2013

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

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Chapter 1: Introduction and Background

1.1 Introduction

Early Parenting Services (EPS) and nursing have a long and interesting history in Australia. The past is described as prior to the 1990s and the current is from the 1990s to the present day. In discussing the future, the focus is on the following 10 years. This chapter will give an outline of the format of the thesis, provide a background to the research topic and explain the need to conduct research in this area.

1.2 Background to the Research Topic

1.2.1 Early Parenting Services

EPS within Australia have a key role in providing services to support families with young children. They strive to continually keep abreast of new evidence, and evaluate their services to align with best practice in the field of early childhood and parenting (Hauck, Kelly, & Fenwick, 2007). There is substantial national and international evidence (Hertzman & Power, 2003; Keating & Hertzman, 1999; Maselko, Kubzansky, Lipsitt, & Buka, 2010; McCain & Mustard, 1999; Shonkoff & Phillips, 2000; Zubrick, Silburn, & Prior, 2005) that comprehensive prevention and early intervention services and programs for children and their families have long-term benefits for physical and mental health, educational achievement and emotional functioning.

Families present to EPS for a range of issues including adjustment to parenting and isolation in the parenting role; an infant's dysregulated sleep and feeding behaviour; behaviour management strategies; nutrition issues; poor maternal postpartum mental health; and parenting assessments for child protection (Fisher & Rowe, 2003; Hauck, Hall, Dhaliwal, Bennett, & Wells, 2011; Phillips, Sharpe, & Nemeth, 2010; Turner, D'Arcy, & Allen, 2006).

For over a century, nursing has been the major discipline within the multidisciplinary setting of EPS in Australia. It is timely to focus on these services because a range of

factors are influencing national directions in family support and children's services, such as families' needs in presenting to services; the impact of government policy on services; the professional skill mix to meet the needs of today's families; and predictions of future nursing shortages over the next two decades (Belardi, 2012).

EPS within Australia have had a vital role in the community in supporting vulnerable parents with young children who need extra assistance in their parenting role. These services are not the universal child health services provided in each state, instead providing services such as intensive support, parent education and targeted services that focus from pregnancy through to the pre-school years. There is at least one Service in each State and each has, to some extent, its origins in the first part of the twentieth century. These services, listed below, are mostly situated in the capital cities of each state, as shown in Figure1:

1. Western Australia: Ngala
2. Queensland: The Ellen Barron Family Centre
3. New South Wales: Tresillian Family Care Centres
4. New South Wales: Karitane
5. ACT: Queen Elizabeth II Family Centre
6. Victoria: Tweddle Child & Family Health Service
7. Victoria: O'Connell Family Centre
8. Victoria: Queen Elizabeth Centre
9. Tasmania: Parenting Centres (3 day stay services) Hobart, Launceston and Burnie
10. South Australia: Torrens House.

Figure 1. Early Parenting Services in Australia

1.2.2 Ngala in Perth, Western Australia

Ngala, a not-for-profit early parenting organisation, originated in 1890 as the 'House of Mercy' and was established as a 'Refuge for fallen women' in Perth (Lang, 1980). Over 120 years, the organisation has evolved and changed to meet the needs of society's families with young children. This work has included a refuge for pregnant young women, out-of-home care for children, adoption services, parenting support and information and training for mothercraft and child health nurses. From 1916, the organisation changed its name to Alexandra Home for Women. Nurses had a key role in service provision during this time, and in 1959 the organisation was named Ngala Mothercraft and Training Centre. 'Ngala' is an Aboriginal word from the Bibbulmun dialect that means 'mother and child' or 'we two' (Lang, 1980, p. 57). The 1980s brought radical change to Ngala and into the 1990s there was a refocus towards an increased multidisciplinary approach [1] with an expansion and diversification of services from the traditional nursing practice. The majority of disciplines practicing now at Ngala are nursing, midwifery, social work, psychology and early childhood. The predominant discipline continues to be nursing, with most

[1] Prior to this time nurses were the major discipline, along with visiting medical officers. The first introduction of a social worker occurred in the 1980s.

of Ngala's nurses in their emerging years leading up to retirement age. This is consistent with other EPS around Australia.

The challenge for Ngala in the future is how to best plan and meet workforce requirements, the expectations of nurses in this setting, demand from families with young children and the range of complex needs facing many families. Questions about the best skill mix and ratio of staff and how best to prepare for the future are often asked, particularly given the intergenerational issues for the nursing workforce. Issues such as different attitudes to work and the need for increased flexibility, shared governance approaches and ongoing learning opportunities need to be considered (Crowther & Kemp, 2009; Jamieson, 2009; Lower, 2008; Schwarz, 2008; Wilson, Squires, Widger, Cranley, & Tourangeau, 2008b). These issues are expected to affect recruitment and retention and organisational succession planning for the future.

To consider the above issues, it is necessary to understand how nurses perceive their role, and how their non-nurse colleagues perceive the nursing role within an interdisciplinary team.

1.3 Topic and Purpose

Nursing in EPS has evolved and developed over time. Nurses working in this specialist area in Australia are predominantly registered nurses with child health certificates or diplomas, or midwifery certificates or diplomas; mental health nurses; or mothercraft or enrolled nurses. They all work in various contexts within EPS in conjunction with other professional disciplines through centre-based services or community outreach programs. The purpose of the study was to explore the perceptions of nurses and allied professionals to determine how the past and present context of EPS influences its future.

1.4 Significance of Study

The need to provide evidence for how services are operating is a continuous challenge facing EPS throughout Australia. Funding bodies now require reports on outcomes for families and children's services. While over the past decade services have been focusing on evaluation and research for their services, there has been

limited documented evidence of workforce planning for these areas. Duffield has been the most active in the area of nursing in Australia and internationally (Duffield, 2008; Duffield, Gardner, Chang, Fry, & Stasa, 2011; Duffield & O'Brien-Pallas, 2002; Gardner, Chang, & Duffield, 2007) and has looked broadly at the context of paediatrics, neonates and child health (Duffield, 2008). Health Workforce Australia (2012a, 2012b) have also been analysing the nursing workforce data, and have found there to be poor data in the area of community health nursing generally.

Over the next two decades, there will be an exodus of nurses reaching retirement, with little or no evidence currently available for EPS to guide future directions. It is thus timely to ask nurses how they perceive their current role as they work directly with other professionals within this specialist area, and what solutions they see could assist in future planning of workforce directions for EPS.

To establish a comprehensive understanding of this issue, it was necessary to explore the perceptions of nurses and their non-nurse colleagues in one State setting, before then using this specific State case to explore national service sites. In doing so, an overall framework for future directions in nursing is developed that considers an interdisciplinary context and focuses on the needs of families with young children today and for the future.

This study contributes to new knowledge in three areas. Firstly, it describes how nursing has evolved through the history of Ngala and early parenting organisations in Australia. Secondly, it describes the current nursing role within the context of an interdisciplinary team environment. Thirdly, it provides a framework for the future direction of nursing in EPS in Australia and identifies the priorities for the next three to 10 years.

Ngala, as the formative part of this research, informs phases two and three of the case study from a national perspective, which had the aim:

- To explore the past and present and explain the future of nursing in EPS in Australia.

Further questions were developed based on this aim, to guide an exploration of this subject matter.

1.5 Research Questions

The aim and purpose of the study gave rise to the following research questions:

1. How has nursing evolved within EPS at Ngala?
2. How do nurses perceive their role within the context of an interdisciplinary team?
3. How do allied professionals perceive the nursing role within the context of an interdisciplinary team?
4. How has nursing evolved within EPS in Australia since the inception of services?
5. What is the present situation of nursing in the context of EPS nationally?
6. What are the future changes required in EPS as perceived by nurses nationally?

1.5.1 The Research Questions and Related Literature

1.5.1.1 Introduction

This literature review is presented in two parts. This chapter gives the broader context, including the history of the infant welfare movement and its influence on nursing in EPS within Australia (see Section 1.6). This includes the professional context; that is, nursing roles and the development of advanced nursing practice, collaborative and partnership approaches, interprofessional education (IPE) and interprofessional practice (IPP), and changes in government policies. Section 1.7 encompasses literature pertinent to the gaps identified for EPS, including as regards the nursing context within national EPS, the nursing role within interdisciplinary teams and nursing workforce priorities within EPS.

The context and the published literature related to EPS overlaps to a great extent. Therefore, it was decided to include the literature review along with the background in Chapter One, rather than to separate them by chapter. An extensive review of the literature was conducted overall, using library computerised search facilities and the researcher's extensive experience in this area of work. Further, the researcher's current networks in Australia were used to identify further key literature and studies being undertaken, to confirm the gaps in the literature. The search was continuous

throughout the study and enabled the following synthesis of contextual issues to contribute to the understanding of the past, present and future of nursing in EPS.

1.6 Literature Providing a Broad Context to Nursing in EPS

This section focuses on the professional issues affecting the context of nursing in EPS in Australia. However, first, an historical background is provided on the development of EPS (covered in greater detail in Chapter Three) and the infant welfare movement around Australia, and the influence of scientific motherhood.

1.6.1 The Rise of the Infant Welfare Movement

The infant welfare discourses of the first 70 years of the last century were strongly influenced by scientific child-rearing, whereby the nurse's role was to train and teach the skills of 'mothercraft' to 'ignorant and indifferent mothers' (Callaghan, 1992, p. 9; Kitchens, 2005a). Infant mortality was often central to the debates of the 1800s and the first part of the 1900s (Featherstone, 2009; Kitchens, 2005a). The infant welfare movement focused on the health of infants and young children, but with a community emphasis. Internationally, similar trends can be observed from the beginning of the twentieth century in the United Kingdom (UK), Europe, New Zealand (NZ) and the United States (US) (Armstrong, 1939; Bryder, 2003a; Reid, 2001b). In most Australian states and NZ, medical officers were championing the cause of reducing infant mortality. Examples include Armstrong (1939) in New South Wales (NSW), Truby King in NZ (Bryder, 2003b) and Jull (1940) in Western Australia (WA) (Jull, 1940; Lang, 1980). In this context, nurses were responsible for health surveillance, providing support for breastfeeding and the education of mothers in relation to household management, hygiene and efficient child care (Brennan, 2007; Callaghan, 1992; Wilson, 2003).

The rise of this movement was also supported around Australia by many women's volunteer organisations. In some cases, these organisations even employed nurses until governments eventually took control of infant welfare services. These volunteer organisations also assisted with the building, upkeep and running of the infant welfare facilities, including EPS in many states (Kane, 1980; Lang, 1980; Thorley, 2000).

1.6.2 Nursing Roles and the Development of Advanced Nursing Practice

Child and family health nursing is one of the oldest postgraduate certificates for registered nurses, having been available since the early part of the twentieth century. This course could only be undertaken after a nurse had undertaken general and midwifery certificates, with the nurse then known as a 'triple certificate' sister. The 'infant welfare' or child health course transitioned into the tertiary sector during the 1980s, and since this time the role has changed and broadened to align with social, political and economic perspectives, policy changes and societal and family needs (Brookes, Daly, Davidson, & Halcomb, 2007).

Role theory is a useful conceptual framework to describe role perceptions that are influenced by societal attitudes, government policies and trends in professional issues. The theory defines how individuals behave in social situations and how these behaviours are perceived by external observers (Brookes, et al., 2007). A large part of this study involves exploring and understanding the evolving nursing role within EPS in Australia from the perspective of the past, present and future. It was decided to explore 'role theory' to explain the trajectory in the role of nursing in EPS over time. Although this theory initially appeared more relevant to the earlier nursing role, contemporary views also explain societal changes important to the changing role of nursing in EPS. Biddle (1986, p. 68) states that 'role theory concerns one of the most important characteristics of social behaviour—the fact that human beings behave in ways that are different and predictable depending on their respective social identities and the situation' (p. 68).

A number of perspectives on role theory began appearing from the 1930s, and these have been developed since that time. Biddle (1986) addresses this diversity of role concepts by examining the five different theoretical perspectives of functionalism, symbolic interactionism, structuralism, organisational psychology and cognitive social psychology. These theories are organised around the notion that individuals occupy a variety of social roles or positions, each of which specifies certain normative behaviours and attitudes (Biddle, 1986). Biddle argues that norms, beliefs and preferences are tied up in expectations of roles (Biddle, 1986), and that individuals hold expectations for each other. As these expectations become known, individuals will conform either because the person holding the expectation is in a

position of power and can apply sanctions, or because the individual simply internalises the normative expectations.

Some theorists have discussed problems with role theory and the concept of expectations, with some suggesting that role theory holds that social integration is to be valued and that personal satisfaction is intricately tied to one's acceptance and fit within the existing social structure (Biddle, 1986; Jackson, 1998). Although role theory does emphasise conformity and social integration, theorists do recognise that conflicting pressures can occur that create 'role conflict', such as role ambiguity, role overload, role incompatibility or inadequate skills to perform the role (Biddle, 1986; Jackson, 1998).

Jackson (1998) states that the role theory perspective of human agency minimises the creative nature of humans as they adapt on a daily basis to their environments; how people improvise to reach their goals or life choices, given the constraints of their particular situation against a backdrop of social, economic and familial forces, is not sufficiently explored (Jackson, 1998, p. 53). Role theory would say that the support of organisations is crucial while nurses are being challenged with their role expectations during a transition phase, for them to generate a sense of meaning and purpose that contributes to their own psychological wellbeing. Nurses must then modify their attitudes and expectations through anticipatory socialisation and adapt through training and professional support in their new defined role (Burnett, 1999).

As nursing evolved following the introduction of nursing into the tertiary sector, considerable ongoing changes were created for hospital-trained nurses. Models of nursing were developed and implemented in response to changes in policy, clinical management and budgetary constraints (Wagner, 2001). Many of these proposed significant changes to the historical role of nurses working in community settings, including a substantial move towards specialisation (McKenna, Keeney, & Bradley, 2003). Nurses in child and family health services broadened their roles in response to changes in society, the changing nature of family needs and issues, or because no other disciplines were able to do or assist with the work necessary to meet demands (Barnes, Courtney, Pratt, & Walsh, 2003; Borrow, Munns, & Henderson, 2011; Harmer, 2010). While many embraced this change, others found this to create role conflict and overload (Brookes, et al., 2007; Marron & Maginnis, 2009).

Advanced practice roles have developed over time, creating conflict and tension within nursing from some perspectives (Duffield, et al., 2011; Gardner, et al., 2007; Laperrière, 2008; Woods, 1998). Gardner et al. (2007) developed an operational framework to identify, establish and evaluate advanced nursing positions. The authors adapted (Gardner, et al., 2007) and validated (Chang, Gardner, Duffield, & Ramis, 2010; Chang, Gardner, Duffield, & Ramis, 2011) the Strong Model of Advanced Practice by Ackerman, Norsen, Martin, Wiedrich and Kitzman (1996) to provide workforce and health planners with a tool by which to differentiate the profile and service potential of the advanced practice nurse. Table 1 outlines the domains of the framework, with descriptions of each domain.

Table 1. The service parameters of the APN role, adapted from the Strong Model of Advanced Practice (Gardner, et al., 2007, p. 388)

Domain	Descriptor
Direct comprehensive care	The APN role will have a clinical component in a field of health service. This direct care translates to a proficiency in patient care that will enable the clinician to inform care coordination, care delivery and guidance and direction to others relevant to a specific patient population
Support of systems	The APN operates within a system of health service. The APN role will be a response to the need for innovative models to address unmet patient care and/or health service needs. The role will be involved in facilitating the optimal progression of patients through a health care or health service system
Education	Education is part of APN roles and includes a wide range of activities that relate to dissemination of current scientific knowledge. The APN clinician provides education to patients and communities to promote wellness, to patients enabling them to cope with illness and self care, and to trans-disciplinary clinicians and students
Research	The APN role supports the generation of knowledge and integration of research findings into clinical practice. The emphasis in this domain is about creating and supporting a culture that questions current practice and seeks creative and innovative solutions to clinical questions. It is about sustaining a best practice environment for patient and community care
Professional leadership	The APN clinician will demonstrate a commitment to sharing and dissemination of expert knowledge both within and external to the institutional setting. This dissemination relates to involvement with professional activities as well as activities that promote public involvement and public awareness of specific health-related issues

The role of the community child health nurse has been documented internationally (Barnes, et al., 2003; Borrow, et al., 2011; Briggs, 2006, 2007; Cowley, 1995; Eronen, Pincombe, & Calabretto, 2010; Fägerskiöld, Wahlberg, & Ek, 2000; Forbes, While, Ullman, & Murgatroyd, 2007; Grant & Luxford, 2008; Kruske, Barclay, & Schmied, 2006; McPherson, McIntosh, & Mann, 1980; Munns, Downie, Wynaden, & Hubble, 2004; Ochiltree, 1991; Reid, 2001b; Schmied et al., 2012; Shepherd, 2011). Historically, the work of nurses has been divided into the public health role including parent education and the health and wellbeing of children. More recently, this role has broadened to include health promotion and consideration of the psychosocial dimension of families (Briggs, 2006, 2007). In response to growing evidence that childhood experiences are closely linked to later adult functioning,

nurses have had to incorporate this knowledge into their practice (Edgecombe & Ploeger, 2006; Kruske, et al., 2006; Marmot, 2005). Studies also indicate that the nurse–family relationship is central to practice and cultural competence (Briggs, 2007; Drennan & Joseph, 2005; Grant & Luxford, 2011; Kemp, 2005; Riggs et al., 2012). There are descriptions of nurse competencies for the advanced role in child and family health nursing in WA, NSW and South Australia (SA). Briggs (2011) responds to the Productivity Commission's (2011) draft report and highlights the need for national consistency for educational preparation and support for new graduates. Kruske and Grant (2012) also recommend that national consistency of education of child and family health nurses needs close consideration.

1.6.3 Collaborative and Partnership Approaches

Collaboration is a means of producing something together from the interactions of people or organisations, their knowledge and resources. These interactions are facilitated by relationships that are established and maintained by the people and organisations participating in the collaboration. Relationships give collaboration strength and the ability to function effectively. The quality of these relationships is determined by three factors: 'trust, reciprocity and mutuality' (Keast & Mandell, 2010, p. 1).

The key to having an effective partnership model is the surrendering of professional control and reliance on the expertise and ability of the client in understanding, learning and managing their situation. Working in this way does not deny the expertise of the professional; it merely identifies the complementary expertise of the parent (Dunst & Dempsey, 2007; Shields, Pratt, & Hunter, 2006). Effective collaboration with other services and disciplines requires knowledge of the roles and responsibilities of colleagues and recognition of one's own boundaries. This was seen as important for nurses in universal services to increase their engagement with vulnerable families (Schmied et al., 2010). Many child health services have implemented 'family partnership training' with nurses to enable practitioners to work more collaboratively with clients and other professionals (Nemeth, 2008; Rossiter, Fowler, Hopwood, Lee, & Dunston, 2011). Nurses have generally described this experience as 'a large-scale cultural change, taking them out of their comfort zones

and often challenging years of experience' (Fowler et al., 2012; Rossiter, et al., 2011, p. 381).

1.6.4 Interprofessional Education and Practice

Collaboration and working in partnership are crucial elements to successful relationships within IPE and IPP. More universities are now focusing on IPE in their undergraduate programs. Engum and Jeffries (2012, p. 147) consider core elements needed to ensure effective practice, giving their shared competencies for IPE curricula as communication, professionalism, system-based practice, knowledge and problem-solving. The authors stressed that team members must understand their goal, and they reinforced that strong leadership is crucial in managing the various team disciplines, roles and experience levels that comprise collaborative work. The role modelling of partnership and reflective practice approaches is necessary for an interdisciplinary team to work together to achieve the desired goals (Bennett, Hauck, Bindahneem, et al., 2012).

For IPE to be successful when transferring the application of skills into a service organisation, commitment across all settings is required. Champions in the workplace need to be identified to enrich the student placement experience (Missen, Jacob, Barnett, Walker, & Cross, 2012). An exploratory study was undertaken in WA to ascertain the scope and range of IPE activities taking place in WA institutions (mostly universities) (Nicol, 2013). Nicol found that professional perspectives were such that they supported IPE, but many were not prepared to actively engage with it. Some of the perceptions presented were fear of role substitution and insufficient evidence to persuade professionals to adopt IPP. There appeared to be a knowledge deficit of other disciplines and an attitude of 'professional territorialism'. The lack of training for clinicians delivering teaching content was also a matter of concern. The resistance to teaching IPE from teaching staff included the above reasons, as well as perceptions of 'change fatigue', the belief that IPE was a 'flavour of the month' and would not last, and insufficient time for IPE because of the focus on discipline-specific content. The report recommended that local universities establish common cross-disciplinary competency and capability standards and assessment criteria that could become an Australian example (Nicol, 2013, p. 21).

Internationally, support for IPE is gaining momentum, such as in 'learning together for working together' (Barnsteiner, Disch, Hall, Mayer, & Moore, 2007; Barr & Ross, 2006; Clarke, 2006; D'Amour & Oandasan, 2005; Dunston et al., 2009; Hammick, Freeth, Koppel, & Barr, 2007; Matthews et al., 2011; World Health Organisation, 2010b). A study by Matthews et al. (2011) in Australia found that a range of interconnected changes is required to successfully mainstream IPE for health professionals, incorporating policy, cultural, institutional, funding and practical dimensions. Cooper, Braye and Geyer (2004) propose 'complexity theory' as a framework that can provide the scaffolding on which to build IPE and provide clear guidance for its future development, and assist with guiding practice, intervention goals and explanations for outcomes.

1.6.5 Changes in Government Policies

There are many policy drivers driving health care reform and the focus of IPE. First among these is the Australian health workforce shortage. To meet current demand and future challenges, it is becoming increasingly necessary for governments and health care providers to look differently at the provision of health care in Australia. Secondly, there are issues with health demographics and inequalities. These include the demands of an ageing population, necessitating a focus on chronic disease, and the disparities evident for disadvantaged sectors of the Australian population; namely, for Aboriginal and Torres Strait Islander peoples and people with disabilities and mental health conditions. Thirdly, with advancing technology, there are demands for new models of health care and workforce practices. As the fourth driver, consumers now play a critical role in the delivery of services and are increasingly informed. Finally, the focus on quality and client safety has created systems that can be quite cumbersome and administratively burdensome. Together, these issues create a complicated service delivery context, the navigation of which requires effective interdisciplinary teams (Nisbet, Lee, Kumar, Thistlethwaite, & Dunstan, 2011).

Schmied et al. (2011) reviewed policy and frameworks for maternity and child health services around Australia. They found that current policies were in line with international research and policy directions, emphasising prevention and early intervention, continuity of care, collaboration and integrated services. All states are consistently advising health professionals to work in partnership with women and

families, to collaborate with other disciplines and use team approaches to care planning, and to collaborate across the government and non-government sectors (Roche et al., 2005; Schmied, et al., 2011). However, to shift from traditional expert-based system approaches and to work collaboratively requires substantial socio-cultural and organisational change (Dunston, Lee, Boud, Brodie, & Chiarella, 2009).

Integrated approaches to health care delivery are now advocated by governments internationally (Nisbet, et al., 2011). In Australia, strategies have been developed and implemented for a more integrated response to the needs of children and families (Schmied et al., 2008). Localised integrated service models are being developed in most states with the support of both State and Commonwealth Governments to enable better outcomes for families in accessing health, welfare and education services. At a system level, key strategies have included the implementation of liaison positions, multidisciplinary teams, co-location of services and care coordination or case management. Lessons from collaborative practice in the field emphasise a need for health professionals to understand and respect each other's skills and be willing to negotiate spaces for professional engagement (Moore & Skinner, 2010).

These broader professional contextual issues have affected EPS around Australia. The following sections presents the literature that is more directly related to EPS.

1.7 Literature Providing a Context to Nursing in EPS and the Gaps Identified

This section divides the literature into three major groupings, described under the following headings:

1. The nursing context within national EPS;
2. The nursing role within interdisciplinary teams;
3. Nursing workforce priorities within EPS in Australia.

1.7.1 The Nursing Context within National Early Parenting Services

Nurses working within EPS in this study are described as follows:

1. Child health nurses are registered nurses with either a child health nursing certificate or postgraduate certificate/diploma of child and family health nursing. Many child health nurses also have a postgraduate certificate or diploma in midwifery.
2. Midwives are registered midwives with other qualifications such as general nursing and either a midwifery certificate or a postgraduate diploma in midwifery.
3. Mothercraft nurses/enrolled nurses are registered with the Nurses and Midwives Board.
4. Mental Health Nurses are registered nurses with other qualifications such as general nursing and either a mental health certificate or postgraduate diploma in mental health nursing or a postgraduate diploma or Master's degree in infant mental health.

Nurses have been undertaking nursing research in EPS over recent years. Outcomes include the development of a model of care, a Delphi study, and the development of an interdisicplinary research agenda to identify research priorities (Bennett, Hauck, Bindahneem, et al., 2012; Hauck, et al., 2011; Hauck, et al., 2007) and practice-related issues (Briggs, 2007; Chavasse, 2010; Fowler, Rossiter, et al., 2012; Fowler, Rossiter, DeGuio, & Briggs, 2009; Hauck, et al., 2011).

Nurses have been the predominant discipline within EPS for many years, and in many states this remains the case. However, no comprehensive overview of nursing exists for EPS in Australia. Some states have developed competencies for child health nursing (Australian Confederation of Paediatric and Child Health Nurses, 2006; Community Nurses Special Interest Group, 2001; The Child and Family Health Nurses Association (NSW) Inc., 2009a), and various authors have described aspects of nursing history broadly (Mein Smith, 1997) or more specific to their State (Ashton, 2009; Brennan, 2007; Cilento, 1967; Crockett, 2000; Edman, 2010; Kane, 1980; McFarlane, 1968; O'Connor, 1989b; Selby, 1992; Thorley, 2000). Yet there still appears to be a gap in the literature in consolidating this information, or in

specifically focusing on EPS. Moreover, there has been no documentation of the nursing role and context of change at Ngala.

Family-centred practice underpins the work within EPS. Over the past two decades, service delivery to families has been shifting from a professionally centred expert approach, to a family-centred model with increasing emphasis on interventions based on family strengths and supports, rather than solely on their needs and deficits. The other elements of this practice contain characteristics that focus specifically on the premise that the family, parent or carer are the primary influences on the child's development and are critical to the success of early intervention for the child. Family-centred practice places the family as the expert and as central to understanding the wants and needs of their children (Dodd, Saggers, & Wildy, 2009; Dunst & Dempsey, 2007; Keen, 2007; Scott, 2005; Wade, Mildon, & Matthews, 2007).

An increase of allied professionals working in EPS over recent years has meant that nurses are being exposed to and influenced by other ways of working. This process of change has created some overlap in roles and work across discipline boundaries (Orchard, Curran, & Kabene, 2005a; Priddis & Wells, 2010b; Scholes & Vaughan, 2002). Duffield et al. (2011) raised the issue of role blurring, which can be a problem of 'role confusion' more in the context of industrial relations. The various awards and pay scales for different professionals can create some unrest when practitioners from different disciplines work alongside each other and are perceived as doing similar roles. Brown, Crawford and Darongkamas (2000) found some evidence of role blurring in their study with mental health community professionals. This was found to be welcomed by a few respondents, while others sought to preserve their own professional identity within the multidisciplinary environment. Brown et al. noted that lack of managerial direction and the encouragement of generic working seemed to make some respondents all the more insistent on separate professional identities. This reinforces the need for broader policy and support at all levels to ensure interdisciplinary approaches.

1.7.2 The Nursing Role within Interdisciplinary Teams

The numbers of other allied professionals involved in EPS around Australia vary considerably depending on the service. Some services are staffed by diverse

disciplines, while in other contexts and jurisdictions there may be very small numbers of other allied professionals working in the service. The major non-nursing disciplines are: medicine, psychology, early childhood education, social work and other social or applied science disciplines. As the number of other disciplines in EPS is steadily increasing, it is important to understand the role of the nurse within an interdisciplinary team—this is a gap in the literature.

Interdisciplinary team practice is described as a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision making around health issues (Orchard, et al., 2005a, p. 1).

Interdisciplinary teams take different forms in EPS depending on the context of work—whether universal, targeted or intensive. In terms of Ngala's services, these contexts are defined as:

- *Universal Services*—services aimed at the general population, such as the Ngala Helpline, parenting and professional education and early years' resources. (Note: different description than universal child health service system in which the targets are to reach 100 per cent of specific targeted age groups of children through child health centres).
- *Targeted Services*—geographically or culturally targeted, such as Ngala's Parenting and Play Time at metropolitan locations and Ngala's Indigenous parenting and children's service.
- *Specialised/intensive Services*—where an intensive response for parents with young children is required by an interdisciplinary staff team. This includes Ngala's day stay and overnight stay and the parenting advice and support service at Bandyup Women's Prison (Ngala, 2012b).

It is not clear at Ngala or other national services how nurses work with other professional disciplines. Anecdotally, it appears that nurses undertake the major role with families, and use referral mechanisms to allied professionals to share the workload in more intensive work through overnight and day stay services. Within other programs in the community context, there appears to be an increased sharing

and collaboration across roles and disciplines. Briggs (1997, p. 91) describes four models of teamwork:

1. Uni-disciplinary: one professional discipline attempts to serve all the needs of the family and child;
2. Multidisciplinary: several professional disciplines work in parallel to meet the needs of the child and family, with limited interaction and exchange of information and expertise;
3. Interdisciplinary: several disciplines coordinate their services to the child and family but with limited crossing of disciplinary boundaries;
4. Trans-disciplinary: several disciplines provide an integrated service to the child and family, with one professional staff member acting as a conduit of services for the team.

Glenny and Roaf (2008) examine a series of case studies of multiprofessional work to understand what works and why. In the successful case studies, the practitioners were able to reflect on the organisational contexts in which they worked. This was achieved through a carefully managed series of feedback loops, which ensued that good quality information was shared at all levels. With an effective communication system in place, practitioners could resolve difficulties and evolve new ways of working together to improve their joint practice. Glenny and Roaf draw on complexity theory to provide the analytic tools for exploring and developing the communication systems that underpin effective multiprofessional practice. They argue that the effectiveness of working with families with young children is vitally dependent on the quality of the families' relationship with practitioners—communication is the key.

The focus of this study is on elucidating the role of nurses and how they work with other allied professionals in EPS contexts. The perception of these nurses of the future of EPS will also be explored.

Duffield (2008) raises an important issue for future consideration of nurses working within child health, neonatology and paediatrics, and asks whether or not the principles and skills needed are different for nurses, doctors and allied health

professionals. The author puts forward the challenge of whether there are better ways of preparing this specialised workforce given Australia's population and distribution.

1.7.2.1 Family partnerships

Collaboration is the essence of effective teamwork. EPS use one of two frameworks for collaborative practice throughout their services. These are the 'Family Partnership' model by Davis (Davis, Day, & Bidmead, 2002) and the C-Frame framework (Victorian Parenting Centre, 2005). Both frameworks move the practitioner from the need to 'fix things' to a partnership approach when working with a family. The family partnership training works with practitioners to enable them to work with the parent to explore the difficulties they face, to clarify the situation and to develop the most helpful and effective strategies for optimising the psychosocial development of their children (Lamont, 2008). C-Frame also incorporates the family partnership model. Recent studies have been evaluating the effectiveness of the family partnership model in EPS and recommend that organisations ensure sustainable systems to support the process of implementation over the longer term (Fowler, Lee, Dunstan, Chiarella, & Rossiter, 2012; Fowler, Rossiter, et al., 2012; Lamont, 2008; Nemeth, 2008).

For their way of working with families, Ngala in WA uses a strengths-based solution-focused framework called 'C-Frame' (Connect, Collaborate and Change). C-Frame provides a process and tools for practitioners to connect with families and colleagues and work collaboratively towards positive change (Ngala, 2012b). The framework was developed by a consortium of EPS—Tweddle Child and Family Health Service (Victoria), Tresillian Family Centre (NSW) and Queen Elizabeth II Family Centre (ACT)—in conjunction with the Parenting Research Centre in Melbourne (Ngala, 2012b).

Being effective in providing support to families requires constructive and helpful partnerships from the outset, to ensure child safety and wellbeing throughout the stages of child and parenting development. In all kinds of parenting support, from the briefest contacts to extended interventions, professionals and parents come together in a unique relationship. Very different from informal social relationships, this relationship has a specific focus (the child), purpose (helping the parent achieve desired changes) and structure (parameters are placed around the nature and

frequency of contact) (Bennett & Walter, 2010; Pagan, Walter, & Webster, 2004; St John & Flowers, 2009). Parent strengths and life experiences are utilised in the process to motivate the parent/s or significant caregiver towards the positive changes they seek. An underlying principle is that it is the parent/s themselves that need to initiate and maintain behaviour change. Therefore, the relationship between the professional and parent is critical to the process (Hauck, et al., 2011; Victorian Parenting Centre, 2005).

The framework consists of four main phases, which are not necessarily all used or used in any particular order with the exception that phase one is the first step in the process:

- Phase 1: Creating a collaborative relationship;
- Phase 2: Developing a commitment to change;
- Phase 3: Contextual analysis;
- Phase 4: Negotiating change and intervention (Ngala, 2012b).

An example of using C-Frame in a longer consultation (day stay) with parents is cited in Hauck et al. (2011).

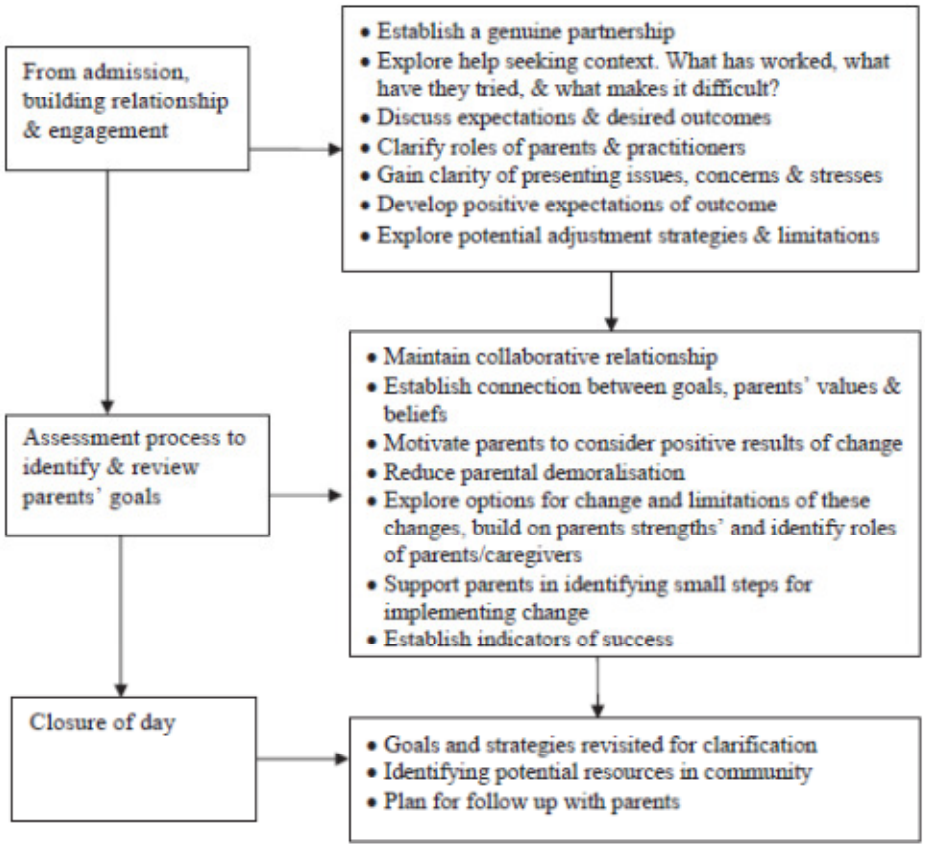

Figure 2. Intervention applied to C-Frame (Hauck, et al., 2011, p. 55)

An important task embedded in C-Frame is the requirement that practitioners engage in regular, scheduled and ongoing reflective practice (Victorian Parenting Centre, 2005). This way of work is also emphasised for when working with colleagues in the organisation (Ngala, 2012b).

While these approaches to care provide a framework for the process of work for practitioners and families, there is no apparent literature available that discusses the nursing role within the interdisciplinary team context in EPS, or how practitioners navigate their roles together with families with young children.

1.7.3 Nursing Workforce Priorities within Early Parenting Services in Australia

As previously stated, Australia's health and community sector workforce is facing significant challenges. Such challenges are well documented and include an ageing population, increased demand for health services, increasing expectations for service delivery, a changing burden of disease and broader labour market issues. In addition, health expenditure as a percentage of gross domestic product is rising, and is projected to increase significantly in the coming decades. It is critical that these

challenges are addressed together to ensure the sustainable delivery of health services that support the health and wellbeing of Australia's population (Health Workforce Australia, 2012b).

EPS has a significant ageing workforce. Gabrielle and Jackson (2008) identified some unmet support needs for older nurses in the health workforce that could discourage them from remaining in nursing. Two major themes were identified. The first was 'feeling uncared for', which contained three sub-themes: unsupportive work relationships, 'we should be helping each other'; workplace bullying and stress; and burnout. The second main theme was 'adapting to ageing'. These findings highlight a need for further research into the support needs of older nurses to find ways to maintain their knowledge and skills in the workplace.

In thinking about the future, Duffield (2008, p. 7) raised questions that can be asked of the early parenting context. Some of these questions relate to the appropriate professional discipline best able to meet the needs of families/children with vulnerabilities today. Further, with the increasing and future demands of families, it is necessary to identify the discrete roles to which nursing contributes, and identify those roles that could be appropriately shared or undertaken by other disciplines.

Duffield (2008, p. 7) also raised the issue that, in this era of intense professional specialisation, we should be 'work[ing] with' parents and children and 'with each other' as professionals, to focus on the needs of our clients, rather than on those of the professional.

With this background in mind for this study, the driver was to understand how nurses working in EPS perceive and understand their role, and how they work with other members of their team in partnership with the parent, family and child to achieve health and wellbeing outcomes.

This study is significant at a local level for the early parenting work at Ngala, but also has potential implications for national parenting centres around Australia. Given the shortage of child health nurses nationally and the lack of research into this specialist area of nursing, it is a timely study. It will also provide direction for future workforce requirements, and the findings will have the potential to be used to

develop, implement and evaluate a range of future strategies for the staffing and training of an interdisciplinary workforce.

1.8 Chapter One Summary

This thesis presents a research project exploring the past and present and explaining the future of nursing in EPS in Australia. Research on these specialist services has been increasing over the past two decades, yet remains scant. No research has been conducted on the nursing role in the context of an interdisciplinary team.

The research project comprised three phases, followed the trajectory from the investigation of a sole EPS site in WA to the national setting of eight other sites. This approach provided rich data through mixed methods and the inclusion of the researcher's own experience in the history of nursing and connection with Ngala. At the time of commencement of this study, uncertainty was being expressed by nurses about the necessary requirements of the workforce, and there was some nervousness about the potential future crisis looming for nursing. The organisation Health Workforce Australia was also gathering momentum and starting to analyse data to make future projections about the need for health workforces.

The following chapters and the research study format have been approached in the following way:

Chapter Two: The methodology chapter gives an overview of the research paradigm and strategy. The details of each phase of the study are addressed, including the sample, data collection and analysis. The researcher's reflection on her personal nursing experience and connection with Ngala is situated at the end of this chapter.

Chapter Three: 'The case' sets the context as EPS with relevant international and national literature and the historical experience and overview of each state. The history of nursing at Ngala is explored in-depth.

Chapter Four: The analysis of the data and findings are presented in this chapter, with the three phases of the study presented in respective sections.

Chapter Five: The discussion of the findings is presented with a summary of the new knowledge in relation to the relevant literature and theoretical considerations.

Chapter Six: The conclusions and recommendations consider the significance of the findings, their limitations and the implications for clinical practice, education, research and organisations.

The importance of the early years of life is well documented, but despite this there remains a shortage of good quality evidence to guide organisations on the nursing role when working closely with other disciplines in EPS. Likewise, no framework exists for future directions in workforce development for EPS. This study bridges this gap and provides recommendations for the future.

In this chapter, the general background of the topic leading to the research questions was introduced. This included a discussion of the overall context of EPS and Ngala, and the significance of this study to Australian EPS. The following chapter will present the research paradigm and the case study strategy, while Chapter Three provides a detailed description of the case of interest—that is, nursing in EPS in Australia.