What is it about breastfeeding that might protect against later overweight and obesity?

Co-producing parenting practice: learning how to do child and family health nursing differently

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June 2012

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We have had a busy start to the year. This was prompted by holding our annual face-to-face meeting early in the year, in order to set strategic directions for the ongoing development of the position of maternal child and family health nurses (MCFHN) in Australia. In times of such rapid change, positioning ourselves strategically in a competitive workplace is essential.

The two primary goals identified for our professional group of maternal child and family health nurses are to:

1. Unify us nationally as a group while respecting and maintaining the value and contribution of individual states and territories.
2. Raise the profile of our organisation within the profession of nurses and midwives, the community of child health professionals, employees and consumers.

In order to achieve these goals, we aim to:

a. Develop a body of evidence for MCFHN practice.

b. Develop a framework for credentialling, including national practice standards (including identification of unique capabilities, scope of practice, position statements) national competencies and national education standards.

c. Continue to develop and maintain a strong presence/representation on national and international committees, for example, Coalition of National Nursing Organisations (CoNNO), the National Primary Health Care Partnership and The National Community Child Health Council (NCCHC).

We have actively begun working on these goals by determining required changes to our name and constitution, which are currently being written up for ratification in the near future. We have released our breastfeeding position statement and are near to releasing our position statement on national minimum education recommendations. We have engaged with a number of small research projects in relation to the role and scope of the maternal child and family health nurse in addition to education requirements for practice. All of these are the small pieces of the jigsaw puzzle required to lead us towards national credentialling.

National conference: CONNECTIONS with families, with communities, with colleagues

Plans for the national conference are coming along extremely well, with a number of our keynote speakers already booked in. Our Canberra team is working tirelessly on making this a wonderful experience for us all. That’s all for now; watch this space for future developments.

Kind regards,

Julian
Editorial
Medicare Locals

Carolyn Briggs
Editor

The 1st July will see the last tranche of Medicare Locals become operational. They are a key component of the Australian Government's plan to reform the health care system to make health care services more responsive to future health needs. Whilst Medicare Locals are initially focussed on improving primary care services in the local community, the long-term goal is to include preventative health care and health promotion activities within their ambit. As such, it is worthwhile for maternal child and family health nurses to familiarise themselves with the Medicare Local network as part of the reforms to primary health care.

Information on the proposed Medicare Locals has been available from the website of the Australian Government under the umbrella of the National Health Reform. Readers will note that the policy documents provided are short on detail, and indeed, the Australian Medical Association has criticised them for their lack of specific information as to how the policies will be implemented (AMA Statement, March 2011). The information given below is taken directly from policy documents available on the Australian Government website (Department of Health & Ageing, 2010).

The 62 Medicare Locals across Australia will be a national network of primary health care organisations. Most Medicare Locals are situated on the east coast of Australia as this is where the highest concentration of population occurs. The Australian Government website www.yourhealth.gov.au gives a map of all sites.

The Commonwealth will be responsible for the funding, establishment and ongoing operation of Medicare Locals. The Australian Government will establish a national body with responsibility to lead and support Medicare Locals and to assist them to act as a cohesive network.

Each Medicare Local will be incorporated as a company limited by guarantee, rather than a government body, and as an independent legal entity will be managed by a Board. The membership of the Board will include individual primary health practitioners, local health and aged care providers and members of the local community. The composition of the Board is expected to reflect the broad remit of the Medicare Local.

The existing Divisions of General Practice, where these occur, will transition into a Medicare Local structure. As such, they will retain and expand the functions and activities currently undertaken by the Divisions. A specific function of the Medicare Locals is to ensure coordination of after-hours local General Practitioner (GP) services.

As part of the National Health Reform, Medicare Locals will work closely with Local Hospital Networks to establish better linkages between the primary health care and acute care sectors. They are also expected to promote integration between the acute care and aged care sectors. A stated key role is to improve patients' access to local health services, and this will be done by linking local health practitioners, including GPs and nurses, with hospitals and health care organisations. It appears that the most impact in the first instance will be in services for aged care, mental health, and management of chronic disease.

Importantly, Medicare Locals are charged with identifying local health needs and gaps in local health services and with initiating new services where applicable. They are also charged with improving the health of Indigenous populations and disadvantaged groups within the community.

Medicare Locals will take on the responsibility for primary health care services transferred to the Commonwealth from the states and territories (as outlined in the National Health and Hospitals Network Agreement) and support their coordination and integration.

There is a clear intention for Medicare Locals to be active in expanding provider support and to include a wider range of service providers and health practitioners, such as nurses working in primary health care.

For most maternal child and family health services, the advent of Medicare Locals will not lead to obvious changes in service delivery. Whilst the state and territory governments retain control and funding of child and family health services, most nurses will remain removed from the activities of their Medicare Locals. This situation could change if there is a move to include a wider range of preventive and health promotion services within the Medicare Local network.

At the moment, the Australian Government has concentrated attention on the primary care needs of the aged in our community and persons with a chronic illness. However, national health reform has relocated funding and the responsibilities for primary health care with the Australian Government, and some primary health care services have already been moved from the state and territory governments to the Commonwealth. If this momentum continues it must lead, sooner or later, to a consideration of the place of child and family health services within the reform agenda for primary health care.

References
What is it about breastfeeding that might protect against later overweight and obesity?

Background

In 2010 the World Health Organization reported that approximately 43 million pre-school children throughout the world were considered to be overweight or obese (de Onis, Blossner & Borghi 2010). This figure was predicted to rise to almost 60 million by 2020, with the majority of these children being in developing countries.

Such an increase in numbers, if proven, will of course have a dramatic knock-on effect on levels of overweight and obesity in later childhood and in adulthood. Amongst other interventions, there is a need to try to find a broad public health intervention that could reduce the current and predicted levels of adiposity within the population.

A number of systematic and quantitative reviews have suggested that the mode of infant feeding may have an effect on levels of overweight and obesity in later life (Owen et al. 2005a; Owen et al. 2005b; Arenz et al. 2004). As concluded by Arenz and colleagues, “breastfeeding seems to have a small but consistent protective effect against obesity in children”. In their review of nine studies with more than 69,000 subjects, the adjusted odds ratio of breastfeeding versus formula feeding on childhood obesity was 0.78 (95% CI: 0.71, 0.85).

It is obvious, however, that such a crude comparison has the possibility of masking or disguising what it is about breastfeeding that seems to matter in the protective mechanism. Such information is important if we are considering providing infant feeding policies to maximise the apparent protective effect of breastfeeding.

The analysis of the literature in this area is hampered by a number of important factors. Firstly, the definitive, randomised, controlled trial cannot, for obvious reasons, be undertaken. Thus studies that compare the effect of breastfeeding versus non-breastfeeding, regardless of outcome, will have confounders such as maternal education and maternal adiposity. Secondly, the reader is often surprised by the variation in the literature of some key definitions relating to infant feeding. Exclusive breastfeeding seemingly has various definitions in the literature, as does formula feeding. For example, in a recent study (Huh et al. 2011) formula-fed infants were defined as children who were never breastfed or stopped breastfeeding before the age of four months. Finally, many of the studies in this area are retrospective, relying on parents to be able to accurately recall how they fed their infant, sometimes after many years have elapsed.

Any breastfeeding versus no breastfeeding

Clearly, from the reviews mentioned above, any breastfeeding at all is reported to have a small protective effect against later overweight and obesity. The following sections aim to tease apart, if possible, more of the fine detail of the relationship between breastfeeding and later adiposity, and explore some of the mechanisms that have been proposed to explain this phenomenon.

Duration of exclusive breastfeeding

There are virtually no data to support the hypothesis that the duration of exclusive breastfeeding is an important factor in the protective nature of breastfeeding against later obesity. The PROBIT (Promotion of Breastfeeding Intervention Trial) initiated in Belarus in the 1990s is a particularly rich source of data concerning outcomes in children for whom much detail of infant feeding practices are known. For example, Kramer and colleagues (Kramer et al. 2009) compared anthropometric and other outcomes in the children when they were aged 6.5 years in relation to the duration of exclusive breastfeeding. The PROBIT cohort was divided into those infants who were exclusively fed for three months and those who were exclusively fed for six months. At 6.5 years of age mean body mass index, triceps and subscapular skinfold thickness differed significantly between the two groups, but with the exclusive to six months group having greater values. This was clearly not the expected outcome if the duration of exclusive breastfeeding protects against later overweight and/or obesity.

Von Kries and colleagues (Von Kries et al. 1999) produced data that, on first assessment, would suggest a relationship between the duration of exclusive breastfeeding and the prevalence of being overweight or obese in five- and six-year-old children in southern Germany. A notable concern, however, in this study is the fact that apparently 121 parents reported that they “exclusively breastfed” their infant for greater than 12 months. These data must suggest that the parental understanding of the definition of exclusive breastfeeding was not the same as the investigators.

Liese et al. (2001) reported an incremental decline in the prevalence of being overweight, in two cohorts of infants from Germany,
based on the duration of exclusive breastfeeding. Nevertheless, when the analysis was restricted to the cohort of 1754 breastfed infants, whilst the odds ratio of the infant being overweight when aged nine to 10 years fell from 0.91 in those infants breastfed exclusively from between two and four months, to 0.47 for those infants exclusively breastfed for greater than six months, the 95% confidence intervals of both these ratios clearly show that the odds ratio is not significant.

Duration of any breastfeeding

In contrast to the data relating to the duration of exclusive breastfeeding, there is much published work to suggest that an extended duration of any breastfeeding has a positive impact on the reduction of being overweight and obesity. For example, Gillman and colleagues (Gillman et al. 2001) clearly showed the odds ratio of the risk of being overweight in adolescence falling with the length of any breastfeeding, with the odds ratio reaching statistical significant when the infants had been breastfed for more than nine months. Also, Liese et al. (2001) found a significant odds ratio, 0.41 (95% CI: 0.18–0.90) of a reduction in being overweight, at age nine to 10 years, when any breastfeeding continued for longer than 12 months.

The findings of Liese and colleagues of statistical significance in the reduction of levels of overweight in later life after 12 months of any breastfeeding, and the findings of Gillman and colleagues that nine months of any breastfeeding was associated with a statistically significant reduction in later obesity, might be sending an important message about the necessary duration of any breastfeeding. In a study conducted in the Czech Republic, Toschke and co-workers (Toschke et al. 2002) found very similar levels of overweight and obesity in children when aged six to 14 years regardless of length of any breastfeeding, but their analysis stopped at greater than six months’ breastfeeding and did not examine the effect specifically of breastfeeding for greater than nine months or 12 months as above.

Mechanisms

Numerous possible mechanisms have been proposed that might explain how breastfeeding may protect against later overweight and/or obesity. One popular theory is that breastfed infants are able to self-regulate energy intake to a greater extent than formula-fed infants (Dewey 2003) and evidence to support this hypothesis indeed goes back a number of decades (Lucas et al. 1980). Also others (Birch et al. 1998) have shown that the ability to adjust energy intake at a meal following a preload meal of high-energy content is better in breastfed infants.

A possible endocrine/metabolic mechanism has been proposed by a number of researchers based upon the early findings that endocrine response to bottle and breastfeeding were different (Lucas et al. 1980). Notably there seem to be differences in the levels of plasma insulin in breastfed and formula-fed infants, which are consistently reported in the literature. These higher insulin levels in formula-fed infants have been related to a greater rate of fat deposition and weight gain in a number of studies (for example, Odeleye et al. 1997).

A further mechanism that has been of burgeoning interest in recent years is the effect of the differing protein content of breast milk and formula. The higher protein content of formula (approximately 14 to 15 gm/l compared with approximately 10–12...
GM/l in breast milk) is required as the amino acid profile in cow’s milk, from which most formula milks are made, is different from that found in human milk. This means that the quantity of protein in formula needs to be raised to ensure that the quality and range of essential amino acids present are adequate. This is especially true for L tryptophan. This increased protein concentration in formula has been linked not only to the differences in endocrine response described above, but also to a greater secretion of insulin-like growth factor (IGF-1).

These responses, then, are associated with greater early weight gain in infancy, which, in turn, is associated with a greater risk of later obesity (Koletzko et al. 2009). Indeed, in a recent randomised trial such findings were confirmed (Koletzko et al. 2009). This multicentre study randomly assigned infants to receive one of two formulas with differing protein content. The first group received infant formula with 2.9 g protein per 100 kcal energy with a follow-on formula provided with 4.4 g protein per 100 kcal energy. The second group received a lower protein load with the formulas offered containing 1.77 g protein per 100 kcal energy and then 2.2 g protein per 100 kcal energy. A cohort of breastfed infants was also recruited. These infants were then followed prospectively for two years with anthropometric assessments being made on a number of occasions during this time. The key findings were that the higher protein content of infant formula was associated with higher weight gain in the first two years of life but no such differences were found in measurements of length for age at two years of age. Koletzko and colleagues suggested that lower protein intake in infancy might diminish the later risk of over-weight and obesity (Koletzko et al. 2009).

A further important and interesting study in this area was published by Trabulsi and colleagues in 2011 (Trabulsi et al. 2011). This study trialled what was referred to as an experimental formula that contained only 12.8 g/l protein. This reduction in protein concentration was made possible by enriching the formula with alpha lactalbumin, the predominant whey protein found in breast milk. Thus the amino acid profile, quality and quantity was maintained but at the lower concentration. Weight gain in g/day over the first 120 days of life in the infants fed the experimental formula was below that of infants fed a standard formula but still higher than the weight gain reported in a cohort of breastfed infants. Length gain was very similar between the infants fed the standard and experimental formula but the breastfed infants had a significantly lower length gain than the infants fed the experimental formula. Trabulsi and colleagues concluded that the experimental formula supported “age appropriate growth”, and that further studies were required to evaluate whether the differences found in this study persisted into later life.

**Conclusions**

Breastfeeding clearly endows the infant with many advantages over the non-breastfed infant, especially regarding protection against infectious diseases. Whether one other advantage is a reduction in later adiposity is less clear for some of the reasons discussed earlier. Different aspects of breastfeeding might convey advantages in different ways and in different circumstances. The available evidence suggests that partial breastfeeding for a prolonged time (possibly greater than nine months) produces a protective effect against later overweight or obesity; however, it has been suggested that:

> ... it would be unwise to depend upon current efforts to promote exclusive and prolonged breastfeeding as an effective population health strategy for stemming the current obesity epidemic or reducing the risk of future hypertension (Kramer et al. 2009).

Nevertheless, we clearly require more prospective, well-defined studies that add to the literature in this important area.

**References**


Co-producing parenting practice: learning how to do child and family health nursing differently

Abstract
Child and family health (CFH) nurses are increasingly required to examine the way in which they work with parents, in order to achieve more effective parenting outcomes and more sustainable health services. New approaches to working successfully with parents require acknowledgement that parents are competent, knowledgeable, resourceful and uniquely experienced with their child/children. This calls for an approach to practice that enables ongoing parental learning and capability development, in contrast to more traditional practices.

This article discusses the implications of these new approaches with reference to the idea of co-production, a concept that sits at the heart of recent initiatives in public sector and health service reform. Co-production extends previous thinking about the nature and scope of parent participation, locating parents as equal partners and producers alongside health professionals.

Introduction
Recent years have seen significant changes in understanding of child and family health (CFH) nursing practice. There are increasing references to “working in partnership with parents”, “focusing on strengths”, and using “relationship-based practice” (for example, see: Aston 2008; Farrell Erickson & Egeland 1999; Gottlieb & Feeley 2005). For many nurses, these changes are both challenging and potentially enabling, as they provide a common language and a legitimacy for the way that many nurses would like to (or, in some instances, already do) engage with parents.

The implications of this rethinking are becoming visible in all areas of CFH service development and delivery – policy development, governance, priority setting, health service design and evaluation, and the development of research (for example, see: NSW Health 2009; South Australian Department of Human Services 2003). At the level of clinical practice, these shifts are increasingly identified in service models and best practice approaches that focus on the particular needs and circumstances of the parent and family, emphasising partnership, collaboration, relationship, working and learning together, and the vital role of parents in developing and delivering services (Davis, Day & Bidmead 2002; Houston & Cowley 2002). The effectiveness of such partnership approaches is now well established in the research and other literature (Davis, Day & Bidmead 2002; Dunlap & Fox 2007; Gottlieb & Feeley 2005).

Informing many of these changes has been a profound rethinking of the role and capability of parents when interacting with health professionals and health systems. From parents being seen as, by definition, deficient in knowledge or capability, and as the passive recipients of the “expert” advice of health professionals, they are increasingly repositioned as knowledgeable, competent, resourceful and, most importantly, as essential partners in the development of successful and sustainable health services (for example, see Fowler et al. 2011; Rossiter et al. 2011).

Increased parent participation has been a well-developed feature of health reform agendas for the past two to three decades. Most recently, these ideas have been re-presented and extended in the concept of co-production. Co-production is a central element in the reform and modernisation of the public sector and involves a fundamental “... re-imagining of the relationship between state and citizen” (Newman 2001, p. vii). There is widespread national and international agreement on the need for more substantial and expansive engagement between health systems and citizens (Dunston et al. 2009). A crucial aspect of this engagement is for citizens, health consumers and local communities to be more actively involved as co-producers at all levels and in all aspects of health system development and functioning (Dunston et al. 2009; Peters 2004; Davies, Wetherell & Barnett 2006; Andersson, Titter & Wilson 2006).

Co-production is a policy philosophy and practice approach that locates citizens alongside service providers as necessary co-participants and co-partners as opposed to the still dependent terminology of health “consumers”. (Ostrom 1996; Leadbeater 2004; Bovaird 2007). What differentiates co-production from more traditional approaches to consumer participation – approaches that tend to focus on consumer preferences (consumer choice) and consumer participation in decision making (consumer voice)
– is that co-production involves consumers in the production of services (Andersson, Titter & Wilson 2006; Bovaird 2007; Boyle, Conisbee & Burns 2004).

The implications of co-production are profound for all aspects of health professional practice and education, and for the development of health system governance and delivery. Cahn and Gray (2004) identify the possibilities of system-wide co-productive practice and identify co-production as generating profound processes of system (as well as practice) change that arise from redefining the product, process, producer and consumer of a service. Bovaird (2007) discusses this in terms of blurring the traditional boundaries between the professional and the consumer, resulting in a redistribution of power. In the CFH nursing context, both professionals and parents gain new insights and opportunities to learn and construct new knowledge. A two-way knowledge development and transfer starts to occur – from professional to parent and from parent to professional.

This two-way process requires different skills and capacities for both providers and consumers of health services. Yeatman (1994) in her ground-breaking work on reconceptualising and redesigning disability services, speaks of the need to develop “dialogic co-productive capacity” in both parties to achieve outcomes that address presenting problems, facilitate the building of new capabilities, and respond to the citizenship and co-equal status of the client. This is counterintuitive to traditional models of professional practice, including nursing practice. In CFH nursing, for example, a strong professional boundary exists between expert health professionals’ knowledge and what is understood as parents’ experiences and understanding. The resulting outcome is usually a privileging of professional knowledge over a parent’s knowledge (Fowler & Lee 2007). This can create tensions between “what is known” as a professional and “what is experienced” as a parent.

In order to address the profound implications of these changes for practice, Kemmis (2005) challenges professionals to consider the need to draw on more than their professional practice knowledge to include “situated knowledge”. This is gained through the ability to “… stay open-eyed (to changing objective conditions) and open-minded (about changing subjective conditions) …” (Kemmis 2005, p. 407). Co-productive practice is strongly situated within the parents’ world, experience and knowledge (Davis, Day & Bidmead 2002), and strongly focused on developing each interaction between nurse and parent as an opportunity for learning, for the co-production of knowledge and for the development of new parenting capabilities.

A central feature of co-production is its focus on the relationship between the nurse and parent as an opportunity for co-learning and as a:

… joint inquiry [of nurse and parents], which requires the mutual acceptance of each other’s points of reference and appreciation of what each party brings to the inquiry (Ospina, Godsoe & Schall 2001, p. 3).

Effective co-production thus requires nurses to develop a markedly different approach to knowledge and intervention from that drawn upon in more expert-based models. Rather than professional expertise being defined with reference to nurses’ ability to deliver content and answers, co-productive practice requires nurses to be skilled in creating the conditions for parental and professional co-learning. More particularly, it requires nurses to be knowledgeable and capable in developing interactional processes of inquiry and reflection. This necessitates a view of learning as gained from participation rather than from an abstract notion of knowledge transfer (Hodkinson 2005). This participation will begin with parents’ own experiences and perceptions of their situation and will base the identified management strategies or advice provided on what parents are capable of contributing (Centre for Community Child Health 2007).

Such a focus was strongly endorsed in a 2007 policy brief to inform and support health professional translate policy into practice (Centre for Community Child Health 2007). This brief identified the process of the interaction as critical to achieving positive and sustainable outcomes: “… how services are delivered is as important as what is delivered” (Pawl & St John 1998, cited in Centre for Community Child Health 2007, p. 1). Most critically, in terms of realising the benefits of co-production for adding value and sustainability, clinical practice needs to focus on a broader learning agenda that aims to provide CFH services that enable parents to build new parenting capabilities and to develop and use their own situated parenting knowledge.

The potential of co-production has benefits for both individuals and systems. There are, however, several problems with developing and embedding such practices within particular health services and, more broadly, across the health system.

Firstly, at the micro level of clinical practice, the nature of co-productive practice remains under-described and under-researched. To date, there is little detailed description of co-productive practice as this occurs in situ, and even less description of how co-productive clinical decision making and interventions differ from more traditional, expert-based health professional practice (see Bovaird 2007).

Secondly, at the macro level of organisational practice, there is little identification of organisational practices that will enable, embed and sustain co-production as a defining feature of all of health system practice. Addressing co-production at both the micro and macro levels will be critical for the development and sustainability of co-production at both the local and system-wide levels.

In the remainder of this article, we explore two approaches to clinical and organisational practice that address the micro and macro issues identified above. Firstly, we will discuss how CFH nursing practice can become co-productive, or perhaps, more co-productive. Secondly, we will highlight the critical importance of organisational practices that support the development of a co-productive practice. We will discuss the importance of reflective practice as an organisational approach to legitimating, modelling and sustaining co-production at both the clinical and organisational levels.

**Developing co-production – the micro level of clinical practice**

A starting point for examining what co-productive practice looks like and how it can be developed is for nurses and parents to redefine teaching and learning about parenting as a shared practice. Part of this challenge is the capacity to acknowledge and work with the differences in experiences, perspectives and knowledge between parents and nurses.
Partnership practice is strongly engaged with the experience and knowledge of parents, and strongly focused on developing each interaction between the nurse and the parent as an opportunity for learning. This way of thinking about nurse–parent interactions locates CFH nursing within an education and learning context. It also locates it as a process of co-production – the joint production of knowledge and of practice. The outcome is not just about parents’ learning or nurses’ learning but shared learning for the development of new parenting and nursing capabilities.

For nurses, this mode of learning involves different kinds of expertise; for example, knowing when and how to develop opportunities to assist parents to learn. The importance of creating a relationship context and process that invites, facilitates and supports parents talking or thinking out loud with the nurse is vital to the overall success of the interaction and to maximising learning. In their analysis of the sociocultural aspects of learning, Boreham and Morgan (2004, p. 315) identify this work as “... opening spaces for the creation of shared meanings”, a similar concept to that developed by Fowler (2000) in her concept of “spaces of engagement”. Working to create such spaces is typical of an approach that recognises and values the contribution of parents to the learning process, as they are able to model sensitive behaviour, appropriate language and touch, as well as praising the mother and assessing the baby’s wellbeing. In these moments, mothers will often ask the difficult questions or discuss the often previously unspoken concerns and taboos about feelings of maternal inadequacy, anxiety and depression, and fears of harming their infants. Opportunistic and incidental learning, when the putative focus is on a mechanical activity, is a powerful way to build trust, intimacy and confidence. Frequently, official accounts of clinical practice underestimate the learning potential of everyday interactions and incidental learning. This kind of learning mostly occurs informally, almost by stealth. Nurses need to be conscious of these occurrences and purposive when selecting opportunities for learning within their everyday contact with parents.

When working with parents, nurses constantly choose what kind of practice approach they will develop. While such choices need to be informed by a range of contextual and situational factors, in broad terms, nurses can choose either to be a provider of expert parenting knowledge – knowledge frequently derived from the “good parent” discourses – or to work co-productively with parents to explore their experience, understanding and knowledge and to develop their own particular and unique approach to parenting. This approach to nursing can function as social mediation to reduce the oppressive and hegemonic impact of these “good parent” discourses (Aston 2008; Aston et al. 2006). Consistently choosing to focus on technical content and to be a provider of expert knowledge may well feel safe and familiar for the nurse, but it is restrictive in terms of developing the nurse–parent relationship, and of opening up the space for joint learning and growth for both parent and nurse.

The focus of co-productive practice relies far less on the nurse ‘knowing’ and presenting solutions, and far more on the joint inquiry by a parent and nurse to produce new understanding, new knowledge and new parenting capabilities. This approach enables and supports parents to consider questions such as: “Whose problem is this? Is it a problem at all? What have I already tried? What parenting strategies will be appropriate for my infant? Do I have the necessary support and confidence to implement this strategy? If not, what type of support do I need, or how can I modify the strategy?” A co-productive approach takes as its point of departure the particulars of the parenting situation. The knowledge developed is situated knowledge, knowledge that works for these particular parents and this particular child in this particular situation. Co-productive practice is, by definition, a process of shared, ongoing learning.

In summary, clinical practice that is co-productive focuses on the relationship and partnership between the nurse, the parents and the child as the mechanism for generating new knowledge and new capabilities. It focuses on the immediate or everyday concerns of parents, their capacity to identify and utilise particular strategies in their day-to-day parenting and on what they know and can do, rather than on their deficits and what they do not know. It draws on existing strategies of focusing on parental strengths, and developing a nurse–parent partnership. It develops strategies that are tailored to the particular context in which this parent will care for this child. And it enables the parent and the nurse to build on their existing expertise and experience, without privileging one set of experiences or skills over the other. External expert knowledge exists as one resource amongst many that may be utilised to support parental learning. The nurse starts to take part in a continual dance with the parent (Powell 1999) as they negotiate the joint learning and share their experiences and knowledge.

Developing co-production – the macro level of organisational practice

Making the transition from expert-based to co-productive practice requires a professional and organisational culture to enable nurses to develop the capabilities and competencies necessary to engage parents in the co-production of parenting knowledge and solutions. Co-productive organisational practices are critical not only to supporting local co-productive practice, but also to the broader agenda of developing and sustaining co-production across the health system.

In this section, we discuss the provision of regular practice reflection as one important organisational strategy for enabling and sustaining co-productive practice. Reflection can be a powerful and productive way of modelling co-productive practice and highlighting the experience that parents will have when nurses utilise such practices. Reflective practice provides the tools to delve beneath our assumptions and conventional knowledge in order to see the world anew (Schön 1983). It allows us to review, reconsider and reinterpret our experience and our understanding of the world. Reflective practice “… goes beyond the simple intake of knowledge, and involves a critical awareness of the sociocultural environment in which the learning takes place” (Rolfe 2002, p. 2).

Reflective practice is typically divided into two types: reflection-in-action and reflection-on-action (Schön 1983). Reflection-in-action is the ability to be attentive to our own experience and the behaviour of others by watching, questioning and adjusting previously developed reactions and approaches (Schön 1983). The
Towards an asset-based NHS, New Co-production challenges many aspects of existing practice. It can be developed, embedded and sustained at both clinical and organisational levels. The benefits and possibilities of co-production are strongly argued in the micro level, the level of clinical practice, and at the macro level, the international reform agenda within the public sector and health services. We have located these changes as part of a larger national and international reform agenda within the public sector and health services: Policy Brief no. 6, The Royal Children's Hospital, Melbourne.

Reflection-on-action (often facilitated through clinical supervision or mentoring) is the regular and systematic opportunity to reflect on a situation or incident after the event (Schön 1983). This enables the nurse to examine clinical practice in a critical and thoughtful manner, thereby enhancing learning and self-awareness (Playle & Mullankey 1998). Reflection-on-action during clinical supervision (individual, group or with a mentor) allows clinical issues to be explored with a knowledgeable other, enabling the co-production of new insights and knowledge between the nurse and the supervisor or mentor as they jointly explore issues in practice. Using reflection-on-action can provide the structure to solve problems through interaction with others without resorting to the use of a conventional knowledge hierarchy. Boud and Middleton (2003) argue that this helps deal with the atypical and hence to understand what is safe and unsafe in parenting practice. Practice defined primarily by information-giving – a ‘content’ as opposed to a ‘process’ emphasis – tends to focus communication on issues and concerns of a general nature. While this may at times be helpful, it tends to miss the more particular and underlying parenting issues that can cause the most distress. Such issues are frequently the most important and challenging for parents and are rarely resolved by the application of generalised solutions. An emphasis on providing information also misses the many opportunities to assist parents to learn and develop new understanding and parenting capabilities.

Both forms of reflective practice assist nurses to challenge the automatic and default position of the “expert” nurse. Developing organisational, supervisory and clinical processes of critical reflection enables nurses to stop, reflect and question, asking for example: “Do I really always act in this way? Why and how does this occur? Could it be different? What do I attend to in this situation?”

Changing practice is not easy, especially when such changes challenge existing forms of knowledge and existing practices. In addition to developing co-productive practice within the organisational context, changes in the educational preparation of nurses will be vital to ensuring the development of a nursing workforce capable of such practice.

References

Centre for Community Child Health 2007, Effective Community-based services: Policy Brief no. 6, The Royal Children’s Hospital, Melbourne.

Development of these skills requires the ability to think and interact in a focused and exploratory way (Edwards 2007; O’Connor 2008). This is greatly aided by a clear understanding of the principles underpinning specialist clinical practice in this field. For example, being mindful of attachment theory, using strengths-based approaches (Bennett 2008) and working in partnership (Davis, Day & Bidmead 2002) are equally appropriate when assisting a mother settle her infant and when mentoring a staff member.

Refining the ability to reflect critically on day-to-day practice provides nurses with a way of engaging with and managing the complex and often challenging events of clinical practice. Developing critical reflection skills within the organisational and supervisory contexts supports them to take these skills into their interactions with parents, to model reflective behaviours and, as a consequence, to assist parents to produce – co-produce – new understanding and new solutions. In addition, a commitment to practice reflection as a core organisational learning and development strategy develops a culture in which clinical practice and organisational practice operate as supportive and parallel processes.

Conclusion

In this article we have identified and examined significant policy changes in what is required of CFH nurses – in particular, that CFH nursing practice should engage with parents in a process of co-production – the co-production of understanding, knowledge and situated solutions.

We have located these changes as part of a larger national and international reform agenda within the public sector and health system. This agenda argues the importance of co-production at the micro level, the level of clinical practice, and at the macro level, the level of system-wide governance and development. Whilst the benefits and possibilities of co-production are strongly argued in the policy literature, far less attention has been given to how co-production can be developed, embedded and sustained at both clinical and organisational levels.

Co-production challenges many aspects of existing practice. It also poses new possibilities in which expert knowledge can be used as part of a broader health service agenda, an agenda in which practitioners and parents work together in a process of joint inquiry and learning to co-produce more responsive, effective and sustainable outcomes.

CFH nurses are ideally positioned to take a lead in developing a co-productive approach to practice. Working co-productively as enablers of parental learning and knowledge development, rather than as providers of expert knowledge to parents, in no way diminishes the role or expertise of nurses. On the contrary, co-productive practice extends their role. It calls not only for skilled content knowledge to be used as a resource for parental consideration, but also requires nurses to be skilful in building relationships and enabling learning. The flexibility and responsiveness of co-productive practice, its situated focus and parent-centeredness, can only be successfully achieved if nurses feel confident about the limits of nursing practice and clearly understand what is safe and unsafe in parenting practice. Practice defined primarily by information-giving – a “content” as opposed to a “process” emphasis – tends to focus communication on issues and concerns of a general nature. While this may at times be helpful, it tends to miss the more particular and underlying parenting issues that can cause the most distress. Such issues are frequently the most important and challenging for parents and are rarely resolved by the application of generalised solutions. An emphasis on providing information also misses the many opportunities to assist parents to learn and develop new understanding and parenting capabilities.

Changing practice is not easy, especially when such changes challenge existing forms of knowledge and existing practices. In addition to developing co-productive practice within the organisational context, changes in the educational preparation of nurses will be vital to ensuring the development of a nursing workforce capable of such practice.
Developing the *Parent Engagement Resource*: a tool for enhancing parent–professional relationships and identifying psychosocial issues in families

**Abstract**

Early identification of parental concerns and linkage to appropriate community-based support services is essential to facilitate better outcomes for children and their families. The *Parent Engagement Resource* was designed to enhance the development of the parent–practitioner relationship and to assist practitioners in the early identification of psychosocial issues that have an adverse effect on child health and wellbeing outcomes. This paper provides an overview of the work underpinning the development of the *Parent Engagement Resource*. Consultations with parents and professionals who work with parents of young children were undertaken and a feasibility study was conducted amongst a small number of maternal and child health nurses and their clients working in two local government areas in Victoria. The findings suggest that the *Parent Engagement Resource* is acceptable to parents. Parents were positive about their interactions with maternal and child nurses who utilised the resource. The tool appears to be useful for maternal and child health nurses, assisting them to engage parents in a conversation about concerns and issues in their lives. However, time constraints upon nurses appear to limit its applicability and for clients with multiple and complex problems the *Parent Engagement Resource* may not be appropriate. Further research is required to establish the effectiveness of the *Parent Engagement Resource* in universal and targeted services.

**Introduction**

Services continue to struggle with the engagement and retention of families. Those families that are especially difficult to engage are often those with the greatest needs and fewest resources, and their children are at greatest risk of poor outcomes in development, health and wellbeing (Fram 2003; Ghate & Hazel 2002; Offord 1987). There needs to be particular efforts made to develop ways of engaging and retaining contact with the most marginalised and vulnerable families, and making all aspects of the service system more equitable and inclusive (Carbone et al. 2004; Hertzman 2002b; Offord 2001).

One of the challenges facing practitioners is the issue of how to find and engage vulnerable families so as to help them make best use of the existing services. Early identification of psychosocial issues that have an adverse effect on child health and wellbeing outcomes and linkage to appropriate community-based support services is essential to facilitate good outcomes for children and their families.

The *Parent Engagement Resource*, developed by the Centre for Community Child Health and the Murdoch Children’s Research Institute was designed to enhance the development of the parent–practitioner relationship and to assist practitioners who work with families in the early identification of psychosocial issues that have an adverse effect on child and health wellbeing outcomes.

In this paper the process that informed the development of the *Parent Engagement Resource* is described. The findings of a study that sought to ascertain the acceptability of the tool to parents and maternal and child health nurses, and its usability within the maternal and child health setting, is reported. The future of the *Parent Engagement Resource* as a means of enhancing the development of the parent–practitioner relationship and assisting in the early identification of psychosocial issues are discussed.

**What is the Parent Engagement Resource?**

The *Parent Engagement Resource* is a tool, consisting of a series of questions, that is designed to be used by professionals who work with parents of young children in order to enhance the development of the parent–practitioner relationship and to assist practitioners in the early identification of psychosocial issues that have an adverse effect on child health and wellbeing outcomes. The questions within the resource are grouped according to the following bio-psychosocial domains:

- child and adult physical health or disability
- child and adult mental health
- financial, housing or employment issues
- drug or alcohol use
- family relationships
- family violence
- child abuse and neglect
- the parent’s concept of their parenting role.
For clarification purposes, it is important to note what the Parent Engagement Resource is not. The resource is not:

- A scientifically validated screening instrument. It is a tool to enhance professional practice in detecting emerging psycho-social issues that may impact on child development and family functioning, and then provide appropriate service system responses.
- A specialist administration tool. It is a tool designed for frontline practitioners, such as maternal and child health nurses, working with families in common child and family settings.
- A tool requiring the practitioner to be proficient at treating or managing problems themselves. It is a tool to identify emerging problems and provide appropriate referrals to services and supports for families with these problems.
- A tool for the purpose of screening for risk factors or determining which children are ‘at risk’. It is to respond to parental concern about psycho-social issues.

One of the key features of the Parent Engagement Resource is that it helps practitioners ask the ‘hard questions’ related to underlying bio-psychosocial issues with families such as drug and alcohol use and family violence. However, because many of these issues are highly sensitive, one of the risks of using the resource is that it will be experienced by parents as intrusive or judgemental. In the Parent Engagement Resource, reducing this potential involved (a) framing the questions in terms of parental – rather than professional – concerns about the child and; (b) focusing on the possible impact of particular family environmental factors on the child, rather than parental behaviours or qualities.

**Development of the Parent Engagement Resource**

Development of the Parent Engagement Resource began in 2005. In developing the resource, the intention was to design a tool – similar to the Parent Evaluation of Developmental Status tool (PEDS) – that could be used by professionals across a range of early childhood settings providing services to families. One of the strengths of the PEDS is that it treats the parent as a valid informant about the child, and thereby operationalises the principle of a partnership between parents and professionals. This partnership is based upon parents and professionals sharing their knowledge and expertise: the parent is treated as an ‘expert’ in their child and their child’s development, while the professional is an expert in children in general and in the factors that influence development.

The Parent Engagement Resource seeks to replicate this partnership approach. The parent is treated as an expert in the family and in the family circumstances that might be affecting the child in particular or the family in general.

**Consultations during the development phase**

The development of the Parent Engagement Resource involved the following steps:

- identifying a set of underpinning principles to guide tool development
- reviewing existing psychosocial screening tools
- conducting a literature review to inform the selection of the issues to be included in resource
- consultations with parents and practitioners to test the acceptability of the questions within the resource.

The specific bio-psychosocial domains in the resource were chosen because they met the following criteria:
importance – the issue is relatively common and there is evidence of a strong and consistent link with child or family functioning
- under-identified – the issue is currently not being well detected or addressed
- modifiable – the issue has a direct effect on the child and family at the present, is not merely an indicator of future risk, and an effective and acceptable service response is available.

Twelve issues meeting these criteria were identified.

The first version of the Parent Engagement Resource included 16 questions: two lead-in questions (that is, these questions provide a gentle introduction to the tool and ask the parent to reflect on their parenting), 12 substantive questions, and two lead-out questions (that is, these questions aim to complete the interaction with a positive outlook).

Consultations to test the acceptability of the questions within the resource were undertaken with parents and practitioners during 2006. In addition to testing the acceptability of the resource, parents were also consulted to determine how and by whom the Parent Engagement Resource could be best utilised and consultations with professionals sought to identify the level of training and support and the optimum conditions required for them to be able to utilise the resource safely and appropriately.

Six professional groups were consulted between May and October 2006, with almost 40 professionals taking part. These professionals came from a range of backgrounds and included: social workers, maternal and child health nurses, early childhood workers, psychologists and family support workers. The first version of the Parent Engagement Resource, along with an accompanying manual, was completed in 2007.

The next step
The aforementioned consultations with parents and professionals tested the acceptability and usability of the resource; however, questions about its usability in the field remained. The main questions were whether the Parent Engagement Resource could be used by frontline service providers to help families identify concerns about parental and family functioning, and whether it would lead to more families receiving the help they needed to address these concerns. Therefore, a feasibility study was undertaken to test the usability of the Parent Engagement Resource in the field.

The Parent Engagement Resource Feasibility Study
The Parent Engagement Resource Feasibility Study was undertaken between September 2010 and November 2011 in two separate local government areas in the Southern Metropolitan region of Melbourne. This study aimed to ascertain the requirements for successful implementation of the resource and to test the practical acceptability of the resource amongst a core group of practitioners (that is, maternal and child health nurses). Prior to trialling the resource in the field, it was necessary to first consider recruitment of participant nurses for the trial and the approach to consulting with and training nurse participants about the Parent Engagement Resource.

Recruiting participants for the trial
Nurses
In an effort to ensure that ‘duty of care’ remained a priority for both the project team and the participants, a decision was made early to take a targeted approach to the recruitment of the nurse participants. The project team made a decision to work with local agencies to engage only highly skilled maternal and child health nurses. In the participating local government areas the decision was further refined to identify nurses who possessed the following qualities and attributes:
- knowledge of the wider determinants of child health and development and the many factors that impact on children and families
- a well-developed understanding of family-centred practice and a history of establishing a “partnership” with parents in their work
- effective communication skills and a demonstrated ability to develop a rapport with all families, particularly vulnerable families
- a demonstrated ability to work with families from culturally and linguistically diverse (CALD) backgrounds.

A prerequisite to implementing the resource was the completion of the training in using the resource to ensure competency, and respectful and culturally safe practices. Ideally, staff who participated in the study were familiar with or have undergone PEDS training and the service itself was familiar with and committed to a family-centred philosophy and approach. Twelve nurses were involved in the initial consultation and training sessions. Nine nurses trialled the Parent Engagement Resource in Phase 2 and eight nurses trialled it again in Phase 3.

Parents
Families received an information letter about the Parent Engagement Resource and were informed of the opportunity to participate in the evaluation. The Parent Engagement Resource provides a framework for maternal and child health nurses to conduct their normal practice in a more systematic way, hence no formal consent from parents was needed. Parent participation in the study was voluntary.

Consultation and training approach
The consultations and training that were undertaken during this trial utilised a family partnership model of practice to inform the facilitation process (Davis et al. 2007) An environment of open discussion was encouraged, whereby the nurses’ education, knowledge and experiential learning was heavily drawn upon. This method of facilitation aimed to maximise engagement of the participant in development of the Parent Engagement Resource and the associated practice change process.

Phases of the Feasibility Study
After the recruitment process and the consulting and training approach were established, the Parent Engagement Resource Feasibility Study began. The study involved three distinct phases:
- Phase 1: Reviewing modifications to the resource.
· Phase 2: Development of training methodology and guidelines.
· Phase 3: Piloting, trialling and evaluating the resource.

Each of these phases is described below.

**Phase 1 (November 2010 – February 2011)**
An initial consultation with the coordinators of both maternal and child health services was undertaken followed by a full day consultation participatory workshop involving the coordinators along with nurses from both sites. During this workshop a range of questions relating to implementation were addressed including:

- How can the Parent Engagement Resource be delivered?
- What might the difficulties or barriers to implementation be?
- What clinical support and supervision is required for nurses delivering the Parent Engagement Resource?
- What training and support needs are required?

This workshop provided valuable feedback that influenced the rewriting of a number of the key questions in the resource. Most importantly, an introductory sentence was added to each of the 16 questions. The aim of the introductory sentence was to provide a context for each question and consequently support the development of a more free-flowing conversation.

**Phase 2 (March 2011 – June 2011)**
A training session was completed with 12 nurses from each site. Following the training session, the nurses were asked to trial the resource with a limited number of parents. To determine the most efficient and optimal way to administer the resource – namely whether it could be administered over a few consultations, or whether it could be administered only in part – nurses were asked to experiment with the number of questions asked from the resource.

During this phase, an evaluation of the training and support processes was undertaken. Feedback from nurses was collected via interview and/or online surveys. Another review of the resource and its application was completed based on these initial evaluation outcomes.

**Phase 3 (July 2011 – September 2011)**
With the findings and modifications from the first two phases now in place, the resource was administered again in the two sites. Updated guidelines were available for the participating nurses.

The final evaluation of the Parent Engagement Resource began during this phase. Phone consultations were conducted with all the participating nurses to ensure that the newly drafted implementation guidelines were user-friendly, and to ascertain if the nurses needed more assistance in the implementation of the resource. This process endeavoured to provide a forum for the nurses to express their thoughts and relay their experiences on the delivery, effectiveness and efficacy of the Parent Engagement Resource. All of the data from the parent and nurse surveys, consultations and interviews were then analysed.

**Results**
Five key findings emerged from both the aforementioned development phase and the Parent Engagement Resource Feasibility Study. Firstly, one of these key findings of the development stage consultations regarded the way in which the questions were asked. Participating professionals and parents did not like the way in which the ‘hard questions’ were asked and indicated that they would be confronting for the parent and may also place the practitioner in a difficult or uncomfortable position.

**Question 8. Adult mental health.**
“Do you have any concerns that your child is being affected by your state of mind?”

“State of mind” includes feelings like sadness, tearfulness, worrying, panicking, not coping, irritability, unnecessarily blaming yourself, poor sleeping, or disturbing thoughts.

This question aims to identify whether there may be any concerns on parent mental health that warrant further assessment or support. This question is not a diagnostic or screening test for mental illness. The examples of “state of mind” provided are common symptoms of mental illness, particularly of postnatal depression. It is the state of mind or mood of the parent over recent days or weeks that is of significance, not just their state of mind on that particular day.

This feedback informed the decision to change the format of the Parent Engagement Resource. To facilitate the engagement process, each question was rewritten to include a preamble. The aim of each statement was to ‘break down the barriers’ and normalise the content – and in doing so respectfully engage the parent in the conversation about their family (see Box 2 for an example of a redeveloped question).

**Question 8. Adult mental health.**

It’s not unusual for parents to feel emotional, depressed, angry, anxious, or exhausted or even have strange thoughts such as harming yourself or others.

“Do you have any concerns that your child and family are being affected by you having any of these feelings?”

The second key finding was that with some flexibility the Parent Engagement Resource was viewed by nurses as a useful tool to engage parents in a conversation about their concerns and issues relating to their lives. One nurse commented that the resource led to the identification of issues within a family that she had not identified during previous consultations. However, although nurses viewed the resource as useful, it was generally not viewed by them as applicable within their already busy model of care. Time restraints associated with the key ages and stages service model were reported as limiting the nurses capacity to follow up on referrals identified through application of the resource.
After concerns about time were raised, the Parent Engagement Resource guidelines were updated. Nurses were initially encouraged to trial the resource in part, but in order to reduce the time taken for the delivery of the resource, the guidelines were amended so that nurses could choose to ask the parent questions from between one and three of the ‘clusters’ (that is, groups of questions that related to key overarching topics such as social support, parenting and relationships) along with mandatory introductory and closing questions. Consequently, the nurse could choose to ask between eight and 16 questions. Nurses could use their clinical judgement to ask parents questions from the parenting cluster, or randomly choose a cluster if they weren’t sure which cluster was most relevant to the parent. During the second trial there was a significant reduction in the amount of time required to successfully apply the resource.

The third key finding was that the process of learning about the Parent Engagement Resource was beneficial to nurses. Involvement in the Parent Engagement Resource trial enhanced the skill and knowledge providing in administering a resource that focuses on potentially sensitive psychosocial issues.

The fourth key finding related to the utilisation of the tool with clients who have multiple and complex problems. One nurse commented:

"I didn’t feel comfortable using the Parent Engagement Resource with clients with highly multiple complex issues, especially mental health issues. These clients would find the Parent Engagement Resource too intrusive."

The nurse expanded on this comment, expressing her concern that the questions were worded too formally, which hindered her from establishing a free-flowing conversation with the client and hence she felt she couldn’t engage the more complex, high-need clients. This sentiment was echoed by many nurses during consultations, as the following comments demonstrate:

"A lot of nurses get the same information from the Parent Engagement Resource but by asking things in different ways. It would be nice to launch into questions quite quickly. EMCH already have a rapport with families so the preamble is unnecessary."

Further research is required to establish in what circumstances – and for which clients – the Parent Engagement Resource is most useful and appropriate.

The final key finding is that parents who were involved in consultations where the Parent Engagement Resource was being used were overwhelmingly positive about the nurses’ engagement skills. Thirty-five of the 36 parents during the Phase 2 testing agreed or strongly agreed that the nurse demonstrated qualities of engagement (that is, made you feel at ease, showed care and compassion). During Phase 2, all 27 participating parents agreed or strongly agreed regarding the nurses’ qualities of engagement.

Conclusions

The acceptability of the Parent Engagement Resource for parents and professionals has been tested, along with its usability within a maternal and child health setting. The resource has undergone significant amendments in order to ensure it is acceptable to both parents and professionals and that it meets the needs of the professionals who use it.

Maternal and child health nurses view the resource as a useful tool for engaging parents; however, time constraints appear to limit the extent to which the tool can benefit the process of engagement. This raises a broader question about the conflict between the time constraints placed upon professionals who work with parents and the importance of engagement.

The findings from the feasibility suggest that in some cases the Parent Engagement Resource is not appropriate and perhaps not even necessary. However, evidence suggests that engaging parents can be difficult. A tool such as the Parent Engagement Resource can facilitate that process; however, only if professionals have enough time to use it.

The advantages of the Parent Engagement Resource are:

- it is comprehensive in its coverage of family stressors yet far shorter than other tools that seek to cover the same ground
- it provides professionals with a framework for having a positive conversation with parents about issues that can be highly sensitive and otherwise difficult to broach
- it focuses on the impact of family stressors on the children, thereby minimising direct challenges to parents
- it has been shown to be acceptable to parents.

Further research is required in order to find out:

- if frontline practitioners other than highly skilled nurses can use the tool effectively
- what form of supervision, training or support is needed by practitioners using the resource who are not social work or psychology trained
- which clients the resource is not useful or appropriate for – this is especially important to test for clients with multiple and complex problems.

With the findings from the study presenting some encouraging outcomes, the next step for the Parent Engagement Resource is to implement a rigorous application of the resource with practitioners from both universal and targeted service to examine the effectiveness of the Parent Engagement Resource.

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Young ones, small steps: the journey of Hume Healthy Mothers Healthy Babies

Introduction
The focus of this paper is to describe the Hume Healthy Mothers Healthy Babies program (HHMHB), and discuss the support of young pregnant women in the program between January 2009 and December 2011. The Healthy Mothers Healthy Babies (HMHB) program is an innovative model that provides flexible support to vulnerable women during their pregnancy and early postnatal period. There is a focus on continuity of care for the woman through working alongside the maternity and maternal and child health services. Key activities of the program are client engagement, assessment and goal setting, care coordination and referral to appropriate services.

The principal focus of this paper on women aged under 21 years has been selected based on a number of factors, including the comparatively high number of mothers under 21 and births for this group within the City of Hume compared to North and West Victorian figures (City of Hume 2009). In addition, there are demonstrated evidence-based risk factors and vulnerability in terms of psychological, physical and social health indicators for both the young women and their children (Gilligan 2009).

The focus of the HMHB program is to support women who are pregnant, not to clinically manage the pregnancy. It is a model of interdisciplinary collaboration with teams consisting of midwives, social workers and welfare workers. It is, thus, an approach that focuses on the outcomes for the women and not the particular clinical strategies, instead reflecting a unifying strategy based on a holistic assessment of each woman within her lived experience. As Slee comments:

There is a growing consensus that rather than thinking about certain families as being hard to reach, it is more useful to think of them as being people whom services find it difficult to engage and retain (Slee 2006).

Background
Hume Healthy Mothers Healthy Babies (HHMHB) provides support for women with complex health, welfare and social needs. It is available to women over 12 weeks' pregnant, living in the City of Hume and who are economically disadvantaged. In addition, they may be from culturally and linguistically diverse (CALD) communities including refugees, asylum seekers and those of Aboriginal or Torres Strait Island descent. Other vulnerable groups included are women who have mental health issues; are at risk of postnatal depression; who have a physical or intellectual disability; who have a history of drug or alcohol issues; or are under 21 years of age.

The aims of the program are to improve the health and wellbeing of mothers and babies and to provide community-based outreach supports which are beyond the capacity of current acute services. The key objectives of the program are to improve women's access to antenatal care and to support healthy behaviours in pregnancy and beyond. In addition, the program provides support, links and community-based education. It is an outreach program that offers home visits, or a safe visiting place of the woman’s choice. HHMHB assists the woman to identify her priorities for her family based on the social model of health.

Literature search
The following literature search does not set out to represent a complete review of relevant research. The authors’ purpose here is to support the reader’s understanding of the relevant City of Hume demographic and social health factors in relation to women accessing the HMHB and the impact of the program within the first two years of its service delivery.

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The study
There is limited evidence evaluating the experiences of vulnerable women during pregnancy (HDG Consulting Group 2011). A challenge for the authors was the constraints imposed by ‘work in progress’ aspects of the results and the size of the sample and our inability to assess longitudinal impact. The study uses a combination of quantitative and qualitative approaches, based on HHMHB performance criteria and a limited content analysis of emergent themes and a brief literature search including demographic information, evidence-based risk factors and related models of care. Women accessing the program were asked to participate in a de-identified evaluation of the HHMHB program and written consent was obtained.

Risk factors and vulnerability issues
In 2008, Hume City had the highest proportion of total confinements to mothers younger than 20 years (3.2%), of all Local Government Areas (LGAs) in the North and West Metropolitan Region. There were 12.5 births per thousand females aged 15–19 years in Hume City during 2008 (Hume City Council 2009). The Hume City Family and Children’s Plan, 2008–2013 notes that breastfeeding data for all age groups collected in Hume reveals that a significantly lower proportion of babies are breastfed than the length of time recommended by the World Health Organization, with 40% of women fully breastfeeding at two months post-birth compared with 70% of women at discharge from hospital (Hume City Council 2008).

As the City of Hume Municipal Health and Wellbeing Plan 2009–2013 comments: “Giving birth as a teenager is associated with poor outcomes for both mother and baby” (Hume City Council 2009).

The particular vulnerability of young pregnant women is well supported by the literature search. The Queensland comparative study of Gilligan et al. indicates that pregnant women under the age of 19 are the most vulnerable compared to other age cohorts (Gilligan et al. 2009). Within this study, key variables of vulnerability include body mass of mother, smoking status, and severity of domestic violence. These findings are also supported by the report, Are we there yet: Indicators of inequality in health, the authors commenting that:

… higher rates of infant mortality, higher risk of pre-term birth and low birth weight and higher rates of accidents and falls in infancy … (combined with ) … developing emotional disturbances and behavioural problems, (is) in part due to higher levels of poor emotional health among teenage mothers (Allen Group Consulting Group 2008).

An added factor, particularly prevalent amongst pregnant women, is the experience of domestic abuse. Of the women surveyed by the Women’s Safety Australia study who experienced violence by a previous partner, 42% experienced violence during the pregnancy, with half of these women stating that violence occurred for the first time while they were pregnant. Critically, 23% of the women who were aged between 18 and 24 years reported higher levels of violence compared to the older women interviewed (Mouzos & Makkai 2004).

These type of impacts and links to the social, psychological and physical wellbeing of adolescent motherhood have drawn increased attention from researchers, including social isolation, (Breheny & Stephens 2006); experienced negative public attitude, (Hanna 2001); greater exposure to physical abuse (Hanna 2001; Mulroney 2002); propensity to develop postnatal depression, (Ernisch 2003), and experience of chronic poverty (ACOSS 2011).

In addition, a significant barrier to improved outcomes for young pregnant women and their babies is poor access to service provision. Frequently there are structural reasons for women not accessing services, particularly amongst young women, including access to available public transport, financial restraints, housing instability, lack of knowledge about services, and previous negative experiences of services.

Evidence for the HHMHB model
The evidence for the HMHB model of care draws on an understanding of the relationship between social wellbeing and physical health. This focus – and its value in addressing concerns of young women – is reflected in the Mission Australia National 2011 Survey of Young Australians which surveyed approximately 45000 young people. Of this total, 22912 were aged under 20 and ranked school or study problems, coping with stress and body image as the three top “issues of personal concern” (Mission Australia 2011).

HHMHB is also informed by the synthesis of the knowledge of developmental psychology, social science, and early brain and child development evidenced in the Reversing the real brain drain: early years study report (McCain and Mustard 1999). In its community vision and knowledge base, HHMHB is a successor to this report, in its practical application. As McCain and Mustard comment:

What is fascinating about the new understanding of brain development is what it tells us about how good nurturing, good nutrition and good health in early life create the foundation for brain development (1999, p. 33).

One of the defining features of the HMHB service model is its multidisciplinary approach. A key researcher in the development of support for a multidisciplinary approach to working with vulnerable pregnant women is David Olds. Olds et al. developed a randomised study of multidisciplinary staff home visiting, concluding:

… responsive mother–child interaction indicates that the program was operating as intended in helping parents provide more sensitive and responsive care … thought to promote secure attachment and healthy, emotional and behavioural development (Olds et al. 2002, p. 496).
The response: The HHMHB model of care: young pregnant women’s participation in the HHMHB program

For young vulnerable pregnant women and the HHMHB staff whose responsibility it is to support them, this understanding of the interconnectedness of the relationships between the self and environment is central their care. Subsequently, the first priority of HHMHB is on the development of three sets of critical relationships to enhance the unique opportunity provided by this program: firstly for the woman and her child, secondly, for the woman and her service provider(s), and thirdly, the relationship between the woman, her child, her family and her community.

Within the HHMHB, young pregnant women are able to access the program through three linked activities: individual care and support; an antenatal and postnatal group program; and consumer participation in the HHMHB reference group. These activities focus on the joined-up goals of the program to provide individual support and care based on the principles of empowerment, social justice and social support and evidenced in a social health and consumer participation knowledge base.

Results

Service model

The primary activity of the HHMHB program is individual support where the young women are supported by the social worker and/or midwife. The midwife provides individual education to the young woman where is it appropriate. Antenatal appointments are made where possible to meet the local maternal and child health nurse, or postnatal appointments are made. Depending on the client’s individual needs, referrals are made to other community services as required. The number of times each woman is seen during her engagement with the HHMHB program is based on weekly to fortnightly phone calls or in-person meetings. This is based on the client’s request, the stage of pregnancy and complexity of issues. Towards the end of the pregnancy and the early postnatal days, each woman is seen more regularly.

The secondary activity is the development of mothers’ groups, which are a collaboration between Enhanced Maternal Health nursing and HHMHB staff. Teenage pregnant women have the opportunity to participate in a weekly group, which provides education and opportunities to build friendships. This group has been very successful in retaining participants and as a consequence of expressed interest HHMHB developed a mentoring group for completing participants. This weekly group focuses on multidisciplinary leadership skills and education on breastfeeding, quitting smoking, healthy eating, confidentiality issues, listening skills and group dynamics. Significantly, the group has enabled participants to consolidate friendships, with women evaluating the three most useful aspects of the program as “education around breastfeeding”, “contacts to local services” and “socialising in a group”. A number of graduates of these groups have become mentors to new groups, consolidating their own learning and enabling the pregnant teenagers in the new groups to observe the parenting skills of the new mothers.

Thirdly, the HHMHB reference group includes participants in its membership with invited consumer representation at each meeting. This is a source of pride in achievement for the women, with one mother commenting in the evaluation process “I spoke at the launch of the HHMHB program and to staff at the hospital and now I am on the steering group for HMHB”.

Participation rates

All young women under 21 participating were pregnant with their first baby. The participation of young women in the program also suggests the effective take-up rate by this group of women in terms of age and indicators of vulnerability, such as past involvement with child protection and/or family services, CALD background (combining asylum seekers, newly arrived and refugees within a single group), Aboriginal and Torres Strait Islander background and income level; the latter reflected in that 100% of the participants’ main source of income was through government benefit or pension.

Table 1. Participation profile. Women under 21 years accessing HHMHB (January 2009 – December 2011).

<table>
<thead>
<tr>
<th>DEMOGRAPHICS</th>
<th>No. of women &lt; 21 years</th>
<th>% of women accessing program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young mothers (i.e. &lt;21 years)</td>
<td>25</td>
<td>17%</td>
</tr>
<tr>
<td>Past involvement with child protection or family services</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Newly arrived or refugee</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td>5</td>
<td>20%</td>
</tr>
<tr>
<td>Government pension main source of income</td>
<td>25</td>
<td>100%</td>
</tr>
</tbody>
</table>

Service needs

The findings for service needs were identified in terms of ‘identified client needs’, a standardised, evidence-based cluster of indicators of vulnerability used by all HMBH programs which includes disability, domestic or family violence, financial insecurity, housing insecurity, illicit drug use, lacking social support, mental illness, poor on non-attendance for antenatal care and risk of postnatal depression.

In terms of presentation for need, economic and social needs appear to dominate the issues identified by the women in their request for support. Twenty-one of the 25 participants identified financial insecurity as a need. The significance of impact of material factors on need is also reflected in the women’s request for support with housing needs with 44% of women identifying...
housing insecurity as their second highest need. Of the total of 25 women included in the evaluation for all ages, 24% required assistance to attend the antenatal visits from the HHMHB team.

Perinatal outcomes
The Australian National Feeding Survey (Australian Government 2010) shows 96% of babies are breastfed initially, with this percentage reduced to 61% at one month of age. Of the total of women accessing HHMHB, 85% expressed a positive intention to breastfeed, 93% initiated breastfeeding and 27% were exclusively feeding at six weeks post-birth. This contrasts with experience of the subset of women under 21, with 64% expressing a positive intention to breastfeed carried through into initiation but declining to 12% (three) of young women, six weeks post-birth. A significant perinatal outcome is that eight of the 25 women under 21 were continuing to maintain links with other women they had met through participation in HHMHB groups. This is despite the fact that 44% of women experienced high levels of housing instability throughout their pregnancy and being forced to move because of housing affordability and safety issues.

Discussion
A defining feature of HHMHB data is the significance of social and financial factors impacting on the experience of the pregnancy and early motherhood. This is also reflected in the fact young women experiencing financial insecurity have maintained their relationships begun with HHMHB despite the withdrawal of material support available when they were in the program. Pregnant young mothers are often difficult to recruit to groups; however, the HHMHB maintained continued participation of these women. This is contrasted with the dramatic reduction of young women breastfeeding between initiation at birth and six weeks post-birth. This is despite a clear intention to breastfeed, presumably made on the basis of information as to its value; for example, participants identified information about breastfeeding as one the reasons for their having attended the groups.

Other social factors appear to have supported their participation in the groups with pride in membership of the HHMHB reference group being identified as important at their exit from the program. The program model is highly tailored to individual need, with each participant involved in a regular relationship with staff in all aspects of antenatal care, including home visits, visits for antenatal appointments and local agencies.

The number of women identifying family violence as an identified need – two out of 25 participants – is small compared to the national incidence and prevalence of 7.3% for young women aged between 18 and 24 (Australian Domestic Violence Clearing House 2003). The significance of this is difficult to assess given the small size of the HHMHB sample.

Table 2. Service needs. This table is based on routinely collected program data.

<table>
<thead>
<tr>
<th>IDENTIFIED CLIENT NEEDS</th>
<th>No. of clients</th>
<th>% of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Domestic or family violence</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Financial insecurity</td>
<td>21</td>
<td>84%</td>
</tr>
<tr>
<td>Housing insecurity</td>
<td>11</td>
<td>44%</td>
</tr>
<tr>
<td>Illicit drug use</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Lacking social support</td>
<td>10</td>
<td>40%</td>
</tr>
<tr>
<td>Mental illness</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Poor or non-attendance for antenatal care</td>
<td>6</td>
<td>24%</td>
</tr>
<tr>
<td>Risk of postnatal depression</td>
<td>5</td>
<td>20%</td>
</tr>
</tbody>
</table>

Table 3. Perinatal outcomes up to client exit from program.

<table>
<thead>
<tr>
<th>PERINATAL OUTCOMES</th>
<th>No. of complete data sets</th>
<th>No. of complete HHMHB clients</th>
<th>% of complete HHMHB clients</th>
<th>No. of &lt;21 years HHMHB clients</th>
<th>% of &lt;21 years HHMHB clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total births</td>
<td>79</td>
<td>25</td>
<td>94%</td>
<td>25</td>
<td>100%</td>
</tr>
<tr>
<td>Full term births</td>
<td>78</td>
<td>73</td>
<td>94%</td>
<td>25</td>
<td>100%</td>
</tr>
<tr>
<td>Positive breastfeeding intention</td>
<td>73</td>
<td>61</td>
<td>84%</td>
<td>16</td>
<td>64%</td>
</tr>
<tr>
<td>Breastfeeding initiated</td>
<td>63</td>
<td>58</td>
<td>92%</td>
<td>16</td>
<td>64%</td>
</tr>
<tr>
<td>Exclusively breastfeeding six weeks post-birth</td>
<td>67</td>
<td>18</td>
<td>27%</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>Partially breastfeeding six weeks post-birth</td>
<td>67</td>
<td>22</td>
<td>33%</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>Exclusively bottle feeding six weeks post-birth</td>
<td>67</td>
<td>27</td>
<td>40%</td>
<td>14</td>
<td>56%*</td>
</tr>
<tr>
<td>Community contacts: maintained relationships with group attendees</td>
<td>8</td>
<td>32%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Incomplete data set: 20% of women <21 years moved out or the area or disengaged before completing the program.
Similarly, the referral rate and access to other agency and health programs as a consequence of HHMHB participation is difficult to assess because of the small size of this group of young women. It will be important to evaluate these issues with participants six months and 12 months out from the program. However, what is significant is the interplay of social factors and physical wellbeing and the role of the multidisciplinary approach to supporting the outcomes of the program. Social workers and midwives working together extend the experience and expertise available to participants, combining both social support and medical knowledge.

**Recommendations**

- The importance of social factors in the experience of young pregnant women under 21 provides a lens into improving continued breastfeeding. The task then becomes how to culturally support the community, families and the women themselves to be positive about continued breastfeeding.

- Housing and financial insecurity, combined with the emotional and physical challenges of early motherhood, suggests that six weeks post-birth is too early for HMHB to be withdrawing its intensive, tailored and group-based support. It is recommended that the HHMHB provide support to mothers beyond the early postnatal days to two years postnatal.

- In addition, longitudinal research should be conducted to explore the benefits of antenatal outreach support for young pregnant women, specifically for women 21 years and under. A three-month evaluation after discharge from the program will add to the qualitative evaluation of the HMHB program.

**Acknowledgements**

We would like thank all those who contributed to the data collection: Stephanie Yung, Ann Marie Li, Sarah Hagen and Rina Reiss. Also, we would especially like to thank the mothers and families we have the privilege of working alongside.

Finally, we wish to acknowledge the work of HDP Consulting Group, funded by the Victorian Department of Human Services to evaluate the results of all HMHB programs (HDP Consulting Group 2011). The HDG Consulting Group has completed a literature search of the evidence for the HMHB model as part of its evaluation of all the funded HMHB programs.

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Beyond the baby blues

New resources to help health professionals detect and manage depression, anxiety and related disorders in pregnant women and new mothers

Based on the 2011 beyondblue Clinical Practice Guidelines for depression and related disorder in the perinatal period, beyondblue has released a new set of free information resources for primary care and maternity health professionals to assist in the detection and management of perinatal mental health disorders. The resources include practical screening and assessment tools, and guidelines surrounding safe and effective treatments of perinatal depression, anxiety, bipolar disorder and puerperal psychosis.

The results of beyondblue research (2011) highlighted the need for health professionals to have access to information to assist them in their practice of routine screening and/or the provision of evidence-based treatments for women in the perinatal period. This includes guidelines on when and how to assess women for possible mental health disorders, knowledge of safe and effective treatment for women in the perinatal period, and indications of when treatment from a specialist is required.

The items can be ordered individually, or together as the ‘beyond babyblues Perinatal Introductory Pack Health Professionals’

The documents include:

- Psychosocial assessment and management of perinatal mental health disorders: A guide for primary care health professionals booklet.
- Puerperal (postpartum) psychosis: A guide for primary care health professionals fact sheet.
- Edinburgh Postnatal Depression Scale (EPDS) and Psychosocial Questionnaire scoring wheel for health professionals.

Resources can be ordered through the beyondblue website www.beyondblue.org.au or by phoning the beyondblue information line 1300 22 4636.
State and territory reports

Victoria

The Victorian Association of Maternal and Child Health Nurses has been busy over the last few months with preparation for our conference and AGM to be held on 22 June 2012. The theme for the conference is *Mindfulness: Mental health and wellbeing for the family.*

Our Association has been well supported by its members, with membership numbers remaining steady. We have held two member meetings so far this year and both have been well attended. Lael Ridgway was the guest speaker at the April meeting and her presentation was on attending and recording continuing professional development to meet the requirements of registration for the Nursing and Midwifery Board of Australia.

The ANF (Vic Branch) and VAMCHN continue to work together in the promotion and maintenance of the comprehensive educational preparation of Victorian MCH nurses. Midwifery and postgraduate maternal and child health studies are critical to the delivery of the high-quality Victorian MCH Service. Victorian MCH nurses are concerned that if midwifery were to be removed as part of their educational preparation this would reduce the quality of maternal and child health care provided to Victorian families. Protecting and promoting maternal and child health nursing in Victoria will continue to be an issue that will remain a focus of the Association in the year ahead.

VAMCHN provides financial assistance to members to participate in further studies or research that directly enhance professional learning related to maternal and child health nursing practice. Two scholarships for further study or research are available per year to the value of $1,000 and two grants are available per year to the value of $750 to assist members to attend a conference or seminar. The presentation of awards and scholarships to the successful applicants will occur at the AGM.

I would like to thank the Executive Committee – Sue, Karen, Lisa, Heather, Naomi, Kim, Lael and Wendy for all their hard work over the last year. We have several members retiring from the Executive Committee this year. Sue Berg has been a fantastic Treasurer for the last three years and has implemented a number changes to modernise membership renewals – many thanks for all that you have been involved in as a committee member. Karen Mainwaring has been instrumental in recruiting for and promoting our Association and we thank her for all her work on the committee for the last few years. Lisa Zubic undertook to learn about and manage our website and now has IT skills she was not expecting to have as a result of being on the committee; thanks Lisa, you have done a wonderful job with the website. Thanks to Naomi Brown for all the work that she has done as Secretary over the past year. Pam Hillis is also retiring from the role as Editor of our newsletter. Pam has sourced some great articles and has been very committed to producing an informative newsletter; thanks Pam. We are looking forward to the nomination and election of some new Executive Committee members at the AGM.

Please visit the website www.vamchn.org.au for member information and resources.

Joanne Fittock, President

Queensland

Queensland elections recently saw a change of government to the Liberal National Party. The LNP had a pre-election promise of a re-energised child and family health service to offer all families home visits at two and four weeks of age, and free consultations at community centres at two, four, eight and 12 months old.

This increase in services for all families will have significant impact on the workforce and we are currently trying to access the new minister and his advisers on how this will look for the child and family health workforce.

Membership continues to be a challenge. QCAFHNA currently has 41 financial members and a small group of dedicated Executive members who meet every two months to develop strategies on how we can improve this.

We recently launched our new website, so check us out at http://www.qcafhna.org.au/

Sue Kruske, President

New South Wales

Since the last journal report CAFHNA has said goodbye to Debbie Nemeth as the President due to relocation and a new career opportunity. Debbie is greatly missed by CAFHNA members and was actively involved in the committee for more than nine years. Deb has a passion for child and family health nursing and actively advocated for the role of child and family health nursing at every opportunity. CAFHNA wishes Debbie all the best in her new position.

Our online resources continue to grow. In late 2011, early 2012 CAFHNA launched the ‘blog’ in the members’ only section of the CAFHNA website. The aim of the blog is to encourage active dialogue between members across NSW and the committee regarding topical issues in child and family health nursing. In 2011, more than 65% of membership renewals were attended online, saving time and resources. The website is continuing to evolve with more resources being added to support professional development and to help keep members informed. The CAFHNA Professional Development Grant was also launched with the aim to support CAFHNA members in attendance at education events such as conferences, seminars or courses as well as supporting ongoing education. Information is available online.

The association continues to publish two journals yearly. The journal showcases the great work of child and family health nursing, including our rural child and family health nurses. It also provides child and family health postgraduate students with an opportunity to showcase student writings; and regularly features ‘Clinical Chatter’ with a review of websites, journal articles, DVDs and books; and ‘Diary Dates’ providing members with information on upcoming conferences. CAFHNA also produces a regular e-newsletter (emailled to all members across NSW) aimed at supporting the practice and professional development of our members as well as providing informative information to members.
News
Debra Thoms, NSW Chief Nursing Officer, has resigned and is leaving to take up a new position as head of the Australian College of Nursing. The Australian College of Nursing has been formed as a result of an amalgamation agreement between the Royal College of Nursing Australia and the College of Nursing. The NSW Chief Nursing Officer position is now being advertised.

CAFHNA, Karitane and Tresillian have come together with an exciting, new, premier conference in child and family health. The 2012 conference Moving Forward is being held at Doltone House, Sydney, on 23 and 24 August 2012. The conference focuses on best practice in child and family health by bringing together a wide range of professionals who work with families, to network and be inspired by quality sessions and keynote speakers.

Julie Maddox, President

Australian Capital Territory

As we sail through 2012 we are planning a very exciting Twilight Seminar. On 20 July Professor Dorothy Scott is going to present “Self, Service and Supervision: Reflections on Contemporary Maternal and Child Health Practice”. This promises to be an event not to be missed – we will start registrations for the event shortly.

Our member evenings continue – the next meeting is planned for Wednesday 13 June 2012 at QEII, Carruthers Street, Curtin at 5.30 pm. All are welcome. If you are not a current member you can come along and decide whether you wish to join.

Member meetings are planned in advance and we really look forward to seeing you at one plus we welcome suggestions for future meetings.

The 2013 national conference planning is well under way and registrations will be opening soon.

Currently we have 30 members. I would like to see CAFNAACT grow in membership and continue to share and inspire child and family health nurses in the area.

For further information or to join, please email at cafnaact@gmail.com

Christine Burrows, President

Northern Territory

Northern Territory C&FHN Association has been active in getting out the message that there is a group in NT who is dedicated to supporting other nurses working in the field of child health. To assist communication and discussion, a web page at groupspaces has been set up: ntcanfdhna@gmail.com

Current membership is 19, so efforts to increase this are ongoing.

Support for the future generation of nurses through sponsorship of a C&FHN student prize at Charles Darwin University has been allocated.

Currently some sponsorship for The Chronic Diseases Conference in Darwin 20-21 September 2012 is being explored; however, our logo has proven to be difficult to format for printing onto organising organiser’s shirts.

Our next big project is an education session on “Failure to Thrive”. Thanks to energetic planning from our small committee team members, a cross-disciplinary approach is being pursued with dietitian and Aboriginal Strong Women programmes as well as a presentation on Pakistan relief work undertaken by a member.

Gail Clee, Chairperson

South Australia

The SA Child and Family Health Nurses Association have had another productive year as it continues to offer quarterly professional development sessions for its members.

The committee
We have had some changes amongst the committee since the AGM in November with Anne Ford finishing in her role as she embarks on her new life in retirement. We also welcomed three new committee members Alison Martin, Cathy McInnes and Emily Dwyer-Fjeldstad. The following committee members have continued on the committee with some changes in their office bearer roles; Alice Steeb (president) Ruth Steer (vice president) Philippa Spooner (secretary), Sharon Teleki (treasurer) and our national board representatives Pam Murphy and Julian Grant (national president).

With the changes in the committee the initial focus of 2012 was to review the committee’s functions and business to ensure that all governance and legal requirements were being met.

Membership
Our membership continues to grow and we have the highest number of members (approximately 85) since the association’s establishment. Our main goal is to serve our members and to provide them with relevant professional development opportunities. To ensure that the professional development events offered are meeting the members’ needs, we have recently completed a survey of our members. The committee will review the responses and ensure that the planning of events is responsive to the members’ feedback.

Raising our Public Voice
One of the strategic activities identified by the committee is to raise our public voice. The committee have identified a number of activities and have developed a plan to action these. The development of a website is a priority on the agenda. SACFHNA was also privileged to be invited to have a display at the Safe Sleep Space Conference in February 2012.

The committee have also responded to two public consultations. Firstly the NHMRC consultation on the Clinical Practice Guidelines for Primary Care Health Professionals on the Management of Overweight and Obesity in Adults, Adolescents and Children and secondly on the Australian Human Rights Commission Amendment (National Children’s Commissioner) Bill 2012.

We would like to thank the support of our members and look forward to a productive remainder of the year.

Alice Steeb, President
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The Australian Journal of Child and Family Health Nursing aims to reflect the work and interests of Australian child and family health nurses. We will include articles, book reviews, comments, letters and other material relating to child and family health nursing clinical, management and education practice.

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