

## **Literature Review**

### **The role and nature of universal health services for pregnant women, children and families in Australia.**

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on behalf of the

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## **SECTION 1: INTRODUCTION**

Recent reports indicate that social policy in developed countries has seen positive results in well-child health and safety, child material security, education and socialisation (UNICEF, 2007). In countries where child health is supported by policy, children have relatively high levels of well-being as measured by material well-being, health and safety, educational well-being, family and peer relationships, behaviours, risks and subjective well-being (UNICEF, 2007).

In Australia, the overall health, development and well-being of children is high on many indicators. Childhood mortality rates have halved over the last two decades, the incidence of vaccine-preventable diseases has been reduced since the introduction of immunisation (92% of two-year-olds being fully vaccinated in 2004) and the proportion of households with young children in which a household member smoked inside the house has decreased over the past decade (Australian Institute of Health and Welfare, 2005). However, concerns are emerging related to rapid social change and the associated new morbidities such as increasing levels of behavioural, developmental, mental health and social problems. This has resulted in early childhood becoming a priority for Australian government and non-government organizations (Australian Institute of Health and Welfare, 2005). Health indicators also continue to show significant disparities between Indigenous and non-Indigenous children. The Aboriginal and Torres Strait Islander Infant mortality is three times the rate of non-Indigenous Australians and more than 50 per cent higher than Indigenous children in the USA and New Zealand (National Aboriginal Community Controlled Health Organisation & Oxfam Australia, 2007), and Indigenous babies are more than twice as likely to be born with low birth weight or premature, with a negative impact on their growth and development (Australian medical Association report care series, 2005).

The landmark Canadian Early Years Study states that:

Societies and governments have an obligation to the future to devise systems that ensure effective parenting, support good early child development (McCain & Mustard, 1999).

One significant component of a system or program of early childhood services is the availability of, and access to, universal health services at the primary care level, particularly for disadvantaged and vulnerable children and families. Furthermore, engagement with universal primary care services and maximising opportunities for intervention requires recognition that early childhood care begins in pregnancy.

### **1.1 Purpose of the Review**

The purpose of this review of the literature was to explore and critique the evidence related to the role and effectiveness of universal health services for pregnant women,

children and families, and to determine how well these services respond to the needs of disadvantaged and vulnerable children and families.

More specifically the review aimed to:

- Outline the role of the universal health services
- Describe what is known about the impact or effectiveness of services provided by midwives, child and family health nurses and general practitioners for disadvantaged and vulnerable children and families
- Explore factors that facilitate collaborative working
- Identify areas where further research is needed.

## **1.2 Universal health services for children and families**

There is an understanding within both government and the community that all children should have equal opportunity for optimal growth and development in the early years. Like school education, universal access to antenatal care and well-child health services is expected in a fair and just society. Universal primary health systems have important roles in providing equitable access to health services, in taking action to reduce health risks, in increasing the capacity of people to make decisions that will improve health and in working with communities to address the underlying determinants of health (Dixon, Douglas, & Eckersley, 2000; Whitehead, 1990).

Australia has a well-established system of universal health services directed at meeting the needs of pregnant women, infants, young children and families and provided at multiple contact points. All women have access to antenatal care in public hospitals or in community-based services, provided by midwives, obstetricians or general practitioners. Similar to the United Kingdom, New Zealand and Sweden, Australia also has a system of free, universal services for children from birth to the age of five years, provided by community-based child and family health nurses. In Australia, child and family health nurses are often the first point of contact for well-child care, with families accessing general practitioners for all other child health care (Kuo et al., 2006).

In a recent review conducted in the United Kingdom, Forbes et al. conceptualised the role of nurses in contributing to child health services (Forbes, While, Ullman, & Murgatroyd, 2007). Their analysis of over 11,000 papers, policy documents and expert opinion has identified four integrated dimensions of nursing work: assessment, health promotion, clinical care and health-care organisation (for example, reports on the skill and experience of the nurses). Health promotion featured centrally in the role of community-based nurses, such as health visitors, including preventative treatment (for example, mass immunisation programs), individual and group health education, interventions (both structured and unstructured), peer-group initiatives, and community development work.

More recently, midwives and child and family health nurses have, in a number of Australian states as well as internationally, become key front-line workers in whole-of-government initiatives. This provides a 'window of opportunity' to identify families needing additional support and many services have incorporated psycho-social screening as part of routine care (Austin, 2003; NSW Department of Health, 2003). General practitioners have a very clear role in caring for children with acute and chronic childhood illness, however, nationally and internationally, the role of general practice in preventative health and the care of mothers and babies is less well understood (Ni Bhrolchain, 2004).

In the main, women and families in Australia access these universal primary care services and find them acceptable. A study by Goldfeld et al. found that health-service use in the first 12 months of life is relatively high in middle socio-economic urban areas of Australia, averaging approximately fortnightly visits to a range of health services in the first year of life, including medical and nursing services, hospitals, pharmacists, naturopaths and allied health services (Goldfeld, Wright, & Oberklaid, 2003). Such high service use suggests there may also be overlaps in child health service provision in Australia, with different professionals often providing the same services to the same women, children and families, resulting in an unnecessary duplication of services (Haertsch, Campbell, & Sanson-Fisher, 1998; Regalado & Halfon, 2001). In countries where various professionals provide well-child care, there is often little coordination between services such as child and family health nurses and general practitioners (Kuo et al., 2006). For example, a Victorian survey found that half of general practitioners had no contact with their local child and family health nurse in the previous month, and of those who did, almost all found it helpful for themselves and the mother (Mbwili-Muleya, Gunn, & Jenkins, 2000).

### **1.3 Meeting the needs of vulnerable families**

There is evidence that universal health services in developed countries are not available equally and are not accessed by all women, children and families. As Tudor Hart (1971) observed, there is an 'inverse care law' that operates within health systems, which means those who are in most need of health services are least likely to receive them unless action is taken (Furler et al., 2002; Hart, 1971).

Maternal and neonatal outcomes are poorer for women from disadvantaged, vulnerable or socially excluded groups, although national-level data is often incomplete. The Report of the Confidential Enquiry into Maternal Death (CEMACH) in the United Kingdom for 2000–2002 found that very vulnerable and socially excluded women, including asylum seekers and those who cannot speak English, were at greater risk of a maternal death (Lewis, 2004). There are a range of factors that may contribute to poorer outcomes in these groups. These include language barriers and poor communication, unfamiliarity with the health service, concerns about confidentiality, and a lack of provision of services to meet the individual needs of these women. Murray and Bacchus (Murray & Bacchus, 2005) described the 'multitude of barriers to accessing timely and optimal care, including the lack of

timely and optimal care, lack of accessible information in appropriate formats; negative and stereotypical attitudes of staff; lack of continuity of care; and poor communication and coordination between maternity and other services’.

In the current trial of sustained nurse home visiting in south-western Sydney, 40% of families in the ‘usual care’ control group did not receive any child and family health nurse services in the first six weeks following the birth (Harris, Aslam, & Kemp, 2007). This is despite local policy that states all newborns and their families should be offered a home visit by a child and family health nurse within two weeks of discharge from maternity services. Recent reviews in Victoria (Brotherhood of St Laurence, 2005) and Queensland (Hirst, 2005), have identified the inadequacy of maternity services in responding to the needs of vulnerable and disadvantaged families. The Brotherhood of St Laurence found that vulnerable families did not receive the care they needed, with overlaps in roles of service providers, lack of coordination of available services and few mechanisms to transition care from one service to another. This pattern of fragmented maternity care results in women having to explain sensitive details of their personal history repeatedly (Brotherhood of St Laurence, 2005). Hirst also reported the following: ‘one woman reported having to explain details of female genital mutilation to the three different midwives who provided her labour care’ (Hirst, 2005). In the Victorian review, families who were interviewed reported having up to sixty-two appointments within twelve months with different service-providers (Brotherhood of St Laurence, 2005).

#### **1.4 Scope of the review**

The focus of this review is on the universal health services that are provided by midwives, child and family health nurses and general practitioners to pregnant women, children and families. Particular attention is given to examining the role and impact of these service providers on children and families who are distressed or vulnerable to poor outcomes. In Sections 2, 3 and 4 of the review we examine the literature on the role and impact of each of the three health professional groups in meeting the needs pregnant women, children and families.

It is important to distinguish between universal, targeted and specialist health services. As noted, the role of governments is to provide a comprehensive service system that responds effectively to the needs of parents and carers, and contributes to building stronger families. As a key principle, governments need to provide universal services that support the role of parents. Further intervention may be needed where access to universal services is restricted or unsuccessful due to the challenging circumstances or disadvantage faced by parents or the difficulties faced by a particular child. In these circumstances, governments can target additional support to these families to assist them to access universal services or more specialised.

*Universal Services* (sometimes also referred to as mainstream services) are those services that are provided to, or are routinely available to, all pregnant women, children and their families. Universal services are designed to meet the sorts of needs

that all pregnant women, children and families have; they include antenatal care, early childhood education and care, mainstream schools as well as health services provided by GPs, midwives, and child and family health nurses.

*Targeted Services* - Targeted services provide support aimed at particular groups of children, but often from within universal (or mainstream) services. This includes services such as sustained nurse home visiting programs and Sure Start Children's Centres in the United Kingdom that are aimed at all children in a targeted area where children are known to be less likely to achieve optimal outcomes, as well as services provided directly to individual children who have been identified as having additional needs, such as those provided via schools to children with special educational needs.

*Specialist Services* - Specialist services are those that are provided specifically for children with acute or high-level needs who would otherwise be at high risk for poor outcomes. For example, specialist services will include specialist medical care, child protection services, adoption and fostering services and services for children with serious mental health problems.

([www.everychildmatters.gov.uk/deliveringservices/multiagencyworking/glossary](http://www.everychildmatters.gov.uk/deliveringservices/multiagencyworking/glossary))/

The focus of this review is on universal services provided by midwives, child and family health nurses and general practitioners. In some services universal health service professionals will provide targeted and specialist services: for example, sustained nurse home visiting provided by child and family health nurses to families identified as needing additional support.

This review will also examine the role of these professionals in collaborative models of service delivery. Over the past decade there has been increasing emphasis on the development of 'whole-of-government' initiatives and integrated services. Collaboration exists on a continuum from relationships of coexistence and communication at one end of the continuum to collaboration and integration or co-ownership at the other end (VicHealth, 2003; Walter & Petr, 2000; B. Williams, Sankar, & Rogers, 2004). In Section 5 we examine the role of midwives, child and family health nurses and general practitioners in working in collaboration with each other and with other professional groups. Non government organisations are partners in the ARACY research collaboration that has prepared this review, however it is not within the scope of this paper to review literature reporting the impact of non government services for children, families and communities.

### **1.5 Search strategy**

The search strategy for this review used a number of databases, including: Children and Youth Service Review, CINAHL plus full text, AMED, Health Source/nursing/academic edition, Meditext, Medline, Mobys Nursing Consult, PubMed, Informit, Scopus, Psychinfo, Current Contents Connect, Proquest, EBSCO and the Cochrane library. A more general search using Google and Google Scholar

provided access to national and international government and non-government reports and practice guidelines.

The search strategy included combinations of the following keywords: child health, well child health, family health, early childhood, pregnancy, primary health care, primary care, midwifery, general practice, physician, doctor, child and family health nurse (and variations), health visitors, family nurse, community, maternity care, antenatal care, postnatal care, disadvantaged, vulnerable, interventions, young mothers, mental health, substance misuse, domestic violence, child welfare, psychological assessment, collaboration, communication, coordination, cooperation, partnership, linkage, multidisciplinary team, case management, pathways, continuity of care, models of care and shared care. Each search was limited to the publication date being within the period 1995 to 2007.

To determine studies for inclusion, the search strategy and review process was designed to locate any relevant systematic reviews (e.g. those of models of midwifery care, interventions for breastfeeding (Britton, McCormick, Renfrew, Wade, & King, 2007) and narrative reviews (Forbes et al., 2007; Regalado & Halfon, 2001) of the services and roles of universal health service professionals. The review also draws on single studies, randomised control trials (RCTs) and other comparative studies, where available and appropriate.

## **1.6 Methodological limitations of research**

There is limited literature examining the effectiveness of universal health services. In this review the most robust evidence comes from randomised control trials of continuity models of midwifery care and models of postpartum care and support. While individual trials demonstrate an effect in reducing caesarean section or in increasing parental competence, the overall impacts on child outcomes are small or have not been tested. In addition, specific data on the impact of maternity-based universal services for vulnerable or disadvantaged women is limited.

There is even less literature that examines the role and impact of child and family health nursing services and general practice on the health of children and their families. A recent scoping exercise in the United Kingdom, Forbes et al. (2007) reviewed over 11,000 papers and found that the majority of published and unpublished papers and reports describing nurses' roles in child health and child health services were descriptive in nature, and less than one quarter were evaluation studies. A smaller number of reviews, papers describing service innovation and those reporting parents' views of nursing services were identified. Most empirical work comprised evaluation studies, the majority of which were quasi-experimental. To date, there have been few rigorous evaluations of universal services provided by child and family health nurses or the equivalent in other countries, although, as noted in the introduction, countries with universal child health services appear to demonstrate better outcomes for infants and children (UNICEF, 2007).

## **1.7 Summary**

Universal health services, including midwives, child and family health nurses and general practitioners, provide well accepted, primary-care services for Australian families, yet little is known about their individual and collaborative roles. In 2007 the Victorian Government produced a compendium of evidence-based programs and strategies known to impact on key indicators of child health and well-being (Victorian Government, 2007). The report identified strategies and programs found to increase for example, attendance at antenatal care and at maternal and child health services, breastfeeding initiation and duration, immunisation, physical activity, child protection. While midwives, child and family health nurses and general practitioners are seen as key service-providers for many of these evidence-based programs and strategies, the Victorian review did not focus specifically on the roles of these service-providers. In this literature review, we take the opportunity to examine the published and other literature to describe what is known about the impact of these services for pregnant women, children and families.

## **SECTION 2: MIDWIFERY**

### **2.1 Role of the midwife**

This section will address the evidence in relation to the role of the midwife with regard to women from disadvantaged or vulnerable groups.

The role of the midwife has been changing in Australia in the past decade. A number of changes have occurred in recent years, which have impacted on the role of the midwife. Recent Australian reports have recognised the changing role of the midwife in relation to ‘new models’ of care and the need for midwives to further develop their skills in order to take responsibility and work to the full potential of their role (AMWAC, 1998; NHMRC, 1996, 1998). Recognition that midwifery is a separate profession from nursing has been a recent phenomenon and has also impacted on the role of the midwife. The international definition of a midwife (ICM, 2005) provides scope for midwives to practise according to the full potential of the role. While this definition is not universally used in its original form, the intent is nonetheless similar in all Western countries where midwifery is a profession in its own right.

#### ***2.1.1 ICM definition***

The International Confederation of Midwives (2005) defined a midwife as ‘a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

In Australia, as in many other countries, midwifery is being seen as having a strong role in primary health care and public health (CSE Homer et al., 2007). Increasingly it is being recognised that midwifery must be a public health strategy and that midwives need to emphasise their role in a way that does not view pregnancy, birth and the postpartum period in isolation from the other factors that influence health and well-being (Tyler, 2005).

The most recent Australian Competency Standards for the Midwife (ANMC, 2006; Homer et al., 2007) recognise this emerging role of the midwife with an explicit domain of 'Midwifery as Primary Health Care' and contains the competencies that relate to midwifery as a public health strategy. This is the first time that midwifery has recognised the pivotal nature of this component of the role, especially in relation to women and families from vulnerable and disadvantaged groups.

## **2.2 The impact and effectiveness of midwifery continuity of care models<sup>1</sup>**

Since the 1980s, in many Western countries, there has been a movement to build services or practices that enable midwives and women to get to know each other and develop a relationship of trust and confidence in each other (Sandall, 1995). This move to regain 'continuity of care' and to work in partnership with women (Guilliland & Pairman, 1995) has been an important part of the renaissance of midwifery in recent decades in many countries, including Australia. Continuity of care is seen as a fundamental aspect of midwifery practice, which had been lost in the move to fragmented, hospital-based care.

A number of studies have examined the outcomes for women who experienced midwifery continuity of care. Two studies offered a caseload model of care (North Staffordshire Changing Childbirth Research Team, 2000; Turnbull et al., 1996) and eight studies provided a team model of care (Biro, Waldenström, & Pannifex, 2000; Flint, Poulengeris, & Grant, 1989; Harvey, Jarrell, Brant, Stainton, & Rach, 1996; Hicks, Spurgeon, & Barwell, 2003; Homer et al., 2001; MacVicar et al., 1993; Rowley, Hensley, Brinsmead, & Wlodarczyk, 1995; Waldenström, MacLachlan, Forster, Brennecke, & Brown, 2001).

The composition and modus operandi of the teams varied between studies. Women were classified as being at low risk of complications in six studies (Flint et al., 1989; Harvey et al., 1996; Hicks et al., 2003; MacVicar et al., 1993; Turnbull et al., 1996; Waldenström et al., 2001) and as 'low and high' and 'high' in four studies (Biro et al., 2000; Homer et al., 2001; North Staffordshire Changing Childbirth Research Team, 2000; Rowley et al., 1995).

Overall, women were:

- less likely to use an opiate and regional analgesia
- less likely to have an episiotomy
- less likely to have an instrumental birth
- more likely to experience spontaneous vaginal birth
- more likely to feel in control during labour and childbirth

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<sup>1</sup> Much of this section is drawn from a chapter in a book due to be published in May 2008: Chapter 2: Midwifery Continuity of Care – What is the Evidence? Authors: Jane Sandall, Lesley Page, Caroline Homer and Nicky Leap. In *Midwifery Continuity of Care: A Practical Guide*. Edited by Caroline Homer, Pat Brodie and Nicky Leap, Elsevier: Sydney.

- more likely to be attended at birth by a known midwife.

Further work needs to occur to determine the impact of midwifery continuity of care models on outcomes for mothers and infants in relation to breastfeeding, parenting self-efficacy and confidence, and levels of postnatal depression.

While a number of midwifery continuity of care schemes have been intentionally provided to more vulnerable and socially at risk groups of women, only recently has attention turned to the relationship between continuity of care, increased safety and access (Cook, Render, & Woods, 2000). This is an attempt to address the poor health outcomes associated with these communities.

### **2.3 The impact and effectiveness of midwifery for women from disadvantaged or vulnerable groups**

In the United Kingdom, the Confidential Enquiry into Maternal and Child Health (CEMACH) (Lewis, 2004) has advocated midwifery continuity of care as a way of combating the problems of lack of access and follow-up care, inadequate translation, inadequate referrals and poor interagency working. It has suggested:

Women with complex pregnancies and who receive care from a number of specialist agencies should receive the support and advocacy of a known midwife throughout her pregnancy. Her midwife will help with promoting the normal aspects of pregnancy and birth as well as supporting and advocating for the women through the variety of services she is being offered (p. 4).

These recommendations formalise what many of the earlier projects to develop continuity of care have acknowledged by situating the development in more deprived areas. A number of projects in the United Kingdom have been situated within Sure Start community-based schemes ([www.surestart.gov.uk/](http://www.surestart.gov.uk/)). Sure Start programs were set up by the British Government to establish support for families living in areas of deprivation and where there is social exclusion. They are designed to bring together a number of agencies concerned with health, education and employment and social welfare in a centre where families may seek the complex support they often need. Where midwives are situated in these services, they become part of a multi-agency team that can attempt to address some of the social and economic needs of pregnant women, mothers and young children. Many Sure Start services were run from Children's Centres (Ukoko, 2005).

In other countries, midwifery care has been found to be effective for women from disadvantaged or vulnerable groups. For example, in the USA, a systematic literature review of research on midwifery care of poor and vulnerable women was undertaken and identified 44 published studies between 1955 and 2003 (Raisler & Kennedy, 2005). The studies, which were mostly retrospective and descriptive, demonstrated that in the USA midwives predominantly care for women who are young, poor,

immigrants, or members of racial and ethnic minorities. Changes to the organisations and funding of the health system were shown to be making it more difficult to provide effective care and counselling to disadvantaged women, especially in managed care settings. The review highlighted that future research should include more intervention studies and use both qualitative and quantitative methods to investigate midwifery processes of care, the process–outcome connection and vulnerable women’s experiences of childbirth.

Other research has shown that women living in poverty can benefit from community midwifery care. Hunt’s (2004) ethnographic study of a small group of women from disadvantaged areas showed that midwives had significant potential to impact on outcomes for these women. Her research provided a series of recommendations for midwives and service-providers, including a need to provide non-judgemental and respectful care within a woman-centred framework. The study highlighted the unique contribution that midwives can make, especially in terms of providing individualised care and developing a trusting relationship with woman that supports disclosure, from which strategies can be developed collaboratively.

Most of the models of care are based on a one-to-one approach (one midwife or other practitioner and one woman). In contrast, another model of care that is based on a group approach is gaining acceptance and demonstrating effectiveness, especially in women from vulnerable and disadvantaged groups. For example, the Centering Pregnancy program is an innovative and effective way of providing antenatal care in groups that is demonstrated to reduce the rate of low birth weight and premature birth (Ickovics et al., 2007; Massey, Rising, & Ickovics, 2006; Rising, 1998; Rising, Powell Kennedy, & Klima, 2004). The group model has been particularly effective for women from vulnerable and disadvantaged groups who traditionally have poor outcomes. A small study is underway in Australia on centring pregnancy (Teate, Leap, & Homer, 2006); but more work is needed on the feasibility and applicability of such a model and how it integrates with other services.

While these new models are significant in demonstrating the impact that midwifery care can have on outcomes for women, it is rare that they are mainstream services. Often, the vulnerable and disadvantaged will only be given care depending on the midwife’s personal interest or evident local need, due to the lack of clear and specific strategies concerning inequalities in health at the management level (A. Hart & Lockett, 2002).

### ***2.3.1 Models of care for women from Indigenous communities***

In some states, continuity of care models have been implemented for specific groups of women, for example, Indigenous women. The *NSW Aboriginal Maternal and Infant Health Strategy* placed midwives and Aboriginal Health Workers in community settings to provide continuity of care antenatally and postnatally for women for up to six weeks postpartum. This approach (the evaluation was undertaken by one of our collaborative team members) has demonstrated significant

improvements in attendance at antenatal care and breastfeeding and a trend to decreased perinatal deaths (NSW Health, 2005b).

In Queensland, the Townsville Aboriginal and Islanders Health Service offers the *Mums and Babies Program*. The program provides comprehensive integrated primary health care for young families. The accompanying services include antenatal and postnatal care, immunisation and child health monitoring, transportation assistance, childcare/playgroup on-site, testing for sexually transmitted infections (STI), referral, advocacy and social support. In addition to these services, the program also offers brief interventions for risk factors such as smoking cessation, nutrition, breastfeeding and sudden infant death syndrome (Panaretto et al., 2007).

In the Northern Territory, the Strong Women, Strong Babies, Strong Culture program was established in 1992. The program aims to increase infant birth weights by earlier attendances at antenatal clinics and improved maternal weight status. Aboriginal women in three pilot communities work with pregnant women in a program that emphasises Western medicine and traditional practices. Intervention services include: community-based maternal education and support by respected community women, advice on nutrition, reduced smoking and alcohol use, early antenatal care, testing and treatment for STIs, advice on seeking medical care and adhering to prescribed medication (Department of Health and Ageing, 2005).

While these programs are being shown to be acceptable and accessible for women, ongoing support is needed for the midwives and Aboriginal health workers who provide the service. High levels of stress have been reported by some staff in these models, as the work can be emotionally challenging, isolated and demanding, due to the social and emotional needs of the clients and a shortage of midwives (Hendy, 2007).

## **2.4 Summary**

Models of midwifery care have benefits, however, they have not been widely adopted in Australia. Expansion is limited by both education and workforce shortages. Many midwives are inadequately prepared to meet the new challenges and, equally, health services and systems are often inflexible and redesign is difficult.

## SECTION 3: CHILD AND FAMILY HEALTH NURSES

### 3.1 The role of the child and family health nurse

Child and family health nurses are registered nurses with specialised qualifications and experience in child and family health nursing.<sup>2</sup> The child and family health nurses work in primary, secondary (day stay units; sustained home visiting programs) and tertiary (early parenting centres) health services. This section will focus on the community-based services, in particular the provision of universal services within universal home visiting and centre-based services.

Child and family health universal services' core function involves providing a schedule of contacts and activities for all families, however, the way in which this is offered varies in each state and territory.<sup>3</sup> Similar universal services are available in New Zealand, United Kingdom, Scandinavian countries and in parts of Canada<sup>4</sup> (Cowley, Caan, Dowling, & Weir, 2007; Department of Health UK, 2004; Fagerskiold, Wahlberg, & Ek, 2000). The model of service delivery includes home visits, one-on-one centre-based consultations (by appointment and 'drop in' services), telephone 'helplines', education and support, group consultations and parenting groups. Universal services are also provided in other settings such as child care centres, shopping complexes, mobile services (Royal Flying Doctor Service), community halls and within Aboriginal cooperative services (Barnes, Pratt, & Walsh, 2003; Briggs, 2007; Henderson et al., 2007; Kruske, 2005; NSW Health, 2005a; State Government of Victoria, 2006). Some services are also offered by nurses working within pharmacies. These nurses do not always have the appropriate child and family health nursing qualifications and the consultation is often provided with limited privacy.

Traditionally, the role of the child and family health nurses in Australia and overseas was aligned to a medical model of health. The nurse was frequently positioned as the 'expert' providing advice and information to individual families on the health of their children and performing public health functions such as immunisation, child health and development screening, surveillance and assessment including hearing and vision screening of children up to the age of five years, behavioural management, and infant

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<sup>2</sup> In Australia, child and family health nurses have a different nomenclature in most states and territories. In New South Wales, Northern Territory, South Australia and Tasmania the nurses are known as child and family health nurses, in Victoria maternal and child health nurses, in Queensland and Western Australia they are called child health nurses. For the purpose of this document we have used the title of child and family health nurses (CFHN). The preparation for speciality practice is also inconsistent across Australia in the level of qualifications and curriculum focus.

<sup>3</sup> For example, in Victoria, the service provides ten key ages and stages consultations from birth to 3.5 years; this includes an initial home visit after birth, consultations at two weeks, four weeks, eight weeks, four months, eight months, 12 months, 18 months, two years and 3.5 years old (NSW Health, 2005a; State Government of Victoria, 2006).

<sup>4</sup> These are health visitors in the United Kingdom and Norway, child health nurses in Sweden and Finland, Plunkett nurses in New Zealand, public health nurses in Canada.

nutrition and feeding education and support (Barnes et al., 2003; Elkan et al., 2000; Kruske, Barclay, & Schmied, 2006)

Contemporary child and family health practice is informed by ecological and social models of health and is located within a population health and primary health-care framework to provide preventative health care. While nurses continue to address the health and development issues of infancy and early childhood, and implement strategies to promote normal development and behaviour and identify risk of harm (NSW Health, 2005a; State Government of Victoria, 2006), there has been a shift towards enhancing the provision of psychological support for parents and families (Barnes et al., 2003; Briggs, 2007). Recent policy directions in some states require nurses to include a standardised approach to the assessment of the parent (in most instances the mother), including screening for postnatal depression, substance misuse and domestic violence (NSW Health, 2005a; State Government of Victoria, 2006).

In some states, nurses are providing targeted and specialist services through sustained or intensive home visiting and multifaceted case management or enhanced service for families with complex needs (Victorian State Government; Henderson 2007). In addition, some nurses have received training in facilitating structured parenting programs such as the Triple P program (Positive Parenting Program) (Barnes et al., 2003; Dean, Myors, & Evabs, 2003), the Circle of Security (Marvin, Cooper, Hoffman, & Powell, 2002) and the 'Seeing is believing' and STEEP programs (Farrell Erickson & Egeland, 1999). This section will focus on universal services rather than these more intensive services.

### ***3.1.1. Universal health home visiting***

Universal home visiting is now being implemented in all Australian states and territories. In NSW it is described as:

The purpose of the universal health home visit (UHHV) is to enhance access to postnatal child and family services by providing all families with the opportunity to receive their first postnatal health service within their home environment, and thus engage more effectively with families who may not have otherwise accessed services. The UHHV provides an opportunity to identify needs with families in the context of their own home, and facilitate early access to local support services, including the broader range of child and family health services (NSW Health, 2006).

Child and family health services aim to visit the parent within two weeks (or as early as possible) after the baby's birth at a location that is convenient for the parent(s). This visit is identified as a mechanism for engaging families into the network of available services that are available to provide support for new parents and for introducing the child and family health nursing services to parents (NSW Health, 2006). The recommendation is for nurses to do the first health check, including

psychosocial assessment, support and education about current parenting issues and concerns, and determine the ongoing support needs for the families such as sustained home visiting, inclusion in parenting groups, and referral to other services (NSW Health, 2006).

### ***3.1.2 Centre-based child and family health nursing services***

Centre-based services are provided within a local geographical area. The service provision is in most instances governed by population need and size. For example, smaller rural communities may have a weekly or fortnightly clinic offered within a local community hall. The child and family health nurse may be co-located with other child and family health nurses, allied health workers and other community services.

The child and family health nurse provides services related to the specific states' or territories' schedule of contacts (including developmental screening, surveillance and assessment and psychosocial assessment), parenting anticipatory guidance (child safety, infant nutrition and parentcraft advice), assessment and management of parenting problems and concerns, and parenting groups (including education and therapeutic groups). The child and family health nurse is a resource person for parents, providing parenting information, referral to other community services (such as volunteer home visiting, secondary and tertiary child and family health services).

### ***3.1.3 Practice approach***

The policy and practice changes over the past decade require nurses to work in a more egalitarian partnership model with families<sup>5</sup>, and greater attention is being paid to the processes used in engaging and developing a relationship with families (NSW Health, 2005a). To support the changing role of the child and family health nurses, nurses, in all states and territories, have been encouraged to participate in family partnership training (Davis, Day, & Bidmead, 2002; Jackiewicz, 2004; Keatinge, Fowler, & Briggs, 2007). Recently Briggs undertook a synthesis of the literature that examines the 'nurse-client' relationship (Briggs, 2007). This research suggests that nurses are able to articulate how they form and maintain a relationship with families characterised by mutual respect and connectedness (Chalmers, 1992; Jack, DiCenso, & Lohfeld, 2005).

Child and family health nurses work within communities fostering social networks by bringing families together, supporting the development of playgroups, participating in family fun days and mobile visiting playgroups and strengthening local community connections (Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007; Kruske et al.,

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<sup>5</sup> While many of the programs and strategies are described within the literature as new and innovative, it is essential to acknowledge that many child health nurses have well-established practices based in community development and participation, work in collaboration with others and in partnership with the family. The issue is that this practice has not been described or evaluated.

2006; Rabab et al., 2006; State Government of Victoria, 2006). Both Australia and overseas child and family health nurses are expected to be part of the broader health system, collaborating with other services, agencies and professionals to meet the additional needs of children and families while maintaining the universal nature of the service (Cowley et al., 2007; Department of Health UK, 2004; State Government of Victoria, 2006). This is seen clearly in the role afforded to health visitors in some of the Sure Start sites and the new Children's Centres in the United Kingdom and now in Australia. For example, in Victoria, nurses working in the Enhanced Maternal and Child Health Service support families and children at risk of 'poor outcomes'. This program requires strong collaborative relationships with a range of other professionals to achieve successful outcomes (Edgecombe & Ploeger, 2006).

### **3.2 The impact and effectiveness of child and family health nursing services**

Overall, there is limited Australian and international research examining the outcomes or impact of child and family health nursing services. In a recent scoping exercise in the United Kingdom, Forbes et al. reviewed over 11,000 papers and found the majority of published and unpublished papers and reports describing nurses' roles in child health and child health services were descriptive in nature and less than one quarter were evaluation studies (Forbes et al., 2007). A smaller number of reviews and papers describing service innovation and those reporting parents' views of nursing services were identified. Most empirical work comprised evaluation studies, the majority of which were quasi-experimental. To date, there has been no rigorous evaluation of universal services provided by child and family health nurses or the equivalent in other countries, although, as noted in the introduction, countries with universal child health services appear to demonstrate better outcomes for infants and children (UNICEF, 2007).

Satisfaction surveys have overwhelmingly reported that the users of the child and family health services are satisfied with what they receive. A recent evaluation of Maternal and Child Health Nursing services in Victoria (Victorian Government, 2006) found services to be accessible and acceptable to most parents and families and mothers reported that they were provided with high-quality information, education and support. Similarly, Fagerskiold et al. reported that Swedish mothers believe their expectations for information, support and advice from the nurses are being met, that services are accessible and nurses approachable (Fagerskiold, Wahlberg, & Ek, 2001). While parents who use the service appear satisfied with what is provided, there is little knowledge of the frequency and intensity of services required to achieve optimum outcomes.

#### **3.2.1 Postpartum support**

A key role of child and family health nurses is to provide postpartum support to new parents. This is frequently undertaken through facilitating peer support groups for new parents. Quasi-experimental and qualitative research reports have demonstrated increased levels of social support and parenting confidence and high levels of

satisfaction amongst parents who attend new parents groups facilitated by child and family health nurses (Hanna, Edgecombe, Jackson, & Newman, 2002; Kruske, Schmied, Sutton, & O'Hare, 2004; Scott, Brady, & Glynn, 2001). These groups appear to be successful in de-emphasising the power and expertise of the professional (S. Kruske et al., 2004). Kruske and her co-authors also found that participating in parenting groups soon after birth can increase the duration of breastfeeding at eight weeks (Kruske, Schmied, & Cook, 2007). These groups often become self-sustaining social networks providing important support for parents (Scott et al., 2001).

Shaw et al., found, however, in a systematic review of the impact of postpartum support programs on maternal knowledge, attitudes, and skills related to parenting, maternal mental health, maternal quality of life and maternal physical health, that universal postpartum support to unselected women at low risk did not result in statistically significant improvements for any outcomes examined (Shaw, Levitt, Wong, & Kaczorowski, 2006). For example in the United Kingdom, two studies of universal postpartum support provided by nurses and tested in controlled trials, showed little if any benefits. Reid et al. conducted an RCT to compare the effect of three strategies to support women with uncomplicated pregnancies in the postpartum period. One group received a self-help manual, a second group received the offer of attending a support group facilitated by health visitors at two weeks postpartum and a third group received both the manual and the group. Each strategy was compared to normal care. There were no differences in outcomes related to physical or mental health or social support. It was noted that only 18% of the parents attended the group (Reid, Glazener, Murray, & Taylor, 2002).

Similarly, Wiggins et al. compared two forms of additional postnatal support to new mothers living in disadvantaged areas in the United Kingdom (Wiggins et al., 2005). One intervention was a monthly supportive listening visit for 12 months by a health visitor. At 12 and 18 months, there was little impact from either intervention, however, on average, mothers only received three visits, which closely resembles normal care provided by health visitors in the United Kingdom. However, an Edinburgh trial, in which health visitors were provided with brief training in non-directive counselling principles and then provided 24 women who were diagnosed as being depressed with eight listening visits demonstrated that 69% recovered from their depression within three months, compared to only 35% of the 26 women in the control group (Holden, 1994).

From this review it would seem that infants and their families considered at low risk do equally well whether they access or do not access these support services, although there may be a 'dose'-related effect, with more intensive support providing positive outcomes for some women. McArthur et al. responded to the review by Shaw et al., emphasising that when flexible services based on identified need are provided universally, it is possible to improve maternal psychosocial outcomes (MacArthur, Winter, & Bick, 2007)

Further, the review by Shaw and colleagues has not considered the controlled studies on postpartum support for breastfeeding. Child and family health nurses or their equivalents are regularly involved in interventions providing structured breastfeeding support. Cochrane reviews have identified the importance of support to the success of breastfeeding (Britton et al., 2007) with both peer and professional support for breastfeeding shown to be effective in increasing breastfeeding rates during the first two months following birth. Furthermore, a systematic review and meta-analysis conducted by (Guise et al., 2003) for the USA Preventative Services Task Force found that both education and support interventions provided postnatally increased breastfeeding duration up to six months of age.

It is also important to consider the context in which an intervention is put in place. For example in Australia, United Kingdom and New Zealand there are systems of well-established universal services. In Australia and New Zealand there are many metropolitan areas of low-density housing and very limited government and council services and infrastructure, and rural and isolated areas with sparse population and significant distance required to be travelled by the child and family health nurse to visit families or to provide a centre-based service.

### **3.3 The impact and effectiveness of child and family health nurses for families from disadvantaged or vulnerable groups**

Parents with greater needs or who are vulnerable have at times expressed hesitancy in using this universal service, or overt avoidance (Jack et al., 2005; Marcellus, 2005; Peckover, 2003). Mothers report that the nurse is 'watching over them' particularly in home visiting, creating fear and a lack of trust. Unless the engagement is performed sensitively by the nurse and a good relationship is formed, mothers can often feel vulnerable and powerless (Jack et al., 2005). Marcellus has explored this further, calling for nursing work to be informed by a framework of relational ethics in which child and family health nurses 'hold mutual respect towards everyone, no matter what the circumstances, engage in sensitive, responsive interactions with the family and child and embodiment (emotional engagement, attunement and a developing sense of moral agency)' (Marcellus, 2005).

To meet the challenge of increasing parents' ability to trust and reducing fear experienced by parents will require the refinement of the child and family health nurse's relational skills. The personal qualities that the child and family health nurse is required to bring to the relationship with the parent (family) include being empathetic, caring and understanding (Briggs, 2007), being dependable, honest and persistent (Bakker, de Vries, Mullen, & Kok, 2005; Zeanah, Larrieu, Boris, & Nagle, 2006). In addition, a positive relationship between the nurse and client involves flexibility, by being able to shift focus when unexpected problems arise. To engage the parent in the initial visits, it has been suggested that the nurse may meet the mother antenatally to explain their role and to encourage the mother to accept the service (Briggs, 2007). The synthesis by Briggs has identified phases of the

relationship including 'entry work', 'getting to know the client'; 'settling in the relationship'; 'developing mutual trust and creating connectedness' (Briggs, 2007).

In recent years there has been an increasing emphasis on the provision of psychosocial assessment and support as an essential element in the engagement of vulnerable children and families and the provision of appropriate and timely services. It is now well accepted that psychosocial adversity is often associated with adult mental illness, which has strong links with infant and child adverse outcomes. Child and family health nurses are well placed to continue with the assessment process, commenced during the antenatal period, through the use of a standardised assessment tool. Inclusion of information about perinatal morbidity and mortality within education programs is essential (Austin, Kildea, & Sullivan, 2007). The difficulty for child and family health nurses is that once families are identified as vulnerable or 'at risk' there are often insufficiently developed referral pathways or readily accessible intervention programs and/or organisational restrictions about the time allowed to be spent with families needing additional support or management intervention. According to Austin et al., psychosocial assessment should not be implemented unless there are clear referral guidelines and resources in place (Austin et al., 2007).

There is some evidence gained through the systematic review on postpartum support interventions by Shaw et al., indicating that for women and families at high risk for either family dysfunction or postpartum depression, home visitation or peer support, respectively, produced a statistically significant reduction in Edinburgh Postnatal Depression Scale scores (Shaw et al., 2006).

In the Victorian study by Morse et al., 40 maternal and child health nurses were provided with enhanced training to better meet the needs of first-time mothers who were identified as having high levels of distress either during pregnancy or in the early postnatal period. The intervention included assessment of all new mothers at six weeks postpartum, provision by nurses of brief non-directive counselling by the nurses for women who were mildly distressed and referral to a clinical psychologist or psychiatric services for those who were moderately or severely distressed. The level of intervention provision was based on the Edinburgh Postnatal Depression score. The nurses also had access to a liaison psychiatric network for consultation. There were no significant differences in outcomes for women who were distressed in either the intervention or control group, indicating that the additional nurse training did not make any difference to outcomes (Morse, Durkin, Buist, & Milgrom, 2004). The study found, however, that there were difficulties with implementation, and the nurses reported that they often did not have sufficient time to undertake the counselling intervention.

Home visiting by professionals is used widely as a strategy to provide support to families with identified vulnerabilities or risk factors. Nurses remain one of the key professionals used in the provision of home visiting programs. In the well-known work of David Olds, the Nurse Family Partnership program has been tested in three separate large-scale, randomised control trials with different populations living in

different contexts. Results from these trials indicate the program has demonstrated improved parental care of the child reflected in fewer injuries and ingestions, increased infant emotional and language development, as well as improving the maternal life course, reflected in fewer subsequent pregnancies, greater work-force participation, and reduced dependence on public assistance and food stamps (Olds, 2006). These positive findings have been difficult to replicate in other trials using nurses, as well as those using paraprofessionals or volunteers. When results are combined in meta-analyses the effect of home visiting is generally small and modest at best (Gomby, 2005).

Daro takes a positive view of the current knowledge about home visiting, suggesting that we need to view the incremental developments that are occurring in home visiting and that over time there will be increasingly positive outcomes (Daro, 2006).

The key features that represent programs most likely to meet the needs of parents and to influence outcomes are:

- Solid internal consistency that links specific program elements to specific outcomes
- Well-trained and competent staff
- High-quality supervision that includes observations of the provider and participant
- Solid organisational capacity
- Links to other community resources and supports
- Consistent implementation of program components (Daro, 2006 p. 11).

Much additional family consultation, support and intervention, in particular the provision of sustained nurse home visiting programs, could be provided by child and family health nurses if there was an increase in workforce numbers, adequate provision of clinical supervision, additional ongoing professional development and planning for future education needs for the preparation of a child and family health nurse with advanced knowledge and skills. Kemp et al. in their investigation of current generalist and child and family health nursing competencies, identified that they ‘... do not encompass the different and advanced competencies needed to support the delivery of a comprehensive biopsychosocial model of SNHV for vulnerable and at-risk families’ (Kemp, Anderson, Travaglia, & Harris, 2005)

### **3.4 Summary**

Child and family health nurses have been identified as key professionals in enhancing parental access to primary-level child and family health services: the universal maternal psychosocial assessment, an increased focus on the promotion of the infant and parent relationship and health home visiting (both universal and sustained). To enable child and family health nurses to increase their engagement with vulnerable families, additional and ongoing support and consultation will be required. For

example, there should be inclusion of child and family health nurses in the consultation and planning process at state and local levels, review of the post-graduate education preparation for child and family health nursing, ongoing continuing education, provision of clinical supervision and support for research into child and family health nursing practice.

## SECTION 4: GENERAL PRACTITIONERS

### 4.1 Role of the general practitioner

Children are important users of general practice services: general practitioners (GP) had 13.5 million encounters with children aged under 15 in 2004–05, compared with only 545,000 episodes of children’s hospitalisations (Britt H & et al, 2005). The nature of the illnesses of children presenting to general practice in Australia is well documented (Charles, Pan, & Britt, 2004), and in Australia the role of general practice in the provision of care for episodic and chronic illness in children is clear. Internationally, however, there is longstanding debate about the role of GPs and general practice activities in early childhood, with debate over the gate-keeping role of GPs and direct access to specialists such as paediatricians (Ni Bhrolchain, 2004), the role of specialist general practitioners (Piele, 2004), the development of the role of the practice nurse and nurse practitioners (Hall & Lawson, 2004), and the changing expectations of parents (Sowden, 2004).

Much less is known about the provision of ‘well’ mother and child care, that is, preventive and health-promoting care by general practitioners for mothers and young children: the exception being the provision of shared-care antenatal services. Although GPs do not routinely provide guidance on preventive and health-promoting matters such as breastfeeding or sleeping position, parents who receive their primary care from GPs report high levels of overall satisfaction with the given care (Lemoine, Lemoine, & Cyr, 2006) and most women view their GPs as trustworthy, accessible and highly skilled in antenatal and prenatal care (Mason, 2003).

This section will focus on universal services by general practitioners in early childhood with a focus on the *well* mother and child, and is structured in two sections dealing with the care of the mother and the care of the infant and young child.<sup>6</sup>

#### 4.1.1 Maternal care

The Royal Australian College of General Practitioners Guidelines for Preventive Activities in General Practice (The Royal Australian College of General Practitioners, 2005) state that GPs have a role in preventive activities before pregnancy, including recommending folic acid supplementation, genetic screening, immunisation and providing advice regarding lifestyle risks (smoking, alcohol and other drug use) and the risk of listeriosis.

GPs may also undertake care of the woman during pregnancy, however, few GPs in Australia provide sole care for pregnant women or undertake intrapartum care including delivery, due to lifestyle choices and costs of indemnity insurance (Weaver, Clark, & Vernon, 2005). Shared antenatal care provides an opportunity for women to

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<sup>6</sup> This review is focused on general practice, and hence, only limited literature from the USA is included, as well-child care in the USA is provided by primary-care paediatricians.

receive continuity of care from their general practitioner in conjunction with midwifery care during pregnancy, can reduce the overcrowding in antenatal clinics and improve services for pregnant women. In the late 1990s, Haertsch (1998) reported that 80% of hospitals in NSW had GPs providing antenatal care and 28% had a shared-care program. Very few GPs provide intrapartum care. Gunn reports that in 1998, only 17.7% of Victorian GPs provided intrapartum care (Gunn, 2003).

There has been little research exploring the role of general practitioners in the postnatal care of women. A postal survey of Australian GPs (Gunn, Lumley, & Young, 1998) demonstrated that when presenting to their GP for routine postnatal care, the GPs focused on examination of the woman's abdomen, blood pressure, perineum, vagina, pelvic floor, and breasts at the six-week check-up. Physical problems (urine and bowel symptoms, back problems), sexual issues, relationship and parenting issues were not routinely discussed, although female GPs were more likely to believe that the GP should routinely discuss maternal feelings, infant sleeping/behaviour, maternal sleeping/diet/tiredness, coping with other children, relationship with the woman's partner, and household work. Training programs can assist in improving GPs skills in these areas (Gunn, 2003).

General practitioners also have a role in the detection and management of perinatal depression (M-P Austin, 2003; The Royal Australian College of General Practitioners, 2005). The limited research on GP practice in this area suggests, however, that GPs do not routinely screen for maternal depression during well-child visits and do not often use validated screening tools (Gunn et al., 1998; Seehusen, Baldwin, Runkle, & Clark, 2005). Whilst GPs are able to recognise depression (Buist et al., 2005), they are also more likely than other professional groups to prescribe pharmacological, rather than the psychological or social management preferred by women (Buist et al., 2006; Buist et al. 2005).

Breastfeeding is another area in which general practitioners may have a key role (Dykes, 2006) and support for breastfeeding is identified in the RACGP prevention guidelines as an activity to be undertaken during every GP visit (The Royal Australian College of General Practitioners, 2005). An RCT in France has demonstrated that provision of a routine, preventive visit within two weeks of birth with primary-care physicians with appropriate training can significantly improve breastfeeding duration (Labarere et al., 2005). In order to fulfil this role, general practitioners in England were found to welcome additional, practical forms training in the support of breastfeeding women (Wallace & Kosmala-Anderson, 2006). The role of the Australian GP in supporting or promoting breastfeeding has not been reported.

#### ***4.1.2 Care of the infant and young child***

The family general practitioner is a valued resource for some women with young babies (Mason (2003). In a prospective study in middle socio-economic urban areas of Melbourne, mothers attended the GP for their infant an average of 10.9 times in the first year of life, with half of these visits being for a sick child and a quarter for

immunisation (Goldfeld et al., 2003). This frequent contact with infants and young children places GPs in the position to identify potential problems, respond to problems early and influence parents (Bethell, Peck, & Schor, 2001), however, little is known about the early-childhood preventive care practices of general practitioners (Young & Boltri, 2005). Preventive care guidelines for general practice in Australia (The Royal Australian College of General Practitioners, 2005) advocate the provision of parent education (such as accident/injury prevention, sun protection and nutrition advice) during every GP visit, and child health surveillance focused on growth, hearing, vision and speech at the time of immunisation and opportunistically. There is no research, however, reporting the actual delivery of these health promotion initiatives. General practice is also an effective site for the delivery of immunisation (Rixon et al., 1994; The Royal Australian College of General Practitioners, 2005).

#### **4.2 The impact and effectiveness of general practice for children and families**

Although women have positive views of their GP in general, when compared to midwifery care in a birth centre, private obstetricians and public clinics, Gunn reported that only 33% of women receiving shared care rate it as 'very good' (Gunn, 2003). A study of non-English-speaking migrant women in hospitals in Melbourne found that women preferred hospital-based care only based on a belief of superior care; they under-evaluated GPs' expertise and competence and had a lack of knowledge of the GPs' credentials (Markovic, Bandyopadhyay, Nicolson, & Watson, 2003). A documented source of dissatisfaction with GP-shared care is communication problems, particularly between the GP and the hospital, and initiatives have been implemented to improve this (Nicolson, Pirotta, & Chondros, 2005).

A common solution to the communication problems between hospitals and GPs has been to adopt a liaison position, 'a communicator', to be responsible for the communication outcomes. Significant improvements have been seen if one person was made responsible for a communication outcome (Nicolson et al., 2005). Thus, individual accountability may be the solution to problems in shared care. Lombardo describes what was considered a successful shared-care program in Geelong, Victoria. Established in 1994, the program included regular meetings of midwives, obstetricians and division personnel to sort out difficulties. The program has evolved and brought new benefits in improved continuity and coordination of care, up-skilling medical staff, rationalising resources and promoting linkages between midwives, GPs and obstetricians (Lombardo, 2003).

Initiatives of integration between general practitioners and hospitals to improve collaboration and continuity of care were evaluated across seven pre-existing GP-hospital programs (Lloyd, Davies, & Harris, 2000). Findings were varied due to the time constraints of measuring long-term effectiveness for patients, although some positive findings of integration were existent. The Brisbane Southside Collaboration found that GPs valued the involvement with patient care throughout the entire pregnancy; GPs were motivated to ensure continued care was received by patients through maintaining contact with patients and following women throughout their

pregnancy, as a result of being able to care for their babies after birth. In addition, the NSW Central West pre-admission systems enabled access to GP-held pathology, thereby reducing duplication. Overall collaboration was viewed to benefit patients, general practitioners and hospitals if successful, although barriers were evident, such as communication breakdowns, resource constraints and cultural differences between GPs and hospitals.

There is evidence from studies in the USA that attending the recommended number of preventive early childhood visits in the first year of life is associated with an increased rate of visits to the general practitioner for episodic illness, a decreased rate of presentation to emergency departments for ambulatory sensitive conditions (Pittard, Laditka, & Laditka, 2007), and a decrease in avoidable hospitalisations for poor children (Gadomski, Jenkins, & Nichols, 1998; Hakim & Bye, 2001). Evidence from the USA also suggests that there is a gap between the recommended provision of preventive care and child health surveillance and actual provision (Bethell et al., 2001). In particular, parents were found to want more information about developmental status and psychosocial issues including behavioural development (Schor, 2004). Providing anticipatory guidance for parents to enhance the development of their child is most effective where the general practitioner has an interest in child health (Brown, Hampshire, & Groom, 1998), and where there is a continuous relationship between the family and provider (Inkelas, Schuster, Olson, Park, & Halfon, 2004).

#### **4.3 The impact and effectiveness of general practice for women from disadvantaged or vulnerable groups**

Health inequality research has effectively demonstrated that countries with strong primary health care (PHC) infrastructure have healthier communities and lower health costs (Lemoine et al., 2006; Starfield, 1996). Whilst there is little published evidence on the provision of GP services for well mothers, rates of use of general practitioners is related to socioeconomic status. In England, children from lower socioeconomic groups have been noted as making more visits to GPs than children from more affluent groups, due to the greater frequency and severity of illness in disadvantaged groups. Consultations for preventive activities, however, were fewer in children from lower socioeconomic groups (Saxena, Majeed, & Jones, 1999).

The Australian government has made available a medical rebate for general practitioners outside hospitals to provide a comprehensive health check for children of Aboriginal or Torres Strait Islander descent, aged 0 to 14 years. The service includes an assessment of the child's health, and her/his physical, psychological and social well-being. It is also designed to assess what preventive health care, education and other assistance should be offered to the patient, to improve her/his health and well-being (Department of Health and Aging, 2006).

#### **4.4 Summary**

Although general practitioners are an important provider of services to women and young children, and visits to the GP provide opportunities for anticipatory guidance and preventive care activities, little is known about how GPs provide this care, with some evidence that such care is poorly delivered and less likely to be routinely provided to vulnerable and disadvantaged children.

## **SECTION 5: THE ROLE OF UNIVERSAL HEALTH SERVICES IN COLLABORATION AND INTEGRATED MODELS OF SERVICE DELIVERY**

Over the past decade, significant efforts have occurred both nationally and internationally to redesign, refocus and strengthen the services provided to families with young children, particularly those who are disadvantaged. Such initiatives include: Sure Start in the United Kingdom, Healthy Families America, Strengthening Families in New Zealand, Stronger Families Stronger Communities in Australia. Both federal and state governments in Australia acknowledge the need to improve the health of children and young people; policy is directed at prevention and early intervention encouraging healthy development of children and young people (J. Williams, Toumbourou, McDonald, Jones, & Moore, 2005). Most states and territories in Australia have, or are developing, whole-of-state government strategies for a more integrated response to the needs of children and families. These strategies have all given a key role to universal health care service providers, particularly child and family health nurses. In the United Kingdom, Sure Start also enlisted midwives to identify and support vulnerable women during pregnancy and the early postpartum period. In Australia, little consideration has been given to how midwives and GPs can work alongside child and family health nurses in integrated service models to better support vulnerable families.

In this section of the paper we draw on Australian and international literature to describe the roles that universal services play in collaborative models of service delivery, discuss the impact of collaboration, particularly on outcomes for vulnerable and disadvantaged families, and examine some of the factors that facilitate collaboration.

There are now many studies of collaboration and integration focused around social care and child welfare services (Frost & Robinson, 2007; Huxham & Vangen, 2004; Katz & Hetherington, 2006; O'Brien et al., 2006; Tomison, 1999). In the health sector, studies of collaboration and integration are more likely to be found in the chronic and aged care sector (for example, (Fisher & Fine, 2002; Tieman et al., 2006). There are studies of collaboration linking secondary health services with other agencies such as mental health and child protection (Darlington, Feeney, & Rixon, 2004), and there is strong support for coordinated responses to domestic violence including health, police and child protection services (Mulroney, 2003). Specialist models also exist, for example, public health nurses are located within child welfare services to provide health services for children in out-of-home care (Schneiderman, Brooks, Facher, & Amis, 2007). Little research however, has explored the role that universal health services play in collaborative models of service delivery for pregnant women, children and families, or indeed how care is coordinated or integrated across these services.

## 5.1 Models of collaboration

Collaboration exists on a continuum. At one end are relationships of coexistence and formal and informal communication such as referral mechanisms and at the other end, collaboration and integration or co-ownership (VicHealth, 2003; Walter & Petr, 2000; Williams et al., 2004). Integration and collaboration need to occur at three levels that is, the service system – design and funding, operations and program implementation and the service delivery level. Evaluations of integrated models and service networks, such as Families First (Families NSW), most frequently describe outcomes at the system or operational management level and rarely at the level of service delivery on the ground (Valentine, Fisher, & Thomson, 2006). Similarly, in the evaluation of Sure Start in England, arrangements for cooperation in governance and strategic developments were more advanced than for procedural or frontline professional practice (O'Brien et al., 2006). This review has focused on the level of service delivery.

## 5.2 The impact and effectiveness of universal health services in collaborative models of service delivery

The studies of collaboration involving universal health services predominantly reflect initiatives to move services from the level of co-existence or minimal communication to models of coordination and collaboration. In this field, there are a range of strategies used by universal health services to communicate information, facilitate transition of care as a family moves from one service to another or one professional to another, and to build working relationships among each other and with other professionals and services. These strategies include: the implementation of liaison positions, multidisciplinary teams, co-location of services and care coordination or case management. One of the main purposes of communication or collaboration is to facilitate the transition of care. Transitional care is defined by Coleman and Berenson as ‘a set of actions designed to ensure the coordination and continuity of health care as patients (clients) transfer between different locations or different levels of care in the same location’ (Coleman & Berenson, 2004).

*Liaison positions* are a common way to establish and maintain communication between services and different professionals. Liaison nurse positions have been used to provide a direct link between families and GPs or medical practices (Bower, 1997; Margolis et al., 2001) or between services and professionals (Rodríguez & des Rivières-Pigeon, 2007). For example, in many areas in Australia where GPs provide antenatal care, the local Division of General Practice will employ a GP liaison midwife. This GP liaison role includes facilitating communication between maternity units and GP practices, ensuring that GPs are informed of policy and practice developments, and attending meetings at the local maternity units. It is rare that such roles have been evaluated.

Participants in a current study of the transition of care of women and their babies between midwifery and child and family health nursing services conducted by the

authors of this paper, described liaison roles, such as the community liaison midwife or the hospital liaison child and family health nurse, as an effective way to link women to ongoing services, to ensure that transfer of information (Homer et al., under review). Yet in effect, liaison positions keep universal health-service professionals at a distance from each other, with only the liaison person communicating across services or professionals and holding all the information about the community. The liaison person becomes the repository of information and collaboration remains the business of a few rather than a central element of mainstream services.

*Multidisciplinary teamwork*, characterised by common objectives, common knowledge base and awareness of other team members' roles and responsibilities has demonstrated positive outcomes in primary health care (Williams & Laungani, 1999), perinatal care (Rodríguez & des Rivières-Pigeon, 2007) and in facilitating collaborative working in Sure Start (Morrow, Malin, & Jennings, 2005). In multidisciplinary teamwork, cases are brought for discussion, for learning purposes rather than decision-making, and to promote trust between professionals and agencies (Katz & Hetherington, 2006; Morrow et al., 2005). Teamwork allows professionals to identify and analyse problems, define joint working goals and assume joint responsibility for actions and interventions to accomplish the goals (Hall, 2005).

*Co-location of services and professionals*: There are descriptive reports in the literature on the value of co-located services in primary care (Payne & King, 1998) and in child welfare services (Frost & Robinson, 2007). These suggest benefits that include increased and quicker referrals between primary-care professionals and services, more appropriate referrals and an increase in opportunistic referral as well as, a greater likelihood of referrals for wider range of problems, such as social and emotional issues. In addition, efficient and appropriate referrals increase trust and respect, particularly amongst disadvantaged communities. Traditionally, many universal health service-providers, particularly child and family health nurses, have been isolated from both their peers and managers (Glendinning, Rummery, & Clarke, 1998). Co-location of services, however, does not automatically mean that services will engage and collaborate with each other. Anecdotally, nurses that are part of the new Children's Centre model in Victoria find there is little time for linking with other services and workers in the centre, as they spend the majority of their time in the community visiting families (Edgecombe, 2007).

In a review of collaboration in perinatal care, Rodríguez & des Rivières-Pigeon (2007) found that care coordination is increasingly being explored as a mechanism to link different services. However, the outcomes of care coordination appear less consistent and are difficult to measure. Interestingly, Rodríguez and des Rivières-Pigeon (2007) concluded that the majority of women in the perinatal period without complications do not appear to require a tightly integrated service system to ensure better health outcomes. For women and infants with specific needs or who are vulnerable, the author identified three strategies with the potential to improve the effectiveness and equity of the system – ensuring continuity of care, working in interdisciplinary teams, and developing services adapted to clientele.

### **5.3 The impact and effectiveness of models of collaboration and universal health services for vulnerable families**

Evaluations suggest that major policy and service innovations have been somewhat successful in increasing collaboration and integration among multidisciplinary and multi-sectorial service-providers (Belsky, Melhuish, Barnes, Leyland, & Romaniuk, 2006; O'Brien et al., 2006; Valentine et al., 2006). As yet, however, they have not necessarily demonstrated improved outcomes, particularly for children from vulnerable or disadvantaged families (Roberts, 2007). Much of the research in this area is process-oriented, describing the factors that facilitate or impede effective collaboration. Table 1 provides a summary of factors that facilitate successful collaboration.

Sure Start in the United Kingdom is considered by many to be one of the most ambitious attempts to provide integrated services for disadvantaged and vulnerable children and families (Valentine, Katz, & Griffiths, 2007). Research conducted by the National Evaluation of Sure Start (NESS) team investigated variations in the way programs were implemented (their proficiency) and their impact on the children and parents (their effectiveness) (Anning, Stuart, Nicholls, Goldthorpe, & Morley, 2007). The report highlighted the achievements of the Sure Start Local Programs in their holistic approach to implementing the Sure Start vision and for their efforts around developing sustainable, multi-agency systems for enabling parents, children and practitioners to feel empowered. However, the barriers in reaching 'hard to reach' groups were difficult to overcome and Belsky et al. (2006) reported that Sure Start Local Programs appear to have an adverse effect on the most disadvantaged children.

Health-led Sure Start Local Programs were more effective than other Sure Start Local Programs. As noted in the introduction to this section, midwives and health visitors in the United Kingdom played a role in many Sure Start projects, but there are few published reports on the impact of their contribution. Similarly, evaluations of whole-of-government initiatives such as Best Start in Victoria (Rabab et al., 2006) and Families First in NSW (Families NSW) (Valentine et al., 2006) say little about the outcomes for children and families from services provided by midwives or child and family health nurses. The findings of the Best Start evaluation in Victoria did, however, demonstrate an increase in attendance at Maternal and Child Health Services at Best Start sites and there is a possible association between this and increased breastfeeding rates at three and six months in these sites (Rabab et al., 2006). While the intention was there, it has been rare for GPs to participate in these initiatives.

There have also been a number of community-wide interventions that use universal health services to improve preventative services for children and families. These interventions, for example, in the USA (Margolis et al., 2001) and in Australia (Lumley et al., 2006), were not designed as whole-of-government initiatives, nonetheless, they used multiple strategies, services and professionals and have been rigorously evaluated.

Margolis et al. conducted a large observational intervention study in a North Carolina county (USA) that aimed to achieve changes in the process of care delivery, particularly the interaction between care-providers and low-income pregnant mothers to improve health and developmental outcomes for families (Margolis et al., 2001). The study focused on primary-care practices and involved community, practice, and family-level strategies, including home-visiting, to achieve policy change, engage multiple practice organisations, improve communication and coordination across multiple public and private services, and to achieve outcomes for families in the community. Staff received training, support and supervision, there were structured protocols for care delivery, and regular feedback data about implementation of the program. Margolis et al. reported high levels of practice and family participation, changes in the delivery system, and improvements in preventive health outcomes. Intervention group women were significantly more likely to use contraceptives, not smoke tobacco, and have a safe and stimulating home environment for their children. Children were more likely to have had an appropriate number of well-child care visits and were less likely to be injured. Margolis et al. reported that many improvements have been sustained since the project was completed. From this study it was concluded that tiered, interrelated interventions directed at an entire population of mothers and children hold promise to improve the effectiveness and outcomes of health care for families and children (Margolis et al., 2001).

In contrast, a community-based initiative to reduce postnatal depression in mothers with newborn infants in Melbourne was not effective (Lumley et al., 2006). The Program of Resources, Information and Support for Mothers (PRISM) was a community-randomised trial to improve maternal health in the first year after birth in which GPs and Maternal and Child Health Nurses (MCHNs) were involved in multi-faceted education and training programs (Lumley et al., 2006). The main objective was to increase the recognition of and an active response to depression in mothers of young children. One key project strategy was to provide explicit offers of time to talk by both maternal and child health nurses (that is, child and family health nurses) and GPs, and to increase the recognition and treatment of physical and mental health problems, which are common after birth. The trial was not successful in reducing depression, or in improving the physical health of mothers six months after birth. The authors argue that the lack of integration of nurses with other primary-care services such as GPs may have contributed to the non-success of the trial.

One of the most successful attempts to provide integrated multidisciplinary services for Aboriginal women is seen in the Mums and Babies program in Townsville, North Queensland. As described in Section 2, health service-providers have worked together with the Indigenous community to strengthen antenatal services. This program takes a team approach, ensuring that each woman is seen by Aboriginal health workers, midwives/child health nurses, doctors, the obstetric team and an Indigenous outreach health worker. The Mums and Babies program uses a number of mechanisms to maintain contact with families including a monthly pregnancy register, daily walk-in clinics, and transport services, as well as care plans to facilitate care across

disciplines, An evaluation after four years revealed improved access to quality antenatal care and significantly reduced preterm birth rates, but not perinatal mortality rates (Panaretto et al., 2005). After seven years, an evaluation showed previous results were sustained and the reduction in preterm births had been translated into significantly reduced perinatal deaths (Panaretto et al., 2007).

#### **5.4 Factors found to facilitate collaboration**

Lasker and Weiss, at the Centre for the Advancement of Collaborative Strategies in Health in New York, believe two questions – Who is involved? How are they are involved? – are key to understanding collaboration (Lasker & Weiss, 2003). Their research has identified four criteria for effective collaboration: leadership and management, critical process characteristics, proximal outcomes (individual empowerment, bridging social ties, creating synergy), and collaborative problem-solving. According to Lasker and Weiss, collaborations need leaders who believe in the ability of all sorts of people and organisations to work together to solve problems. Leadership needs to be facilitative and leaders must ensure that there is enough time and resources allocated to working in a collaborative way, including time for communication and group processes (Lasker & Weiss, 2003). Further, integrated services require a common philosophical framework which guides the intervention process, consistent policies and procedures across all disciplines (Mulroney, 2003).

Lasker and Weiss suggested that participants need to have real influence in and control over the collaborative process. People are not fully empowered when they are limited to providing a lead agency with only input or advice. Participants need to take part on an equal footing. This means being involved in identifying problems, being listened to about the causes of problems, developing strategies, and taking collective action (Lasker & Weiss, 2003). Effective collaborations make use of the skills of each participant; use participants' resources and time well; and establish relationships at all levels (at the top, middle and operational level of an agency).

The need for frequent and effective communication is central (Darlington et al., 2004; Scott, 2005; Valentine et al., 2007), for example, establishing an inclusive advisory committee and smaller executive committees to assist with problem-solving (Valentine et al., 2006) and encourage team members to participate in team development and in service planning at the structural/organisational level (Frost & Robinson, 2007). It is important to make the time for opportunities to understand the culture of each participating group (Frost & Robinson, 2007; Johnson, Zorn, Tam, Lamontagne, & Johnson, 2003), and learning to value each team member (Morrow et al., 2005; Richardson & Asthana, 2006). As Haertsch et al. found when examining shared antenatal care, the philosophies of practice differ and may result in confusion for women (Haertsch et al., 1998). On a day-to-day basis, Frost and Robinson highlighted team-building, establishing joint activities and developing shared protocols, as strategies suggested to increase communication and the cohesiveness of multi-disciplinary teams (Frost & Robinson, 2007).

Others have emphasised the importance of involving parents and representatives on committees and other bodies, developing a common language and to develop a mutual general understanding (Frost & Robinson, 2007; Valentine et al., 2007). Finally, Katz and Hetherington emphasised that good inter-disciplinary and interagency work builds on values that the development of good working relationships, both with families and with other professionals (Katz & Hetherington, 2006).

**Table 1: Key elements of successful collaboration**

- Shared vision and values
- Agreement on common goals and clearly stated aims
- Inspirational and energetic leadership
- Build on the enthusiasm and commitment of others
- Sound governance, clarity of leadership and assessment of risks
- Recognition of and valuing diverse professional contributions
- Capacity to address issues of power and achieve an equitable distribution of resources
- A willingness to share risks and problems as well as any positive outcomes,
- Mechanisms in place to deal with conflict
- Recognising all contributions, public recognition of worth
- Evaluations to assess effectiveness and cost-effectiveness
- The need for frequent and effective communication
- Time and resources particularly to have time to spend in building relationships with other professionals
- Mechanisms to facilitate sharing of information and administrative data as appropriate
- Understand participants' practice, philosophy, culture, ideas and beliefs.

(Darlington et al., 2004; Foster-Fishman, Salem, Allen, & Fahrback, 2001; Hudson, 1999; Huxham & Vangen, 2004; Johnson et al., 2003; Katz & Hetherington, 2006; Roberts, 2007; Scott, 2005; Valentine et al., 2007; Walter & Petr, 2000).

Yet collaboration and service integration take time and commitment to become embedded in practice and, for many, professional collaboration goes no further than referral to other services and it is rare that information is fed back to the referring practitioner or service. Work by Kruske et al. has indicated that at the level of management and service delivery, child and family health nurse services have rarely had the opportunity or time to participate in interagency planning meetings, to be part of project teams or even to be involved in case conferences (Kruske et al., 2006). The evaluation of the Maternal and Child Health Nurses (child and family health nurses) in Victoria found nurses were not always involved in local planning and collaboration. Further, Valentine et al. reported that collaboration and planning activities for Families First (Families NSW) were restricted to government agencies at the management level, and those at service level reported they did not necessarily see the benefits of service networks on the ground (Valentine et al., 2006). Morrow et al. also reported that the perception of boundaries between groups may prevent effective

teamwork in child health professions. In the United Kingdom, a study of multidisciplinary teamwork within a Sure Start site reported that authority and power in the team rested with certain members and professional groups and others believed they did not have the authority to express their views (Morrow et al., 2005).

#### ***5.4.1 Professional cultures and boundaries***

Professional role boundaries and professional cultures can act as barriers to effective collaboration and integration. The limited literature reporting on the role of universal health services in collaborative models, suggests there is considerable tension experienced by some professionals around the clarity of professional boundaries (Ellefsen, 2002; Homer et al., under review). A study of health visiting in Norway and Scotland (Ellefsen, 2002) found 'collaborative strain', jurisdictional threats and team conflicts were experienced by health visitors who believed other health services such as general practitioners were not clear about role definition, authority and responsibility in grey areas.

Professional cultures can also act as barriers to effective collaboration and teamwork. Each professional group identifies with a set of values, beliefs, attitudes, customs and behaviours which differ from one another. When working together in teams, professional cultures conflict with each other, and unless participants are motivated and willing to break down these cultural barriers and adopt an understanding and respect for each other, effective inter-professional collaboration is non-existent (Hall, 2005).

Scott argued, however, that conflict is a normal and expected component of collaborative working between and within services and professions and occurs at all levels (Scott, 2005). She suggested that conflict is most effectively managed by acknowledging and normalising it and identifying the sources of conflict. Clavering and McLaughlin suggested finding opportunities for professional groups to discuss how they view themselves and others in the particular health context. In this way professional boundaries become visible and tension can be addressed (Clavering & McLaughlin, 2007).

The long time call for 'seamless' services and more permeable boundaries (Belsky et al., 2006) among child and family services risks losing the clarity of roles. To minimise 'turf' issues, many argue it is crucial that a clear distinction between professions is maintained when implementing collaborative models. A study by Reveley described strong cohesion between GPs and a nurse practitioner, suggesting this was a result of each discipline protecting and maintaining the boundaries of their work (Reveley, 2001).

It is argued that from the client and family perspective, multi-disciplinary teams and integrated service models need to create a sense of certainty across professions. Instead of trying to eliminate boundaries and risk blurring and confusion of roles, Rushmer and Pallis suggested the importance of clear and coherent boundaries;

whereby each profession is able to contribute unique and different views to the team (Rushmer & Pallis, 2002). Thus, instead of 'seamless services', perhaps it is more important to have services that are 'well stitched' in the right places.

### **5.5 Summary**

For some time governments internationally and in Australia have developed and implemented strategies for a more integrated response to the needs of children and families. At a system level, key strategies have included the implementation of liaison positions, multidisciplinary teams, co-location of services and care coordination or case management. Lessons from collaborative practice in the field emphasise a need for health professionals to understand and respect each others' skills and a willingness to negotiate spaces for professional engagement. Questions remain about the extent to which service integration and collaborative models are needed to support all families or only those with greater need. The review by Rodríguez and des Rivières-Pigeon (Rodríguez & des Rivières-Pigeon, 2007) suggests that the majority of women in the perinatal period without complications do not require a tightly integrated service system to ensure better health outcomes. Those who are vulnerable, however, may benefit most from continuity of care, working in interdisciplinary teams, and developing services adapted to clientele.

## SECTION 6 –CONCLUSION: SUMMARY OF FINDINGS, KEY POINTS AND FUTURE RESEARCH.

The purpose of this review of the literature was to explore and critique the evidence related to the role and effectiveness of universal health services for pregnant women, children and families, and to determine how well these services respond to the needs of disadvantaged and vulnerable children and families.

Specifically the review aimed to:

- Outline the role of the universal health services
- Describe what is known about the impact or effectiveness of services provided by midwives, child and family health nurses and general practitioners for disadvantaged and vulnerable children and families
- Explore factors that facilitate collaborative working
- Identify areas where further research is needed

### **6.1 Summary of findings**

Australia has a well established system of universal health services directed at meeting the needs of pregnant women, infants, young children and families and provided at multiple contact points. Midwives, child and family health nurses and general practitioners strive to provide holistic care that incorporates all aspects of health including social, emotional and spiritual as well as the physical. These services have a strong health promotion focus. The services provided by these professionals are overall, highly accepted by the Australian population.

Over the past decade there has been recognition that pregnant women, children and families require a diverse range of flexible services provided at the universal, targeted and specialist levels. Most State and Territory governments in Australia have responded by initiating universal health home visiting after the birth of a baby and some have made a commitment to establishing midwifery continuity of care models. Further, some states have established structured psychosocial screening and assessment during pregnancy and after birth and in the case of South Australia, have introduced sustained nurse home visiting for families who require additional support after the birth of a baby. There is however, evidence that universal health services in Australia are not available equally and are not accessed by all women, children and families (Brotherhood of St Laurence, 2005; Hirst, 2005).

Importantly, this literature review has highlighted the limited research on the effectiveness or impact of universal health services both in Australia and internationally. Nevertheless, there are some findings from the review that can inform the development, implementation and testing of new models of care.

### ***6.1.1 Midwifery services***

- Models of midwifery continuity of care have demonstrated benefits however, they have not been widely adopted in Australia.
- Further work needs to occur to determine the impact of midwifery continuity of care models on outcomes for mothers and infants in relation to breastfeeding, parenting self-efficacy and confidence, and levels of postnatal depression.
- Based on the positive birth outcomes for women from continuity of care models, there has been strong advocacy in the UK for the provision of midwifery continuity of care for vulnerable populations. To date however, only a few studies have examined the impact of midwifery care for vulnerable groups. Recent evaluations of midwifery services provided within Aboriginal communities indicates the potential of increasing access to antenatal care, reducing perinatal mortality and increasing breastfeeding rates.
- Expansion of midwifery models of care is limited by both education and workforce shortages. Many midwives are inadequately prepared to meet the new challenges and equally, health services and systems are often inflexible and redesign is difficult.

### ***6.1.2 Child and family health nursing***

Child and family health nurses have been identified as key professionals in enhancing parental access to primary level child and family health services: undertaking the universal maternal psychosocial assessment, promoting the infant and parent relationship and providing health home visiting (both universal and sustained).

- There is limited Australian and international research examining the outcomes or impact of child and family health nursing services
- There is some evidence that nurse facilitated peer support groups for new parents can improve breastfeeding duration, parenting confidence and social support (Britton et al., 2007; Kruske et al., 2007; Kruske et al., 2004; Scott et al., 2001). However universal, and therefore limited postpartum support to unselected women at low risk does not appear to provide any particular benefits to women, children and families (Shaw et al., 2006)
- Women identified as having higher levels of need after birth particularly for postpartum depression, can benefit from more intensive or targeted individual services such as those provided through home visiting programs or group-based programs (Shaw et al., 2006). Workforce pressures and organisational constraints however, impact on the ability of nurses to provide enhanced support for women, children and families (Morse et al., 2004)
- Child and family health nurses undertake psychosocial assessment of all women at the universal home visit. However, there is concern that there are currently insufficiently developed referral pathways or readily accessible intervention programs and organisational restrictions about the time allowed to

be spent with families needing additional support or management intervention. (Austin et al., 2007).

To enable child and family health nurses to increase their engagement with vulnerable families additional and ongoing support and consultation will be required. For example, inclusion of child and family health nurses in the consultation and planning process at state and local levels, review of the post graduate education preparation for child and family health nursing, ongoing continuing education, provision of clinical supervision and support for research into child and family health nursing practice.

### ***6.1.3 General Practice***

There is evidence from studies in the USA that attending the recommended number of preventive early childhood visits in the first year of life is associated with increased rate of visits to the general practitioner for episodic illness and a decreased rate of presentation to emergency departments for ambulatory sensitive conditions (Pittard et al., 2007), and a decrease in avoidable hospitalisations for poor children (Gadomski et al., 1998; Hakim & Bye, 2001).

A number of studies identified the need for better transmission of information between general practitioners providing maternity care and public hospital services, that is shared care (Bower, 1997; Nicolson et al., 2005). A common solution to the communication problems between hospitals and GPs as well as in other areas requiring multidisciplinary cooperation has been to adopt a liaison position or an inter-organisational coordinator, responsible for ensuring communication between and across services and disciplines. Significant improvements in GP shared care have been seen if one person was made responsible for a communication outcome (Nicolson et al., 2005).

Overall, however little is known about the role and impact of general practice in providing care for pregnant women and children in particular, the effectiveness of care provided to vulnerable and disadvantaged children.

## **6.2 Key issues arising in the literature review**

### ***6.2.1 The importance of relationships***

Relationships form the basis of effective practice with pregnant women, children and families. Professionals that are emphatic have excellent communication skills and who are supported by a system of good communication and effective cooperation between professionals in different disciplines and between agencies are crucial (Katz & Hetherington, 2006). The literature indicates that many professionals particularly nurses and midwives, report that they recognise the importance of and acknowledge the effort required to engage and work in partnership with women and families to positively influence outcomes for children (Briggs, 2007; Henderson et al., 2007; S. Kruske et al., 2006).

Observational studies of nursing practice suggest however, that it is not easy to change from a medical or 'expert' model of practice to working in partnership with families. (Barnes et al., 2003; Henderson et al., 2007; S. Kruske et al., 2006). In Australia, UK, Hong Kong and Sweden suggest that priority is still given to the public health functions such as immunisation, advice on developmental issues, diet and feeding, screening and information on child health and development (Chan & Twinn, 2003; Fagerskiold et al., 2000; Forbes et al., 2007; S. Kruske et al., 2006). With high workloads, nurses, midwives and general practitioners report experiencing tension between working within the partnership model providing psychosocial support or the expert model looking for problems and giving health information (Barnes et al., 2003).

Where health professionals do recognise and prioritise the relationship with parents, mostly mothers, they often appear reluctant to confront parents about behaviours that may be detrimental to their health during pregnancy or to their infant or child for fear they may risk losing the relationship (Marcellus, 2005). As Stewart-Brown suggests, nurses may be providing support for parents but may not be providing support for parenting (Stewart-Brown, 2006).

### ***6.2.2 Collaborative working***

Integrated service delivery and collaborative working have for some time been considered the best way to provide a comprehensive service network for all pregnant women, children and families. The work of Katz and Hetherington (Katz & Hetherington, 2006) and others (Huxham & Vangen, 2004; Johnson et al., 2003) has identified that trust, authority and negotiation are three underlying principles fostering improved collaboration and better engagement with children and families.

In the context of universal health services one of the key aims of collaboration is to facilitate continuity of care between and across services. Strategies to facilitate the transition of care include: the implementation of liaison positions, multidisciplinary teams, co-location of services and care coordination or case management.

However, not all are convinced of the value of current efforts to develop integrated services. Leutz (1999) noted that in the United States, the most productive experiments with integrated services have been those that involve coordinated management and clinical integration, not those aimed at complete structural integration. Gardner argued that while effective co-operation and communication are considered crucial to delivering services, it is equally important to have a good range of available services, time available for practitioners to deliver the services and skills to offer strong partnership work with families (Gardner, 2006). Further, Katz and Hetherington believe that the energy and expense of bringing diverse professionals and agencies together to work in collaborative and integrated models may not be the key to delivering outcomes for children and families (Katz & Hetherington, 2006). They argue that structures do not play a critical or even central part in achieving a good outcome and that creating positive relationships between everyone nearest to the

problem including parents can contribute to the effectiveness of communication and cooperation.

In conclusion, there is an urgent need to evaluate in a rigorous manner, the often taken for granted services provided by midwives and in particular, by child and family health nurses and general practitioners at the universal level for pregnant women, children and families in order to inform service delivery nationally. Further, there is a need to strengthen and in some cases begin to establish an evidence base for the effectiveness of the role that midwives, general practitioners and child and family health nurses play in providing targeted and specialist services for vulnerable and disadvantaged populations.

### **Future research questions**

- What are the core or foundation health care and support services that should be provided at the primary service tier by universal health services to all pregnant women, children aged zero to three and their families? What constitutes over servicing of families?
- What is the role of Non Government organizations across universal and targeted services and how do these relate to statutory services?
- What are the minimum education requirements, qualification and competencies for professionals to provide universal and targeted health service? In the era of severe workforce shortages are there other levels of workers that could assist or support the work of the universal health service providers?
- Describe and map the current and potential role and nature of universal health services in responding to the needs of all pregnant women, children and families and in particular to families who are vulnerable or disadvantaged
- What are the experiences and needs of disadvantaged or vulnerable pregnant women, children and families who receive universal health services? What factors facilitate or hinder their decision to accept / access services? How effective is the 'one off' universal home visit in engaging disadvantaged and vulnerable families in services?
- How do services continue to engage families into the toddler and pre-school years and what are the services that they require?
- How can universal health services collaborate more effectively with non government organizations?

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