How Does the Enhanced Maternal and Child Health Program in Victoria Support Women Experiencing Family Violence?

Submitted by

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Contents

Acknowledgment of country

La Trobe University has campuses and undertakes teaching, learning and research activities in the traditional lands of the following people: Wurundjeri, Boonerwrung, Jaara Jaara, Latji Latji, Barkindji, Muthi Muthi, Wiradjuri, Dhudhuroa, WayWurru, Yorta Yorta, Bangerang, and Taunerong.

I acknowledge Australia's first peoples as the traditional owners and custodians of the land on which we work and deliver our services to families and their children.

I pay respect to the Wurundjeri people of the Kulin nation on whose land I reside. I pay my respect to these people, their cultures, and their elders, both past and present. I appreciate their connection with the land, community, families, and young children.

Statement of authorship

This thesis consists primarily of work by the author that has been published as described in the text. Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis accepted for the award of any other degree or diploma. No other person's work has been used without due acknowledgment in the main text of the thesis. This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

I have undertaken all the work in this thesis under the guidance of my supervisors, Professor Angela Taft, Judith Lumley Centre, La Trobe University, and Associate Professor Leesa Hooker, La Trobe Rural Health School, La Trobe University.

Under the guidance of my supervisors, I conceived the idea for this thesis project, and I am responsible for all aspects of the thesis. This thesis is presented as a thesis with publications comprising five papers, of which I am the primary author. I have made a substantial contribution to all papers, including developing, piloting, and finalising data collection tools, data collection, management, and analysis throughout the study. Co-authors have contributed to the overall study design, intellectual input, drafting and editing of manuscripts. The relevant Ethics Committees approved all research procedures reported in the thesis. This work was supported by an Australian Postgraduate Award Scholarship.

Catina Adams

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Acronyms and abbreviations

ACE	Adverse Childhood Experiences
ANFPP	Australian Nurse-Family Partnership Program
ARIA	Accessibility Remoteness Index of Australia
AHPRA	Australian Health Practitioner Regulation Agency
ARACY	Australian Research Alliance for Children and Youth
ASQ	Ages and Stages Questionnaires
CALD	Culturally and Linguistically Diverse
CCCH	Centre for Community Child Health
CDIS	Child Development Information System
CFAP	Child and Family Action Plan
CRAF	Common Risk Assessment Framework
DET	Department of Education and Training
DEECD	Department of Education and Early Childhood Development
DH	Department of Health
DHHS	Department of Health and Human Services
DOVE	Domestic Violence Enhanced Home Visitation Program
DV	Domestic violence
EHVS	Enhanced Home Visiting Service
EMCH	Enhanced Maternal and Child Health
EPDS	Edinburgh Postnatal Depression Scale
FNP	Family Nurse Partnership – UK
FV	Family violence
IPV	Intimate partner violence
IRIS	Integrated Reports and Information System
KAS	Key Ages and Stages
LGA	Local Government Area
MARAM	Family Violence Multi-Agency Risk Assessment and Management Framework
MAV	Municipal Association of Victoria
MCH	Maternal and Child Health
MIECHV	Maternal, Infant and Early Childhood Home Visiting program

MOC Model of Care

MOVE Maternal and Child Health nurse screening and care for mothers experiencing family violence

NFP Nurse-Family Partnership – US and Canada

NHS National Health Service – UK

OECD Organisation for Economic Co-operation and Development

PHC Primary Health Care

PICF Participant Information and Consent Form

RCT Randomised Controlled Trial

SDH Social Determinants of Health

UK United Kingdom

UMCH Universal Maternal and Child Health

US United States of America

VEYLDF Victorian Early Years Learning and Development Framework

WHO World Health Organization

List of figures

Abstract

Background:

Family violence is a significant public health issue with serious health consequences for women and children. In Victoria, Australia, Enhanced Maternal and Child Health home visiting nurses provide coordinated care for families with additional challenges, including those experiencing family violence. However, evidence is lacking on the family violence practice of Enhanced Maternal and Child Health nurses, and the management and professional support needs required by Enhanced Maternal and Child Health nurses.

Research question:

How does the Enhanced Maternal and Child Health program support women who are experiencing family violence?

Aims:

- To map the Victorian Enhanced Maternal and Child Health program.
- To analyse Enhanced Maternal and Child Health nursing family violence practice.
- To explore the characteristics of Enhanced Maternal and Child Health nurses working with women experiencing family violence.
- To explore how Enhanced Maternal and Child Health nurses are supported by their managers.
- To identify the systems needed to support effective family violence nursing practice.

Methods:

An explanatory sequential approach , including two research phases (a cross-sectional study of clinical practice via a quantitative survey and then an interpretive description study comprising qualitative interviews with nurses and managers) facilitated a sequential and progressive empirical investigation (McKenna et al., 2021). Applying the principles and methods of Interpretive Description has provided a comprehensive knowledge and a rich understanding of the perceptions and experiences of the group being studied (Thorne, 2016).

A mapping survey of the Enhanced Maternal and Child Health program across Victoria informed the design of subsequent phases of the research. A systematic review of qualitative research focused on the roles of home visiting nurses working with women experiencing family violence produced a thematic synthesis of the roles of nurses.

Interviews with 25 Enhanced Maternal and Child Health nurses and 12 Enhanced Maternal and Child Health nurse managers provided rich qualitative data for thematic analysis and interpretive description of nurse and manager roles, the support needs of nurses and managers, and the characteristics of Enhanced Maternal and Child Health nurses.

Findings:

Mapping the Enhanced Maternal and Child Health program identified significant variation between programs with different intake criteria, clientele, and practice models. The interviews with nurses confirmed they fulfil a broad range of roles, dynamically responding to the changing needs of women experiencing family violence. These roles can be conflicting, creating personal and professional challenges for the nurse.

Identifying the extrinsic and intrinsic characteristics of Enhanced Maternal and Child Health nurses has provided insight into their work and the support, skills, and education they need for effective family violence nursing practice. Specific personal attributes were identified as required to work with women experiencing family violence, reflecting that not all nurses can fulfil this specialist role. Nurses can learn family violence practice skills and knowledge; however, there are inherent characteristics required, and without these, the nurse may struggle to support families effectively.

The interviews with managers confirmed the complexity of the managers' role, with competing responsibilities and multiple reporting relationships. Managers highlighted their need for better role preparation, ongoing professional development, and the supervision skills required to support Enhanced Maternal and Child Health nurses effectively.

Conclusion:

How the Enhanced Maternal and Child Health program supports women experiencing family violence has been analysed, identifying the interwoven elements of Enhanced Maternal and Child Health nurses' and their managers' work. Enhanced family violence nursing practice supports women in several ways, including identification and assessment. The effectiveness of this Enhanced Maternal and Child Health nursing practice is variable, impacted by the characteristics of the individual nurse, and the support of the nurse's manager.

Nurses and their managers have highlighted the need for a coherent system-wide approach to improve outcomes for families, with a consistent policy framework, collaborative practice, clinical governance, shared clinical resources and screening tools, and improved organisational support. This study contributes to strengthening the Enhanced Maternal and Child Health program's response to violence against women.

Dedication and acknowledgements

This thesis is dedicated to “the countless women and children who are victims and survivors of violence, those left to rebuild, and those who have lost their lives. It is for the women whose stories continue to inspire our work and drive us to do more (Department of Social Services, 2019, p. 4).

It takes a village to raise a child, and this is also true for a PhD. Although it felt like a solitary effort at times, I was supported by key people and groups.

I acknowledge the support of my supervisors, Professor Angela Taft, and Associate Professor Leesa Hooker. They had faith in my ability to complete this project, even when the going was tough. I was inspired and motivated by their passion and commitment to improve outcomes for women and children experiencing family violence. I was also blessed with an excellent Research Progress Panel chaired by Professor Helen McLachlan and valued contributions from Professor Cathy Humphries, Ms Megan Leuenberger, Ms Marcia Armstrong, and Ms Lael Ridgway.

I was also fortunate to be supported by other groups. The PhD OWLS, an international community of older PhD scholars, provided an endless source of laughs, inspiration, and commiseration. The Judith Lumley Centre provided an academic climate that promoted rigour and collegial support. The RED team at La Trobe provided an excellent array of training opportunities to support those new to scholarship, including the very valuable SUAW sessions. I acknowledge the fine-tooth applied by Ms Celeste Thorn, copy editor, ever-patient despite changing deadlines and submission dates.

I want to thank the nurses who participated in this study and for their work with families. I also wish to acknowledge the work of anonymous peer reviewers and editors whose comments and suggestions helped improve the papers published as part of this thesis. Feedback from my PhD examiners also improved the final thesis.

Finally, I want to thank my family and friends, who believed I could conquer my own Mount Everest and encouraged me, even when the oxygen levels were low.

Thank you, David, my life partner, for everything.

Preface – the structure of the thesis

This work is presented as a thesis with publications. The La Trobe University doctoral thesis by publication guidelines state that the format of the thesis is based primarily on work completed during candidature and may be presented "as a collection of articles or book chapters including at least one substantial integrating chapter, or a separate introduction, general discussion and conclusion that reveal the way the articles and book chapters are thematically linked" (La Trobe University, 2019). This thesis is structured according to these guidelines (see Appendix i). The publications have been incorporated into the main body of the thesis document as PDFs.

Chapter 1 introduces the story behind the thesis, my position as a clinician-researcher, and the thesis.

Chapter 2 is a background chapter, providing a context for the study with a history of the Victorian Maternal Child Health service, the Maternal and Child Health service today, and the creation of the Enhanced Maternal and Child Health (EMCH) program. A review of family violence, and health systems responses internationally, nationally and in Victoria, Australia, complete the background to the thesis.

Chapter 3 reviews the research pertaining to enhanced nurse home visiting programs.

Chapter 4 articulates the research question and aims.

Chapter 5 provides the theoretical framework and methodology for the research, including the project design and ethical considerations.

Chapter 6 introduces the research findings with five publications published in peer-reviewed journals. They are presented in the format in which they were published.

Chapter 7 is the first published paper of the thesis - The Enhanced Maternal and Child Health nursing program in Victoria: a cross-sectional study of clinical practice.

Citation	Aim	Study methods
Adams, C., Hooker, L., & Taft, A. (2019) The enhanced maternal and child health nursing program in Victoria: a cross-sectional study of clinical practice. *Australian Journal of Primary Health, 25*(3), 281-287 https://doi.org/https://doi.org/10.1071/PY18156	To describe the diversity of the Enhanced Maternal and Child Health program between Local Government Areas as it has evolved over the past 15 years	A service-mapping survey with descriptive statistics with open-ended questions using content analysis.

Chapter 8 is the second published paper - A systematic review and qualitative meta-synthesis of the roles of home visiting nurses working with women experiencing family violence.

Citation	Aim	Study methods
Adams, C., Hooker, L., & Taft, A. (2022). A systematic review and qualitative meta-synthesis of the roles of home-visiting nurses working with women experiencing family violence. Journal of Advanced Nursing, 00, 1-22. https://doi.org/10.1111/jan.15224	To document the roles of home visiting nurses working with women experiencing family violence.	A systematic search and a meta-synthesis of the qualitative research related to the roles of home visiting nurses and family violence work.

Chapter 9 is the third published paper -Threads of practice: Enhanced Maternal and Child Health nurses working with women experiencing family violence.

Citation	Aim	Study methods
Adams, C., Hooker, L., & Taft, A. (2021). Threads of Practice: Enhanced Maternal and Child Health Nurses Working with Women Experiencing Family Violence. *Global Qualitative Nursing Research 8*, 1-11. DOI:10.1177/23333936211051703	To explore how nurses encountered the clinical presentation of family violence, how they described their role and the challenges that arise in undertaking family violence work.	Interviews with 25 Enhanced Maternal and Child Health nurses to explore their nursing roles in working with women experiencing family violence.

Chapter 10 is the fourth published paper -The characteristics of Maternal and Child Health home visiting nurses undertaking family violence work: an interpretive description study.

Citation	Aim	Study methods
Adams, C., Hooker, L., & Taft, A. (2022). The characteristics of Australian Maternal and Child Health home visiting nurses undertaking family violence work: An interpretive description study. Journal of Advanced Nursing, online (1), 1-15. https://doi.org/10.1111/jan.15160	To explore the family violence practice of home visiting nurses, focusing on the intrinsic and extrinsic characteristics of the nurse.	Analysis of semi-structured interviews conducted over four months in 2019-2020 using Reflexive Thematic Analysis.

Chapter 11 is the fifth published paper - Managing maternal and child health nurses undertaking family violence work in Australia: A qualitative study.

Citation	Aim	Study methods
Adams, C., Hooker, L., & Taft, A. (2021). Managing maternal and child health nurses undertaking family violence work in Australia: A qualitative study. *Journal of Nursing Management*, August, 1-9. https://doi.org/10.1111/jonm.13466	To explore the experience of managers managing Maternal and Child Health nurses undertaking family violence work in Victoria, Australia.	Analysis of 12 semi-structured interviews conducted over four months in 2019-2020 using Reflexive Thematic Analysis.

Chapter 12 is the Discussion, which includes recommendations for practice and the implications of the study.

Chapter 13 identifies strengths and limitations, areas for future research, and concludes the thesis.

The **Appendices** include all documents related to the research, and the **Reference List** follows**.**

1. INTRODUCTION

> The first years of life are crucial to lifelong learning, well-being, and success. This begins with giving every child a good start in life by strengthening early childhood services for children and families. There is consensus that a loving, healthy, and intellectually stimulating early childhood is critical to a person's well-being and success throughout their life. Children who have a strong start in life are more likely to do well academically and socially as they grow older. Conversely, young children who miss out on positive experiences with parents, caregivers and educators are much more likely to have to struggle to catch up.
>
> — Department of Education and Training, 2016, p. 3.

1.1 Where it all started: The story behind the thesis

In Victoria, Australia, all families are visited at home by a Maternal and Child Health nurse within two weeks of their child's birth. Ideally, the same nurse will work with the family until the child is five years old and will often see subsequent children as the family grows. The Maternal and Child Health service in Victoria comprises the universal Maternal and Child Health Service, the Maternal and Child Health Line (a 24-hour telephone service), and an Enhanced Maternal and Child Health program offering home visits to support families with additional challenges.

As an Enhanced Maternal and Child Health nurse working in Melbourne's most socio-economically disadvantaged communities, I witnessed first-hand, women and children affected by family violence. I worked in the Enhanced Maternal and Child Health program as a nurse and then as a team leader, supporting and supervising Enhanced Maternal and Child Health nurses. This was an increasing challenge with significant demands on an overworked and overstretched team.

During this time, I contributed to a research project that trialled a new Maternal and Child Health nurse screening and care model for mothers experiencing family violence. The MOVE randomised controlled trial aimed to test an enhanced screening and care model included a self-completion maternal health and well-being checklist, a clinical pathway and guidelines, nurse mentors, and linked family violence liaison workers based in family violence services (Taft et al., 2015). Although the model did not increase routine screening or referrals, it significantly increased safety planning over 36

months among postpartum women (Taft et al., 2015). Both nurses and women welcomed the self-completion checklist for family violence screening which contributed to the sustainability of the model (Hooker L et al., 2016)

My involvement in this research project led me to consider the nature of the Maternal and Child Health nurse and client relationship. Despite universal screening for family violence at the 4-week postnatal appointment, very few women disclose it at that point, even though risk for family violence is heightened during the perinatal period (Brown et al., 2020; Hooker et al, 2020; ABS, 2003). Up to 16% of Victorian women report partner violence in the first 12 months following the birth of a first child (Gartland, 2021), with nearly 30% women reporting partner abuse in the first four years postpartum (Gartland, 2014).

I considered the impact of the nurse relationship on facilitating disclosure, particularly the soft entry that home visiting enables. Often a referral to the Enhanced Maternal and Child Health nurse would ostensibly be about sleep issues or toddler behaviour; however, once trust develops between the nurse and the woman, more severe problems may be disclosed, including family violence.

My interest in how Maternal and Child Health nurses support women was further informed when I undertook a Churchill Fellowship to examine a sustained nurse home visiting program called the Nurse-Family Partnership (NFP) (Olds et al., 1988). The first randomised controlled trial to evaluate the effectiveness of the Nurse-Family Partnership program was conducted in Elmira, New York, with two subsequent trials conducted in Memphis, Tennessee and Denver, Colorado. Following the completion of these trials and demonstrated and replicated benefits for mothers and children, this program is now implemented across 41 states in the United States and in seven other countries

Because the program in the US is predominantly philanthropically funded, it must demonstrate a return on investment with explicit program goals and outcome measurement. With forty years of evidence, the Nurse-Family Partnership demonstrates the benefit to mothers and children of sustained home visiting by nurses, beginning in the antenatal period and continuing on until the child is two years old (Olds et al., 2019).

Figure 1: The Brooklyn Nurse-Family Partnership team, 2015

The supervision structure particularly struck me as focused on supporting nurses, enabling reflective practice, and delivering a workforce with high job satisfaction and retention.

After the Churchill Fellowship, I was inspired but frustrated by the lack of evidence to support the Enhanced Maternal and Child Health program. The program had evolved over the last fifteen years without scrutiny or evaluation. I was aware that each Local Government Area (LGA) was offering a variation on how the program was initially introduced. However, the extent of this variation was anecdotal. Without clear program goals or outcome measures, it is difficult to know if the Enhanced Maternal and Child Health program is making any difference to the women and children of Victoria.

This combination of professional experience and personal interest led me to ask how the Enhanced Maternal and Child Health program supports women who are experiencing family violence.

1.2 Reflexivity: Positioning myself as a clinician-researcher

> A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions.
>
> — Malterud, 2001, p. 484.

Undertaking qualitative research required me to consider how my own position and experiences might contribute to the research process (Scharp and Thomas, 2019). I reflected on my professional and clinical experience, but also my personal experiences, which very likely drew me to work with women experiencing adversity.

In the interests of positionality, I declare that I am a white woman, born in Australia, in a long-term heterosexual relationship, with five children. In many ways, I am privileged, in that I am educated, financially secure, with a supportive family. However, I was raised in poverty, and I am a victim/survivor of family violence.

Having previously worked as a nurse and nurse manager, I understood that undertaking research on the work of nurses and managers would entail close reflection on my perspective (Berger, 2015; Nagel, 1986). I needed to be explicit in my motivation to confront inherent or potential bias in the design of the research project. Through reflexive journaling and discussions with colleagues and my supervisors, I was able to explore and describe my history and the personal interests that brought me to this research. In most qualitative research, the researcher is identified as an integral part of the research process (Attia & Edge, 2017). The credibility of a study rests on the self-awareness of the researcher throughout the research process (Cresswell & Poth, 2018; Houghton et al., 2014; Thompson Burdine et al., 2021). As Attia and Edge put it, "Reflexivity involves a process of ongoing mutual shaping between researcher and research" (2017, p. 33).

The clinician-researcher has an advantage in recruiting participants and the potential for reciprocity in interviewing. However, this position of privilege also brings heightened responsibility to ensure rigour in data collection and analysis (Benner, 1994; Dodgson, 2019; McNair et al., 2008). The researcher "must be attuned not only to the text as narrative but to (their) own narrative" (Benner, 1994, p. 77). I relied on extensive journaling and reflection with my supervisors to ensure that the analysis of the data

focussed on the participants' voices. I also reflected on my role as a previous manager of nurses and ensured that the interview participants did not include any nurses I had previously worked with or supervised.

Using a semi-structured interview guide brought the participant's voice to the forefront; however, sections of the interviews were more conversational. I was known to many of the participants, and their stories were familiar to me through my own experience as an Enhanced Maternal and Child Health nurse and manager. This familiarity increased their comfort in disclosing their personal feelings and experiences; however, this relationship may have introduced an element of social desirability bias. Instead of choosing responses that reflected their true feelings, nurses may have given more socially desirable answers. However, the heterogeneity of responses would indicate that the nurses spoke from their own perspective and their own truth.

1.3 Introducing the thesis

In Victoria, Australia, EMCH nurses provide coordinated care for families with additional challenges, including those experiencing family violence. However, researchers lack insight into the family violence practice of EMCH nurses, the roles they fulfil, and the characteristics of effective nurses. Critically, we also lack research insight into the roles of managers and their professional support needs. This thesis explores the Enhanced Maternal and Child Health program and the roles and characteristics of nurses and their managers who support women experiencing family violence.

Studying the Enhanced Maternal and Child Health program as it has evolved and describing Enhanced Maternal and Child Health nurse family violence practice, has enabled insight into nurses' and their managers' work, and the health system-wide support for nurse family violence practice.

Chapter 2 provides a background to the thesis, starting with a history of the Maternal and Child Health service in Victoria, including the establishment of the Enhanced Maternal and Child Health program. This leads to a consideration of the research on early childhood development and the impact of Adverse Childhood Experiences and the social determinants of health. Nursing approaches to working with families, including those with additional challenges, are reviewed. The background

chapter concludes with an examination of the family violence literature, and health systems responses to family violence.

Chapter 3 reviews the evidence for nurse home visiting programs. The research question and thesis aims are explored in **Chapter 4**. These have arisen from the background and literature review chapters, which have identified the gaps in what is known about the Enhanced Maternal and Child Health program and how nurses and their managers support women experiencing family violence.

Chapter 5 describes the theoretical framework and methodology of the study. As a clinician-researcher, I sought to understand the clinical wisdom embedded in the everyday practice stories of nurses. Applying the principles and methods of Interpretive Description has provided a comprehensive knowledge and a rich understanding of the perceptions and experiences of the group being studied.

Chapters 6 to 11 are the research study's findings.

Chapter 12 is the Discussion, which includes recommendations for practice and the implications of the study.

Chapter 13 identifies the strengths and limitations of the thesis, areas for future research, and presents the thesis conclusion.

2. BACKGROUND

2.1 Introduction

This background chapter describes the creation of the Maternal and Child Health service in Victoria, the shift in service focus from Infant Welfare to Maternal Health, the social and political context of maternal care, and the changing demographic of the Victorian population over the last century. The current Victorian Maternal and Child Health service is described, including the Key Ages and Stages framework (KAS), the philosophical underpinnings of service delivery, and working with families with complex needs. Families with additional challenges, the predominant clients of the Enhanced Maternal and Child Health program, are discussed, and Social Determinants of Health, the impact of Adverse Childhood Experiences are examined.

Having established the Victorian Maternal and Child Health service and Maternal and Child Health nursing approaches to working with families, the Enhanced Maternal and Child Health program is introduced in detail, which works in parallel with the universal Maternal and Child Health service to support families in Victoria experiencing additional challenges.

A background to family violence in Australia has been provided – definitions, the prevalence of family violence, the health effects on women and children, and intersectionality. Health systems responses to family violence are then explored.

2.2 History of the Maternal and Child Health service in Victoria

> Infection, malnutrition, and accidents were hardly surprising in an environment of ignorance, dirt, poverty, and overcrowding.
>
> — Flood, 1998, p. 45.

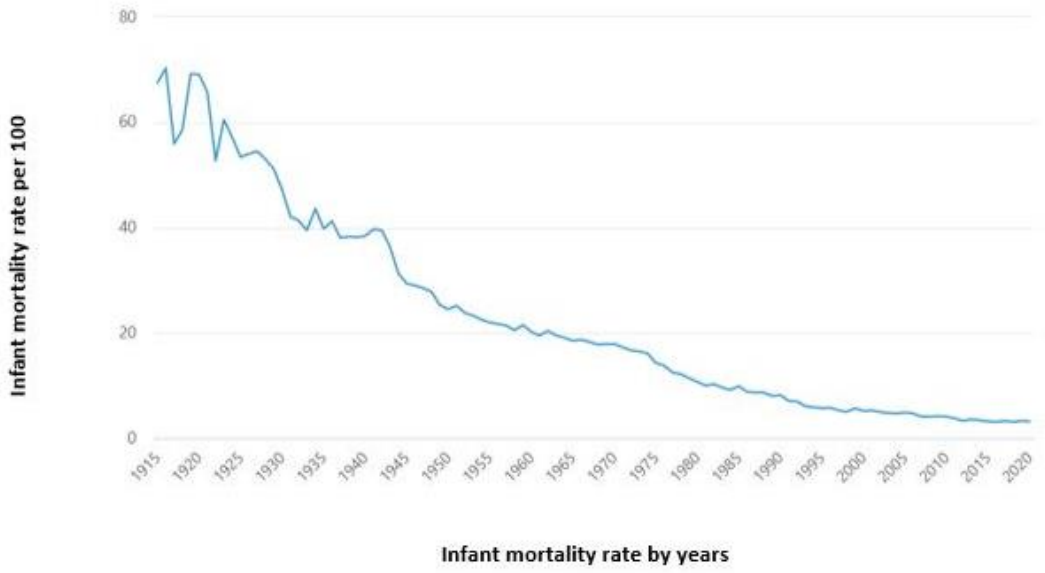
2.2.1 Infant mortality

At the beginning of the 20th century, almost nine percent of Australian infants died in their first year of life (Flood, 1998). The leading causes of death were diarrhoeal diseases, wasting diseases, prematurity, and respiratory infections. Poor maternal health during pregnancy increased the risk of mortality and morbidity for newborns.

Infant mortality was worse in impoverished Melbourne suburbs in Victoria, where many families lived and worked in crowded and unhygienic conditions (Flood, 1998). Infants and young children died of preventable causes, such as gastrointestinal infections, with artificial feeding directly implicated in these deaths. Women were likely to wean early (Crockett, 2000), which meant infants were exposed to cow's milk that was transported and stored in unhygienic and unrefrigerated conditions. In Victoria, from December to April 1911-1916, almost 1,700 babies died of 'summer diarrhoea' (Sheard, 2007).

The infant mortality rate is the number of deaths of children under one year old per 1,000 live births. In Victoria in 1915, the rate was 70 deaths per 1,000; in 2010, the rate was 4.1 deaths per 1,000 live births and this decreased to 3.2 deaths per 1,000 in 2020 (Australian Bureau of Statistics, 2020) The graph in Figure 2 (below) illustrates the sharp decline in infant mortality rates from 1915-2020.

Figure 2: Australian infant mortality rates, 1915-2020 (Australian Bureau of Statistics, 2020)



There remains a significant difference in the infant mortality rate for Aboriginal and Torres Strait Islander (First Nations) infants. In 2010, the infant mortality rate for First Nations infants was 9.7 deaths per 1,000 live births (4.1 for the non-Indigenous population), falling slightly to 9.4 in 2020 (3.2 for the non-Indigenous population). In the

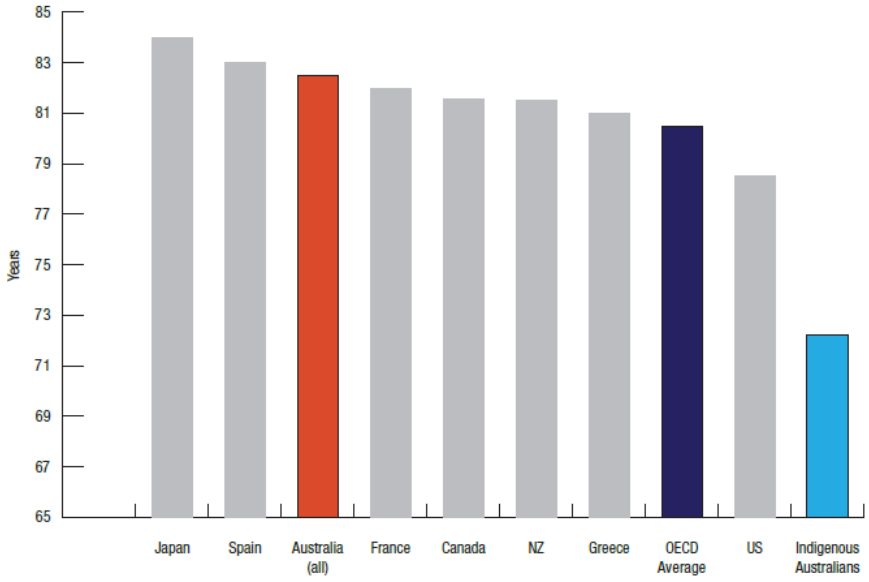
Northern Territory, where there is a high proportion of First Nations people, the rate in 2020 was 13.1 deaths per 1,000 births (Australian Bureau of Statistics, 2020).

There has been little improvement in Aboriginal and Torres Strait Islander maternal and infant outcomes since the Council of Australian Governments announced "closing the gap" in 2007 (Council of Australian Governments (COAG), 2007). Ten years later, the same health discrepancies have been highlighted (Council of Australian Governments (COAG), 2018), indicating that the Australian governments have not succeeded in closing the health gap.

First Nations people were not included in the census until 1971, after Australians voted in 1967 to change the Constitution to include them as part of the national population. This means that data about First Nations infant mortality was not systematically collected, or separately identified prior to 1971. Before 1971, the official census count only included First Nations people if they had some European ancestry. First Nations people who were described at the time by the offensive phrase 'full-blooded' were excluded. From the 1971 Census onwards, all Australians have been officially included in the national census (Australian Bureau of Statistics. (2020).

Figure 3 shows the significant variation in life expectancy at birth for Australian First Nations people, compared to selected Organisation for Economic Co-operation and Development (OECD) countries.

Figure 3: Average life expectancy at birth (2015) – selected OECD countries (Council of Australian Governments (COAG), 2018).



2.2.2 Disease prevention and health promotion

> Initially, the Infant Welfare Society women would scour the streets for clients, looking for signs of babies – a pram on the verandah or nappies on the clothesline. But as more women heard about the service, they wanted their babies and children to be seen by a specialist nurse.
>
> — Crockett, 2000, p.48

The focus of medical services up to the early 1920s was centred on curing disease rather than preventing it. Dr Isabel Younger had studied child welfare in the United States (US) and Britain and could cite the success of infant welfare services in these and other countries. She campaigned for the establishment of infant welfare services in Victoria. She believed that mothers and their babies needed support that would have far-reaching effects: they needed education (Flood, 1998).

Dr Younger, Mrs Ramsay, and Mrs Hemphill used their personal funds to set up the first clinic for infants, which opened in June 1917 in Richmond, an inner-city suburb of Melbourne, in Victoria. These pioneering women were motivated by a sense of social justice and "a charitable concern with the state of health of poor mothers and their infants" (Keleher & Reiger, 2004, p. 18). Miss Muriel Peck was hired as the first infant welfare nurse. Her role was to advise mothers on the care of their babies (Flood, 1998). Within a short time, a second clinic opened in Carlton, and by December 1917, six Melbourne clinics had opened, and a state-wide Infant Welfare Service was founded in 1926.

Nurses examined, weighed, and measured infants, and gave advice on most child-rearing practices, such as feeding, sleeping, and teething, as well as maternal health advice (Sanders, 2014). Breastfeeding was encouraged, but nurses also advised mothers how to prepare alternative food, such as formula or cow's milk, to reduce the prevalence of disease and death caused by diarrhoea (Sanders, 2014).

This work eventually attracted the interest and support of industry and government (Yarra City Council, 2017) to "spread the knowledge of the laws of health to mothers wherever they were living" (Victorian Baby Health Centres Association, 1920, p. 2). It had become clear that the state was potentially losing the next generation of workers, particularly following the losses of the First World War (Reiger, 2001; Yarra City Council, 2017). Local government councillors were so impressed by the work of the

nurses, to the extent that they contributed to nurse's salaries and provided rooms on council premises. The connection between Maternal and Child Health services and local government was evident from the very start and foreshadowed the co-location of Maternal and Child Health centres in community facilities that occurs today in Local Government Areas in Victoria.

The earliest baby health centres operated out of a variety of venues: town halls, kindergartens, shops, law courts, public halls, a library, a newspaper office and, in a few municipalities, a purpose-built building. By the 1930s, mobile services were offered to families in rural and remote locations, via the Better Farming Train and a custom-designed baby health centre van, with a baby health centre in the front and sleeping quarters for nurses in the rear (Crockett, 2000).

Figure 4: Sister Muriel Peck gives a demonstration on the Better Farming Train. Courtesy of the Public Records Office Victoria. The Better Farming Train (VAMCHN, 2017)

Figure 5: Department of Infant Welfare Health van. Courtesy of the Public Record Office Victoria. The Travelling Baby Health Centre (VAMCHN, 2017)

In 1925, the first Victorian Department of Maternal and Child Health was created, which established infant welfare nurse training and practice standards. Within ten years of the first centre opening, 92 centres had opened, and the infant mortality rate dropped from 87 to 56 deaths per 1,000. Twenty years after that, there were 296 clinics and a mortality rate of 32 in every 1,000 children (Sanders, 2014). These declining mortality rates cannot be exclusively attributed to the success of the infant welfare service, as infant mortality rates were already declining gradually before the infant welfare service began (Flood, 1998). Other contributing factors were decreased family size and improved sanitation. Nevertheless, the infant welfare service played a significant role in lowering mortality and morbidity rates and improving outcomes for children.

2.2.3 A growing and diverse population

> One can say over the years that mothers do not change; they are always anxious to do the best for the family. Most mothers have the same object, to give their children the best foundation possible. The parents consider the Health Centre to be an essential service.
>
> — Yarra City Council, 2017, p. 8.

In the early 20th century, population growth was due to natural increases, with births outnumbering deaths due to improved living conditions. In the 1950s, Australia actively encouraged immigration to boost the population, which saw the demographics of the inner city change as new migrants began to settle in. Many of the new migrants lacked English language proficiency and did not understand the role of Maternal and Child Health services (Yarra City Council, 2017), and may not have understood a preventive model of health, due to different health care models in their country of origin.

Two-thirds of today's Australian population are Australian-born; however, 75% of Australians identify with an ancestry other than Australian; about 3% of Australians identify as being Aboriginal or Torres Strait Islander (or both); and 45% report having at least one parent who was born overseas (Australian Bureau of Statistics, 2020). Nearly one-third of Australians were born overseas, according to the 2020 Australian Bureau of Statistics (ABS) migration data, which is twice the proportion of overseas-born residents of the US (14%), Canada (22%), and the UK (14%) (Connor & Lopez, 2016). Many migrants have young families, and the clients of the Maternal and Child Health service, especially in the urban areas, reflect this increasing socio-economic and cultural diversity.

From the 1960s, the inner-city 'slums' of Melbourne were replaced by public housing high-rise towers, changing the physical and social landscape of the inner city. Many of the new families in the inner city had babies and small children with very different needs to those living in suburban houses. Challenges for families in the inner city remained, with infant deaths in Melbourne's inner suburbs two to three times the rate of deaths in the outer suburbs (Yarra City Council, 2017), with high rates of poverty persisting for inner-city families at the time.

However, there was another shift in demography in the 1970s and 1980s, with young professionals settling into the inner city in Melbourne, drawn by the attractions of metropolitan living, and starting families. These families tended to be financially stable, and the parents were well-educated and looking for other support from the Maternal and Child Health service. For these more privileged families, the Maternal and Child Health service supported the social and emotional needs of the mother and the health

and well-being of the family, rather than "just weighing the baby and talking about feeding" (Yarra City Council, 2017, n.p.).

With birth rates declining, overseas migration accounted for 55% of Australia's population increase since 2001 (Australian Bureau of Statistics, 2020). The Maternal and Child Health service experienced new challenges with the arrival of Vietnamese families, and migrants and refugees from the Middle East and Africa. Nurses worked with clients who had experienced trauma, and these waves of migration meant the Maternal and Child Health service needed to adopt more culturally and trauma-informed practices. A nurse at the Fitzroy Maternal and Child Health centre in 1983 commented on the changing demographic profile, describing it as "the most amazing place to work. The world changed around me while I sat in the same seat" (Yarra City Council, 2017, p.3).

Demographic changes have affected the care of young children and the social context in which they are reared, which has implications for the design and location of child health services. These include the trend of smaller families, an increase in the number of single parents raising children alone, and increased poverty, much of which is associated with living in a female-headed, single-parent family after divorce (Australian Bureau of Statistics, 2018; Ochiltree, 1990).

This growing and diverse population means that health care practitioners, including Maternal and Child Health nurses, must adopt culturally appropriate practices (Pokharel et al., 2021) with insight into the challenging experiences of the many families who have come to live in Australia. This is particularly so when working with women who are experiencing family violence (Lor et al., 2016). First Nations women and women from immigrant backgrounds experience racism, language barriers, inequitable access to health care, support services, education, and employment opportunities (Pokharel et al., 2021), and high rates of family violence (Petrosky et al., 2017).

2.2.4 From Infant Welfare to Maternal and Child Health

> First came the reformers, members of the old ruling class, the bourgeoisie, whose aim was the moral reform of the working class. Succeeding but also combining efforts with these come the technocrats, the experts, who create new social knowledge and new means of applying it. — Reiger, 1985, p. 37.

A change in name from Infant Welfare to Maternal, Infant and Pre-School Welfare in the early 1950s signified the increasing interest from the Victorian Department of Health (DH) in the health of mothers, and the evolving expectation that nurses cared for both the mother and her child (Keleher & Reiger, 2004). The role of the local Maternal and Child Health service was affirmed when it became enshrined in the Health Act 1958 (Vic), which stipulated birth notifications were to be sent to Maternal and Child Health centres within 24 hours of birth. This legislation enabled the creation of the 'universal service' (Yarra City Council, 2017).

In her monograph, *The disenchantment of the home: modernizing the Australian family* (1985), Reiger describes the full range of strategies aimed at the social structuring of the family and personal relationships. Keleher and Reiger also examine the struggles between health professionals, volunteers, and doctors and nurses (2004). Doctors sought to control nurses, preventing them from overstepping the professional boundaries of the 'cure-care' division of responsibility (Keleher, 2000), with doctors insisting that the Infant Welfare Service could only be a 'well-baby' health service. Medical directors led the service until the late 1980s, with nurses under the direction of doctors through the Department of Health.

The tension over the orientation of the Maternal and Child Health service towards a medical or social model of health continued into the 1990s, The emphasis on child health surveillance was established in Maternal and Child Health program guidelines and became embedded in state and local government funding formulas based on 'key ages and stages' of child development (Reiger, 2001; VAMCHN, 2017).

With an increased focus on medically-oriented health surveillance, the Department of Health required standardised information on attendances, home visits, and referrals to doctors (Keleher & Reiger, 2004). However, there is evidence that the nurse's work included other activities such as facilitating playgroups, parenting support groups, mail delivery on visits to remote mothers, and writing community newsletters. Infant welfare nurses also provided material aid for families through the food and clothing parcels offered by the local charities and the committees of the baby health centres (Yarra City Council, 2017).

Social and community development work is an essential aspect of public health nursing practice; however, the government did not formally record this (Keleher & Reiger, 2004). It was often 'invisible work' unseen in the official recording of nurses' work for both nurses and mothers but was an essential aspect of the Maternal and Child Health service (Keleher, 2000).

In a medically focused health system, the public health nurse's role has a cultural focus on the health and development of the child, hence the symbol of the baby weighing scales as the tools of the trade (Shepherd, 2011). The scales "get us in the door" but are also used to legitimise the covert function of the role and one woman's connection with another to share and support the experience of mothering (Shepherd, 2011, p. 146).

The Declaration of Alma-Ata (World Health Organization, 1978), followed by the Ottawa Charter for Health Promotion (World Health Organization, 1986), reflected the rise in global awareness about the importance of Primary Health Care and a shift in focus toward health promotion and maternal health and well-being. This shift in focus highlighted maternal health and a focus on early childhood in establishing the basis of health and well-being. Similar consideration in other countries of the role of the home visiting child and family nurses highlighted this shift from health surveillance to health promotion, along with working in partnership with families (Astbury et al., 2017; Clark et al., 2016; Gulino & Lamonica, 1986; Psaila et al., 2014).

In addition, in the 70's and 80's, feminist scholars were studying the woman's experience of mothering and contributed to an awareness of the more complex social needs of new mothers (Keleher & Reiger, 2004; Reiger, 1985). In the 1980s, the service in the state of Victoria became known as the Maternal and Child Health Service.

This broader perspective of the service and scope of nursing practice enables the Victorian Maternal and Child Health nurse to work with women experiencing additional challenges, such as family violence. As they see nearly all new families in their homes after their child is born, Victorian Maternal and Child Health nurses are uniquely positioned to ask women about family violence, offer support and strategies, assist with safety plans, and refer them to specialist agencies. As noted in the Royal Commission into Family Violence (2016), Maternal and Child Health nurses often receive the first

disclosure of family violence, often being the one consistent source of advice and support for new parents (State of Victoria, 2016b).

2.3 The Maternal and Child Health service today

One hundred years on, the Victorian Maternal and Child Health service has developed, evolved, and expanded to its current form, supporting families in parenting, children's health and development, health promotion, well-being and safety, referrals, and linking with local communities (Department of Health and Human Services, 2019c). The Maternal and Child Health service in Victoria works in partnership with parents and early years' services and aims to promote healthy outcomes for children and their families (Department of Education and Early Childhood Development, 2009; Department of Health and Human Services, 2019c). Over the past century, the Victorian Maternal and Child Health service has evolved from focusing on measuring the growth of the infant and child into a service that has greater insight into Primary Health Care, addressing the Social Determinants of Health and applying a socio-ecological lens to support families.

The Maternal and Child Health service in Victoria is a free service with almost 100% engagement with families at birth. By the time the child is 3.5 years-old, nearly 65% of families continue to attend the service (Department of Health and Human Services, 2019e). Jointly funded by local governments and the Victorian State government, it includes a universal Maternal and Child Health service, an enhanced program that supports families with additional needs (Enhanced Maternal and Child Health), and a 24-hour Maternal and Child Health telephone support line.

Hospitals in Victoria are required by legislation to notify Local Government Areas of births. Maternal and Child Health nurses in the local Maternal and Child Health service usually make the first contact with mothers by offering a home visit, almost all of which are accepted. Maternal and Child Health nurses in Victoria are generally qualified with a degree in Nursing and Midwifery, and a postgraduate qualification in Child, Family, and Community Health. Subsequent consultations are usually in Maternal and Child Health centres, where parents can discuss their concerns, their parenting experiences, and how to optimise their child's health, growth, and development.

2.3.1 A Primary Health Care provider

> By providing care ***in*** the community as well as care ***through*** the community, Primary Health Care addresses not only individual and family health needs, but also the broader issue of public health and the needs of defined populations.
>
> — World Health Organization, 2021a.

The Maternal and Child Health service in Victoria is a Primary Health Care service that supports the physical, mental, and social well-being of families, being wellness-centred rather than disease-centred. Primary Health Care focuses on people's needs as early as possible, and as close as feasible to people's everyday environment (World Health Organization, 2021a). Primary Health Care seeks to protect and promote the health of communities and intervene early to address problems at an early stage.

Primary Health Care services often provide continuity of care, health promotion and education, community involvement, and concern for population and individual health. This approach addresses the broader determinants of health by empowering individuals, families, and communities to take charge of their health.

2.3.2 Social determinants of health

The World Health Organization (WHO) describes the Social Determinants of Health as the conditions in which people are born, grow, work, live, and age. Broader forces shape the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, driven by political systems (World Health Organization, 2008). They include socioeconomic status, education, neighbourhood and physical environment, employment, social support networks, and access to health care.

Whitehead's definition is helpful here: health inequalities are health differences that are avoidable, unnecessary, and unjust (1992). Research focused on the Social Determinants of Health confirms that disadvantage affects health (Bambra et al., 2010; Liamputtong et al., 2012). The number of parent-based disadvantages relate directly to children's social, developmental, and health outcomes (Andermann, 2016; Janus et al., 2021).

Bronfenbrenner's ecological systems theory views child development as a complex system of relationships shaped and affected by multiple levels of the surrounding

environment (Bronfenbrenner & Ceci, 1994). The social context influences our health and development (Bronfenbrenner, 1979), including the "characteristics of their families, social networks, neighbourhoods, communities, and the interrelations among them" (Olds et al., 2003, p. 279). Children's health and development outcomes follow a social gradient: the further up the socioeconomic spectrum, the better the outcomes. Health interventions need to be proportionately targeted across the social gradient to reduce health inequities (The Marmot Review, 2010). The Enhanced Maternal and Child Health program which is discussed below (2.4) is an example of a targeted intervention to improve outcomes for children.

A multi-level response is required to reduce inequities during early childhood. Such a response might include:

- approaches to governance and decision-making
- policies that improve access to quality services
- service systems that reflect the characteristics of universalism, such as providing services from a universal platform with an increasing scale and intensity proportionate to the level of disadvantage
- delivering evidence-based programs in inclusive environments
- strong, supportive communities; and
- information and timely assistance for parents to feel supported and confident are other elements of the service response (Moore et al., 2015).

The early years of life are when lifelong trajectories of health vulnerability are determined by the complex interaction between the Social Determinants of Health (Irwin L et al., 2007; Maggi et al., 2010). These social determinants characterise the environments that individuals are exposed to, influencing lifelong developments and health outcomes (Goldfeld et al., 2014; Maggi et al., 2010). Improving Maternal and Child Health requires a commitment to health equity by addressing the Social Determinants of Health and providing special attention to the needs of individuals at the most significant risk (Braveman, 2014; Dills et al., 2022).

2.3.3 The early years

Studies in neurobiology and neurodevelopment show that the early years are critical in brain development. In children under 5-years-old, there is a rapid process of 'sculpting'. A well-sculpted brain has developed in response to a positive environment with healthy visual, verbal, emotional, and physical stimuli (Maggi et al., 2010; Shonkoff et al., 2012). Research has demonstrated that both risk and protective factors experienced by a child during this period can have enduring developmental consequences (Crouch et al., 2020; Hughes et al., 2017; Waterhouse, 2022). These early years provide the foundation for the child's future health, well-being, learning, and development (Shonkoff et al., 2012), which can be directly affected by adverse experiences during the prenatal and postnatal periods (Hertzman, 2017).

The Nurturing Care Framework (World Health Organization, 2018a) identifies a whole of society approach to supporting families to improve the growth and development of children in their early years of life. The most powerful impact on child development comes from parenting and family relationships. Supporting parents who care for children is the foundation for healthy childhood growth and development (Britto et al., 2017). By optimising maternal health and well-being, child and infant health, well-being, learning, and development is optimised (Ribaudo et al., 2022). For positive outcomes, infants and children need consistent and responsive caregiving; opportunities to interact, explore, and participate in a range of social and physical environments; adequate and appropriate nutrition; and protection from physical and psychosocial harms (Azzi-Lessing, 2011; Department of Health and Human Services, 2019b; Moore et al., 2017).

The nature of the bond that a child forms with their parent(s) or primary caregiver(s) is described as "attachment" (Bowlby, 1969). A secure attachment style is associated with improved self-esteem, self-confidence, emotional regulation, resilience, and positive relationships in childhood and early adulthood (Barnes & Theule, 2019; Egeland & Erickson, 1993; Staver, 2016). Sensitive and responsive caregiving fosters a secure attachment style (Lucas et al., 2018; Mermelshtine & Barnes, 2016).

One of the key messages of the literature addressing the risk and protective factor is that the first 1,000 days are crucial to building solid foundations and establishing the

competencies that lead to essential relational, self-regulation, and problem-solving skills (Fox et al., 2015). Early in a child's life, there is a critical window of opportunity for engaging with parents, given their openness to change, their contact with the universal child and family health system, and the impact of a mother's health and family circumstances on foetal health (Olds, 2006).

2.3.4 Early intervention

Early intervention in Maternal and Child Health is a key public health approach, encompassing primary and secondary prevention, protecting, and promoting health, and preventing disease through early detection. A report prepared for the Australian Research Alliance for Children and Youth (ARACY) in 2015 reviewed early intervention research (Fox et al., 2015, p. 15). The report argues that effective prevention and early intervention may be the most promising strategy for changing the trajectories of children. This is supported by Allen and Smith, who contend that "early intervention … is less expensive … and more effective than late intervention. It is no longer viable to take ever-increasing amounts of taxation from the public to deal with the ever-increasing impact of failing to intervene early"(2008, p.113).

Some early intervention researchers question the impact on child health of early intervention (Avellar & Supplee, 2013; Peacock et al., 2013). However, most researchers argue that early intervention and evidence-based prevention can lead to "measurable and substantial reductions in the factors that place children and families at risk of poor outcomes" (Fox et al., 2015, p.15). Early intervention is considered by many to be an appropriate approach to tackling vulnerability and reducing the incidence of poor outcomes for children (Dodge et al., 2021; Middleton & Hardy, 2014).

Nurse home visiting models, such as the Enhanced Maternal and Child Health program, may address some of the issues that inhibit access to services for families experiencing additional challenges and provide timely interventions. Families with fewer socioeconomic resources often experience barriers to accessing health services, which exacerbates potential issues for their children (Goldfeld et al., 2018). Families with the greatest needs are often the least able to access health and support services, which may explain the persistence of health inequities (Pavalko & Caputo, 2013). Providing

parenting support is an early intervention that promotes the health and well-being of children and families.

2.3.5 Parenting support

Effective parenting support is especially beneficial to families experiencing additional challenges. These parents may have a reduced capacity to provide basic care and a stable, nurturing environment for their children (Parker & McDonald, 2020). Parenting support improves the long-term developmental trajectories of children experiencing disadvantage, including those early intervention programs that specifically address certain aspects of parent-child interactions and relationships (Shonkoff et al., 2017). All parents can benefit from parenting support, which may come from telephone advice lines, written and online resources, parent education programs, and health programs, including the Maternal and Child Health service, which includes a systematic and structured approach to parent support.

Nurse home visiting is an example of an early intervention service that supports parents by providing coordinated care for families with additional challenges (Eckenrode et al., 2000; Molloy et al., 2019; Olds et al., 1988; Pavalko & Caputo, 2013; Saïas et al., 2016). Clients in home visiting programs often include those experiencing significant social and emotional issues and may also be experiencing family violence. Women's disclosure of challenging personal circumstances reflects the trust that may develop between the nurse and mother as Maternal and Child Health nurses come to know the family (Jack et al., 2005; Shepherd, 2011).

2.3.6 Progressive universalism

Maternal and Child Health nurses are independent practitioners, and the increasing complexity of family presentation has led to an intensified scope of practice and increased requirement for expert knowledge and skills development (Fraser et al., 2016). With a limited public health budget, prioritising services to those most in need would be tempting. However, providing services primarily to the disadvantaged will not eliminate population- wide health burdens (Brinkman et al., 2012). Children from all socioeconomic backgrounds may experience poor development and health; however,

the most disadvantaged children experience this at a disproportionate rate (Goldfeld et al., 2014; Moore et al., 2015).

Progressive universalism is a service-based response to address inequities, providing a universal service base that adds levels of support progressively for those with additional needs (Barlow et al., 2007; Department of Health and Human Services, 2019b; Moore et al., 2015; The Marmot Review, 2010). Progressive or proportionate universalism maintains that all children and families need access to a universal level of support and services, "with additional support commensurate with additional needs" (Schmied et al., 2014, p. 178). Providing services from a universal platform with an increasing scale and intensity proportionate to the level of disadvantage reduces the risk of stigmatisation which may come with a referral to a specialist service for vulnerable families (Oberklaid et al., 2013). A progressive universalism approach that combines universal and targeted interventions is the optimum approach to support families (Fox et al., 2015; Schmied et al., 2014; The Marmot Review, 2010).

Children's health in resource-rich countries is better with universal well-child health care; however, the exact number of visits required to achieve better outcomes is unknown (Schmied et al., 2015). There is no evidence to recommend the frequency or timing of Maternal and Child Health appointments in Australia (Schmied et al., 2014) and a lack of evidence to demonstrate that children in Victoria achieve improved outcomes compared to those in other states in Australia that offer a more limited Maternal and Child Health service delivery (Fraser et al., 2016). The Maternal and Child Health Service in Victoria has often been cited as the "gold standard", with the triple qualification (Nursing, Midwifery, and Child and Family Health) required to practice as a Maternal and Child Health nurse enshrined in Victorian legislation in 2020 (State of Victoria, 2020). However, the basis of this "gold standard" claim is unsubstantiated.

2.3.7 The Victorian Maternal and Child Health Key Ages and Stages framework

Assessment of the health and development of infants and children is an essential element of the Victorian Maternal and Child Health nurse's role as a Primary Health Care provider. Nurses conduct assessments to identify potential physical, social, and emotional issues to enable referrals to secondary or tertiary health services for early

intervention (Barbaro & Dissanayake, 2010; Poutiainen et al., 2015). Schmied et al.'s review of universal child and family health services in Australia found a significant variation in service provision between the states. Queensland does not offer a routine schedule of services. South Australia provides a universal home visit following birth, and other appointments are by request. The Australian Capital Territory and Western Australia offer five and six scheduled visits, respectively, to school entry (2014).

A study that sought to explore the work of Child and Family Health nurses across Australia, produced results that were difficult to interpret, with significant underrepresentation from states other than Victoria, thereby skewing the data (Rossiter et al, 2016). A recent scoping review found that there is little understanding of how Child and Family Health nurses support families to improve outcomes for children (Wightman et al., 2021), arguing for further research in this area. National Standards of Practice for Maternal, Child and Family Health nurses in Australia were published in 2017 (Grant et al, 2017), however, these standards have not contributed to a regularising of the services across Australia.

The universal Maternal and Child Health service in Victoria comprises 10 Key Ages and Stages consultations for all children and their families from birth to school entry (Department of Health and Human Services, 2019e). Figure 6 shows the universal engagement with families from birth. As children get older, families may perceive they have less need to attend Maternal and Child Health appointments and may also attend their family doctor for the child's compulsory pre-school check (at age 4) instead of attending the Maternal and Child Health service for the 3.5-year-old check

Figure 6: Schedule of Key Ages and Stages consultations and % attended

Key Ages and Stages consultation	% Attended
Home visit	100
Two weeks	96.7
Four weeks	97.1
Eight weeks	95.9
Four months	94.1
Eight months	85.8
12 months	83.4
18 months	74.2
Two years	70.6
3.5 years	64.2

In 2020, there were more than 647,000 families with children in Victoria, as reported by the Australian Bureau of Statistics (2020). In 2014–15 Victoria's Maternal and Child Health nurses delivered 666,035 Key Ages and Stages consultations with children ranging in age from newborn to 3.5 years (Department of Education and Training, 2018). In that year, there were 128,909 instances of parent counselling, with nurses advising them on their children's vision, hearing, congenital anomalies, cognitive and emotional development, potentially disabling conditions, nutrition, dental care, communication, growth, illnesses, and accidents (VAMCHN, 2017).

2.3.8 Enhanced Maternal and Child Health program

The Victorian Maternal and Child Health Enhanced Home Visiting Service (EHVS) commenced in 1999-2000 in a response from the Labor Government to emerging early years research highlighting the importance of neurobiological, behavioural, and environmental influences that affect the development of infants and young children (Department of Human Services, 2003).

A state-wide program was introduced in 2003 and became known as the Enhanced Maternal and Child Health program, running in parallel with the Maternal and Child Health universal service to provide support and intervention for high-risk families. The Enhanced Maternal and Child Health program in 2003 was a predominantly home visiting program of up to 15 hours per family and up to 17 hours for rural families, focused on specific groups, including teenage mothers, rurally isolated families, culturally and linguistically diverse families, and Aboriginal and Torres Strait Islander families (Department of Human Services, 2003).

The delivery of the Enhanced Maternal and Child Health program varies widely between Local Government Areas, and the composition of the Enhanced Maternal and Child Health team means that Enhanced Maternal and Child Health nurses may be supported by allied health and early years team members. The overall aim of the Enhanced Maternal and Child Health program is to improve the health and well-being of children by providing more focused and intensive support for families experiencing

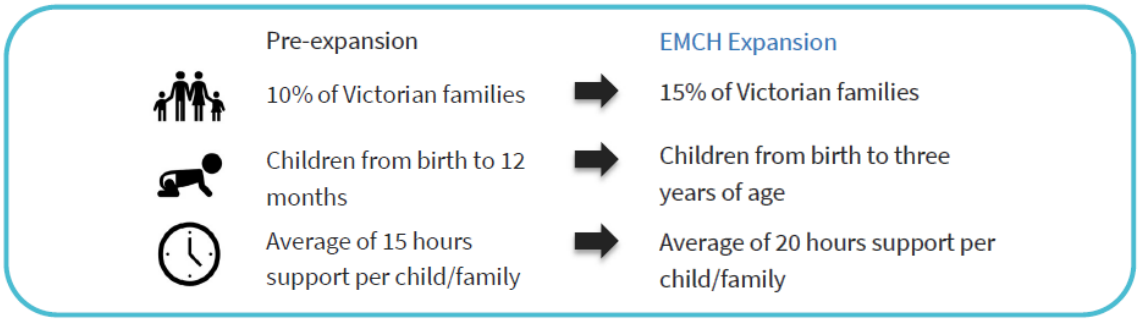
significant early parenting difficulties and children identified as being at risk of harm (Department of Human Services, 2003).

The guidelines encouraged Local Government Areas to offer "flexible models of service delivery and service activities based on local demographics and the identified needs of families" (Department of Human Services, 2003, p. 7). Over time each Local Government Area has developed an Enhanced Maternal and Child Health program responding to local needs and demands. Several factors have influenced the service models, including organisational context, local community demographics, the size of the Enhanced Maternal and Child Health program, and professional qualifications of the Enhanced Maternal and Child Health staff. As identified by the Centre for Community Child Health (CCCH) (Moore et al., 2011a), specific practice across the state is varied. This variation primarily arises from the loosely articulated objectives, which have enabled flexible service delivery models tailored to local demographics and specific community needs and resources. For example, in services where a youth worker is available, they may offer young mother's groups. A service with early childhood workers may offer parenting programs focusing on early childhood development and parenting (Adams et al., 2019).

In 2016/2017, a review of service data by the Department of Health and Human Services revealed a higher than expected proportion of families were accessing the Enhanced Maternal and Child Health program, with families receiving less than the anticipated number of hours and families with older children were being supported by the program (Arefadib et al., 2021).

In response, the Enhanced Maternal and Child Health program was expanded in 2018 as part of the Victorian Government's Early Years Reform Plan (2017-18). Previously, the Enhanced Maternal and Child Health program aimed to reach 10% of Victorian families with children from birth to 12 months, with an average of 15 hours of support for each child/family. The expansion aimed to increase the program's coverage to 15% of Victorian families with children from birth to three years of age, with up to 20 hours of support for each child/family (Jennings, Ghazarian, et al., 2021b). The rationale for this increase in hours and age of children has not been provided.

Figure 7: Expansion of the Enhanced Maternal and Child Health program (Jennings, Ghazarian, et al., 2021a)



The Enhanced Maternal and Child Health program provides targeted interventions for infants, children, mothers, and families with additional needs who are currently experiencing vulnerability with two or more risk factors (Department of Health and Human Services, 2019b). The Enhanced Maternal and Child Health eligibility criteria and risk factors in the expanded program include:

- The mother or parent is less than 20 years of age
- Infant/child identified as being of Aboriginal or Torres Strait Islander descent and is not actively engaged with the service
- Family is socially isolated (housing, cultural group, transport, unemployment)
- Parent expresses or demonstrates poor attachment towards their infant/child
- Mental health illness currently impacting parenting capacity
- Substance abuse-related issues currently affecting parenting capacity
- Family violence is currently impacting safety, parenting, and infant/child development
- Current intervention from Child Protection Services
- Infant/child born with congenital abnormalities
- Infant/child with complex growth, health, and development issues
- Concerns expressed by the assessing nurse
- Families who are not currently engaged with the universal Maternal and Child Health program

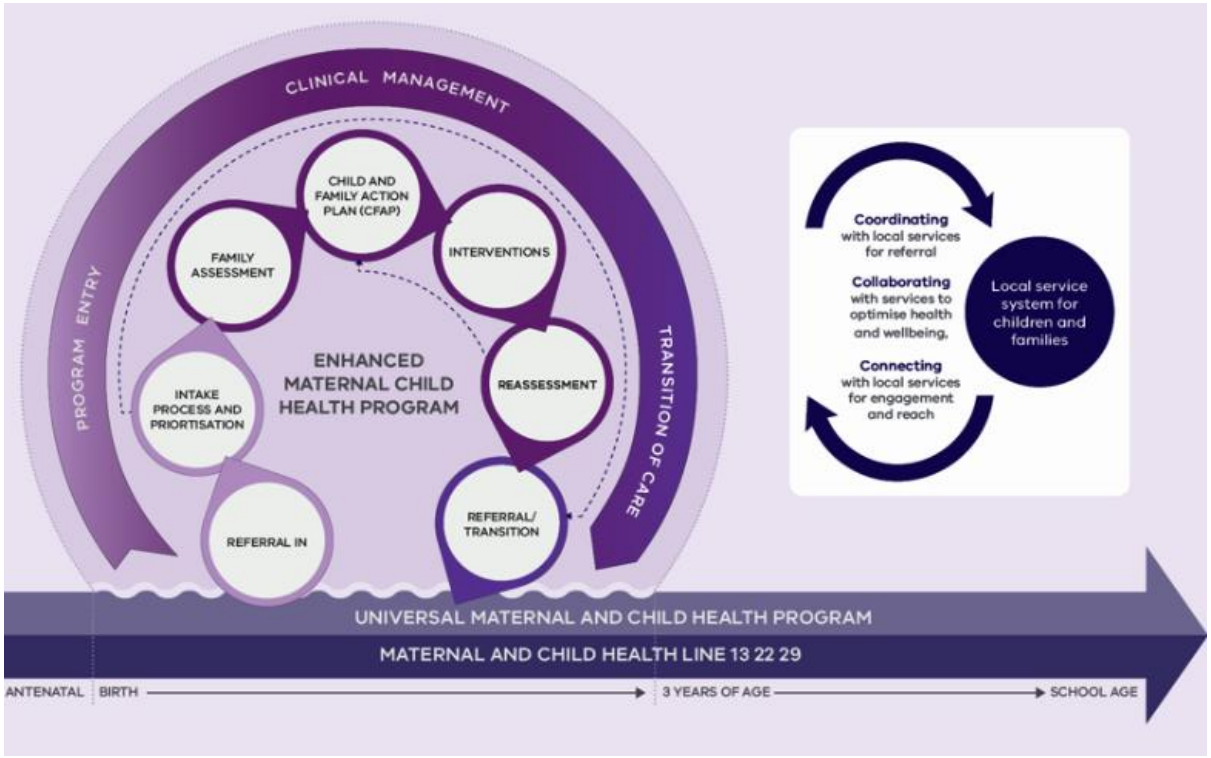
The revised Enhanced Maternal and Child Health Program Guidelines (Department of Health and Human Services, 2019b) include a Model of Care (MOC) with three stages for the delivery of the program:

Stage 1 – Program entry,

Stage 2 – Clinical management,

Stage 3 – Transition of care (see Figure 8)

Figure 8: Enhanced Maternal and Child Health Model of Care (Department of Health and Human Services, 2019b)



The new Model of Care relies on family partnership and strength-based models, applying a trauma-informed lens to the care and support of families. The program plays an increasing role in identifying and supporting women experiencing family violence. The Child and Family Action Plan (CFAP) provides the program's central focus, providing an opportunity for family assessment and goal setting. The Child and Family Action Plan should seek to build on family strengths and include clear outcomes, short- and medium-term goals, and tasks designed to facilitate positive changes for the child and family. These are the elements of the Child and Family Action Plan:

- objectives and goals to help guide Enhanced Maternal and Child Health staff and family members in developing appropriate and achievable strategies and interventions for the child and family.
- appropriate learning goals for the children (if appropriate). These may incorporate the Play, Learn and Grow resources. Goals and objectives should be flexible; new goals may be added to a Child and Family Action Plan at any stage and goals that are no longer relevant for the family may be removed.
- the interventions to be undertaken, and the roles and responsibilities of family members and Enhanced Maternal and Child Health program staff in implementing these.
- a transition plan for the family's involvement in the program, which is used for Enhanced Maternal and Child Health closure or to identify the need for further assessment or service provision to support the child and family (Department of Health and Human Services, 2019b).

It is argued that actively involving the family in the development of the plan enhances the relationship with the family and supports the principle of family-centred practice, engaging and empowering parents as partners in the program (Department of Health and Human Services, 2019b).

The new Enhanced Maternal and Child Health program has been inconsistently adopted by Local Government Areas across the state, with the uptake ranging from not at all to fully taken up. Even with those services that have more thoroughly engaged with the new model, there remains confusion about how to include the Child and Family Action Plan in the client record. Additional in-service training was provided to Enhanced Maternal and Child Health nurses and managers the year after the program was launched; however, a recent review has found that the program continues to be unevenly applied (Jennings, Ghazarian, et al., 2021b). This has a resultant impact on data integrity, reducing opportunities for research and data analysis. Specifically, in family violence nursing practice, more consideration is needed to ensure that the Child and Family Action Plan can be used securely, with potential safety and confidentiality issues. The family retains the Child and Family Action Plan, it being a client-held record, but this may not be safe for a woman experiencing family violence.

2.4 Nursing approaches to working with families

The Victorian Maternal and Child Health program aims to place the family at the centre of care, offering child-centred, maternal, and family-focused practices designed to respond to the family's needs, especially when families are trying to manage difficult circumstances (Department of Health and Human Services, 2019b). Identifying the support offered by the Enhanced Maternal and Child Health program for families experiencing additional challenges, including family violence, highlights the organisational, professional, and individual factors such as program flexibility, collaborative practices, and recognition of the parents' roles in decision-making (Ridgway et al., 2020).

2.4.1 Strengths-based approach

The strength-based approach requires service providers to view families through a lens of possibilities and potential rather than incapacities and deficits, to facilitate necessary change (Fox et al., 2015; Pattoni, 2012; Williams, 2019). This approach enables the nurse to recognise parental expertise and self-efficacy (Kemp et al., 2014). It works from a perspective of empowerment that builds on family strengths (Fusco, 2019), identifies resources to help people reach goals (Saleebey, 1996), and is relationship-based (Platt, 2012). Strengths-based practice can help identify solutions to problems while building rapport with clients (Weick et al., 2009).

Maternal and Child Health nurses aim to work in partnership with families, and encouraging families to take control of their health and well-being is fundamental to strength-based practice (Gottlieb, 2014). Nurses consider "what is working" (Manthey et al., 2011, p. 136), recognising a family's or individual's competency and capacity, exploring the resources the family has available to manage challenges and promote and maintain their health and well-being (Oliver & Charles, 2016).

Self-efficacy theory (Bandura, 1977) provides a framework for nurses to understand how parents make decisions for themselves and their children. According to self-efficacy theory, individuals choose behaviours that they believe will result in a particular outcome and that they can successfully carry out (Olds et al., 2003). Nurses aim to improve the family's sense of self-efficacy and their feelings of control over their

lives and relationships by using techniques such as motivational interviewing (Manthey et al., 2011). These techniques may result in increased confidence to make changes for the better for themselves and their children (Scottish Government, 2019).

Enhanced Maternal and Child Health nurses strive to work from a strength-based perspective, viewing the client as the expert in their experience, requiring a shift from the nurse as a 'fixer' to collaborator or partner. This is particularly important when working with women experiencing family violence (Asay et al., 2016). A trusting relationship between the nurse and their client is crucial for achieving positive client engagement and improved client outcomes, resulting in better outcomes for children. Nurses role model positive and consistent behaviours that many clients may not have experienced previously (Scottish Government, 2019).

It is simplistic to view nurses' relationships with mothers as straightforward. Women are balancing their need for nurse support and protection with their fears that disclosing the violence they are experiencing may lead to the removal of their children (Peckover, 2002). Nurses are very conscious of their legal mandate to report child maltreatment (Davidov, Jack, et al., 2012), which brings ambiguity to the nurse role.

Maintaining safety and security while offering a therapeutic relationship creates a tension (Cuthill & Johnston, 2019; Davidov, Jack, et al., 2012), because of the potential contradiction between supporting the mother and prioritising the safety of the children.

2.4.2 Family-centred care

Family-centred care (FCC) is a strength-based relational approach to working in partnership with families (Ridgway et al., 2020). It aims to improve outcomes through family involvement and is based on core principles of dignity and respect, information-sharing, participation, and collaboration (Institute for Patient- and Family-Centered Care, 2016). A recent scoping review identified four themes in FCC: creating and maintaining respectful relationships, adapting and contextualising care, supporting autonomy and agency, and building a shared understanding through effective communication (Ridgway et al., 2020). Relational work is underpinned by the family partnership approach to care, with nurses providing support and health information as a trusted source (Astbury et al., 2017).

In Victoria, the child is the client of the Maternal and Child Health service, whereas in the Enhanced Maternal and Child Health program, the mother is identified as the client (Department of Health and Human Services, 2019b, 2019d). This can mean that the needs of fathers can be overlooked, and opportunities for health promotion and discussions about healthy relationships can be missed (Bennett et al., 2021; Wells et al., 2022). A recent study showed that fathers who reported greater support from midwives and family nurses also reported more positive co-parenting, and benefited from additional clinical and social support (Wells et al., 2022). However, a more father-inclusive practice may be difficult if there is family violence in the home. Nurses are not able to ask questions about violence, if there is a potential perpetrator present (Department of Health and Human Services, 2019). Contradictions in the family violence nursing role might arise, if the nurse is potentially working with the woman and the perpetrator is also present, as well as creating potential issues of safety for the woman and the nurse (Family Safe Victoria, 2019).

Maternal and Child Health and Enhanced Maternal and Child Health nurses identify risk factors for poor outcomes for children and families, and further, protective factors. Protective factors increase a family's capacity to address challenges (Panisch et al., 2020). Through open and curious, non-judgemental enquiry, an Maternal and Child Health nurse can work with the family as active participants, facilitating decision-making and goal setting (Askew et al., 2020). Maternal and Child Health nurses aim to support families in identifying their strengths and resources (Department of Health and Human Services, 2019b; Oliver & Charles, 2015).

Using an FCC approach means that the nurse builds on the relationship, connecting at a deeper level and flexibly responding to the family's needs. This is especially important in families where there is family violence, with nurses needing to apply a trauma- and violence-informed lens to their practice (Wathen & Varcoe, 2019).

2.4.3 Trauma-and-violence-informed practice

The traumatic impacts of families' exposure to family violence have long-term effects, whether the violence is ongoing or in the past. If health care practitioners lack insight into trauma-and-violence-informed care, they may miss opportunities to provide

effective service and risk causing further harm (Scott & Jenney, 2022; Wathen & Varcoe, 2019).

Trauma-and-violence-informed care acknowledges the structural aspects of trauma experience. Discriminatory systems, structural barriers, historic and current inequities, and harmful institutional practices all influence the likelihood of experiencing trauma and the responses of social systems to that trauma (Wathen & Varcoe, 2019). Health care practitioners need to consider the intersecting dimensions of power, to ensure that clients are treated in a compassionate, non-judgmental, trauma-informed manner (Scott & Jenney, 2022). Often the health systems response to violence contributes to "patriarchal, racist, colonial, ableist, and heteronormative structures and systems" (Scott and Jenney, 2022, p.3).

A trauma-and-violence-informed approach to practice includes the provision of safety, creating a trusting environment, offering choice, creating a solid working alliance between the woman and the nurse, and promoting empowerment (Bath, 2008; Leitch, 2017). All Maternal and Child Health nurses in Victoria have undertaken education and training in trauma-informed practice. 'MERTIL: My Early Relational Trauma-Informed Learning' is an education package designed and provided to 1500 Victorian Maternal and Child Health nurses in 2018 by the Victorian Department of Health and Human Services (DHHS) (Clancy et al., 2020). MERTIL emphasises observation and recognition of traumatised states within the parent-child dyad and early support for repair through frontline engagement, resonance with both parent and infant, strengths-based conversations and targeted practical responses (Clancy et al., 2020).

Globally, approximately 70% of people will experience at least one trauma across their lifespan (World Health Organization, 2022). In Australia, people who may have experienced higher levels of trauma include First Nations people, through loss of land and disconnection from kin and culture (Fiolet, Roberts, et al., 2021); people experiencing natural disasters such as droughts, floods and bushfires; families experiencing violence or sexual abuse (Australian Institute of Health and Welfare, 2019); and experience of torture and displacement for recent refugees and asylum seekers (Vaughan et al., 2016).

Working from a trauma-and-violence-informed perspective must also include a consideration of protective factors. Without minimising the impact of family violence on women, women's strengths, resilience, and capacity for recovery should be acknowledged. Research identifying the post-traumatic growth that can occur for some women highlights the potential for positive psychological change in a person following severe difficulties and trauma (Tedeschi & Moore, 2021).

A trauma orientation may create a single-point focus, which works against a strength-based perspective, undervaluing the strength and resilience of clients (Leitch, 2017). This single-point focus may also mean that "windows of opportunity" can be missed when protective factors may have a more significant impact or whether there are differential effects of some protective factors (for example, family factors, community factors, peer factors) (Leitch, 2017, p. 5).

Working with perpetrators requires a strong understanding of the complexity of family violence dynamics, issues of safety, and intergenerational trauma and its impacts. Trauma-and-violence-informed practice considers the potential for "unintentional activation of trauma" (Scott & Jenney, 2022, p. 15) when working with perpetrators of abuse, which may increase risk to women and child(ren). Further evaluation and analysis are required about whether consideration of men's trauma will be used by men and by systems (for example, courts, and child protective services) to excuse men's abuse and minimise its impact. Practitioners need support via regular high-quality trauma-and-violence-informed supervision to successfully work with families experiencing trauma in ways that maintain a focus on men's accountability for abuse (Scott & Jenney, 2022).

2.4.4 Families with complex needs

> People with complex needs may have to negotiate a number of different issues in their life, for example, learning disabilities, mental health problems, and substance abuse. They may also be living in deprived circumstances and lack access to stable housing or meaningful activity. It is valuable to describe multiple interlocking problems where the total represents more than the sum.
>
> — Rankin & Regan, 2003, p. 87.

Rankin and Regan (2003) describe a framework for understanding complex needs which encompasses the dimensions of breadth (multiple needs, that is, more than one) and depth (the severity or enduring nature of need). The Protecting Victoria's Vulnerable Children Inquiry (State of Victoria, 2013) reports identified risk factors arising from the parent, family, or caregiver relationships. These included a history of family violence, alcohol and other substance misuse, mental health illness, intellectual disability, parental history of abuse and neglect, and situational stress.

In 2020, social services in Victoria identified a 'newly vulnerable' group that found themselves in need of services for the first time due to the Covid-19 pandemic. This finding highlighted the fragility of financial security and brought to light the variable and compounding nature of risk factors that expose individuals to harm, including family violence (Roy Morgan, 2021).

Population surveys estimate the proportion of families with risk factors with some at risk in more than one area, with 20–30% of Victorian families (130,000 to 195,000 families) experiencing significant stresses at some time in their lives (State of Victoria, 2013). A higher risk group of eight percent of families (54,000 families) are already involved with specialist services — for example, police attending family violence incidents where a child is present. These estimates are based on data from Victoria Police, child protection, drug and alcohol treatment, mental health, and homelessness services (State of Victoria, 2013). Each year, child protection services establish a risk of maltreatment requiring further investigation for around 1.5% of families in Victoria (10,000 families).

2.4.5 Adverse Childhood Experiences

The Adverse Childhood Experiences study in 1998 involved over 17,000 middle-class adults in a retrospective and prospective analysis of how ten categories of common traumatic life experiences in childhood manifest in adult life (Felitti et al., 1998). The ten original Adverse Childhood Experiences included:

- physical abuse
- sexual abuse
- psychological abuse

- physical neglect
- witnessing domestic abuse
- parental separation or divorce
- having a close family member who misused drugs or alcohol
- a family member with a mental health illness, or
- a family member who served time in prison.

Recently, there have been additions to the original 10 experiences, including adverse community environments such as poverty, discrimination, violence, and community disruption such as the effects of the COVID-19 pandemic.

Adverse Childhood Experiences have a cumulative, dose-response effect on a wide range of physical and mental health, behavioural, cognitive, social, and biomedical outcomes (Hamai, 2022). Having multiple exposures to adversity or a high 'ACE score' has been associated with chronic diseases in adulthood, such as ischemic heart disease, Type II diabetes, liver disease, autoimmune disease, obesity, and depression (Van Niel et al., 2014). One study showed that individuals with six or more Adverse Childhood Experiences died nearly 20 years earlier than those with no Adverse Childhood Experiences history (Felitti et al., 1998; Van Niel et al., 2014).

Maternal and Child Health clients and families with complex needs often have experienced significant adversity. Physical and emotional abuse, neglect, and family violence profoundly impact children's mental and physical health and social adjustment, academic achievements, and employment histories in adulthood (Moore et al., 2015). Children experiencing family violence are deeply affected by a form of toxic stress that impacts every aspect of health and well-being (Brown et al., 2009). Violence in the household increases a child's risk of maltreatment, as a culture of violence is established within that household (Walker-Descartes et al., 2021). Further, exposure to violence in any form is associated with impairment in children similar to other forms of child abuse and maltreatment (Walker-Descartes et al., 2021).

Resilience, the ability to rebound or positively adapt despite experiencing adversity, can reduce the adverse outcomes of Adverse Childhood Experiences (Hamai, 2022). Promoting resilience, secure attachments, and social support works differently

for different families (Van Niel et al., 2014). Women who have experienced family violence often demonstrate resilience and strength; they manage the risk presented by the perpetrator and protect their children and other family members (State of Victoria, 2016b).

2.4.6 Families that face barriers to access

In Australia, sections of the community are eligible for services or programs but face barriers to engaging in the service, such as the Aboriginal and Torres Strait Islander or First Nations communities in Australia. The impacts of colonisation, dispossession, and long-term socioeconomic factors have had unique influences on First Nations peoples (Kotz et al., 2021). Intergenerational and complex trauma, cultural disruption, and social inequities such as poverty, racism, housing pressures, illness, and suicide mean that First Nations women experience significant risks to their mental health, including high rates of family violence, premature births, and infant death (Australian Institute of Health and Welfare, 2020; Kotz et al., 2021).

By all measures, Aboriginal and Torres Strait Islander women's maternal and infant outcomes do not match their non-Indigenous peers (Marriott et al., 2021). Culturally unsafe perinatal services and fragmented service delivery, often arising from inadequate consultation with Indigenous women, have resulted in their disengagement with the Maternal and Child Health and Enhanced Maternal and Child Health services explored here (Kotz et al., 2021).

Doherty et al. offer a frame of reference to consider the sections of the community that face barriers to accessing services:

- The underrepresented: groups that are marginalised, poor, or socially excluded, whose disengagement from opportunity makes them underrepresented in social programs.
- The invisible or overlooked: families who service providers overlook or fail to cater for their needs. Models of service provision may leave some groups underserved or alienated.

- The service-resistant: those who do not engage with services, including those who may feel wary about service involvement (for example, for fear of children being removed). (Doherty et al., 2003).

More recently, researchers acknowledge that the term “service resistant” is problematic, as it blames the individual for not engaging, rather than reflecting on the issues with the service itself. Although the work of Doherty is important, more recent research acknowledges these barriers to access, including lack of trust, the physical location of services, bureaucratic hurdles, culturally unsafe practices, and workforce shortages (Fox et al., 2015; Kotz et al, 2021; Pokharel, 2021).

Families with the most significant levels of need, or the greatest potential to benefit from targeted interventions, are often the least likely to access them. Moreover, those at risk are the most difficult to retain in an intervention long enough to receive the ‘dosage’ needed to change outcomes (Fox et al., 2015).

Reviews of child and family service systems, both in Australia and in other first world countries identify a common set of systemic issues impairing engagement:

- A fragmented and poorly coordinated system in which specific service sectors primarily focus on issues or groups of vulnerable people without a whole system view.
- A program focus, instead of a client focus, where the onus is on people to make sense of services, navigate from door to door, and ‘fit’ a program to qualify for support.
- Services that fail to consider clients’ family circumstances, particularly the existence and experience of children.
- A traditional welfare approach that focuses on crisis support and stabilisation may encourage dependency.
- A focus on solving problems after they occur, rather than anticipating and intervening to prevent them from arising (Department of Human Services, 2011, p. 5)

2.5 Family violence

Family violence has a significant impact on women and children. The following sections will enable an understanding of family violence in Australia – the definition, prevalence, the health effects on women and children, and considerations of intersectionality.

2.5.1 Definition

The terms intimate partner violence (IPV), domestic violence, and family violence are common globally (Stubbs & Wangmann, 2017). However, each term has a specific definition. Some of the research in this literature review refers to intimate partner violence or domestic violence, rather than family violence, and where this is the case, if the term intimate partner violence or domestic violence has been used, it has been retained. In Victoria, Australia, family violence is used in legislation and policy documents, setting it apart from other Australian jurisdictions and countries, such as New Zealand, the UK, Canada, and the US (Heyman et al., 2022), that use either family violence or intimate partner violence.

Family violence includes violence within a broader definition of the family (Council of Australian Governments, 2010). Family violence is most often thought of as occurring between intimate partners or immediate relations living in the same home, but can also be perpetrated by someone who is in a 'family-like relationship' (such as a carer), or relationships where there is cultural recognition by the community of a 'family-like' relationship (such as in Aboriginal or Torres Strait Islander communities) (Family Violence Response Centre, 2022).

Family violence is not limited to physical violence and is defined by the Family Violence Protection Act (2008) as behaviour that is:

> physically or sexually abusive; or emotionally or psychologically abusive; or economically abusive; or threatening; or coercive; in any other way controls or dominates the family member and causes that family member to feel fear for the safety or well-being of that family member or another person (State of Victoria, 2008, p. 12).

Family violence refers to violence within a family, typically where the perpetrator exercises power and control over another family member, involving coercive and

abusive behaviours by the perpetrator that are designed to intimidate, humiliate, undermine, and isolate, resulting in fear and insecurity (Family Safety Victoria, 2018; State of Victoria, 2016a).

The most common and pervasive instances occur in intimate (current or former) partner relationships, usually referred to as intimate partner violence (Australian Institute of Health and Welfare, 2018). Research has shown that a woman is more likely to be assaulted, injured, raped, or killed by a current or former partner than any other person. The perpetrator is usually male (Ellsberg & Heise, 2005; World Health Organization, 2018b). Psychological aggression and coercive control are the most common form of violence. Trauma is a common impact, and post-trauma effects include physical and mental harm, financial consequences, housing instability, and social stigma (Flasch et al., 2020).

Although anyone can perpetrate sexual violence, it often occurs within intimate relationships (Dicola & Spaar, 2016; Hegarty et al., 2013). In Australia, dowry abuse has recently been recognised as family violence, which includes behaviour or threats that aim to control a partner or their family by causing fear or threatening their safety and gaining control over their dowry (Department of Social Services, 2022). Forcing someone into marriage is illegal in Australia, and visa status cannot be used as a weapon against a woman by a partner, family members, or other people.

2.5.2 Prevalence

Violence against women is a serious, prevalent, and preventable human rights abuse (Our Watch, 2021), and a public health concern of pandemic proportions (World Health Organization, 2021b). At least one in three women worldwide in 2018 has experienced gender-based physical and/or sexual violence (World Health Organization, 2018b), equating to approximately 736 million women. Intimate partner violence is the most common form of violence toward women, with an estimated 641 million women subjected to intimate partner violence (World Health Organization, 2021b). The true figures are likely far higher, given the stigma attached to disclosing violence of this nature, meaning that the prevalence is underreported and underestimated (United Nations, 2021c).

Almost one in four adolescent girls aged 15–19 (24%) who have been in a relationship have experienced physical and/or sexual violence from an intimate partner or husband (World Health Organization, 2021b), with 16% of young women aged 15–24 experiencing this violence in the past 12 months (World Health Organization, 2021b). The impact on young women is profound, with the violence occurring at a significant developmental age, affecting the ability to lay foundations for healthy relationships.

These numbers do not reflect the impact of the current COVID-19 pandemic, with increases in violence against women being reported to helplines, police forces, and other service providers (Carrington et al., 2021; Morley et al., 2021; Usher et al., 2021; Wake & Kandula, 2022; World Health Organization, 2021b).

In Australia, police are called to an family violence incident every two minutes. Twelve women per day are hospitalised due to violence, and a woman is killed by a current or ex-partner every nine days (Department of Social Services, 2019). Family violence may often begin during pregnancy and increases in severity into the first years of motherhood. Younger women (under 22 years of age) and First Nations women are at a greater risk of experiencing domestic and family violence during pregnancy (Australian Institute of Health and Welfare, 2014; Hooker L et al., 2016). Women of childbearing age are at the highest risk for family violence, and most studies have found the prevalence of family violence during pregnancy to range up to eight percent (Gartland et al., 2021).

Accurately measuring the prevalence of family violence is complex, with challenges including variations in the definitions used (intimate partner/family members/household members); the type of violence measured (whether physical or sexual, but not emotional, financial or harassment); the time frames considered (lifetime abuse or past 12 months); and the study sample (nationally representative or smaller samples) (Hooker L et al., 2016).

Figure 9: Risk for violence (Australian Institute of Health and Welfare, 2018)

Violence in the community is often hidden. Many people, bystanders, and some victims do not recognise that what is happening is, in fact, family violence (McInnes, 2022). It is often unreported, and sometimes incidents are not recorded by authorities such as police as family violence – or are not recorded at all (State of Victoria, 2016b). Whereas violence in public places is subject to scrutiny and action by witnesses, violence in private residences, where women and children are most at risk, is largely concealed behind closed doors (McInnes, 2022). The capacity to accurately measure the prevalence of family violence depends on the victims' perception of what constitutes violence, the victims' willingness to disclose or report the incident, and how the incident is disclosed or reported (Australian Bureau of Statistics, 2018).

The drivers of family violence can reflect inequalities in the distribution of power, resources, and opportunity between females and males (Cox, 2016; State of Victoria,

2022; Webster & Flood, 2015). Our Watch is an Australian organisation with the goal of primary prevention of violence against women and their children, and they describe the drivers of family violence to include:

- The condoning of violence against women
- Men's control of decision making
- Limits to women's independence in public and private life
- Rigid gender stereotyping and dominant forms of masculinity; and
- Male peer relations and cultures of masculinity that emphasise aggression, dominance and control (Our Watch, 2021, p. 36).

Communities with attitudes reflecting more significant levels of gender equality generally have lower rates of domestic, family, and sexual violence (UNIFEM - United Nations Development Fund for Women, 2010). Gender equality is measured by UNIFEM using a range of indices which measure women's and men's political, economic and social achievement, with gender equality ranging from 0 (complete inequality) to 1 (perfect equality) (UNIFEM - United Nations Development Fund for Women, 2010).

Men are more likely to experience violence from strangers, and in a public setting. In contrast, women are more likely to know the perpetrator (often their current or a previous partner), with the violence more likely occurring in their home (Australian Institute of Health and Welfare, 2018).

Some Victorian research has found that rurality is related to an increase in the frequency and severity of intimate partner violence (Hooker, Theobald, et al., 2019; Strand & Storey, 2019). This may be related to delays in identification and reporting of violence due to the lack of local services. In addition, some risk factors may be of greater significance in remote and rural areas (Strand & Storey, 2019). In contrast, a review of differences between rural and urban locations contended that there was an increase in frequency of family violence in rural areas, but the severity of the incidents was exacerbated by poor access to services, with worse psychosocial and physical health outcomes (Edwards, 2015). To address this conflicting stance, further rural family violence research is required.

Over half of the women who experience family violence have children in their care (ANROWS, 2014), with more than one million Australian children affected by family violence (Australian Institute of Health and Welfare, 2019). Children do not have to directly witness the family violence for adverse outcomes to present (Wathen & MacMillan, 2013).

Children's exposure to violence occurs in a variety of ways:

- witnessing violence
- hearing but not observing the violence
- observing the aftermath (for example, seeing bruises on the mother, broken furniture)
- becoming aware of the violence through a third party (Campo, 2015).

Despite progress in the past two decades to recognise violence against women as a severe human rights violation and public health concern, the number of women subjected to intimate partner violence and sexual violence has remained unchanged over the past decade (World Health Organization, 2021b).

2.5.3 Health effects on women and children

Violence in intimate relationships contributes more to the disease burden for Australian women aged 18 to 44 years than any other risk factor, such as smoking, alcohol use, or being overweight or obese (Brown et al., 2020; Webster et al., 2018). In addition to these personal impacts, the broader social and economic costs of this violence in Victoria are substantial. Estimates suggest that the annual financial cost of family violence in Victoria in 2014–2015 was approximately $3.1 billion (State of Victoria, 2022). In 2016-2017, the estimated annual financial burden of violence against children and young people in Australia was $34.2 billion; and the lifetime cost was $78.4 billion (Deloitte Access Economics, 2019). The estimates show that a large proportion of the annual cost is child and family services. Over the longer term, the lifetime burden shifts significantly to the health care system (Deloitte Access Economics, 2019).

Family violence confers considerable risk to the woman's health. Victims of family violence are at increased risk of depression, suicide ideation and attempted suicide, physical injury, symptoms of mental illness or personality disorder, unwanted

pregnancy, and being killed by a spouse (Trevillion et al., 2012). The experience of gender-based violence is also linked to post-traumatic stress disorder (Zlotnick et al., 2006), a range of mental and physical illnesses, and the woman may suffer medically unexplained symptoms (Bryngeirsdottir & Halldorsdottir, 2022).

Women abused by partners in their reproductive years are vulnerable to adverse physical and mental health consequences, affecting parenting and infants (Gartland et al., 2019; Hooker L et al., 2016). Family violence disturbs the woman's experience of motherhood (Hooker, Samaraweera, et al., 2016), with the relationship between women and children bearing the brunt of the effects of family violence (Thiara & Humphreys, 2017).

Forty-nine percent of Australian women assaulted by their current partner had children in their care at the time, with the child seeing or hearing the violence, and it is estimated that 11% of Australian children are exposed to family violence during childhood (Australian Bureau of Statistics, 2017). Family violence during pregnancy is associated with risks to the foetus, child, and mother (Taft et al., 2011). New-born infants of women experiencing family violence exhibit higher rates of morbidity, including low birth weight, preterm birth, small for gestational age, and neonatal mortality rates up to eight times higher (Alhusen et al., 2015; Burnett et al., 2021).

Children exposed to Adverse Childhood Experiences, and specifically violence, are at an elevated risk for emotional, behavioural, and cognitive problems (Cutuli et al., 2016; Sharps et al., 2007; Vu et al., 2016). They are affected across all stages of child development (Crouch et al., 2020; Dessimoz Künzle et al., 2022; Howell et al., 2016), with a higher risk of poor language development, and impaired cognitive development (Gartland et al., 2021). Progress towards developmental milestones may be impaired, such as social skills development, emotion identification and expression, or self-regulation (Bender et al., 2022). Exposure to violence during prenatal and infant stages has been associated with insecure relationship attachment (Levendosky et al., 2011). There is a lack of therapeutic support for mother-child dyads exposed to family violence, with more research needed focusing on the mental health care needs of infants and young children (Hooker, Toone, et al., 2019; Orr et al., 2022).

Thiara and Humphreys contend that “hearing and seeing their mothers attacked, becoming caught in the violence themselves, and living in an atmosphere of fear and unpredictability where there may be little attention to their needs, undermines children’s development, their mental health and well-being” (2017, p. 138). Children insecurely attached to their caregivers exhibit lower social competence in peer relationships (Howell et al., 2016). Exposure to family violence leads to increased odds of poor school attendance and school suspension (Orr et al., 2022), which may be related to the child’s higher risk of being bullied, or the child’s concern about their mother’s safety at home (Buckley et al., 2006). School-aged children exposed to violence struggle more with emotional identification and regulation skills than their non-exposed peers, resulting in difficulty navigating peer interactions (Bender et al., 2022). This impact persists into adolescence with underdeveloped skills related to emotion identification, expression, and regulation in interpersonal relationships. These teenagers may develop attitudes that violence is acceptable in conflict with peers, dating partners, or family members (Bender et al., 2022; Voisin & Hong, 2012).

Children may become victims or perpetrators of violence later in life, with the effects of family violence being passed on to the next generation (State of Victoria, 2016b). Compared to children who do not experience violence, children who do are 12 times more likely to have attempted suicide, seven times more likely to abuse alcohol, and ten times more likely to have injected street drugs by adulthood (Van Niel et al., 2014). Conversely, other research argues there is variation in the impact of family violence on children, with one study arguing that a child’s social-emotional competence may be a protective factor. This may explain why some children exposed to family violence are not as severely affected as others (Fogarty et al., 2019). One meta-analysis found that 37% of intimate partner violence-exposed youth had adjustment outcomes the same or better than non-exposed youth (Bender et al., 2022; Kitzmann et al., 2003).

Victim-survivors of family violence (and their children) in marginalised communities experience heightened violence related to how various aspects of their identities intersect under structures of power. Understanding the unique factors for different communities helps develop intervention and prevention programs and strategies suited to targeted populations (Li et al., 2022; Spencer et al., 2019).

2.5.4 Intersectionality

An intersectional lens focuses on a person's location in a social hierarchy based on age, sex, race, ethnicity, sexual orientation, gender identity, disability status, socioeconomic status, and cultural experiences (White & Geffner, 2022). Acknowledging intersectionality is necessary for advocacy, interventions, and policy development (White & Geffner, 2022).

Bisexual people are at increased risk of intimate partner violence compared to people of other sexualities (Walters et al., 2013) and may face additional barriers to seeking help (Bagwell-Gray et al., 2020; Calton et al., 2016). There is a lack of research on the risk and protective factors for bisexual people, despite them experiencing a disproportionate risk of intimate partner violence (Corey et al., 2022; White & Geffner, 2022).

Culturally diverse women's experiences of family violence are often intertwined with experiences of racism, language barriers, and inequitable access to health care and support services (Pokharel et al., 2021). Immigrant women in family violence situations have needs that differ from those of the mainstream population, particularly where threat of deportation, including potential loss of children is used as a weapon against the woman (Segrave, 2021). Culturally diverse women experience systemic racism, language barriers, and cultural beliefs that promote silencing about family violence (De Schrijver et al., 2018), and culturally appropriate family violence responses must be mindful of these additional layers of complexity (Li et al., 2022; World Health Organization, 2017).

Women of colour are less likely than white women to seek help formally from police and legal aid services and suffer disproportionately from family violence (Fiolet, Tarzia, et al., 2021; Nelson et al., 2020). They are more likely to seek informal support such as family members or friends (Decker et al., 2019). Recent research has aimed to identify First Nations people's experiences and expectations of health care professionals when experiencing family violence (Fiolet et al., 2020), and suggests that First Nations peoples are reluctant to engage in help-seeking for family violence support, despite experiencing higher rates of family violence than the non-Indigenous population (Fiolet,

Tarzia, et al., 2021). This reluctance may be due to distrust of a system that is not culturally informed.

With culturally appropriate knowledge, attitudes, and behaviours, health care practitioners may overcome some of the barriers created by generations of systemic racism and historical trauma experienced by people from marginalised communities (Fiolet et al., 2020; Pokharel et al., 2021). System-wide interventions need to be intentional in design and cognisant of the impact of cumulative harm and intersectionality, and the structural aspects of trauma, such as discriminatory systems, structural barriers, historic and current inequities, and harmful institutional practices (Scott & Jenney, 2022).

2.6 Health systems' responses to family violence

To identify how nurses can best support women experiencing family violence, further insight into the community and health system Enhanced Maternal and Child Health nurses work in, as part of a broader health systems family violence response is required. The health sector fulfils an essential role in early identification and providing care and support to women affected by violence. Women's health is impaired due to family violence, and most women connect with the health sector at some point in their lives. Health care providers are among those who women are more likely to trust with a disclosure (O'Doherty et al., 2016; Spangaro et al., 2016; World Health Organization, 2021b).

2.6.1 International responses

The work on reducing violence against women is extensive and worldwide. For example, UN Women was formed in 2010 to lead the work towards gender equality, which includes the issue of violence (United Nations, 2021b). The United Nation's *Agenda 2030,* adopted by nations worldwide, includes eliminating violence toward women and girls (United Nations, 2021a). The UN has also presented a strategic plan for ending violence against women, including multiple focus areas (United Nations, 2021a).

In 2016, the WHO released a global plan to address interpersonal violence, particularly against women, girls, and children (World Health Organization, 2016b). The WHO stated that all forms of interpersonal violence lead to adverse health outcomes

and identified health services as an appropriate entry point (World Health Organization, 2017).

Health systems have a crucial role in multi-sector responses to violence against women (García-Moreno et al., 2015). The health system needs to enable conditions for providers to address violence against women at a state and country level, including coordination and referral networks, protocols, and capacity building. The Center for Disease Control and Prevention (Niolon, 2017) proposed six strategies for preventing violence from happening in the first place, or preventing it from continuing. These six strategies include: teaching safe and healthy relationship skills, engaging influential adults and peers, disrupting the developmental pathways toward intimate partner violence, creating protective environments, strengthening economic support for families, and supporting survivors to increase safety and lessen harm (Niolon et al., 2022, p. 2740).

Interventions for prevention need to include action at multiple levels, for example: challenging social norms that support masculinities based on power and control over women and that condone violence against women, reforming discriminatory family/divorce laws (Easteal et al., 2021), and strengthening women's economic rights (Eggers Del Campo & Steinert, 2020). Women's economic empowerment may decrease violence against women (Eggers Del Campo & Steinert, 2020; Goodman et al., 2016). However, the risk of intimate partner violence can increase among economically empowered women (Abramsky et al., 2019; Leite et al., 2020), particularly in low-to-middle income countries (Leesa et al., 2021).

The safety of women and children requires that violence perpetration is addressed, including working with those who have perpetrated violence and abuse (Thiara & Humphreys, 2017). "The safety of women and children can never be fully realized without ending violence perpetration, which in turn, requires working with those who have perpetrated violence and abuse" (Scott & Jenney, 2022, p. 4).

2.6.2 Australian responses to family violence

Family violence is an increasing community concern and a priority for Australian federal, state, and territory governments. Recent national, state, and territory inquiries

have highlighted the need to invest in prevention and early intervention, and improve the integration of service responses for victims (Australian Institute of Health and Welfare, 2018), at the primary, secondary, and tertiary levels.

The Australian Government has developed a comprehensive national strategy to prevent violence against women titled *The national plan to reduce violence against women and their children 2010-2022* (Department of Social Services, 2010). This plan was developed from the earlier work of the National Council to Reduce Violence against Women and their Children (2008) through broad consultation and by examining existing research on violence against women. The evidence-based plan *Time for action: the national council's plan for Australia to reduce violence against women and their children, 2009-2021* indicated that the high rates of family violence, and the significant health and economic costs associated with the abuse of women and children, warranted immediate and urgent action (National Council to Reduce Violence against Women and their Children, 2009).

This 2010-2022 plan identifies primary prevention as a critical component and prioritises improvements to service system responses. It states that current domestic and family violence service systems are complex and challenging for people to navigate. The plan called for collaboration across services, sectors, and workforces to ensure that responses to women affected by domestic, family, and sexual violence are coordinated, meet women's needs, and avoid women having to retell their stories (Council of Australian Governments, 2019).

The plan aimed to encourage attitudinal and behavioural change at the individual, organisational and community levels, focusing on the young to promote generational change. To be implemented over four three-year plans, its six key national outcomes include:

1. communities are safe and free from violence
2. relationships are respectful
3. indigenous communities are strengthened
4. services that meet the needs of women and their children experiencing violence
5. justice responses are effective, and
6. perpetrators stop their violence and are held to account (Council of Australian Governments, 2019).

Outcome 4, **services that meet the needs of women and their children experiencing violence,** includes strategies for services to meet the needs of abused women and children. These include a 'first door approach', which enables women seeking assistance to receive high quality, professional help from any first point of contact, and support for mainstream services to improve early identification and support. A 'first door approach' was the introduction of The Orange Door in Victoria, which is discussed in the next section.

2.6.3 Program responses in Victoria

Australia's first Royal Commission into Family Violence was established after several Family violence-related deaths in Victoria, most notably the death of Luke Batty (Coroner's Court of Victoria, 2015). Luke was murdered by his father after years of abusive behaviour directed at Luke's mother, Rosie Batty. The role of the Commission was to find ways to prevent family violence, improve support for victim-survivors, and hold perpetrators to account. The Commission included 25 days of public hearings. Community conversations were held with over 800 Victorians, and nearly 1,000 written submissions were received. The Commission made 227 recommendations to reduce the impact of family violence in the community (State of Victoria, 2016b).

The Royal Commission generated increased interest and focus on screening, identifying, and supporting women experiencing family violence. The Commission acknowledged that the universal nature of the Maternal and Child Health service means that Maternal and Child Health nurses are uniquely positioned to ask women about family violence, offer support and strategies, assist with safety plans, refer to specialist agencies, and often receive the first disclosure of family violence (State of Victoria, 2016b).

Maternal and Child Health nurses promote early identification and intervention, particularly for at-risk children and families, and improve linkages with other early childhood support systems (Department of Human Services, 2003). Women and children facing adversity such as family violence and other additional challenges may be referred to the Enhanced Maternal and Child Health program. Specifically, the program aims to

provide additional support for families experiencing early parenting difficulties, improve family functioning, and the health and well-being of vulnerable children and families.

The WHO recommends indicator-based assessments, asking women attending antenatal care and other health care services, who present with specific risk indicators about family violence. (World Health Organization, 2013). Routine screening of all women is not recommended. Furthermore, a recent review found little evidence on whether screening and other interventions improve outcomes for women experiencing family violence in the perinatal period (O'Doherty et al., 2015). Research is needed on how perinatal and family health services can best support women with a history or current experience of family violence, respond appropriately and safely, and thus improve health outcomes for women and their infants in the perinatal period (Hooker & Taft, 2021; Howard et al., 2013).

A Cochrane Review on screening women for intimate partner violence found that screening increases the identification of women experiencing intimate partner violence in health care settings. However, identification rates were low relative to what might be expected in women seeking health care (O'Doherty et al., 2015). Pregnant women in antenatal settings may be more likely to disclose intimate partner violence when screened (O'Doherty et al., 2015); however, more research is needed to confirm this. Further research is required to compare **universal screening** (the application of a standardised question to all symptom-free women according to a procedure that does not vary from place to place) to **case-finding** (asking questions if specific indicators are present) (O'Doherty et al., 2015).

Since 2009, Maternal and Child Health nurses screen all women for family violence at the 4-week maternal health and well-being consultation if it is safe to do so, and at other times if clinically indicated (Department of Health and Human Services, 2019d). Nurses ask the following questions, ensuring that the woman is alone when asked:

- Are you in any way worried about the safety of yourself or your children?
- Are you afraid of someone in your family?
- Has anyone in your household ever pushed, hit, kicked, punched, or otherwise hurt you?
- Would you like help with this now?

Despite this requirement, research has shown low family violence screening rates by Maternal and Child Health nurses (Hooker et al., 2020; O'Doherty et al., 2016; Taft et al., 2015; Taillieu et al., 2021). Researchers have explored this reluctance to screen women for family violence (Taft et al., 2015), identifying that Maternal and Child Health nurses have received limited family violence education and training (Hooker et al., 2021) and may lack confidence in family violence work (Taillieu et al., 2021). Nurses are not equipped with effective family violence practice tools and skills (Hooker et al., 2020).

In one of the very few studies attempting to improve health systems and nurse identification and response to family violence, a cluster Randomised Controlled Trial (RCT) conducted in Victoria aimed to test a theory-informed Maternal and Child Health-designed Model of Care to (i) increase Maternal and Child Health team screening rates, disclosure, safety planning, and referrals at three months postpartum, compared with teams implementing government mandated care at one week postnatally and (ii) to test independent program sustainability 24 months later (Taft et al., 2015). The nurse-designed best practice model included a self-completion maternal health screening checklist at three months, an family violence clinical pathway with clinical guidance, and identified nurse mentors and family violence liaison workers for direct referral and secondary consultation for Maternal and Child Health nurses.

There was no increase in routine screening for family violence or referrals to specialist support services stemming from the study; however, the study significantly increased safety planning (implying increased disclosure following case-finding) over 36 months among postpartum women. Nurses and women appreciated the self-completion family violence screening checklist. Some researchers have considered whether referrals should be the desired or appropriate goal for women in pre-contemplative or contemplative phases of the abuse cycle, and whether safety planning may offer improved care for postpartum women (Reisenhofer & Taft, 2013).

One of the recommendations of the Royal Commission into Family Violence (State of Victoria, 2019) was the introduction of the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM). This was introduced in 2018, with a roll-out to all services in 2020 (Family Safety Victoria, 2018). The MARAM provides a system-wide approach and shared responsibility for responding to family violence risk.

The Royal Commission into Family Violence found organisations working with victims and perpetrators of family violence collect a wide variety of information to:

- keep victims safe
- hold perpetrators to account

The Commission also discovered that:

- important information wasn't being shared effectively between organisations
- failure to share crucial information with frontline workers can have catastrophic consequences for victims of family violence (State of Victoria, 2021)

The Family Violence Information Sharing Scheme was introduced to support effective assessment and management of family violence risk. It enables risk relevant information to be collected, used, and shared between authorised workforces (Family Safety Victoria, 2018).

The MARAM replaced the previous Common Risk Assessment Framework (CRAF) (Department of Health and Human Services, 2007) to address clinical and service practice gaps. The MARAM Framework provides professionals and services with a shared understanding of family violence, facilitating consistent, effective, and safe responses for people experiencing family violence (Family Safety Victoria, 2018). The MARAM was intended to cover all aspects of service delivery, from early identification, screening, risk assessment and management, to safety planning, collaborative practice, stabilisation and recovery, in response to issues and gaps identified by Victoria's Royal Commission into Family Violence (Department of Health and Human Services, 2019a).

The implementation of the MARAM is yet to be reviewed, despite a call for an evidence base demonstrating how change is occurring in hospitals and other health settings (McKay et al., 2021; Royal Melbourne Hospital Family Safety Team, 2022). The MARAM requires the relevant Minister to periodically (up to every five years) review the framework's operation, and for Ministers responsible for framework organisations to report annually on the framework's operation (Family Safety Victoria, 2020). According

to the latest government advice, the 5-year review commences in early 2022, scheduled for tabling in parliament in 2023 (State of Victoria, 2021).

The Family Violence Information Scheme enables the sharing of information between authorised organisations to assess and manage family violence risk (State of Victoria, 2021), The Royal Commission into Family Violence (State of Victoria, 2019) found organisations working with victims and perpetrators of family violence collect a wide variety of information to keep victims safe and hold perpetrators to account. However, the Commission found that important information wasn't being shared effectively between organisations. It was argued that failure to share crucial information with frontline workers can have catastrophic consequences for victims of family violence (State of Victoria, 2021).

In a review of the related Family Violence Information Sharing Scheme, “timing and sequencing” issues were highlighted as hindering the development of quality training content, including accompanying materials (McCulloch et al., 2020, p. 13). These delays significantly impacted the roll-out of the Maternal and Child Health elements of the MARAM. As identified in the Family Violence Reform Implementation Monitor report, the changing timelines created risks for the information sharing schemes that were dependent on strong risk assessment and management practices being in place before they commenced. The delays created gaps in risk management training and management and undermined confidence in the new framework (Cartwright, 2019).

The State of Victoria has recently released a primary prevention strategy that focuses on the drivers of violence, working with the whole community, reaching people in various places, connecting and coordinating prevention efforts, and building continuity with the response system (State of Victoria, 2022). The report calls for a sound understanding of primary prevention in the Victorian workforce, particularly Maternal and Child Health nurses, because of their “broad reach” in all parts of the community (State of Victoria, 2022, p. 47). Although the strategy focuses on family violence primary prevention, the MARAM is not referred to as an element of the response system (State of Victoria, 2022). It must be included in the call for an “ongoing commitment to and investment in research, monitoring and evaluation … and a coordinated monitoring framework” (State of Victoria, 2022, p. 44).

In 2018, the first four Orange Doors were rolled out with the intention that there would be an Orange Door in the 17 Department of Health and Human Services areas. It was intended that The Orange Door network would be an integral part of the family violence and family services systems, providing an entry point into the continuum of service provision that aims to ensure there is no wrong door to access high quality, consistent and effective support for family violence and children and families in communities (The Orange Door Network, 2020).

A review by Price Waterhouse Cooper acknowledged the significant challenges that arose from the rapid start-up – specifically a lack of operational guidance, and a lack of consistent practices and processes within, and between, the areas (Price Waterhouse Coopers, 2019). This is not surprising, as several separate agencies and services were quickly brought together. There were significant workforce shortages, inadequate risk assessment and risk management of clients over time, and issues with the service system interface for services arranging referrals to The Orange Door (Family Safety Victoria, 2019).

The impact of this patchy roll-out of the program was that Maternal and Child Health and Enhanced Maternal and Child Health nurses were reluctant to refer clients experiencing family violence, as they were not sure of the reception clients would receive (Price Waterhouse Coopers, 2019). This perception has improved over time due to The Orange Door's strengthening in operational guidance, increased workforce, and relationship building with allied services such as Maternal and Child Health and Enhanced Maternal and Child Health (The Orange Door Network, 2020). In 2021, The Orange Door was operating in 12 of the 17 Department of Health and Human Services areas, with full coverage anticipated by 2022 (The Orange Door, 2022).

2.7 Conclusion

In this background chapter, a history of the Maternal and Child Health service in Victoria has been described, and the development of its role as a Primary Health Care provider. A description of the philosophical basis of some Maternal and Child Health nursing approaches including the needs of families with complex needs has been described.

Family violence has been discussed, its prevalence, the impact of family violence on child health and development, and maternal health and well-being. To better understand how nurses and systems can best support women experiencing family violence, the context within which Enhanced Maternal and Child Health nurses work requires exploration, so critically studying health systems' responses to family violence has enabled insight into how the work of nurses and their managers is framed as part of a broader service response.

The following chapter reviews the evidence for nurse home visiting and enhanced home visiting programs. This review of the literature has been extended to a Systematic Review - A systematic review and qualitative meta-synthesis of the roles of home visiting nurses working with women experiencing family violence (chapter 8).

3. LITERATURE REVIEW

3.1 Introduction

In the previous chapter, I have provided a background to the research study. While family violence research has been conducted in the universal Maternal and Child Health service, very few researchers have studied the Enhanced Maternal and Child Health service and the work of home visiting nurses supporting women experiencing family violence.

The focus of this literature review is on the evidence for nurse home visiting and enhanced home visiting programs. This review of the literature was then extended to a Systematic Review - A systematic review and qualitative meta-synthesis of the roles of home visiting nurses working with women experiencing family violence (chapter 8).

3.2 Nurse home visiting

Supporting families with the resources to change the trajectory of a child's life can be challenging (Van Niel et al., 2014). Understanding the intergenerational transfer of violence and abuse requires a biopsychosocial perspective, acknowledging the cumulative effects of repeated exposure to violence of all forms (White & Geffner, 2022). The biopsychosocial model was first described by George Engel in 1977 (Black & Hoeft, 2015), suggesting that to understand a person's medical condition it is not simply the biological factors to be considered, but also the psychological and social factors. This biopsychosocial approach underpins the Enhanced Maternal and Child Health program and influences the work of Enhanced Maternal and Child Health home visiting nurses undertaking family violence nursing practice.

Nurse home visiting is a strategy to deliver health services to families within the home environment usually over an extended period (Eckenrode et al., 2000; Molloy et al., 2019; Pavalko & Caputo, 2013; Saïas et al., 2016; Stamuli et al., 2015; Van Assen et al., 2020). Clients in home visiting programs often include those experiencing significant medical, social, and emotional issues and may also be experiencing family violence. Nurses fulfil complex roles that are sometimes conflicting, such as supporting the woman (maintaining the relationship) and legal mandates for nurses regarding reporting the family and/or child abuse. This conflict in role creates tension for nurses, with

researchers identifying the potential for role confusion (Jack, Gonzalez, et al., 2021; Peckover & Golding, 2017).

Factors that can impact service access may include the family's health literacy, such as their inability to identify family needs, seek out services, reach those services, and receive appropriate services (Fox et al., 2015; Kotz et al, 2021; Pokharel, 2021). Nurse home visiting is one way of overcoming these difficulties with access (Goldfeld et al., 2018).

There are obvious benefits for families, such as not having to find transport to get to the service. Home visiting programs also allow the nurse to observe the family's environment and help build a rapport with families that may not be possible with more traditional service offerings. This is especially important for families who may have lost trust in mainstream universal service providers (Goldfeld et al., 2017). Daro and Dodge (2010) propose that the most benefit to be gained from home visiting would come from:

> a home-visitation policy framework that embeds high quality targeted interventions within a universal system of support that begins with an assessment of all new parents. This assessment process would carry the triadic mission of assessing parental capacity, linking families with services commensurate with their needs, and learning to do better (Daro & Dodge, 2010, p. 79).

Some researchers have called for a tempering of the "international enthusiasm" for home visiting programs, arguing that even the most successful home visiting programs have moderate effects (Goldfeld et al., 2018, p. 156). Other researchers argue that published studies do not provide enough information about the program content or implementation to identify which components make for an effective program (Moore et al., 2011b). Overall, researchers argue that home visiting is not a 'universal panacea' but does contribute to early intervention as part of a range of strategies to enhance and improve early childhood development (Office for Planning Research and Evaluation, 2017).

Several evidence-based home visiting programs have been reviewed; however, they cannot be effectively compared as they differ in goals, the dosage, the clientele, and the staff delivering the program (Goldfeld et al., 2018). Nurse home visiting programs such as the Nurse-Family Partnership are intensive, structured, and include

manualised programs commencing antenatally, compared with the Victorian Enhanced Maternal and Child Health program that predominantly is offered postnatally, is more intensive (meaning shorter in duration), and arguably more flexible to client needs.

The programs reviewed in the next section include the Nurse-Family Partnership, the Family Nurse Partnership, the Australian Nurse-Family Partnership Program, the Maternal Early Childhood Sustained Home-Visiting (MECSH) program, and right@home.

3.3 In the United States and Canada

Key findings from the US Mother and Infant Home Visiting Program Evaluation (MIHOPE) evaluation concluded that evidence-based home visiting has improved outcomes for parents and children across a wide range of child ages, outcome areas, and national models. Evidence-based home visiting appears to be cost-effective in the long term, with the most significant benefits from this home visiting model coming through reduced spending on government programs and increased individual earnings (Office for Planning Research and Evaluation, 2017).

The Maternal, Infant and Early Childhood Home Visiting (MIECHV) program was implemented in 2010, providing funding to US states, territories and tribal entities for home visiting services, prioritising low-income families, young mothers or parents with a history of substance abuse, among other risk factors (Fernandes-Alcantara, 2018). The MIECHV requires all recipients of federal funding to implement one of 14 programs that meet specific and rigorous standards of evidence.

The program's introduction drew on earlier research evaluating the effectiveness of early childhood home visiting models, which showed some benefits to children and their parents. Although this research identified improvements in child and maternal health and well-being outcomes, these improvements were minor when compared between the intervention and comparison arms of the RCT, and inconsistent across different programs (Cannon et al., 2017; Fernandes-Alcantara, 2018).

The Home Visiting Evidence of Effectiveness (HomVEE) reviewed home visiting program models to ensure they effectively meet family needs (US Department of Health and Human Services, 2016). According to this review, 20 home visiting models met HomVEE and other eligibility criteria. Awardees reported on their program’s

performance for 19 measures across six statutorily defined benchmark areas and demonstrated improvements in at least four benchmark areas. The benchmark areas were (i) improvements in maternal and newborn health; (ii) prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; (iii) improvements in school readiness and achievement; (iv) reduction in crime or domestic violence; (v) improvements in family economic self-sufficiency; and (vi) improvements in the coordination and referrals for other community resources and supports.

3.3.1 Nurse-Family Partnership

The first evaluation of the program now known as NFP was conducted in Elmira, New York, which has been replicated in other US states, countries, and population settings, including Memphis, Tennessee; Denver, Colorado; the Netherlands; and the UK (Kitzman et al., 2019; Olds, 1997; Olds et al., 2019). The Prevention Research Center established a process for international evaluation and replication of the program. Currently, there are 7 countries that are engaged in adapting, piloting, and evaluating NFP in their local contexts, including NFP (Canada), the Family Nurse Partnership programme (England, Scotland, and Northern Ireland) and the Australian Family Nurse Partnership program (NFP international, 2022) https://nfpinternational.ucdenver.edu/international-program.

In the original Nurse-Family Partnership, nurses regularly visited young first-time pregnant women, commencing antenatally until the child was two years of age. The three key goals of Nurse-Family Partnership are to: (i) improve pregnancy and birth outcomes through improved prenatal health behaviours; (ii) improve child health and development through positive, responsive caregiving; and (iii) improve the economic self-sufficiency of the family through developing a vision and plans for the future (Nurse-Family Partnership, 2022).

Nurse-Family Partnership nurses are experienced, university-qualified nurses, who undergo extensive additional training to take on the role of nurse home visitor. Understanding the underpinning theories and their application within the program is a critical element of their training (Adams, 2015). Further, Nurse-Family Partnership

nurses and their supervisors are provided with education, training, and ongoing support to use a range of clinical methods, including solution-focused approaches, strength-based approaches, client-centred principles, behaviour change strategies, agenda matching, and motivational interviewing. The Nurse-Family Partnership nurses carry a maximum caseload of 25 clients (Nurse-Family Partnership, 2022). In the Canadian NFP program, nurses carry a maximum caseload of 20 clients (Jack, 2012).

Subsequent programs broadened the clientele to include women with additional challenges, such as those experiencing low income. Nurse-Family Partnership nurses provide new mothers with the confidence and tools they need to assure a healthy start for their babies and envision a life of stability with opportunities for success for both mother and child (Arefadib et al., 2021). The founder of the program, Professor David Olds, observed:

> There is a magic window during pregnancy – It's a time when the desire to be a good mother and raise a healthy, happy child creates motivation to overcome incredible obstacles, including poverty, instability or abuse, with the help of a well-trained nurse (Nurse-Family Partnership, 2022, n.p.).

The Nurse-Family Partnership in the US is a mature program, with over 30 years of delivery and is facilitated by highly experienced nurses and supervisors. The first babies of this program are now fully adults. This strong history has enabled longitudinal studies to demonstrate the sizable, sustained, short-term and long-term benefits to the mother and child (Adams, 2015; Social Programs That Work, 2020).

The program is funded by philanthropic grants in the US, which means that rigorous evaluation of return on investment is required. The program costs approximately $15,000 USD per woman over the three years of visits (2019 dollars) (Social Programs That Work, 2020). The US does not have a universal Maternal and Child Health service, so it is not surprising that coming from such a low baseline of support, women engaged with Nurse-Family Partnership do so much better than those with limited other supports (Adams, 2015; Owen-Jones et al., 2013; Robling et al., 2016).

Positive outcomes were found 15 years after the first child's birth, including fewer subsequent births, increased spacing between the births of the first and second child, improved health, educational and employment outcomes for both mother and child (in

adulthood), and decreased rates of criminal behaviour and homelessness (Eckenrode et al., 2000; Olds et al., 2019). Subsequent research found gender differences in early-childhood program effects; however, the results were equivocal. On the one hand, boys maintain more prolonged treatment effects than girls (Heckman et al., 2017). On the other hand, fewer girls enter the criminal justice system and found fewer program effects for boys (Eckenrode et al., 2010).

The specific effects that were reproduced in two or more of the RCTs were a reduction in measures of child abuse and neglect (including injuries and accidents), a reduction in mothers' subsequent births during their late teens and early twenties, a reduction in prenatal smoking among mothers who smoked at the start of the study, and improvement in cognitive development, skill sets, and academic outcomes for children born to mothers with low psychological resources (Social Programs That Work, 2020).

Nurse home visiting programs seek to recruit and support families experiencing adversity, including family violence (Prosman et al., 2015). Researchers evaluating the Nurse-Family Partnership found that domestic violence may limit the effectiveness of interventions to reduce the incidence of child abuse (Eckenrode et al., 2010). They argued that the effects of domestic violence on the mothers' caregiving capacities may have reduced their capacity to prevent child maltreatment; however, researchers were not able to articulate the mechanisms to explain the moderating effects of domestic violence (Eckenrode et al., 2000).

The VoorZorg trial in the Netherlands demonstrated a reduction in self-reported Intimate Partner Violence during pregnancy and two years after birth (Mejdoubi, 2013). This study highlighted the major benefit of home-visiting interventions, in reaching high-risk young pregnant women, who are difficult to reach for regular services, during a vulnerable stage in their life, over a prolonged period of time.

Other researchers have assessed the effect of adding an 'Intimate Partner Intervention' to the Nurse-Family Partnership; however, an RCT found that it did not significantly improve women's quality of life at 24 months after delivery (Jack, Boyle, et al., 2019). It should be noted that a limitation of the RCT was a low level of fidelity to the intervention, which may have affected the achievement of the primary outcome.

Adherence to the model was a challenge in the study, and further process evaluation may reveal why the intervention did not significantly impact maternal outcomes (Hooker & Taft, 2019; Jack, Olds, et al., 2019).

A very recent study identified within the context of implementation, low fidelity does not necessarily imply a problem with nursing practice. In addition to explaining the observed low fidelity, these findings provided important insights about the challenges of addressing intimate partner violence in home visiting practice and the clinical judgments made by nurses to preserve the therapeutic relationship and to ensure that practice aligns with client priorities. Nurses emphasized the importance of clinical reasoning in determining whether it was appropriate to use various components of the clinical pathway (Jack et al., 2022).

Given the documented benefits of the program in the US, there was interest internationally to adapt, pilot, and evaluate the program. However, the program's effectiveness cannot be assumed to be transferrable to other countries and settings. A four-phase model for implementing the program in countries outside the US includes (i) identifying any adaptations required in the local context; (ii) conducting feasibility and pilot studies; (iii) testing the program with an RCT and; (iv) implementing the adapted program (Jack et al. 2012). For example, one aspect that arose as an issue with the translation of the program from the US to Canada was the nurse caseload. Canadian Public Health nurses could not maintain a caseload of 25 active clients because of the different working conditions of Canadian nurses compared to US nurses, such as additional leave entitlements.

3.3.2 Domestic Violence Enhanced Home Visitation intervention

The objective of the DOVE study was to determine the effectiveness of an intimate partner violence intervention in reducing violence against women in the perinatal period by using community health nurse home visitors (Sharps et al., 2016). DOVE was an intervention that was added to existing paraprofessional or professional home visiting programs, including the Nurse Family Partnership.

The DOVE was a multisite trial conducted from 2006 to 2012. Home visitors in both arms of the DOVE trial received a 4-hour training session which included information

about intimate partner violence, perinatal intimate partner violence and health outcomes, and the importance of screening and intervening in perinatal intimate partner violence. The nurses in the intervention arm received a second 4-hour training program, which included using DOVE screening and assessment instruments and developing individualised safety plans (Sharps et al., 2016).

The trial demonstrated a significant decrease in violence using the structured IPV/DOVE. The researchers described the DOVE intervention as a low-cost adjunct for any home visiting program, working via the nurse/client relationship to enable discussions about intimate partner violence and empower the woman to plan her safety. A follow-up study sought to identify which core aspects of DOVE facilitated or inhibited its success, and what was most critical to optimal intimate partner violence screening and intervention practices (Burnett et al., 2021). They found that establishing a relationship with the women before screening was important in delivering DOVE. According to the home visitors, the training and support increased comfort levels in addressing intimate partner violence (Burnett et al., 2021).

There were several limitations to the study including a high refusal rate, though this was comparable to other similar studies. This high refusal rate may have skewed the characteristics of the sample if those experiencing more severe abuse excluded themselves from the study, for reasons which might include a reluctance to have the intervention delivered in their home. There was also substantial attrition occurring at the 18- and 24- month time points with a related concern that those women more severely abused were prevented from continuing in the study by controlling partners. The study used self-report measures only, and was only offered to English speaking women, and so was not generalisable to other populations (Sharps et al., 2016).

Burnett's follow up study further identified that support from the nurse's manager was instrumental in the success of the implementation. This is one of the few studies that specifically mention the role of the nurse's manager in supporting women experiencing family violence (Burnett et al., 2021).

3.4 In the United Kingdom - Family Nurse Partnership

Conversely, in the United Kingdom (UK), the program is a National Health Service (NHS) government-funded program, renamed the Family Nurse Partnership to shift the focus on the relationship with the family rather than the nurse. An RCT conducted in the UK found no significant positive effects on primary outcomes (e.g., maternal smoking rates during late pregnancy, birthweight, repeat pregnancy within 24 months, emergency department or hospital admissions) (Robling et al., 2016).

This marked discrepancy from the US RCTs may include: (i) the control group in the UK study received more comprehensive care than the control groups in the US studies, including, for example, an average of 16 home visits from a nurse home visitor up to the child's second birthday; and (ii) the UK study targeted a lower-risk sample of mothers than the US studies (Sanders et al., 2019; Robling, 2018). Other studies found effects of the Family Nurse Partnership strongest among higher-risk mothers (Social Programs That Work, 2020).(Robling et al., 2018; Cavallaro et al. 2020; Robling et al. 2022)

In 2019, an initial evaluation of the Family Nurse Partnership program in Scotland highlighted that family nurses, the families they work with, wider family members, and professionals and service providers, saw value in the work of Family Nurse Partnership (Scottish Government, 2019), despite not achieving significant positive effects on primary outcomes. Specific aspects of the program included the supportive nature of the nurse and client relationship and the holistic approach to breaking intergenerational cycles of poor caregiving. This approach aimed to reduce the risk of abuse and bring intragenerational equity to this population, supporting maternal outcomes, including mental health wellbeing, confidence and self-efficacy, and education and employment. The program aimed to support children's development with positive parenting approaches, improving inter-agency collaboration and reducing the workloads of other services (Scottish Government, 2019).

The Family Nurse Partnership program offers a schedule of structured visits, and Family Nurse Partnership nurses are encouraged to match their schedule of visits and the content of these to individual clients' specific needs and goals. Family Nurse Partnership nurses have an extensive suite of materials to support client engagement and the development of knowledge, skills, and confidence. During each visit, the nurse

considers six domains: personal health, maternal role, life course development, family/friends, environmental health, and health and suman services to build on previous learning (Scottish Government, 2019).

Family Nurse Partnership nurses identified vulnerabilities such as anxiety and other mental health illness, with 63% of clients in their caseload with this vulnerability. Aspects of violence were separately identified and may have been concurrent, however, percentages of each aspect were identified as follows: experience of emotional abuse 25%; intimate partner violence 18%; physical abuse 16%; sexual abuse 6%; sexual assault 9%; and client's mother treated violently 17% (Scottish Government, 2019).

The evaluation of the trial in Scotland highlighted the value placed on the Family Nurse Partnership program by clients, nurses, and other professionals; however, improvements in objective outcome measures were not achieved, and a causal relationship between Family Nurse Partnership and improvement in maternal and child outcomes was not identified (Scottish Government, 2019). This variation in program achievements is perhaps not surprising, given the higher level of family support in the UK compared to the US, with the control group in the UK study receiving more comprehensive universal care than the control groups in the US studies.

3.5 In Australia

3.5.1 Maternal Early Childhood Sustained Home-Visiting program

The Maternal Early Childhood Sustained Home-visiting (MECSH) program grew out of an intervention research project conducted between 2002 and 2008 in a lower socio-economic area of south-western Sydney, Australia (Kemp et al., 2017). The MECSH program is part of a tiered service model within a broader universal health system. The program provides long-term structured support to all families vulnerable to poorer outcomes for both child and parent (Kemp et al., 2017). The goals are achieved through 25 scheduled home visits from pregnancy until the child is two years old. Nurse home visitors offer a structured child development parent-education program and enable the use of community-based support groups and services.

The program also aimed to improve child health and development by helping parents interact with their children in developmentally supportive ways. Nurses

modelled positive parent-infant interaction and delivered a standardised, structured child development parent education program (Kemp et al., 2017). A feature of the program is that it commences at antenatal stage and is embedded within a universal child and family health service system, providing a structured home visiting schedule.

An RCT demonstrated that the MECSH program effectively improved child and maternal outcomes and the developmental quality of the home environment (Kemp et al., 2011). The program aims to improve the transition to parenting by supporting mothers through pregnancy, including providing support with the mother's and family's psychosocial and environmental issues, supporting the health and development of the family, including older children. Further, the program provides an opportunity for discussion, clarification, and reinforcement of clinical antenatal care provided by usual antenatal midwifery and obstetric services, and preparation for parenting.

Mothers receiving the MECSH intervention were more emotionally and verbally responsive (HOME observation) during the first two years of their child's life than the comparison group mothers receiving usual care. Duration of breastfeeding was longer for intervention mothers than for comparison mothers, and mothers assessed antenatally as having psychosocial distress benefited from the intervention across several areas. There was no significant difference in parent-child interaction between the intervention and comparison groups and no significant overall group differences in child mental, psychomotor, or behavioural development (Kemp et al., 2011). The RCT also found no differences in first-time mothers' outcomes compared to more experienced mothers, unlike other nurse home visiting programs such as the Nurse-Family Partnership program, that assumes their benefits are confined to first-time mothers (Olds et al., 2002).

The MECSH program had many features similar to other successful home visiting programs, for example, nurses delivered the program, it was research-based and paid close attention to fidelity, quality, and supervision (Kemp & Harris, 2012). However, the small sample size of the trial limited the capacity to assess the effectiveness of the MECSH program for women with more complex issues such as domestic violence or drug and alcohol issues (Kemp et al., 2011). The MECSH program has expanded

internationally, despite limited effectiveness to support families experiencing adversity, such as family violence.

3.5.2 right@home

right@home is an Australian nurse home visiting program with similarities to the Nurse-Family Partnership and MESCH programs, however, it seeks to differentiate itself in several ways. right@home identifies a target group of women at risk, aims to improve outcomes for these women and their children, and uses a structured visiting schedule (Goldfeld et al., 2019). right@home differs from other nurse home visiting programs because it was designed and tested for delivery within a universal Maternal and Child Health program. Families were recruited who were identified by using a broad range of psychosocial and socioeconomic risk factors known to negatively impact children's learning and development, rather than families being selected based on risks such as young age, parity, or single parenthood.

Although the researchers acknowledged that families experiencing the most adversity are often the least able to access health services and support, the RCT excluded non-English speaking women or women with severe intellectual disabilities (Goldfeld et al., 2019). Women were excluded if they had <2 out of ten risk factors, dichotomised to yes/no responses to a survey while in the antenatal clinical waiting room. The ten risk factors were young pregnancy, (not) living with another adult, (lack of) support in pregnancy, smoking, global health, long-term illness, anxious mood, (low) education, (low) income, and (not) ever worked (Goldfeld et al., 2019). The study did not include data on how the participants scored, for example, how many were lower risk (under 5), or those scoring higher on the survey. Risk factors such as family violence, homelessness, and drug and alcohol misuse were not included. This lack of detail makes it difficult to assess the program's efficacy for supporting families with complex needs, from a comparative perspective against other studies.

A multidisciplinary team (nurses and social care workers) delivered the program. The number of visits was limited to approximately 25, reportedly giving parents space to build their problem-solving, self-management capacity, and service system engagement. The right@home RCT demonstrated benefit across three primary outcome domains:

parental care, responsivity, and the home learning environment. These outcomes can be compared with more ambitious outcomes in other sustained home visiting programs, such as Nurse-Family Partnership, where the program focuses on maternal life-course outcomes, such as improved maternal mental health, improved education and employment, and improvements in maternal and newborn health, prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits, reduction in crime or domestic violence.

High fidelity and retention were a feature of the right@home RCT, however, a significant limitation of this study is the reliance on parent's reports of outcome measures. More objective measures in addition to parent reporting would help to alleviate response bias. Although direct assessment of child development at ages 3, 4 and 5 years is planned, strengthening the evidence base for measuring child developmental outcomes is needed (Goldfeld et al., 2017).

3.5.3 Australian Nurse-Family Partnership Program

The Australian Nurse-Family Partnership Program (ANFPP) is a nurse-led home visiting program that supports women pregnant with an Aboriginal and/or Torres Strait Islander child. Adapted from the Nurse-Family Partnership program, it aims to improve Aboriginal and Torres Strait Islander mothers, infants, and children outcomes, and disrupt intergenerational cycles of social and economic disadvantage (Zarnowiecki et al., 2018). In 2008, the Nurse-Family Partnership was adapted to be more culturally suitable for use with Aboriginal and Torres Strait Islander families, including the addition of an Aboriginal and Torres Strait Islander Family Partnership Worker to act as a cultural liaison and advisor to managers, nurse home visitors, and clients (ANFPP National Support Service, 2021).

After ten years, breastfeeding rates within the Australian Nurse-Family Partnership Program are higher than comparative national data for First Nations children across all areas. Immunisation targets were consistently met during the last six years of the program delivery. However, a recent review of the program found that the level and nature of client adversity and complexity impacted program delivery (Zarnowiecki et al., 2018). It was found that many clients experienced multiple adversities, including

insecure or overcrowded housing, low education attainment and low literacy, low or no income, unemployment, and family violence. Many were experiencing family violence, with almost one-third of clients experiencing more than two episodes of violence in the previous 12 months.

Issues with program implementation arose in some areas because of inadequate preparation to identify the adaptations required in the local context. Although the adversities that clients in the Australian Nurse-Family Partnership Program were quantitatively similar to those in the Memphis trial of the Nurse-Family Partnership, there was an additional qualitative layer of complexity and disadvantage experienced by Central Australian Aboriginal clients (Zarnowiecki et al., 2018). Client complexity and their living environment were reported to impact program delivery, for example, how and where the program could be delivered, with homelessness and insecure living arrangements a constant feature of these clients' lives (Segal et al., 2018). Problems also occurred with the caseload, which was difficult to sustain according to the Nurse-Family Partnership model, with the increased complexity of the majority of the clients (Zarnowiecki et al., 2018).

3.6 Conclusion

By reviewing a range of enhanced home visiting programs, the limited research into how women experiencing family violence are effectively supported has been identified. Some programs have trialled adjunct intimate partner violence interventions (Jack, Boyle, et al., 2019; Sharps et al., 2016), however, there is very limited research evaluating intimate partner violence screening and intervention in the perinatal period (Hooker, Small, et al., 2016; Sharps et al., 2016). There is even less research focused on nurses' perspectives of family violence work (Burnett et al., 2021), and no study that has examined the roles of the manager in supporting the nurse in family violence practice.

Reviewing the research on sustained nurse home visiting programs in Australia and overseas has enabled insight into the research base for these models of early intervention and parenting support for families, particularly those experiencing additional challenges. The generally robust evidence base for these programs highlights the lack of evidence for the Enhanced Maternal and Child Health program.

Very little is known about the Enhanced Maternal and Child Health program, and specifically, the work of Enhanced Maternal and Child Health nurses supporting women experiencing family violence. Other than anecdotally, almost nothing is known about the roles of Enhanced Maternal and Child Health nurses, their professional and personal characteristics, and how the Enhanced Maternal and Child Health nurse is supported by their manager. To address this gap in scholarly research, the next chapter articulates my research question and aims, including a rationale for the study. The theoretical framework, methodology, and project design are then discussed in Chapter 4.

4. RESEARCH QUESTION AND AIMS

4.1 Rationale

The work of the Maternal and Child Health and Enhanced Maternal and Child Health programs is to improve outcomes for infants and children by working with parents to improve the nurturing environment of the home and family (Department of Health and Human Services, 2019c; World Health Organization, 2018a). The nurse's role in health promotion and Primary Health Care requires careful consideration of the interwoven and overlapping influences of social, environmental, and biological factors (Binns et al., 2016; Bronfenbrenner & Ceci, 1994).

International studies have examined the work of Nurse-Family Partnership nurses and family violence practice (Eckenrode et al., 2017; Jack, Boyle, et al., 2019), and health care professionals' training needs relating to women's experiences of violence (Seymour & Jack, 2021). Some local studies have considered Maternal and Child Health nurse practice more generally (Fraser et al., 2016), or have focused on family violence practice in the universal Maternal and Child Health service (Hooker et al., 2020; Taft et al., 2015). Others have studied the work of other health care practitioners, such as General Practitioners (Kalra et al., 2021; Tarzia et al., 2021).

Until 2021, there had been no evaluation of the Victorian Enhanced Maternal and Child Health program, and a lack of data has hampered effective insight into the program's value, and this inhibits future planning.

4.2 Question

How does the Enhanced Maternal and Child Health program in Victoria support women experiencing family violence?

4.3 Aims

Very few studies have explored the Enhanced Maternal and Child Health program in Victoria, and the Enhanced Maternal and Child Health nurse role, particularly concerning the support of women and children subjected to abuse. In this study, a contemporary exploration of the Victorian Enhanced Maternal and Child Health program and Enhanced Maternal and Child Health nurse family violence practice, and the system-wide measures to support family violence work was undertaken. Identifying and

analysing how the Enhanced Maternal and Child Health program fits within a multi-sector response is critical to ensuring effective support for women experiencing family violence.

The aims of this research study are to:

- Map the Victorian Enhanced Maternal and Child Health program.
- Analyse Enhanced Maternal and Child Health nursing family violence practice.
- Explore the characteristics of Enhanced Maternal and Child Health nurses doing family violence work.
- Explore how Enhanced Maternal and Child Health nurses are supported by their managers.
- Identify the systems needed to support effective family violence nursing practice.

5. THEORETICAL FRAMEWORK AND METHODOLOGY

> As nurses, our ways of knowing have not yet been fully articulated but will emerge if we allow ourselves to see the world through the eyes of practicing (sic) nurses and their clients.
>
> — Schultz & Meleis, 1988, p. 217.

My position as a clinician-researcher means that I have a perspective of the research question from my own lived experience. I sought to understand the clinical wisdom embedded in the everyday practice stories of nurses. It was my own experience that inspired my desire to know more about the work of Enhanced Maternal and Child Health nurses and their managers, and this shaped the research question and the design of the research project.

This approach presupposes expert knowledge on the researcher's part, guiding inquiry and making the investigation a significant undertaking. Heidegger (1962) emphasised that it is impossible to rid the mind of the background of understandings that has led the researcher to consider a topic worthy of research in the first place. Subjective experience is affirmed in contrast to the objectivity and reductionism sought through a positivist perspective (Neubauer et al., 2019).

According to Heidegger, the interpretive process is circular, moving back and forth between the whole and its parts, and between the investigator's previous understanding and what was learned through the investigation. Heidegger referred to this process as entering a hermeneutic circle of understanding that reveals a blending of meanings articulated by the researcher and the participants (Heidegger, 1962).

5.1 Theoretical perspective

My interest in how the Enhanced Maternal and Child Health program supports women experiencing family violence required a research design where I could ask nurses and their managers about their work, collecting rich and diverse data. The interpretivist framework of inquiry supports the ontological perspective that there is not just one reality but multiple constructed realities (Denzin & Lincoln, 2013). Interpretive scholars believe truth is revealed through language, shared consciousness, and other social interactions, and will design qualitative research questions that seek to understand the

how and the why, rather than the who, what, and when (Liamputtong, 2019; Thorne, 2016).

Being a clinician-researcher known to many participants meant that the nurses and managers often said: “You know what I am talking about”. Sharing their experience with an interviewer familiar with the program’s work meant that nurses were very open in disclosing their experiences. Moreover, the participants had a keen desire to share their knowledge and experiences. Recent feedback on one of the papers in this thesis came from one of the participants: “I can’t begin to explain how grateful I am to learn that someone is finally listening to us and wanting to develop this area of expertise” (Rosa).

The investigator and the investigated are interactively linked in creating findings, with the investigator as a “passionate participant” (Toma, 2000, p. 182). The interpretive perspective evolves in the interaction and interpretation between the researcher and study participants.

5.2 Interpretive description

> In interpretive description, credibility rests on the researcher's ability to logically analyse, evidence and justify relationships. The demands of analysis require close researcher engagement and conceptual sensitivity. The researcher brings their history, language, and assumptions to the task of interpreting and actively constructing meaning with participants. Therefore, the integrity in an interpretive description study rests on the shoulders of the researcher to adequately account for their decisions: choosing what to include, what to leave out, what to notice and what to ignore. Quality also depends on the extent to which the findings are seen as applicable, defensible, and relevant to the intended audience.
>
> — Thompson Burdine et al., 2021, p. 342.

Interpretive description is a widely used qualitative research method within nursing. It offers an accessible and theoretically flexible approach to analysing qualitative data (Thompson Burdine et al., 2021). According to Thorne (2016), interpretive description enables the discovery of recurrent patterns or shared realities within human experiences. Interpretive description is grounded in an interpretive

orientation that acknowledges the constructed and contextual nature of human experience (Thompson Burdine et al., 2021).

When a study aims to capture the subjective experience of a group and intends to use this knowledge to inform practice, interpretive description facilitates the development of comprehensive knowledge informed by the perceptions and experiences of the group being studied. This enables a rich understanding, generating knowledge to advance clinical practice (Hunt, 2009; Thorne et al., 1997).

Interpretive Description takes an inductive analytic approach to capture themes and patterns, answer clinical questions about everyday practice, and inform clinical understanding (Thorne, 2016). By sharing clinical stories, nurses have explored their role in the story. This method of gaining insight is familiar to nurses, as story-telling is a relational activity that gathers others to listen, empathise, reflect critically, and problem solve (Riessman, 2012). Stories are co-constructed and negotiated between the people involved to capture nuanced, complex, and multi-layered understandings of the phenomenon (Etherington & Bridges, 2011).

5.3 Project design

Using an explanatory sequential approach increases the likelihood that the sum of data collected would be richer, more meaningful, and ultimately more helpful in answering the research question (Cresswell & Plano Clark, 2017). The two research phases (a cross-sectional study of clinical practice via a quantitative survey and then an interpretive description study comprising qualitative interviews with nurses and managers) facilitated a sequential and progressive empirical investigation (McKenna et al., 2021).

In the first phase of the research, a mapping survey of Enhanced Maternal and Child Health programs across Victoria in December 2016/January 2017 was undertaken. There was anecdotal evidence of a wide variation in Enhanced Maternal and Child Health programs between Local Government Areas. The mapping survey aimed to confirm and explore the variation in Enhanced Maternal and Child Health programs, collecting both quantitative and qualitative data, with the quantitative data analysed

using descriptive statistics. The open-ended questions in the survey were analysed using content analysis.

The survey identified significant variations in clientele, differences in the referral and discharge process, how services collaborate with other services, the staff delivering the programs, and the alternative modes and location of service delivery. This variation in how programs are structured and delivered correlates with the Local Government Area demographics, with the strongest variations between advantaged or disadvantaged urban Local Government Areas, or differences between urban and rural and remote locations. Although the intake criteria and clientele varied, over 20% of the Enhanced Maternal and Child Health clients were experiencing family violence in all services.

The design of the second phase of the research was informed by the survey results, particularly the high levels of family violence that were identified. Semi-structured interviews with 25 Enhanced Maternal and Child Health nurses and 12 managers identified the nurse characteristics and roles of working with women experiencing family violence. The role of managers in supporting nurses was also explored. These data were combined to answer the research question: how does the Enhanced Maternal and Child Health program support women experiencing family violence?

Data derived from semi-structured interviews were analysed using reflexive thematic analysis, a six-phased process developed by Braun and Clarke (2006). I conducted and transcribed the interviews, so the content was familiar on first coding. I then generated preliminary themes from the interview guide; inductive coding identified other themes. A list of thematic nodes and their descriptions was exported from NVivo and reviewed by my supervisors. This enabled a refining of the analysis over several iterations.

5.4 Ethical considerations

The research was approved by the La Trobe University Human Ethics Committee (Ethics approval number 22227) and the Department of Health and Human Services (HHSD/19/129427). The joint approval ensured consideration of ethical matters, such as

risk and safety, data storage and security, privacy and disclosure, and informed consent (Wang & Geale, 2015).

In designing the project, I considered the safety of respondents and the confidentiality of the stories they shared. I was guided by the WHO recommendation for intervention research on violence against women (World Health Organization, 2016a). Informed consent was sought at three points, initially when the participants expressed an interest in being interviewed, then at the start of the interview, and again after the interview was completed (World Health Organization, 2016c). The interviews were anonymised before transcription, and during thematic analysis, each participant was allocated a pseudonym.

There was a risk that the nurses or managers could have become upset in discussing the emotional load of their practice or when describing negative feelings about their work. It was also likely that some participants were themselves a victim-survivor of family violence and discussing the work they did with women experiencing family violence could have caused distress.

I ensured that the nurses and managers were provided with resources and support before the interviews, such as the Nurse and Midwife phone support line, the Employee Assistance Program, or referral to family violence support services if the nurse became distressed by discussing a personal experience of family violence. These resources were included in the Participant Information and Consent Form (PICF). After each interview, I checked by asking, and also by visually observing, whether the participant had experienced any distress due to the discussion. Another member of the research team, an experienced Enhanced Maternal and Child Health nurse and clinical teacher, was available to take calls from participants to discuss their experience after the interview, although none of the participants took up this option.

6. FINDINGS

This work is presented as a thesis with publications. The publications have been incorporated into the main body of the thesis document as PDFs. Additional background, findings, and discussion have been included. Each publication (chapter) is concerned with one element of the overall thesis.

Chapter 7: The Enhanced Maternal and Child Health nursing program in Victoria: a cross-sectional study of clinical practice.

Citation	**Aim**	**Study methods**
Adams, C., Hooker, L., & Taft, A. (2019). The Enhanced Maternal and Child Health nursing program in Victoria: a cross-sectional study of clinical practice. Australian Journal of Primary Health, 25(3), 281-287. https://doi.org/https://doi.org/10.1071/PY18156	To describe the diversity of the Enhanced Maternal and Child Health program between Local Government Areas as it has evolved over the past 15 years	A service-mapping survey with descriptive statistics with open-ended questions, using content analysis.

Chapter 8 is the second published paper - A systematic review and qualitative meta-synthesis of the roles of home visiting nurses working with women experiencing family violence.

Citation	Aim	Study methods
Adams, C., Hooker, L., & Taft, A. (2022). A systematic review and qualitative meta-synthesis of the roles of home-visiting nurses working with women experiencing family violence. Journal of Advanced Nursing, 00, 1-22. https://doi.org/10.1111/jan.15224	To document the roles of home visiting nurses working with women experiencing family violence.	A systematic search and a meta-synthesis of the qualitative research related to the roles of home visiting nurses and family violence work.

Chapter 9: Threads of practice: Enhanced Maternal and Child Health nurses working with women experiencing family violence.

Citation	Aim	Study methods
Adams, C., Hooker, L., & Taft, A. (2021). Threads of Practice: Enhanced Maternal and Child Health Nurses Working with Women Experiencing Family Violence. Global Qualitative Nursing Research, October 2021. https://doi.org/10.1177/23333936211051703	To explore how nurses encountered the clinical presentation of family violence, how they described their role and the challenges that arise in undertaking family violence work.	Interviews with 25 Enhanced Maternal and Child Health nurses to explore their nursing roles in working with women experiencing family violence.

Chapter 10: The characteristics of Maternal and Child Health home visiting nurses undertaking family violence work: an interpretive description study.

Citation	Aim	Study methods
Adams, C., Hooker, L., & Taft, A. (2022). The characteristics of Australian Maternal and Child Health home visiting nurses undertaking family violence work: An interpretive description study. Journal of Advanced Nursing, online (1), 1-15.	To explore the family violence practice of home visiting nurses, focusing on the intrinsic and extrinsic characteristics of the nurse.	Analysis of semi-structured interviews conducted over four months in 2019-2020 using Reflexive Thematic Analysis.

Chapter 11: Managing maternal and child health nurses undertaking family violence work in Australia: A qualitative study.

Citation	Aim	Study methods
Adams, C., Hooker, L., & Taft, A. (2021). Managing maternal and child health nurses undertaking family violence work in Australia: A qualitative study. Journal of Nursing Management, 1-9.	To explore the experience of managers managing Maternal and Child Health nurses undertaking family violence work in Victoria, Australia.	Analysis of 12 semi-structured interviews conducted over four months in 2019-2020 using Reflexive Thematic Analysis.

7. THE ENHANCED MATERNAL AND CHILD HEALTH NURSING PROGRAM IN VICTORIA: A CROSS-SECTIONAL STUDY OF CLINICAL PRACTICE

7.1 Introduction

The Maternal and Child Health EHVS commenced in 1999-2000, with a state-wide program introduced in 2003, known as the Enhanced Maternal and Child Health program. The Enhanced Maternal and Child Health program provides support for families experiencing additional challenges, with additional funding of 15 hours per family (17 hours for rural families). Since its introduction, the Enhanced Maternal and Child Health program has evolved, with each Local Government Area offering a variation on the original program. The guidelines permitted this variation, encouraging Local Government Areas to offer "flexible models of service delivery and service activities based on local demographics and the identified needs of families" (Department of Human Services, 2003).

In 2011, the State government commissioned a study by the Centre for Community Child Health, however this was not publicly released. The study found that the Enhanced Maternal and Child Health program lacked a clear and comprehensive service delivery framework, positing that the service outcomes, aims, and objectives were not fully articulated, and contended that there were no suitable performance measures in place (Moore et al., 2011). The results of the survey confirmed this observation. The variation in Enhanced Maternal and Child Health programs arises from individual Local Government Areas interpreting and applying the Enhanced Maternal and Child Health program's poorly articulated criteria and objectives.

As a manager, I was aware there were significant issues with Enhanced Maternal and Child Health data, and this was confirmed in the survey with respondents who could not provide accurate measures of client engagement. In the survey and subsequent interviews, Enhanced Maternal and Child Health nurses admitted to under-reporting their activities to adhere to the 15-hour guideline for client engagement, or they discharged and re-enrolled clients as they approached 15 hours of service.

In more socially or economically advantaged areas, clients might be automatically admitted to the Enhanced Maternal and Child Health program due to having a

premature baby, twins, or experiencing breastfeeding difficulties. However, in other Local Government Areas with communities experiencing higher social or economic disadvantage levels, these clients would not automatically qualify for referral to the Enhanced Maternal and Child Health program, requiring additional issues of vulnerability. This difference in intake criteria adds to the complexity of evaluating the Enhanced Maternal and Child Health program, as the clientele varies so widely.

This paper describes the variation in the Enhanced Maternal and Child Health program between Local Government Areas as it has evolved over the past 15 years.

7.2 Methods

A mapping survey was undertaken in 2017 to answer specific fundamental questions: Who are the clients of the Enhanced Maternal and Child Health program? What work is being done and where? What clinical planning tools and outcome measures are in place? Approximately 70% of Maternal and Child Health coordinators (managers) responded to the survey (n=55). Using descriptive statistics, and a content analysis of the qualitative data, enabled a thorough mapping of the Enhanced Maternal and Child Health program to be developed.

7.3 Declaration of contribution

Citation	Nature and extent of the candidate's contribution	Nature and extent of the co-author's contribution
Adams, C., Hooker, L., & Taft, A. (2019) The enhanced maternal and child health nursing program in Victoria: a cross-sectional study of clinical practice. Australian Journal of Primary Health, 25(3), 281-287 https://doi.org/https://doi.org/10.1071/PY18156	80% contribution by the candidate. This included study design, data collection, data analysis, interpretation of results, drafting the paper, and manuscript revisions.	20% contribution by the co-authors. This included contributing to data analysis and interpretation. Co-authors also provided a critical review of the paper.

I, Catina Adams, declare that I have made a substantial contribution to this paper, including study design, data analysis, interpretation of results, and drafting the paper. My supervisors, Professor Angela Taft, and Associate Professor Leesa Hooker, contributed to the study design, intellectual input, and editing the manuscript.

I, Angela Taft, declare that Catina Adams made a substantial contribution to this paper. She contributed to all aspects and drafted the manuscript.

7.4 Published paper: The Enhanced Maternal and Child Health nursing program in Victoria: a cross-sectional study of clinical practice

CSIRO PUBLISHING

Australian Journal of Primary Health, 2019, **25**, 281–287
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Research

The Enhanced Maternal and Child Health nursing program in Victoria: a cross-sectional study of clinical practice

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Abstract. The Maternal and Child Health (MCH) service in Victoria comprises a universal service, an enhanced program providing additional support for vulnerable families (EMCH) and a 24-h MCH telephone line. There is anecdotal evidence of variation in EMCH programs between Local Government Areas, and this study aims to explore the variation in EMCH programs to inform future EMCH policy and practice. An online survey was sent to MCH coordinators in Victoria in December 2016 ($n = 79$), with a response rate of 70% (55/79). Quantitative data have been analysed using descriptive statistics, with open-ended questions examined using content analysis. The data confirms that EMCH programs vary significantly across the state. Differences include a variation in referral and intake criteria, different models of service and modes of delivery, differences in EMCH nurse working conditions, issues with data collection and a lack of systematic clinical tools. Variation in the EMCH program is greatest between urban and rural services and between advantaged and disadvantaged urban councils. Lack of consistent service delivery and data collection impairs program evaluation, including outcome measurement and evidence of program effectiveness.

Additional keywords: child health centres, early intervention, family health, maternal–child health centres, women's health services.

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Introduction

Research into the social determinants of health shows that disadvantage affects health, with a clear relationship between the number of parent-based disadvantages and children's social, developmental and health outcomes (World Health Organization 2008; Zare *et al.* 2018). Evidence-based prevention and early intervention can lead to substantial reductions in the factors that place children and families at risk of poor outcomes (Heckman 2006; Middleton and Hardy 2014; Fox *et al.* 2015).

Early intervention programs improve the health and life outcomes for children who are identified at higher risk (Heckman 2006). Nurse home visiting is a key strategy for providing coordinated care for vulnerable and at-risk families (Pavalko and Caputo 2013; Fox *et al.* 2015). Clients in home visiting programs include those experiencing significant social and emotional issues and may also be experiencing family violence (Middleton and Hardy 2014; Davidov *et al.* 2018).

The Victorian Maternal and Child Health (MCH) service works in partnership with parents and early years' services to improve outcomes for children and families (Department of Education and Early Childhood Development 2009). The MCH service is jointly funded by local government and the Victorian State Department of Education and Training (DET), and comprises a universal service, an enhanced MCH home visiting program (EMCH), which provides additional support for vulnerable families and a 24-h MCH telephone line. Victorian MCH nurses have qualifications in nursing, midwifery and child and family health.

The universal MCH service offers 10 key ages and stages (KAS) consultations, which are a schedule of appointments for children and their families from birth to school entry. Almost all families receive a home visit within 2 weeks of birth. By 3.5 years, nearly 65% of families remain engaged with the service (Department of Education and Training 2018) (Table 1).

The EMCH program provides additional support for families experiencing challenges, focussing on specific groups such as Aboriginal and Torres Strait Islander families, teenage mothers, rurally isolated families and culturally and linguistically diverse families (Department of Human Services 2003). Introduced in 2003, this predominantly home visiting program supports families with children up to 12 months of age for up to 15 h (17 h in rural locations).

The aim of the EMCH program is to 'improve the health and wellbeing of children by providing more focussed and intensive support for vulnerable families experiencing significant early parenting difficulties and children identified as being at risk of

What is known about the topic?

- The Enhanced Maternal and Child Health program in Victoria provides support for families experiencing challenges. Anecdotally, the program varies widely across the state, since it was introduced in 2003.

What does this paper add?

- Significant variation in the Enhanced Maternal and Child Health program has been confirmed, including referral and intake criteria, modes of delivery and clinical tools. This variation hampers effective evaluation of the program.

harm' (Department of Human Services 2003, p. 5). The guidelines encourage Local Government Areas (LGAs) to offer 'flexible models of service delivery and service activities ... based on local demographics and the identified needs of families' (Department of Human Services 2003, p. 6).

The EMCH program runs in parallel with the MCH universal service and, over time, each LGA has developed services in response to local need and demand. Until now, the extent of this variation has been anecdotal, without any formal review of the program since its inception.

This variation may be a result of each LGA developing a program and mode of delivery unique to local needs and resources; however, there has been no analysis of this variation. This lack of data hampers an effective analysis of the value of the program and inhibits future planning of enhanced programs for the vulnerable families of Victoria. This study aims to describe the diversity of the service model between LGAs as it has evolved over the past 15 years.

Methods

An online survey was sent via the Municipal Association of Victoria (MAV) to MCH coordinators in all LGAs in Victoria in December 2016 ($n = 79$) using the Qualtrics platform (Qualtrics, 2019, Provo, UT, USA). The survey aimed to identify the variation in the EMCH program across the state – the different clientele and the alternative modes of delivery.

The survey collected both quantitative and qualitative data, with the quantitative data analysed using descriptive statistics. Content analysis (Hsieh and Shannon 2005) using NVivo version 12 (QSR International, 2019, Melbourne, Vic., Australia) examined the MCH coordinators' answers to open-ended questions. To maintain confidentiality, each LGA has been allocated a number, which has been used in the reporting of survey response data below.

The survey data were triangulated with LGA demographic data (Australian Bureau of Statistics 2018) and service utilisation data (Department of Education and Training 2017*b*, 2018; Department of Health and Human Services 2018).

La Trobe University (LTU) and the Insight and Evidence Branch of DET granted ethics approval in 2016 (LTU S16–210 and DET 2016_003246).

Results

Fifty-five surveys were completed, resulting in a return rate of 70% (Table 2).

The interface LGAs are those that form a ring around metropolitan Melbourne and are the fastest growing municipalities, with more than one in four Victorians living in these areas (Department of Local Government 2018).

Analysis of the survey data reveals wide variation in EMCH programs across the state, including: a variation in referral/intake criteria, different models of service, different modes of delivery and differences in EMCH nurse working conditions.

Referral/intake criteria

The original EMCH referral criteria (Department of Human Services 2003) are in the left-hand column, with additional criteria adopted by some LGAs in the right-hand column (Table 3).

This variation in referral criteria tends to correlate with the Socioeconomic Indexes for Areas (SEIFA) status of the LGA (Australian Bureau of Statistics 2018). Communities with higher levels of vulnerability are more likely adhere to the original guidelines for referral, with the additional social pressures and demands of their communities, and pressure on services. LGAs with the highest levels of vulnerability will require two or more criteria for referral to the EMCH program.

> The criteria need to be quite high to get into the program due to the significant social disadvantage within our Council area [LGA 16].

Table 1. Schedule of key ages and stages (KAS) consultations and percentage attended

KAS consultation	% attended
Home visit	100
2 weeks	96.5
4 weeks	96.7
8 weeks	95.2
4 months	94.3
8 months	85.5
12 months	83.0
18 months	72.6
2 years	69.3
3.5 years	64.5

Table 2. Enhanced Maternal and Child Health (EMCH) survey return rate

LGA, local government area

Type of LGA	Number of surveys	(number of LGAs)
Metropolitan	14	(31)
Interface	9	(10)
Regional city	7	(10)
Rural/Remote	25	(28)
Total	55	(79)

Presenting issues

Survey respondents describe EMCH clients as highly complex, presenting with multiple, concurrent issues. Also, the reason for the initial referral can change over the period of engagement.

> . . .the initial referral may be for sleep settling but when the home visit is conducted there is disclosure of relationship difficulties and family violence or drug/alcohol use, or mental health etc. Many of the refugee and asylum seeker families are in such distress due to their experiences in detention or in the camps or in what their Visa is or whether they will get permanent residence or worry of the rest of their family still not in Australia etc. [LGA 33].

Figure 1 outlines mental health, family violence and drug and/or alcohol issues are the most common reason for referral.

Although a family being known to child protection services is one of the original criteria, many of the respondents do not consider this to be grounds enough for referral to the EMCH program and would only refer if the family was not engaged with the universal MCH nurse.

> All the listed criteria would be eligible for EMCH but in reality, some choose to participate in the universal service instead [LGA 26].

Furthermore, clients who fulfil the referral criteria for the EMCH program may not necessarily be referred; for example.

> if maternal mental health is being managed by adult services and the mother is engaged with the universal MCH service [LGA 4].

One coordinator provides this insight:

> Every family can become vulnerable at any time in their parenting experience and by addressing the issues, which are forcing them to be more vulnerable early and quickly, the spiral is halted, and they seem to develop coping strategies and resilience to address the next crisis themselves [LGA 53].

Table 3. Criteria for referral to the Enhanced Maternal and Child Health (EMCH) program
LGA, local government area

Original criteria for referral (Department of Human Services 2003)	Additional criteria used by some LGAs
• Drug and alcohol issues	• Sleep settling
• Mental health issues	• Parenting
• Family violence	• Social isolation
• Homelessness	• Material aid
• Attachment issues	• Emotional support
• Prematurity	• Breastfeeding problems
• Unsupported parents under 24 years	• Multiple birth
• Parent or child with a disability	• Refugee
• Low income	• Transport issues
• Socially isolated	• Toddler behaviour issues
• Single parent families	• Sex workers
• Families known to Child Protection	• Involvement with the justice system

Clinical tools

Some of the tools used by EMCH nurses include a genogram, a locally devised risk assessment template, a risk versus protective factors analysis template, a locally developed triage tool, the Victorian Family Violence Common Risk Assessment Framework (CRAF) (Department of Health and Human Services 2017) and the Family Partnership assessment tool (Davis 2002). One-third of respondents use a systematic intake or triage tool, often via an intake meeting to consider and prioritise referrals. More than half of respondents use an assessment planning tool.

When asked about evaluation of outcomes, most respondents describe key performance indicators (KPIs) or output measures; that is, the number of clients seen, the number of contact hours, nurse/client throughput.

> No, the service has been measured on volume only. Outcomes in enhanced are often not measurable in the short term [LGA 7].

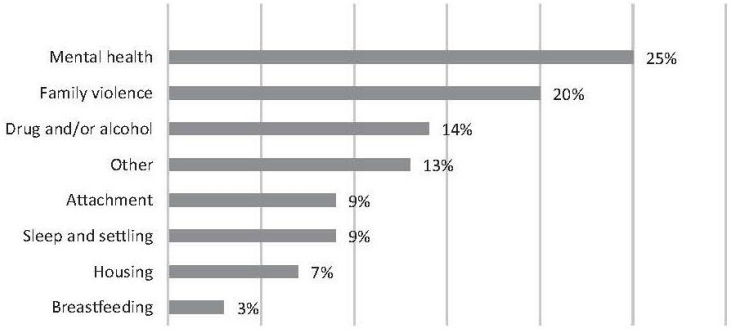

Fig. 1. Most common reason for referral. 'Other' includes prematurity, multiple birth, young parents, refugee background, homeless, Child Protection involvement.

None of the survey respondents describe EMCH work in terms of child and family outcomes.

Different models of the EMCH program

Of the 55 respondents, 40 offer a separate EMCH program, in parallel with the universal MCH service. The remaining 15 LGAs offer the EMCH program within the universal service; that is, the enhanced clients are integrated within the universal nurse's caseload. This variation in model generally relates to the demography of the LGA; that is, a program is more likely to be integrated where there is a low number of EMCH clients and a small team of nurses working over large geographical areas (i.e. rural councils).

One interface LGA has chosen to integrate the EMCH clients because of the type of EMCH program they wish to offer. This coordinator speaks of the value of a continuous relationship with the same nurse:

> We chose to move from the model of having a separate EMCH nurse program. Our funding was limited and only paid for 11 hours/week and this was vastly insufficient to meet the demand . . . Our current system allows each nurse to provide extra services to her own clients. . .in the form of extra home visits, centre visits and telephone contact [LGA 53].

Even in services with a separate EMCH program, there is evidence of clients being 'held' within the universal service, either by the client's preference or until they can be taken up by the EMCH program. Other respondents described the notion of 'shared care', where the client attends both the universal and EMCH programs, with the two running in parallel.

> . . .the Universal MCH staff hold a number of clients who should be considered enhanced but either because the client declines enhanced, or the enhanced workloads prevent the client being transferred to enhanced . . . [LGA 5].

> . . .the nurses in the universal service have some of their own Enhanced clients. These might be clients . . . [who] continue to have appointments with the nurse that knows them. . . [LGA 33].

Home visits

The EMCH clients receive up to 15 h of funding (17 h in rural locations) and the EMCH nurses generally spend 61% of their time doing home visits and 5% of their time in groups. The remaining 33% of the nurse's time is spent in non-face-to-face client work (administration and travel).

There is a wide variation in the number of home visits per day, ranging from two to six per day, with most nurses seeing three clients per day. The length of the home visit also varies widely, ranging from 30 to 120 min, with most visits being 60–90 min in duration. This variation in the number and duration of home visits per days indicates that different work is occurring depending on whether a home visit is 30 min or 2-h long.

The data from this mapping survey have led to the next stage of the research project, which is currently underway; a phenomenological study of EMCH nurses and their supervisors. The study will explore the work undertaken by EMCH nurses and their supervisors in the various locations, and EMCH service models, the barriers and enablers, particularly for EMCH nurses working with women experiencing family violence.

Coordinators are divided in their responses to the optimal number and duration of home visits. One argues for limiting the number to three per day:

> . . .I have tried to manage an extra client to see 4 in a day - but have found without exception that this will mean unpaid overtime and a diluted focus for each of those families. Quality of service is compromised with increased numbers [LGA 27].

Another coordinator argues for shorter, but more frequent visits.

> We find that more complex families do not cope well with very long visits. Even though there may be more issues, it doesn't help addressing them by staying longer. More frequent shorter visits are better [LGA 40].

Length of enrolment

Most EMCH clients receive more than the funded 15 h, with some reportedly enrolled for up to 100 h. More than 50% of respondents report average client enrolment of greater than 16 h, with nearly 20% of clients enrolled for greater than 26 h. The EMCH nurses admit to under-reporting their activities to adhere to the 15-h guideline, or they will discharge and re-enrol clients as they approach 15 h of service.

One coordinator speaks about the

> limited referral pathways, with nurses sometimes holding a degree of risk waiting for services, especially mental health [LGA 12].

This adds to the time that a client remains in the EMCH program. Another coordinator describes the varying nature of the clients in an EMCH caseload:

> Families are at different stages in the level of service response. A staff member may be carrying a case load of 15 clients with five clients each at high, medium, and low intensity [LGA 45].

Although client intensity is more commonly discussed in acute healthcare settings (Prescott *et al.* 1991; MacPhee *et al.* 2017), the MCH nurse managers also categorise clients on the basis of the amount of care they require and the skill level at which that care is provided. In the quote above, the coordinator is referring to clients who may require high-intensity care on initial intake, but over time may need lower-intensity support.

EMCH nurse workload

Annual births range from 26 in the smallest LGA up to nearly 5000 per annum in some of the largest LGAs. Remote services may only have one birth a fortnight, whereas LGAs in the urban growth corridors may be receiving up to 100 new births per week. In metropolitan LGAs, MCH nurse/client ratios vary between 118 and 149 clients per full-time equivalent (FTE) nurse. This variation in nurse/client ratio represents a workload variation of ±20%.

The proportion of EMCH clients ranges from 5 to 25% of the total MCH load, depending on the LGA, and the client profile varies widely between LGAs, in terms of acuity, complexity and chronicity of clients. For example, in some LGAs, where breastfeeding or sleep settling are acceptable criteria for referral, this increases the number of clients in their EMCH program. For other LGAs, often under pressure because of the socioeconomic status of their clientele, these clients would not qualify for referral to the EMCH program. One coordinator argues:

> The program is not funded adequately to address the number of high-risk clients living in no less than nine blocks of high-rise dwellings [LGA 53].

Clinical supervision

Many EMCH nurses report burnout from the heavy workload. One coordinator describes:

> the complexity of the cases and emotional toll this can have on the EMCH nurse. There is a high burn out in this service [LGA 29].

Another coordinator says:

> nurses have been burnt out and need to move back to Universal to regain that sense of optimism [LGA 13].

In metropolitan areas, all EMCH nurses receive supervision, with half receiving both individual and group supervision, usually offered by a psychologist or social worker. Only one-third of nurses in rural/regional services receive clinical supervision. Some teams cite the coordinator or manager as the clinical supervisor. Video conference platforms like Skype have been used to enable some remote nurses to have supervision, but in smaller teams, even this is not an option.

> You can't deliver clinical supervision to yourself. I may call peers in neighbouring shires for a debrief and emotional support [LGA 12].

Remuneration

In ~50% of LGAs, EMCH nurses receive up to five per cent additional remuneration, with varied views on the need for additional remuneration. One coordinator argues:

> I believe that there are good reasons for higher earnings for EMCHNs - Greater responsibilities around risk assessment and management for clients and increased risk to personal safety and wellbeing [LGA 38].

Another coordinator is very firm in her belief that EMCH nurses should be paid the same as universal nurses.

> We do not view enhanced MCH as 'special'. Our nurses can work both universal and EMCH service. I don't see a need for additional payment [LGA 46].

Discussion

In the 15 years since the EMCH program was introduced, our insight into the challenges faced by families has increased. Government reports such as Victoria's Vulnerable Children (State of Victoria 2013), the Roadmap for Reform (Department of Health and Human Services 2016) and the Family Violence Royal Commission (State of Victoria 2016) have raised community expectations for effective prevention and early intervention to improve outcomes for children.

Accordingly, the work of the Universal MCH service has evolved, by incorporating Family Partnership (Keatinge *et al.* 2008) and strength-based models (Kemp *et al.* 2005; Kruske *et al.* 2006; Department of Education and Training 2017*a*). MCH nurses play an increasing role in identifying and supporting women experiencing family violence (State of Victoria 2007), and apply a trauma-informed lens to their care and support of families (Lyons-Ruth *et al.* 2017).

The EMCH program has also evolved, but not in the systematic way the Universal MCH service has. LGAs have developed very different models of EMCH service delivery and service activities. The greatest variation in the EMCH program is between advantaged and disadvantaged urban councils, and between urban, interface and rural and remote locations. The demography of the LGA is the major factor in determining the model of EMCH support and service.

Given these significant variations in clientele, staffing and service model, the EMCH program in Victoria is not a single program. It is, in fact, a range of very different programs, with different clientele, different modes of engagement and arguably different goals. Although a more standardised and consistent service was identified by respondents as desirable, such a standardised approach may not enable the flexibility and responsiveness required by the diverse communities of Victoria.

Nevertheless, a clearer articulation of goals and outcomes will enable a meaningful ongoing evaluation of the service. This will be a challenge for new iterations of the program, as research highlights the difficulty in evaluating child and family outcomes, with a lack of homogeneity of client needs and varied interventions and dosage (Gardner *et al.* 2010; Kemp *et al.* 2011; Filene *et al.* 2013).

A complex service intervention is difficult to evaluate without a program logic. A sustainable EMCH nurse intervention requires model fidelity, nurse skill identification and maintenance, supportive resources and ongoing education and monitoring of clinical work (Hooker *et al.* 2016).

For evaluation to inform policy and practice, emphasis is needed on whether interventions 'work', but also on how they are implemented and how effects differ from one context to another (Medical Research Council 2014). Some areas that may be measured in the future include child cognitive outcomes, maternal life course, parental conflict and family violence, preventing child maltreatment, supporting positive parenting, improving maternal and child health and promoting child development and school readiness (Minkovitz *et al.* 2016).

Conclusion

The EMCH program in Victoria is characterised by a wide variation across all elements, often in response to local needs and resources. An effective evaluation of the program is hampered by poor data integrity, and the lack of homogeneity in referral and intake criteria, models of service and modes of delivery. Under-reporting of service hours and manipulation of EMCH enrolments undermines the integrity of the EMCH program data.

This will be an ongoing challenge for future evaluation of program output and return on investment.

Without a program logic, including systematic clinical intake and discharge tools, measurement of child and family health outcomes is compromised. This hampers an effective analysis of the value of the service to Victorian families.

Conflicts of interest

The authors declare no conflicts of interest.

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7.5 Conclusion

The mapping survey results confirmed our anecdotal belief that Enhanced Maternal and Child Health programs varied significantly across the state. Differences included a wide variation in referral and intake criteria, different models of service, alternative modes of delivery, differences in Enhanced Maternal and Child Health nurse working conditions, issues with data collection and analysis, and a lack of systematic clinical tools. On the one hand, survey respondents suggested this variation in models enabled the flexibility and responsiveness required by the diverse communities of Victoria. However, this variation in Enhanced Maternal and Child Health programs has inhibited any meaningful review and evaluation of the program.

Most Local Government Areas offered a separate Enhanced Maternal and Child Health program (70%) in parallel with the universal Maternal and Child Health service. However, the remaining fifteen Local Government Areas in the study (30%) offer Enhanced Maternal and Child Health within the universal service, meaning that the Enhanced Maternal and Child Health clients are integrated within the universal nurse's caseload. This variation generally relates to the demography of the Local Government Area. The program is more likely to be combined if there are fewer Enhanced Maternal and Child Health clients and a small team of nurses working over large geographical areas, such as rural councils.

The most marked variation between Enhanced Maternal and Child Health programs was how the program was delivered. The number of home visits per day ranged from two to six, with an average of three per day. The length of the home visit varied accordingly, from 30 minutes to two hours. The question this raised for me was: what are the nurses doing on these home visits? With such a variation in time (and frequency) of visits in each Local Government Area, the nurses must be doing very different work. This question led to further research into the roles and characteristics of Enhanced Maternal and Child Health nurses (Chapters 9 and 10).

Enhanced Maternal and Child Health clients have complex needs, with multiple concurrent issues. More than 25% were referred to the Enhanced Maternal and Child Health program with mental health illness, and more than 20% experienced family violence. This proportion of women experiencing family violence is likely higher though,

as family violence in the community is often undisclosed. There is a high correlation between poor mental health and family violence (Brown et al., 2020).

In the qualitative data in the survey, most managers referred to the new Enhanced Maternal and Child Health framework, with the hope that it would bring some consistency to the care model. Other managers felt that offering a more tailored service to the local area's needs was preferable. As one manager observed:

> anyone who's worked in the service knows that each council does its own thing. And 15 years ago, you know, enhanced was introduced with very loose guidelines, so it's not surprising that we ended up with seventy-nine different enhanced programs. (Prue)

In 2019, after the survey was undertaken, the Enhanced Maternal and Child Health program was expanded, and a new Enhanced Maternal and Child Health Model of Care was introduced. The Enhanced Maternal and Child Health program expansion is discussed in Chapter 2 and the new Enhanced Maternal and Child Health program is further discussed in Chapter 12.

8. A SYSTEMATIC REVIEW AND QUALITATIVE META-SYNTHESIS OF THE ROLES OF HOME VISITING NURSES WORKING WITH WOMEN EXPERIENCING FAMILY VIOLENCE

8.1 Introduction

Family violence often begins during pregnancy and increases in severity into the first years of motherhood (Australian Institute of Health and Welfare, 2014; World Health Organization, 2021b). Family violence places the physical and emotional health of the woman and children at risk (Meyer et al., 2021; Sharps et al., 2007). Nurse home visiting is a crucial strategy for providing early intervention and coordinated care for vulnerable and at-risk families (Fox et al., 2015; Pavalko & Caputo, 2013; Saïas et al., 2016).

This systematic review has synthesised qualitative research describing the roles of home visiting nurses working with women experiencing family violence. Previous systematic reviews have explored related research questions, such as home visiting interventions (Van Assen et al., 2020); the effects of sustained home visiting programs for disadvantaged women and children (Molloy et al., 2021); interventions to decrease abuse in children (Levey et al., 2017); the effectiveness of home visiting in reducing partner violence (Prosman et al., 2015); mothers' and health visitors' perceptions of support (Eynon et al., 2012); the economic evidence on home visitation programs (Stamuli et al., 2015); intimate partner violence risk assessment (Nicholls et al., 2013); barriers for health care practitioners in addressing intimate partner abuse (Tarzia et al., 2021); and health care practitioners readiness to address domestic violence (Hegarty et al., 2020). However, home visiting nurses' roles in family violence work have not been previously examined.

8.2 Methods

Using comprehensive systematic review methods (Page et al., 2021; Riesenberg & Justice, 2014), we identified 26 relevant papers, pertaining to the roles of home visiting nurses working with women experiencing family violence. The following manuscript provides a thematic synthesis of the data, identifying the roles of home visiting nurses working in home visiting programs and supporting women experiencing family violence.

8.3 Declaration of contribution

Citation	Nature and extent of the candidate's contribution	Nature and extent of the co-author's contribution
Adams, C., Hooker, L., & Taft, A. (2021). A systematic review and qualitative meta-synthesis of the roles of home visiting nurses working with women experiencing family violence. Journal of Advanced Nursing, 00, 1-22. https://doi.org/10.1111/jan.15224	80% contribution by the candidate. This included study design, data collection, data analysis, interpretation of results, drafting the paper, and manuscript revisions.	20% contribution by the co-authors. This included contributing to data analysis and interpretation. Co-authors also provided a critical review of the paper.

I, Catina Adams, declare that I have made a substantial contribution to this paper, including study design, data analysis, interpretation of results, and drafting the paper. My supervisors, Professor Angela Taft, and Associate Professor Leesa Hooker, contributed to the study design, intellectual input, and editing the manuscript.

I, Angela Taft, declare that Catina Adams made a substantial contribution to this paper. She contributed to all aspects and drafted the manuscript.

8.4 Published paper: A systematic review and qualitative meta-synthesis of the roles of home visiting nurses working with women experiencing family violence

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JAN WILEY

REVIEW

Intimate Partner Violence

A systematic review and qualitative meta-synthesis of the roles of home-visiting nurses working with women experiencing family violence

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Abstract

Aims: To systematically review and synthesize qualitative research exploring home-visiting nurses' roles and identify the challenges for nurses working with women experiencing family violence.

Design: We undertook a thematic synthesis of qualitative studies, focusing on the family violence work of nurse home visitors.

Data sources: A systematic search of four scientific databases (ProQuest Central, CINAHL, MEDLINE, EMBASE) was undertaken in August 2021. Grey literature was searched, including government and non-government research documents, theses, clinical guidelines, policy documents and practice frameworks.

Review methods: Inclusion criteria included research from high-income countries, peer-reviewed qualitative studies in English published from 1985 to 2021, and included research on home-visiting nurse family violence practice. The first author conducted the data search and the initial screening. The first and second authors independently reviewed the full text of 115 papers, identifying 26 for inclusion in the thematic synthesis (Figure 1—PRISMA flowchart).

Results: The thematic synthesis identified two themes: (1) relationship building—with the client, with services and with colleagues/self; and (2) family violence practice—ask/screen, validate/name, assess risk/safety plan and safeguard children.

Conclusion: The thematic synthesis confirmed the multiple roles fulfilled by home-visiting nurses and enabled insight into the challenges they face as they undertake complex and demanding work. The roles of the home-visiting nurse have evolved, with the initial focus on safeguarding children leading to broader family violence nursing practice roles, including the identification of family violence and safety planning discussions with women.

Impact: Our meta-synthesis has confirmed the high-level communication and rapport-building skills required by nurses undertaking complex and conflicting roles. Nurses need support and supervision to undertake emotionally demanding work. Integrated

health systems, clinical practice guidelines and tools, and training programmes need to encompass the breadth and complexity of the roles of these specialist practitioners.

KEYWORDS
family violence, intimate partner violence, maternal and child health, nurse home visiting, nursing role, qualitative meta-synthesis, systematic review

1 | INTRODUCTION

Family violence, described as violence between family members, is a violation of human rights (Kelly, 2006). It is a significant public health concern bringing a heavy burden to health and social service resources, causing social disruption and creating obstacles to child and maternal health and wellbeing (Graves & Gay, 2022). Women and children predominantly experience violence at the hands of male perpetrators (World Health Organization, 2017), and the gendered nature of family violence reflects inequalities in the distribution of power, resources and opportunity (Cox, 2016; State of Victoria, 2016; Webster & Flood, 2015).

In Australia, police are called to a family violence incident every 2 minutes; 12 women per day are hospitalized due to violence; and every 9 days, a woman is killed by a current or ex-partner (Department of Social Services, 2019). Family violence often begins during pregnancy and increases in severity into the first years of motherhood (Australian Institute of Health and Welfare, 2014; World Health Organization, 2021), conferring considerable risk to the physical and emotional health of women and children (Meyer et al., 2021; Sharps et al., 2007).

Maternal and Child Health nurses in Australia are uniquely positioned to inquire about family violence, home visiting most families after the birth of their child and continuing to see families until the child reaches school age. Nurses are usually welcomed into the client's homes because of the universal, non-stigmatizing nature of the service. This relationship of trust may enable the disclosure of challenging personal issues such as family violence (Adams et al., 2019). However, very little is known about how home-visiting nurses work with women experiencing family violence. This systematic review has examined the literature concerned with the roles of home-visiting nurses, enabling an insight into the nursing practice of this complex and demanding work.

2 | BACKGROUND

The terms intimate partner violence, domestic violence and family violence are commonly used in Australia and overseas (Stubbs & Wangmann, 2017); however, each term has its own definition. In Australia, 'family violence' is used in legislation and policy documents, setting it apart from other countries such as New Zealand, the United Kingdom, Canada and the United States (Heyman et al., 2022).

In Australia, family violence refers to violence between family members, typically where the perpetrator exerts power and control over another person. This can be between family members but most commonly occurs in intimate partner relationships (Australian Institute of Health and Welfare, 2018). Most victims are women, and women of childbearing age are at higher risk, with studies finding the prevalence during pregnancy ranging from 4% to 8% (Howard et al., 2013). Family violence confers considerable risk to the woman's health (Hooker, Kaspiew, & Taft, 2016) and negatively impacts the experience of motherhood (Hooker, Samaraweera, et al., 2016). Children exposed to family violence are at an elevated risk for emotional, behavioural and developmental problems (Cutuli et al., 2016; Howard et al., 2013; Meyer et al., 2021).

Nurse home visiting offers coordinated care for families with additional social or medical challenges (Fox et al., 2015; Olds et al., 2014; Pavalko & Caputo, 2013). Clients in home-visiting programmes often include those experiencing significant social and emotional issues and may also be experiencing family violence (Adams et al., 2019). The development of relationships of trust between the nurse and woman can occur as nurses come to know the family, enabling disclosure by women of difficult personal circumstances (Adams et al., 2021b; Jack et al., 2016; Shepherd, 2011). Models of nurse home visiting vary; however, in countries such as the United States, Canada, the United Kingdom, New Zealand and Australia, nurses are baccalaureate-prepared, or college/university prepared, often with additional qualifications in child and family health.

Previous systematic reviews and meta-synthesis have explored related research questions such as the effects of sustained home-visiting programmes for disadvantaged women and children (Molloy et al., 2021); barriers for healthcare practitioners addressing intimate partner abuse (Tarzia et al., 2021); and health care practitioners readiness to address domestic violence (Hegarty et al., 2020). These systematic reviews provide a rich context to explore the enhanced family violence practice roles of the home-visiting nurse, which has not been adequately described in the existing literature.

By examining the qualitative research describing the roles of home-visiting nurses working with women experiencing family violence, we can explore the multiple roles nurses fulfil undertaking family violence practice. Having a better insight into the challenges of these specialist workers, such as the conflicting demands on the nurse, may enable the development of improved resources and models of care and integrated health system responses to better support nursing work.

3 | THE REVIEW

3.1 | Aim

We aimed to systematically review and synthesize qualitative research exploring home-visiting nurses' roles and identify the personal and professional challenges of these nursing roles for nurses working with women experiencing family violence.

3.2 | Design

We undertook a systematic review of the qualitative research pertaining to nurse home visitors and their roles with families experiencing family violence. Our data extraction focused on the findings and discussion sections of the identified studies. We used NVIVO (QSR International, 2020) to code the data and complete the thematic analysis. We developed themes inductively, comparing data from each study for similarities and differences.

3.3 | Search methods

This systematic review was registered with PROSPERO (CRD42021272813). Four databases were searched in August 2021: ProQuest Central, CINAHL, MEDLINE, EMBASE. Grey literature was searched, including government reports, theses, practice guidelines and policy documents (Paez, 2017). Citation and reference harvesting occurred.

The database searches used keywords: Child and family health nurse (and its international equivalents); family violence (and its synonyms) and home visit (see Table 1). There was no predetermined upper or lower limit in the number of studies to be included. The initial screening and exclusion process determined there was enough qualitative research to provide a meaningful synthesis.

We included articles with the following characteristics in the systematic review: they were peer-reviewed, used qualitative methods for data collection, had been analysed using qualitative methods, were in English language, published from 1985 to 2021, and conducted in high-income countries.

We excluded quantitative papers such as randomized-controlled trials and surveys without qualitative results and clinical case studies and surveys unless they contained open-ended qualitative questions analysed using qualitative methods. We excluded studies with nurses delivering hospital-in-the-home care, acute care, support for chronic illness and studies focusing on paraprofessional home visitors. Other papers were excluded if they were related to domestic violence towards women without children, domestic violence towards men, abuse towards children only and studies focusing on health care professionals generally unless data on nurses was an identifiable subset of the qualitative data.

TABLE 1 Search strategy

DATABASE	keywords
CINAHL PROQUEST MEDLINE EMBASE GOOGLE SCHOLAR (grey literature)	nurs* **AND** (role* **OR** scope* **OR** practi*)
Limiters: • Peer Reviewed • English Language • Published Date: 1985 - 2021 • Geographic Subset: Australia & New Zealand, Canada, Continental Europe, Europe, UK & Ireland, USA.	Maternal and Child Health nurs* **OR** Public health nurs* **OR** Health visit* **OR** Child and family health nurs* **OR** Community health nurs* **OR** Plunket
	Family violence **OR** Domestic violence **OR** Intimate partner violence **OR** Domestic abuse **OR** Partner abuse
	Well child **OR** Home visit

3.4 | Search outcome

The first author (CLA) searched the data, identifying the papers from searched databases and other sources and uploading the files into COVIDENCE (Covidence, 2021). Duplicates were removed, and CLA applied the predetermined exclusion criteria to exclude records by screening titles and abstracts. The first and second authors (CLA and LH) reviewed the full text of included papers and screened them for inclusion or exclusion. A third assessor (AT) reviewed three papers under dispute, and they were excluded from the final selection as they did not pertain to nurse family violence work.

We found 1631 studies, 1516 were excluded, and 115 full-text studies assessed, with a final sample of 26 papers dating from 1992 to 2021. A PRISMA flowchart (Page et al., 2021) documents the selection process and the number of articles, with reasons excluded at each stage (Figure 1).

3.5 | Data extraction

Using a data extraction template, we described the following study characteristics of the included texts:

- Study ID,
- Title, author(s),
- Year of publication,
- Country where the study was conducted,

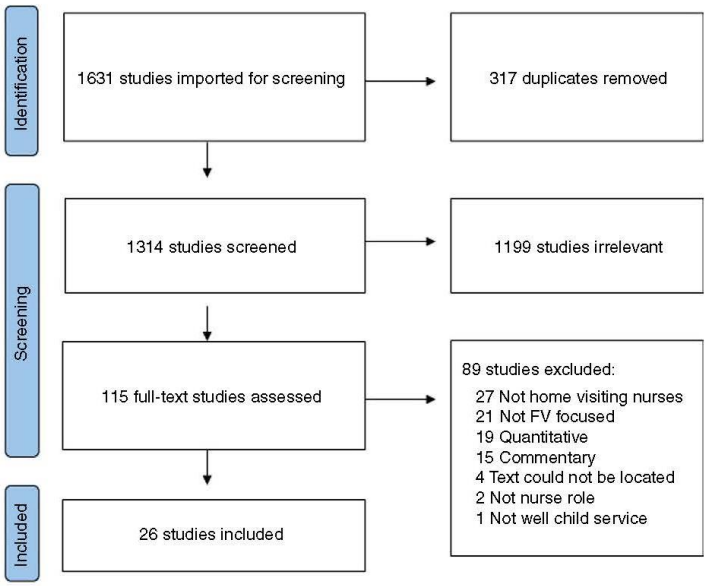

FIGURE 1 PRISMA flowchart

- The aim, analysis method, data collection,
- Number of participants, gender, and
- Level of nursing education, family violence training, years of experience (where given).

Table 2 summarizes the included studies.

3.6 | Quality appraisal

Using the CASP (Critical Appraisal Skills Programme, 2021), two reviewers (CLA and LH) independently reviewed all included studies. We determined that all 26 included studies were methodologically sound, with some 'minor concerns' noted (Table 3). The minor concerns related to one or both of two aspects—the relationship between the participant and the researcher was not adequately considered (reflexivity), or ethical issues were not clearly identified or articulated (including lacking evidence of ethics approval). In appraising the research using CASP, we identified a development over time in the quality of nursing scholarship, with recent papers more clearly articulating the elements of research design and analysis.

3.7 | Synthesis

We used NVIVO (QSR International, 2020) to assist with the thematic synthesis. The Findings and Discussion sections from the selected studies were analysed, and the first author (CLA) undertook inductive coding. Thomas and Harden (2008) recommend this approach to qualitative synthesis—coding the data, preserving the original language, grouping the data into descriptive codes, and identifying themes. This coding method enabled us to identify the roles of home-visiting nurses as described in the studies and cluster them into themes. A second reviewer (second author LH) reviewed the coding spreadsheets, and any differences in opinion about the descriptive themes were discussed, achieving consensus.

3.8 | Reflexivity

The first author (CLA) is a clinician-researcher who has worked as an enhanced home-visiting nurse, working with women experiencing family violence. Bringing their own experience, knowledge and insight (Aronowitz et al., 2015) could be considered a strength and a weakness. Reflexive journaling enabled reflection on the researcher's position (Rowland, 2016), supported by regular meetings with research supervisors.

4 | RESULTS

Our search identified 26 studies published between 1996 and 2021. Figure 1 depicts the flow of studies presented following the PRISMA guidelines (Page et al., 2021). We drew on studies from a range of countries—Australia (3), Canada (10), New Zealand (1), the United Kingdom (8) and the United States of America (4). These

studies describe the work of nurses in a range of family health and support programmes, such as the work of Maternal and Child Health Nurses (3); Nurse-Family Partnership nurses (6); Nurse health visitors (9); New Zealand's Plunket nurses (1); and Public Health Nurses (7).

Nurse home visiting provides coordinated care for families with additional challenges (Eckenrode et al., 2000; Molloy et al., 2019; Pavalko & Caputo, 2013; Saïas et al., 2016). Clients in home-visiting programmes often include those experiencing significant medical, social and emotional issues and may include those experiencing family violence. Some home-visiting programmes commence antenatally, aiming to improve pregnancy outcomes. Others are postnatal programmes aiming to improve the health and wellbeing of parents and children.

In all these studies, the nurse home-visiting workforce is predominantly female, staffed by college/university-educated nurses, often with additional child and family health training. The Maternal and Child Health service in Victoria, Australia, offers a universal programme of 10 Key Ages and Stages consultations for children from birth to school age (Hooker, Small, & Taft, 2016). Plunket nurses in New Zealand offer a universal, well-child government-funded service, offering eight consultations from birth to preschool. Health Visitors in the United Kingdom provide home visits under the framework of the Healthy Child Programme, with enhanced programmes such as Sure Start and the Family Nurse Partnership providing an enhanced home-visiting programme for families with additional challenges (Robling et al., 2016). In the United States and Canada, the Nurse-Family Partnership engages with vulnerable first-time mothers, commencing antenatally with a sequence of regular home visits until the child is 2 years old (Olds et al., 2019).

Nurse home visitors work with women experiencing family violence, and the data from these qualitative studies provided insight into the roles of nurses working with women experiencing abuse. The thematic synthesis identified two themes: (1) *Relationship Building*—with the client, with services and with colleagues/self; and (2) Family Violence Practice—ask/screen, validate/name, assess risk/safety plan and safeguard children (Figure 2).

4.1 | Relationship building

4.1.1 | Relationship building with the client

Building a relationship between the nurse and the woman was identified by most studies (24 out of 26) as the primary nursing role (see Table 4). Building a supportive relationship allowed trust to grow (Cox et al., 2001) and facilitated the disclosure of personal issues such as family violence (Bradbury-Jones et al., 2014; Jack et al., 2016), increasing options for women and children to receive support (Davidov et al., 2012). Cuthill and Johnston described the delicate and fragile relational endeavour (2019) where home visitors attend the home by invitation. Other researchers described the bond of trust that may enable discussions about experiences of violence between the nurse and the client and when the client does not feel rushed (Jack et al., 2016).

Many researchers characterized the relationship between the nurse and client as therapeutic (Cuthill & Johnston, 2019; Davidov et al., 2012; Dmytryshyn et al., 2015), highlighting the amount of time it takes to establish the relationship (Jack et al., 2016; Jack, Kimber, et al., 2021). In the research related to the Nurse-Family Partnership, the nurses' primary role was to establish, maintain and evaluate a 'therapeutic alliance' (Jack et al., 2016; Jack, Kimber, et al., 2021). Contemporary clinical nursing skills promote empowerment and client self-efficacy, compared with past practices where nurses may have focussed on health education rather than relationship (Dmytryshyn et al., 2015).

Other researchers spoke of the substantial benefit to the relationship of having the same nurse over time (continuity of carer), as Public Health Nurses follow women through pregnancy, postpartum screening, infant and child immunisations and follow-up home visits (Hughes, 2010; Taylor et al., 2013). Continuity in the relationship facilitated disclosure (Vallant et al., 2007) by building a relationship with the client before expecting her to disclose violence in her relationship and facilitated client retention in the home-visiting programme (Dmytryshyn et al., 2015).

The nurse's clinical skills enable observation of maternal strengths, including positive maternal–infant interactions, which can mitigate against actual or perceived risks (Jack et al., 2016). Cuthill identified that working in the client's home may remove some professional barriers, facilitating relationship building (Cuthill & Johnston, 2019). However, nurses in many of the studies were aware of the double-edged nature of the nurse-client relationship,

> Nurses consistently described their relationships with the families they served as being critical for the program to be successful, and this cornerstone was also related to how they managed the process of reporting (Holland et al., 2021, p. 7).

Peckover also explored the duality of the nurse-client relationship, on the one hand, describing the relationship-building techniques as 'noncoercive', establishing a social relationship with the woman by talking and listening, and on the other hand, in terms of 'disciplinary power' (Peckover, 2002b). Relationships between nurses and their clients were described as complicated, with the policing role often in conflict with the supportive role (Peckover, 2002b).

The relational aspects of 'care' and 'support' were explored, with researchers noting that care, compassion and empathy have historically defined the nursing identity (Cuthill & Johnston, 2019). Simply being there, being a consistent presence in the client's life, was considered a vital nurse role (Dmytryshyn et al., 2015; Webster et al., 2018). Zerwekh spoke of the additional challenge for nurses when building trust, especially when 'increasing numbers of clients have little experience with trust' (1992, p. 18). The

TABLE 2 Included studies

Authors	Title	Year	Country where the study was conducted	Aim of study	Analysis method	Data Collection
Pamela Abbott, Emma Williamson	Women, Health and Domestic Violence	1999	UK	To assess family violence awareness, knowledge, perception of the Health Care Practitioner role and health service role	Other	Survey with open-ended questions
Caroline Bradbury-Jones, Julie Taylor, Thilo Kroll,Fiona Duncan	Domestic abuse awareness and recognition among primary healthcare professionals and abused women: a qualitative investigation	2014	UK	To investigate the dynamics of domestic abuse awareness and recognition among primary healthcare professionals and abused women.	Framework analysis	Interviews
Helen Cox, Penelope Cash, Barbara Hanna, Frances D'Arcy-Tehan, Carol Adams	Risky business: stories from the field of rural community nurses' work in domestic violence.	2001	Australia	To analyse the understandings and perceptions of Australian rural nurses supporting women experiencing family violence	Thematic analysis (unspecified)	Focus groups
Fiona CuthillLesley Johnston	Home level bureaucracy: moving beyond the 'street' to uncover the ways that place shapes the ways that community public health nurses implement domestic abuse policy	2019	UK	To explore the day-to-day experiences of Home Visitors using a 'routine enquiry' approach to domestic abuse with women following childbirth.	Thematic analysis (unspecified)	Interviews
Danielle M. Davidov, Susan M. Jack, Stephanie S. Frost, Jeffrey H. Coben	Mandatory Reporting in the Context of Home Visitation Programs	2012	Canada	To identify and describe issues related to mandatory reporting within the context of home visitation.	Content analysis	Focus groups
Florence DicksonLeslie Tutty	The role of public health nurses in responding to abused women.	1996	Canada	To focus on the thoughts, feelings, and actions of 125 public health nurses when working or contemplating working with women who are abused.	Not specified	Survey with open-ended questions
Anne L Dmytryshyn, Susan M Jack, Marilyn Ballantyne, Olive Wahoush,Harriet L MacMillan	Long-term home visiting with vulnerable young mothers: an interpretive description of the impact on public health nurses.	2015	Canada	To identify and describe the nature of the challenges and perceived benefits experienced by all PHNs working in the NFP program in Hamilton, Ontario, Canada and to explore what was needed to effectively deliver the program.	Interpretative description	Interviews
Tracy A. Evanson	Intimate partner violence and rural public health nursing practice: challenges and opportunities.	2006	United States	To describe the potential role of home-visiting MCH nurses in Domestic Violence prevention and intervention	Other	Interviews
Amanda M. Ferrara, Miranda P. Kaye, Grejika Abram-Erby,Sean Gernon, Daniel F. Perkins	Army home visitors' implementation of military family violence prevention programming in the context of the COVID-19 pandemic.	2021	United States	To examine how a shift to a telehealth model has impacted Army Home Visitors' services, practice, and professional role.	Grounded Theory	Focus groups
Marion Frost	Health visitors' perceptions of domestic violence: the private nature of the problem.	1999	UK	To investigate health visitors' perceptions of domestic violence	Content analysis	Interviews
Angela Henderson	Factors influencing nurses' response to abused women: what they say they do and why they say they do it.	2001	Canada	To analyse how nurses make sense of the interface between themselves and their nursing actions with abused women	Not specified	Interviews

Participants	Level of nursing qualification	FV trained?	Number of participants	Male/ female	Years of experience as a nurse home visitor
Nurse Health Visitors	Nurse or midwife, postgraduate qualification in community pubic health nursing	58% have done specific FV training	59	All female	Not included
Nurse Health Visitors	Nurse or midwife, postgraduate qualification in community pubic health nursing	No specific FV training described	16	Not disclosed, however, most health vistiors are female.	Not included
Maternal and Child Health (MCH) nurses	Registered nurse and midwife, postgraduate qualification in child, family and community nursing	No specific FV training described	24	All female	Not included
Nurse Health Visitors	Nurse or midwife, postgraduate qualification in community pubic health nursing	100% have done specific FV training	17	all female	6 months–30 years (range)
Nurse Family Partnership (NFP) nurses	Majority Bachelor degree quaifiied nurse (92%)	No specific FV training described	48	Not disclosed, however, most PHN and NFP are female.	Average: Nursing = 19 years NFP = 4.4 years
Public Health nurses (PHN)	Majority Bachelor degree quaifiied nurse (93.6%)	No specific FV training described	125	All female	Average: PHN = 12 years
PHN (6) NFP nurses (4)	Bachelor degree quaifiied nurse	No specific FV training described	10	Not disclosed, however, most PHN and NFP are female.	Average: Nursing = 18 years NFP = 10 years
Public Health Nurses	Bachelor degree quaifiied nurse	100% have done specific FV training	13	All female	Average: Nursing = 15 years PHN = 13 years
Home visitors (US)	Bachelor degree quaifiied nurse	No specific FV training described	20	All female	< 1 year = 43% 1–5 years = 7% > 5 years = 50%
Nurse health visitors	Nurse or midwife with postgraduate qualification in community pubic health nursing	No specific FV training described	24	Not disclosed, however, most health vistiors are female.	> 6 years = 83%
Public Health nurses	Majority Bachelor degree quaifiied nurse (% not specified)	No specific FV training described	49	48 female, 1 male	6 months–33 years (range)

TABLE 2 (Continued)

Authors	Title	Year	Country where the study was conducted	Aim of study	Analysis method	Data Collection
Leesa Hooker, Rhonda Small, Cathy Humphreys, Kelsey HegartyAngela Taft	Applying normalization process theory to understand implementation of a family violence screening and care model in maternal and child health nursing practice: a mixed method process evaluation of a randomised controlled trial.	2015	Australia	To investigate the MCH nursing context surrounding the MOVE trial and using NPT; identify the barriers and enablers that have impacted on the successful implementation of the MOVE model.	Framework analysis	Interviews
Leesa Hooker, Rhonda Small,Angela Taft	Understanding sustained domestic violence identification in maternal and child health nurse care: process evaluation from a 2-year follow-up of the MOVE trial	2016	Australia	To investigate factors contributing to the sustained domestic violence screening and support practices of Maternal and Child Health nurses 2 years after a randomized controlled trial	Framework analysis	Interviews
Judy Hughes	Putting the pieces together: how public health nurses in rural and remote Canadian communities respond to intimate partner violence.	2010	Canada	To document how nurses identify female clients who have experienced intimate partner violence, how they intervene in these situations and the challenges of responding in isolated rural practice contexts	Thematic analysis (unspecified)	Interviews
Susan M. Jack, Ellen Jamieson, C. Nadine Wathen, Harriet L. MacMillan	The feasibility of screening for intimate partner violence during postpartum home visits.	2008	Canada	To examine public health nurses' (PHNs) perceptions of screening for Intimate Partner Violence (IPV); explore the feasibility, from the perspective of PHNs, of IPV screening during home visits; describe PHNs' screening practices; and describe PHN training in relation to IPV.	Content analysis	Interviews
Susan M Jack, Marilyn Ford-Gilboe, C Nadine Wathen, Danielle M Davidov, Diane B McNaughton, Jeffrey H Coben, David L Olds, Harriet L MacMillan	Development of a nurse home visitation intervention for intimate partner violence.	2012	United States	To summarize the process that was conducted to develop the Intimate Partner Violence intervention and provide an overview of the intervention's primary elements.	Content analysis	Focus groups
Susan M Jack, Marilyn Ford-Gilboe, Danielle Davidov, Harriet L MacMillan	Identification and assessment of intimate partner violence in nurse home visitation	2016	Canada	To develop strategies for the identification and assessment of intimate partner violence in a nurse home visitation programme.	Content analysis	Focus groups
Susan M. Jack, Melissa Kimber, Danielle Davidov, Marilyn Ford-Gilboe, C. Nadine Wathen, Christine McKee, Masako Tanaka, Michael Boyle, Carolyn Johnston,Jeffrey Coben, Mariarosa Gasbarro, Diane McNaughton, Ruth O'Brien, David L. Olds, Philip Scribano, Harriet L. MacMillan	Nurse Family Partnership nurses' attitudes and confidence in identifying and responding to intimate partner violence: An explanatory sequential mixed methods evaluation	2021	Canada	To evaluate the effect of an intimate partner violence intervention education component on nurses' attitudes in addressing intimate partner violence	Interpretative description	Interviews

Participants	Level of nursing qualification	FV trained?	Number of participants	Male/ female	Years of experience as a nurse home visitor
Maternal and Child Health nurses	Registered nurse and midwife, with postgraduate qualification in child, family and community nursing	100% have done specific FV training	23	All female	<1 year = 3%1–9 years = 37%10–20 years = 28% >20 years = 32% (across both arms of study)
Maternal and Child Health nurses	Registered nurse and midwife, with postgraduate qualification in child, family and community nursing	100% have done specific FV training	14	All female	<1 year = 10%1–9 years = 33%10–20 years = 27% >20 years = 30% (across both arms of study)
Public Health nurses	Majority Bachelor degree quaifiied nurse (% not specified)	No specific FV training described	6	Not disclosed, however, most PHN are female.	Ranged from 2.5 to 35 years (average 13.8 years).
Nurse Family Partnership nurses	Bachelor degree quaifiied nurse	100% have done specific FV training	6	Not disclosed, however, most PHN are female.	Nursing - ranged from 4 to 28 years (average 19 years). PHN—ranged from 1 to 25 years (average 7 years).
Nurse Family Partnership nurses	Bachelor degree quaifiied nurse	100% have done specific FV training	22	Not disclosed, however, most PHN are female.	Not included
Nurse Family Partnership nurses	Bachelor degree quaifiied nurse	100% have done specific FV training	27	Not disclosed, however, most PHN are female.	Not included
Nurse Family Partnership nurses	Bachelor degree quaifiied nurse	100% have done FV training. Intervention arm have done enhanced FV training and education	47	All female	Provided for overall study, but not included for interview participants only.

TABLE 2 (Continued)

Authors	Title	Year	Country where the study was conducted	Aim of study	Analysis method	Data Collection
Beverly Leipert	Women's health and the practice of public health nurses in northern British Columbia.	1999	Canada	To explore the practice of public health nurses	Thematic analysis (unspecified)	Interviews
Sue Peckover	Supporting and policing mothers: an analysis of the disciplinary practices of health visiting.	2002	UK	To discuss whether the professional practices inherent in British health visiting can be understood in terms of support or surveillance	Framework analysis	Interviews
Sue Peckover	Focusing upon children and men in situations of domestic violence: an analysis of the gendered nature of British health visiting.	2002	UK	To study British health visiting practice in relation to women experiencingdomestic violence.	Content analysis	Interviews
Sue Peckover	Health visitors' understandings of domestic violence.	2003	UK	To explore nurses' understandings of the extent and nature of domestic violence in the context of their work.	Framework analysis	Interviews
Julie Taylor, Caroline Bradbury-Jones, Thilo KrollFiona Duncan	Health professionals' beliefs about domestic abuse and the issue of disclosure: a critical incident technique study	2013	UK	To explore community health professionals' beliefs about domestic abuse and the issue of disclosure	Framework analysis	Interviews
Sharon Vallant, Jane Koziol-McLain, Brenda Hynes	Plunket Family Violence Evaluation Project	2007	New Zealand	To identify partner violence screening enablers and barriers	Interpretative description	Focus groups
Fiona Webster, Michelle Sangster Bouck, Bonnie Lynn Wright, Pam Dietrich	Nursing the social wound: public health nurses' experiences of screening for woman abuse.	2006	Canada	To describe the experiences of public health nurses (PHNs) who screen for woman abuse within their clinical practice.	Grounded Theory	Interviews
Joyce V. Zerwekh	Laying the groundwork for family self-help: locating families, building trust, and building strength	1992	United States	To describe the expert competencies of public health nurses who visit society's most vulnerable young families in their homes.	Grounded Theory	Interviews

nurses in Vallant et al.'s study also spoke about care in personal terms:

> Because I do not want to break the relationship between me and my client. I want to let her know that I care for her, and I value her, and I want her to trust me as I trust her. And I want her to know that I am there for her and I want her to feel safe with me (Vallant et al., 2007, p. 11).

Nurses in another study believed their expression of personal integrity made the difference in caring for clients, providing honesty, stability, consistency and being straightforward and honest. 'Sometimes the doing is not doing, but just being there.' (Zerwekh, 1992, p. 18). Some researchers recognized that this relationship could place the Public Health Nurse at physical and emotional risk (Dmytryshyn et al., 2015). As Cox identified,

> it is clear that nurses work constantly with considerable danger and with considerable courage, and with far greater skill than they often give themselves credit for (Cox et al., 2001, p. 284).

The acceptance of the Home Visitor in the home is mainly due to the non-stigmatizing nature of the nursing service (Frost, 1999). Although relationship-based, underpinning the Nurse-Family Partnership programme is the nursing process of assessment, diagnosis, planning, intervention and evaluation (Jack et al., 2016). Evanson reported nurses speaking positively about their generalist role, resulting in benefits from home-visiting work with families experiencing family violence (Evanson, 2006). Nurses used their expertise and ability to assess and use screening questions to identify women and children at risk of violence. Using nursing observational skills, nurses clinically evaluated the client's situation (Vallant et al., 2007). Over the course of the relationship, nurses were able to work with women on family violence issues,

Participants	Level of nursing qualification	FV trained?	Number of participants	Male/ female	Years of experience as a nurse home visitor
Public Health nurses	Bachelor degree quaifiied nurse	No specific FV training described	10	All female	PHN - ranged from 1 to 26 years (average not provided).
Nurse health visitors	Nurse or midwife with postgraduate qualification in community pubic health nursing	No specific FV training described	24	Not disclosed, however, most health vistiors are female.	Not included
Nurse health visitors	Nurse or midwife, postgraduate qualification in community pubic health nursing	No specific FV training described	24	Not disclosed, however, most health vistiors are female.	Not included
Nurse health visitors	Nurse or midwife, postgraduate qualification in community pubic health nursing	No specific FV training described	24	Not disclosed, however, most health vistiors are female.	Not included
Nurse health visitors	Nurse or midwife, postgraduate qualification in community pubic health nursing	No specific FV training described	16	Not disclosed, however, most health vistiors are female.	Not included
Plunkett nurses	Nurse, postgraduate certificate in child health	Most have done "some" FV training	17	Not disclosed, however, most Plunket nurses are female.	Not included
Public Health nurses	Bachelor degree quaifiied nurse	100% have done specific FV training	11	All female	PHN - ranged from <5 to 20 years (average not provided).
Public Health nurses	Majority Bachelor degree quaifiied nurse (97%)	No specific FV training described	30	Not disclosed, however, most PHN are female.	Nursing - average 20 years PHN— average 14 years

even though the original engagement may have been about child development or parenting difficulties (Hughes, 2010).

4.1.2 | Relationship building with other services

Cuthill described the diversity of nurse roles, where on the one hand, the home visitor fulfils the more traditional role of 'mother's friend' and juxtaposed this with 'agent for reform' (Cuthill & Johnston, 2019, p. 1438). Most studies articulated this advocacy role for nurses—listening, empowering and referring (Cox et al., 2001) and supporting women in navigating social service systems (Jack et al., 2012). Knowing local services and relationships with local service providers enabled advocacy and professional collaboration and communication (Abbott & Williamson, 1999; Dickson & Tutty, 1996; Evanson, 2006; Ferrara et al., 2021; Henderson, 2001; Webster et al., 2006).

Researchers spoke of the benefit of early engagement with social services and the need for nurses to know the types of community resources available to women experiencing intimate partner violence and how to access these supports (Hughes, 2010; Jack, Kimber, et al., 2021). Referring may also involve educating the client on navigating other health, social, education, child care, employment, justice, domestic violence and housing services (Jack et al., 2012). Nurse-Family Partnership nurses provide education included information on social services agencies such as housing, legal aid, financial services (Abbott & Williamson, 1999; Dickson & Tutty, 1996) and Child Protective Services (Davidov et al., 2012).

Hughes (2010) described the additional challenges for Public Health Nurses living in rural areas. The nurses in their study spoke of the difficulties of reduced access to community resources which increased the challenges for these Public Health Nurses (Hughes, 2010). Evanson spoke further about rural Public Health Nurses who were more likely to have personal relationships with providers in other agencies, making it easier to advocate for women when connecting with community services (Evanson, 2006).

TABLE 3 Quality appraisal of the studies

Authors	Title	Year	Statement of research aims?	Qualitative method appropriate?	Research design appropriate?
Pamela Abbott, Emma Williamson	Women, Health and Domestic Violence	1999	Yes	Yes	Yes
Caroline Bradbury-Jones, Julie Taylor, Thilo Kroll,Fiona Duncan	Domestic abuse awareness and recognition among primary healthcare professionals and abused women: a qualitative investigation	2014	Yes	Yes	Yes
Helen Cox, Penelope Cash, Barbara Hanna, Frances D'Arcy-Tehan, Carol Adams	Risky business: stories from the field of rural community nurses' work in domestic violence.	2001	Yes	Yes	Yes
Fiona CuthillLesley Johnston	Home level bureaucracy: moving beyond the 'street' to uncover the ways that place shapes the ways that community public health nurses implement domestic abuse policy	2019	Yes	Yes	Yes
Danielle M. Davidov, Susan M. Jack, Stephanie S. Frost, Jeffrey H. Coben	Mandatory Reporting in the Context of Home Visitation Programs	2012	Yes	Yes	Yes
Florence DicksonLeslie Tutty	The role of public health nurses in responding to abused women.	1996	Yes	Yes	Yes
Anne L Dmytryshyn, Susan M Jack, Marilyn Ballantyne, Olive Wahoush,Harriet L MacMillan	Long-term home visiting with vulnerable young mothers: an interpretive description of the impact on public health nurses.	2015	Yes	Yes	Yes
Tracy A. Evanson	Intimate partner violence and rural public health nursing practice: challenges and opportunities.	2006	Yes	Yes	Yes
Amanda M. Ferrara, Miranda P. Kaye, Grejika Abram-Erby,Sean Gernon, Daniel F. Perkins	Army home visitors' implementation of military family violence prevention programming in the context of the COVID-19 pandemic.	2021	Yes	Yes	Yes
Marion Frost	Health visitors' perceptions of domestic violence: the private nature of the problem.	1999	Yes	Yes	Yes
Angela Henderson	Factors influencing nurses' response to abused women: what they say they do and why they say they do it.	2001	Yes	Yes	Yes
Leesa Hooker, Rhonda Small, Cathy Humphreys, Kelsey HegartyAngela Taft	Applying normalization process theory to understand implementation of a family violence screening and care model in maternal and child health nursing practice: a mixed method process evaluation of a randomised controlled trial.	2015	Yes	Yes	Yes
Leesa Hooker, Rhonda Small,Angela Taft	Understanding sustained domestic violence identification in maternal and child health nurse care: process evaluation from a 2-year follow-up of the MOVE trial	2016	Yes	Yes	Yes
Judy Hughes	Putting the pieces together: how public health nurses in rural and remote Canadian communities respond to intimate partner violence.	2010	Yes	Yes	Yes
Susan M. Jack, Ellen Jamieson, C. Nadine Wathen, Harriet L. MacMillan	The feasibility of screening for intimate partner violence during postpartum home visits.	2008	Yes	Yes	Yes

Recruitment strategy appropriate?	Data collection method described?	Relationship between researcher and participants adequately considered?	Ethical issues taken into consideration?	Data analysis sufficiently rigorous?	Clear statement of findings—supported by evidence?	Overall assessment of quality
Yes	Yes	No	No	Yes	Yes	7/9 = some concerns
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	Yes	Yes	Yes	Yes	no concerns
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	No	Yes	Yes	7/9 = some concerns
Yes	Yes	Yes	Yes	Yes	Yes	no concerns
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	No	Yes	Yes	7/9 = some concerns
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern

TABLE 3 (Continued)

Authors	Title	Year	Statement of research aims?	Qualitative method appropriate?	Research design appropriate?
Susan M Jack, Marilyn Ford-Gilboe, C Nadine Wathen, Danielle M Davidov, Diane B McNaughton, Jeffrey H Coben, David L OldsHarriet L MacMillan	Development of a nurse home visitation intervention for intimate partner violence.	2012	Yes	Yes	Yes
Susan M Jack, Marilyn Ford-Gilboe, Danielle Davidov, Harriet L MacMillan	Identification and assessment of intimate partner violence in nurse home visitation	2016	Yes	Yes	Yes
Susan M. Jack, Melissa Kimber, Danielle Davidov, Marilyn Ford-Gilboe, C. Nadine Wathen, Christine McKee, Masako Tanaka, Michael Boyle, Carolyn Johnston,Jeffrey Coben, Mariarosa Gasbarro, Diane McNaughton,Ruth O'Brien, David L. Olds, Philip Scribano, Harriet L. MacMillan	Nurse Family Partnership nurses' attitudes and confidence in identifying and responding to intimate partner violence: An explanatory sequential mixed methods evaluation	2021	Yes	Yes	Yes
Beverly Leipert	Women's health and the practice of public health nurses in northern British Columbia.	1999	Yes	Yes	Yes
Sue Peckover	Supporting and policing mothers: an analysis of the disciplinary practices of health visiting.	2002	Yes	Yes	Yes
Sue Peckover	Focusing upon children and men in situations of domestic violence: an analysis of the gendered nature of British health visiting.	2002	Yes	Yes	Yes
Sue Peckover	Health visitors' understandings of domestic violence.	2003	Yes	Yes	Yes
Julie Taylor, Caroline Bradbury-Jones, Thilo KrollFiona Duncan	Health professionals' beliefs about domestic abuse and the issue of disclosure: a critical incident technique study	2013	Yes	Yes	Yes
Sharon Vallant, Jane Koziol-McLain, Brenda Hynes	Plunket Family Violence Evaluation Project	2007	Yes	Yes	Yes
Fiona Webster, Michelle Sangster Bouck, Bonnie Lynn Wright, Pam Dietrich	Nursing the social wound: public health nurses' experiences of screening for woman abuse.	2006	Yes	Yes	Yes
Joyce V. Zerwekh	Laying the groundwork for family self-help: locating families, building trust, and building strength	1992	Yes	Yes	Yes

4.1.3 | Relationship building with colleagues/self

These studies acknowledged the nurse's relational role in providing formal and informal debriefing to support colleagues. Nurses sought and valued debriefing, making this a vital nursing role. Nurses needed to debrief their reactions to abuse situations and explore strategies to deal with them (Dickson & Tutty, 1996; Evanson, 2006; Webster et al., 2006) and would reach out to each other for professional support beyond purely social connections (Ferrara et al., 2021). Other studies described the practice of informal debriefing with colleagues to mitigate work-related stress; however, for some, this represented a burden in itself (Dmytryshyn et al., 2015).

In addition to this role in supporting colleagues, nurses also described relating to their own feelings and responses. The nurse's clinical role requires reflexive practice, enabling reflection to help them 'see the complexity of domestic abuse' (Bradbury-Jones et al., 2014, p. 1065). Ongoing reflective monitoring of domestic violence work is essential for sustainable change in practice (Hooker et al., 2015; Hooker, Small, & Taft, 2016), and nurses' roles require reflective practitioners (Dmytryshyn et al., 2015; Henderson, 2001).

Recruitment strategy appropriate?	Data collection method described?	Relationship between researcher and participants adequately considered?	Ethical issues taken into consideration?	Data analysis sufficiently rigorous?	Clear statement of findings—supported by evidence?	Overall assessment of quality
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	Yes	Yes	Yes	Yes	no concerns
Yes	Yes	No	No	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	No	Yes	Yes	Yes	8/9 = minor concern
Yes	Yes	Yes	Yes	Yes	Yes	no concerns
Yes	Yes	No	No	Yes	Yes	7/9 = some concerns

Nurses working with women experiencing family violence may experience strong negative feelings. Nurses in one of the studies spoke of their fear for themselves in a dangerous situation (49%), fear for the woman and children's safety (41%), frustration at the woman's ambivalence about her abusive partner (38%), and helplessness when experiencing the limits of their capacity to help change the situation (28%). The nurses also noted feeling angry at the abusive partner and described their overwhelming impulse to rescue the woman and children. A small number (30%) mentioned that they questioned their professional abilities if the woman did not follow through with the suggested changes (Dickson & Tutty, 1996).

Later research noted this persisting frustration with 'women who do not act on [the nurse's] advice' (Hooker, Small, & Taft, 2016), arguing this lack of insight and recognition of women's readiness for change indicated that nurses needed more education in strength-based, women-centred practice (Hooker, Small, & Taft, 2016).

Clinical supervision was highlighted as necessary to reflect on the conflicting roles in the nurse-client relationship (Dmytryshyn

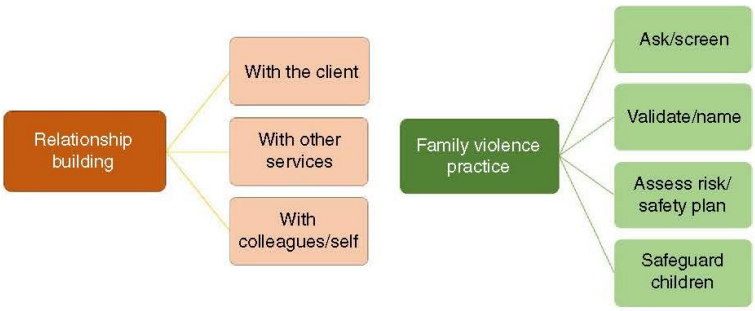

FIGURE 2 Themes

et al., 2015; Holland et al., 2021; Hooker, Small, & Taft, 2016; Jack, Kimber, et al., 2021). Home visitors described the tension of ensuring safety for the child and the harm that disruption to the family home could bring from a disclosure of domestic abuse. This highlighted the inherent contradiction of supporting the mother while prioritizing child safeguarding duties (Cuthill & Johnston, 2019). Home visitors depended on their supervisors, especially when difficult reporting decisions needed to be made, making the relationship between home visitors and supervisors important and valued (Jack et al., 2008).

4.2 | Family violence practice

4.2.1 | Ask/screen

The later studies in this meta-synthesis explicitly describe the role of family violence identification in asking and screening, reflecting the nurses' increasing confidence in working with women experiencing or at risk of family violence (Cuthill & Johnston, 2019; Dmytryshyn et al., 2015; Jack et al., 2016). Home-visiting nurses agreed that they must ask about abuse because this assists with 'calling it out' (Bradbury-Jones et al., 2014; Taylor et al., 2013). Researchers spoke of nurses using a more conversational open style, using open-ended questions, active listening and validating client experiences (Jack et al., 2016). A non-judgmental attitude was essential to facilitate disclosure (Bradbury-Jones et al., 2014).

Cuthill described the insight and expertise of home-visiting nurses and the discretion required 'in their day-to-day work because they were aware that to ask questions about Domestic Abuse positioned them as both a danger and in danger in the family home' (Cuthill & Johnston, 2019, p. 1431). Half of the nurses in Dickson and Tutty's study expressed a range of strong negative feelings when asking women about family violence. The emotions ranged from the nurse's fear for herself in a dangerous situation, fear for the woman and children's safety, frustration at the woman's ambivalence about her relationship with her abusive partner, and helplessness when experiencing the limits of her capacity to help change the situation (Dickson & Tutty, 1996).

In other earlier research, some nurses were 'wary of asking probing questions for fear of damaging the health visitor client relationship' (Frost, 1999, p. 595). Nurses were aware that they needed to screen for violence but felt ill-prepared. They were keen to learn how to ask family violence screening questions and different approaches that ensured using the 'right words' or the 'right timing' so they could fulfil this role (Vallant et al., 2007).

4.2.2 | Validate/name

The nurse role of validating the women's experience was essential to help women recognize their experience as abusive (Bradbury-Jones et al., 2014; Dickson & Tutty, 1996; Hughes, 2010; Peckover, 2003). Researchers spoke of nurses actively listening, acknowledging, accepting and understanding women's experiences of abuse, and working with women to help them define the perpetrators' behaviours as abusive (Jack et al., 2012). Nurses identified open-ended conversations with clients as a strong nursing practice rather than the more traditional nursing approach of 'telling' clients what to do (Jack et al., 2016).

> The nurse's objective is not necessarily to remove a woman from an abusive relationship but to guide her in identifying a healthy relationship, in recognizing patterns of power and control, and in making her own decisions (Webster et al., 2006).

More than that, nurses had a role in supporting clients to understand that intimate relationships can exist free from abuse (Jack et al., 2016).

4.2.3 | Risk assessment/safety plan

Only a few studies referred to the nurse's role in risk assessment and safety planning with women. Assessing immediate risk and helping women develop safety plans were mentioned in Hughes' (2010) and Henderson's work (2001). However, it is in later research where it is more explicitly described, reflecting the shifting of the nurse's role with new models of care (Cuthill & Johnston, 2019; Dmytryshyn et al., 2015; Jack et al., 2016).

More contemporary researchers highlighted the importance of woman-centred care, particularly for women experiencing family

TABLE 4 Nurse roles - per study

Theme	Found in articles	Sub-themes					
Relationship building	(Abbott & Williamson, 1999) (Bradbury-Jones et al., 2014) (Cox et al., 2001) (Cuthill & Johnston, 2019) (Davidov et al., 2012) (Dickson & Tutty, 1996) (Dmytryshyn et al., 2015) (Evanson, 2006) (Ferrara et al., 2021) (Frost, 1999) (Henderson, 2001) (Holland et al., 2021) (Hughes, 2010) (Jack et al., 2008) (Jack, 2010) (Jack et al., 2012) (Jack et al., 2016) (Jack, Kimber, et al., 2021) (Peckover, 2002a, 2020b) (Peckover, 2003) (Taylor et al., 2013) (Vallant et al., 2007) (Webster et al., 2006) (Zerwekh, 1992)	**With the client** Care/support	(Abbott & Williamson, 1999) (Cuthill & Johnston, 2019) (Dickson & Tutty, 1996) (Dmytryshyn et al., 2015) (Ferrara et al., 2021) (Henderson, 2001) (Hughes, 2010) (Jack, 2010) (Peckover, 2002a, 2020b) (Vallant et al., 2007) (Webster et al., 2006) (Zerwekh, 1992)	**With other services** Advocate/ Refer	(Abbott & Williamson, 1999) (Cox et al., 2001) (Dickson & Tutty, 1996) (Evanson, 2006) (Ferrara et al., 2021) (Henderson, 2001) (Holland et al., 2021) (Hughes, 2010) (Jack et al., 2012) (Jack, Kimber, et al., 2021) (Webster et al., 2006)	**With self/ colleagues** Reflect/ Debrief	(Bradbury-Jones et al., 2014) (Dickson & Tutty, 1996) (Dmytryshyn et al., 2015) (Evanson, 2006) (Ferrara et al., 2021) (Henderson, 2001) (Hooker, Small, and Taft, 2016) (Webster et al., 2006)
Family violence practice	(Abbott & Williamson, 1999) (Bradbury-Jones et al., 2014) (Davidov et al., 2012) (Dickson & Tutty, 1996) (Frost, 1999) (Holland et al., 2021) (Hooker et al., 2015) (Hooker, Small, and Taft, 2016) (Hughes, 2010) (Jack et al., 2012) (Jack et al., 2016) (Jack, Kimber, et al., 2021) (Leipert, 1999) (Peckover, 2002a, 2020b) (Peckover, 2003) (Taylor et al., 2013) (Vallant et al., 2007) (Webster et al., 2006)	Ask/Screen	(Bradbury-Jones et al., 2014) (Davidov et al., 2012) (Frost, 1999) (Hooker et al., 2015) (Hooker, Small, and Taft, 2016) (Hughes, 2010) (Jack et al., 2012) (Jack, Kimber, et al., 2021) (Peckover, 2002a, 2020b) (Taylor et al., 2013) (Vallant et al., 2007)	Validate/ name Assess risk/ Safety plan	(Bradbury-Jones et al., 2014) (Dickson & Tutty, 1996) (Hughes, 2010) (Jack et al., 2012) (Jack, Kimber, et al., 2021) (Leipert, 1999) (Webster et al., 2006) (Hughes, 2010) (Jack et al., 2016) (Jack, Kimber, et al., 2021)	Safeguard children	(Abbott & Williamson, 1999) (Cuthill & Johnston, 2019) (Davidov et al., 2012) (Holland et al., 2021) (Jack et al., 2012) (Jack, Kimber, et al., 2021) (Peckover, 2002a, 2020b) (Peckover, 2003)

violence. Although the early research alluded to the home-visiting nurses' ecological understanding of the broader impact of violence on health (Leipert, 1999), nurses have developed more contemporary perspectives of child and maternal health and new skills to fulfil additional clinical roles. Research on trauma-informed practice, maternal and child interaction, and the social determinants of health have contributed to nurses fulfilling these broader roles.

Jack et al. described the Nurse-Family Partnership Intimate Partner Violence education, which prepares nurses to use assessment tools and collaboratively develop safety and plans with their clients (Jack, Kimber, et al., 2021). Hooker et al. (2015) also described the steps taken by nurses and nurse teams to normalize family violence screening, risk assessment and safety planning, which increased as nurses became more familiar with family violence resources and screening practices.

4.2.4 | Safeguard children

The early work of Abbott and Williamson (1999) described nurses as more concerned with the safety of children rather than women. Nurses viewed the mandatory reporting requirements of the nurse to safeguard the child as having the potential to jeopardize the relationship with the client (Frost, 1999). Peckover's research described the policing role of health visiting, drawing attention to 'the exercise of power and the discourses that produce health visitors and mothers' (Peckover, 2002b, p. 375). She argued that it is simplistic to view health visitors' relationships with mothers as straightforward. Women are balancing their need for nurse support and protection with their fears that disclosing the violence they are experiencing may lead to the removal of their children (Peckover, 2002a).

In this earlier research, nurses frequently mentioned their legal mandate to report child maltreatment (Davidov et al., 2012). Even in 2001, Cox recognized the ambiguity of the nurse role,

> Within these themes are the stories of trauma for women/clients and families; stories of torment for nurses who carry the burden of trying to help in a climate where they are unsure of their skill and often feel unsupported in their roles (2001, p. 284).

Later researchers have identified the tension of maintaining safety and security while offering a therapeutic relationship (Cuthill & Johnston, 2019; Davidov et al., 2012) because of the inherent contradiction of supporting the mother and prioritizing the safety of children. The requirement for home visitors to routinely ask about violence appeared to amplify their surveillance role (Cuthill & Johnston, 2019).

5 | DISCUSSION

Nurses fulfil complex roles which are sometimes conflicting (Adams et al., 2021b). The data from the systematic review have confirmed the multiple roles fulfilled by nurses and has enabled an insight into the challenges nurses face as they undertake complex and demanding work. The meta-synthesis has highlighted the challenge for home-visiting nurses to fulfil conflicting roles, such as supporting the woman (maintaining the relationship) and legal mandates for nurses about reporting child abuse. Other research describes this tension for nurses (Adams et al., 2021b; Jack, Gonzalez, et al., 2021; Peckover & Golding, 2017), which can result in role confusion.

Insight into the impact of adverse childhood experiences (Hughes et al., 2017) and the social determinants of health (Maggi et al., 2010) has contributed to nursing practice evolution. Abundant research affirms the benefit of home-visiting support for families experiencing additional challenges (Mejdoubi et al., 2013; Molloy et al., 2021; Rossiter et al., 2017; Sama-Miller et al., 2017).

Over time, society generally, and health services and nurses particularly, have a greater understanding of the cycle of violence and the stages of change women go through when experiencing violence (Adams et al., 2021b; Reisenhofer & Taft, 2013). Improved family violence training, resources and models of care may also have influenced evolving nursing roles (Family Safety Victoria, 2020; Kalra et al., 2021; World Health Organization, 2013, 2017).

The family violence practice roles of home-visiting nurses identified in many of the later studies in this meta-synthesis appear to reflect the recommended first-line response (World Health Organization, 2014) of LIVES—Listen, Inquire about needs, Validate, Enhance safety and Support. Other research highlights the critical importance of nurses recognizing, validating and understanding abuse (Adams et al., 2021b; Bacchus et al., 2016; Spangaro et al., 2016).

Building and maintaining a therapeutic relationship with the woman was identified as pivotal, which is confirmed by other research which emphasizes the importance of a strong relationship between the woman and the nurse home visitor (Duffee et al., 2017; Gomby, 2005; Jack, Gonzalez, et al., 2021; Schaefer, 2016; Sharp et al., 2003). This woman-centred nursing practice ensures the woman's voice is at the forefront, so her wishes are prioritized, which is upheld in research (Brady et al., 2019; Goodman et al., 2016).

Strong working relationships between services contribute to effective support for families, with research identifying the need for collaborative communication and practice (Williams et al., 2021). Families with additional challenges often require services beyond the scope of an individual organization, and issues can arise with a lack of alignment in service goals (Tung et al., 2019). The nurse plays a vital role in enabling communication and coordination of family service plans, providing the clinical expertise that other service agencies cannot provide (Zlotnik et al., 2015).

The role of supervisors and managers in supporting nurses has been described (Adams et al., 2021a), reflecting the increasing responsibility and challenges for nurses at the front line of family violence work and their need for supervision and support. Nurses value having a supportive manager for regular follow-up, mentoring and supervision (Hooker, Small, & Taft, 2016). Supervisors can help nurses address challenging clinical cases and improve their

clinical and communication skills, ensuring ongoing training and supervision to avoid vicarious trauma and burnout (World Health Organization, 2017).

5.1 | Strengths and weaknesses of the study

Including older studies has strengthened this meta-synthesis by enabling insight into the change in home-visiting nurse roles over the past three decades. Systematic and rigorous methods of searching and data analysis have enabled a high-quality meta-synthesis which has produced insights into the roles of home-visiting nurses doing family violence work. Including quantitative studies may have provided additional insight into the roles of nurses, providing potential for richer reflection on the roles and challenges for nurse home visitors undertaking family violence work.

We did not discuss the variation in the goals and purposes of the home-visiting programmes, their private or government funding sources, and the impact this variation may have on the roles nurses play. For example, some programmes may focus on pregnancy outcomes, parenting and child development or preventing child abuse. The nurses' roles may vary accordingly.

By excluding studies from Low- or Middle-Income Countries, we may have missed some useful studies. However, including these papers may have introduced additional challenges for meta-synthesis of the research with different models of nursing care and diverse contexts of practice. This decision, however, may have arisen from unconscious bias on the part of the authors (Harris et al., 2017).

5.2 | Future research and recommendations

A broader analysis of the roles of nurses would be enriched by including quantitative studies. Future research into the diversity of women's perspectives (e.g. migrant and refugee women) would help us better understand home-visiting nurses' roles in the differing contexts of family violence work. Research into how home-visiting nurses work with other services, such as police, child protective services, family violence agencies and immigration services, would further explore nurses' roles in collaborating, referring and case-managing women experiencing family violence and how government and other funding sources and their policies affect practice.

6 | CONCLUSION

This qualitative synthesis has reviewed the literature concerned with the roles of home-visiting nurses working with women who are experiencing family violence. Family violence nursing practice has evolved with increased societal awareness of the importance of supporting women and children at risk of or experiencing family violence (State of Victoria, 2016; UN Women Asia and the Pacific, 2019; World Health Organization, 2020). The pivotal role of establishing and maintaining a relationship with the woman highlights the need for nurses to be skilled in communication and rapport building. Nurses need support to manage conflicting roles, and improved resources and models of care may contribute to supporting nurses in this challenging work.

CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version after drafting the article and revising it critically for important intellectual content. The first author (CLA) conducted the data search, and the initial screening; CLA and the second author (LH) reviewed the full text of included papers and screened for inclusion or exclusion. A third reviewer (AT) was available for an independent opinion of any disputed decisions. CLA wrote the paper, with editing input from LH and AT.

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DATA AVAILABILITY STATEMENT

Data may be made available.

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8.5 Conclusion

The thematic synthesis confirmed the complexity of the multiple roles fulfilled by home visiting nurses and enabled an insight into the challenges nurses face as they undertake complex and demanding work. Building and maintaining a therapeutic relationship with the woman was identified as the pivotal role of the home visiting nurse. This finding supports other research that emphasises the importance of a strong relationship between the woman and the nurse home visitor as the foundation for all other nursing work (Jack et al., 2016), and describes one element of how nurses and the wider Enhanced Maternal and Child Health program support women experiencing family violence.

The literature search was extended to 1985 to capture the early work of the Nurse-Family Partnership and nurse Home Visitor researchers in the UK in the early 2000s. This longer-term perspective has provided insight into how home visiting nurse roles have changed over time. The nurse's role has evolved with the introduction of improved family violence training, resources, models of care (Family Safety Victoria, 2020; World Health Organization, 2013, 2017), and increased societal awareness of the importance of supporting women and children at risk of or experiencing family violence (State of Victoria, 2016b; UN Women Asia and the Pacific, 2019; World Health Organization, 2020).

The thematic synthesis provided a rich context for the next phase of the research: interviewing 25 Victorian Maternal and Child Health nurses and 12 managers, enquiring about their roles (Chapters 9 and 11) and the characteristics of the Enhanced Maternal and Child Health nurse (Chapter 10).

9. THREADS OF PRACTICE: ENHANCED MATERNAL AND CHILD HEALTH NURSES WORKING WITH WOMEN EXPERIENCING FAMILY VIOLENCE

9.1 Introduction

This study is the first qualitative study to explore Victorian Enhanced Maternal and Child Health nurses' diverse roles in supporting women experiencing abuse. 25 nurses and 12 managers were interviewed in urban, regional, and rural settings. The nurses shared stories about the women they worked with in the Enhanced Maternal and Child Health program. This method of gaining insight and understanding is familiar to nurses: storytelling is a relational activity that gathers others to listen and empathise (Riessman, 2012). Recounting stories focuses on considering events that have taken place and considering our role in the story.

This research element, the interviews, required the most reflexive consideration. The interviews sometimes crossed over into conversations between the nurses and managers and me as the clinician, researcher, and interviewer. In theme, if not detail, the scenarios were familiar to me, having worked as an Enhanced Maternal and Child Health nurse and manager.

The nurses explored their responses to women experiencing violence and reflected on their nursing roles. The stories illustrated that women have different needs at different times, and the Enhanced Maternal and Child Health nurse's role is necessarily dynamic in response.

9.2 Methods

In the interviews, the 25 nurses explored how they encountered family violence's clinical presentation, how they described their roles, and the personal and professional challenges in undertaking family violence work.

A thematic analysis of the interviews identified three themes, characterised as threads of nursing practice, with nurses modifying the focus and nature of their work as the woman's needs change. The threads of nursing practice are (i) validating/reframing, (ii) non-judgmental support/safeguarding, and (iii) following/leading.

9.3 Declaration of contribution

Citation	Nature and extent of the candidate's contribution	Nature and extent of the co-author's contribution
Adams, C., Hooker, L., & Taft, A. (2021). Threads of Practice: Enhanced Maternal and Child Health Nurses Working with Women Experiencing Family Violence. Global Qualitative Nursing Research, October 2021. https://doi.org/10.1177/23333936211051703	80% contribution by the candidate. This included study design, data collection, data analysis, interpretation of results, drafting the paper, and manuscript revisions.	20% contribution by the co-authors. This included contributing to data analysis and interpretation. Co-authors also provided a critical review of the paper.

I, Catina Adams, declare that I have made a substantial contribution to this paper, including study design, data analysis, interpretation of results, and drafting the paper. My supervisors, Professor Angela Taft, and Associate Professor Leesa Hooker, contributed to the study design, intellectual input, and editing the manuscript.

I, Angela Taft, declare that Catina Adams made a substantial contribution to this paper. She contributed to all aspects and drafted the manuscript.

9.4 Published paper: Threads of practice: Enhanced maternal and child health nurses working with women experiencing family violence

Single-Method Research Article

Threads of Practice: Enhanced Maternal and Child Health Nurses Working With Women Experiencing Family Violence

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Abstract

Family violence is a serious public health issue with significant health consequences for women and children. Enhanced Maternal and Child Health nurses (EMCH) in Victoria, Australia, work with women experiencing family violence; however, scholarly examination of the clinical work of nurses has not occurred. This qualitative study explored how EMCH nurses work with women experiencing abuse, describing the personal and professional challenges for nurses undertaking family violence work. Twenty-five nurses participated in semi-structured interviews. Using interpretive description methodology has enabled an insight into nurses' family violence work. Threads of practice identified included (1) Validating/Reframing; (2) Non-judgmental support/Safeguarding and (3) Following/Leading. The nurses highlighted the diversity of experience for women experiencing abuse and nurses' roles in family violence nurse practice. The research contributes to understanding how EMCH nurses traverse threads of practice to support women experiencing family violence.

Keywords

intimate partner violence, domestic violence, family violence, maternal and child health, qualitative research, nursing, Australia

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Introduction

Intimate partner violence is any behaviour within a past or current intimate relationship that causes harm to those in that relationship. It can include physical, emotional or psychological harm (Australian Institute of Health and Welfare, 2019). Perpetrators of intimate partner violence may use controlling or dominating behaviour, including emotional, sexual and physical abuse, and harassment that can worsen over time (Family Safety Victoria, 2020). The terms intimate partner violence, domestic violence and family violence may be used interchangeably (Stubbs & Wangmann, 2017). In Victoria, Australia, 'family violence' is used in legislation and policy documents, setting it apart from other Australian jurisdictions and countries such as New Zealand, the United Kingdom, Canada and the United States.

Family violence is a serious public health issue with significant health consequences for women and children (Brown et al., 2020). In Australia, police are called to a family violence incident every 2 minutes; 12 women per day are hospitalised due to violence and every 9 days, a woman is killed by a current or ex-partner (Department of Social Services, 2019). The violence often begins during pregnancy and may increase in severity into motherhood (García-Moreno et al., 2015) and is one of the leading causes of death and injury for childbearing women (Breiding et al., 2014).

Family violence during pregnancy is associated with risks to the foetus, child and mother (Howard et al., 2013). It has a negative impact on the experience of motherhood and parenting (Hooker et al., 2016). More than 1 million Australian

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children are affected by family violence (Australian Institute of Health and Welfare, 2019). Children exposed to violence are at higher risk for emotional and behavioural problems, poorer language development and impaired cognitive development (Cutuli et al., 2016). Children do not have to directly witness the family violence for there to be negative outcomes (Wathen & MacMillan, 2013).

Maternal and Child Health service in Victoria, Australia

The Maternal and Child Health (MCH) service works with parents and early years' services, promoting healthy outcomes for children (0–6 years) and their families (Department of Health and Human Services, 2019b). MCH nurses are triple qualified in Nursing, Midwifery, and Child, Family and Community -Nursing, providing consultations where parents can discuss their concerns, parenting experiences and optimise their child's health, growth and development. The MCH service is a free, universal service with almost 100% engagement with families from birth and nearly 65% at 3.5 years of age (Department of Health and Human Services, 2019d).

The Royal Commission into Family Violence (State of Victoria, 2016) generated increased interest and focus on screening, identifying and supporting women experiencing family violence. The universal nature of the MCH service means that MCH nurses are uniquely positioned to ask women about family violence, offer support and strategies, assist with safety plans, refer to specialist agencies and often receive the first disclosure of family violence. MCH nurses screen all women for family violence at the 4-week maternal health and well-being consultation if it is safe to do so and at other times if clinically indicated (Department of Health and Human Services, 2019c). Nurses ask the following questions, ensuring that the woman is alone when asked:

> *Are you in any way worried about the safety of yourself or your children?*
>
> *Are you afraid of someone in your family?*
>
> *Has anyone in your household ever pushed, hit, kicked, punched, or otherwise hurt you?*
>
> *Would you like help with this now?*

Despite this clinical requirement, research indicates low family violence screening rates by MCH nurses (Hooker et al., 2020; O'Doherty et al., 2016; Taillieu et al., 2021). Although all MCH nurses completed training in the Common Risk Assessment Framework (CRAF) (Department of Health and Human Services, 2007) in 2009, this has not equipped them with effective family violence practice tools and skills (Hooker et al., 2020). Researchers have explored this reluctance to screen women for family violence (Taft et al., 2015), identifying that MCH nurses may lack confidence (Taillieu et al., 2021) and have received limited family violence education and training (Hooker et al., 2021). The Multi-Agency Risk Assessment and Management Framework training (Family Safety Victoria, 2020) updated and expanded the CRAF in 2020 after this study was undertaken.

Enhanced Maternal and Child Health program

The Enhanced Maternal and Child Health (EMCH) program runs in parallel with the MCH universal service, responding assertively to the needs of families with children at risk of poor outcomes. The EMCH program is a nurse home visiting program of up to 20 hours per family (up to 22 hours for rural families). EMCH clients are often highly complex, presenting with multiple, concurrent issues, with more than 25% referred to the EMCH program with mental health issues and more than 20% experiencing family violence (Adams et al., 2019). Despite the high rates of family violence among EMCH clients, very few studies have explored the EMCH program and the nurse's role in responding to women and children subjected to abuse.

The Study

This research is part of a larger study, comprising sequential quantitative and qualitative data collection and analysis, exploring how the EMCH program supports women experiencing family violence. There are three parts to the overall study:(i) a state-wide service-mapping of the EMCH program; (ii) interviews with 25 EMCH nurses to explore how they support women experiencing family violence and (iii) interviews with 12 MCH nurse managers to analyse how they support nurses undertaking family violence work. This paper reports on aspects of part (ii) of the study.

Aim

To explore how nurses encountered the clinical presentation of family violence, how they described their role and the personal and professional challenges that arise in undertaking family violence work.

Methodology

An Interpretive Description approach (Thorne, 2016) guided the research design, participant sampling, and data collection, and has enabled a rich description of the experience from the nurses' viewpoint. Interpretive Description takes an inductive analytic approach to capture themes and patterns, answer clinical questions about everyday practice and inform clinical understanding (Thorne, 2016). By sharing clinical stories, nurses have explored their role in the story. This method of gaining insight is familiar to nurses, as story-telling is a relational activity that gathers others to listen, empathise, reflect critically and problem solve (Riessman, 2012). Stories are

Table 1. Details of Participants and Interviews.

Characteristics	N
Total number of nurses	25
Local government area	
• Urban	12
• Regional city	7
• Rural/remote	6
Years of MCH nursing experience	
• < 3 years	0
• 3–5 years	2
• 6–8 years	6
• 9–10 years	3
• 10–5 years	5
• > 15 years	9
Mode of interview	
• Face-to-face	23
• By telephone	2

Table 2. Interview Questions.

Tell me about your job - what do you do?
How did you come to be doing this work?
Can you tell me about any training you have had?
What training do you think has helped you most to do this work?
Can you think of a family you have worked with experiencing family violence?
What were the biggest challenges you faced in responding to them? (prompts - screening, risk assessment, safety planning, referral)
How did you work with this family? What tools, techniques and skills did you bring?
(prompt) Why did you work in this way?
(prompt) What have you based this on?
For rural nurses, how does your rural setting impact how you work with women and children experiencing FV?
What problems have you encountered in addressing FV when you are home visiting?
How safe do you feel in this work? (prompt) physical safety, emotional safety
What do you do if a consultation causes you to feel stressed, anxious or helpless?
When undertaking this work, what feelings come up for you?
Any other questions or observations?

co-constructed and negotiated between the people involved to capture nuanced, complex and multi-layered understandings of the phenomenon (Etherington & Bridges, 2011).

Setting and sample

We emailed MCH nurse managers in all 79 Local Government Areas in Victoria to invite MCH nurses working with EMCH clients to participate in the study. All MCH nurses working with EMCH clients were eligible for inclusion. Participation was voluntary, and there were no exclusions. The number of participants was not pre-determined; instead, we aimed to ensure the participants represented a range of experiences and geographical areas within the community of practising nurses (Sim et al., 2018). We anticipated we would need to interview at least 20 nurses from a potential pool of approximately 120 nurses specialising in EMCH practice to achieve diversity of participants and adequate depth of information (Malterud et al., 2016). Using purposive sampling, we recruited 25 nurses with various experiences and backgrounds (Table 1). On recruitment, informed consent to participate was obtained, followed up with written consent at the time of the interview, including permission to record the interview digitally. The interviews were conducted in English, and all participants were female. The average length of the interviews was 45 minutes (range 29–79 minutes) (Table 1).

Data Collection

The first author developed a semi-structured interview guide, with input from two research supervisors, one with considerable experience in qualitative interviewing and the other who is an experienced MCH clinician-researcher. The interview questions were tested with MCH nurse researchers, who provided feedback on the questions' scope and the researcher's interviewing technique. This feedback, coupled with reflexive journaling, contributed to revisions to the interview guide and interview technique to ensure open, curious questioning of the nurses (Table 2).

Most interviews were conducted face-to-face, with two by telephone, over 3 months in 2019/20. The interviews were digitally recorded and transcribed using NVivo Transcription (QSR International, 2020). The first author checked the transcriptions to ensure fidelity to the audio recording. Demographic information was collected; however, the participants' identities were not included in the data analysis. Nurses and clients have been given pseudonyms.

Data Analysis

Data derived from semi-structured interviews were analysed using reflexive thematic analysis, a six-phased process developed by Braun and Clarke (2006). The first author conducted and transcribed the interviews, so the content was familiar on first coding. The first author generated preliminary themes from the interview guide; inductive coding identified other themes. Using an NVivo codebook ensured consistent coding (QSR International, 2020), and the first and co-authors reviewed codes and interpretations over several iterations. The analysis focused on the nurses' exploration of their roles working with women experiencing abuse.

Reflexivity

Reflexivity involves making the research process a focus of inquiry and adds credibility to qualitative research (Carolan,

2003). As an insider researcher (Leslie & McAllister, 2002), the first author is known by nursing colleagues as a researcher who is also an MCH nurse and previous MCH nurse manager. The first author brings an insider's understanding of nurses' language and terminology, work conditions, and the MCH and EMCH programs' professional and operational workings. Their connection to the field enables access to EMCH nurses and managers to facilitate participant recruitment and has guided the interview guide's creation (Aronowitz et al., 2015).

Journaling has enabled rigour, reflection and self-awareness throughout the study, supported by frequent supervision and consultation with colleagues and supervisors. The journaling has framed an awareness of the researcher and the participants' social, personal and cultural contexts, enabling insight into how these contexts impact the ways we interpret our world (Etherington, 2004). This reflexivity has informed the research design, interviewing and data analysis. Journaling also enabled exploration of the role the researcher plays in the co-construction of the story. The researcher creates the context for the story-telling by deciding what will be investigated, formulating a research question, and selecting the participants, establishing whose story will be told (Murray, 2009). Methods to avoid possible role/ethical conflict included reinforcing to participants that the interviewer was acting in the role of researcher and not an MCH nurse.

Ethics

The research has been approved by the La Trobe University Human Ethics Committee (Ethics approval number 22227) and the Department of Health and Human Services (HHSD/19/129427). The joint approval ensures consideration of ethical issues, such as risk and safety, data storage and security, privacy and disclosure, and informed consent (Wang & Geale, 2015).

The interviewer (first author) is an experienced clinical supervisor and ensured that the nurses and nurse managers were provided with resources and support if they experienced any distress due to the interviews. Support services might have included the Nurse and Midwife phone support line, Employee Assistance Program or referral to family violence support services if the nurse became distressed by discussing a personal experience of family violence. Another member of the research team, an experienced EMCH nurse and clinical teacher, was available to take calls from participants to discuss their experience after the interview; however, this did not eventuate.

Findings

The nurses told stories about women experiencing family violence, reflecting on their various roles at different times. Analysis revealed the following threads of nursing practice: (1) Validating/Reframing; (2) Providing non-judgmental support/Safeguarding and (3) Following/Leading.

Validating/Reframing

Nurses understood their first responsibility was to validate the woman's story. As Coral said, 'They want to be listened to. I think that's a huge thing. And believed. Yes, we get it'. Sharon reflected on the need to listen and wait, 'I think sometimes they like to be heard but without the pressure to do anything. Because often, you know, it takes them a while to realize that they do need to leave and leaving is huge, isn't it'? Working with women in rural locations, Cassie said,

> The mums are aware that their husbands are controlling and manipulative, but they're in positions where they've got a lot to lose … the mum could move out, but it will mean they have to sell the house, their car, and they don't want to go and live in a different wherever. (Cassie)

Nurses highlighted the importance of naming violent behaviours, especially when they are not physical, such as controlling behaviour. In these cases, the nurses validated the woman's experience, listening carefully and with empathy, 'listening, not judging' (Penny) and 'being present and having some empathy and understanding' (Grace).

Beth told a story of a young woman (Asra) experiencing sexual and reproductive coercion. Beth recognised her vulnerability, as Asra came from a refugee background. Asra's husband threatened her with deportation and the loss of her children if she did not comply with his demands. She had three children under 3 years of age, against her will. The woman was frightened, and she also carried the burden of cultural expectation, which led her to fear judgment from her community. Beth reflected, '… the thing that really worried me was that she didn't see it as violence or marital rape. She just thought that was her culture. And that's just something that happens'. Beth described how she validated the woman's experience; however, she then reframed the story, 'We spoke a little bit more about controlling behaviour. I just saw it wash over her face. That she came to realize - this is not OK'. Beth described what followed:

> So that was a really long visit. I stayed there for about two hours, and we spoke a lot about safety. I was trying to help her see the little escalations that had been occurring since the new baby came home. (Beth)

Beth's reflected that her initial role in this scenario was to validate Asra's story; however, she moved from validation to reframing and reflecting via a dynamic thread of nursing practice. The segue from validating to reframing enabled a discussion about risk and safety planning, assisting Asra to gain insight into the situation's escalating danger, including the threat to her children and herself.

Nurses acknowledged the woman might not view her relationship as abusive or minimise the abuse, being in a pre-contemplation stage. Many nurses used the language of

'stages of change', affirming that a woman may be reluctant to disclose at different times. Coral spoke about how it felt when a woman did not disclose family violence, but the nurse suspected it. 'They work hard not to disclose'. Milly also talked about knowing the boundaries of how far to go 'when they don't want to disclose. If they don't want to, you can't push them to it'.

By validating and then reframing behaviour as family violence, the nurse is helping the woman to explore what a respectful or healthy relationship looks like. In this way, nurses supported women to understand that they were experiencing family violence and then 'helping them gradually walk that path' (Amanda).

Beth witnessed and validated the young refugee woman's story and reframed it to offer Asra a new perspective of her experience. Beth reflected that this was a pivotal moment for Asra, disclosing for the first time outside of her community and for the first time to a health professional. Beth's initial role validating the woman's experience developed when she reframed the story, enabling conversations about safety and risk along a dynamic thread of nursing practice.

Providing Non-Judgmental Support/Safeguarding

Nurses aimed to be non-judgmental in their response to women; however, they are also mandated to notify Child Protection services if they are concerned for a child's safety. In the story above, Beth notified Child Protection, which had a negative impact on her relationship with Asra. Beth spoke about the delicate balance between 'risk and relationship'. Another nurse, Nancy, reflected on moving between providing non-judgmental support and the nurse's mandated safeguarding role and 'keeping the child in mind'. 'We need to be mindful of the children, their safety, and when we have to intervene'. Nurses spoke of a 'holding space', with the thread of practice becoming taut with increasing risk and responsibility.

Some nurses described strategies to influence the woman's choices, such as highlighting the children's risk and convincing them that change is needed. Betty recounted, 'Often you can see the light bulb moment when you bring in the child and what might be happening for a child'. Nancy spoke of the challenge of maintaining engagement with the family and balancing that with concern for the child:

> And you should be non-judgmental, but the other thing is not to go too soft, just because you want to stay there. There's a bit of a balance there. Like you, you want to stay in. But, well, you know, this little child. This child is being neglected. Like it's all right for my colleague to say, "I think we need to go softly, softly". I would say, "I think we've gone softly, softly enough". (Nancy)

Nurses traversed professional and personal boundaries, caring for clients and worrying about them. As women moved through stages of change and sometimes remained in dangerous environments, nurses felt anxious about the risk to the woman and child.

> I can't watch the news anymore. If I hear of a mother or child that has been killed, I wait to hear what suburb, dreading it. Is that one of our clients? You're on high alert. And then I feel awful for feeling relieved that it's not one of ours. (Rachel)

Clinical supervision was often referred to as maintaining balance when stretching these taut threads of practice.

> I know when I was working as an enhanced nurse. It depends on how close the tears are to the surface. If they just started like that, I feel like they're just below the surface. I'm only just holding them in. And so that's where supervision is so critical. (Cindy)

Following/Leading

Nurses sometimes struggled to achieve collaborative practice, which respects and fosters the client's strengths. A strengths-based perspective views the client as the expert in their experience, requiring a shift from the nurse as expert and 'fixer' to collaborator. When 'walking beside the woman', nurses spoke of starting with the woman's priorities and having the woman determine her own pace. The nurses spoke of sometimes following, sometimes leading, but striving to accompany the woman on her journey. Doris spoke about 'meeting the family where they're at and hearing what they want … and that's a moving target that changes'. Penny said, 'I think probably it is more walking that journey … and getting them ready to make that next step'. Many nurses spoke in this way of 'walking with' or 'walking beside' families, using the language of a journey, 'a journey that families cannot make quickly' (Doris).

Zoe described a slightly different approach, where she sought to motivate a young woman towards change, leading her in the journey.

> She's a young mum of 22, and she's got three little children. And I actually knew her through my daughters. No, she didn't always admit violence. She said, oh, no, no, we're okay. But then you would hear back that he was being very violent, and then she would say, yes, things aren't good. But he had very much a hold on her. And basically, three babies later, she finally left him. But he still controls her by the phone, through the children, you know, because they organize picking up with the kids. So, he's still very much in control of her. (Zoe)

When asked about her role in this story, Zoe said, 'to listen to her, and help her imagine a different future'.

Some nurses admitted to using strategies to motivate change in the woman, such as mentioning the impact on the children or speaking bluntly about the woman's risk. Nurses recognised that using strategies to inspire change in the woman can be counterproductive, alienating the woman and causing her to disengage from the nurse relationship. Doris described the need for self-awareness, 'It's also about tuning

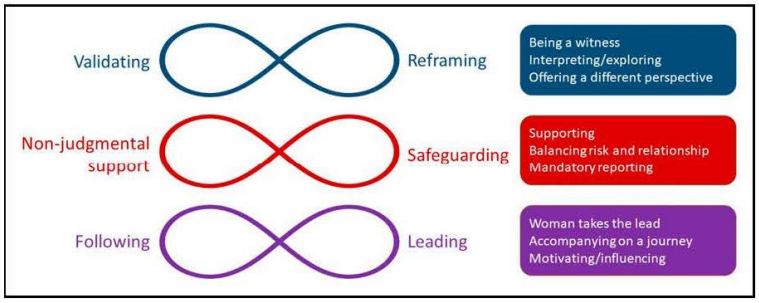

Figure 1. Conceptual model: Threads of nursing practice.

into yourself and making sure that you're not trying to rush the family', and the challenge of holding back, letting the woman take the time she needs.

> Maintaining engagement and maintaining a rapport and maintaining that, you know, that connection with them whilst helping them slowly come around to that understanding. And it can be a really, long, slow walk. It can be frustrating and challenging. (Doris)

Other nurses in this study spoke of the patience required to walk with the woman, accompanying the woman on her journey. When the chaos gets overwhelming, some nurses will turn to fixing – 'I've been in that house, and it's just been putrid. I've taken the baby's washing home, washed it, dropped it off the next day to them. It's not just personality, it's nurses, we help'. This impulse to 'fix' things harks back to an earlier biomedical model of nursing care – nurse as 'expert' and 'fixer'. Zoe said, 'I am much more of a hands-on person that really, really enjoys helping mums. To support families and just to make their life a little bit happier'. Suzie described one of her colleagues, 'She was a great soldier of a nurse … if she needed something, you know, she was resourceful in getting what she needed (material aid for the client)'. However, Coral reflected on how a focus on 'fixing' can disempower the woman, increasing her sense of shame and dependence – 'We want to get crackin' on those needs. And sometimes that's the worst thing you can do'.

Nurses spoke of their frustration with the time-limited nature of the EMCH program, which is limited to 20 hours per family. They felt they had to focus their efforts on referral and safety planning and what could be achieved in a relatively short time. In contrast, the nurses reflected that the woman often sought continuity of relationship with the same nurse. The nurses spoke of needing to set boundaries with other agencies, 'we're not the police, we're not the cavalry', but also worried that the woman might 'fall between the cracks' when referring a woman to another agency. Nurses also noted that women might enter the EMCH program, be discharged and re-engage when their situation changes, in a revolving door of engagement/re-engagement.

Nurses highlighted the importance of letting the woman know that they can help when she needs it and that making a change may take time. Most nurses felt they could offer women appropriate responses, suitable to their readiness to disclose and accept support. This dynamic and sometimes tenuous thread of practice required patience, walking alongside the woman, requiring perceptive clinical judgment to assess risk and identify the need for guidance.

Discussion

This study is the first qualitative study to explore Australian EMCH nurses' diverse roles in supporting women experiencing abuse. Women have different needs at different times, and the EMCH nurse's role is necessarily dynamic in response. This study has identified threads of nursing practice, with nurses modifying the focus and nature of their work as the woman's needs change. (Figure 1)

Researchers argue that validation is the first element of the health care practitioner's response to a family violence disclosure (Malpass et al., 2014). Health care practitioners must listen but also believe, acknowledge and validate the woman's experiences (Bacchus et al., 2016; Spangaro et al., 2016; Tarzia et al., 2020). In this study, nurses did not hesitate to 'call out' coercive or controlling behaviours as family violence, understanding that emotional abuse is often a precursor to physical abuse (Taillieu et al., 2021). Nurses validated the woman's experience but then moved along the practice thread to interpret and reframe the woman's story. By reframing and offering a new perspective, nurses moved beyond validation to explicitly name perpetrator behaviour as violence, working with the woman to review her situation, assess risk and enhance safety.

Women subjected to family violence identify healthcare providers as professionals they trust with disclosure (García-Moreno et al., 2015; Kalra et al., 2021). Some healthcare professionals are reluctant to enquire about family violence, whether for systems-level issues, such as lack of time or resources (Sprague et al., 2012) or more personal barriers, such as lack of education or training programs (Eustace et al., 2016; Finnbogadóttir & Dykes, 2012; Hooker et al., 2020).

Our study confirmed that EMCH nurses aim to practice a woman-centred approach, supporting the woman to decide her pathway to safety (García-Moreno et al., 2015). Woman-centred practice entails the nurse listening to the woman with empathy, without judging, responding to her needs and concerns, validating her experience, enhancing safety, and providing support and follow-up (World Health Organization, 2014). A woman-centred response requires skilful personal communication skills to achieve a rapport that enables trust (Brijnath et al., 2020; Cuthill & Johnston, 2019; Goodman et al., 2016). The first time a woman discloses is a fragile moment, with the nurse needing to sensitively connect with the woman when she may be feeling shame.

Nurses moved along this practice thread – validating, interpreting, reframing and revalidating when new elements emerge. This dynamic response required reflective practice, and nurses valued clinical supervision as an opportunity to regulate and reflect on their role and ensure that their practice was responsive to the woman's changing needs. Regular clinical supervision also supports the safety of the nurses undertaking emotionally charged work, enabling them to reflect on boundaries (Jarrett & Barlow, 2014) and provide increased self-awareness (Shea et al., 2019).

Women experiencing family violence need time, encouragement and ongoing support to enable disclosure (Hooker et al., 2020), including inquiring about their needs. Women appreciate ongoing, sustained engagement from their healthcare provider (Hooker et al., 2020), and increasing trust over time can improve disclosure and safety planning (Brijnath et al., 2020; Taft et al., 2015). Women want healthcare providers to be sensitive, compassionate, and non-judgmental and respect their decisions. They want an emotional connection and practical support through action and advocacy tailored to their changing needs (Tarzia et al., 2020). The development of a therapeutic nurse–client relationship, built on a foundation of acceptance, trust and strong rapport, is at the core of sustained home visiting programs with vulnerable populations (Duffee et al., 2017; Jack et al., 2016). This relationship may facilitate nurse home visitors' abilities to ask about family violence and other significant social issues and increase clients' comfort levels in disclosing family violence (Cuthill & Johnston, 2019; Jack et al., 2012). Nurses in this study affirmed other research findings that establishing rapport was an essential first step in identifying violence, leading to more effective support for women, including safety planning.

Nurses struggled with the dual role of providing non-judgmental support and surveillance. They used clinical supervision to explore this dynamic thread of practice, particularly their fear that the relationship with the woman would be undermined when they fulfilled the mandated role of reporting to Child Protection services. This mindful consideration of the multiple roles nurses fulfil is essential to safe, professional practice. Although nurses clearly understood the mandated requirement to make a child notification if there is a risk to the child and made notifications when required, they regretted losing trust when a notification was made. Nurses recognised that damage to the relationship between the nurse and the client could limit future disclosure of abuse, as described in other research (Davidov et al., 2012; Jack et al., 2021). Nurses spoke of balancing risk and relationship, traversing this practice thread as the woman's situation changed and risk was reassessed.

For women experiencing family violence, decision making is not linear, and women report experiencing turning points on the journey brought about by internal and external influences (Chang et al., 2010). This nursing thread of practice is dynamic, with nurses responding to the woman's readiness to make decisions about her life. By listening to the woman closely, with empathy, without judging, nurses can offer women appropriate responses, suitable to the woman's readiness to disclose and accept assistance. However, nurses in the study often spoke of their concerns for the woman's safety and worked with the woman to enhance her safety by identifying a safety plan. They highlighted the importance of supporting the woman in reaching higher stages of change when she was ready, such as contemplation when the woman identifies and labels her experience as abuse, or preparation where the woman may enact change (Reisenhofer et al., 2019).

For women who disclose and are not ready to act, informational support is most effective, coupled with emotional support (Jack et al., 2021). Nurses are in a position of privilege with the women, and EMCH nursing work requires reflective practice, acknowledging this imbalance of power. Attempts to motivate the woman to change, although well-intentioned, can be interpreted by the client as coercive or threatening and may be counterproductive, alienating them and causing them to disengage from the EMCH program (Janczewski et al., 2019; McTavish et al., 2019).

Practice Implications

There are practice implications for each of the nursing practice threads – validating and reframing, following or leading, and providing non-judgmental support while also safeguarding. Nurses aspire to fulfil the breadth of these roles; however, there are limitations imposed by the EMCH program, which does not enable nurses to engage with women over a more extended period. Research is needed to evaluate this short-term home visiting program's efficacy, compared with longer-term sustained home visiting programs, for which there is an evidence base.

Nurses need regular practical training in active listening to enable more effective validation and reframing of the women's stories. This thread of practice requires insight and the ability to reframe the woman's story in culturally safe and accessible language. High-level communication skills and culturally safe practice requires ongoing training and supervision.

Personal and clinical skills training in woman-centred practice will enable the nurses to work with the woman to identify and achieve goals. The skills to accompany the woman

on her journey, without leading or following, needs regular access to quality clinical supervision, so the nurse can explore her practice, ensuring it is woman-centred and not dominated by the nurse's priorities. Clinical supervision is also critical to allow the nurse to explore the tension between providing non-judgmental support for the woman and safeguarding the child.

The new EMCH program guidelines (Department of Health and Human Services, 2019a) introduced around the time of these interviews address some of the old program's limitations by developing a systems model approach that better supports nurses to undertake family violence work. The new guidelines articulate the scope of the EMCH program, the model of care and program delivery. More work is needed to integrate the program administratively, such as safely incorporating the Family Action Plan as a living document into the clinical documentation tool.

Confidence to screen for family violence and support women experiencing abuse increases with regular up-to-date education and training in family violence practice (Hooker & Taft, 2021). There is a correlation between the number of hours and recency of MCH nurses' training and feelings of being well prepared to complete family violence work (Hooker et al., 2021). Research has found that some rural nurses feel less confident undertaking family violence practice, with fewer referral options (Hooker et al., 2021). Developing a model of care for rural nurses that takes account of the reduced access to specialist family violence services may improve clinical practice and reduce stress on nurses.

Attention needs to focus on improved clinical guidance, referral pathways and collaborative engagement with other services that can support a longer-term view of the woman's experience.

Strengths and Limitations

This study has been strengthened by interviewing 25 nurses with diverse experiences and backgrounds, from rural and urban Local Government Areas, working in advantaged and disadvantaged areas. The nurses had the opportunity to speak fully of their experiences, with interviews averaging 45 minutes.

Most nurses knew the interviewer, which could be viewed as both a strength and a limitation. This relationship may have introduced an element of social desirability bias. Instead of choosing responses that reflect their true feelings, nurses may have given more socially desirable answers (Grimm, 2010). However, the heterogeneity of responses would indicate that the nurses spoke frankly from their perspective. The nurses appreciated that their responses would be reported anonymously, as they wanted to be truthful in their answers without fear of recrimination.

Conclusion

This study examined how EMCH nurses in Victoria, Australia, encounter the clinical presentation of family violence. The nurses highlighted the diversity of experiences for women experiencing family violence and the range of roles in family violence nursing practice. Nurses identified the personal and professional challenges working with women experiencing family violence, describing dynamic threads of nursing practice.

This research contributes to our understanding of Australian families experiencing additional challenges and how to support those experiencing family violence. The insights gained from this interpretive description approach may inform the development of clinical roles, nurse education and skill development, and clarify professional boundaries and supports to improve the experience of EMCH nurses working with families and improve outcomes for women and children.

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Author Biographies

Catina Adams is a Midwife and Nurse academic. She is undertaking her PhD which is due for submission early in 2022, which is examining how the Enhanced maternal and Child Health program supports women experiencing family violence. Her research interests include Family Violence; Child, Family and Community Nursing practice; family inclusive practice; Scholarship of Teaching and Learning; and Clinical Governance.

Leesa Hooker is a nurse/midwife academic and Senior Research Fellow at La Trobe University, leading the Child, Family and Community Health nursing research stream within the Judith Lumley Centre. She has established expertise in the epidemiology of family violence, women's mental and reproductive health and parenting. Her research includes intervention trials, observation studies and systematic reviews with a focus on improving maternal and child health outcomes, and the healthcare service response to abused women and children.

Angela Taft is a Principal Research Fellow and former Director of the Judith Lumley Centre, La Trobe University, Australia. She has led a major competitively funded program of research at JLC on intimate partner/gender-based violence, including Cochrane systematic reviews and multi-method randomised controlled trials of IPV interventions in general practice and maternal and child health nursing. Her interests also include studies to improve women's health and reduction of violence in migrant and refugee communities and in the Asia-Pacific, especially in Timor-Leste.

9.5 Conclusion

Health care practitioners, including Enhanced Maternal and Child Health nurses, fulfil an essential role in identifying, responding to, and supporting women experiencing family violence (García-Moreno et al., 2015), offering emotional connection, practical support, and validation of the women and children's experience (Family Safety Victoria, 2020). In asking how the Enhanced Maternal and Child Health program supports women experiencing family violence, each support element must be examined: the program, the nurses, the managers, and the broader health service system.

In this study, Enhanced Maternal and Child Health nurses shared stories of women experiencing family violence, highlighting how they undertake their role, their skills, and the challenges they face. The interviews with nurses and managers confirmed the complexity of the multiple roles fulfilled by nurses, as previously described in Chapter 8 in the systematic review of home visiting nurse roles. These insights help us understand how the Enhanced Maternal and Child Health program supports women experiencing family violence by highlighting the nurses' roles in family violence nursing practice.

In the following chapter, analysis of the data from the interviews has identified the characteristics of the Enhanced Maternal and Child Health nurse, asking the questions: What is needed for effective Enhanced Maternal and Child Health nurse family violence work? Can anyone be an Enhanced Maternal and Child Health nurse?

10. THE CHARACTERISTICS OF MATERNAL AND CHILD HEALTH HOME VISITING NURSES UNDERTAKING FAMILY VIOLENCE WORK: AN INTERPRETIVE DESCRIPTION STUDY

10.1 Introduction

This element of the study further explored Enhanced Maternal and Child Health nurse family violence practice and how Enhanced Maternal and Child Health nurses support women experiencing family violence. This paper analyses the family violence practice of home visiting nurses, focusing on the characteristics of the nurse. This exploratory study sought to answer the following research questions:

- How does the Enhanced Maternal and Child Health nurse describe their role and responsibilities, and the focus of their work?
- What skills, knowledge, and personal attributes do the Enhanced Maternal and Child Health nurse bring to the role?

10.2 Methods

Twenty-five Enhanced Maternal and Child Health nurses and 12 managers in Victoria, Australia, were interviewed over four months in 2019-2020, from urban, regional city, and rural/remote settings. Forty percent of the nurses are highly experienced, with more than 15 years of Maternal and Child Health nursing experience. Forty-eight percent of the Enhanced Maternal and Child Health nurses are from an urban location, with 28% from regional cities and 24% from rural councils.

A thematic analysis of the interviews enabled a categorisation of the nurses' and managers' discussion of what the nurses bring to their work into two broad themes: (i) ‘Things you can learn’, and (ii) ‘You just bring yourself’.

10.3 Declaration of contribution

Citation	Nature and extent of the candidate's contribution	Nature and extent of the co-author's contribution
Adams, C., Hooker, L., & Taft, A. (2022). The characteristics of Australian Maternal and Child Health home visiting nurses undertaking family violence work: An interpretive description study. Journal of Advanced Nursing, online (1), 1-15. https://doi.org/10.1111/jan.15160	80% contribution by the candidate. This included study design, data collection, data analysis, interpretation of results, drafting the paper, and manuscript revisions.	20% contribution by the co-authors. This included contributing to data analysis and interpretation. Co-authors also provided a critical review of the paper.

I, Catina Adams, declare that I have made a substantial contribution to this paper, including study design, data analysis, interpretation of results, and drafting the paper. My supervisors, Professor Angela Taft, and Associate Professor Leesa Hooker, contributed to the study design, intellectual input, and editing the manuscript.

I, Angela Taft, declare that Catina Adams made a substantial contribution to this paper. She contributed to all aspects and drafted the manuscript.

10.4 Published paper: The characteristics of Maternal and Child Health home visiting nurses undertaking family violence work: an interpretive description study

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The characteristics of Australian Maternal and Child Health home visiting nurses undertaking family violence work: An interpretive description study

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Abstract

Aims: To explore the family violence practice of home visiting nurses and identify the personal and professional characteristics of nurses undertaking family violence work.

Design: A qualitative research design using interpretive description.

Methods: The family violence nursing practice and characteristics of home visiting nurses in Victoria, Australia, were explored by analysing semi-structured interviews (n = 37) conducted over 4 months in 2019–2020. Twenty-five nurses and 12 nurse managers worked in urban, regional city and rural/remote settings. The data were analysed using reflexive thematic analysis.

Results: We categorized the characteristics of home visiting nurses into two broad themes with sub-themes: 'Things you can learn'; and 'You just bring yourself'.

Conclusion: By researching the characteristics of home visiting nurses undertaking family violence work, this study has identified the personal characteristics managers should consider when recruiting nurses to this specialist role. Identifying the personal and professional skills required will improve nurses' working experience by reducing the risk of a potential skill/role mismatch. These insights may enhance the effectiveness of home visiting nurses so that the Enhanced Maternal and Child Health program contributes effectively to the support of women experiencing family violence.

Impact: Interviewing home visiting nurses and their managers has enabled a clearer insight into this specialist practitioner's previously unexplored work. Identifying the nurses' personal, professional, and clinical characteristics should inform the development of position roles and identify nurses who are best suited for this role. This knowledge will ensure that the Maternal and Child Health program effectively supports women experiencing family violence.

KEYWORDS
Australia, family violence, home visiting, maternal and child health, qualitative research

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1 | INTRODUCTION

Home visiting nurses support families with infants and young children, monitoring children's growth and development, promoting health, and supporting maternal health and well-being. Nurses in home visiting programs are ideally positioned to identify and respond to disclosures of family violence; however, very little is known about how these nurses work with women experiencing abuse and the personal and professional characteristics of the most effective nurses.

Researchers have called for studies to systematically evaluate the characteristics of nurse home visitors (Jones Harden et al., 2010; McKelvey & Fitzgerald, 2020; Schaefer, 2016; Wasik & Roberts, 1994). To the best of our knowledge, no studies have explored the characteristics of home visiting nurses undertaking family violence work.

This interpretive descriptive study provides insight into the characteristics of nurse home visitors that best equip them to undertake effective family violence nursing practice.

2 | BACKGROUND

2.1 | Family violence

The terms intimate partner violence, domestic violence and family violence are common in Australia and overseas (Stubbs & Wangmann, 2017); however, they cannot be used interchangeably. Family violence refers to violence between family members, typically where a person exercises power and control over another person and may include violence perpetrated by intimate partners or other family members. The most common instance of family violence is intimate partner violence (Australian Institute of Health and Welfare, 2018).

Intimate partner violence is any behaviour that causes harm in a past or current intimate relationship (Australian Institute of Health and Welfare, 2019; World Health Organization, 2017). Violence against women may include physical, emotional or psychological harm and is a serious public health issue for women and children (World Health Organization, 2013). Intimate partner violence is most likely to begin during pregnancy or in the first year of a child's life (García-Moreno et al., 2015; Gartland et al., 2019). A recent study found more than one in four children in Australia witnessed family violence between caregivers (Gartland et al., 2021).

Abundant research has noted the short- and long-term effects of family violence on children's social and emotional well-being (Gartland et al., 2021; Hooker et al., 2016; Noble-Carr et al., 2020; Vu et al., 2016). Adverse outcomes for children may still arise, even when the violence is not directly witnessed by the child (McTavish et al., 2016; Meyer et al., 2021).

The Royal Commission into Family Violence (State of Victoria, 2016) generated increased interest and focus on screening, identifying and supporting women experiencing family violence. The Family Violence Risk Assessment and Risk Management Framework, also known as the Common Risk Assessment Framework or CRAF, was developed in Victoria to guide common approaches to assessing risk where domestic or family violence was present (Department of Health and Human Services, 2007). The CRAF was designed to support an integrated system approach and standardize service responses across Victoria. In 2018, the Victorian Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) replaced the CRAF (Family Safety Victoria, 2018), enabling a shared understanding of family violence and consistent, collaborative practice.

The Commission noted Maternal and Child Health nurses play an important role in supporting families and are often the one consistent source of advice and support for new parents (State of Victoria, 2016). In Victoria, Maternal and Child Health nurses routinely ask women about family violence at the 4-week consultation if it is safe to do so and at other times as indicated. Nurses are guided in their family violence work by the MARAM framework by offering support and strategies, undertaking a risk assessment, assisting with safety plans, and referring to specialist agencies (Family Safety Victoria, 2020).

2.2 | Maternal and child health service in Victoria, Australia

Maternal and Child Health nurses work with parents and early years' services, promoting healthy outcomes for children (0–6 years) and their families (Department of Education and Early Childhood Development, 2009; Department of Health and Human Services, 2019b). Maternal and Child Health nurses are qualified in Nursing, Midwifery, and Child, Family and Community Health. The Maternal and Child Health service is a free service with almost 100% engagement with families at birth and comprises a series of Key Ages and Stages consultations at specified ages—a home visit shortly after birth, and at 2 weeks, 4 weeks, 4 months, 8 months, 12 months, 18 months, 2 years and 3.5 years. The consultations focus on health promotion, monitoring infant growth and development, and maternal health and well-being. In addition to the universal Maternal and Child Health service, the service also includes an enhanced home visiting program and a 24-h Maternal and Child Health phone line.

2.3 | Enhanced Maternal and Child Health program

The Enhanced Maternal and Child Health (EMCH) program is a nurse home visiting program that supports families experiencing additional challenges (Department of Health and Human Services, 2019a). A recent review found that clients of the EMCH program are highly complex, with multiple concurrent issues. More than 25% were referred with mental health issues, and more than 20% were experiencing family violence (Adams et al., 2019).

2.4 | Nurse home visiting

Early childhood home visiting is a structured model of interaction with families, typically addressing maternal and child health, early childhood development and family well-being (Fox et al., 2015; Schaefer, 2016). Home visiting programs are grounded in Bronfenbrenner's ecological theory (1979), focusing on the child and family and the community and societal contexts in which families are nested (Kirkland, 2013). This approach to providing support to families of young children increases opportunities to adapt services to meet each family's specific needs in the context of their everyday environment (Peterson et al., 2013).

Nurse home visiting has generally proven beneficial and cost-effective in providing services to families (Schaefer, 2016) and improving outcomes for children and families (Doggett, 2013). However, the benefits can vary according to the elements of the individual programs and delivery location (Molloy et al., 2021). Although home visiting models vary widely, they all emphasize the importance of a strong relationship between a nurse home visitor and the family (Duffee et al., 2017; Jack et al., 2021; Schaefer, 2016; Sharp et al., 2003). Home visitors share their knowledge and skill with clients by establishing a relationship with the client (Schaefer, 2016). 'From the point of view of families, home visitors are the program' (Gomby, 2005, p.40).

Maternal and child health services in Victoria aim to provide continuity of care, fostering a rapport between the woman and their nurse, enabling trust to develop and increased potential for disclosure of issues for the family (Schroeder, 2011). Developing a therapeutic nurse–client relationship built on a foundation of acceptance, trust and strong rapport is at the core of most long-term home visiting programs with vulnerable populations. This relationship may facilitate nurse home visitors' abilities to ask about family violence and other significant social issues and increase clients' comfort levels in disclosing family violence (Jack et al., 2012).

3 | THE STUDY

3.1 | Aims

This research is one element of a sequential quantitative and qualitative project exploring how the Victorian EMCH program supports women experiencing family violence. The two research phases (a quantitative survey, then qualitative interviews) facilitated a sequential and progressive empirical investigation.

The first phase of the research was a mapping survey of EMCH programs across all LGAs in Victoria, undertaken in December 2016/January 2017. The survey results, particularly the high levels of family violence identified, informed the design of the second phase of the research.

Semi-structured interviews with 25 EMCH nurses and 12 nurse managers identified the nursing roles and characteristics of nurses working with women experiencing family violence, specifically the skills, knowledge and attributes required. The role of nurse managers in supporting nurses was also explored.

This element of the study sought to answer the following research questions:

- What skills and knowledge do nurse home visitors bring to family violence nursing practice?
- What are the personal characteristics of nurse home visitors working with women experiencing family violence?

3.2 | Design

Interpretive description is a qualitative research approach that uses inductive strategies to interpret characteristics of complex clinical phenomena (Thorne, 2016) and is particularly relevant to our exploration of nurse FV practices and attributes. The interpretive researcher looks for multiple truths, looking for explication, understanding and meaning rather than cause and effect (Thorne, 2016). The investigator and the investigated are interactively linked in creating findings, with the investigator as a 'passionate participant' (Toma, 2000, p.182).

Thorne suggests that quality in interpretative research design aligns the purpose, the process and the context of the study into a 'coherent and convincing account' (Thorne, 2016, p.239). Our research question has epistemological integrity, that is, we are asking real-world questions with answers which will inform clinical practice.

Being a clinician researcher known to many participants meant that the nurses and managers often said—'You know what I am talking about'. Sharing their experience with an interviewer familiar with the EMCH program meant that nurses were very open in disclosing their experiences. Adopting this interactive approach required extensive reflexive journaling to ensure that the interviewer was self-aware and the voice of the participants emerged as the focus of the interviews.

3.3 | Sample/participants

Nurse managers in 79 Local Government Areas in Victoria were emailed and asked to invite nurses working with EMCH clients to participate in the study. There were no exclusions, and participation was voluntary.

We received expressions of interest from 30 nurses and 14 managers, and we sampled for diversity in our purposive sampling framework and identified a group of nurses ($n = 25$) and nurse managers ($n = 12$) with a variety of experiences and backgrounds (Table 1).

3.4 | Data collection

Semi-structured interviews were conducted by the first author (CLA) face-to-face in the participant's workplace over 4 months

TABLE 1 Demographic details of participants

Nurses	*N* (%)	Nurse managers	*N* (%)
EMCH nurses	25	Nurse managers	12
Local government area		Local government area	
Urban	12 (48)	Urban	7 (59)
Regional city	7 (28)	Regional city	4 (33)
Rural/remote	6 (24)	Rural/remote	1 (8)
Years of MCH nursing experience		Professional experience	
3–5 years	2 (8)	Previous MCH nurse	6 (50)
6–10 years	9 (36)	Previous EMCH nurse	5 (42)
10–15 years	5 (20)	Early Childhood	1 (8)
>15 years	9 (36)		
Qualifications		Qualifications	
Registered nurse midwife	25 (100)	Registered nurse midwife	12 (100)
Bachelor's degree	21 (84)	Bachelor's degree	8 (66)
Masters' degree	4 (16)	Masters' degree	4 (33)

in 2019/20 (see Figure 2 for the interview guide). The nurse interviews ranged from 29 to 79 min (mean 45 min), and the nurse manager interviews ranged from 35 to 95 min (mean 52 min). Demographic information was collected, but the data analysis did not include participants' identities, with pseudonyms allocated to each participant. The face-to-face interviews were recorded digitally and then transcribed using NVivo Transcription. CLA checked the transcriptions to ensure fidelity to the recording before uploading them to NVivo for data analysis (QSR International, 2020).

3.5 | Ethical considerations

The research was approved by the La Trobe University Human Ethics Committee (Ethics approval number 22227) and the Department of Health and Human Services (HHSD/19/129427).

3.6 | Data analysis

The data were analysed using reflexive thematic analysis (Braun & Clarke, 2006, 2020). The six phases of thematic analysis enabled a rich analysis and reporting of the data. CLA conducted the interviews, so the content was already familiar with the initial coding. The interview guide provided initial deductive themes, and then we inductively explored the data. CLA coded the interviews by generating initial codes, reviewing and naming themes. NVivo was used to assist with coding and theme development (QSR International, 2020). A detailed NVivo codebook enabled consistent definitions for the second author (LH) to review the coding. We used a spreadsheet matrix to summarize the data, developing themes and sub-themes to generate coherent data reporting.

3.7 | Rigour

Using the COREQ checklist in the design, data collection, analysis and reporting (Tong et al., 2007) enhanced this qualitative research study (attached). CLA, an experienced EMCH nurse and nurse manager, developed the interview guide with input from two research supervisors, one with extensive qualitative interviewing experience and an experienced clinician researcher.

As an insider researcher (Leslie & McAllister, 2002), CLA is a researcher who is also a Maternal and Child Health nurse. Using reflexive journaling enabled them to consider how the clinician researcher's experiences can intervene in the research process and how their professional and personal experiences might affect nurses' relationships. The reflexive journaling and discussion with experienced colleagues enabled the 'thoughtful practitioner test' to be applied—a collateral data source that allows triangulation with what the participants were reporting in their interviews (Thorne, 2016).

Piloting the questions with nurses provided feedback on the questions' scope and the student researcher's interviewing technique. This feedback specifically identified any bias the interviewer brought from her experience as an EMCH nurse and manager of EMCH nurses. This feedback, coupled with extensive reflexive journaling, enabled revisions to the interview guide and interviewing technique to ensure open, curious questioning (see Figure 2 for interview guide).

4 | FINDINGS

To the best of our knowledge, the characteristics of home visiting nurses undertaking family violence work have not been studied. We interviewed 25 nurses and 12 nurse managers working in a

range of urban, regional and rural/remote settings (Table 1). The data from the interviews have enabled an insight into the nurses' work with families and the characteristics that contribute to the most effective care and support of women experiencing family violence.

All nurse participants were triple qualified with at least a Bachelors' degree in Nursing and postgraduate qualifications in Midwifery, and Child, Family and Community Nursing. Sixteen per cent of nurses had Masters' level qualifications. The nurses were highly experienced, with 56% having more than 10 years of experience as an MCH nurse. Most managers were MCH nurses, with one early childhood education qualified manager. Two managers had a Master of Nursing, and one had a Master of Business Administration (Table 1).

When asked about the characteristics of EMCH nurses doing family violence work, most respondents focused on what they viewed to be intrinsic qualities. They argued these personal characteristics were inherent and were difficult, if not impossible, to 'learn'. The characteristics (intrinsic) included being passionate, self-aware and authentic.

The professional (extrinsic) skills described included clinical nursing expertise, communication skills and family violence expertise. We categorized the nurses' and managers' discussion of what the nurses bring to their work into two broad themes: (1) 'Things you can learn' (extrinsic); and (2) 'You just bring yourself' (intrinsic). We also asked the question—Can anyone be an effective EMCH nurse? We have summarized the responses to this question under the theme 'Not everyone can do this work'. Figure 1 summarizes the themes and subthemes, and Table 2 presents the themes and illustrative quotes.

5 | THINGS YOU CAN LEARN

Being a nurse and midwife is an essential element of what the EMCH nurse offers to the client and contributes to their credibility. The nurses and managers identified the education and skills that could be 'learnt' by the EMCH nurse, such as specialist training in family violence practice, infant mental health, trauma-informed practice, family partnership models, motivational interviewing and reflective practice skills. Nurses with these skills were often viewed as excellent EMCH nurses who had the most to offer in their practice.

5.1 | Clinical nursing expertise—physical assessment, nursing care planning and strength-based practice

EMCH nurses have highly attuned clinical observation and assessment skills in maternal health, well-being and child health and development. The nurses spoke of using health assessments as ice-breakers. 'I'm often called upon for rashes and various things', but this entry point would serve to develop the relationship and a rapport that enabled connection at a deeper level.

> So, you know, so as far as Enhanced goes, sometimes the Key Ages and Stages (developmental screening) run a second because that's not what the client wants. I mean, they love the weights and measures, and she's happy I'm there. She knows she can talk to me. We've

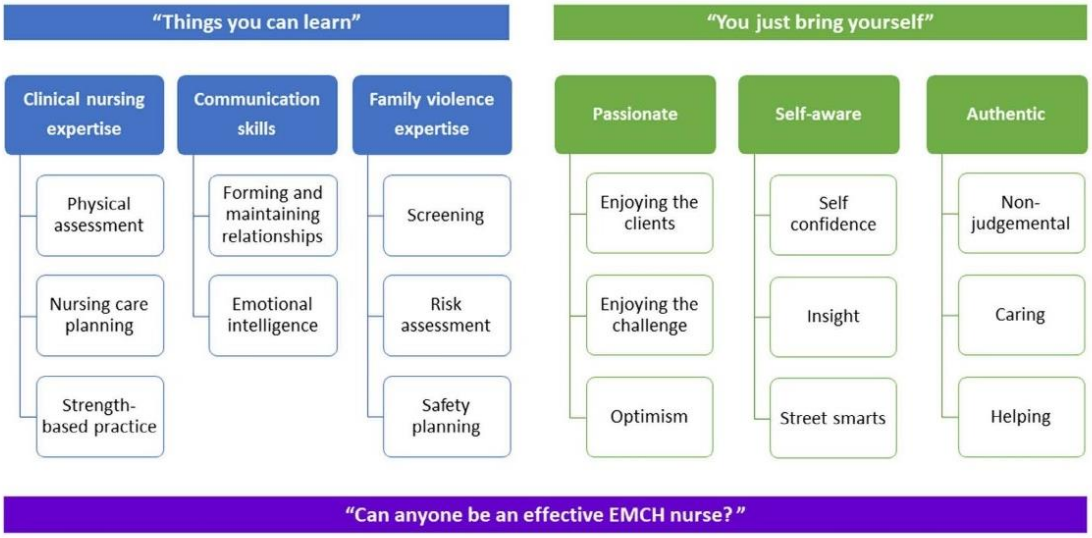

FIGURE 1 Themes and sub-themes

TABLE 2 Themes and illustrative quotes

Things you can learn Clinical nursing expertise Physical assessment Nursing care planning Strength-based practice	Our scales get us in the door (Cassie, nurse) I bring my knowledge of health. I'm often called upon for rashes and various things. Also, interestingly, my midwifery knowledge is used because a lot of families know that I work as a midwife, and they are having the next baby. My knowledge of health and well-being. I think that's utilized quite a lot (Grace, nurse). Watching how children react, if they're in the room with the mother, just how they play. And if dad, the partner came, be observant to how kids would change. Yes. watching. Yeah. Just observing (Diana, nurse). There is a mum that I am working with who was referred to us by a social worker. There was an intervention order because there was family violence during the pregnancy. And I have met with her and she's saying that there's no family violence anymore, just denying it. So, I'm just building a rapport with her. We are just addressing some physical issues, feeding issues, and I am taking it slow (Amanda, nurse) If I had the perfect Enhanced nurse, they would have mental health training, child protection training and family violence training. And refugee trauma training. (Yvonne, manager). They need sound theoretical knowledge. Yes. Particularly in that trauma-based care, child development, mental health, you know, of course, family violence (Cath, manager). These nurses have a real skill. You know, you always hear them talking about the strengths and talking about the positives and finding a space. They quickly work out who are the protective people around babies. They're very good at that. They use that language. They'll work with whoever's protective. They seem to work in a way that they find that person (Belinda, manager). Finding the strength in the family that presents when everyone writing them off. Yeah. Yeah. Because everyone's got a strength (Cassie, nurse). Somebody that's able to engage quickly and build rapport. In a way that's very family partnership, family led, rather than fix it mentality. I think that would be the perfect person. But, you know, everyone comes with different and different strengths and you never going to get the perfect person. I think the skills need to be that they can work very closely with the family at the family's level. And see the client (Yvonne, manager)
Things you can learn Communication skills Forming and maintaining relationships Emotional intelligence	You can kind of read the body language of someone and you can know if it's gonna be okay, maybe to ask a little bit more or if it's not. If maybe it's not a good time to be doing that so you can follow it up with a phone call or another appointment. And being guided by the woman. Sometimes they'll say, I don't want to talk about it, or they might say there are issues, but I don't want to talk about it yet. And having that respect to say, okay, that's okay (Beth, nurse). So, you know, so as far as Enhanced goes, sometimes it's the Key Ages and Stages (developmental screening) run a second, because that's not what the client wants. I mean, they love the weights and measures, but walking in there and she's happy I'm here. She knows she can talk to me. We've got that rapport so we can do more if she wants more (Grace, nurse) I'd always allow quite a long time when I would do my cold calls with her in case we could get on a roll and, you know, because once she starts talking, she continues. If you don't ask the questions in the right way, she shuts down like she wouldn't feel comfortable talking. So, my thing with her was just giving her the time (Michelle, nurse). Once I've got to know her, and you know, had some home visits and this family has got to know me and there's some sort of a rapport and a trust. And then I ask the more direct questions. I tip my toe in the water, gauge the body language, their response, and then I can add a little bit more and a bit more. You know, you can ask the questions and they go, nah, nah, nah. But the body language is saying yeah, yeah, yeah (Penny, nurse). Being able to build a relationship and being patient with that, because sometimes they don't even want you in the house, you know what I mean. So, it's about trying to connect in some way, you know, in a way that's really comfortable for them and then build on that (Coral, nurse).
Things you can learn Family violence training Screening Risk assessment Safety planning	And like I had a very big case this year, there was big physical family violence. And the mum had never known any different. And so even though she could acknowledge that what was happening wasn't okay. When you've never had someone treat you well in your life, it's hard for them to see, to imagine a different life. Yeah, because they don't know any different. And that's really challenging. And how to work with a mum who has had so much trauma and violence in her life and how she will in one sentence say, ah, I'm worried because I can see this is affecting my children. But then in the next sentence, she'll minimise, saying, nah, that's okay. They didn't see us having that physical fight, because they were playing in the backyard (Betty, nurse). I don't feel as equipped as I possibly could be. We're in this very challenging position of not being family violence workers, but being at the frontline of family violence disclosures, and I don't think we're well-trained in it. As MCH nurses. I think, you know, when we all went off and did training, it was good training, but it was at a very broad level or generic. It was for everyone. And there was no meat behind it. It didn't really give me the tools that I needed (Doris, nurse). I think with her. We had to build trust with her. Build that trust cause she's never, the fact that she didn't disclose any family violence with her older two children. That sort of told me that she had a real issue with opening up. And I remember her just saying it, can I trust you with this? And that to me, sort of amplified everything that we were doing, like the fact that I was consistent and visiting her and telling her that I'm here for you (Michelle, nurse)

TABLE 2 (Continued)

You just bring yourself Passionate Enjoying the clients Enjoying the challenge Optimism	I've just always been interested in marginalized families (Grace, nurse) And to me, I enjoy people. I really enjoy them, and I love I love their story. And the enhanced gives you the opportunity to get the story before you do anything else (Bronwyn, nurse). I think you've got to want to do it. If you're not interested in working with clients who are facing these difficulties, then it's not something that you should be doing. But even having an open mind to explore the possibility, is probably what's important. I think you have to be open and flexible and fairly well grounded to be able to do the work (Nancy, nurse). I think there's a different passion for the work. You know, the enhanced nurses truly enjoy the clients to some level. You know, they really want to be there to make the difference and to help and to try and be effective (Belinda, manager). I enjoy it because of the variation in it, the continuity that you get, particularly when you're a one nurse enhanced service, you know that's all they're seeing is you. And being able to feel like you're getting a little bit more into the meat of what's going on with families, working with other services as well (Doris, nurse). It's challenging in different ways. It can be. You know, there's that feeling of really, really pushing things uphill sometimes (Cassie, nurse) Passion, I guess a real belief in the work they're doing and the belief that working with this cohort of people with young infants and children can make a difference. The persistence. The optimism (Zalie, manager).
You just bring yourself Self-aware Insight Self-confidence Street smarts	You've got to have nerves of steel and steel and to be able to hear the hair-raising stories and not judge. Absolutely. Just be respectful of people's pasts and histories no matter what it is, you know? (Cath, manager) A broad world view and nonjudgmental attitude. I think the ability to accept other people's choices for what they are. Yes. Without feeling the need to impose your own thought values and opinion (Naomi, manager) You're softening and then hardening. You've got to go from one to the other. You've got to harden so it doesn't overwhelm you, and you've got to soften because you don't want to be this hard person who doesn't care (Eve, nurse). You have to have your radar up with these guys. Yeah. I just think that you have to have a pretty good understanding of humanity. And I'm saying I'm streetwise. I think you have to be street smart (Bronwyn, nurse) I think life experience would be the beginning, rather than training per se. The training is all helpful. But I think the biggest thing would just be getting older and having more life experience (Grace, nurse) I think having a strong sense of what my role is, a sense of confidence in my boundaries and how far I go (Nancy, nurse)
You just bring yourself Authentic Non-judgemental Helping Caring	I think just that highly nonjudgmental attitude like being able to work with what is in front of you and being able to sift through the chaos. So being able to sift around that a little bit and get some rapport and engagement (Belinda, manager) I think by listening and being present and just having some empathy and understanding (Grace, nurse) I just have a desire to try to do something that's helpful for people, and I think that that's what drew me into nursing, and midwifery. I feel like even if it's a small difference that's made, it's worthwhile. And I think the rewards that you get out of it, make the hard times worth it (Beth, nurse) Well, I mean, how else do you do it? I mean, you just bring yourself, don't you? You just bring yourself. That's right. And they can pick a fraud. (Cassie, nurse)
Can anyone be an effective EMCH nurse?	I think some people will get a lot out of it. will really enjoy it. Will like sinking their teeth into it. And I think some people don't. Some people like the regimented you know structure of the universal service (Doris, nurse). I think you have to have a certain skill set to be able to do Enhanced. A lot of that comes down to personality. And it's very hard to measure that (Cath, manager). But I also think not everyone wants to do that work and that's okay. If you're not passionate about it, you're not going to do it well (Doris, nurse). I think Enhanced nurses do carry a very different skill set to universal nurses. And I think that should be recognized, that it's not anyone can just come across and work in and Enhanced team as a maternal health nurse and run with it (Cath, manager) Over time, I've just built up my skills and experience and empathy. And I think you also bring your own personal set of skills to enhanced. Not everyone can do it. No, I think you have to be compassionate and nonjudgmental. I think it's very important because we're dealing with every sort of community (Jenny, nurse) I'm still discovering whether I'm actually suited for it. Trying to put your own biases and value system that I've grown up with aside, realizing that these people are, you know, a lot of the families I'm working with have grown up with totally different circumstances. And their world view is completely different than mine, and so what I think is the best, is not necessarily what they think is (Sharon, nurse).

got that rapport, so we can do more if she wants more (Grace, nurse).

Other nurses spoke of the referrals to the EMCH program that were ostensibly about sleep or behavioural issues. What started as a sleep and settling consultation often developed into a discussion about an unhealthy relationship or the mother's depression or anxiety. 'It's never just about the baby' (Lorraine, nurse).

Nurses spoke about the opportunistic observations in their practice—'watching how children react, if they're in the room with the

EMCH nurse - Questions to prompt the discussion

Tell me about your job – what do you do?
How did you come to be doing this work?
Can you tell me about any training you have had? What training do you think has helped you most to do this work?
Can you think of a family you have worked with experiencing family violence (de-identified)?

- What were the biggest challenges you faced in responding to them? (prompts – screening, risk assessment, safety planning, referral)
- How did you work with this family?
- What tools, techniques, and skills did you bring?
- (prompt)
- Why did you work in this way?
- (prompt)
- What have you based this on?

For rural nurses - How does your rural setting impact on the way you work with women and children experiencing FV?
Do you perceive any tensions between what you do, and what you are expected to do?
What problems have you encountered in addressing FV when you are home visiting?
How safe do you feel in this work? (prompt) physical safety, emotional safety
What do you do if a consultation causes you to feel stressed, anxious or helpless?
When undertaking this work what feelings come up for you?
Any other questions or observations? Thank you for your contribution and time.

EMCH nurse supervisor - Questions to prompt the discussion
Please describe your role as an EMCH nurse supervisor? What does it entail?
Can you tell me about any training in supervision you have had? What training do you think has helped you most?
For rural nurse supervisors - How does your rural setting impact on the way you support EMCH nurses?
Thinking about the official tools and documents you have used - how do they support you in this work? How did they hinder your work?
Do you perceive any tensions between what you do, and what you are expected to do?
What additional support does an enhanced nurse provide in their work with women and children experiencing FV?
What problems have you encountered in supporting nurses doing family violence work?
What resources or supports are required for EMCH nurses working with women at risk of, or experiencing FV? And for EMCH nurses working with children at risk or experiencing family violence?
When supporting nurses doing family violence work, what feelings come up for you?
How safe do you feel in this work? (prompt) physically, emotionally
Where do you currently turn if your supervision of EMCH nurses causes you to feel stressed, anxious, or helpless?
Any other questions or observations? Thank you for your contribution and time.

FIGURE 2 Interview guide

mother, just how they play. And if dad, the partner came, be observant to how kids would change. Yes, watching. Yeah. Just observing' (Diana, nurse). Another nurse spoke about a family that refused to open the door when a relieving nurse arrived without her scales: 'The families won't open the door. No, they won't, they just trust that one person. Well, they might have thought it was child protection' (Grace, nurse).

Nurses spoke of using the Child and Family Action Plan to plan EMCH care with the family. The Child and Family Action Plan is a component of the EMCH program which supports the principle of strength-based, family-centred practice by engaging and empowering parents/carers as partners in the program (Department of Health and Human Services, 2019a).

Working collaboratively with families is a learned skill, and some nurses struggled with this new approach to articulating their work.

> I know many nurses talk about struggling with the idea of the Child and Family Action Plan, that they feel like families have no way of knowing what they need. But if you have a good plan in place, that is the family's plan, it gives you the mechanism to discharge. Whereas if you don't have goals, you've got no basis to discharge ever (Naomi, manager).

Table 2 includes examples of the nurses describing how they have learnt to apply a strength-based approach (Williams, 2019) and a knowledge of trauma-informed care (Isobel et al., 2019) in planning care with families. Managers also felt that a strength-based approach was critical—'We certainly always work from a strength-based perspective. At all times identifying what is going well for the family and working with that' (Naomi, manager).

When working with women experiencing family violence, the nurses highlighted that the Child and Family Action Plan was unsuitable for family violence work, being a client-held record, with the potential for a breach of privacy with perpetrators and implications for the woman's safety. Most nurses referred to the MARAM as providing more effective tools for working with women experiencing family violence, for example, working with the woman to develop a safety plan (Family Safety Victoria, 2020).

5.2 | Communication skills—forming and maintaining relationships, emotional intelligence

The nurses and managers described communication skills as extrinsic (things you can learn) and intrinsic to some extent. Most acknowledged the value of their education and training in communication skills, particularly body language and active listening.

> Once I've got to know them, and you know, had some home visits, and this family has got to know me, and there's some sort of a rapport and a trust. And then I ask the more direct questions. I tip my toe in the water, gauge the body language, their response, and then I can add a little bit more, and a bit more. You know, you can ask the questions and they go, Nah, Nah, Nah. But the body language is saying Yeah, Yeah, Yeah (Penny, nurse).

The nurses also valued having gained knowledge of emotional intelligence, including forming and maintaining relationships. Managers spoke of the value of nurses, on the one hand being able to engage quickly and build rapport, and in other cases, being able to build a relationship over time and being patient with that. One nurse spoke of the flexibility required when meeting with the woman on her terms:

> I'd always allow quite a long time when I would do my cold calls with her in case we could get on a roll and, you know, once she started talking, she would continue. If you don't ask the questions in the right way, she'd really shut down like she wouldn't feel comfortable talking. So, my thing with her was just giving her the time (Michelle, nurse).

Nurses spoke of the benefit of clinical supervision in honing their communication skills, which they felt were even more critical when working with women experiencing family violence, where sensitivity is required when asking women about their safety in the home.

5.3 | Family violence expertise—screening, risk assessment and safety planning

All the nurses spoke of being attuned to the elements of family violence work—screening, risk assessment, safety planning and referral. They reflected on the training they had received through the MARAM framework, and one nurse appreciated the family violence education she had received:

> I think our training has been good and thorough. I found it helpful to understand the deep-rooted, you know, I guess they call it, the drivers of family violence. It's that deeper understanding of gender equity and control and feeling more confident in that space of working with families where that was present (Sharon, nurse).

However, other nurses felt they needed additional training that was tailored to the work of child and family health:

> I don't feel as equipped as I possibly could be. We're in this very challenging position of not being family violence workers, but being at the frontline of family violence disclosures, and I don't think we're well-trained in it. As MCH nurses. I think, you know, when we all went off and did the training, it was good training, but it was at a very broad level or generic. It was for

> everyone. And there was no meat behind it. It didn't really give me the tools that I needed (Doris, nurse).

One manager also expressed concern that nurses were not as well-trained as they needed to be: 'To be completely honest. I'm not sure that nurses have the skill set now to do safety planning with their clients. Because it's not their bread and butter' (Amanda, manager). It is important to consider the impact on nurses if they are ill-equipped for their work and the increased risk to both the nurse and the woman if the nurse lacks confidence in family violence work.

6 | 'YOU JUST BRING YOURSELF'

When asked about the characteristics of EMCH nurses doing family violence work, most respondents focused on what they viewed to be inherent personal characteristics. Passion for EMCH nursing and social justice was a common driver for many nurses and their managers. Nurses spoke of enjoying the challenge, the variety of the work and were strongly optimistic, trusting in the woman's ability to keep herself and her children safe and enact change when she was ready.

Michelle (nurse) spoke of bringing all the aspects of being an EMCH nurse together when working with women experiencing family violence.

> We had to build trust with her. Build that trust, because she didn't disclose any family violence with her older two children. That sort of told me that she had a real issue with opening up. And I remember her just saying it, can I trust you with this? And that to me, sort of amplified everything that we were doing, like the fact that I was consistent and visiting her and telling her that I'm here for you (Michelle, nurse)

6.1 | Being passionate—enjoying the clients/enjoying the challenge/optimism

Many nurses spoke of enjoying the clients, enjoying people generally, and loving their stories. 'As hard as it can be, I really enjoy this work. I get so much out of it' (Beth, nurse). Most nurses spoke of enjoying the variation, 'it really appeals to me, something different and really challenging' (Cindy, nurse). Other nurses enjoyed the continuity, and 'particularly when you're a one-nurse enhanced service, you know all they're seeing is you. And being able to feel like you're getting a little bit more into the meat of what's going on with families' (Doris, nurse).

Nurses spoke of the optimism required to be strength-based in practice, 'finding the strength in the family that presents when everyone is writing them off. Yeah. Because everyone's got a strength' (Cassie, nurse). Nancy also spoke of having an open mind to explore the possibilities, 'you've got to want to do it. If you're not interested in working with clients who are facing these difficulties, then it's not something that you should be doing'.

More than one manager described the passion of the nurses: 'Passion, I guess a real belief in the work they're doing and the belief that working with this cohort of people with young infants and children can make a difference. The persistence. The optimism' (Zalie, manager). 'I think there's a different passion for the work. You know, they really want to be there to make the difference, and to help, and to try and be effective' (Belinda, manager).

One manager described the experience of an EMCH nurse who did not have this optimistic perspective, who ended up leaving the service. She experienced burn-out, and the manager attributed this, among other things, to an inherent lack of optimism, leading to her feeling defeated in the role.

6.2 | Self-awareness—self-confidence, insight and street smarts

Many nurses and managers spoke of needing life experience and self-confidence to carry themselves in challenging scenarios. Grace explains, 'I think life experience would be the beginning, rather than the training per se. The training is all helpful. But I think the biggest thing would just be getting older and having more life experience' (Grace, nurse). The nurses and managers felt that life experience was essential when working with women experiencing family violence, and inexperienced or naïve nurses could be easily overwhelmed and experience vicarious trauma. *You've got to have nerves of steel to be able to hear the hair-raising stories and not judge. Absolutely. Just be respectful of people's pasts and histories no matter what it is* (Cath, manager).

6.3 | Authentic/non-judgmental/caring/helping

Being authentic in the relationship with the woman was viewed by both nurses and managers as critical, enabling a therapeutic rapport, which could lead to a discussion about the challenges facing the woman. 'Well, I mean, how else do you do it? I mean, you just bring yourself, don't you? You just bring yourself. And they can pick a fraud' (Cassie, nurse).

It was these inherent characteristics of which most nurses and managers spoke—

> I think just that highly non-judgmental attitude, like being able to work with what is in front of you and being able to sift through the chaos. So being able to sift around that a little bit and get some rapport and engagement (Belinda, manager).

Beth (nurse) identified the personal qualities that drew her to EMCH nursing work, extending her previous career as a nurse/midwife, as being empathetic and caring. However, sometimes, these same

qualities caused challenges for some nurses. Nurses spoke of needing to soften, to be open and empathetic, but also needing to harden so as not to be overcome by the emotion of the family's situation.

> You've got to go from one to the other. You've got to harden, so it doesn't overwhelm you, and you've got to soften because you don't want to be this hard person who doesn't care. But you can't be too soft and vulnerable (Eve, nurse).

6.4 | 'Can anyone be an effective EMCH nurse?'

Managers spoke of the qualities that detract from effective EMCH nursing work. Some nurses may encourage the client to depend on them and may themselves develop a dependence on the client. This can result in the client being retained in the EMCH program when a better option is a referral to other services.

> But of course, all the nurses have got different personalities. This one nurse that works in our council who is very good with clients with emotional health issues. However, I think once she develops a rapport with the client, she likes to hold on to them and she's always getting in trouble for doing too many additional consultations (Moira, manager).

The nurses and managers identified personal characteristics required for effective family violence nursing practice and reflected that not all nurses were suited to do this enhanced work. Skills and knowledge can be learned, but they argued there are inherent characteristics, and without these, the nurse may not be able to support families effectively. 'Personality plays a strong role I would certainly say. That's why not all MCH nurses are suited' (Betty, nurse). Many universal nurses do not want to do EMCH work, viewing it too challenging. 'They like the regimented structure of the universal service' (Doris, nurse).

Cath (manager) said, 'I think you have to have a certain skill set to be able to do Enhanced. A lot of that comes down to personality. And it's tough to measure that'. In this part of the interview, the managers described the qualities they look for in an EMCH nurse. 'If I had the perfect Enhanced nurse, they would have mental health training, child protection training and family violence training. And refugee trauma training' (Yvonne, manager). 'They need sound theoretical knowledge. Yes. Particularly in that trauma-based care, child development, mental health, and of course, family violence' (Cath, manager).

Nurses also considered these aspects, with one nurse reflecting on whether she was suited for the role,

> I'm still discovering whether I'm actually suited for it. Trying to put your own biases and value system that I've grown up with aside, realising that these people are, you know, a lot of the families I'm working with, have grown up with totally different circumstances. And their worldview is completely different from mine, so what I think is the best is not necessarily what they think is (Sharon, nurse).

7 | DISCUSSION

Home visiting maternal and child health nurses are highly skilled practitioners, bringing extrinsic and intrinsic characteristics to their professional practice. Interviewing EMCH nurses and nurse managers has enabled a discussion of how nurses work with women experiencing family violence. Other research has sought to identify the characteristics of home visiting nurses (Schaefer, 2016); however, our study has identified both extrinsic (those which can be learned) and intrinsic characteristics nurses need for effective family violence nursing practice. We have highlighted the most important qualities in supporting women experiencing family violence. In reviewing these characteristics, we have also considered the question, 'Can anyone be an effective EMCH nurse?'

Home visiting programs depend on creating a relationship between the home visitor and the parent (Gomby, 2007; Jack et al., 2002). Jones Harden (2010) considered the links between home visitor characteristics and program quality to uncover what home visitor characteristics are linked to program success. They identified the personal characteristics of the nurse, together with improving nurse capacity and confidence, as having the most significant impact on the success of the program (Jones Harden et al., 2010). Other research has attempted to identify the characteristics of exemplar nurses (Schaefer, 2016) as a means of ensuring that nurses recruited to home visiting nursing work were suited for the challenges of the work.

The EMCH program is funded to deliver up to 20 h per client, so where a nurse provides more than this, it can lead to an overstretched service. Overservicing can occur where there is a lack of clarity around the family goals, resulting in unfocused work. This 'holding' can also happen where there is a lack of referral options, and the client is 'held' in the EMCH program. Both nurses and managers highlighted clinical supervision to ensure that nurses continued to be reflective in practice and self-aware of tendencies to overstep the role

Some researchers have focussed on personality (Sharp et al., 2003), describing elements such as negative emotionality as associated with less time spent in home visits. Our study highlighted the impact of an optimistic perspective as contributing to the successful engagement of the family and the nurse's capacity to work in challenging scenarios. This intrinsic characteristic is consistent with other researchers who argue that having a non-judgmental, optimistic attitude about parents is more likely to increase family participation and positive family outcomes (Beeber et al., 2007).

An extensive body of research that examines the concept of 'caring' in nursing describes caring behaviours as specific, recognizable and observable actions performed by nursing professionals, which

cause an impression on patients and on which they rely to judge whether they feel cared for or not (Clark et al., 2016). Caring has also been described as a set of displayed behaviours in the nurse–client relationship which includes knowledge, skills and specific attitudes, or a collection of ideas, attitudes and actions (Romero-Martín et al., 2019),

The nurses and managers in our study agreed that caring, having a sense of optimism and expressing genuine enjoyment in working with families experiencing challenges were essential characteristics for the EMCH nurse. Other research upholds these qualities and the capacity to be self-aware, work flexibly, develop a positive helping relationship with families (Korfmacher et al., 2013) and personal characteristics such as persistence and being conscientious (Brookes et al., 2006). Our research also found being authentic was critical in working with families, similar to the 'genuineness' described by Schaefer (2016).

The nurses and managers in this study described the building and maintaining of relationships with families as integral to home visiting work. Other researchers have highlighted the skill nurses bring with a variety of relationship-based strategies that are particular to the developmental phase of the relationship (Beeber et al., 2007). Working in the home has been identified as bringing additional challenges, with an ever-changing context, and enabling more intimate access to the family (Beeber et al., 2007). Nurses in our study also spoke of the need to be flexible in their responses, considering the unpredictable nature of the home environment.

Emotional intelligence as a concept was first developed by Mayer et al. (1990) and has been defined as the emotional, personal and social skills that influence one's ability to succeed in coping with environmental demands and pressures (Harper & Jones-Schenk, 2012). Our research identified that emotional intelligence is a highly valued nursing characteristic; however, participants also felt that some of these skills could be learned if the nurse was not inherently emotionally intelligent. This insight aligns with contemporary psychosocial theories arguing that emotional intelligence is not static but amenable to development (Harper & Jones-Schenk, 2012).

Building trust and rapport is a significant facilitator for effective family violence support, and forming a relationship with clients has been described as critical (Davidov et al., 2021). The nurses and managers in our study also found that having the skills to build and maintain a relationship was even more critical when working with women experiencing family violence. A relationship of trust enables disclosure, which can then lead to safety planning and referrals.

8 | CLINICAL IMPLICATIONS

Our study identified several clinical implications to improve how the EMCH program supports women experiencing family violence. By identifying the extrinsic and intrinsic characteristics of ideal EMCH nurses, managers should be able to develop position roles that would describe the inherent characteristics of home visiting nurses undertaking family violence work and identify those nurses best suited for the role. Clearer role definition will improve nurses' experience by reducing the stress and burn-out that can arise from a skill/role mismatch. Identifying training and education needs for nurses to supplement any perceived deficits in skills and knowledge will improve the quality of the workforce and will also reduce stress for nurses by ensuring they feel well-equipped to undertake this emotionally challenging work.

These insights may enhance the effectiveness of home visiting teams, identifying potential skill mix with allied health team members, to ensure that the EMCH program contributes effectively to the support of women experiencing family violence. By identifying the characteristics of effective support for women experiencing family violence, managers may identify other members of the EMCH team with complementary skills and knowledge, such as social workers, early childhood practitioners and specialist family violence workers.

Ensuring nurses have access to high quality regular clinical supervision will enable self-reflection on whether they are intrinsically suited to undertaking enhanced work. These insights will allow nurses and managers to make ongoing employment choices if they are inherently unsuited for the position.

9 | STRENGTHS AND LIMITATIONS

This study has been strengthened by interviewing 25 nurses and 12 managers with diverse experiences and backgrounds, from rural and urban LGAs, working in advantaged and disadvantaged areas. The participants had the opportunity to speak at length of their experiences, with interviews lasting up to 75 min.

We did not conduct member checking in this study, which could be considered a limitation of the study; however, this would not typically occur with an Interpretative Description study (Thorne, 2016). However, the heterogeneity of responses would indicate that the nurses spoke frankly from their perspectives. The nurses appreciated that their responses would be reported anonymously, as they wanted to be truthful in their answers without fear of recrimination.

By interviewing both nurses and their managers, we explored the research questions from multiple perspectives, which could have identified differences between the nurses and managers; however, the responses were generally aligned.

This research would be supported by asking clients their view of effective EMCH nurse characteristics and the most supportive elements when experiencing family violence.

10 | CONCLUSION

In this study, we aimed to explore the family violence practice of home visiting nurses and identify the personal and professional attributes of nurses undertaking family violence work. By interviewing nurses and their managers, we have identified the skills

and knowledge and personal characteristics of nurse home visitors required for nurses to work effectively with women experiencing abuse.

Nurses need skills and knowledge that can be learnt through regular, high quality and targeted training and education, including clinical nursing expertise, communication skills and family violence expertise. In addition, EMCH nurses doing family violence work have inherent personal characteristics which are difficult, if not impossible, to 'learn'. The personal characteristics (intrinsic) include being passionate, authentic and self-aware.

Identifying the personal characteristics required to work with women experiencing family violence confirms that not all nurses can or should do this enhanced work. Skills and knowledge can be learned, but the inherent characteristics are required for effective family violence nursing practice.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the author(s).

DATA AVAILABILITY STATEMENT

Data may be available on request

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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10.5 Conclusion

No studies have explored the characteristics of Enhanced Maternal and Child Health nurses undertaking family violence work. When asked about the characteristics of Enhanced Maternal and Child Health nurses, most respondents focused on what they viewed to be their intrinsic qualities. These personal attributes were inherent and were difficult, if not impossible, to 'learn'.

The professional (extrinsic) skills included clinical expertise, nursing care planning, trauma-informed care, strength-based practice, communication skills, emotional intelligence, forming and maintaining relationships, family violence screening, risk assessment, and safety planning. The personal attributes (intrinsic) included enjoying the clients, enjoying the challenge, having optimism, being non-judgmental, warm and caring, being authentic, passionate, having self-awareness and insight, being self-confident, and having so-called street smarts.

In this research, the nurse characteristics that contribute to the most effective care and support of women experiencing family violence have been identified, and the personal attributes that managers should consider when recruiting nurses to this specialist role. Identifying the professional and personal skills required may improve nurses' experience by reducing the stress that can arise from a skill/role mismatch and ensuring the meeting of training and education needs. These insights may improve the work of home visiting teams to ensure that the Enhanced Maternal and Child Health program contributes effectively to the support of women experiencing family violence.

The manager's role in supporting these specialist practitioners has not been previously explored. In the following chapter, the crucial role played by the manager in ensuring an effective service response as part of the wider health system is explored.

11. MANAGING MATERNAL AND CHILD HEALTH NURSES UNDERTAKING FAMILY VIOLENCE WORK IN AUSTRALIA: A QUALITATIVE STUDY

11.1 Introduction

This paper explores the experience of Maternal and Child Health managers in their role of managing Maternal and Child Health nurses undertaking family violence work in Victoria, Australia. The study describes the impact of effective management on the well-being of high emotional labour employees, such as Maternal and Child Health nurses supporting women and children experiencing abuse.

11.2 Methods

Semi-structured interviews with 12 managers in 2019-2020 explored how they supervised and managed nurses. The data were analysed using Reflexive Thematic Analysis. Three themes were identified: (i) managing the service and being resourceful; (ii) supporting nurses' emotional safety; and (iii) hitting the ground running: the demands on the manager.

11.3 Declaration of contribution

Citation	Nature and extent of the candidate's contribution	Nature and extent of the co-author's contribution
Adams, C., Hooker, L., & Taft, A. (2021). Managing maternal and child health nurses undertaking family violence work in Australia: A qualitative study. Journal of Nursing Management, 1-9. https://doi.org/10.1111/jonm.13466	80% contribution by the candidate. This included study design, data collection, data analysis, interpretation of results, drafting the paper, and manuscript revisions.	20% contribution by the co-authors. This included contributing to data analysis and interpretation. Co-authors also provided a critical review of the paper.

I, Catina Adams, declare that I have made a substantial contribution to this paper, including study design, data analysis, interpretation of results, and drafting the paper. My supervisors, Professor Angela Taft, and Associate Professor Leesa Hooker, contributed to the study design, intellectual input, and editing the manuscript.

I, Angela Taft, declare that Catina Adams made a substantial contribution to this paper. She contributed to all aspects and drafted the manuscript.

11.4 Published paper: Managing maternal and child health nurses undertaking family violence work in Australia: a qualitative study

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ORIGINAL ARTICLE

WILEY

Managing maternal and child health nurses undertaking family violence work in Australia: A qualitative study

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Abstract

Aim: To explore the experience of nurse managers managing maternal and child health nurses undertaking family violence work in Victoria, Australia.

Background: Health care practitioners' ability to address violence against women is strengthened by health service systems that include effective staff management and leadership. Maternal and child health nurses work with women experiencing abuse; however, their support by the health system and their managers has not been examined.

Method: Semi-structured interviews with 12 nurse managers in 2019–2020 explored how they supervised and managed nurses. The data were analysed using reflexive thematic analysis.

Results: We identified three themes—(a) managing the service: being resourceful; (b) supporting nurses' emotional safety; and (c) hitting the ground running: the demands on the manager.

Conclusion: Inadequate support for nurse managers undermines workplace well-being and role satisfaction, impacting the safety and supervision of nurses doing family violence work.

Implications for Nursing Management: An integrated family violence systems approach must include improved training and support for nurse managers to enable reflective practice and ensure effective support for nurses working with women experiencing abuse.

KEYWORDS
family violence, health service systems, intimate partner violence, maternal and child health, nurse manager, reflexive thematic analysis

1 | BACKGROUND

1.1 | Family violence

Intimate partner violence is the most common form of family violence in Australia (Australian Institute of Health and Welfare, 2019). Family violence may include emotional, physical or psychological harm and is a severe, preventable public health issue that has harmful effects on women's health and well-being (World Health Organization, 2013). Family violence often begins during pregnancy or in the first year of a child's life (García-Moreno et al., 2015; Hooker, Samaraweera, et al., 2016). It is one of the

leading causes of death and injury for women of childbearing age (Breiding et al., 2014).

More than one million Australian children are affected by violence (Australian Institute of Health and Welfare, 2019), and these children are at higher risk for impaired cognitive development (Shonkoff et al., 2012) and poorer health and developmental outcomes (Gartland et al., 2021; Romano et al., 2019).

1.2 | Health systems response to family violence

The broader health system has to respond effectively and can be the entry point to a network of supporting social and legal services (World Health Organization, 2017). In the integrated family violence system, managers play a critical role in primary and secondary prevention (Hooker et al., 2021). With organizational support, managers can lead the service response, mentoring and supervising health care providers (nurses), thus strengthening the health system's response to violence against women (World Health Organization, 2017).

In 2018, in Victoria, Australia, the introduction of a Multi-Agency Risk Assessment and Management (MARAM) Framework articulated a shared responsibility for assessing and managing family violence risk (Family Safety Victoria, 2018). Arising from the Victorian Royal Commission into Family Violence, the terms of reference included developing consistent systemic responses to family violence. It aimed to train all professionals across the continuum of service responses, covering all aspects of service delivery from early identification, screening, risk assessment and management, to safety planning, collaborative practice, stabilization and recovery (Family Safety Victoria, 2018).

Maternal and child health nurses play an essential role in supporting vulnerable families, often a consistent source of advice and support for new parents. (State of Victoria, 2016). The MARAM includes role-specific advice and training for maternal and child health nurses in first-line responses in a Screening and Identification Training module (Family Safety Victoria, 2020).

1.3 | Maternal and child health service in Victoria, Australia

The maternal and child health service comprises a free, universal primary health care service for families with children 0–6 years of age, an enhanced home visiting program that supports families with additional challenges, and a 24-h maternal and child health phone line. Jointly funded by Victorian state and local governments, the Maternal and Child Health service aims to improve young children's health and developmental outcomes (Department of Health and Human Services, 2019).

To practise in Victoria, maternal and child health nurses must be registered in general nursing and midwifery and hold postgraduate qualifications in child, family and community health. Nurses work in centres located throughout local government areas. Most urban local government areas have created multicentre hubs with nurses working together; however, rural and remote nurses are more likely to work alone. Safety issues may arise for these isolated practitioners (Royal College of Nursing, 2016). The population size and subsequent nurse workloads vary significantly across the state, with births per year ranging from 26 to over 5,000 in the largest local government areas (Adams et al., 2019). The nurse manager (sometimes known as the coordinator) is usually located within the council administrative offices, managing nurses remotely. Figure 1 illustrates the reporting relationships for the Maternal and Child H.

1.4 | Enhanced Maternal and Child Health program

The Enhanced Maternal and Child Health program provides an outreach service for children, mothers and families at risk of poor outcomes. The program was introduced in 2003 and was intended to focus on specific groups, including teenage mothers, rurally isolated families, Aboriginal and Torres Strait Islander and culturally linguistically diverse families (Department of Health and Human Services, 2019). A recent review of the program found that Enhanced Maternal and Child Health clients are complex, with multiple concurrent issues. More than 25% were referred with mental health issues, and more than 20% experienced family violence (Adams et al., 2019).

Over time, with very little clinical guidance or oversight, the Enhanced Maternal and Child Health program has evolved with local government areas offering a range of service delivery models and service activities, often responding to local needs and resources (Adams et al., 2019). Some local government areas have a separate Enhanced Maternal and Child Health program, with nurses working exclusively with Enhanced Maternal and Child Health clients. Other services have integrated the program within the universal service, with all nurses carrying an Enhanced Maternal and Child Health caseload. In 2019, the Department introduced an Enhanced Maternal and Child Health model of care to provide standardized guidance and a consistent basis for program delivery across the state (Department of Health and Human Services, 2019). At the time of this study, the Maternal and Child Health services were at different stages of adopting elements of the new programe.

1.5 | Purpose of the study

This study aimed to explore the experience of nurse managers supervising maternal and child health nurses undertaking family violence work in diverse settings in Victoria, Australia.

2 | METHODS

2.1 | Design

This study is one element of a more extensive project exploring how the Enhanced Maternal and Child Health program supports women

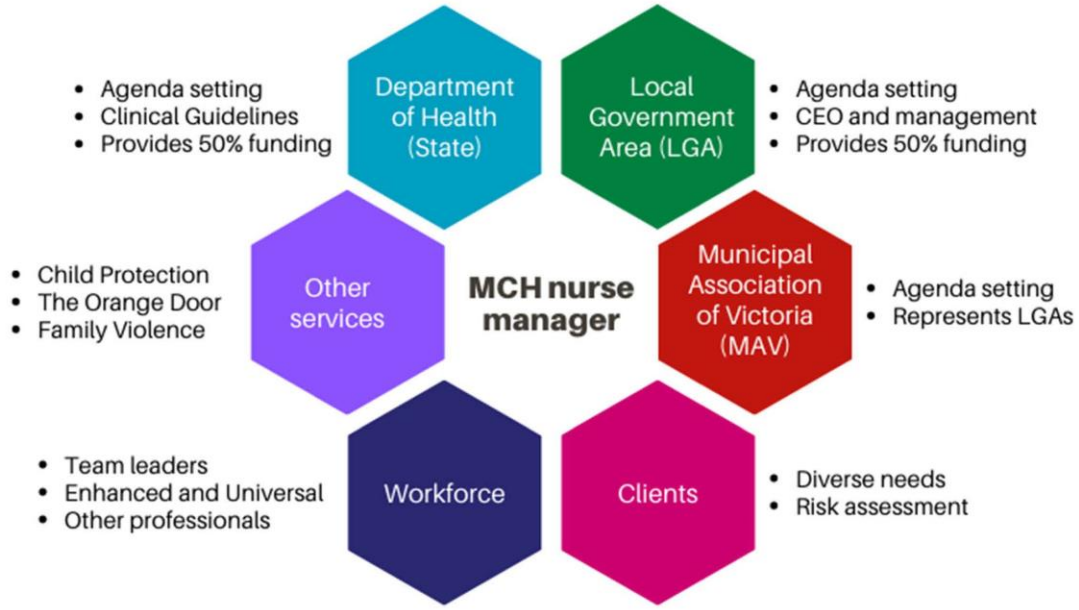

FIGURE 1 Reporting and other relationships of the Maternal and Child Health (MCH) nurse manager

experiencing family violence. There are three parts to the study—(i) a state-wide service-mapping of the Enhanced Maternal and Child Health program (Adams et al., 2019); (ii) interviews with 25 nurses to explore how they support women experiencing family violence (Adams et al., 2021); and this third part of the study (iii) interviews with 12 nurse managers, to analyse how they support nurses undertaking family violence work.

2.2 | Sample/participants

Maternal and Child Health nurse managers in 79 local government areas in Victoria were emailed explaining the study and inviting them to participate. Fourteen responded, and we purposively selected 12 managers with diverse experiences and backgrounds (see Table 1). The two respondents who were not selected for interview were from local government areas with similar demography to other participants. All participants were female, as are most of the Maternal and Child Health nursing workforce.

2.3 | Data collection

Semi-structured interviews were conducted by the first author, face to face in the managers' workplaces, over 4 months in 2019/20. Demographic information was collected, but the data analysis did not include participants' identities, with each participant given a pseudonym. The face-to-face interviews were recorded digitally and transcribed using NVivo Transcription (QSR International, 2020a). The first author checked the transcriptions to ensure fidelity to the recording before uploading them to NVivo for data analysis (QSR International, 2020b).

TABLE 1 Details of participants and interviews

Characteristics	N
Number of nurse managers	12
Professional background	
• Maternal and Child Health nurse	7
• Enhanced Maternal and Child Health nurse	4
• Early childhood educator	1
Local government area	
• Urban	6
• Regional city	4
• Rural/remote	2
Length of interview	
• Range 35–95 min (mean 52 min)	

2.4 | Data analysis

A detailed analysis of the interviews identified patterns of meaning, reported in a thematic form using elements of reflective thematic analysis (Braun & Clarke, 2006, 2020). The first author conducted the interviews, so the content was already familiar on first coding (Braun & Clarke, 2012), used NVivo to assist with coding and theme development (QSR International, 2020b), then summarized the data using a spreadsheet matrix, enabling a coherent report for sharing

across the team (Braun & Clarke, 2012; Gale et al., 2013). The co-authors reviewed the transcripts, the NVivo codebook and the spreadsheet matrix, examined the data's interpretation and assisted with identifying themes.

2.5 | Rigour

The first author developed the interview guide with input from two research supervisors with qualitative interviewing experience. We piloted the interview guide and refined the questions' scope. A COREQ checklist has been provided (Tong et al., 2007).

2.6 | Reflexivity

The first author is a researcher who has also been a Maternal and Child Health nurse and nurse manager. She used reflexive journaling to identify how her insider researcher's experiences might bias or influence the research process and to allow consideration of how her professional and personal experiences might affect relationships with participants (Leslie & McAllister, 2002).

2.7 | Ethical considerations

The interviewer (first author) provided the nurse managers with resources and support should they experience any distress due to the interviews. Support services might have included the nurse and midwife phone support line, the Employee Assistance Program, or referral to family violence support services if the nurse manager became distressed by discussing a personal experience of family violence. Another member of the research team, an experienced Maternal and Child Health nurse was available to take calls from participants to discuss their experience after the interview; however, this did not eventuate.

3 | RESULTS

We interviewed 12 nurse managers working in various councils in Victoria, Australia, in urban, regional and rural/remote locations (see Table 1). We categorized the managers' discussion of their work, focussing on how they supported family violence nursing practice. We identified the following themes—(a) managing the service: being resourceful; (b) supporting nurses' emotional safety; (c) hitting the ground running; the demands on the manager.

3.1 | Managing the service: Being resourceful

When asked what their primary role as manager was, many responded it was to ensure the service ran smoothly.

> There is an element of accountability, that we're funded for so many hours. So, you know, making sure that we're not over-servicing. We stay within our scope to ensure that we service as many families as we can within those parameters. (Wendy)

Many managers spoke of clinical governance, with quality improvement being a key part of their role,

> doing audits, you know, following up with staff, regular portfolio visits to everybody, running PD (professional development) for the team. (Bettina)

Most managers spoke of needing to be 'resourceful', particularly for nurses undertaking challenging work:

> Making sure they are safe, making sure they have got phones, making sure they have got easy parking, you know, parking permits, and, you know, things that help them get around in a safe and easy way. You know, they can communicate with the people they need to, that they have got good technology (Belinda). It's a lot of coordinating the where, why, and how. A lot of the background things that allow the nurses to actually get on and perform the role as effectively as they can when they are on the ground. (Naomi)

Another manager spoke of the need to defend the program:

> there's that need to justify and fight that battle and make the business case. And I suppose this is where I'm thinking the manager's work is to provide that buffer between what the nurse is doing, which is poorly understood really. (Belinda)

Many of the managers reflected that within the Council bureaucracy, the scope of the nurse's work was underestimated—"they just weigh babies". Conversely, other services, such as Child Protection or Family Violence services, would overestimate the nurse's capacity to provide extensive, ongoing support and surveillance.

Managers also described their role as gatekeepers, maintaining the boundaries between services and protecting the nurses, where boundaries and responsibilities could be overstepped. This gatekeeper role was alluded to when discussing the relationship between maternal and child health, family violence services and child protection services. When considering a service response, managers highlighted their responsibility to ensure effective communication with other service providers, including sharing information and joint consultations. Many reflected that without effective service coordination, there was potential for overlap and duplication, or conversely for clients 'to fall between the cracks'.

3.2 | Supporting nurses' emotional safety

According to most managers, ensuring the nurses' emotional safety was critical. The managers who had previously worked as Enhanced Maternal and Child Health nurses felt they brought a different insight to the nurse role. They were more likely to describe their role as 'protective' and 'managing burnout':

> I see my role is supporting them with their workloads, with their emotional load. How they're coping. (Bettina)

> Having been a worker, and really knowing what it feels like to be overwhelmed, the impact on you. (Anna)

> Without that experience, I probably wouldn't have understood the demands and just the daily world of enhanced. (Yvonne)

All the managers characterized the work of the nurses as challenging:

> These are staff who are not just doing data entry. They are staff who are dealing with challenging conversations. (Anna)

> They are doing really hard stuff, day in, day out. It's not just a two-weeker (2-week-old baby) coming in for a quick weigh and measure. (Naomi)

Managers spoke of having to ensure the team had access to adequate clinical supervision.

> I had to go out and argue for more money to expand the supervision. (Sarah)

> I want to be doing the right thing for them. I want them to stay well in their jobs. I guess I have a sense of responsibility. (Moira)

One manager reflected on their capacity to provide the level of support required by individual nurses when working with family violence clients.

> The comment that was made at the (family violence) training was that anytime a nurse felt uneasy or wasn't sitting well with a contact she'd had with the client, she should be able to speak to her supervisor about it. And I just thought, I do not know how I'd do that with the number of staff I've got and the number who work off-site. And, you know, I just felt a little bit deflated. I just sat there thinking I cannot provide the level of support they are saying nurses need from their supervisor. (Sarah)

Nearly all the managers said they would welcome training in clinical supervision.

> That supports me to help a staff member debrief, reflect on her practice, problem solve. So, you know, find clarity about the work she's doing. I guess primarily to keep her safe. (Sarah)

> I feel ill-prepared, mainly in the family violence context. So, if a crisis happens, being able to do a crisis debrief, I suppose, and the idea of holding space for nurses that are doing really, really hard work. (Bettina)

Almost none of the managers have funded access to clinical supervision, and a few managers spoke of funding it themselves:

> I will just go out and do it myself, pay for it myself because I'm really conscious that my work is about supporting people, all the time. (Yvonne)

Wendy also spoke of the emotional pressure of feeling isolated and unsupported: "I had a moment just in the last three or four weeks where I thought, oh, my gosh, I just feel so defeated." Other managers spoke of relying on informal networks and other sources of support; however, being geographically isolated for rural services made it hard to identify and maintain these supports.

3.3 | Hitting the ground running: The demands on the manager

Generally, Maternal and Child Health nurse managers are appointed to the role because of their clinical expertise and experience. Many managers felt they initially lacked essential managerial skills and knowledge and were unprepared to transition to the position. Yvonne reflected on suddenly "being brought into the council world. Yes, that whole political, bureaucratic reporting can be a different world. And you're expected to hit the ground running and sort of know how to do management." Naomi also spoke of lacking "budget basics. team management, all of that policy."

The managers identified that medium-sized teams of between 15 and 20 nurses were challenging to manage, where the team is too small for more than one manager but too big for one manager alone. Many managers highlighted the issues with providing effective line management:

> in some supervision structures, you do have daily contact with staff. Whereas with Maternal and Child Health nurses, they're isolated, independent practitioners. I don't want to micromanage, but you rely on them to flag when something is challenging, or if they are struggling. (Sally)

Conversely, some managers felt they had to physically distance themselves from the team to have the headspace to fulfil their strategic and managerial responsibilities.

> (Previously) my door would open into the waiting room. I was very much knee-deep in the operational stuff. So, I physically had to move myself. (Moira)

Most of the managers recognized the roles of line manager and clinical supervisor as distinct. However, they felt constantly pulled between managing a team of nurses and providing individual clinical support. Yvonne reflected that she felt she had the skills to support nurses emotionally but did not have the time, "if that was the only part of my job, you know, I think I would be fine." Another manager spoke of their heavy line management responsibility, with a direct report of over 25 nurses.

> Every year when I have to do performance appraisals, and they (Human Resources) say they shouldn't take you too long because you shouldn't have more than five or six to do. And I have 25 to do. (Sally)

Managers spoke of working in isolation and often in the absence of organizational direction and articulated clinical governance. Yvonne reflected, "I wonder what other roles can exist in such an autonomous fashion with no oversight." Most managers felt this autonomy brought opportunities for innovation and role flexibility. However, they also reflected that working in isolation created stress and that their role was ill-defined.

The managers of the medium-sized teams felt the highest levels of role conflict, with responsibilities ranging from operational line manager, clinical lead and clinical supervisor. Managers in larger local government areas were able to separate the elements of management and supervision by appointing a team leader with more frequent face-to-face contact with the team:

> Our council asked us to rename it to team leader. It's someone who does not have a client load in those appointed hours and is responsible for supporting the team. (Bettina)

Many managers understood the critical role of clinical governance:

> Looking at how does the service as a whole run, and deal with those clients experiencing vulnerability and how we are accountable, and our process is right. When we look at that risk that we hold because we do sit with a lot of risk in Maternal and Child Health. (Sally)

4 | DISCUSSION

The results of this research align with other research describing the impact of management on the well-being of high emotional labour employees, such as Maternal and Child Health nurses supporting women and children experiencing abuse (Brunetto et al., 2014). The nurse manager role is increasingly complex, requiring high-level interprofessional communication and management skills (Henriksen, 2016) and nurturing nurses' psychological and organizational needs (O'Toole et al., 2021). Nurse managers strive to fulfil competing responsibilities and have multiple reporting relationships (see Figure 1).

Nurse managers in this study recognize their role in leading quality improvement, monitoring routine data and reflecting this to the team as key to achieving sustained nurse family violence practice, as recognized in other research (Hooker et al., 2021). Building the capacity and changing the attitudes and clinical practice of health care providers and their managers is a long-term endeavour requiring consistent investment (World Health Organization, 2017). Managers also identified the need to improve coordination and referrals between health services and family violence and relevant community-based services, such as the police, in line with recommendations for improved service delivery (Dowrick et al., 2021; World Health Organization, 2017).

As noted in other research (Shirey et al., 2010), most nurse managers were appointed based on their clinical expertise but needed a more complex skill set beyond on-the-job training. The nurse managers in our study discussed being promoted without adequate management skills, consistent with other research (Wood et al., 2020). Most of the managers indicated they would have liked access to clinical supervision for themselves; however, only those who paid for their own had access regularly. Nurse managers often worked in isolation and created informal support networks of fellow professionals, valuing these professional connections. The managers spoke about peer support as a critical condition upon which effective advanced practice was based (Wood et al., 2020).

Our research highlighted the value to nurses having a supportive manager available to them for regular follow-up, mentoring and supervision (Hooker, Small, et al., 2016). Nurse managers have a role in motivating nurses to offer best-practice care. They can also help nurses address challenging clinical cases and improve their clinical and communication skills, ensuring ongoing training and supervision to avoid vicarious trauma and burnout (World Health Organization, 2017). Managers in this study have described the challenges of effectively managing large nurse teams while also supervising nurses individually.

Many of the managers in our study identified that they were often unavailable when nurses needed them, being caught up in operational or managerial responsibilities. They also felt they lacked the training to support reflective practice and offer adequate clinical supervision. The managers also identified the need for regular, high-quality professional education in communication skills, supervision

and support for staff undertaking heavy emotional work, in line with recommendations from other research (Adams et al., 2021; Crombie et al., 2016). Training health care providers and their managers to respond to violence against women should be an ongoing process rather than a one-off event (Kalra et al., 2021).

Although the manager's role may vary depending on the size and nature of the teams (Adams et al., 2019), our research indicated common concerns for most managers. Clinical governance enables service delivery that is safe, effective, high quality and continuously improving (Australian Commission on Safety and Quality in Health Care, 2017), however, the Service lacks a clearly articulated Clinical Governance structure.

4.1 | Strengths and limitations

This study has been strengthened by interviewing 12 nurse managers with diverse experiences and backgrounds, from rural and urban local government areas, working in advantaged and disadvantaged areas.

The interviewer was known to many managers, which may have also introduced an element of social desirability bias.

5 | CONCLUSION

Our study has important implications for supporting maternal and child health nurse managers. They are a dedicated workforce committed to the well-being of families. They play a crucial role in creating healthy work environments, maintaining the quality of care for families and enhancing nurses' job satisfaction. They support nurses to meet their professional responsibilities and aspire to build a positive workplace culture and optimize care for families (Australian Commission on Safety and Quality in Health Care, 2017). However, managers must attend to line management responsibilities, making them less available for clinical nursing support and supervision.

Inadequate support for nurse managers threatens workplace well-being and role satisfaction, jeopardizing the safe supervision of nurses doing family violence work. There is an urgent need to clarify nurse manager role descriptions to enable the multiple and conflicting demands on the manager to be considered.

5.1 | Implications for nursing management

In this research, nurse managers have highlighted the lack of preparation for the nurse manager role, the structural impediments to support nurses doing challenging work, and the lack of ongoing support and education to develop communication and supervision skills, including critical incident debriefing. An integrated systems approach should include better training for managers and clinical resources and screening tools, organizational support, opportunities for clinical supervision and reflective practice (Withiel et al., 2020; World Health Organization, 2017). Opportunities for manager peer support should be identified, particularly for nurse managers working in isolation and newly appointed to the role.

We recommend regular training and updates for leadership teams and nurse managers to build their leadership role to support staff safety (Hooker et al., 2021). This recommendation is consistent with successful maternal and child health family violence interventions (MOVE) (Taft et al., 2015) and recent recommendations for a family violence professional development plan for nurses and managers (Hooker et al., 2020). Sustained family violence practice change requires nurse managers who can lead strategies in an integrated family violence system. The MARAM (Family Safety Victoria, 2018) introduction has enabled nurses and their managers to contribute to a system-wide intervention to support women experiencing abuse.

Nurse managers need training in reflective practice, clinical supervision, effective data monitoring, enhanced service integration and leadership training. Managers would benefit from specific training in effective support strategies for nurses doing challenging work and regular access to funded clinical supervision. Training for managers should aim to strengthen their ability to manage nurses' physical and emotional safety.

A Clinical Governance framework for the Maternal and Child Health service needs to be developed to ensure safe, effective, accountable and person-centred healthcare underpinned by continuous improvement (Safer Care Victoria, 2017)

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CONFLICT OF INTEREST

The authors have no conflict of interest.

ETHICAL APPROVAL

The research has been approved by the La Trobe University Human Ethics Committee (Ethics approval number 22227) and the Department of Health and Human Services (HHSD/19/129427).

DATA AVAILABILITY STATEMENT

Data are available on request from the authors.

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11.5 Conclusion

By interviewing managers, the manager's role was confirmed as increasingly complex, requiring high-level interprofessional communication and management skills, for which they are often ill-prepared. The research highlights the vital role of managers to be supportive and available to nurses for regular follow-up, mentoring, and supervision. However, many of the managers in this study identified that they were often unavailable when nurses needed them, being caught up in operational or managerial responsibilities. They also felt they lacked the training to support reflective practice and offer adequate clinical supervision.

Managers strive to fulfil competing responsibilities and have multiple reporting relationships. They play a crucial role in creating healthy work environments, maintaining the quality of care for families, and enhancing nurses' job satisfaction. An integrated systems approach should include better training for managers and improved clinical resources and organisational support.

A recent review of the Enhanced Maternal and Child Health program neglected to examine the critical role that managers fill in the effective delivery of the program (Jennings, Ghazarian, & Stockdale, 2021). This oversight highlights the lack of consideration given to the needs of managers for support in supervising nurses doing challenging work. The research provides a voice for the managers who feel ill-prepared for the role and struggle with conflicting demands.

The following chapter discusses the research and implications for practice, with the concluding chapter (Chapter 13) including an evaluation of the strengths and limitations of the study, and recommendations for future research.

12. DISCUSSION

12.1 Introduction

At the start of my PhD studies, I used a mind map to plan the structure of my research. My initial research question asked: How do the Enhanced Maternal and Child Health **nurses** support women experiencing family violence? The mapping process led me to realise that the nurse fulfils a role within a far more complex picture, with other functions filled by managers, other service providers, local, state, and federal government, the design of the Enhanced Maternal and Child Health program, and the resources provided to do the work. As a result, the research question evolved, becoming: How does the Enhanced Maternal and Child Health **program** in Victoria support women who are experiencing family violence?

I considered gaps in our knowledge, including barriers and enablers for effective family violence nursing practice, and the physical, psychological, and political context of family violence work.

With these insights, I designed the mapping survey of the Enhanced Maternal and Child Health program, the first such investigation undertaken in the 15-year history of the program. My questions were fundamental and led to my later research interviewing nurses and managers. Questions included: Who are the Enhanced Maternal and Child Health clients? What is the work of the Enhanced Maternal and Child Health nurse? How do nurses work with women experiencing family violence? How is the nurse supported to do family violence work? What is the manager's experience? What individual and systems changes need to happen to improve nurses' experience in working with women experiencing family violence, and to improve outcomes for women and children?

The answers to these questions have, in turn, helped answer my own research question: How does the Enhanced Maternal and Child Health program support women who are experiencing family violence?

12.2 The Enhanced Maternal and Child Health program

As can be seen in Figure 10 (below) the Victorian Enhanced Maternal and Child Health program has undergone several changes during my candidature from 2016 to date.

Figure 10: Timeline of the Enhanced Maternal and Child Health program

2009	2015	2016	2019	2021	2022
Enhanced Maternal and Child Health program introduced			New Enhanced Maternal and Child Health program introduced	New Enhanced Maternal and Child Health program revised	Evaluation of the Enhanced Maternal and Child Health program
	PhD candidature commenced	Enhanced Maternal and Child Health mapping survey	Enhanced Maternal and Child Health nurse and manager interviews		PhD completed

The mapping survey occurred in 2016 before a revised Enhanced Maternal and Child Health program was introduced in 2019. In the mapping survey, the managers said they were looking forward to improved guidance from the new Enhanced Maternal and Child Health program and the proposed increased funding.

The interviews happened around when the new program was introduced; however, the roll-out was patchy with poor communication and dissemination, and some interview participants were better informed about the new Enhanced Maternal and Child Health Model of Care than other Enhanced Maternal and Child Health nurses and managers. There was confusion about the new model and how it might be implemented. Many nurses said they were reluctant to implement some of the central aspects of the new program, such as the Child and Family Action Plan, due to confusion about how to include the plan in the client record, and a lack of specific training in the strength-based approach to eliciting parental concerns.

In 2016/2017, a review of Victorian Enhanced Maternal and Child Health program data confirmed a higher-than-expected proportion of families accessing the program,

with families receiving less than the anticipated average number of support hours (Arefadib et al., 2021). The review also identified that older children were supported through the Enhanced Maternal and Child Health program, despite the program being initially aimed at families with infants under 12 months old. This review, and the mapping findings, confirmed how many nurses and managers perceived the Enhanced Maternal and Child Health program. That is, that the program was inadequately resourced, without measurable outcomes, and lacked a cohesive Model of Care.

The new Enhanced Maternal and Child Health program proposed to increase funding, expand the service to raise the percentage of children accessing Enhanced Maternal and Child Health to 15%, increase the age of children permitted access to the program to three years old, and increase the average number of service hours offered to 20 (22.67 hours in rural/remote areas). Although there was no rationale for this increase in hours, most nurses and managers interviewed welcomed both the increase in time allocation and age bracket. As many said, it more closely reflected what was already happening, however, it was often 'invisible' work, and not accurately recorded.

A recent evaluation of the expanded Enhanced Maternal and Child Health program commissioned by the Department of Heath sought to:

- Determine if the Enhanced Maternal and Child Health program was reaching the intended families and children
- Understand how the Enhanced Maternal and Child Health program has been implemented
- Examine the extent to which the Enhanced Maternal and Child Health program outcomes have been achieved
- Review the suitability and utility of the proposed monitoring measures; and
- Develop recommendations to iteratively improve the Enhanced Maternal and Child Health program (Jennings, Ghazarian, et al., 2021b, p. 7).

During the evaluation period, the evaluation team experienced challenges, including changes to data management systems, government structure changes, and perhaps most significantly, the emergence of the COVID-19 pandemic, which impacted

the usual delivery of Maternal and Child Health and Enhanced Maternal and Child Health services.

The evaluation confirmed ongoing issues with data integrity that persist, even with the introduction of the new program. This lack of data accuracy makes it very difficult to state with certainty whether the new program is reaching and engaging the intended families. Based on "available evidence", there is a substantial shortfall in the delivery of Enhanced Maternal and Child Health program hours, with most Local Government Areas not implementing their funded hours (Jennings, Ghazarian, et al., 2021b, p. 40). This aspect needs scrutiny, as many Enhanced Maternal and Child Health programs have significant waiting lists. The underspend on hours-of-service delivery is likely related to workforce issues and the impact of the COVID-19 pandemic on service delivery.

The research identified that some Enhanced Maternal and Child Health clients wait many weeks to be admitted to the Enhanced Maternal and Child Health program and are "held" within the universal Maternal and Child Health service. More consideration is required to maintain the safety in this interim stage if they are experiencing family violence, and there may be an increased risk for the woman and child(ren). Some Enhanced Maternal and Child Health referrals are inappropriate because they are not suited to the short-term engagement that the Enhanced Maternal and Child Health program offers. Some clients with longer-term issues could be referred to other services, such as Integrated Family Services (Child First), Early Intervention services (including the National Disability Insurance Scheme - NDIS), specialist community mental health, or family violence agencies.

The ongoing challenge for the Enhanced Maternal and Child Health program is articulating goals and outcomes that enable a meaningful ongoing evaluation of the service. Research highlights the difficulty in evaluating child and family outcomes, even more so when there is a lack of homogeneity of client needs and varied interventions and dosage (Filene et al., 2013; Gardner et al., 2010; Kemp et al., 2011). Nevertheless, more attention is required to identify measures of long- and short-term family, maternal, and child outcomes, such as the Ages and Stages Questionnaires (ASQ) to measure and monitor child development (Michalopoulos et al., 2019; Richards & Guerin, 2022; Squires & Bricker, 2009) and other measures of maternal and child mental health.

The new Enhanced Maternal and Child Health program logic identifies short and long-term outcomes and impacts but does not identify any way of measuring these (Department of Health and Human Services, 2019b). The challenge for the Enhanced Maternal and Child Health program in the future will be to identify outcomes, and to have consistent data collection to enable the measurement of these outcomes.

Recommendation One:

The Victorian Department of Health needs to identify outcome measures, using validated tools, performance standards, and the minimum benchmarks for effective Enhanced Maternal and Child Health program evaluation.

Recommendation Two:

Data integrity must be addressed as a priority to enable effective monitoring of the Enhanced Maternal and Child Health program. Particular attention needs to be paid to how the additional Family Violence consultation is used and recorded, as family violence prevalence rates within the Victorian Maternal and Child Health community are significantly inaccurate.

Recommendation Three:

The Maternal and Child Health and Enhanced Maternal and Child Health programs need a triage pathway, using a clinical algorithm at the point of referral to Enhanced Maternal and Child Health to ensure appropriate, timely intake to the most appropriate support program.

12.3 Enhanced Maternal and Child Health nurses' Family Violence roles

Enhanced Maternal and Child Health nurses aim to practice according to the guidelines of the program, providing strength-based, family-centred care (Department of Health and Human Services, 2019b). Although there is awareness of the need to screen and identify women experiencing family violence, identification rates by Victorian Maternal and Child Health and Enhanced Maternal and Child Health nurses remain poor (Hooker et al., 2021; O'Reilly et al., 2010; Taft et al., 2015). Building and maintaining a therapeutic relationship with the woman is pivotal for the home visiting nurse (Nygren

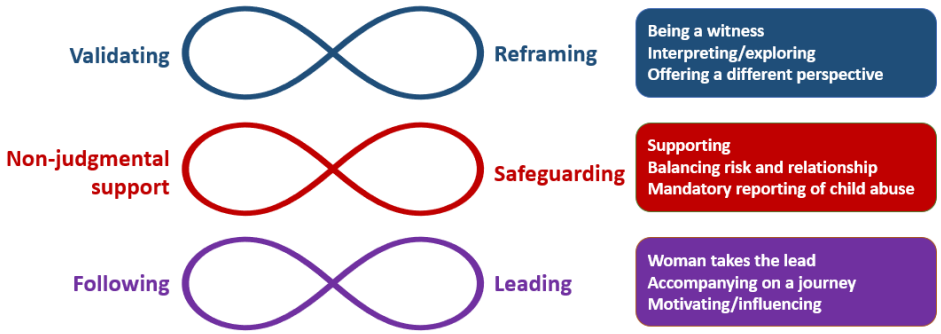
et al., 2018). This finding confirms other research which emphasises the importance of a strong relationship between the woman and the nurse home visitor (Duffee et al., 2017; Gomby, 2005; Schaefer, 2016; Sharp et al., 2003).

This relationship may facilitate nurse home visitors' abilities to ask about family violence and other significant social issues and increase clients' comfort levels in disclosing family violence (Jack et al, 2012). Disclosure by women of challenging situations, including experiences of family violence, reflects the development of trust between the nurse and the woman, and occurs as nurses come to know the family (Shepherd, 2005).

Nurses fulfil complex and demanding roles which are sometimes conflicting. The research has enabled an insight into the challenges nurses face as they undertake emotionally demanding roles. The thematic synthesis has highlighted the challenge for home visiting nurses in fulfilling these conflicting roles, such as supporting the woman (and maintaining the relationship), and safeguarding children. Other research describes this tension for nurses (Jack, Gonzalez, et al., 2021; Peckover & Golding, 2017), sometimes resulting in role confusion.

Family violence nursing roles identified from the interviews were identified as threads of nursing practice. The imagery of threads of practice has enabled the visualisation of the relationship between the woman and the nurse as a thread that can be flexible and supportive and, at times, restrictive and limiting, pulled taut under tension. The threads are iterative and dynamic. This imagery also lends itself to viewing the support offered as a woven fabric, with many threads contributing support at different times.

Figure 11: Conceptual model - threads of nursing practice



Nurses navigate the practice threads – validating, interpreting, reframing, and revalidating – when new elements emerge. This dynamic response requires reflective practice, and nurses value clinical supervision as an opportunity to regulate and reflect on their role and ensure that their practice is responsive to the woman's changing needs. Regular clinical supervision supports the safety of the nurses undertaking emotionally charged work, enabling them to reflect on boundaries (Jarrett & Barlow, 2014) and providing increased self-awareness (Shea et al., 2019). Managers may also fulfil a role of effectively managing boundaries which can be difficult for the nurse to identify, with the distance the managers can maintain through observation

The study confirmed that Enhanced Maternal and Child Health nurses aim to practice a woman-centred approach, supporting the woman to make decisions about her safety (García-Moreno et al., 2015). Women experiencing family violence need time, encouragement, and ongoing support to enable disclosure (Hooker et al., 2020). The nurses aim to listen to the woman with empathy, without judging, responding to her needs and concerns, validating her experience, enhancing safety, and providing support and follow-up (Brijnath et al., 2020; Cuthill & Johnston, 2019; Goodman et al., 2016). However, this is a struggle for some nurses. This difficulty is discussed in the next section, where recommendations framed around the characteristics of effective Enhanced Maternal and Child Health nurses are made.

The first time a woman discloses is a fragile moment, with the nurse needing to sensitively connect with the woman when she may be feeling shame.

> It's also about tuning into yourself and making sure that you're not trying to rush the family, and the challenge of holding back, letting the woman take the time she needs. Maintaining engagement and maintaining a rapport and maintaining that, you know, that connection with them whilst helping them slowly come around to that understanding. And it can be a really, long, slow walk. It can be frustrating and challenging. (Doris)

Nurses noted that often the reason for the initial referral could change over time, such as a sleep settling referral, which may segue into a more complex picture. The underlying issues are often disclosed once a relationship is established, highlighting the importance of developing a therapeutic relationship with the woman, as established in other research (Barton et al., 2020; Bradbury-Jones et al., 2014; Davidov, Nadorff, et al.,

2012; Jack et al., 2016). As one manager observed, “The initial referral may be for sleep settling, but when the home visit is conducted, there is a disclosure of relationship difficulties, family violence, drug/alcohol use, or mental health issues” (LGA 33).This provides an additional layer of complexity when attempting to identify and evaluate the work for the Enhanced Maternal and Child Health program, as the true nature of the work may be hidden within the data.

Building trust and rapport is a significant facilitator for effective family violence nursing practice, and forming a relationship with clients is pivotal (Davidov et al., 2018). The nurses and managers in the study found that having the skills to build and maintain a relationship was even more critical when working with women experiencing family violence. A relationship of trust enables disclosure, which can then lead to safety planning and referrals. The nurses felt privileged to be welcomed into the family home and considered the confidence placed in them indicative of trust.

One of the features of the Maternal and Child Health program in the past has been the long-term relationship that develops with the family seeing the same nurse with their child from birth to 4 years of age and then for subsequent children. The research has confirmed the value placed on this relationship in establishing trust and rapport with the woman, even more so when the woman is experiencing additional challenges such as family violence.

However, the demands on the service with increased births, staffing shortages, and lockdowns due to the COVID-19 pandemic have led to fragmented rostering (Adams et al., 2020), focusing on throughput and the number of families seen per day, rather than the quality of the nurse/client relationship that develops with continuity of carer. This change in focus is to the detriment of the client/nurse relationship, potentially reducing the women's comfort to disclose personal issues such as family violence. The nurse/client relationship improves retention in home visiting programs (Barton et al., 2020) and brings increased satisfaction to both the consumer and the nurse (Jack, Gonzalez, et al., 2021; Nygren et al., 2018).

Recommendation Four:

Maternal and Child Health and Enhanced Maternal and Child Health programs should prioritise continuity of carer, which was previously a feature of both programs, to facilitate building a trusted relationship between the nurse and family over time, which is even more important when the woman is experiencing family violence. Significant workforce shortages must be addressed to enable improved experiences for nurses and clients.

12.4 The characteristics of effective Enhanced Maternal and Child Health nurses

Improved education and support for nurses in addressing intimate partner violence may not necessarily result in improved adherence to the intervention or improvement in client outcomes (Jack, Gonzalez, et al., 2021). Education in intimate partner violence practice alone is not enough to equip a nurse for effective practice (Kalra et al., 2021). It is also important to identify and address the other barriers to family violence nursing practice, such as lack of systems support, unclear referral pathways, lack of Maternal and Child Health clinical guidance tools, and perceived lack of time (Taft et al., 2015).

Nurses need easy-to-access clinical tools, reliable and consistent referral pathways (Sharps et al., 2016), and recognition of the additional time required to support relationship and rapport building, determining an achievable client case load (Jack, Kimber, et al., 2021). Nurses' confidence to address family violence is enhanced by education, tied to screening and safety planning skills development. However, this confidence does not necessarily translate to improved family violence nursing work or client outcomes (Jack, Kimber, et al., 2021).

Home visiting programs depend upon creating a relationship between the home visitor and the parent (Gomby, 2007; Jack et al., 2002). Jones Harden (2010) considered the links between home visitor characteristics and program quality to uncover what home visitor characteristics are linked to program success. They identified the personal characteristics of the nurse, together with improving nurse capacity and confidence, as having the most significant impact on the success of the program (Jones Harden et al., 2010). Other research has attempted to identify the characteristics of exemplar nurses

(Schaefer, 2016) to ensure that nurses recruited to home visiting nursing work are suited for the challenges of the work.

Some researchers have focused on personality (Sharp et al., 2003), describing elements such as negative emotionality (being prone to negative emotions such as anxiety or anger and being mistrustful) as associated with less time spent in-home visits. The research highlighted the impact of an optimistic perspective as contributing to the successful engagement of the family and the nurse's capacity to work in challenging scenarios. This intrinsic characteristic enables a non-judgmental attitude towards parents that is more likely to increase family participation and positive family outcomes (Beeber et al., 2007).

Recent research on critical reflective practice would encourage a closer scrutiny of the concept of the nurse striving to be "non-judgmental". More accurately, nurses strive to be open-minded, critically reflecting on their practice (Tomlin, Hines and Slum, 2016; Forstadt, 2012) and attempting to recognise, attend to and hold judgement (Gerace et al, 2017; Rasheed, 2015;). This reflective practice may be facilitated via clinical supervision (O'Neill, Edvardsson and Hooker, 2021;) or practitioner reflective practice skill development (Marshall, 2019).

The nurses and managers in the study agreed that caring, having a sense of optimism, and expressing genuine satisfaction in working with families experiencing challenges were essential characteristics for the Enhanced Maternal and Child Health nurse. Other research upholds these qualities, along with the capacity to be self-aware, work flexibly, develop a positive helping relationship with families (Korfmacher et al., 2013), and personal characteristics such as persistence and being conscientious (Brookes et al., 2006). The research found being authentic was critical in working with families, similar to the "genuineness" described by Schaefer (2016).

With a clearer insight into the work of the Enhanced Maternal and Child Health nurse and the characteristics required, the development of position roles and identification of professional boundaries and supports may be enabled. The pivotal role of establishing and maintaining a relationship with the woman highlights the need for nurses to be emotionally intelligent and skilled in communication and rapport building. Nurses need to manage conflicting roles, and improved resources and models of care

may contribute to supporting nurses in this challenging work, when paired with other forms of knowledge and personal characteristics.

Ensuring nurses have access to high quality, regular clinical supervision will enable self-reflection on whether they are intrinsically suited to Enhanced Maternal and Child Health nursing work, including working with women experiencing family violence. This insight will allow both nurses and managers to make choices about ongoing employment choices, potentially reducing stress and burnout from a mismatch between the worker and role.

Identifying the nurses' personal and professional characteristics could inform the development of position roles and ensure training and education needs are fulfilled. This knowledge may also contribute to developing education and training programs to focus on and supplement any perceived deficits in skills and knowledge to improve the quality of the workforce. By identifying the extrinsic and intrinsic characteristics of ideal home visiting nurses, managers could develop position descriptions that will describe and identify those nurses best suited for the role. These insights may improve the effectiveness of home visiting teams to ensure that the Enhanced Maternal and Child Health program contributes effectively to the support of women experiencing family violence.

Recommendation Five:

The development of Enhanced Maternal and Child Health nurse position descriptions to include the personal characteristics required to ensure that the work of the Enhanced Maternal and Child Health nurses contributes effectively to the support of women experiencing family violence, and to improve the experience of Enhanced Maternal and Child Health nurses working with families.

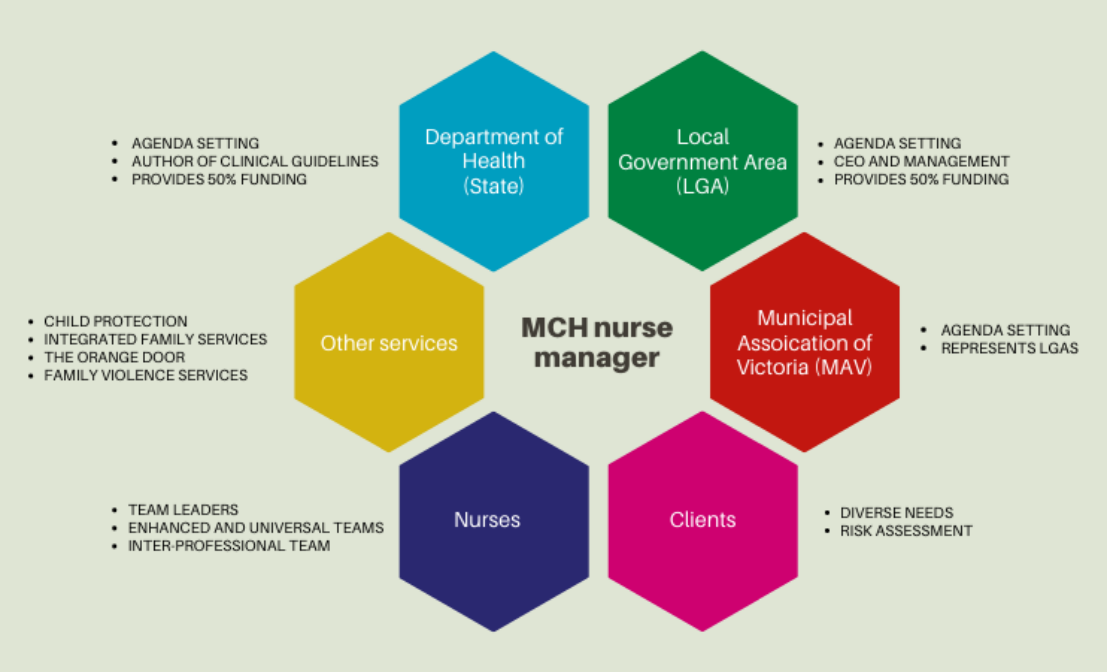
Recommendation Six:

That all Enhanced Maternal and Child Health nurses and their managers have access to regular, high quality clinical supervision, including rural and remote nurses and managers. The use of digital technology in rural and remote settings may assist with this recommendation.

12.5 How are Enhanced Maternal and Child Health nurses supported by their managers?

The findings align with other research on high emotional labour employees and their managers (Brunetto et al., 2014). The manager role is complex, requiring high-level interprofessional communication and management skills (Henriksen, 2016) and the ability to nurture the psychological and organisational needs of nurses (O'Toole et al., 2021). Managers strive to fulfil competing responsibilities and have multiple reporting relationships.

Figure 12: Reporting and other relationships of the Maternal and Child Health manager



There is very little research on managers supervising nurses doing family violence work. As noted in other research (Shirey et al., 2010), most managers have been appointed based on their clinical expertise, but they need a more complex skill set beyond 'on-the-job' training. The managers interviewed for this study described being promoted without adequate management skills, which is consistent with other research (Wood et al., 2020). Managers often worked in isolation and created informal support networks of fellow professionals, valuing these professional connections:

> There is no one else but me, the one Maternal and Child Health nurse who does universal, Enhanced Home Visiting, immunisations and all the admin for four centres across a very vast shire. You can't deliver clinical supervision to yourself. I may call peers in neighbouring shires for a debrief and emotional support. (Rose)

Research has highlighted the value to nurses of having a supportive manager available to them for regular follow-up, mentoring, and supervision (Hooker, Small, et al., 2016), however, managers are generally not available because of other demands. Managers have a role in motivating nurses to offer best-practice care. They can also help nurses address challenging clinical cases and improve their clinical and communication skills, ensuring ongoing training and supervision to avoid vicarious trauma and burnout (World Health Organization, 2017).

The managers identified the need for regular, high-quality professional education in communication skills, supervision and support for staff undertaking heavy emotional work, in line with recommendations from other research (Crombie et al., 2016). Training health care providers and their managers to respond to violence against women should be an ongoing process rather than a one-off event (Kalra et al., 2021). Managers also identified the need to improve coordination and referrals between health services and family violence and relevant community-based services, such as the police, in line with recommendations for improved service delivery (Dowrick et al., 2021; World Health Organization, 2017).

Inadequate support for managers threatens workplace well-being and role satisfaction, jeopardising the safe supervision of nurses doing family violence work. The safety of their nursing teams is critical, and the inability to provide support when required creates a sense of tension, with the manager pulled between maintaining safety of their team and the operational demands of their role. There is an urgent need to review manager role descriptions to enable consideration and review of the multiple and conflicting demands on the manager.

Although the manager's role may vary depending on the size and nature of the teams (Adams et al., 2019), most of the managers had common concerns. Many identified that they were often unavailable when nurses needed them, being caught up in operational responsibilities. Managers of medium-sized teams have described the challenges of effectively managing nurse teams while also supervising nurses individually. Some felt they lacked the training to support reflective practice and offer adequate clinical supervision.

> The comment that was made at the (family violence) training was that anytime a nurse felt uneasy or wasn't sitting well with a contact she'd had with the client, she should be able to speak to her supervisor about it. And I just thought, I don't know how I'd do that with the number of staff I've got and the number who work off-site. And, you know, I just felt a little bit deflated. I just sat there thinking I cannot provide the level of support they're saying nurses need from their supervisor (Sarah).

The study has important implications for supporting Maternal and Child Health managers. They aim to create healthy work environments, maintain care quality for families, and enhance nurses' job satisfaction. They support nurses to meet their professional responsibilities and aspire to build a positive workplace culture and optimise care for families (Australian Commission on Safety and Quality in Health Care, 2017).

Managers recognise their role in leading quality improvement, monitoring routine data, and reflecting this to the team as the key to achieving sustained nurse family violence practice, as demonstrated in other research (Hooker et al., 2021). In the integrated family violence system, managers play a critical role in the primary and secondary prevention of family violence (Hooker et al., 2021). With organisational support, managers can lead the service response by mentoring and supervising health care providers (nurses), thereby strengthening the response from the health system to violence against women (World Health Organization, 2017).

A recent review of the Enhanced Maternal and Child Health program neglected to examine the critical role that managers fill in the effective delivery of the program (Jennings, Ghazarian, & Stockdale, 2021). Clinical supervision is funded for Enhanced Maternal and Child Health nurses but only one-third of rural nurses have access to regular clinical supervision, and there is no funded provision for nurse managers in the new Enhanced Maternal and Child Health model. According to the research, many Enhanced Maternal and Child Health managers privately funded their supervision, as they recognised how important it was to have access to quality supervision. This lack of consideration for the needs of managers supervising nurses who are doing difficult work means that the emotional and professional needs of managers are critically overlooked.

Recommendation Seven:

The development of Maternal and Child Health coordinator/manager position descriptions, which specify nurse/manager ratios to enable appropriate support and supervision of nurses, and the safe workload for managers.

Recommendation Eight:

Better training for managers, improved clinical resources and screening tools, organisational support, opportunities for clinical supervision, and reflective practice will enable a more cohesive Maternal and Child Health system response to family violence, enabling alignment with the broader health system response.

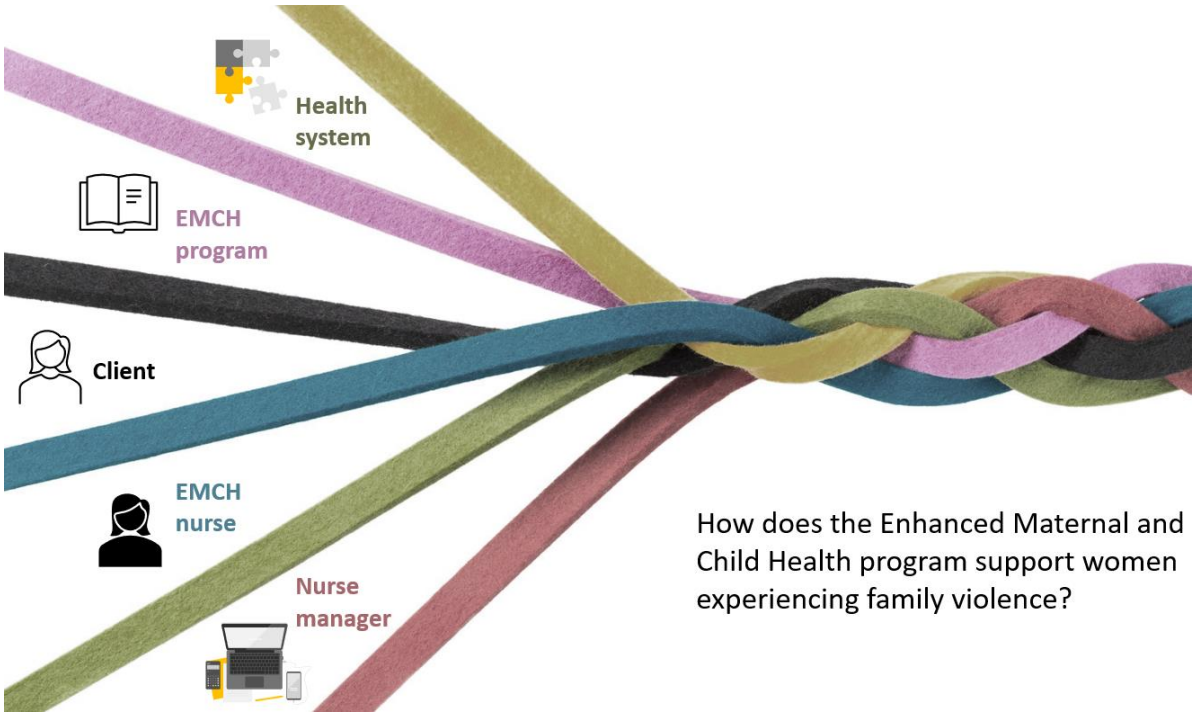
Recommendation Nine:

Opportunities for manager peer support should be identified, particularly for managers newly appointed to the role, and for those working in isolation with limited organisational direction or support.

12.6 System-wide support for effective family violence nursing practice

Discussions with the nurses and their managers highlighted the need for a coherent system-wide approach to improve outcomes for families, with a consistent policy framework, collaborative practice, shared clinical resources and screening tools, and improved organisational support. The Enhanced Maternal and Child Health program, Enhanced Maternal and Child Health nurses and managers, and the broader integrated family violence and health system contribute to supporting women experiencing family violence, ideally in an interwoven support model.

Figure 13: An interwoven model of support



Underpinning any service design requires a clear articulation of clinical governance. Defining the relationships between regulators, funders, managers, health care providers, the workforce, clients, and other stakeholders will ensure optimal clinical outcomes for those experiencing family violence. Safety and quality systems and processes ensure the delivery of safe, high-quality health care. A robust clinical governance framework assures clients and the community of safe health care and drives improvements in services (Council of Australian Governments (COAG), 2019; Safer Care Victoria, 2017).

The universal Maternal and Child Health and Enhanced Maternal and Child Health programs lack a clinical governance framework. This is likely a result of the diverse management structures across the state, with each Local Government Area maintaining the role of local governance. Although a number of frameworks exist to support Maternal and Child Health practice –a 'unifying' framework to support the role of the universal and enhanced Maternal and Child Health program is missing (Halloran, 2022). In recent years (2009-2022), the Maternal and Child Health program has moved between the State Government Departments of Education, Early Childhood

Development; Education and Training; Health and Human Services; and most recently, to the Department of Health. Aside from the disruption that this continuing realignment has caused administratively and functionally, the professional identity of the service has been ill-defined. Until recently, the Maternal and Child Health service has been aligned within the community or education sector, rather than as a Primary Health Care service, where it currently resides in the Department of Health.

In addition, the role of the Chief Maternal and Child Health Nurse has recently moved to Safer Care Victoria, the peak state authority for quality and safety improvement in health care. It oversees and supports health services to provide safe, high-quality care to patients. The separation between the Maternal and Child Health service and the Chief Maternal and Child Health nurse may appear incongruent, however, this shift creates opportunities for policy and governance alignment with the hospital and broader health sector. Clinical governance enables service delivery that is safe, effective, of high quality, and continuously improving (Australian Commission on Safety and Quality in Health Care, 2017).

By identifying and articulating the existing frameworks and standards that govern Maternal and Child Health/Enhanced Maternal and Child Health work, gaps in clinical governance may be identified, undermining the quality and safety of the Maternal and Child Health/Enhanced Maternal and Child Health programs, with an impact on client safety and outcomes. The National Safety and Quality Primary and Community Healthcare Standards provide a starting point to consider the role of clinical governance with the Maternal and Child Health program's unique elements, working between the State government and local government jurisdictions (Australian Commission on Safety and Quality in Health Care, 2021).

Recommendation Ten:

An urgent development of a state-wide clinical governance framework is required for the Maternal and Child Health and Enhanced Maternal and Child Health programs, articulating safety and quality systems and processes to provide assurances to clients and the community of safe health care and improvements in services.

13. CONCLUSION

13.1 Strengths and limitations of the study

This is the first comprehensive review of the work of Victorian Enhanced Maternal and Child Health nurses and their managers. A rigorous project design enabled many aspects of the research question to be explored. A diverse sample of participants from a range of Local Government Areas produced rich data for analysis.

The research project was supported by the clinical community, who were keen to have better insight to the work of the Enhanced Maternal and Child Health program. Being a clinician-researcher gave me access to the community of nurses and managers, and reflexive insight into their work.

Although it was not included in the design of the project, member checking may have added to the rigour of the study. Although any aspects of the research question were explored, there remained some areas for further exploration, outlined below.

13.2 Recommendations for future research

This research project has raised many further questions, and opportunities for future research include:

- Women's voices (their experience of Enhanced Maternal and Child Health and family violence).
- Nurses' work with perpetrators.
- Nurses' work with children.
- Nurses' personal experience of family violence.
- Managers' support and training needs.
- Rural family violence research
- Evaluation of an intensive model of EHV (<20 hours).

13.3 Conclusion

The research has examined the work of Enhanced Maternal and Child Health nurses and their managers, identifying the service-wide response required to support effective family violence practice. Interviewing home visiting nurses and managers has provided insight into how nurses work with women experiencing abuse, and how their managers support them in this role. The roles of Enhanced Maternal and Child Health

nurses are dynamic, with nurses modifying their response as women's needs change. This dynamic response has been characterised as threads of practice, which can flex, but also become taut in the emotionally charged space of family violence nursing practice.

Until now, there has been little insight into the characteristics of the Enhanced Maternal and Child Health nurse. Nurses and managers have described what they bring in terms of their skills, knowledge, and personal attributes, and how these elements contribute to supporting women who are experiencing family violence. Effective Enhanced Maternal and Child Health nurses are highly skilled practitioners, bringing extrinsic and intrinsic characteristics to their professional practice. The research identified specific personal attributes required to work with women experiencing family violence, reflecting that not all nurses are well-suited to fulfil this specialist role.

Managers play a crucial role in creating healthy work environments, maintaining the safety and the quality of care for families, and enhancing nurses' job satisfaction. Enhanced Maternal and Child Health nurses and their managers often work without clear role definition or program goals, with inadequate resources and limited supervision and support. Inadequate support for nurses and their managers threatens workplace well-being and role satisfaction, jeopardising the safety and supervision of nurses doing family violence work. This lack of support undermines the capacity of the Enhanced Maternal and Child Health program to support women experiencing family violence.

Enhanced Maternal and Child Health nurses work with parents to improve the nurturing environment of the home and family. The Enhanced Maternal and Child Health program and Enhanced Maternal and Child Health nurse family violence practice and the existing system-wide measures to support family violence work has been comprehensively explored. The nurse's role in health promotion and Primary Health Care requires careful consideration of the interwoven and overlapping influences of social, environmental, and biological factors. Analysing how the Enhanced Maternal and Child Health program fits within a multi-sector response is critical to ensuring effective support for women experiencing family violence.

14. APPENDICES

i. Graduate Research Examinations Schedule B- Presentation of Theses for Graduate Research Degrees

ii. Mapping survey - Ethics application and approval

iii. Participant Information and Consent form (PICF)

iv. Survey questions

v. Survey invitation

vi. Oral presentation (MCaFHNA conference – 2017)

vii. 3MT – Three-minute thesis (La Trobe 2017)

viii. Poster (MCaFHNA conference - 2019)

ix. Enhanced Maternal and Child Health nurse and manager interviews - Ethics application and approval

x. Participant Information and Consent form (PICF)

xi. Survey invitation

xii. Interview guide

xiii. Interview schedule and participants (de-identified)

xiv. Poster (MCaFHNA conference)

xv. Poster (AIFS conference 2021)

xvi. Visualise Your Thesis (La Trobe 2021)

Appendix i: Graduate Research Examinations Schedule B- Presentation of Theses for Graduate Research Degrees

LA TROBE UNIVERSITY

GRADUATE RESEARCH SCHOOL

Graduate Research Examinations Schedule B- Presentation of Theses for Graduate Research Degrees

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Section A – General requirements

This schedule describes the requirements for all theses[1], being any major written components for the examination of a higher degree by research (including an exegesis), whether you are submitting in thesis mode or practice-based mode. These requirements apply to both the written works you present for initial examination, and the final versions that you submit for the award of the degree, including any amendments required following the examination.

Word length

Your thesis should be written as concisely as possible. The word length of a thesis will be influenced heavily by the discipline of your research, the content of the research and, in the case of the practice-based mode of submission, any accompanying artefacts and other examinable components. Guidelines to the maximum word limits for the thesis for each type of degree are:

Degree type	Mode of submission	Maximum word length
Doctor of Philosophy	Thesis mode	80,000 words
Doctor of Philosophy	Practice-based mode	50,000 words
Professional doctorate	Thesis mode	60,000 words
Master's by research	Thesis mode	40,000 words
Master's by research	Practice-based mode	25,000 words

Word counts do not include footnotes, appendices and the bibliography or references.

Publications in your thesis may impact the recommended length. Please see Section B below for more information.

asked to verify your contribution on the Authority to Submit form

- where there are one or more co-authors outside your supervisory team your supervisor will need to verify on the Authority to Submit Form that they have sighted written confirmation from the co-author or the coordinating author (as defined in the University's Authorship of Research Outputs Policy) verifying your contribution to the work.

Section B – When a thesis contains accepted or published works

Any thesis or exegesis may contain work that has been submitted or accepted for publication.

General

Your thesis may contain one or more scholarly articles or chapters, published, accepted or submitted for publication by reputable journals or publishers. The thesis in its entirety may also have been published or submitted for publication as a scholarly book. When your thesis contains articles or chapters, these will be thematically linked and describe a coherent research program.

Where your thesis contains publications, you must still adhere to all the general requirements outlined in Section A and Appendix 1, in addition to any specific requirements outlined in this section.

If you have been given approval to include papers that have been published in a language other than English language in your thesis you will need to provide appropriate English language synopses for each relevant paper.

Format

Publishers will normally allow articles or chapters to be included in your thesis but you must have express permission to do this and must follow any specific requirements that they may have in relation to the format in which the chapter/paper appears in your thesis, and for its eventual publication in the La Trobe University's Institutional online repository.

Any articles/chapters that you include in your thesis will be as published, or as submitted (preprint) or accepted for publication (post print) if not published at the time of submission and should not be modified in content. The letter of agreement that you have from the publisher, or the conditions

outlined on their website, will provide advice relating to the print version and format of a publication that may be included in the version of the thesis that is eventually published in the La Trobe University's Institutional Repository.

Volume of work where publications form the majority of the thesis

Where publications form the majority of your thesis the number of articles/chapters to be included will depend on the significance, originality and length of each and take account of the University's requirements for the degree and the amount of research normally expected for the degree in question.

Your particular discipline area may set additional specific requirements. The articles or chapters along with the required framing material (see below) should consist of and/or describe work equivalent to a thesis without publications in the same field of research for the degree.

If the published work is collaborative you may need more articles depending on your role and contribution to the work.

Normally, where publications constitute the majority of the thesis there will be four to six articles/chapters for a doctoral degree and three to four articles/chapters for a master's by research degree.

Framing material

Where you have a majority of publications in your thesis you will need to include 'framing material' that describes and analyses the way the articles and chapters are thematically linked. This will be either:

- at least one substantial integrating chapter, or
- a separate introduction, general discussion and conclusion.

In cases where the articles or chapters do not in themselves provide the detail normally provided in a thesis, the framing material may serve to provide further critical appraisal of relevant literature and/or further details of the methods or methodology.

Publication status of individual articles included in the thesis

You will need to include full publication details/citations with the material that you submit for

examination in either the preface or in each relevant chapter. Where publication is forthcoming, you will need to include the contract/letter of acceptance for publication for each article/chapter in the thesis (e.g., in an appendix).

You will need to list in the bibliography and/or references any published or forthcoming work that appears in the thesis.

Section C - Presentation of a book for examination

Format

If your thesis takes the form of a book (this does not include books generated in the practice-based mode of submission which is dealt with in *Guidelines for Examinable Components in the Practice-Based Mode of Submission*) it should be submitted for examination as published (or as accepted for publication if not published at the time of submission) and may not be modified in any way.

You should present the book in digital format if this is available and you have permission from the publisher to provide the University with a digital copy. This should be in portable document format (PDF).

If the book is only published in print, a print copy should be presented to the GRS unless you have a copy of the book available in digital format. If you have a digital copy and you have permission from the publisher to provide the University with a digital copy, this should be in portable document format (PDF).

If the book is not already published, you should include the contract for the publication of the book with the material submitted for examination.

You should also submit copies of any agreements on authorship (required by the Authorship of Research Outputs Policy) with the book.

Appendix ii: Ethics application and approval - survey

LA TROBE UNIVERSITY

Research and Graduate Studies Committee
University Human Ethics Committee
College Human Ethics Sub-Committees
www.latrobe.edu.au/researchers/research-office/ethics/human-ethics

Research Office

NEGLIGIBLE RISK PROJECT – HUMAN RESEARCH ETHICS

1. **Project Title**	The Enhanced Maternal and Child Health service in Victoria – How does the program support vulnerable families, in particular those experiencing family violence?
2. **Chief Investigator / Supervisor:** (academic staff members only)	Name: Professor Angela TAFT Email address: A.Taft@latrobe.edu.au Department: Judith Lumley Centre, School of Nursing and Midwifery
3. **Student Investigator** (if applicable)	Catina Adams 82914215@students.latrobe.edu.au

4. **Provide a description of the project in plain language including:**
   - *Aims of the research (Including a brief background to the research)*
   - *Methods (if recruiting participants please include specific detailed step-by-step recruitment methods)*
   - *Nature of participants and participation (if any).*

The Enhanced Maternal and Child Health (EMCH) program in Victoria works with vulnerable families alongside the universal Maternal and Child Health (MCH) service. The EMCH service is delivered flexibly, usually via a home visiting program of up to 15 hours per family (up to 17 hours for rural families).

Each Local Government Area (LGA) offers a variation on the EMCH program as it was originally introduced twelve years ago. This is a result of LGAs developing programs and modes of delivery unique to local needs and resources. A number of factors have influenced the different service models including organisational context, local community demographics, size of the EMCH service, and professional qualifications of the EMCH staff.

I propose to undertake a survey of all Local Government Areas (LGAs) in Victoria to describe this variation in programs. The survey will reveal a variation in clientele, differences in the referral and discharge process, how services collaborate with other services, the different staff who are delivering the programs, and the alternative modes and location of delivery.

The survey may reveal patterns of how programs are structured and delivered, when correlated with the demographics of the LGA. For example, variations between advantaged or disadvantaged urban councils, or differences between urban and rural and remote locations.

Data collection will involve examination of any output and outcome measures, as described locally, and analysis will include comparing the data with the IRIS database (data held by the Department of Education and Training).

5. Specify the precise location/s where recruitment and data collection will occur.

A survey will be distributed online to all Local Government Areas in Victoria (n=79), with a letter of support from the Victorian State Department of Education and Training. The survey will be completed by the Maternal and Child Health Coordinator (or equivalent management position).

The survey will be distributed using Qualtrics, which will be used for data collection and analysis.

6. Specify the precise location/s data will be stored (both electronic and hard copy data)

The data and survey will be stored on the La Trobe University server which hosts the Qualtrics program. The data will be analysed on password protected University computers at the Judith Lumley Centre.

7. Type of Project (indicate whichever is applicable)

☐	Research by Academic Staff Member	☒	Postgraduate Research
☐	Contract Research	☐	Masters Research/Coursework
☐	Undergraduate Research	☐	Honours Research
☐	Clinical Trial	☐	Funded by external grant (please specify funding body and title of project) Click here to enter text.

8. Please provide evidence for why the study should be classified as negligible risk (not low risk) as defined by the National Statement (as per sections 2.1.7 , 5.1.6-8 and 5.1.22-23)

"The expression 'negligible risk research' describes research in which there is no foreseeable risk of harm or discomfort; and any foreseeable risk is no more than inconvenience." Section 2.1.7

This survey presents no foreseeable risk of harm or discomfort, other than the inconvenience of asking busy managers to find time to gather the data and complete the responses.

9. RESEARCH USING EXISTING DATABASES

If research involves access to existing data bases provided by an institution/s, please indicate:

a) Where the data is held, source/s and number of records
N/A

b) Whether data to be used will be non-identifiable, re-identifiable (e.g. coded) or identifiable
N/A

c) Whether permission has been granted by donors to use these data for research purposes
N/A

d) Whether formal permission/clearance has been sought or obtained from the relevant institution/s
N/A

10. Complete an Investigator Template for each La Trobe investigator involved.

<table>
<tr><td colspan="4">Chief Investigator: La Trobe University Staff Only
For database purposes please ensure that all details are up to date and correct.</td></tr>
<tr><td rowspan="2">Name</td><td rowspan="2">Professor Angela TAFT</td><td>Staff/ Student No.</td><td>Click here to enter text.</td></tr>
<tr><td rowspan="2">Email address</td><td rowspan="2">A.Taft@latrobe.edu.au</td></tr>
<tr><td>School/Institute</td><td>Judith Lumley Centre,
School of Nursing and Midwifery, La Trobe University</td></tr>
<tr><td>Role on the project (e.g. interviewing participants, data analysis etc.)</td><td colspan="3">PhD supervisor,
Research and survey design consultant</td></tr>
<tr><td colspan="4">Co-Investigator: La Trobe University Staff Only
For database purposes please ensure that all details are up to date and correct.</td></tr>
<tr><td rowspan="2">Name</td><td rowspan="2">Dr Leesa HOOKER</td><td>Staff/ Student No.</td><td>Click here to enter text.</td></tr>
<tr><td rowspan="2">Email address</td><td rowspan="2">L.Hooker@latrobe.edu.au</td></tr>
<tr><td>School/Institute</td><td>Department of Rural Nursing and Midwifery,
La Trobe Rural Health School,
La Trobe University</td></tr>
<tr><td>Role on the project (e.g., interviewing participants, data analysis etc.)</td><td colspan="3">PhD co-supervisor,
Research and survey design consultant</td></tr>
<tr><td colspan="4">Investigator 2: Student Investigator
For database purposes please ensure that all details are up to date and correct.</td></tr>
<tr><td rowspan="2">Name</td><td rowspan="2">Catina ADAMS</td><td>Staff/ Student No.</td><td>82914215</td></tr>
<tr><td rowspan="2">Email address</td><td rowspan="2">82914215@students.latrobe.edu.au</td></tr>
<tr><td>School/Institute</td><td>Judith Lumley Centre,
School of Nursing and Midwifery, La Trobe University</td></tr>
<tr><td>Role on the project (e.g., interviewing participants, data analysis etc.)</td><td colspan="3">PhD student
Administering survey, collating data, analyzing results.</td></tr>
</table>

The form must be submitted electronically by the Chief investigator from the La Trobe University staff email account. Please ensure you also submit:

- A completed Human Ethics Risk Assessment Checklist [PDF 1.7 MB]
- Any permissions obtained or indicate when permissions will be obtained from the applicable institutions.
- Participant Information Statements (if collecting data from participants).
- Surveys, questionnaires and/or interview sample questions (if applicable)
- Recruitment material such as posters, draft emails, drafts for a facebook page or website etc. (if applicable)

Negligible risk project please submit to either:

ASSC College Human Ethics Sub-Committee – chesc.assc@latrobe.edu.au

SHE College Human Ethics Sub-Committee – chesc.she@latrobe.edu.au

SHE COLLEGE HUMAN ETHICS SUBCOMMITTEE (SHE CHESC)

MEMORANDUM

To:	**Professor Angela Taft; Dr Leesa Hooker**
Student:	**Catina Adams**
From:	**Secretariat, SHE College Human Ethics Sub-Committee (SHE CHESC)**
Reference:	**S16-210 - Ethics application for negligible risk project - accepted**
Title:	**A SURVEY OF THE ENHANCED MATERNAL & CHILD HEALTH SERVICE IN VICTORIA - 2006-2016**
Date:	**17 November 2016**

The SHE CHESC Chair has evaluated your application as being of negligible risk and has accepted the project without review.

As a negligible-risk project (see Negligible risk guidelines), you are not required to submit annual and final reports, but you are required to maintain auditable records of the project.

Negligible risk studies cannot be modified using the Modification form, minor changes to a project do not require review. Researchers are responsible for informing the CHESC of any major modifications that may mean the research no longer fits the requirements of a negligible risk project. The Chief Investigator should send an email to the relevant CHESC entitled "modification for negligible risk project" with the project reference number (e.g. S16-500). Researchers will be informed via email if they are required to submit an application for human ethics review and approval to the CHESC or UHEC or if the modification is acceptable.

Please note that any data and consent forms need to be retained for a minimum of 5 years and that the consent forms must be stored separately from the data. Please also ensure that each participant retains a copy of the Participant Information Statement.

Kind regards,

Ms Kate Ferris MPH BPsych (Hons)
Human Ethics Officer
Secretariat – SHE College Human Ethics Sub-Committee
Ethics and Integrity / Research Office
La Trobe University Bundoora, Victoria 3086
M-F 9am – 5pm
T: 03 9479 3370 | E: chesc.she@latrobe.edu.au
http://www.latrobe.edu.au/researchers/research-office/ethics/human-ethics
Research Office Reception +61 3 9479 1144
CRICOS Provider 00115M

Appendix iii: Approval to conduct research from the Department of Education and Training

Department of
Education & Training

2 Treasury Place
East Melbourne Victoria 3002
Telephone: 03 9637 2000
DX210083

2016_003246

Ms Catina Adams
Judith Lumley Centre
School of Midwifery and Nursing
College of Science Health and Engineering
La Trobe University
215 Franklin Street
MELBOURNE 3000

Dear Ms Adams

Thank you for your application of 18 September 2016 in which you request permission to conduct research in Victorian early childhood settings titled *The Enhanced Maternal and Child Health (EMCH) service in Victoria. How does it support vulnerable families, particularly those experiencing Family Violence?*

I am pleased to advise that on the basis of the information you have provided your research proposal is approved in principle subject to the conditions detailed below.

1. The research is conducted in accordance with the final documentation you provided to the Department of Education and Training.

2. Separate approval for the research needs to be sought from centre directors. This is to be supported by the Department of Education and Training approved documentation and, if applicable, the letter of approval from a relevant and formally constituted Human Research Ethics Committee.

3. The project is commenced within 12 months of this approval letter and any extensions or variations to your study, including those requested by an ethics committee must be submitted to the Department of Education and Training for its consideration before you proceed.

4. As a matter of courtesy, you advise the relevant Regional Director of the schools or governing body of the early childhood settings that you intend to approach. An outline of your research and a copy of this letter should be provided to the Regional Director or governing body.

5. You acknowledge the support of the Department of Education Training in any publications arising from the research.

6. The Research Agreement conditions, which include the reporting requirements at the conclusion of your study, are upheld. A reminder will be sent for reports not submitted by the study's indicative completion date.

I wish you well with your research. Should you have further questions on this matter, please contact Youla Michaels, Project Support Officer, Insights and Evidence Branch, by telephone on (03) 9637 2707 or by email at michaels.youla.y@edumail.vic.gov.au.

Yours sincerely

[redacted]

Joyce Cleary
Director
Insights and Evidence

5/12/2016

VICTORIA State Government

Appendix iv: Participant Information and Consent Form (survey)

LA TROBE UNIVERSITY

Participant Information Statement and Consent Form

The research is being carried out in partial fulfilment of PhD under the supervision of Professor Angela Taft and Dr Hooker. The following researchers will be conducting the study:		
Role	**Name**	**Organisation**
Student	Catina Adams	Judith Lumley Centre, School of Nursing & Midwifery, La Trobe University
Prinicipal supervisor	Professor Angela Taft	Professor, Judith Lumley Centre, School of Nursing & Midwifery, La Trobe University
Co-supervisor	Dr Leesa Hooker	Judith Lumley Centre, Lecturer in Nursing and Midwifery, Department of Rural Nursing and Midwifery, La Trobe Rural Health School, La Trobe University, Bendigo
Research funder	The student is in receipt of a federal government PhD scholarship.	

1. **What is the study about?**
   You are invited to participate in a study of Enhanced Maternal and Child Health (EMCH) nurse practice when working with women experiencing family violence. We hope to learn what the EMCH nurse brings to the role, in terms of her skills, knowledge and personal attitudes, and to identity barriers and enablers for EMCH nurses working with women experiencing family violence.

   Your contact details have been provided by you, in response to an email sent by the Municipal Association of Victoria (MAV) to all Maternal and Child Health (MCH) coordinators.

2. **Do I have to participate?**
   Being part of this study is voluntary. If you want to be part of the study, we ask that you read the information below carefully and ask us any questions.

   You can read the information below and decide at the end if you do not want to participate. If you decide not to participate this won't affect your relationship with La Trobe University or any other listed organisation.

3. **Who is being asked to participate?**
   You have been asked to participate because:
   - You have experience working as an EMCH nurse in a Victorian Local Government Area (LGA).

4. **What will I be asked to do?**
   If you want to take part in this study, we will ask you to participate in an interview. It will take approximately 60 minutes of your time to be part of this study. The interview guide will be provided to you prior to the interview, so you have a chance to consider your answers, and also if you wish withdraw consent from the study.

5. **What are the benefits?**
   The benefit of you taking part in this study is that you will have the opportunity to discuss your work, to identity barriers and enablers for you working with women experiencing family violence.
   .
   The expected benefits to society in general are this research will add to the knowledge around engagement of families experiencing challenges, and how best to support those at risk of or experiencing family violence. Exploring the role of the EMCH nurse may inform the development of role definition, to improve the experience of EMCH nurses working with families.

6. What are the risks?

With any study there are (1) risks we know about, (2) risks we don't know about, and (3) risks we don't expect. If you experience something that you aren't sure about, please contact us immediately, so we can discuss the best way to manage your concerns.

Name/Organisation	Position	Telephone	Email
Catina Adams	PhD student	[redacted]	catina.adams@latrobe.edu.au

We have listed the risks we know about below. This will help you decide if you want to be part of the study.

- There is a risk you may become upset in discussing the emotional load of the work you do. You may also become upset when describing negative feelings about the work you do.
- You may be a victim/survivor of family violence and discussing the work you do with women experiencing family violence may cause you distress.

The interviewer will ensure that you are provided with resources and support, such as referral to your council's Employee Assistance Program (EAP), to Family Violence support services, or to other support services as required.

7. What will happen to information about me?

We will collect and store information about you in ways that will not reveal who you are. This means you cannot be identified in any type of publication from this study.

We will keep your information for 7 years after the project is completed. After this time, we will destroy all of your data.

We will collect, store and destroy your data in accordance with La Trobe Universities Research Data Management Policy which can be viewed online using the following link: https://policies.latrobe.edu.au/document/view.php?id=106/.

The information you provide is personal information for the purposes of the Privacy and Date Protection Act 2014 (Vic). You have the right to access personal information held about you by the University, the right to request correction and amendment of it, and the right to make a complaint about a breach of the Information Protection Principles as contained in the Information Privacy Act.

8. Will I hear about the results of the study?

We will let you know about the results of the study by giving you a copy of the transcript of interview, to ensure that your views have been accurately captured. All participants will have access to the published work that arises from this research, via journal article, conference presentation and thesis submission.

9. What if I change my mind?

At any time you can choose to no longer be part of the study. You can let us know by:

1. Completing the 'Withdrawal of Consent Form' (provided at the end of this document);
2. Calling us;
3. Emailing us

Your decision to withdraw at any point will **not** affect your relationship with La Trobe University or any other organisation listed.

When you withdraw we will stop asking you for information. Any identifiable information about you will be withdrawn from the research study. However, once the results have been analysed we can only withdraw information, such as your name and contact details. If results haven't been analysed you can choose if we use those results or not.

10. Who can I contact for questions or want more information?

If you would like to speak to us, please use the contact details below:

Name/Organisation	Position	Telephone	Email
Catina Adams	PhD student	[redacted]	Ccatina.adams@latrobe.edu.au

11. What if I have a complaint?

If you have a complaint about any part of this study, please contact:

Ethics Reference Number	Position	Telephone	Email
22227	Senior Research Ethics Officer	+61 3 9479 1443	humanethics@latrobe.edu.au

Consent Form – Declaration by Participant

I (the participant) have read (or, where appropriate, have had read to me) and understood the participant information statement, and any questions have been answered to my satisfaction. I agree to participate in the study, I know I can withdraw at any time. I agree information provided by me or with my permission during the project may be included in a thesis, presentation and published in journals on the condition that I cannot be identified.

I would like my information collected for this research study to be:

☐ Used for future related studies

☐ I agree to have my interview audio recorded

☐ I would like to receive a copy of the results via email or post. I have provided my details below and ask that they only be used for this purpose and not stored with my information or for future contact.

Name	Email (optional)	Postal address (optional)

Participant Signature

☐ I have received a signed copy of the Participant Information Statement and Consent Form to keep

Participant's printed name	
Participant's signature	
Date	

Declaration by Researcher

☐ I have given a verbal explanation of the study, what it involves, and the risks and I believe the participant has understood

☐ I am a person qualified to explain the study, the risks and answer questions

Researcher's printed name	
Researcher's signature	
Date	

* All parties must sign and date their own signature

Withdrawal of Consent

I wish to withdraw my consent to participate in this study. I understand withdrawal will not affect my relationship with La Trobe University of any other organisation or professionals listed in the Participant Information Statement. I understand the researchers cannot withdraw my information once it has been analysed, and/or collected as part of a focus group.

I understand my information will be withdrawn as outlined below:

- ✓ Any identifiable information about me will be withdrawn from the study
- ✓ The researchers will withdraw my contact details, so I cannot be contacted by them in the future studies unless I have given separate consent for my details to be kept in a participant registry.
- ✓ The researchers cannot withdraw my information once it has been analysed, and/or collected as part of a focus group

***if you have consented for your contact details to be included in a participant registry you will need to contact the registry staff directly to withdraw your details.*

I would like my already collected and unanalysed data
☐ Destroyed and not used for any analysis
☐ Used for analysis

Participant Signature

Participant's printed name	
Participant's signature	
Date	

Please forward this form to:

CI Name	Catina Adams
Email	catina.adams@latrobe.edu.au
Phone	[redacted]
Postal Address	Judith Lumley Centre, School of Nursing & Midwifery, La Trobe University, Bundoora 3083

Appendix v: Research dissemination

Papers published

Adams, C., Hooker, L., & Taft, A. (2019). The enhanced maternal and child health nursing program in Victoria: a cross-sectional study of clinical practice. Australian Journal of Primary Health, 25(3), 281-287. https://doi.org/https://doi.org/10.1071/PY18156

Adams, C., Hooker, L., & Taft, A. (2021). Threads of Practice: Enhanced Maternal and Child Health Nurses Working with Women Experiencing Family Violence. Global Qualitative Nursing Research, October 2021. https://doi.org/10.1177/23333936211051703

Adams, C., Hooker, L., & Taft, A. (2021). Managing maternal and child health nurses undertaking family violence work in Australia: A qualitative study. Journal of Nursing Management, 1-9. https://doi.org/10.1111/jonm.13466

Adams, C., Hooker, L., & Taft, A. (2022). A systematic review and qualitative meta-synthesis of the roles of home-visiting nurses working with women experiencing family violence. Journal of Advanced Nursing, 00, 1-22. https://doi.org/10.1111/jan.15224

Adams, C., Hooker, L., & Taft, A. (2022). The characteristics of Australian Maternal and Child Health home visiting nurses undertaking family violence work: An interpretive description study. Journal of Advanced Nursing, online (1), 1-15. https://doi.org/10.1111/jan.15160

Conference presentations

International

Adams, C., Taft, A., Hooker, L. (2022) Poster accepted, Threads of practice: The roles of Enhanced Maternal and Child Health home visiting nurses working with women experiencing family violence. Institute of Health Visiting, Evidence-based conference, September 15, 2022. In Manchester, UK

Adams, C., Taft, A., Hooker, L. (2022) Managers' experiences supervising Maternal and Child Health nurses undertaking family violence work in Australia: a qualitative study, 24th NNVAWI Conference, June 21-23, 2022, in Durham, North Carolina, USA.

Adams, C., Taft, A., Hooker, L. (2022) Threads of practice: The roles of Enhanced Maternal and Child Health home visiting nurses working with women experiencing family violence. 24th NNVAWI Conference, June 21-23, 2022, in Durham, North Carolina, USA.

National

Adams, C., Taft, A., Hooker, L. (2022) Threads of practice: The roles of Enhanced Maternal and Child Health home visiting nurses working with women experiencing family violence. MCaFHNA, Canberra

Adams, C. (2022) Family violence: nurse managers and their experiences supporting nurses. Australian College of Nursing Conference, August 17-19, in Darwin, Australia.

Adams, C., Taft, A., Hooker, L. (2022) Threads of practice: The roles of Enhanced Maternal and Child Health home visiting nurses working with women experiencing family violence. Australian Institute of Family Studies Conference, 15-17 June 2022, Melbourne.

Adams, C., Taft, A., Hooker, L. (2021) Enhanced Maternal & Child Health nurses working with families experiencing family violence, Australian Institute of Family Studies, https://aifs.paperlessevents.com.au/presenters/1896

Adams, C. (2021) How does the Enhanced Maternal and Child health program support women experiencing family violence, Visualise your thesis, La Trobe University. https://youtu.be/IKaRdXuVuGY

Adams, C., Taft, A. and Hooker, L. (2019) The Enhanced Maternal and Child Health nursing program in Victoria – a cross-sectional study of clinical practice. Poster presentation at the MCaFHNA conference, Sydney.

Adams, C. (2017) Changing course: How nurses support women experiencing family violence, 3MT presentation, La Trobe University.

Adams, C., Taft, A. and Hooker, L. (2017) How does the Enhanced Maternal and Child Health service support vulnerable families in Victoria? Oral presentation at the MCaFHNA conference, Melbourne

Appendix vi: Conference presentation (MCaFHNA – 2017)

Appendix vii: Poster presentation (MCaFHNA - 2019)

In Australia, on average one woman per week is killed by her current or ex-partner

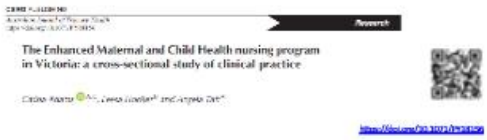
Maternal and Child Health nurses play an important role in supporting families … often the one consistent source of advice and support for new parents (2)
We ask all women about family violence, offer support, assist with safety plans, and refer to specialist agencies.

The Enhanced Maternal and Child Health nursing program in Victoria.

Women are most likely to experience family violence for the first time when pregnant or in the first year of their child's life, with younger women and women of Aboriginal or Torres Strait Islander origin at greater risk of experiencing domestic and family violence during pregnancy (1).

In Victoria, the Enhanced Maternal and Child Health (EMCH) program provides an intensive model of care and support for families. Few studies have explored the EMCH program and the EMCH nurse role, particularly in relation to working with women and children experiencing family violence.

A recent survey has revealed significant state-wide variation in the EMCH program. This variation is greatest between urban and rural services and between advantaged and disadvantaged urban councils (3).


Research

The Enhanced Maternal and Child Health nursing program in Victoria: a cross-sectional study of clinical practice

EMCH nurses & their supervisors working with women experiencing family violence.

Up to thirty EMCH nurses and their supervisors are being interviewed to explore the role of the EMCH nurse particularly when working with women experiencing family violence.

- How does the EMCH nurse describe her role and responsibilities and the focus of her work?
- What does the EMCH nurse bring to the role, in terms of her skills, knowledge and personal attributes?
- What are the experiences of EMCH nurses working with families at risk of or experiencing family violence?
- How does the EMCH nurse's supervisor support her in working with families experiencing family violence?
- What are the barriers and enablers for EMCH nurses working with women experiencing family violence?

With a clearer insight into the work of EMCH nurses and their supervisors, we aim to contribute to the development of position roles, identify professional boundaries and supports, and ensure that the work of the EMCH program contributes effectively to the support of women experiencing family violence.

References:
1. Australian Institute of Health and Welfare, 2018, https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/data
2. State of Victoria (2016) Royal Commission into family violence: summary and recommendations. State of Victoria: Melbourne, Vic., Australia.
3. Adams, C., Hooker, L. and Taft, A (2019) The Enhanced Maternal and Child Health nursing program in Victoria: a cross-sectional study of clinical practice. *Australian Journal of Primary Health*, https://doi.org/10.1071/PY18156

LA TROBE UNIVERSITY

School of Nursing and Midwifery
Judith Lumley Centre
Catina Adams, Leesa Hooker and Angela Taft

Appendix viii: Survey questions

Default Question Block

This survey is being conducted as part of a PhD program to describe current Enhanced Maternal and Child Health (EMCH) practice in Victoria. The Department of Education and Training (DET) has contributed to the development of this survey, and the data collected will assist with planning of future enhanced programs.

The EMCH program was introduced in 2003, as a state-wide initiative. Today, each Local Government Area (LGA) offers a variation on the EMCH program as it was originally introduced. This is a result of LGAs developing programs and modes of delivery unique to local needs and resources.

An exploration of the EMCH program will describe existing service delivery and inform future change. A study which focuses on describing health and social outcomes for children and families will enable better planning for future programs.

Three time points are being surveyed – 2005-6, 2010-11 and 2015-16, to align with ABS census data and to enable analysis of trends and changes in the Maternal and Child Health (MCH) program.

Thank you for your time in completing this survey.

Catina Adams
RN RM MClinNursg(Child Family & Community)
PhD student
Judith Lumley Centre,
La Trobe University

Professor Angela Taft
Judith Lumley Centre,
La Trobe University

Dr Leesa Hooker
School of Rural Nursing
La Trobe University

November 2016

What is the name of your Local Government Area (LGA)?

The State of Victoria has 79 Local Government Areas:

- 31 metropolitan (including 10 interface councils)
- 48 rural and regional (including 10 regional cities)

How would you describe your LGA?

- Metropolitan
- Interface
- Regional city
- Rural

For each financial year, please provide details of client enrolments and EFT (effective full-time) staffing for your universal MCH service.

	2005-6	2010-11	2015-16
Total client enrolments			
Birth notifications			
MCH nurses (EFT)			
Coordinator/Team leader (EFT)			
Admin (EFT)			
Other (EFT) please specify			
Other (EFT) please specify			

In your LGA, do you have a separate EMCH program, or is it offered within your universal service?

- ○ Separate EMCH program
- ○ Within the universal service

For each financial year, please provide details of client enrolments and the qualifications of staff in your Enhanced Maternal and Child Health program.

	2005-6	2010-11	2015-16
Client enrolments			
MCH nurses (EFT)			
Coordinator/Team leader (EFT)			
Early childhood educators (EFT)			
Social workers (EFT)			
Admin (EFT)			
Others (EFT) please specify			
Others (EFT) please specify			
Others (EFT) please specify			

Any comment?

STAFFING INFORMATION

Have EMCH nurses in your LGA undertaken any other education? Please tick all that apply.

- [ ] Family Partnership
- [ ] Infant Mental Health
- [ ] Circle of Security
- [ ] Specialist Adult Mental Health
- [ ] Specialist Alcohol and Drug
- [ ] Specialist Refugee nurse
- [ ] other (please specify)
- [ ] other (please specify)

Have Parent Support workers in your LGA undertaken any other qualifications? Please tick all that apply.

- [ ] Family Partnership
- [ ] Infant Mental Health
- [ ] Circle of Security
- [ ] other (please specify)
- [ ] other (please specify)
- [ ] We don't have Parent Support workers on our EMCH team.

Are EMCH nurses in your LGA paid more than universal nurses?

- ( ) Yes
- ( ) No

If yes, how much more per annum?

Any comment?

Do the EMCH staff in your LGA receive clinical supervision?

- ○ Yes
- ○ No

If yes, is it group or individual clinical supervision?

- ○ Group
- ○ Individual
- ○ Both

How many hours per month?

Who provides the clinical supervision?

Any comment?

Do the universal MCH nurses in your LGA receive clinical supervision?

- ○ Yes
- ○ No

If yes, how many hours per month?

If yes, is it group or individual clinical supervision?

- ○ Group
- ○ Individual
- ○ Both

Who provides the clinical supervision?

Any comment?

CLIENT CASELOAD

Although the service is funded to provide up to 15-17 hours per client, in your LGA, on average, how many hours is a client engaged with EMCH?

- ○ less than 5 hours
- ○ 5-10 hours
- ○ 11-15 hours
- ○ 16-20 hours
- ○ 21-25 hours
- ○ 26-30 hours
- ○ 30+ hours

Any comment?

What is the average client caseload per EMCH nurse EFT?

Any comment?

On average, how many EMCH nurse consultations are done per day?

On average, how long is an EMCH client consultation (not including travel time and admin)?

- ○ <30 minutes
- ○ >30 minutes - < 60 minutes
- ○ >60 minutes - < 90 minutes
- ○ >90 minutes - <120 minutes
- ○ >120 minutes

Any comment?

What is the work of the EMCH nurses in your LGA?
Please describe as a % of 100%.

Home visits	0
New parent groups	0
Specialist groups	0
Admin/meetings	0
Travel	0
Other, please specify	0
Other, please specify	0
Total	0

Any comment?

Does the EMCH nurse undertake Key Age and Stage (KAS) visits or does the Universal nurse continue to see the client for KAS?

- ○ EMCH nurse does the KAS
- ○ Universal nurse does the KAS

Any comment?

What is the work of the Parent Support Workers in your LGA?
Please describe as a % of 100%.
Please skip this question, if this does not apply.

Home visits	0
New parent groups	0
Specialist groups	0
Admin/meetings	0
Travel	0
Other, please specify	0
Other, please specify	0
Total	0

Any comment?

What is the work of the Social Workers in your LGA?
Please describe as a % of 100%.
Please skip this question, if this does not apply.

Home visits	0
New parent groups	0
Specialist groups	0
Admin/meetings	0
Travel	0
Other, please specify	0
Other, please specify	0
Total	0

Any comment?

What is the work of other EMCH workers in your LGA?
(Please specify who the "other workers" are in the comment box below).
Please describe as a % of 100%.
Please skip this question, if this does not apply.

Home visits	0
New parent groups	0
Specialist groups	0
Admin/meetings	0
Travel	0
Other, please specify	0
Other, please specify	0
Total	0

Any comment?

What other family support programs are offered within your LGA? Please tick all that apply.

- [ ] Communities for Children
- [ ] Best Start
- [ ] Access to Early Learning - AEL
- [ ] SSPI - supported playgroups
- [ ] Healthy Mothers Healthy Babies
- [ ] Right @ Home
- [ ] Cradle to Kinder
- [ ] Other, please specify

Any comment?

INTAKE INTO THE EMCH PROGRAM

What are the intake criteria for the EMCH program in your LGA?

In the past twelve months, what proportion (%) of EMCH clients in your LGA have been referred for:

- ○ Family violence
- ○ Sleep and settling
- ○ Breastfeeding
- ○ Attachment

- ○ Mental health
- ○ Drug and alcohol issues
- ○ Housing
- ○ Other issues, please specify

Any comment?

Are all your EMCH clients referred to the EMCH program via the Universal nurse?

- ○ Yes
- ○ No

Any comment?

Where do the EMCH referrals in your LGA come from? Please number in order.

- Universal nurse
- Maternity service
- Hospital Social Worker
- Child Protection
- Child FIRST
- Healthy Mothers Healthy Babies
- Client self referral
- Other, please specify

Any comment?

Are there any clients who are automatically referred to the EMCH program in your LGA? Please check all that apply.

- [ ] Young mother
- [ ] Premature baby
- [ ] Aboriginal & Torres Strait Islander
- [ ] Child Protection involvement
- [ ] Other, please specify

Any comment?

Do you use a systematic tool to determine priority of referrals?

- ( ) yes
- ( ) no

If yes, please describe below.

Do you use a clinical reasoning tool or framework to support the EMCH service work, for example, an assessment planning tool to determine family strengths and risks, family history, presenting issues, client goals, therapeutic action planning, assessment against goals, discharge planning, etc.?

- ○ yes
- ○ no

If yes, please describe below.

Do you have any Key Performance Indicators to measure the success of the EMCH program in your LGA? Please describe any measures used by your LGA to determine maternal and child health output and outcomes.

COLLABORATION

Do the EMCH staff collaborate with any of the following? Please tick all that apply.

- ☐ Universal nurse
- ☐ Hospital
- ☐ Child Protection

- [ ] Child FIRST
- [ ] Healthy Mothers Healthy Babies
- [ ] Early Childhood Intervention Services
- [ ] Specialist family violence services
- [ ] Mental health services
- [ ] Other, please specify

Any comment?

How does the collaboration occur? Please tick all that apply.

- [ ] Joint consultation
- [ ] Case conference
- [ ] Email
- [ ] Information sharing
- [ ] Patchwork
- [ ] Other, please specify

Any comment?

DATA COLLECTION

Do you enter the EMCH clients on to the Integrated Reports and Information System (IRIS)?

- ( ) Yes
- ( ) No

If no, please describe the reasons why you don't enter data on to IRIS?

Do you use any other means to track EMCH clients, for example Excel spreadsheet, in-house database?

- ○ Yes
- ○ No

If yes, please describe below.

DISCHARGE FROM EMCH

Do you use a discharge planning tool? Please describe below.

What proportion of EMCH clients re-engage with the universal service after discharge from EMCH?

- ○ All
- ○ more than 75%
- ○ more than 50%
- ○ more than 25%
- ○ unsure

Any comment?

How does the client re-engage with the universal program? Do you have any strategies to ensure continuing engagement with the universal service?

Is there anything else you would like to share about your EMCH program?
Please enter "No" to skip to the end of the survey.

If you offer the Enhanced Service within your universal MCH program, how is this offered?

- ○ Additional home visits
- ○ Additional centre appointments
- ○ Additional administration
- ○ Other, please describe

Why have you decided to offer the EMCH program within the universal service?

STAFFING

For each financial year, please provide details of client enrolments and EFT (effective full-time) staffing for your universal MCH service.

	2005-6	2010-11	2015-16
Total client enrolments			
Birth notifications			
MCH nurses (EFT)			
Coordinator/Team leader (EFT)			
Admin (EFT)			
Other (EFT) please specify			
Other (EFT) please specify			

Enhanced Maternal and Child Health clients

	2005-6	2010-11	2015-16
Client enrolments			

Do any of the MCH nurses in your LGA have any other qualifications? Please tick all that apply.

- ☐ Family Partnership
- ☐ Infant Mental Health

- [ ] Circle of Security
- [ ] Specialist Adult Mental Health
- [ ] Specialist Alcohol and Drug
- [ ] Specialist Refugee nurse
- [ ] other (please specify)

Do any of the Parent Support Workers in your MCH team have any other qualifications? Please tick all that apply.

- [ ] Family Partnership
- [ ] Infant Mental Health
- [ ] Circle of Security
- [ ] other (please specify)
- [ ] other (please specify)
- [ ] We don't have Parent Support Workers in our MCH team

Do you provide clinical supervision for the MCH nurses in your LGA?

- ( ) Yes
- ( ) No

If yes, how many hours per month?

If yes, is it group or individual clinical supervision?

- ( ) Group
- ( ) Individual
- ( ) Both

Who provides the clinical supervision?

Any comment?

INTAKE INTO THE EMCH PROGRAM

Where do EMCH referrals come from in your LGA?

- [ ] Universal nurse
- [ ] Maternity service
- [ ] Hospital Social Worker
- [ ] Child Protection
- [ ] Child FIRST
- [ ] Healthy Mothers Healthy Babies
- [ ] Client self referral
- [ ] Other, please specify

Are there any clients who are automatically referred to EMCH? Please check all that apply.

- [ ] Young mother
- [ ] Premature baby
- [ ] Aboriginal & Torres Strait Islander
- [ ] Child Protection involvement
- [ ] Other, please specify

Although the service is funded to provide up to 15-17 hours per client, in your LGA, on average, how many hours is a client engaged with EMCH?

- ○ less than 5 hours
- ○ 6-10 hours
- ○ 11-15 hours
- ○ 16-20 hours
- ○ 21-25 hours
- ○ 26-30 hours
- ○ 30+ hours

What are the intake criteria for the EMCH program in your LGA?

In the past twelve months, what proportion (%) of clients have been referred for:

- Family violence
- Sleep and settling
- Breastfeeding
- Attachment
- Mental health
- Drug and alcohol issues

Any comment?

Do you use a systematic tool to determine priority of referrals?

- yes
- no

If yes, please describe below.

Do you use a clinical reasoning tool or framework to support the EMCH service work, for example, an assessment planning tool to determine family strengths and risks, family history, presenting issues, client goals, etc.?

- ○ yes
- ○ no

If yes, please describe below.

Do you have any Key Performance Indicators to measure the success of the EMCH program in your LGA? Please describe any measures used by your LGA to determine maternal and child health output and outcomes.

DATA COLLECTION

Do you enter the EMCH clients on to the Integrated Reports and Information System (IRIS)?

- ○ Yes
- ○ No

If no, please describe the reasons you don't enter data on to IRIS?

Do you use any other means to track EMCH clients, for example Excel spreadsheet, in-house database?

- ○ Yes
- ○ No

If yes, please describe below.

Any comment?

COLLABORATION

Do your nurses collaborate with any of the following? Please tick all that apply.

- [ ] Universal nurse
- [ ] Hospital
- [ ] Child Protection
- [ ] Child FIRST
- [ ] Healthy Mothers Healthy Babies
- [ ] Early Childhood Intervention Services
- [ ] Specialist family violence services
- [ ] Mental health services
- [ ] Other, please specify

How does the collaboration occur? Please tick all that apply.

- [ ] Joint consultation
- [ ] Case conference
- [ ] Email
- [ ] Information sharing
- [ ] Patchwork
- [ ] Other, please specify

What other family support programs are offered within your LGA? Please tick all that apply.

- ☐ Communities for Children
- ☐ Best Start
- ☐ Access to Early Learning - AEL
- ☐ SSPI - supported playgroups
- ☐ Healthy Mothers Healthy Babies
- ☐ Right @ Home
- ☐ Cradle to Kinder
- ☐ Other, please specify

Is there anything else you would like to share about your EMCH program?

Please provide a phone number and/or email address, if we need to contact you for more information.

Thank you for taking the time to answer these questions.

If you have more information to offer, or outcome measurement or triage tools to share, please email to 82914215@students.latrobe.edu.au

Appendix ix: Ethics approval - Interviews

Research Office

To	Angela Taft
From	SHE Low Risk Human Ethics Committee
HEC Number	HEC18516
Project title	Using semi-structured interviews to explore how Enhanced Maternal and Child Health nurses support women experiencing family violence
Subject	Modification request dated 08.08.2019 received from Angela Taft re: 1) Changes to the Participant Information Statement and Consent Form 2) Changes to interview guide with addition of questions
Date	29 August 2019

The modification to this project submitted above was **approved** by the **SHE Low Risk Human Ethics Committee**.

If this project is a multicentre project you must forward a copy of this letter to all Investigators at other sites for their records.

Please note that all requirements and conditions of the original ethical approval for this project still apply.

Should you require any further information, please contact the Human Research Ethics Team on:
T: +61 3 9479 1443| E: humanethics@latrobe.edu.au.

La Trobe University wishes you every continued success in your research.

Warm regards,

Agnes Hazi
Co-chair, SHE Low Risk Human Ethics Committee

Appendix x: Participant Information and Consent Form (interviews)

LA TROBE UNIVERSITY

Participant Information Statement and Consent Form

The research is being carried out in partial fulfilment of a PhD under the supervision of Professor Angela Taft and Dr Leesa Hooker. The following researchers will be conducting the study:		
Role	**Name**	**Organisation**
Student	Catina Adams	Judith Lumley Centre, School of Nursing & Midwifery, La Trobe University
Principal supervisor	Professor Angela Taft	Professor, Judith Lumley Centre, School of Nursing & Midwifery, La Trobe University
Co-supervisor	Dr Leesa Hooker	Judith Lumley Centre, School of Nursing & Midwifery, La Trobe University
Research funder	The student is in receipt of a federal government PhD scholarship.	

1. **What is the study about?**
   You are invited to participate in a study of Enhanced Maternal and Child Health (EMCH) nurse practice when working with women experiencing family violence. We hope to learn what the EMCH nurse brings to the role, in terms of her skills, knowledge and personal attitudes, and to identity barriers and enablers for EMCH nurses working with women experiencing family violence. We also aim to explore the EMCH nurse's supervisor role in supporting the EMCH nurse.

   Your contact details have been obtained in response to an email sent by the Municipal Association of Victoria (MAV) to all Maternal and Child Health (MCH) coordinators.

2. **Do I have to participate?**
   No, being part of this study is voluntary. If you would like to be part of the study, we ask that you read the information below carefully and ask us any questions.

   If you decide not to participate this won't affect your relationship with La Trobe University or any other listed organisation.

3. **Who is being asked to participate?**
   You have been asked to participate because:
   - You have worked as an EMCH nurse in a Victorian Local Government Area (LGA), or you are a supervisor of EMCH nurse/s.

4. **What will I be asked to do?**
   If you are willing to participate, we will ask you to do an interview. It will take approximately 45 minutes of your time to be part of this study. After reading the interview guide, you may decide not to proceed with an interview, by withdrawing consent (see below).

5. **What are the benefits?**
The benefit of you taking part in this study is that you will have the opportunity to discuss your work, and to identity barriers and enablers for you and your colleagues working with women experiencing family violence.

We hope this research will add to the knowledge around engagement of families experiencing challenges, and how best to support those at risk of or experiencing family violence. Exploring the role of the EMCH nurse may inform the development of your role definition, and improve the experience of EMCH nurses working with families.

6. **What are the risks?**
With any study there are (1) risks we know about, (2) risks we don't know about, and (3) risks we don't expect. If you experience something that you aren't sure about, please contact us immediately, so we can discuss the best way to manage your concerns.

Name/Organisation	Position	Telephone	Email
Catina Adams	PhD student	[redacted]	catina.adams@latrobe.edu.au

We have listed the risks we know about below. This will help you decide if you want to be part of the study.

- There is a risk you may become upset in discussing the emotional load of the work you do. You may also become upset when describing negative feelings about the work you do.
- You may be a victim/survivor of family violence and discussing the work you do with women experiencing family violence may cause you distress.

The interviewer will ensure that you are provided with resources and support, such as referral to your council's Employee Assistance Program (EAP), to Family Violence support services, or to other support services as required.

7. **What will happen to information about me?**
We will collect and store information about you in ways that will not reveal who you are. This means you cannot be identified in any type of publication from this study.

We will keep your information for 7 years after the project is completed. After this time, we will destroy your data.

We will collect, store and destroy your data in accordance with La Trobe Universities Research Data Management Policy which can be viewed online using the following link: https://policies.latrobe.edu.au/document/view.php?id=106/.

The information you provide is personal information for the purposes of the Privacy and Date Protection Act 2014 (Vic). You have the right to access personal information held about you by the University, the right to request correction and amendment of it, and the right to make a complaint about a breach of the Information Protection Principles as contained in the Information Privacy Act.

8. **Will I hear about the results of the study?**
We will let you know about the results of the study by giving you a copy of the transcript of interview, to ensure that your views have been accurately captured. All participants will have access to the published work that arises from this research, via journal article, conference presentation and thesis submission.

9. What if I change my mind?

At any time, you can choose to withdraw from the study. You can let us know by:

1. completing the 'Withdrawal of Consent Form' (provided at the end of this document);
2. calling us;
3. emailing us.

Your decision to withdraw at any point will not affect your relationship with La Trobe University or any other organisation listed.

When you withdraw, we will stop asking you for information. Any identifiable information about you will be withdrawn from the research study. However, once the results have been analysed, we can only withdraw information, such as your name and contact details. If results haven't been analysed, you can choose if we use those results or not.

10. Who can I contact for questions or want more information?

If you would like to speak to us, please use the contact details below:

Name/Organisation	Position	Telephone	Email
Catina Adams	PhD student	[redacted]	catina.adams@latrobe.edu.au
Professor Angela Taft	PhD supervisor		a.taft@latrobe.edu.au
Dr Leesa Hooker	Associate PhD supervisor		l.hooker@latrobe.edu.au

11. What if I have a complaint?

If you have a complaint about any part of this study, please contact:

Ethics Reference Number	Position	Telephone	Email
HEC 18516	Senior Research Ethics Officer	+61 3 9479 1443	humanethics@latrobe.edu.au

Consent Form – Declaration by Participant

I (the participant) have read (or, where appropriate, have had read to me) and understood the participant information statement, and any questions have been answered to my satisfaction. I agree to participate in the study, I know I can withdraw at any time. I agree information provided by me or with my permission during the project may be included in a thesis, presentation and published in journals on the condition that I cannot be identified.

I would like my information collected for this research study to be:

☐ Used for future related studies;

☐ I agree to have my interview audio recorded

☐ I would like to receive a copy of the results via email or post. I have provided my details below and ask that they only be used for this purpose and not stored with my information or for future contact.

Name	Email (optional)	Postal address (optional)

Participant Signature

☐ I have received a signed copy of the Participant Information Statement and Consent Form to keep

Participant's printed name	
Participant's signature	
Date	

Declaration by Researcher

☐ I have given a verbal explanation of the study, what it involves, and the risks and I believe the participant has understood; and

☐ I am a person qualified to explain the study, the risks and answer questions

Researcher's printed name	
Researcher's signature	
Date	

* All parties must sign and date their own signature

Withdrawal of Consent

I wish to withdraw my consent to participate in this study. I understand withdrawal will not affect my relationship with La Trobe University of any other organisation or professionals listed in the Participant Information Statement. I understand the researchers cannot withdraw my information once it has been analysed, and/or collected as part of a focus group.

I understand my information will be withdrawn as outlined below:

- ✓ Any identifiable information about me will be withdrawn from the study
- ✓ The researchers will withdraw my contact details, so I cannot be contacted by them in the future studies unless I have given separate consent for my details to be kept in a participant registry.
- ✓ The researchers cannot withdraw my information once it has been analysed, and/or collected as part of a focus group

I would like my already collected and unanalysed data

☐ Destroyed and not used for any analysis

☐ Used for analysis

Participant Signature

Participant's printed name	
Participant's signature	
Date	

Please forward this signed form to:

CI Name	Catina Adams
Email	catina.adams@latrobe.edu.au
Phone	[redacted]
Postal Address	Judith Lumley Centre, School of Nursing & Midwifery, La Trobe University, Bundoora 3083

Appendix xi: Semi-structured interview guide (nurses and managers)

Interview guide - How do EMCH nurses support women experiencing Family Violence?

INTRODUCTION

A state-wide survey of the EMCH program demonstrated a wide variation in referral/intake criteria, different modes of delivery, and differences in EMCH nurse working conditions, including workload, supervision, and remuneration.

We wish to explore the EMCH nurse role, specifically the skills, knowledge and attitudes required when working with women experiencing family violence. There is little knowledge, other than anecdotal, of the role and characteristics of the EMCH nurse, and her ways of working.

This research will enable an informed understanding of current EMCH nurse working practice. With a clearer insight into your work, we will be able to inform the future development of position roles, identifying professional boundaries and supports, and ensuring that the work of the EMCH program contributes effectively to the support of women experiencing family violence

The overall objectives of the interviews are to ask for details of the skills, knowledge and attitudes required to do this work, and to explore the stressors and enablers in supporting women experiencing Family Violence.

Process – I will digitally record the interview, which will then be transcribed. I will then use a computer program to perform a thematic analysis of the transcripts. I am hoping to interview up to twenty-four nurses.

Start recording asking for person's name and check that recorder is working. Note date and start time.

Complete verbal consent and reassure confidentiality

- Ask - do you agree to participate in the study, knowing that any identifiable information is confidential and that you can withdraw at any time? **Yes/ No**
- Do you agree that information provided by you during the project may be included in reports, presentations, published papers and/or student theses and future related studies on the condition that you cannot be identified? **Yes/No**

Commence interview

EMCH nurse - Questions to prompt the discussion

Tell me about your job – what do you do?

How did you come to be doing this work?

Can you tell me about any training you have had? What training do you think has helped you most to do this work?

Can you think of a family you have worked with experiencing family violence (de-identified)? What were the biggest challenges you faced in responding to them? (prompts – screening, risk assessment, safety planning, referral)

How did you work with this family? What tools, techniques, and skills did you bring?

(prompt) Why did you work in this way?

(prompt) What have you based this on?

For rural nurses - How does your rural setting impact on the way you work with women and children experiencing FV?

Do you perceive any tensions between what you do, and what you are expected to do?

What problems have you encountered in addressing FV when you are home visiting?

How safe do you feel in this work? (prompt) physical safety, emotional safety

What do you do if a consultation causes you to feel stressed, anxious or helpless?

When undertaking this work what feelings come up for you?

Any other questions or observations? Thank you for your contribution and time.

Complete interview and stop recording, note stop time. Make field notes about the interview, how it went, thoughts and impressions. Note any hesitancy/cues that there may be a problem with some line of questioning.

Interview guide - How do supervisors of EMCH nurses support them in working with women experiencing Family Violence?

INTRODUCTION

A state-wide survey of the EMCH program demonstrated a wide variation in referral/intake criteria, different modes of delivery, and differences in EMCH nurse working conditions, including workload, supervision, and remuneration.

We are interviewing EMCH nurses to explore their role, specifically the skills, knowledge and attributes required when working with women experiencing family violence. We also wish to explore the role of the EMCH nurse supervisor, in supporting nurses doing this work.

This research will enable an informed understanding of current EMCH nurse working practice. With a clearer insight into your work, we will be able to inform the future development of position roles, identifying professional boundaries and supports, and ensuring that the work of the EMCH program contributes effectively to the support of women experiencing family violence

The overall objectives of the interviews are to ask for details of the skills, knowledge and attitudes required to do this work, and to explore the stressors and enablers in supporting women experiencing Family Violence.

Process – I will digitally record the interview, which will then be transcribed. I will then use a computer program to perform a thematic analysis of the transcripts. I am hoping to interview up to twenty-four nurses, and six nurse supervisors.

Start recording asking for person's name and check that recorder is working. Note date and start time.

Complete verbal consent and reassure confidentiality

- Ask - do you agree to participate in the study, knowing that any identifiable information is confidential and that you can withdraw at any time? **Yes/ No**
- Do you agree that information provided by you during the project may be included in reports, presentations, published papers and/or student theses and future related studies on the condition that you cannot be identified? **Yes/No**

Commence interview

EMCH nurse supervisor - Questions to prompt the discussion

Please describe your role as an EMCH nurse supervisor? What does it entail?

Can you tell me about any training in supervision you have had? What training do you think has helped you most?

For rural nurse supervisors - How does your rural setting impact on the way you support EMCH nurses?

Thinking about the official tools and documents you have used - how do they support you in this work? How did they hinder your work?

Do you perceive any tensions between what you do, and what you are expected to do?

What additional support does an enhanced nurse provide in their work with women and children experiencing FV?

What problems have you encountered in supporting nurses doing family violence work?

What resources or supports are required for EMCH nurses working with women at risk of, or experiencing FV? And for EMCH nurses working with children at risk or experiencing family violence?

When supporting nurses doing family violence work, what feelings come up for you?

How safe do you feel in this work? (prompt) physically, emotionally

Where do you currently turn if your supervision of EMCH nurses causes you to feel stressed, anxious or helpless?

Any other questions or observations? Thank you for your contribution and time.

Complete interview and stop recording, note stop time. Make field notes about the interview, how it went, thoughts and impressions. Note any hesitancy/cues that there may be a problem with some line of questioning.

Appendix xii: Conference presentation (AIFS e-conference 2021)

The Enhanced Maternal and Child Health nursing program in Victoria.

Women are most likely to experience family violence for the first time when pregnant or in the first year of their child's life (1).

In Victoria, the Enhanced Maternal and Child Health (EMCH) program provides an intensive model of care and support for families.

A recent study has revealed significant state-wide variation in the EMCH program, which is greatest between urban and rural services and between advantaged and disadvantaged urban councils (2).

Study aim:

To explore EMCH nurse family violence practice in a diversity of settings, and to explore how EMCH nurses support women experiencing family violence.

Study design:

Using semi-structured interviews, 25 EMCH nurses have been interviewed from a range of Local Government Areas, in rural, regional city and urban locations.

Data analysis:

The interviews were coded using Reflexive Thematic Analysis (3) by generating initial codes, reviewing, and naming themes. Initial deductive themes were generated from the interview guide, then we inductively explored the data.

Preliminary results:

The EMCH nurse interviews have confirmed significant variation in practice when nurses are supporting women and children experiencing family violence, including barriers and enablers to practice. The rollout of a new EMCH program in 2019 (4) has highlighted these differences, as EMCH nurses attempt to modify their practice to the new model.

Nurses describe a sense of increasing responsibility in family violence work, and a lack of role definition and boundaries between nurses and specialist services. Pseudonyms used below.

We're working with families that are really high risk and other support service providers won't help because it's too high risk. We're the last man standing.
(Betty, urban location)

And I keep saying to everybody, we're not the police. We're not the ambulance. We're not the fire brigade.
(Zalie, urban location)

Implications:

The preliminary findings of this study have highlighted the role of EMCH nurses undertaking family violence work and acknowledges the diversity of experience for nurses and women experiencing family violence.

With a clearer insight into the work of EMCH nurses, we aim to contribute to the development of position roles, identify professional boundaries and supports, and ensure that the work of the EMCH program contributes effectively to the support of women experiencing family violence.

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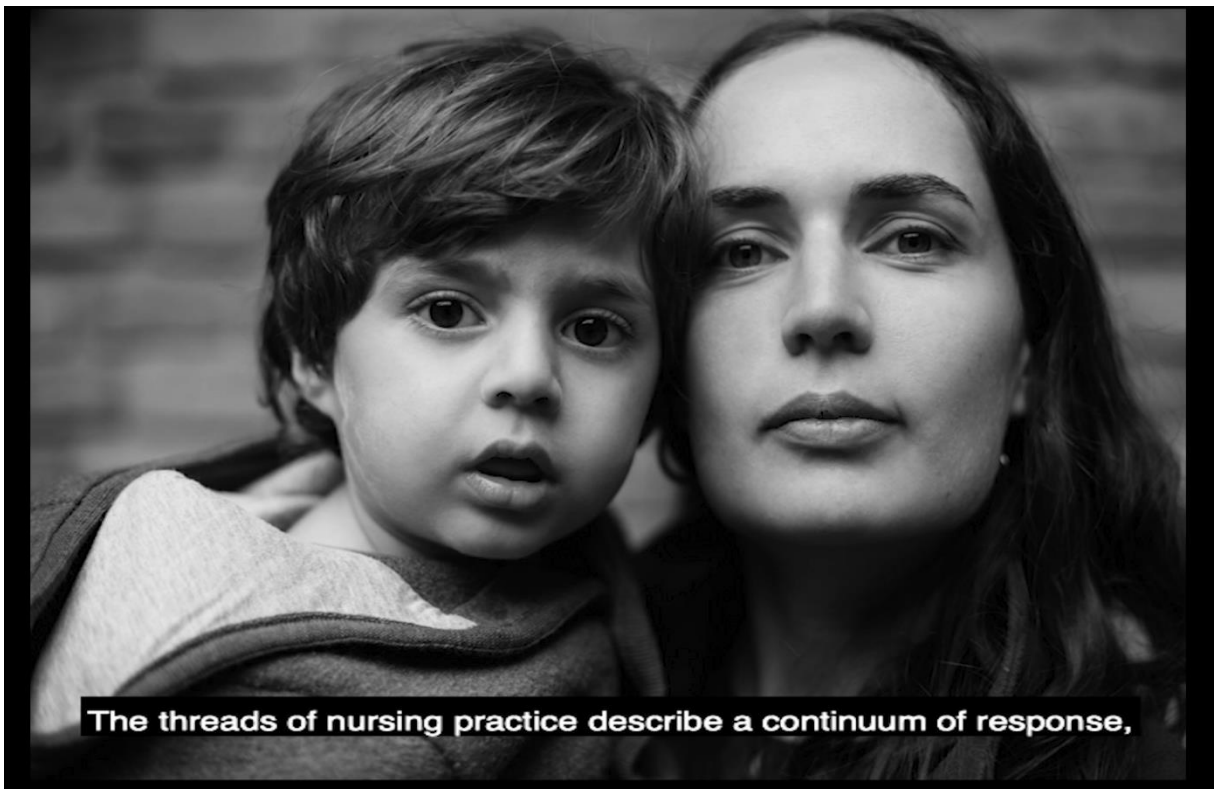
Appendix xiii: 3MT – Three-minute thesis (La Trobe 2017)

Appendix xiv: Visualise Your Thesis (La Trobe 2021)



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