890–1915 as well as a story of the Alexandra Home.

17 This initiative was not without politics from male medical representatives, who saw the infant welfare nurse as a threat to their practice (Hobbs, 1980).
Infant health centres were established from 1922 to assist in the movement to reduce morbidity and mortality and to teach mothers health and hygiene and promote breastfeeding (Hobbs, 1980). By 1949, extensions to Alexandra Home had been built and they had commenced training for mothercraft nurses (Lang, 1980). Planning for a new, larger facility began in the 1950s. The new building, Ngal-a Mothercraft Home and Training Centre, was launched in 1959 at Kensington and became a training facility for the infant welfare certificate. Ngala continued with accommodation for pregnant young women and out-of-home care for children up to five years of age. Preparation for parenting was given by nurses to families adopting children from Ngala. The care for mothers and children undergoing stressful parenting difficulties was maintained in a residential mother and baby unit (Lang, 1980). It was noted by Lang (1980, p. 82) that ‘many of the problems encountered in the early years of the home were fundamentally the same as those of today but the approach to them and the means of dealing with them are very different’ (p. 82).

In 1963, the mother of every new baby was visited by the infant health sister in her district as soon as possible after birth, and country mothers were written by the Service (Hobbs, 1980). The 1960s and 1970s saw strong participation in both child health and mothercraft training programs at Ngala, until the transfer to the tertiary sector during the 1980s. From this time, Ngala entered into a new phase of parenting services in the WA.
Photo 24. Nursing photos from Early Parenting Services 1950s–1960s (National Archives of Australia, 2012)

Barcodes in order: 7587335, 8925298, 11969374, 11868659, 8939921, 30922363.
3.14 History of Nursing at Ngala

Ngala is one of the oldest charities in WA. It has a long history, having commenced as the House of Mercy in 1890. The House of Mercy became Alexandra Home for Women in 1916, and a further name change, to Ngala, occurred in 1959. The period 1959–1980 was also of key importance to the history of Ngala; and the 1980s are worth discussing separately as a time of turbulence. From 1989 to 2011, the period leading up to the present day, is also described in this section. These time periods were identified because they fit with the name change of the organisation and its key periods of leadership. The nursing history at Ngala was gleaned from a range of documents archived at Battye Library in Perth and at Ngala. This comprehensive collection included minutes from Committee meetings, matrons’ records, nursing reports, annual reports, oral histories from nurses and Committee members, correspondence, recorded histories, constitutions, diaries and reviews/reports.

From the investigation of these records, two streams were identified, and both have been integrated into the periods over time:

1. Key milestones of history; and
2. Nursing milestones and recordings of the role of the nurse (in the context of nursing in WA).

These milestones have been captured in a visual timeline, presented in Appendix 7.


The House of Mercy was founded in 1890 (see Photo 25) by an Association for the establishment of ‘a Refuge for fallen women in Perth’. The instigator of the first meeting was a Reverend J. Young Simpson. A committed group of women, chaired by Lady Doyle, continued to develop and run the House of Mercy (Lang, 1980). The name ‘House of Mercy’ was chosen because:

The name reflected the attitude of many members of the committee, towards girls and women who had strayed from the path of moral rectitude; they had done wrong but were to receive the help of what they stood in need. (Jull, 1940, p. 1)
The House of Mercy was established during a time of turmoil in the history of WA, with the 1890s Gold Rush to the eastern goldfields resulting in increased immigration and infectious diseases. Hospital governance commenced with the passing of the first Hospital Act of 1894 in Parliament, which brought in regulations around hospitals and boards of governance (Hobbs, 1980).

A Matron was engaged to run the Home. She was not a certified midwife, so a doctor was called in for births (Jull; Lang, 1980). It was not until much later (1911) that midwives were called in to assist. Young women were admitted during their confinement, up to the child being six to nine months if required (Lang, 1980). The first note of a ‘probationer nurse’ being employed was 1907 (Mattinson, 1970). An Infants Home in connection with the House of Mercy was opened in 1904, which employed untrained nursing staff for the purpose of caring for the children. The purpose of the Home was to care for children ‘for a small fee, after their mothers had obtained situations and left the House of Mercy, as the boarding out system had in so many cases meant death of the children’. These children were often ‘malnourished, sick and/or convalescing’ (Lukin, 1904, p. 1). Volunteer women would come in to assist with the running of the home (Lukin, 1905).

A fee was charged wherever possible at the House of Mercy and some young women were able to help with the running of the Home or perform laundry work, with the Home taking in laundry from private hospitals and families. The Home was registered as a laundry during the year 1900 (Lang, 1980).
Excerpts from the Matron’s diaries 1894–1904 gave examples of young women or babies having infectious disease such as typhoid fever. The doctor visited each day. Women and babies often died in the home due to infections or neglect. Volunteer women would come in to assist with the running of the home. A report in 1905 stated:

The Matron reported the death of two babies Harold Edward and Billie Nottle on Jan 28th. They both died of consumption of the bowels although something possible had been done to save them both by the Doctor and Nurses. An Assistant nurse had to be engaged early in the month as all the children were ill and there was no help available from the House of Mercy. (Lukin, 1905)

The establishment of a maternity hospital was in planning by key community members in Perth, including the matrons of the Perth Hospital, House of Mercy and Children’s Hospital (opened in 1909, see (Piercey, 2006), as well as eminent doctors and high profile community members, including the clergy. A committee was established in view of the debate at the time about whether the Hospital should service both ‘married and single women’. It was noted by Reverend Kench in 1909 that with ‘the good work being done by the House of Mercy amongst single women, we should be conferring with the principals of that Home in regard to the proposed maternity hospital’ (Hobbs, 1980, p. 17).

The following Figures 22–25 are annual reports from the House of Mercy from 1911–1914. Figure 22 highlights the Matron’s position on the Midwifery Board of WA and the difficulty in being able to recruit ‘probationer nurses’. It also alludes to the potential amalgamation of the House of Mercy with the proposed maternity hospital. This was not agreed to by the Committee. Figure 23 highlights the cases that were admitted each year and the services of the Matron.
The House of Mercy Association

REPORT
FOR YEAR ENDING 31ST OCTOBER, 1911.

Record of Cases. During the year twenty-seven cases have been admitted to the House of Mercy, including six married women, who were unable to pay the usual maternity fee. Four of the cases were admitted under the arrangement with the Government, by which two beds are reserved for emergency cases, and are in stock to his humanity. Twenty-five infants have been born, of these two were still-born, and two died—one a premature birth, the other was malformed. Three were at one time in the hospital. Three girls were married during the year. The number of cases shows that these still need the House of Mercy to continue the good work which it has carried on heretofore so quietly and successfully.

Matron. The Matron (Mrs. Harris) still continues to give the Committee every satisfaction, both in her maternity work, and in the economical management of the institution. During the four and a half years in which she has occupied her position, 99 cases have passed through her hands, and under her supervision, the infants have made good recovery. Of the infants born during that period five were still-born, one prematurely born (clouded four days), and two died in hospital from congenital malformation. In September, she left the institution in good health and condition. This is a record which reflects the greatest credit on the Matron, and fully justifies her appointment as one of the members of the Board of Directors of the Mercy Women in this State, which has recently been created by the Government. The Matron has been congratulated upon having such an efficient Matron. During Matron's term of office of 1911, the inmates have been married.

Behaviour of Inmates. On the whole, the inmates have been well-behaved, though, as might naturally have been expected, some of the girls have given a little trouble; the Matron's firmness and kindness, however, has been all that

has been required, and many of the girls have been very grateful for the relief extended to them by the House of Mercy in their hour of need, and they have prevailed upon subsequent behaviour, that "they have been more staid against than active.

Visitors. The Rev. Archdeacon Holdfast has continued his visits to the inmates, but no additional visits have been made. It may not be generally known that the clergy of all denominations are at liberty to see the inmates belonging to their churches, at any time, and that their visits are both welcome and valuable. The thanks of the Association are hereby tendered to the Rev. Archdeacon Holdfast for the kindly interest which he has shown in the inmates. The very few visits which have been during the year, and the members of the House of Mercy Association do not seem to realize that this good which they can do by visiting the inmates occasionally and heightening the shadowed lives of the inmates by a few kind words.

Probationer Nurse. It has been found impossible to secure a suitable Probationer Nurse to assist the Matron, as the time served in the House of Mercy, unfortunately does not qualify as a part of the Midwifery training for Maternity Nurses, recognized by the Board. The Committee intend to deal with this matter during the coming year, to see if anything can be done to remove this difficulty, on the practical training under Matron Harris, or at the highest of all denominations.

Church Street Property. The Church Street property has been sold during the year, and the sale resulted in £96 6s. 6d. being added to our funds.

Finances. The financial affairs of the House of Mercy are in excellent order, as appears in the Financial Statement submitted by the Treasurer.

EEEF from the Paddley Estate. Under the Paddley Estate, the House of Mercy has received considerable sums from which a first payment has been made amounting to £790 9s. 6d. Out of this amount a sum of £326 (principal and interest), has been paid to the trustees of the Estate of the late Lady Hadfield, and the payment has finally extinguished all the debt on the House of Mercy. The Committee are carefully considering what it is best to do with the remainder of this legacy, in order that it may be of permanent benefit to the institution.

King Edward Memorial Hospital. The proposal to amalgamate the projected King Edward Memorial Maternity Hospital, which has been approved by the House of Mercy Association, has not been carried out, and as present

Figure 22. Annual report 1911

THE HOUSE OF MERCY ASSOCIATION.

REPORT
FOR YEAR ENDING 31ST NOVEMBER, 1912.

Record of Cases. During the year twenty-three cases have been admitted to the House of Mercy; of these, three were married women who were not able to pay the usual maternity fee, and three were emergency cases, who were admitted under the arrangement with the Government, by which two beds are reserved for such cases, until the erection of the proposed Government Maternity Hospital. Twenty-five infants have been born in the Institution of these, one was stillborn, and one died in the Infants' Home Hospital, it having been born with Hope and Optimism. The House of Mercy is still needed, as the record of cases proves, and every effort has been made to fulfill its main object, which is to reform girls who have fallen for the first time, and to enable them to resume the path.

Matron. The Matron (Mrs. Harris) still continues to give the Committee every satisfaction, both in the economical management of the Institution and in her kind hearted efforts which she exercises over the inmates. In view of the fact that the amount of her salary has been increased by £10 per annum as long as positions were vacant, it is difficult to allow her to survive of, probably, the best Maternity Nurse in Western Australia. We are now on holiday, Nune Wills took her place and gave every satisfaction to the Committee.

Behaviour of Inmates. The inmates, on the whole, have been well-behaved, and many have been grateful for the help given to them by the House of Mercy, and some, we have reason to believe, are entering to live virtuous and upright lives.

Visitors. The Rev. Archdeacon Holdfast has continued his visits to the inmates, but no additional visits have been made. It may not be generally known that the clergy of all denominations are at liberty to see the inmates belonging to their churches, at any time, and that their visits are both welcome and valuable. The thanks of the Association are hereby tendered to the Rev. Archdeacon Holdfast for the kindly interest which he has shown in the inmates. The very few visits which have been during the year, and the members of the House of Mercy Association do not seem to realize that this good which they can do by visiting the inmates occasionally and heightening the shadowed lives of the inmates by a few kind words.

Probationer Nurse. It has been found impossible to secure a suitable Probationer Nurse to assist the Matron, as the time served in the House of Mercy, unfortunately does not qualify as a part of the Midwifery training for Maternity Nurses, recognized by the Board. The Committee intend to deal with this matter during the coming year, to see if anything can be done to remove this difficulty, on the practical training under Matron Harris, or at the highest of all denominations.

Church Street Property. The Church Street property has been sold during the year, and the sale resulted in £96 6s. 6d. being added to our funds.

Finances. The financial affairs of the House of Mercy are in excellent order, as appears in the Financial Statement submitted by the Treasurer.

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King Edward Memorial Hospital. The proposal to amalgamate the projected King Edward Memorial Maternity Hospital, which has been approved by the House of Mercy Association, has not been carried out, and as present

Figure 23. Annual report 1912
Figure 24 describes the various donations made to the House of Mercy, and the services of the medical officer.

Figure 25 highlights the impact of the maternity bonus and the case of the death of a woman at the House of Mercy.
The Commonwealth introduction of the Maternity Bonus occurred in 1913. This gave young women more choice in where they stayed for their confinement; the numbers of women choosing to stay at the House of Mercy rose accordingly (Lang, 1980). In 1914, there was a well-documented emergency case of a woman dying of a ruptured uterus, known as ‘The Bellevue Case’. Although the House of Mercy was exonerated, the case was presented in the Press, and it demonstrated the need for a fully equipped maternity hospital (Lang, 1980, p. 34).

Infant mortality attracted much public attention in WA during the first two decades of the twentieth century. This period saw a far greater incidence of infant death in WA than in any other State in Australia, predominantly attributable to the Gold Rush. Death mostly occurred in younger infants, with the major causes being congenital debility, digestive illness such as diarrhoea, and respiratory problems such as influenza and whooping cough. Government strategies at this time were to ‘educate the mother in better methods of infant care as well as her basic household tasks’ (Davis, 1983, p. 11). The First World War commenced in 1915 and the KEMH\textsuperscript{18} opened in 1916 (Hobbs, 1980). Also in 1916, the House of Mercy changed its name to Alexandra Home for Women (Lang, 1980). During 1916, a Child Welfare Conference was organised by the Women’s Service Guild in Perth to:

> consider in view of the present world crisis, the necessity for studying the best methods of awakening and of training the capacities of the child; to create a deeper interest in the moral question of child welfare, and to discuss the importance of child psychology and relation to social progress. (Davis, 1988, p. 169).

**3.14.2 Alexandra Home for Women 1916–1958**

The above mentioned name change came at a time of shifting attitudes towards unmarried mothers and their babies (Lang, 1980). Nursing during this era was becoming increasingly professionalised, with advocacy at higher levels of nursing. The training of nurses became more regular, and regulations were introduced for the registration and training of nurses and midwives. The First World War and Depression and then the Second World War were features during this period, as was

\textsuperscript{18} KEMH is now WA’s leading tertiary maternity hospital.
the escalation of the infant welfare movement. Infant health centres were established from 1922 to assist in the movement to reduce infant morbidity and mortality, to teach mothers about health and hygiene and to promote breastfeeding (Hobbs, 1980).

The interchange between the two facilities, KEMH and Alexandra Home, soon developed for the girls during their confinement and then birth of their baby (Lang, 1980). Davis reflects on an article written in a magazine in 1917 called ‘Save our Babies! Our National Asset’. The quotation was from the Editor of ‘Western Woman’ and argued that:

In view of the terrible strain the war makes upon the brightest and most physically perfect of our male population, it is a matter of national concern to do everything in our power to promote the physical and mental welfare of our future citizens … above all to lower the infant death rate which is largely due to improper feeding by the mothers or want of care due to ignorance on their part. (Davis, 1983, p. 13)

The above statement also reflected information emerging from the Health Department about contemporary infant and child rearing.

As mentioned earlier, Dr Roberta Jull was very active and influential in the community of child health. She contributed articles to the magazine ‘Western Woman’ and was able to balance advocating for the medical profession’s role in infant care and the instruction of mothers. At another level, she recognised the value of the experience of being a mother. The medical profession tended to see women as lacking in any sense of how to care for a baby. As such, Dr Jull was driven to write and publish advice articles, pamphlets and books. ‘The constant instruction to the mother was to ensure the cleanliness of herself, her baby and her home’ (Davis, 1983, p. 24).

There were four women’s organisations in WA that were instrumental in improving the conditions of maternal, infant and child care in WA—the Children’s Protection Society, the Women’s Service Guild, the National Council of Women and the Kindergarten Union. These organisations were representative of the contemporary
attitudes towards motherhood and infant care and were closely involved in the initiation of social reform pertaining to child welfare (Davis, 1983, p. 30).

The Infant Health Association (IHA) was established in 1922 with societal interest in the welfare and lowering of the death rate of young children (Davis, 1988). An article in the WA newspaper entitled ‘Save the Babies’ alluded to maternal ignorance, with the need to educate and increase the community and Government’s awareness of their responsibility for children (Davis, 1988, p. 170). The first Infant Health Clinic was opened in 1922 (Hobbs, 1980) and by 1925 there were 10 centres (O'Hara, 1988). The IHA worked closely with and sought advice from the medical profession, and Dr Roberta Jull was a strong advocate and link to gain cooperation from the medical profession, who at that time saw themselves as instructing the role of nurses in the health care of women and children (Davis, 1983). Davis, in her study, found a letter written to doctors and nurses from the IHA.\(^{19}\) A medical advisory committee of the IHA in 1923 provided advice and instruction to midwives and nurses:

> The nurses are instructed that they are not to treat sick babies, but are to refer all cases of illness among the infants under their care to a medical practitioner and to aid the mother in carrying out his instructions. Under no circumstances are they to recommend any particular doctor. (Davis, 1983, p. 37)

The medical profession, with their ‘superior’ knowledge, saw themselves as vital in ensuring the health of the mother and baby.

The Alexandra Home occasionally conducted fundraising events. The West Australian presented an article (Anonymous, 1926) to remind the public of the reason the Home existed and to request funds to keep the Home going (see Figure 26).

\(^{19}\) Davis researched Infant Health Association files.
The WA Government was unable to afford to assume full financial responsibility for the baby clinics when the community-based centres were struggling to raise money during the Depression years. The Government did, however, provide subsidies, and to some extent used these as a means of control in the mid-1930s, such as to raise qualification standards—some of the nurses working in WA centres at the time were not trained in child health (Davis, 1988).

WA was also influenced by the infant welfare training commencing in other states, particularly in NSW. The first approved infant health training commenced at KEMH in 1927 under the guidance of Matron Walsh (1922–1956). She had previously travelled to Sydney (Tresillian) to complete the training. Upon her return to WA, she integrated the infant health training component into the four-month midwifery course. In the following year, the Nurses Registration Board reduced the age of entry into nursing from 21 to 18 years (Hobbs, 1980; O'Hara, 1988).

The Depression followed in the 1930s, and there was an increase in the building of small country hospitals administered by local boards of management and subsidised to some extent by the government. The Flying Doctor Service was also introduced during the Depression era. This was also the period during which the wages and conditions of nurses became the interest of nurses and the newly formed WA State Branch of the Australian Nursing Federation. At this time, the training of nurses was
based on tasks, and the delegation of specific tasks depended on the nurse’s experience (Hobbs, 1980).

The Nursing school set up by the WA Nurses Association (WANA) at Royal Perth Hospital was promoted by the West Australian press with the following article (see Figure 27) in 1935, explained by Hobbs (1980, p. 105). On the demonstration ward, there was a dummy baby and an adult as a resource for training the student nurses.

![Figure 27. Newspaper article West Australian 1935 (Hobbs, 1980)](image)

The first year of general nurse training was limited to domestic work, while as the nurse advanced in seniority, the duties were more orientated towards nursing techniques and nursing care, although the trainee nurse continued to be responsible for some domestic chores (Hobbs, 1980).

In the Alexandra Home, births were still taking place, although less than before KEMH was opened. The Annual Report of November 1933 stated:

The number of girls admitted during the year was 33. There have been 25 births, two girls being admitted with their babies. Of the 28 girls who were discharged, nine went home with their babies, and two girls were married, their husbands adopting the children. At present there are 19 girls in the Home and 14 babies. (The Alexandra Home for Women, 1933, p. 2)

During 1936, women were sent to KEMH for their confinement and then came back to the Home after the birth (Jull, 1940). Jull (1940, p. 4) described that in the same year, the Home had regular visits by a ‘child welfare sister’, who instructed the girls in modern methods of caring for their babies. Friends and volunteers assisted with
cooking lessons and assisted the girls to undertake personal interests and encouraged them to make things for themselves (Lang, 1980). The documents describe the Matrons employed as being engaged with a range of duties. In September, 1936 Matron Ferguson reported:

The urine is always tested twice a week and recorded if necessary. Girls dieted accordingly. Babies are weighed twice a week and same recorded. A certain amount of sterilizing is done every few weeks by me. Sick girls and babies are attended in the nursing ward. The usual interview takes about an hour. I have to sit and listen to tales of woe and sorrow, some of which there is no truth in. Mails are given out twice a day, and immediate answers sent. Take the girls to KEMH when in labour and go up again later to collect the bonus for each girl. There is quite a large correspondence from Mothers of girls from the country. The four sprinklers and hose are moved every hour by me in the summertime and a great deal in winter too. The motor is oiled and greased by me and in my spare time I garden. There are a lot of other duties but I cannot remember them. Numbers of the girls have breast massage and hot and cold foments. Time about half an hour twice a day. Other girls cannot express OR WILL NOT express their breasts. This is then done by me. (Lang, 1980, p. 41)

During the 1940s, the Committee planned the introduction of a training centre for mothercraft nurses, and they also embarked on an expansion of the facilities (see Photo 26). Matron Ulrich (1949a) (see Photo 27), when writing her report, was feeling the pressure of the enormous changes occurring with the renovations and the introduction of the new training course. She stated:

Mrs Snowball has made the nurses’ rooms look very inviting since she hung curtains. The aprons made are most useful to the nurses. So much has been done by ladies of Committee who have generously given time and strength to the point of utter weariness in preparing this Mothercraft Home. There is not space to give them the justice due … I have a vision for this place, or I should not be here, and I should not, certainly not be wearing myself out if I felt this trying time will
pass and our of the trials and confusion, noise and all the hindrances and difficulties will arise a School of which all who laboured to bring it into being will be very proud. (Ulrich, 1949a)

Photo 26. The Alexandra Home 1951

The Nurses Board approved the curriculum and registration for mothercraft training to occur and:

in June 1949 there were 15 trainees in residence for a period of 15 months training under the direction of Matron Ulrich, Dr Edwards, Dr
Cook, and a staff of three nursing Sisters and a Mothercraft Nurse.
(Lang, 1980, p. 50)

The Matron’s report of April 1949 stated that there was an increase in demand for the Home:

Many babies have been refused admission during the month as our nurseries have been overcrowded. The work of the Home amongst the babies seems to be more widely known of recent weeks and we are having difficulty trying to cope with the numbers who would like to place their babies in the Home. If this demand keeps up I would suggest that the time limit be three months for keeping a baby in the Home. Where a child has parents, I think some other arrangement could be made after this time. (Ulrich, 1949b)

Meerwald (1995) was in the first training school of 1949. Prior to this time she had worked as a nursing assistant at the Home. She stated that during this time she was not sure of the qualifications of nurses, but said that the Matron was always a double certificate sister because of the mothers, and the others could have been child health trained, as this course was done at KEMH.

The first resource used during the training was Truby King’s ‘Mothercraft’. The second was ‘A guide to the care of the young child’ by Brown and Campbell (Meerwald, 1995, p. 8). Lectures were given by the Matron and different sisters and doctors from PMH (Paediatrics). Meerwald (1995) stated in her oral history interview:

A Sister Hack came … she was a wonderful woman. She taught us a lot, not only in caring for children but accepting of people and knowledge of people. She had guided us through and it was really very well done. She had a natural instinct to explain because you get, you know, for us country girls and most of us were country girls, incestuous children and that. I mean we’d heard ALL the stories you know, and everything about that, but she helped us understand how these things could occur, how to love the children—we loved the
children anyway, it was only people that had them we didn’t like.
(Meerwald, 1995, p. 9)

She said that the course initially taught the basics of caring for a baby, including hygiene, bathing, clothing, safety, play, feeding, breastfeeding, engorged breasts, infectious diseases and caring for children. The nurses spent time in pre-schools such as Meerilinga20 and various kindergartens and she stated that ‘my mothercraft training provided a good basic education that was built on in further nursing certificates’ (Meerwald, 1995).

In 1949, extensions to Alexandra Home had been built and they had commenced training for mothercraft nurses. Fifteen trainees were in residence for 15 months (Lang, 1980). In the early 1950s, ‘the need for a social worker occupied the thoughts of the Committee’ and the committee of management approached the Child Welfare Department for advice on ‘how to help unmarried mothers to rehabilitate themselves’ (Lang, 1980, p. 54). From the 1890s and up until 1951, medical input had been mostly on a voluntary or honorary basis, with doctors incorporated visiting Ngala as an interest in their professional work. The Commissioner for Public Health instigated a honorarium of 100 pounds per year to look after the babies and this was advertised in the BMA magazine (Lang, 1980, p. 54).

In 1950, His Excellency the Governor Sir James Mitchell visited the Home during his last week in office. The following promotional material was found that explained some of the detail of the Home and its activities (Alexandra Home for Women, 1950) (see Figures 28–33).

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20 Meerilinga is a not-for-profit agency in Perth that has early childhood and family support services.
Figure 28. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (1)

Figure 29. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (2)
Figure 30. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (3)

Figure 31. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (4)
Figure 32. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (5)

Details of the Home...

The Alexandra Home was founded in 1890, originally to care for unmarried girls expecting babies.

The need for Mothercraft Nurses became so apparent, it was decided to incorporate the two and in 1949, after the addition of the necessary Nurseries and Staff accommodation, the Training School was officially opened by Lady Mitchell on April 9th, 1949.

Seventeen trainees have successfully completed the course since the School first commenced. Approximately 300 babies and 150 mothers have been admitted to the Home and cared for since the beginning of 1949.

The Training School has incurred much greater overhead expense, due to the upkeep and maintenance of trainees and staff, the equipment of the nurseries, medical supplies and patent foods for the babies, laundry staff and equipment, fuel and heating.

However, the skilful care and attention given to babies, the education of mothers in infant feeding and the training of Mothercraft Nurses, has justified the additional expense and must ultimately be of great benefit to the community generally.

Figure 33. Brochure of the Governor’s visit to Alexandra Home for Women and Babies and Mothercraft Training School (6)
Due to the inadequacy of the Alexandra Home facility in Lincoln Street in 1955, a vision for a new building was developed with a State Lotteries Grant and further fundraising ensued. The advertising brochure stated the new building would be called ‘Ngal-a’\textsuperscript{21} and explained how it would serve WA:

Ngal-a will board any babies up to three years of age while the parents have a holiday on medical advice;
Ngal-a will care for babies needing dietetic adjustment who have been entrusted to the home on doctors’ advice;
Ngal-a will care for and help unwed expectant mothers in distress and arrange adoptions when required;
Ngal-a boards and cares for any baby in WA from the age of 10 days to 3 years, regardless of the social or financial standing of its parents;
In the event of a mother’s sudden illness, absence or inability to look after her baby because of hospitalisation or domestic upheaval, her baby can still be looked after and loved by Ngal-a;
Ngal-a will have private rooms and special nurseries for mothers who, for leaving maternity hospitals, need postnatal care or convalescence before returning home;
Ngal-a will care for babies (State wards) who have been abandoned by their parents;
Ngal-a will continue to be the only centre in WA to train mothercraft nurses;
Ngal-a will be of value to the nursing profession as it will include a training school for Sisters to enable them to obtain their third certificate in Infant Health instead of them having to leave the State as they do now. This should mean that we lose fewer trained Sisters from our hospitals. (Ngala, 1955)

The years from 1949 to 1959 marked the attainment of unity within nursing, adjustment to changes in the pattern of nursing care and nursing education and the formation of the College of Nursing Australia in 1951 (Hobbs, 1980). During the 1950s and 1960s, there was a considerable increase in the population and a drop in

\footnotesize{\textsuperscript{21}Note that Ngal-a has a hyphen that appears in documents inconsistently and is eventually dropped during the 1980s.}
mortality rates. This rapid growth also generated economic development and growth in health facilities (Piercey, 2006). During this period, nursing training was still heavily influenced by an army style of education and a shortage of nurses generally. There was a movement during the 1960s to build a new curriculum for nurses that was more relevant to the time (Piercey, 2006). There was also a move towards improved nursing pay and conditions (Hobbs, 1980).

Two nursing oral histories (Ellis, 1995; Meerwald, 1995) describe the period of nursing from the 1950s (prior to the transition of Alexandra Home to Ngala) until the transition period into the 1980s, including the key role of the nurse. The sisters in training and the mothercraft nurse roles interfaced, as they often both worked together with the children. These are described in Chapter Four in more detail. One of the key roles of the nurse was as a ‘substitute mother’, and routines for children had to be established, such as for feeding, bathing, dressing, sleeping, walking, playing, cooking, preparing food, checking or supervising, toileting, cleaning, settling of children and making up of milk feeds. The following quotations explain this role:

Nurses undertook all activities that were related to the daily chores of looking after children. We did things that anybody else would do with their children. (Ellis, 1995, p. 9)

We were to care for any child whose mother was unable to care for it, whether she was ill or … while they went on holidays sometimes, or she might have been in hospital or the child could have been for adoption or fostering or for any reason whatsoever that the mother couldn’t care for the child. (Ellis, 1995, p. 7)

The nurses were fantastic … they would often come down when they were off duty and in the evenings, and often feed their babies. (Ellis, 1995, p. 16)

They were to create a homely environment and ‘look on as a home not an institution’; Treat children as individuals, and buy gifts for children and necessities like shoes and nice clothes (Ellis, 1995, p. 8).
Everybody was encouraged to have a baby or toddler that they loved … we had permission from Matron to take children out on outings when we were off duty … and sometimes for weekends (Ellis, 1995, p. 9) (see Photo 28).

![Photo 28. Alexandra Home nurse and babies 1957 (Malloy, 2010)](image)

You’d go into the milk room and that was … and you’d cook the children’s meals and you’d do the special diets for the babies as well as the milk bottles. The main kitchen would cater for the older children—2–3 year olds. (Meerwald, 1995, p. 11)

All feeds were worked out for babies in those days on the calorie intake—how many calories they needed for pound of body weight a day and all the feeds were worked out on that. You’d have a chart for each baby and when you’d finished your shift you’d have to check that the other nurses had all their calorie charts and that baby had had sufficient nourishment for the day. If it wasn’t you’d see that it was increased the next day or if the child was still hungry you’d have to work out another diet for the baby. That was the nurse’s job. Then the matron or the charge sister would come and check it over. (Meerwald, 1995, p. 12)
The other parts of the role are as follows; these are described in more detail in Chapter Four:

- Caring for sick child/mother;
- Caring for disability/special needs;
- Coordination of care;
- Health assessments;
- Doing mothercraft;
- Protecting children and advocacy;
- Giving psychosocial support;
- Training and supervision.

The Baillière's Dictionary for Midwives (Worvell, 1951) used by Matron Grant exemplifies the context of the times and nurses' work during this period (see Figure 34). The advertisement is for an ‘infant powder’ for teething.

Figure 34. Medical treatments advertised in 1951

Nursing notes regarding the children were brief and focused on the physical aspects of the child and any treatments given. Example of this are given in Figures 35 and 36.
Figure 35. Nursing notes 1959 (Ngala, 1959b)
During the late 1950s, planning began for a new facility to be built in George Street, Kensington. The promotion and fundraising campaign began for this during 1957–1958 (see Figures 37–41).

Figure 36. Nursing notes 1960 (Ngala, 1959b)
Figure 37. Promotional brochure for Ngala 1958 (1) (Ngala, 1958, p. 1)

Figure 38. Promotional brochure for Ngala 1958 (2) (Ngala, 1958, p. 5)
This brochure was promoting both training for the mothercraft nurses and the child health course. Figures 40 and 41 highlight the problem of nurses having to go to the ‘East’ to train for the ‘Infant Health Certificate’. The shortage of nurses is identified and the Medical Officer of the Health Department and the Matron of KEMH discuss the benefits of a WA-based training school.

The name Ngala means ‘mother and child’ or ‘we two’ in the Aboriginal Bibbulmun dialect and was chosen by the Committee at the time ‘to describe the scope of the work of the Home in its new surroundings’ (Lang, 1980, p. 57). In Figure 42, Helen Duncan describes how the name came about in the context of their Committee.

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Figure 41. Promotional brochure for Ngala 1958 (5) (Ngala, 1958, p. 10)

Figure 42. Excerpt from Oral History of Helen Duncan (Duncan, 1977, p. 18)
The Committee at Ngala sourced information on the attributes the Matron should possess (see Figure 43).

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**Appointment of Matron.**

Discussions in the Eastern States gave information on the type of person it would be necessary to appoint. She must be young and not too rigid in her ideas. She is a most important person. All staff must have high qualifications, character and broad vision, even to the gardener, as the eyes of all Australia are on Ngala, in fact in time, the eyes of the world.

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**Figure 43. Excerpt from Minutes of General Meeting—The appointment of the Matron at Ngala (Ngala, 1959a)**

Beryl Grant (see Photo 29) was employed in 1959 and served as Matron for the following 21 years (1959–1980). Prior to coming to Ngala, Beryl Grant had received a Florence Nightingale scholarship in 1956 to study at the College of Nursing Australia for a Diploma in Nursing Administration (Grant, 2009; Oliver, 1978). She was a strong advocate for children and families and a leader in nursing in WA. She went on to undertake a Churchill Fellowship in 1968, received an Order of the British Empire (OBE) in 1976 and the Queen’s Jubilee Medal in 1977 (Lang, 1980; Tanner, 2002).

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The minutes of a general meeting of the Committee (see Figure 44) also gave some background on Ngala as being a C-Class Hospital, the decision-making process regarding special case admissions, and fees charged. The discussion about the admission of a ‘mentally retarded child’ is noted because ‘much discussion’ was required by the Committee (Ngala, 1959a).
In 1959, the Nurses Memorial Centre was established for all nurses in WA who had served in war and peace. Beryl Grant and other high profile Matrons in Perth were part of the initiating committee for this cause. This was also the time when Alexandra Home was transferred to new premises and became Ngala Mothercraft Home and Training Centre, undertaking the training and registration of mothercraft nurses and the infant health certificate for general and midwifery nurses (Hobbs, 1980).

The Twelfth Quadrennial Congress of the International Council of Nurses was held in Melbourne 1961. This was a milestone in the history of nursing, and many nurses passed through Perth on their way to the Congress. One of the major curriculum decisions from this Congress was that nurses were to broaden their practice experience to include the obstetric and psychiatric areas of nursing. During the 1960s, the Public Health Department introduced the first paid in-service courses for infant health sisters and school nurses to keep up with the trends in their field of nursing. Up until this time, few nurses married, and if they did, they typically left the nursing profession.

The 1960s also saw the introduction of television; change in the metric system and currency; introduction of the contraceptive pill; the introduction of disposable equipment and a central sterile supply department at major hospitals; the introduction of a manometer and stethoscope for measuring blood pressure; and allied health disciplines. During this time, consideration was also given by the Commissioner of
Public Health to the introduction of health visitors using infant health sisters in implementing this, together with those giving domiciliary care under the Silver Chain service. Nurses were not willing to participate in such an initiative, as it required extra specialised training not available in WA (Hobbs, 1980).

In 1963, the mother of every new baby was visited by the infant health sister in her district as soon as possible after birth, and country mothers were written by the service. A special project operated called the ‘Tea and Sugar Train’. Four times a year, two sisters (and occasionally a medical officer) travelled from Kalgoorlie to Port Augusta and back on the slow goods train that took provisions to people along the trans-continental line. They provided specialist advice and treatment along the way (Department of Health, 1963).

In 1960, Ngala celebrated 70 years of operation. Some promotional material describing the service’s various activities and roles is given in Figures 45–49.

![Figure 45. Ngala Promotion (1) (Ngala, 1960)](image-url)
Figure 46. Ngala Promotion (2) (Ngala, 1960)

Figure 47. Ngala Promotion (3) (Ngala, 1960)

Figure 48. Ngala Promotion (4) (Ngala, 1960)
The 1961 Annual Report highlighted the artwork in the entrance of Ngala. The word Ngala and its meaning was stated to have been ‘taken from a book in the Parliamentary library, written by a Captain Rey, published in 1840’ (Ngala, 1961). This artwork still hangs in the hall by the CEO’s office (see Photo 30).
In the 1961 Annual Report (Ngala, 1961), toddlers were depicted waiting for their food in their chairs (see Photo 31). While this image is not at all ‘home-like’, in the same report, it was stated that:

during its two years of existence, Ngala has endeavoured to preserve as it can, the atmosphere of a ‘home’ and not that of an institution, and with the increase of population, there will always be little children for whom Ngala will be home for months or years. (Ngala, 1961, p. 4).

Photo 31. Toddlers at Ngala in Dining Room (Ngala, 1961)

The Medical Advisory Committee at Ngala oversaw any clinical practice activities occurring at Ngala. Two research projects were reported during 1963. Ngala was part of a wider growth study associated with similar work in Melbourne and Canberra to determine the nutritional requirements and needs for growth in Australian children. They measured the food intake of children and their growth changes. The other project was in conjunction with the Psychology Department of the University of WA. A researcher was undertaking observations of developmental standards in young infants at Ngala. It was found that there was little difference between Ngala babies and babies in domestic homes living with their parents. This was felt to be due to the ‘happy relaxed atmosphere at Ngala and the attitude of nursing staff who try to make up for the personal love and attention which these little children are in danger of missing from being away from their mothers’ (Ngala, 1963, p. 9).

As indicated previously, the major discipline represented in Ngala’s workforce history is nursing. Photo 32 shows registered nurses undertaking lectures at Ngala.
Although the work at Ngala necessitated the knowledge and skills of social work, the earliest recognition of this was in 1953, at which time the need for a social worker was considered by the Committee (Lang, 1980). However, not until 1963 was there a trial placement of a social worker at Ngala (Silver, 1963, p. 5).

I have mentioned the nursing and medical emphasis in a service which seems predominantly social welfare in character. It surprised me greatly when shown the Constitution of Ngala, to note that it had a business and medical advisory body but no social welfare advisory service. This would appear to me to be essential to a place like Ngala, it seems that to neglect the voice of those most active in the provision of social services in WA., could lead to the development of a one-sided service, particularly when plans for an extension of provisions are contemplated. (Silver, 1963, p. 5)

Silver’s (1963) report also indicated the dominance of a medical model within Ngala’s service delivery and suggested the commencement of a social welfare advisory service. It was also noticed through many of the Ngala documents that informal liaison did occur between nursing and the child welfare department, particularly with their adoption services, support with their pregnant young women and referrals into Ngala. During the trial placement of the social worker in 1963, the
report mentions that if a social worker was to be employed, there would need to be a re-distribution of tasks or roles from the Matron and Deputy Matron:

This does not mean that the services of a social worker are not required, it only means that her field of work is among the unmarried mothers in residence, and there is not enough work in this field at present to warrant the services of a full-time social worker. Duties part-time would be in the case work with the unmarried mothers and their families and any needy private cases of children and their families, plus lectures and liaison with other agencies … If a full-time social worker was appointed … she would need to be given some responsibility for the service provided so that her work would develop automatically rather than for much of it only delegated to her from time to time. This would mean that some of the duties now carried by the Matron and Deputy Matron would be transferred to the Social Worker. (Silver, 1963, p. 3)

In 1967, the Medical Advisory Committee advised and recommended the employment of a social worker (Ngala, 1967) (see Figure 50).

However, it was only in the 1980s that the first social worker was employed, followed by the hiring of a small number of social workers during the 1990s for work in a variety of roles and programs.

Medical Practitioners were associated with Ngala from the beginning and came regularly in honorary positions to visit the children and/or mother. The Medical Advisory Committee was established in 1959 and met regularly with a roster system
of visitation. ‘Each specialist took his weekly turn, keeping continuity of service so that the baby always saw the same practitioner’ (Lang, 1980, p. 63; Ngala, 1959a). (see Figure 51 and Photo 33).

**Figure 51. Promotional Ngala booklet—Excerpt from The Medical Advisory Committee (Ngala, 1960)**

**Photo 33. Dr Dugdale, an Honorary Paediatrician (Ngala, 1963)**

For nursing in the 1970s, the expanding role of the community nurse was evidenced by the change of name from ‘infant health’ to ‘maternal and child health’. In 1974, the WA School of Nursing was formed next to Royal Perth Hospital. The building
opened in 1975 and the commencement of the first Bachelor of Applied Science (Nursing) at WAIT began in February of that same year (Hobbs, 1980).

Ngala commenced the services of a child care centre in 1971 on the Kensington site (see Figures 52 and 53). These facilities were staffed by mothercraft and student nurses with a sister in charge.

Figure 52. Promotion for opening of Ngala Child Care Centre (1)

Figure 53. Promotion for opening of Child Care Centre (2)
The Child Health Course was six months in 1978. Four months were allocated to practice at Ngala and two months were spent in child health centres. The curriculum for 1978 was separated into seven units combining theory and practice (see Figures 54 and 55).

**Figure 54. Ngala Child Health Nurse curriculum 1978 (1)**
Figures 55. Ngala Child Health Nurse curriculum 1978 (2)

Beryl Grant AO OBE, nurse and magistrate inductee to the Women’s Hall of Fame 2011 (International Women’s Day, 2011), retired in 1980 (see Photo 34), marking the end of an era. Her philosophy of life was: ‘I think life is what you make it. You don’t look back, you look forward’ (Phillips, 2011).
After her retirement from Ngala, Beryl Grant continued to work as a children’s court magistrate, was the WA Uniting Church’s first woman moderator, and chaired a community panel on prostitution. She received the Advance Australia Award 1993 (Phillips, 2011), the Centenary Medal 2000 and the Order of Australia 2001 (Australian Government, 2012; Grant, 2013).


The 1980s was a turbulent period for Ngala. During this decade, societal changes brought new perspectives on residential care, broader definitions of family and less critical views of single parenting, combined with the challenge to the organisation to shift its focus from mothers and children in isolation to the nature and functioning of children in the context of family. Firstly, the Booth Report (Booth, 1980) recommended a new way forward and the introduction of social work services. Secondly, as a not-for-profit organisation experiencing financial difficulties, the Committee undertook a functional review in 1984. Thirdly, the Department for Community Services undertook a significant review during 1985–1986 in which they examined Ngala’s finances and residential services. Finally, the Child Health course was transferred to WAIT, and mothercraft nurse training at Ngala ceased. At a national level, the traditional mothercraft training was also being replaced by TAFE courses that qualified students for a child care certificate. At this time, there was also evidence that employment opportunities for mothercraft nurses were decreasing and
that enrolled nurses were taking their place (Department for Community Services, 1986).

The Booth Report (Booth, 1980) was commissioned in 1980 before the retirement of Beryl Grant. The report described how social work services could assist in supporting the organisation to move forward (see Figure 56).

![Image: Excerpt from Booth Report (1) (Booth, 1980, p. 2)]

**Figure 56. Excerpt from Booth Report (1) (Booth, 1980, p. 2)**

The report also recommended the reduction in residential care for children. This was seen as no longer being best practice. Instead, a move to family support programs was recommended. Additionally, the report recommended the employment of a nurse educator and a change from a medical advisory to a professional advisory committee that incorporated less medical dominance and included social welfare. Booth also raises the issue of the nursing role being enmeshed with the medical model and communication styles being prescriptive rather than consultative (Booth, 1980) (see Figure 57).
Dr Trevor Parry, Paediatrician, was involved with services at Ngala for many years. For the 1980 Annual Report, Dr Parry contributed the Medical Advisory Committee report, shown in Figure 58. For that year, 409 children had been cared for, with low numbers for adoption. Seventy-nine children were cared for in the mother and baby unit. Dr Parry (Ngala, 1980, p. 8) outlined the reason change needed to occur at Ngala. He described the social dimension of health and the need for a team approach using all disciplines for the current nature and challenges in early parenting work.
Based on the Booth Report, some changes were made, including the employment of a social worker (see Figure 59).
The Functional Review Committee in 1984 questioned the continuation of Ngala as a private hospital with the associated high staffing costs. This finding was also supported by the Department for Community Services (DCS) Review in 1986 (Department for Community Services, 1986). The DCS Report shown in Figure 60 highlighted the role of the child health nurse and saw this as an important component of services at Ngala.

Ngala retains Private Hospital status to the present day.

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**Figure 59. Ngala Brochure early 1980s**
At Ngala, much unrest coincided with and followed the Review process in 1986 as an implementation committee worked to apply the recommendations of the report. There was also unrest in the community and considerable lobbying with Members of Parliament. Questions were even asked in Parliament (see Figure 61). The Review was co-occurring with the transfer of Child Health nursing training to the tertiary sector and the cessation of mothercraft nurse training at Ngala.
As shown in Figure 62, the DCS Report (Department for Community Services, 1986) also reinforced the importance of Ngala’s child health role, but recommended the closure of the residential unit and a shift to a community-based model of care.
The implementation committee recruited a new Executive Director of Services to take the organisation forward.


Mrs Rae Walter commenced as Executive Director with a Board of Management, and the name of the service was once again changed to reflect its new focus, becoming the Ngala Family Resource Centre. Rae Walter had a Bachelor of Economics. Her appointment represented a significant change for Ngala towards creating a business model of operation.
Figure 63. The DCS Review presented a different model for considering the flow of children and families

‘The road was very difficult in the first few years as there was no direction—the organisation was stuck in a time-warp’ (Walter, 2013). The DCS Review offered another perspective on the future of the service. For example, the Report presented a model on the flow of families and children (see Figure 63). The focus when Mrs Walter commenced was to overcome the ‘institution feel of the organisation’ and to begin to shape a family- and child-focused, multidisciplinary organisation (Walter, 2013). Nurses working during this time were from the era of the ‘old’ Ngala, ‘some looked on Ngala as their home’. They had also looked after many children and taken
them home during this time, so things were becoming very different (Walter, 2013). Walter (2013) stated:

one of the things nurses found difficult if they had been working in the children’s unit, was they had to learn how to relate to parents … they hadn’t worked with parents, only worked with children, so it was the children in isolation. (Walter, 2013, p. 5)

During this time, the training for the mothercraft nursing certificate ceased (see Figure 64) and a new Board of Management (see Photo 35) was formed, creating more uncertainty for Ngala.

![Figure 64. The cessation of mothercraft nursing (Pringle, 1989)](image-url)

In 1969, Thai students were sponsored by the Commonwealth Government, and a training programme was developed for Aboriginal students from the north. During the early stages of the Child Care Training course started by the Kindergarten Association, Ngala provided a venue and assistance.

The Fees for this course in 1974 were $35 a term, to cover the cost of some stationery and lecture fees. It was to be for students seeking employment in Kindergarten or Day Nurseries. Initially eight students attended three days a week.

With the opening of the Day Care Centre at Ngala in January 1971, mothercraft nurses were required to care for children up to five years of age, and a tutor in Early Childhood Education and Child Development was appointed to the staff.

A great many changes were beginning to take place in training education throughout Australia. Hospital-based courses were being replaced with college education. Nursing was accepting responsibility beyond the hospital, and a vision of wider community involvement was starting to emerge. The body of knowledge of mothercraft nursing had grown, as qualified members added, pruned and refined.

In September, 1982, the Nurses Board established a Standing Committee to consider the amalgamation of the mothercraft and child care courses. The proposal was for a two year college based course leading to a Certificate in Child Care Studies and registration with the Nurses Board. The graduate would be known as Child Care Nurse and opportunities would be provided for both Child Care Certificate holders and Mothercraft Nurses to take bridging units.

The proposed amalgamation did not eventuate; the winds of change continue to blow.

On February 26, 1989, the last class of Ngala trained mothercraft nurses graduated.

They have always been a select few, following a rich tradition, possessing their own special identity caring for families with young children. A new era of training for mothercraft nurses is about to begin.

Prepared by Dorothy Pringle — extracts from “The Open Door”

* The last Ngala trained Mothercraft Nurse, Julie Kelso-Marsu with the first Ngala trained Mothercraft Nurse, Mrs Pollock, and 9-month-old Cale.

Photo courtesy of the Daily News

The history of mothercraft nursing in Western Australia is deeply interwoven with the history of Ngala.

The first education programme for mothercraft nurses in WA began when in December, 1948, the first curriculum for mothercraft training was approved for registration with the Nurses Board. Lady Dimsa opened the Mothercraft Training Centre at the Alexandra Home in North Perth on the 9th April, 1949.

In response to changing needs, it was decided a new site and building were required for the Home, so Ngala was opened on its present site on August 1, 1959.

Staff, babies and students moved on July 23, 1959 before the official opening. At this time there were 17 mothercraft nurses on the staff at Ngala, with intakes of new students tri-monthly.

First Course

The first Infant Health Course (as it was then known) began on November 2, 1959. The education of mothercraft nurses continued with students coming from all areas in Western Australia and overseas.

Mothercraft Nursing: the end of an era at Ngala

In 1969 three Thai students were sponsored by the Commonwealth Government, and a training programme was developed for Aboriginal students from the north. During the early stages of the Child Care Training course started by the Kindergarten Association, Ngala provided a venue and assistance.

The Fees for this course in 1974 were $35 a term, to cover the cost of some stationery and lecture fees. It was to be for students seeking employment in Kindergarten or Day Nurseries. Initially eight students attended three days a week.

With the opening of the Day Care Centre at Ngala in January 1971, mothercraft nurses were required to care for children up to five years of age, and a tutor in Early Childhood Education and Child Development was appointed to the staff.

A great many changes were beginning to take place in training education throughout Australia. Hospital-based courses were being replaced with college education. Nursing was accepting responsibility beyond the hospital, and a vision of wider community involvement was starting to emerge. The body of knowledge of mothercraft nursing had grown, as qualified members added, pruned and refined.

In September, 1982, the Nurses Board established a Standing Committee to consider the amalgamation of the mothercraft and child care courses. The proposal was for a two year college based course leading to a Certificate in Child Care Studies and registration with the Nurses Board. The graduate would be known as Child Care Nurse and opportunities would be provided for both Child Care Certificate holders and Mothercraft Nurses to take bridging units.

The proposed amalgamation did not eventuate; the winds of change continue to blow.

On February 26, 1989, the last class of Ngala trained mothercraft nurses graduated.

They have always been a select few, following a rich tradition, possessing their own special identity caring for families with young children. A new era of training for mothercraft nurses is about to begin.

Prepared by Dorothy Pringle — extracts from “The Open Door”

* The last Ngala trained Mothercraft Nurse, Julie Kelso-Marsu with the first Ngala trained Mothercraft Nurse, Mrs Pollock, and 9-month-old Cale.

Photo courtesy of the Daily News
Rae Walter was a visionary. An example of her thinking is given in Figure 65, from 1992–1993, wherein she sketched her thoughts on the future of the organisation conceptually. She completed a Churchill Fellowship in 1993.

Part of the change occurring for Ngala (from the culture of an institution) came with the demolition of the old building and its replacement with a family-friendly complex in 1995. Throughout the 1990s, there were many quality reviews that kept the organisation moving forward while trying to keep the focus on the reason for
Ngala’s existence. Rae Walter was interested in asking questions about the quality of practice and impact on families. Nurses found it difficult during this decade because the effect of nursing having moved into the tertiary sector had yet to take effect at Ngala, as there was no critical mass of nurses with degrees to make changes (Walter, 2013).

Nurses went on strike in 1997 (see Figure 66) to increase their pay and conditions. As a result, the first Enterprise Bargaining Agreement (EBA) was signed. This proved to be an opportunity for growth and development of the nurses over time and ensured efficiencies in practice (Ngala, 1997). From this time to the present, the ongoing EBA negotiation processes have run very smoothly.

Figure 66. Ngala nurses on strike, ANF Newsletter, 1997
The organisation began reaching out into the community with various programs to support and educate families with young children. Parent and professional education programs were also scheduled (Ngala, 2000a, 2002), and community development programs were initiated to expand the outreach of the organisation (Walter & Dawson, 2001). The development of systems was a priority, and was an ongoing challenge due to resources.

### 3.14.5.1 Fatherhood work and inclusive practice

Towards the end of the 1990s, a male child health nurse was employed in management, and the introduction of a new program focusing on fathers commenced with the employment of fatherhood workers to run a service called HeyDadWA. This began the challenge of changing the culture of the service to include fathers in programs in a primarily women-only workplace. Donald and Webster (2000, p. 5) stated in a conference paper that:

> it was just over two years ago that Ngala appointed the first male clinical staff member. I am the first male child health nurse to be appointed in 108 years—a significant milestone. … a male GP, a coordinator, another CHN, a social worker and two male social work students. All occurring over two years. (p. 5)

Donald and Webster (2000) argued that this change in staff increased the involvement of fathers at Ngala.

### 3.14.5.2 Review of Services 2000

The focus on being in the new millennium in 2000 was a timely opportunity for Ngala to commence a quality review of how its residential and more intensive services were operating together. The focus was on interdisciplinary and family-focused change and continuity of care (Ngala, 2000b) (see Figure 67). Some of the changes being planned were a one care plan for use by all disciplines, joint meetings, shared leadership and joint training. The evidence used at the time was Documenting the Nursing Process (Hacker Chana, 1992) and The Patient-driven Interdisciplinary Care Plan (Gage, 1994).
3.14.5.3 Perinatal Mental Health and Infant Mental Health

These changes led to more challenges for nurses, with extra training required by the development of perinatal mental health services and a partnership with psychiatry at the KEMH. Regarding Ngala’s research involvement during this period, for over a decade ongoing work was conducted in partnership with Curtin School of Psychology on education and research around infant mental health and parent/child attachment. A therapeutic group work program was commenced towards the end of the 2000s, involving a series of nine groups to increase attachment between mother and child using videos on play scenarios (see Figure 68). Dr Lynn Priddis was the expert behind this project, and she provided a screening tool to enable practitioners
to identify issues in parent–child attachment (Priddis & Wells, 2010a, 2010b; Priddis, Wells, Dores, Booker, & Howieson, 2008).

Figure 66. Tuned in Parenting poster presentation, 2008

3.14.5.4 Partnership approaches

The most substantial change experienced by nurses in the 2000s was the move away from the ‘expert approach’ by nurses to partnership approaches with families and the introduction of ‘C-Frame’. Ngala was involved in the national project partnership of
C-Frame’s development with the Victorian Parenting Research Centre (Victorian Parenting Centre, 2005) and three other national parenting centre sites. Following this, nurses undertook intensive training in moving to partnership approaches. This has been an ongoing journey:

The impact of this then for the nurses was how do we work with each other, and the challenges of that rub together, as well as it gave a common language. It also gave the organisation more of a culture of moving towards a problem-solving approach. (Walter, 2013)

Reflective practice was a crucial strategy incorporated into C-Frame.

Other collaborative partnerships began with universities during 2005. Two research studies were commenced. Firstly, a partnership study with Murdoch University and other agencies examined the issues faced by families involved in fly-in-fly-out employment and provided advice from the sample of families and from associated agencies as to the best way to manage those issues (Gallegos, 2005). The other research project was a Delphi study (Hauck, et al., 2007) undertaken by Curtin University School of Nursing, which examined the research priorities of clinical staff working at Ngala. The study identified seven main areas that Ngala practitioners perceived to be relevant research areas.

The Danae Corser Award had also been initiated a few years before. This supported a successful staff member to attend a conference or relevant professional development (Ngala, 2005). This is still operating to the present day.

3.14.5.5 Organisation Review 2005

In 2005, the Board initiated a major review (Cressida Consulting, 2005) of the structure and governance of Ngala, resulting in two new positions to commence in 2006 to look at specific recommendations and growth for the organisation. These were a Director for Corporate Services, to increase the capacity of support services to respond to service delivery, and a Director of Services (Elaine Bennett, the researcher).

Since this time, the organisation has grown considerably in size, and during 2008, Ngala divided into three companies to represent this growth and change, and for tax
purposes. The key changes for the organisation since 2006 are outlined in the following sections.

3.14.5.6 Documentation of Evidence-Base

The development of a service delivery model document (see Figure 69) was collated in consultation with staff to assist employees to understand the context of the organisation, the evidence for the work and the frameworks to guide practice (Ngala, 2012b). ‘[T]his was a significant milestone as it validated practice and service delivery’ (Walter, 2013).

![Service Delivery Model](image)

**Figure 69. Ngala’s Service Delivery Model 2012 (revised version)**

3.14.5.7 Professional Development and Reflective Practice

There was a new focus on staff development and the encouragement of a dynamic learning environment to assist the development of practice to align with the frameworks and models of care.

3.14.5.8 A Research and Development Unit

A research and development unit was established to assist working across the organisation to develop consistency of practice, collaboration and integration internally and practice development projects.
3.14.5.9 A Research Agenda

A research agenda was developed with key research partners and universities. An article was published on the action learning project in developing the interdisciplinary research framework (see Figure 70).

The process of writing up a framework for interdisciplinary research and practice was a very productive partnership between four professional disciplines—practitioners and researchers:

1. Nursing and Midwifery
2. Early Childhood
3. Psychology
What evolved from the project above was the development of unity and a common language when discussing early childhood and parenting work. It brought together the theories and approaches that informed nursing and midwifery, social work, psychology and early childhood education and assisted to prioritise research themes important in guiding the research plan.

3.14.5.10 Expansion of scope and programs

Many community programs were developed, including parenting support in Bandyup women’s prison, Aboriginal parenting support programs, early literacy programs to facilitate transition of disadvantaged children into school, psychosocial support for parents with children with a developmental delay and peer support programs for parents with a child with a disability. Ngala’s community services have also developed a strong community development focus, supported by many Commonwealth-funded programs.

Online technology services and resources for parents have also been created (see Figure 71). These include resources on sleep and nutrition, breastfeeding, the importance of fathers, and brain development for the early years. A separate website, ‘My Ngala’, was developed as a parent forum. Additionally, a ‘Healthy You, Healthy Baby’ mobile application for pregnant women was developed in conjunction with Edith Cowan University. Ngala also has a facebook page and is on Twitter.
3.14.5.11 Interdisciplinary team work

As mentioned earlier, during the 1990s, Ngala widened its range of disciplines to include social workers. Slowly, professionals from other disciplines were also employed. Early childhood educators were employed in services other than child care. Psychology was introduced in the 2000s, with the commencement of perinatal mental health work. Other professionals were employed such as Aboriginal support workers, health promotion staff and community psychology and occupational therapy workers. The introduction of C-Frame, strengths-based and solution-focused practice also enabled a smoother transition to interdisciplinary work.

As the service delivery model was first documented in 2010, it was reinforced that effective interdisciplinary environments were dependent on the team functioning as a cohesive group. It was thus expected that staff share a common philosophy of practice, recognise and freely exchange knowledge and skills, and work effectively together for the achievement of a set of common goals. It was noted that for an effective interdisciplinary team to develop, it is necessary for individuals to understand each others’ professional frames of reference. They need to be able to define for each other their specific expertise and the usefulness of this in the assessment and delivery of programs to parents and families. Roles and responsibilities can be accorded to team members on the basis of this understanding (Ngala, 2012b).

Increasing amounts of literature are becoming available on interdisciplinary education and practice. The World Health Organisation (WHO) (2010a) provided a
framework for innovative strategies that assisted policy and programs increase the global health workforce. The WHO emphasised the benefits of IPE and collaborative practice as strengthening service delivery systems and improving health and wellbeing outcomes for families and children. McWilliam (2000) recommended four principles to underpin practices in interdisciplinary services:

- collective responsibility—meaning that teamwork is needed;
- a trans-disciplinary approach—whereby team members exchange competencies between themselves;
- functionality—meaning that practice and intervention is based on the needs of service users rather than on those of the professionals; and
- practicality for service users—meaning that interdisciplinary services and strategies should be useful and relevant for service users and simple to implement.

A considerable body of evidence supports the way in which professionals relate to and support families, and this evidence can influence families’ sense of control over their life circumstances. Dunst and Dempsey (2007) discuss that relational helping includes practices typically associated with good clinical practice (for example, active listening, compassion, empathy and respect) and help-giver positive beliefs about family member strengths and capabilities. Straka and Bricker (1996) identify key principles of effective collaboration for early intervention teams:

- having a common goal of purpose;
- involving caregivers;
- developing joint outcomes from assessment;
- coordinating intervention and evaluation activities; and
- evaluating team functioning.

The purpose of Ngala in developing an interdisciplinary research and practice framework was to guide the service’s future research activity, to assist with identifying and developing priorities and to build a stronger and more coherent connection between current research and evidence and the practice that takes place within the organisation (Ngala, 2010b). Collaboration in research activity enabled a common understanding of what each discipline contributes, and considered:
o power and organisational culture;
o theories and concepts across disciplines;
o linkages between different forms of knowledge;
o ethical issues and processes;
o the creation of an environment enabling collaboration between researchers and practitioners (Dagenais, Ridde, Laurendeau, & Souffez, 2009).

Ngala (2010, p. 5) explained interdisciplinary team practice within their framework as:

a partnership between a team of professionals and a client in a participatory, collaborative and coordinated approach to shared decision-making around health (and wellbeing) issues. (Orchard, Curran, & Kabene, 2005b)

Strengthening organisations to implement evidence-based practice is enhanced through the presence of three interacting components: active leadership and commitment to quality, robust clinical process redesign incorporating evidence-based practice into routine operations, and the use of management structures and processes to support and align redesign (VanDeusen et al., 2010).

3.14.5.12 Celebration of 120 years

In 2010, Ngala celebrated 120 years of operation. Figure 72 is a poster presentation reflecting Ngala’s many years of history and the milestones along the way.
Figure 72. Ngala Celebrates 120 years
3.14.5.13 *Ngala in Western Australia*

*Ngala* has physical bases in Perth and outreaches to all parts of WA (see Figures 73 and 74). The main focus has been on the Pilbara, Wheatbelt, Kimberley and parts of the south west. Outreach is subject to funding.

![Ngala rural and remote services in WA](image)

**Figure 73. Ngala rural and remote services in WA**
Ngala has sites and/or a focus on service delivery in 12 areas of Perth (see Figure 74). Perth has now approximately two million people, and the 0–4 age population rate is growing. The population of WA has increased by 14.3 per cent since 2006 (Australian Bureau of Statistics, 2011).
Finally

Photo 36 ends this section by showing the connection between the researcher and the two key influential women leaders in the history of Ngala. Beryl Grant continues to undertake volunteer work in aged care and is a member of the ‘Friends of Ngala’. Rae Walter retired in 2011.

![Photo of Rae Walter, Elaine Bennett and Beryl Grant, 2011](image)

Photo 36. Photo Rae Walter, Elaine Bennett and Beryl Grant, 2011

3.15 National Early Parenting Services: Current Context

This chapter so far has focused on the literature providing the historical context for EPS internationally and in each State of Australia. In addition, an in-depth overview of the history of nursing at Ngala was presented to the current day. This section now gives a brief overview of the current range of national services and the diversity of service contexts and State governance arrangements in EPS in Australia. All services are member organisations to the AAPCH and have collaborated on a number of projects over time. They are all committed to providing centres of excellence in early parenting work and all of their websites demonstrate an ongoing striving towards generating new evidence and evaluation of services.

3.15.1 NSW—Tresillian Family Care Centres, [www.tresillian.net](http://www.tresillian.net)

Tresillian Family Care Centres is a third-schedule public hospital, providing specialised child and family health services. Tresillian’s role is:
• To work towards the promotion of Tresillian as a centre of excellence in child (0–5 years) and family health.

• To provide holistic family care within a primary health care framework through a range of services responsive to community needs. Primary health care includes specialised nursing care, medical support, psychosocial interventions, family advocacy, health promotion and clinical assessment of the growth and development of infants and young children.

• To provide child and family health education and associated resources in child and family health to health professionals and the community.

• To develop Tresillian’s advocacy and research role (Partridge, 2012).

Tresillian’s range of services incorporates:

• Primary services (universal support)—Tresillian Live Advice, Parents’ Help Line and group programs;

• Secondary services (prevention and early intervention)—Outreach and day stay services and education services;

• Tertiary services (complex needs)—Residential services and the Home Visiting Early Intervention Program (Tresillian, 2012).

Tresillian has also joined with the University of Technology Sydney to offer the Graduate Certificate for Child and Family Health Nursing. This allows the course to have a strong clinical focus, enhanced by a rigorous theoretical component. Health professional programs are also offered, including Keys to Care Giving, Family Partnership, tele-health and perinatal mental health.

Tresillian is actively engaged in research. The focus of Tresillian’s research activities include developing new knowledge about child and family health, service evaluation and turning evidence into practice (Partridge, 2012).

3.15.2 NSW—Karitane, www.karitane.com.au

Karitane celebrated 90 years of history in 2013. Karitane is a not-for-profit early parenting organisation providing the traditional services such as a helpline, residential and day stay services. They have a perinatal mental health unit that operates using a day stay model; and a focus on individual, family counselling and
therapeutic group work through to earlier intervention support for anxiety and stressful parenting matters. They also provide a range of community services and volunteer programs and a toddler clinic for young children experiencing behavioural issues with the aim to strengthen the parent–child relationship (Karitane, 2012).

Karitane have joined with the University of Western Sydney to offer the UWS Master of Nursing (Child and Family Health Karitane). They have a range of education services for volunteers and professionals in rural and remote areas and a clinical supervision program. They also offer an Advanced Diploma in Nursing for Enrolled Nurses (Karitane, 2012).

Karitane is actively engaged in research and the focus of their research activities include developing new knowledge about child and family health and perinatal mental health issues.


The Ellen Barron Family Centre is a residential State Government facility providing services for early parenting support through parenting education programs. Areas of education and support may include postnatal difficulties, breastfeeding and infant feeding management, child growth and development, behaviour management and parenting issues (Ellen Barron Family Centre, 2013). The Centre provides a service for well families with children aged birth to three years engaged with a primary carer or agency (Ellen Barron Family Centre, 2013).

The Ellen Barron Family Centre specialises in providing child and family health information, education, strategies and support in a multidisciplinary environment, with discharge planning aimed at linking families back into local resources within their own community (Berry, 2012b). The Centre has state-wide responsibilities and as such conducts training, professional development and support for child health services across Queensland. State-wide video sessions are offered to support child health staff in rural and remote areas of Queensland. The Centre also hosts a number of undergraduate and postgraduate students, including from the medical, nursing and allied health disciplines. The Centre works in collaboration with community-based child health services to offer training positions for registered nurses (Ellen Barron Family Centre, 2013).
3.15.4 ACT—Queen Elizabeth II Family Centre, Canberra www.cmsinc.org.au

The QEII Family Centre, which was not involved in this study, is the tertiary service of ACT Health’s primary health service, the Child Youth and Women’s Health Program. This is a residential centre that operates as a support and referral centre for community-based primary health services, providing day stay, sleep group and lactation clinic. Families are identified as high risk or as families needing additional parenting support after treatment for acute health issues. Cases might include infants and families experiencing complex health and behavioural problems including unsettled babies and children with disordered sleeping pattern, complex lactation and other feeding problems, at risk families, special needs families, mood disorders or failure to thrive. The service also provides parenting support and education.

The QEII Family Centre’s model of care is based upon the principles and practices of primary health care, health promotion and the social indicators of health. The platform for delivery of care is C-Frame. C-Frame complements the primary health care model and affords health providers the tools and strategies to work in partnership to achieve positive outcomes for families. The Centre is staffed with specialist child and family health nurses and midwives, as well as a counsellor, community development officer and medical officer. They also refer to other members of the interdisciplinary team whenever necessary (Canberra Mothercraft Society Inc., 2012).

3.15.5 Victoria—Mercy O’Connell Family Centre, www.mercy.com.au

Mercy Health O’Connell Family Centre is a registered public hospital and one of three early parenting centres in Victoria. Services support the whole family and can enhance parents’ confidence in parenting newborn babies and children up to the age of four. This service provides residential and day stay services through key outreach points. Parenting education sessions are provided to a range of target audiences and information, education and training is made available for health professionals and members of the community. Placements through universities are available for students undertaking Maternal and Child Health and Early Childhood studies (Mercy Health Care, 2010).
3.15.6 Victoria—Tweddle, www.tweddle.org.au

Tweddle is a registered public hospital and offers a range of evidence-based, accredited programs and services that aim to strengthen the family unit and build parenting skills and confidence. The residential and day stay programs (with outreach sites) support parents with guidance and problem-solving skills from experienced health professionals. Nursing and allied health professional services and community programs provide support in adjustment to parenting and in coping with many of life’s other challenges. Tweddle provides a preparation for childbirth and parenting program, and MyTime is a program for parents of children with a disability or chronic illness. Breastfeeding support in some regions of Melbourne’s west is provided. Tweddle works with a number of universities and social and welfare organisations to ensure they continue to innovate and deliver programs and services to those most in need (Tweddle Child & Family Health Service, 2012).

3.15.7 Victoria—Queen Elizabeth Centre, www.qec.org.au

The Queen Elizabeth Centre (QEC) is a registered public hospital with a mission to offer specialised support, care and education to families who have children up to three years of age, with the aim of enhancing the health and development of the family. They provide a range of EPS such as residential, day stay and home-based services, education and training for professionals involved with young children and their families including maternal and child health nurses, childcare or family support workers, general practitioners, psychologists and social workers. They offer professional education seminars and parenting skill development services. The QEC also works with universities, government and non-government organisations to ensure continuation of innovation and service delivery focus on those most in need (Queen Elizabeth Centre, 2012).

3.15.8 Tasmania—Three Parenting Centres, www.dhhs.tas.gov.au

The three parenting centres in Tasmania operate within the government provided universal child health system, the Child Health and Parenting Service (CHAPS). They offer intensive support for families experiencing difficulties with children 0 to 5 years of age through day stay services and a home visit program for adolescent parents (South) in the antenatal period and up to two years. Consultations and group
programs are available with social workers, psychologists and child and family health nurses (South only). Parenting centres provide intensive support for a range of parenting issues including postnatal depression, breastfeeding and relationship concerns that relate to early childhood (0–5 years).

3.15.9 South Australia—Torrens House, [www.cyh.com](http://www.cyh.com)

Torrens House is part of the Child and Family Health Service and operates within the government provided child health system. It is a service for parents and babies up to 12 months old. Torrens House is a residential facility with staff that assist with unresolved feeding, settling and sleeping issues by providing intensive support to address identified health issues. Located in Adelaide, Torrens House offers a three and a half day ‘live-in’ stay Tuesday to Friday for nine families each week. Day stay, helpline and other community-based and home visit programs are offered within larger centres of the Child and Family Health Service.

3.16 Chapter Three Summary

EPS have been in existence for most of the last century, if not longer. Throughout this time, nursing has been the major discipline of EPS, although the past two decades have seen the slow introduction of many more disciplines to complement the work of early parenting. A range of factors are influencing national directions, such as family needs in presenting to services, the impact of government policy, the professional skill mix to meet the needs of today’s families, and predictions of future nursing shortages and population growth in Australia, particularly in WA.

This chapter presented the historical background of EPS internationally and in Australia. It discussed the development of scientific motherhood, the European and NZ experience, and how the child welfare movement developed in Australia. This movement impacted simultaneously on the development of the universal child health system and the development of mothercraft homes in each State of Australia. The history of EPS in each State was briefly reviewed, followed by an in-depth description of the history of Ngala. Finally, the current situation of EPS in each State was discussed.

The following chapter now presents an analysis of the data for this study.