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Nurses' experiences of home visiting new parents in rural and regional communities in Australia: a descriptive qualitative study

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Abstract

Purpose – Child and family health (CAFH) services in Australia initially provide at least one nurse-home-visit following the birth of a child. Planning and referral then commences for the on-going provision of appropriate services to families. Unfortunately, services in rural and regional communities in Australia can be fragmented and poorly resourced. Little is known about CAFH nurses' experiences of working with families in these communities. The purpose of this paper is to examine the way CAFH nurses work within a universal health service model that may be compromised by isolation, discontinuity and fragmentation.

Design/methodology/approach – Focus groups with 26 CAFH nurses from five rural, two regional and one urban community in New South Wales (NSW), Australia were conducted. A secondary, thematic analysis of the qualitative data were undertaken to reflect on change and continuity in the field of universal CAFH services. Analysis was driven by two key research questions: How do CAFH nurses experience their role in universal home-based CAFH services within rural and regional areas of Australia and, what unique factors are present in rural and regional areas that impact on their CAFH nursing role?

Findings – The experience of the CAFH nurses as presented by these data revealed a role that was family centred and concerned for the welfare of the family, yet compromised by the need to meet the disproportionately complex needs of families in the absence of a strong network of services. The opportunity to present the findings provides insight into the way in which families engage with available services in isolated communities. CAFH nurses in the study attempted to maintain service integrity by adapting to the unique context of their work.

Originality/value – It is important to understand the mechanisms through which CAFH nurses operate to work effectively with families referred to their service. This paper describes the way in which CAFH nurses work with families not meeting the threshold for more intensive and targeted home-visiting service delivery in rural and regional communities of NSW, Australia.

Keywords Australia, Child protection, Qualitative methods, Prevention, Nursing, Early intervention, Child and family health, Rural nursing, Universal child health service, Parenting programmes

Paper type Research paper

Introduction

In Australia, child and family health (CAFH) services deliver a wide range of community and home-based nursing and other early intervention and prevention services to healthy children and their parents from birth and throughout childhood. These services are provided free to all families. Services differ slightly across the states and territories (see Schmied *et al.*, 2015), but generally families with complex service needs and cumulative risk factors for child abuse and neglect receive targeted programmes, usually in the form of sustained home-visiting (HV) programmes such as MECSH in New South Wales (NSW) (Kemp *et al.*, 2011) and Family Care in Queensland

(Fraser *et al.*, 2000). These targeted HV programmes are aimed at promoting resilience to adversity. Families not meeting the threshold for these evidence-based programmes may have access to a universal CAFH service aimed at supporting parenting in the early years.

The role of the universal CAFH services in Australia has been moving further away from a model that supports universal prevention and child health promotion through health screening, breastfeeding support, immunisation and so on, to one that is more concerned with social and welfare issues resulting in referral to either child protection services or more intensive targeted programmes. Targeting at risk families for home-based services is a popular primary strategy relied on by governments in Australia and overseas to intervene at an early stage. Yet the programmes can be expensive, and there is continuing debate about their effectiveness (Flemington *et al.*, 2015). Sustained nurse-home-visiting programmes are well reported in the literature, but the creep of child protection work into universal models of CAFH nursing has been largely unnoticed even by nurses undertaking the work. Research led by the University of Western Sydney in NSW has revealed the discontinuity and fragmentation of CAFH services in Australian states and territories and recommends a national approach to service delivery (Schmied *et al.*, 2011).

Increasing evidence suggests that fragmented and ineffective service delivery to families compromises their resilience to adversity. Universal HV services allow for more detailed social assessments of children in terms of their threshold for risk of abuse and neglect and referral to sustained HV or child protection services. At the same time, the study by Cowley *et al.* (2012) warns of the risk to proactive, universal prevention activities of CAFH services when nurses concentrate on risk assessment and referral. Australian CAFH nurses engage in complex home-based work in rural and regional communities and are often isolated. The aim of this study was to explore the way in which CAFH nurses work with families that do not initially meet the threshold for more intensive and targeted HV service delivery, in rural and regional communities of NSW.

The role of nurse-home-visiting in early intervention and prevention

Nurse-home-visiting programmes for early intervention and prevention of a range of CAFH and social welfare outcomes are practiced widely. Internationally, models vary in terms of who visits and whom they visit as well as what they do. In Australia, there has been increasing attention paid to sustained nurse-home-visiting for families at risk of child abuse and neglect. On the other hand, relatively little has been written about universal HV where child protection activity has increasingly become the feature of work formerly considered as universal prevention and child health promotion. This is important. Community CAFH nurses in most Australian jurisdictions, including NSW where this study was undertaken, engage in universal HV. But increasingly the role involves assessment of risk for abuse and neglect, referral and support to access appropriate resources (Cowley *et al.*, 2012; Schmied *et al.*, 2014, 2015).

There is still considerable work to be done in developing a model for this work. In many countries, including the UK and Australia, increasing concern for the protection of children from child abuse and neglect has led to more emphasis on targeted, early intervention strategies. This trend has been accompanied by a desire to identify measurable outcomes for CAFH nursing practice and to plan services according to their evidence. Nurse-home-visiting is one approach noted for its ability to strengthen and improve the family environment into which children are born. But little progress has been made to date in the field to conceptualise this for the nursing workforce (see Cowley *et al.*, 2012 and the excellent contributions by Schmied *et al.*, 2011, 2014, 2015).

As new models of CAFH services have emerged, the role of nurses in community-based services has become the focus of a number of studies. This increase in HV service delivery has not merely seen changes in policy (Schmied *et al.*, 2011), but a shift in the perspectives of how CAFH nurses work with families. In Australia and elsewhere, the focus has changed to give emphasis to psychosocial and emotional care for the mothers for whom they are responsible. CAFH nurses have been concerned about the degree to which they have been consulted (Sawyer *et al.*, 2013). This is especially so in relation to new roles and functions. At the same time, CAFH nurses have found it difficult to articulate their operating processes and have been frustrated with not having

been involved in the planning and development of their service as more targeted and indicated models of prevention have been introduced (Barnes *et al.*, 2003, 2004).

In a comprehensive study of Australian nurses experiencing this shift in the focus of their work, some clear differences in nurses' roles and workloads were established (Kruske *et al.*, 2006). More expertise was needed to complete psychosocial assessment and to respond to complex issues such as domestic violence. Maintaining integrity of the prescribed programme while at the same time balancing the service to meet individual needs of children and families created tension. This tension has been described again more recently by nurses implementing a targeted approach to health visiting in the UK (Condon, 2011).

Specific criticisms of programmes have included disruption to the relationship between the nurse and the parent due to high staff turnover and discrepancies in staff education and training (Duggan *et al.*, 2007). Current initiatives in the suite of HV strategies include those targeting specific high-risk family factors such as domestic violence and parental psychopathology. These programmes seek to augment standard prevention and early intervention techniques designed to improve overall family capacity. Engagement and retention of families with such complex service needs is a major challenge (Flemington *et al.*, 2015). The quality of training and supervision for specialised, targeted work has not been adequately assessed in Australia or overseas (Jarrett and Barlow, 2014).

Nurse-home-visiting also raises issues for nurses in complying with laws requiring them to report suspected child abuse and neglect. Since many HVs are conducted with children who have been or may be at risk of abuse or neglect, nurses are faced with legal and professional decisions and their consequences. On the one hand, they are legally bound to report suspected abuse and neglect, but on the other hand, where this situation arises, it produces further challenges for the therapeutic relationship with both the child and family. Decisions about whether to report, and how to maintain the integrity and quality of the home-based programme, are pressing issues for these nurses. HV allows for observation and response to aspects of the home environment and day-to-day functioning that would not be observed or reported during an office visit. Its role in family surveillance by health professionals is rarely considered while models of support and partnership with parents are promoted (Davis *et al.*, 2002). The survey by Schmeid *et al.* (2014) of 679 nurses working in a universal service model in Australia highlights the constraints of providing complex care with few resources. The nurses in this study saw that their role was enhanced by good support from management and from working in a team environment. These work characteristics are less likely to be experienced by CAFH nurses in rural and regional communities of Australia.

Whether knowledge and skills gained within the context of a CAFH service for new parents can significantly overcome multiple interacting systems that impact on the parent-child relationship depends on many factors. This includes the integrity with which the programme can be delivered. Without clear evidence for what works in rural and regional communities, nurse HV intervention programmes remain a high-risk investment for governments. Moreover, fragmented and ineffective service delivery to families with complex needs compromises their resilience to adversity as previously mentioned.

Study rationale and design

The purpose of this study was to examine the way CAFH nurses work within a universal health service that may be compromised by isolation, discontinuity and fragmentation.

Two research questions were developed on the basis of the literature reviewed above:

RQ1. How do CAFH nurses experience their role in universal home-based CAFH services within a rural and regional area of Australia?

RQ2. What unique factors are present in rural and regional areas that impact on their CAFH nursing role?

Enactment of current Australian state and national child protection legislation and policy has driven significant change in the roles and responsibilities of the CFH workforce, especially in NSW. This has highlighted the role of CFH nurses in conducting child and family screening

and assessment, and child and family care. Importantly, it has demonstrated the need to understand the experience of CFH nurses in responding to families with complex needs and children at risk of child abuse and neglect. The data used in this study were collected (by MH) at a time when these aspects of the CFH nurses' role and responsibilities changed significantly from an expert model of care to what was understood to be a partnership and consultative approach to child and family care. CFH responses to the more recent government health policies of prevention and early intervention for child abuse and neglect risk cases can best be understood through an understanding of the way in which elements of child protection practice were first experienced by CFH nurses within a rapidly changing context at this time of great change in community child health services nationally.

The policy context at the time of data collection was focused on establishing a universal HV programme as part of the CAFH nursing service in rural and regional areas of NSW. Referral was through maternity services and although the role of fathers was recognised, the primary family contact person was the mother (Whitehouse *et al.*, 2006).

Methods

This paper presents the findings of a secondary analysis of data collected from an earlier unpublished study by MH that examined the HV experiences of CAFH nurses. In the primary study, data had been collected via face-to-face focus groups in 2003. The researcher facilitated semi-structured focus groups ranging in size from 2 to 5 participants, with a total of 26 CAFH nurses participating. The focus groups were conducted in Australia, in rural townships ($n=5$), regional centres ($n=2$) and one urban centre. The focus group interviews were up to two hours in duration and were recorded verbatim and professionally transcribed.

In the current study, the reanalysed data were derived from this one primary study. The secondary analysis used the ecological model as an interpretive lens as there has been an emerging conceptualisation of this model in the years since the data were collected. Employing this lens provided the opportunity to investigate new research questions, and extend the context for interpretation of the data (Phillips *et al.*, 2014). In secondary analysis, asking different questions of the data or applying a different lens can be compatible with the aims of the original study (Jackson *et al.*, 2013). Among qualitative researchers, there has been growing consensus on the strengths and validity of secondary analysis, particularly where there is potential to inform practice and policy formulation (Ziebland and Hunt, 2014). Importantly, data from qualitative studies provide a valuable historical record by documenting experiences from a particular point in time (Gillies and Edwards, 2005). Thus, secondary analysis can be approached from a temporal and historically situated perspective. As many of the challenges associated with child and family nursing have their precedent in the past, and the conceptualisation of the role is rooted in historical frames of family health and nursing, it is of interest to reanalyse the earlier experiences of CAFH nurses in light of contemporary theoretical developments as it provides an opportunity to reflect on change and continuity in the field.

The context

The study was undertaken in a rural area health service (AHS) in NSW, Australia. HV nurses employed by the AHS are all registered nurses with specialist post-registration qualifications in CAFH nursing. The health service district covers an area of a little over 20,000 square km, with a range of publically funded services provided to the population of 290,000 residents (ABS, 2010). The catchment includes a number of smaller dispersed rural and more remote populations. In terms of the extent of social disadvantage, the catchment area, according to the Index of Relative Socio-Economic Disadvantage (a government socioeconomic indicator derived from population census data), was 4.2 per cent below the average score for Australia, and below that of rural NSW (PHIDU, 2005). This socioeconomic measure relates to income, education and employment and confirms considerable socioeconomic disadvantages across the AHS catchment area (ABS, 2010). At the time of the study, single parent families constituted 14.9 per cent of all families in the AHS, a proportion higher than the state and national average of

10 per cent. Further, the proportion of people identifying as Aboriginal and Torres Strait Islander ranged from 4 to 8 per cent, with 31.5 per cent of indigenous families being single parent households, which was one of the highest in regional NSW (PHIDU, 2005).

Data analysis

For the secondary analysis presented herein, the entire data set from the primary study was reanalysed to answer questions that related to the two research questions:

RQ1. How do CAFH nurses experience their role in universal home-based CAFH services within a rural and regional area of Australia?

RQ2. What unique factors are present in rural and regional areas that impact on their CAFH nursing role?

Analysis of the data followed the tenets of thematic analysis (Braun and Clarke, 2006) using the two overarching questions. Initially, the focus group transcripts were read and re-read by the researchers to inductively generate an understanding of CAFH nurses' experiences of HV. Detailed analysis of the transcripts involved coding sections of narrative by hand which described aspects of the HV experience (Boyatzis, 1998). Through an iterative process of categorisation and reduction the codes were clustered manually (Miles and Huberman, 1994). These clusters were read and re-read and themes were identified, refined and named. Throughout this process several meetings were held between the principal research analysts (JA) and other researchers (JF & MH) to discuss the identified themes. This process enabled further consolidation and the identification of thematic threads. The resultant themes are presented in a table of major and subordinate themes.

Ethical considerations

The primary study received ethics approval from the relevant human research ethics committee of the hospital and health service districts. Participants were asked for their consent to use their data for research and subsequent publication. They were provided with a comprehensive information sheet about the study and were informed that their commentary was anonymous. The original focus group transcriptions were anonymous and no identifying details had been included in the original transcriptions. To further ensure the protection of participants, the researcher involved in the primary study carefully read through the transcripts and removed any identifying information prior to the commencement of the secondary analysis.

Rigour

The trustworthiness of the secondary analysis is evidenced by the use of the same research tradition in the primary and secondary study and the compatibility of the research questions between the two studies. Contextual trustworthiness of the data analysis was strengthened as the secondary data analysis involved the researcher responsible for data collection in the original study. This proximal knowledge with the primary data provided checks and balances against misinterpretation in the secondary analysis.

Findings

In total, 26 CAFH nurses participated in the focus groups. This represented the total CAFH nurse workforce in the AHS. The majority of respondents worked in rural locations and 96 per cent of participants were female. At the time of the study, the proportion of the nursing workforce aged over 40 years was 60 per cent.

Table I summarises the themes and subordinate themes emerging from these data. The first two major themes identify how CAFH nurses experience their role in universal home-based services within a rural and regional area of Australia (*RQ1*) and, the third major theme explores the unique factors that are present in rural and regional areas that impact the CAFH nursing role (*RQ2*).

Table 1 Major and subordinate themes

<i>Theme</i>	<i>Subordinate themes</i>
Family centred service (RQ1)	Scope of the CAFH nurse role Relationship with the family
Responsibility for family welfare (RQ1)	Child protection: when should the CAFH nurse report Family follow-up
Safety: the rural and regional experience (RQ2)	Risk management Professional vs personal identity: village community

Family centred services

Scope of the CAFH nurse role. The physical assessment of the infant remained a priority for the initial HV for the universal service. In addition, the service also provided detailed psychosocial assessments. The CAFH nurses described additional skills and experience needed to successfully complete these tasks within the home. This included being flexible, non-judgemental, considering how they are perceived by the family and using advanced assessment skills. Listening and communication were identified as essential skills for the nurses:

You've got to be aware of listening [...] to listen and to find out what's happening (Location D).

That's why I think its so exhausting because you're sitting on edge the whole time just observing and listening (Location F).

In focus group discussion, CAFH nurses described experiencing an intuitive feeling about the complex needs of families. This "gut feeling" indicated a number of factors to the nurse. To the CAFH nurse, this could mean that a mother was not coping with the parenting role. It could mean she was not disclosing aspects of her situation or needed additional support. This "gut feeling" was linked to the experience of the CAFH nurse and was described as "[...] all that peripheral stuff that you look at" (Location G) and the "vibe' the nurse picks up during a visit" (Location H).

Considerable limitations to services in rural and regional areas are lack of resources. CAFH nurses in the focus groups discussed the lack of community resources for families with complex needs. Long waiting lists and complicated referral processes meant that by the time the service was available the family no longer needed that service.

The relationship with the family. The relationship with the mother was central to the CAFH nurses' experience of their role as a HV. CAFH nurses sought to develop and maintain a long-term therapeutic relationship with families to be able to complete their role of assessment and provide the intervention.

To initiate this relationship, the CAFH nurse would introduce their role. They considered how to do this by using their experience, their knowledge of the family from the referral and their immediate assessment of the situation when they arrived at a new home:

You know when you walk into a house whether you're welcome or not (Location C).

This infant is part of her family; it's part of her life that I'm just being introduced to. Can be there for good or can be there for ill, she may let me in the door but still have concerns about what I am going to do or say. So, it's building a rapport [...] (Location B).

Some families were antagonistic towards the CAFH nurse HV. In these situations CAFH nurses spoke of modifying their practice to gain entry, both physically and relationally. A unique construction of this in the rural and remote experience is "veranda therapy" where the CAFH nurses completed their HV without physically entering the home:

You know, you'll weigh the baby, you'll measure the baby, in the back of the car and so forth and then the next time you'll probably get your foot in the door (Location G).

Or you do it on the veranda or out of the car (Location G).

Veranda therapy was used as a way to enter into a discussion with the mother. In negotiating entry to the home, physical assessments of the infant gave the CAFH nurse a concrete

reason for visiting. This focus on the baby in the first instance was perceived as less threatening to the mother:

[...] I say what I'm doing: "I'm monitoring the baby". And then over time you can say: "how are you going? Are you sleeping?" [...] I've got this bag that I carry around and in it I've got my assessment tools which are my scales and measuring devices (Location B).

The CAFH nurses tailored their service to both maintain this therapeutic relationship and meet the family needs. This required flexibility on the part of the nurse:

If a mum was in crisis and you went to the home sometimes I was at home with the mum till seven at night trying to work things out (Location A).

[...] its not uncommon for me to do two home visits for a problem [...] So flexibility (Location F).

Responsibility for family welfare

CAFH nurses in the study believed their home visits were a valuable contribution to the prevention and early intervention for child protection. This was particularly highlighted in discussion around families that were considered to be "at risk":

You spend more time with them, particularly the young ones, because you want them to do a good job (Location C).

For instance if you do see that family at risk you are on your guard because you don't want to lose them out further. You need to keep in there. You need to be a bit more careful about what you say, being non judgmental in more of a way so you can keep your foot in the door [...] (Location F).

Nurses have a sixth sense about lots of things. You just know that you need to be more sensitive and more aware of the adjustments and of the little things that are important [...] you really need to just keep in there and follow them up. And give them those early supports to minimise risk further down [...] (Location F).

This term "at risk" was used to describe families known to or who were at risk of child abuse and neglect. "At risk" was described by the CAFH nurses as certain risk factors such as, "single" parents, "domestic violence", "drug and alcohol" use, "mental health" issues, "isolated", "adolescent mothers", "no social supports", "low income", "poverty" and "wound-up with DOCS" known to the Department of Community Services (DoCS)[1] (Location C; Location B; Location H; Location G).

Child protection: when should the nurse report? The CAFH nurses' role in relation to child protection services and their responsibility to report child protection issues was perceived as a source of tension. While the nurses were legally bound to report child protection issues, ethically and relationally they often found it difficult to make this judgment:

[...] the borderline, who I keep thinking should I be reporting. Yes she is angry but [...] what's the fine line here (Location F).

What I am saying is that I will often give these family's greater leeway than perhaps others would (Location F).

As noted earlier some families were antagonistic to the CAFH nurses. This can be related to a suspicion that the nurses were checking up on them, acting as child protection surveillance. To mitigate this antagonism, CAFH nurses used different strategies to distance themselves from these child protection services (DoCS):

I try to do the first visit with DoCS – so I don't come across as the "baby police" [...] (Location D).

One girl thought I was DoCS, and I told her straight away I wasn't anything to do with DoCS (Location B).

While the CAFH nurses described distancing their role from that of monitoring and surveillance that resembled child protection services, there was also a sense in which they were doing these tasks. This was discussed often when considering those families "at risk" or those families already reported to community service:

[...] you think this child's at risk, and they're never going to come to you again, well how much more is that child at risk because now no one's watching them. So you're trying to keep the rapport going [...] (Location F).

You're certainly more aware. And you will certainly do more home visits for a period of time (Location A).

Family follow-up. The HV service provided by CAFH nurses is free and voluntary. The family can refuse the service. This impacts the nurses' practice in their decision of when to persist in their follow-up of families and where their responsibility towards a family ends:

[...] I might be asking three or four different ways: "can I come back again?" if they're giving me the vibe that they don't want me there (Location B).

This decision regarding follow-up was influenced by previous contact with the family. This related to their initial assessments and concerns for the child's safety:

[...] if they are considered to be at risk or if I've got some concerns [...] I've just got a little book in the clinic that I write down people that I check through who haven't been for a while, and I'll give them a ring or get someone to follow them up (Location C).

[...] if you've seen that person and there's potential risk factors, then it enables you to keep in contact with the family by offering further home visits [...] so you can certainly maybe set the agenda with visits (Location G).

Safety: the rural and regional experience

Physical barriers to HV in these rural and regional areas were apparent in the data. This included the distance to travel and the rough geography. CAFH nurses needed resources such as "4WD", vehicles that can manage rough terrain, and "gumboots", footwear which they can use to walk through mud and in the rain. They also had to look out for "dogs that bite" (Location B). These physical barriers were also a concern for safety reasons.

The CAFH nurses alluded to occasionally feeling unsafe; this included visiting families or areas where they did not feel safe, especially, families with a history of domestic violence. They also spoke of certain locations, for example, some caravan parks, that they were restricted from visiting due to safety concerns.

Risk management. In home-based services there is the potential to walk into dangerous situations. This unknown risk meant the nurses used risk management strategies. For example, sometimes they would visit in pairs or carry a satellite phone. Their own safety and security were discussed by nurses at all the focus group locations indicating this issue spanned the whole region and is a noteworthy concern for nurses HV in rural and regional areas.

Significant to these safety concerns was a discrepancy in the referrals given to CAFH nurses. The CAFH nurses were notified of new births through hospital referrals. At times, known potential safety risks within this family, for example, domestic violence, were not indicated in the referral, so the CAFH nurse had no warning prior to the HV:

[...] you never know (what type of situation you are going into). You get the green slip from hospital [...] (Location D).

[...] but sometimes you get to the front door and you think, ok what am I going to find in here (Location G).

[...] I was lucky to have had warning from the hospital so I could get someone to go with me (Location G).

[...] she actually asked me if I was visiting because she was known to docs. But there was nothing on the record (Location C).

Professional vs personal role: the village community. The nature of a rural and regional area influenced the CAFH nurse's perception of their role. The participants' narratives exposed some of the differences that working in a smaller community had on their role. They also spoke to the difficulty in living personally in the community that you professionally service. One nurse described her role within the community:

[...] I guess I'm seen by some as an auntie/grandma [...] I feel like I'm part of a village community and my role is a early childhood nurse (Location F).

In the above quotation, the nurse expressed a close connection between her personal and professional roles in a positive manner. However, this close connection also had negative impacts for some of the CAFH nurses. For example, nurses said some families would ring them at home (Location A), others said they felt unsafe to report to child protection services because they lived

in the community (Location B; Location D; Location F). These safety concerns were not only theoretical. One nurse described a need to put additional security on their clinic after a conflict with a family.

The HV environment could also jeopardise the CAFH nurses' emotional safety. This was expressed as the emotional trauma of being exposed to certain events, situations and stories:

[...] what do you do with the information, I'm not talking legally I'm talking the emotional stuff that could happen [...] (Location A).

Sometimes it's difficult not to take it home [...] teenage daughters and I've seen teenage mothers [...] (Location C).

Some CAFH nurses believed this emotional toll increased in the HV environment. While nurses noted they could mitigate this emotional toll through supervision and debriefing with their colleagues, they expressed concern that they were not always supported through the services' management:

Different times one of us might be fragile [...] But often we don't get that support from management (Location C).

[...] also that child and family health nurses burn out really quickly. And the ones we've got here are very close – they're tired and sick-of-it. And I think it's lack of support (Location D).

Discussion

CAFH nurses in Australia worked out of clinics with targeted and selective HV provided only when necessary for many years (Barnes *et al.*, 2003). Changes in policy at the time these focus groups were conducted, increased the frequency of HV substantially for nurses working in the universal CAFH service of NSW. These findings are nested within a time of policy change with an increase in HV and represent a snapshot of how CAFH nurses in this rural and regional area experienced HV at the time.

Despite the participating CAFH nurses working within a universal, home-based CAFH service, it is clear from the findings that their role in case-finding for child protection services was at odds with their perceived role at the time. The CAFH nurses experienced tension with families over their role as agents for child protection surveillance. Interestingly the CAFH nurses described distancing themselves from child protection services, despite working closely with them in an isolated community with few resources. Closer examination of this tension in the role is critical to future services planning. CAFH nurses enjoy a high level of trust and respect in Australian communities (Barnes *et al.*, 2003, 2004) and CAFH nurses may perceive their responsibility for child protection reporting and response as a threat to their success in proactive universal prevention.

The CAFH nurse and family relationship has been described in numerous other studies of nurse HV. In a targeted HV programme in Tennessee, USA, nurses acknowledged their work involved maintaining a relationship with the mother with the expectation that when the mother is more comfortable in this relationship she will be prepared to accept the nurses' help and advice (Kitzman *et al.*, 1997). In a survey of CAFH nurses working in HV programmes in Australia and the UK, the nurse family relationship was seen as most important in maintaining the family in the programme (Sawyer *et al.*, 2013). In another study from the USA, nurses compared the relationship with families between HV and clinic based services (Zeanah *et al.*, 2006). From experience they concluded the HV model offered the opportunity for a richer therapeutic relationship with families.

The close proximity of the professional and personal relationship was viewed as an advantage to the success of the visits. In a regional area of Northern Canada, an interpretive hermeneutic inquiry investigated the working relationship between nurse-home-visitors and the families they visited (Moules *et al.*, 2010). Relationship boundaries were imposed by resource limitations ahead of personal or professional considerations. The current study found the experience of providing HVs in a community to which you and your own family belong raised challenges for nurses to identify the scope of their professional and personal relationships.

While the CAFH nurse in Australian rural and regional communities works within the family microsystem they can also be a catalyst for its disruption. The CAFH nurse is aware that child welfare concerns may result in the child ultimately being removed from the family. Considering the ecological framework through which the nurses work, this removal signifies a major breakdown in the system. In addition, the nurses also have to continue to work successfully within this family microsystem.

From the perspective of child protection and welfare, it is expected that the nurses will work within this system and their “insiders” view offers a privileged insight into the family microsystem. From this perspective, the nurses should be able to observe harm or potential harm to the child. The nurses’ role as an advocate for the family can be seen as a way to successfully navigate the wider network of health, social welfare and justice systems. This includes navigating child protection services. The tightrope of working with the family to improve parenting capacity while at the same time prioritising the child’s welfare and safety is illuminated in this context. Where appropriate services are unavailable or difficult to access, the nurse may be left frustrated with few options and limited resources particularly for the most complex families.

Relevance to clinical practice

This secondary analysis of data indicates that a shift in emphasis for CAFH services impacted CAFH nurses’ work in rural and regional Australia in a number of ways. Physical assessment of the infant was used to develop the relationship with targeted mothers so that a more detailed psychosocial assessment of the family could be made. This suggests that a better understanding of the way in which mothers experience this focus is needed. Referral to other services is limited in rural and regional communities. Mothers are offered referrals but by the time they are able to access support, the service is no longer needed. This can have a direct impact on child outcomes. For example, if a mother has symptoms of mood disorder, anxiety or depression, responsiveness to her infant’s cues may be diminished. Over time, the symptoms may disappear and the mother’s responsiveness can improve without intervention. In the meantime, the infant will have lost the benefit of warm responsive interactions with the mother, the opportunity will have been lost. Similarly, more specialised or intensive services may have become necessary. The impact on infant growth and development may be compounded.

Because findings reported herein were based on a secondary analysis of data collected at a time of transition, the study was able to highlight the tension experienced by CAFH nurses as child and family advocates. The nurses in this study described attempting to distance themselves from the work of the child protection services, but the close relationship between the two is illuminated in rural and regional communities. These results are important as they illustrate two important points. First, that a model designed to shift service provision from health alone to incorporate social welfare and reform, needs to maintain its focus on responsibility to the most vulnerable individual in the relationship, the child. This in turn affects the way in which the service can support parenting that can lead to improved child health and developmental outcomes. Moreover, the strength of the HV service is compromised when not supported by a strong network of other community-based services. Next, the re-analysis of focus group data collected at a critical time of health policy and practice change using a cohort of practicing CFH nurses working in the complex environment of rural and remote areas of Australia is invaluable to an understanding of rural-urban health and social support differentials which are not well understood.

The development of comprehensive national guidelines for universal and targeted CAFH services for isolated Australian families in rural and regional communities is urgent (Schmied *et al.*, 2011). Practical, evidence-based insights into what elements of existing practice reflect the best investment for rural and regional communities are needed. Rigorous evaluation of family and nurse characteristics, who engages with the services provided, what occurs during the service visits, how many visits are enough and what infrastructure is required to sustain effective partnerships with families is recommended for future research.

Summary of policy and practice implications

- Aim to reduce the need for more specialist and intensive health and family services that are hard to access for isolated families by augmenting opportunities for nurses to gain advanced practice skills.
- Acknowledge and address the emotional burden on staff working with families that feature mental health problems, family violence and child abuse potential. For example, a systematic approach to debriefing using available technologies is recommended.
- Nurses employed in universal services delivered in the homes of children and families play a key role in child protection. They have a responsibility to strengthen collaboration between health and welfare services to advocate for children who are made vulnerable by the environment within which they are cared for.

Note

1. DOCS was the state government department any child welfare concerns were reported to at the time of data collection. This government department is now more widely known as Family and Community Services.

References

- ABS (2010), "Family and community", NSW state and regional indicators, December 2010.
- Barnes, M., Courtney, M., Pratt, J. and Walsh, A. (2003), "Contemporary child health nursing practice: services provided and challenges faced in metropolitan and outer Brisbane areas", *Collegian*, Vol. 10 No. 4, pp. 14-19.
- Barnes, M., Courtney, M.D., Pratt, J. and Walsh, A.M. (2004), "The roles, responsibilities and professional development needs of child health nurses", *Focus on Health Professional Education: A Multi-disciplinary Journal*, Vol. 6 No. 1, pp. 14-19.
- Boyatzis, R. (1998), *Transforming Qualitative Information: Thematic Analysis and Code Development*, Sage Publications, Thousand Oaks, CA.
- Braun, V. and Clarke, V. (2006), "Using thematic analysis in psychology", *Qualitative Research in Psychology*, Vol. 3 No. 2, pp. 77-101.
- Condon, L. (2011), "Do targeted child health promotion services meet the needs of the most disadvantaged? A qualitative study of the views of health visitors working in inner-city and urban areas in England", *Journal of Advanced Nursing*, Vol. 67 No. 10, pp. 2209-19.
- Cowley, S., Kemp, L., Day, C. and Appleton, J. (2012), "Research and the organisation of complex provision: conceptualising health visiting services and early years programmes", *Journal of Research in Nursing*, Vol. 17 No. 2, pp. 108-24.
- Davis, H., Day, C. and Bidmead, C. (2002), *Working in Partnership with Parent: the Parent Adviser Model*, Psychological Corporation, London.
- Duggan, A., Caldera, D., Rodriguez, K., Burrell, L., Rohde, C. and Crowne, S.S. (2007), "Impact of a statewide home visiting program to prevent child abuse", *Child Abuse & Neglect*, Vol. 31 No. 8, pp. 801-28.
- Flemington, T., Waters, D. and Fraser, J.A. (2015), "Maternal involvement and outcomes in nurse home visiting", *Journal of Children's Services*, Vol. 10 No. 4, pp. 311-23.
- Fraser, J.A., Armstrong, K., Morris, J.P. and Dadds, M.R. (2000), "Home visiting interventions for vulnerable families with newborns: follow-up results of a randomized controlled trial", *Child Abuse & Neglect*, Vol. 24 No. 11, pp. 1399-429.
- Gillies, V. and Edwards, R. (2005), "Secondary analysis in exploring family and social change: addressing the issue of context", *Forum: Qualitative Social Research*, Vol. 6 No. 1, p. 44.
- Jackson, D., Hutchinson, M., Peters, K., Luck, L. and Saltman, D.C. (2013), "Understanding avoidant leadership in health care: findings from a secondary analysis of two qualitative studies", *Journal of Nursing Management*, Vol. 21 No. 3, pp. 572-80.

Jarrett, P. and Barlow, J. (2014), "Clinical supervision in the provision of intensive home visiting by health visitors", *Community Practitioner*, Vol. 87 No. 2, pp. 32-6.

Kemp, L., Harris, E., McMahon, C., Matthey, S., Vimpani, G., Anderson, T., Schmied, V., Aslam, H. and Zapart,

- S. (2011), "Child and family outcomes of a long term nurse home visitation program: a randomised controlled trial", *Archives of Disease in Childhood*, Vol. 96 No. 6, pp. 533-40.
- Kitzman, H.J., Cole, R., Yoos, H. and Olds, D. (1997), "Challenges experienced by home visitors: a qualitative study of program implementation", *Journal of Community Psychology*, Vol. 25 No. 1, pp. 95-109.
- Kruske, S., Barclay, L. and Schmied, V. (2006), "Primary health care, partnership and polemic: child and family health nursing support in early parenting", *Australian Journal of Primary Health*, Vol. 12 No. 2, pp. 57-65.
- Miles, M. and Huberman, M. (1994), *Qualitative Data Analysis: An Expanded Sourcebook*, 2nd ed., Sage Publications, Thousand Oaks, CA.
- Moules, N.J., MacLeod, M.L.P., Thirsk, L.M. and Hanlon, N. (2010), "And then you'll see her in the grocery store: the working relationships of public health nurses and high-priority families in northern Canadian communities", *Journal of Pediatric Nursing*, Vol. 25 No. 5, pp. 327-34.
- PHIDU (2005), *Population Health Profile of the Northern Rivers Division of General Practice*, Public Health Information Development Unit, The University of Adelaide, Adelaide, available at: www.adelaide.edu.au/phidu/publications/pdf/2005-2009/dgp-profiles/2005/225_Northern_Rivers.pdf (accessed 2 September 2016).
- Phillips, C., Kenny, A., Esterman, A. and Smith, C. (2014), "A secondary data analysis examining the needs of graduate nurses in their transition to a new role", *Nurse Education in Practice*, Vol. 14 No. 2, pp. 106-11.
- Sawyer, M.G., Barnes, J., Frost, L., Jeffs, D., Bowering, K. and Lynch, J. (2013), "Nurse perceptions of family home-visiting programmes in Australia and England", *Journal of Paediatrics and Child Health*, Vol. 49 No. 5, pp. 369-74.
- Schmied, V., Fowler, C., Rossiter, C., Homer, C. and Kruske, S. (2014), "Nature and frequency of services provided by child and family health nurses in Australia: results of a national survey", *Australian Health Review*, Vol. 38 No. 2, pp. 177-85.
- Schmied, V., Donovan, J., Kruske, S., Kemp, L., Homer, C. and Fowler, C. (2011), "Commonalities and challenges: a review of Australian state and territory maternity and child health policies", *Contemporary Nurse*, Vol. 40 No. 1, pp. 106-17.
- Schmied, V., Homer, C., Fowler, C., Psaila, K., Barclay, L., Wilson, I., Kemp, L., Fasher, M. and Kruske, S. (2015), "Implementing a national approach to universal child and family health services in Australia: professionals' views of the challenges and opportunities", *Health and Social Care in the Community*, Vol. 23 No. 2, pp. 159-70.
- Whitehouse, G., Baird, M., Diamond, C. and Hosking, A. (2006), "The Parental Leave in Australia Survey: November 2006 Report", available at: www.uq.edu.au/polsis/parental-leave/level1-report.pdf (accessed 2 September 2016).
- Zeanah, P.D., Larrieu, J.A., Boris, N. and Nagle, G.A. (2006), "Nurse home visiting: perspectives from nurses", *Infant Mental Health Journal*, Vol. 27 No. 1, pp. 41-54.
- Ziebland, S. and Hunt, K. (2014), "Using secondary analysis of qualitative data of patient experiences of health care to inform health services research and policy", *Journal of Health Services Research & Policy*, Vol. 19 No. 3, pp. 177-82.

Further reading

- Belsky, J. (1980), "Child maltreatment: an ecological integration", *American Psychologist*, Vol. 35 No. 4, pp. 320-35.
- Bronfenbrenner, U. (1979), *The Ecology of Human Development: Experiments by Nature and Design*, Harvard University Press, Cambridge.
- Garbarino, J. and Abramowitz, R. (1992), "The family as a social system", in Garbarino, J. (Ed.), *Children and Families in the Social Environment*, Aldine de Gruyter, New York, NY, pp. 71-97.
- Hogg, R., Ritchie, D., de Kok, B., Wood, C. and Huby, G. (2013), "Parenting support for families with young children – a public health, user-focused study undertaken in a semi-rural area of Scotland", *Journal of Clinical Nursing*, Vol. 22 Nos 7-8, pp. 1140-50.

Kemp, L. and Harris, E. (2012), "The challenges of establishing and researching a sustained nurse home visiting programme within the universal child and family health service system", *Journal of Research in Nursing*, Vol. 17 No. 2, pp. 127-38.

Shepherd, M.L. (2011), "Behind the scales: child and family health nurses taking care of women's emotional wellbeing", *Contemporary Nurse*, Vol. 37 No. 2, pp. 137-48.

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