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DETERMINED TO MAKE A DIFFERENCE:

A study of public health nursing practice with vulnerable families

A thesis presented in partial fulfillment of the
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ABSTRACT

Public health nurses have traditionally worked with vulnerable families in ways that are relational, client driven and contextual, an approach that has been described as a health promoting model of care. There is evidence however, that political and ideological reforms occurring within the health arena over the last fifteen years have had a constraining effect upon this area of public health nursing practice. The aim of this study was to explore the perceptions of public health nurses working with vulnerable families within a New Zealand context. This was in order to provide a contemporary description of how public health nurses work with vulnerable families and factors that enhance or constrain this process. The researcher was interested in whether this aspect of public health nursing practice continues to align with a health promoting model of care.

The research process utilised a qualitative approach. Semi-structured interviews were undertaken and a general inductive approach was utlilised for analysis of the data. The participants consisted of ten public health nurses from a district health board within New Zealand.

The findings identified that New Zealand public health nurses continue to align their practice with a health promoting model of care when working with vulnerable families, particularly if nurses are experienced, embedded within a community and determined to make a difference. It was evident however, that this process is significantly constrained by factors relating to the nature of the families themselves, the business model framing the delivery of public health nursing services and the challenges involved in dealing with the Child Youth and Family Service. This study also highlighted the vulnerability of the public health nurse which may occur as a result of working with vulnerable families and dealing with the constraints referred to above. These outcomes have implications for configuring effective services for vulnerable families and the place of public health nursing within the future primary health care nursing environment.

"And at the end of the day, yeah, it's those children. When I look at them, some have hollow sad eyes and I think, that's the window to their soul and some of those kids are hurting even at the age of five. You think, man they've seen a life story of hell at times and you think, you've got to pull out the stops for them - you've got to give it a try..."

Mavis, p. 23.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

Public health nursing in New Zealand has a rich legacy of responding to the needs of vulnerable families and communities. In the early twentieth century 'native nurses' were sent to isolated rural areas in response to a Maori population debilitated by communicable disease, the impact of war and a changing social and economic environment (Durie, 1998). Eventually this service expanded to involve the wider population, yet public health nursing has, to this day, retained an emphasis upon the disadvantaged and vulnerable. Over the years, public health nurses have worked at a grass roots level within communities, bringing a contextual and client driven perspective to their work with families, and encouraging people to become empowered and self reliant in relation to their health needs (Rafael, 1999a; Selby, 1996; Zerwekh, 1991b). The value of this health promoting approach to the complex and demanding process of working with vulnerable families has been identified in the literature (Appleton, 1996; Falk-Rafael, 2001; Pybus, 1993; Schulte, 2000; SmithBattle & Diekemper, 2001). Studies of expert practice confirm that this process of capacity building is the essence of the way public health nurses work with vulnerable families (Gallaher, 1997; Zerwekh, 1992b).

While public health nurses have historically adopted a health promoting approach to working with vulnerable families, the international literature reveals that in the last decade due to economic and ideological changes within the health arena, the scope of public health nursing practice has been constrained (Falk-Rafael, 2001; Reutter & Ford, 1998; SmithBattle, Diekemper, & Drake, 1999). There has been some suggestion that this has resulted in a distancing of public health nurses from their communities which has inhibited the potential to work in a health

promoting way with families (Rafael, 1997; Reutter & Ford). Anecdotal evidence reveals that recent health reforms have similarly restricted the scope of public health nursing practice within New Zealand which was a vital factor prompting this study. It seemed important to ascertain whether public health nurses in New Zealand are still able to work in a health promoting way with vulnerable families. This study, therefore, explored how public health nurses within the contemporary New Zealand context work with vulnerable families and what factors might constrain or enhance this process, with the aim of identifying how this particular aspect of public health nursing practice might align with a health promoting model of care.

This chapter presents the aims of the study followed by a background to the topic which includes a brief examination of the role of the public health nurse, vulnerable families and a health promoting model of care. This is followed by a discussion of the researcher's own interest in the topic. The significance of the study is then explored, and the chapter concludes with an overview of the thesis.

The research question and the aims of the study

The purpose of this study was to provide a picture of how public health nurses work with vulnerable families and to identify factors that might enhance or constrain this process. Of interest was whether the approach taken by public health nurses when working with vulnerable families encompasses a health promoting model care. The research questions guiding this study are:

- How do public health nurses work with vulnerable families?
- What factors enhance or constrain this process?
- Does the way public health nurses work with vulnerable families align with a health promoting model of care as defined by Hartrick (1997a) and Doane and Varcoe (2005)?

Public Health Nurses

New Zealand Public health nurses work within a variety of community settings throughout the country providing preventative health services to families and communities. The service they provide is underpinned by the principles of the Treaty of Waitangi and is determined by Ministry of Health contracts relating to child and family health, well child assessment and support, health promotion, and communicable disease prevention and management. Much of the work of public health nurses with families consists of home visiting, health education, advocacy, facilitating access to services and providing support in collaboration with other agencies and professionals. Positioned at the interface between schools, home and the wider community, public health nurses have a pivotal role in identifying families and children who are susceptible to negative health and social outcomes (New Zealand Nurses Organisation, 2001).

Vulnerable Families

Public health nurses often work with vulnerable families who experience deprivation and risk relating to compromised social, economic and environmental factors (College of Nurses Aotearoa, 2001). When referring to health status the concept of vulnerability has been defined as 'an increased relative risk or susceptibility to adverse health outcomes' (Flaskerud & Winslow, 1998, p. 69). In New Zealand this has been associated with unemployment, financial limitations, poor housing, cultural constraints, language barriers and isolation contributing to people being unable to access health services (National Health Committee, 1998). Public health nurses have recognized that issues faced by clients tend to be multiple, ongoing and not easily resolved (Gallaher, 1997; Green, 1993; Pybus, 1993). There may be children who have acute or chronic health issues that need addressing or who are suffering from physical or emotional neglect or abuse. Families may have little support, have difficulty accessing health and social services, be reluctant or unable to ask for help or be defensive about being approached. A primary concern of public health nurses is that these vulnerable families can be ignored

and remain invisible within communities (Anderson, 2006; Falk-Rafael, Fox & Bewick, 2005). The contracts determining the provision of public health nursing services to vulnerable groups tend to identify need in relation to the Ministry of Education school decile rating system which focuses on the mean income level of households for a particular area. Decile one aligns with the lowest family incomes and decile ten with the highest (Ministry of Education, 2006).

A health promoting model of care

This contextual and phenomenological approach to family nursing highlights health and capacity, empowerment and transformation rather than problems and deficiency (Hartrick, 1997a; Doane & Varcoe, 2005). A health promoting model of care moves beyond service provision where the health professional intervenes and is in control, to relational practice, a mutual process of participation where the family is the authority and the nurse is the collaborator (Hartrick, Lindsey, & Hills, 1994, p. 88). The focus is on 'understanding and enhancing human experience as it is lived' (Hartrick, 1997b, p.61) and is orientated toward 'freedom, autonomy and responsibility' (Hartrick, p. 64). From a public health nursing perspective this capacity building approach works at a grass-roots level to support and provide a voice for the vulnerable. It encompasses working with families to foster self reliance and build upon strengths through strategies such as relationship building, health education, mentoring and advocacy (Falk-Rafael, 2001; Zerwekh, 1991b).

The researcher's interest in the study

From 1982 until 2002 I worked as a public health nurse in a variety of New Zealand communities. During this time I was privileged to have a number of colleagues whose skill, tenacity and dedication when working with vulnerable families was inspiring. The expert practice of these public health nurses embodied determination, compassion, a contextual focus, skillful relationship building and creative processes of empowerment – an approach that Hartrick defines as a health promoting

model of care. From personal experience I know that by working in this way public health nurses have made a vital contribution to identifying and supporting vulnerable families within the community. However since the early 1990s significant changes within the New Zealand health arena have impacted on the work of public heath nurses.

While practicing as a public health nurse I learned that relationship building over time is the essence of working with vulnerable families. However, in latter years policies were introduced which constrained this way of working. Rather than maintaining connections with families, public health nurses were encouraged to adopt a brokerage role, keeping clients on their books for as little time as possible, referring on and closing cases. My experience has demonstrated that the trust and local knowledge that public health nurses develop by becoming embedded in communities facilitates the process of reaching and working effectively with vulnerable families. However, anecdotal evidence reveals that the potential for public health nurses to create the community infrastructure that supports their practice has been considerably restricted by the health reforms of the last decade (College of Nurses Aotearoa, 2001).

The literature suggests that within New Zealand the public health nurse role can be invisible within communities (Clendon & McBride, 2001); also that the value and complexity of the role is not fully understood or is ignored at a policy level (Gallaher, 1997). My experience is in accord with these findings. Public health nurses work with those whose voices have traditionally not been heard by governments. Salmond (1997) suggests that the low status of these groups may be one reason that the work of public health nurses remains invisible and marginalized.

Another troubling factor is that clinical supervision has not been accepted as mandatory for public health nurses. Clinical supervision ensures professional integrity, safe practice and exists to protect the wellbeing of the nurses themselves (Farrell, 2003). There has traditionally been an informal understanding amongst public health nurses that this support is available from one's colleagues. However I have been disturbed to see

even very experienced and competent public health nurses struggling to cope with the emotional demands of an increasing workload of distressed families. It can be difficult to summon the time and emotional energy to support a colleague when one is similarly burdened by one's work. It has also been of concern that there has not been a regular process of supervision to assist novice public health nurses to deal safely with complex families and child protection issues. This lack of support may be another factor inhibiting the quality of public health nursing practice with vulnerable families.

My motivation to undertake this research emerged from a concern that the potential for public health nurses to work in a health promoting way with vulnerable families may now be severely constrained. This concern has been compounded by rising numbers of neglected and abused children within New Zealand and accounts of vulnerable families not being identified and adequately supported (Department of Child Youth and Family Services, 2004; Welch, 2004). Thus this study provides a contemporary picture of how public health nurses work with vulnerable families and factors that might enhance and constrain this process with the aim of gaining some insight as to whether this aligns with a health promoting model of care.

The significance of the study

The aims of this study are endorsed by recommendations from past research into the way New Zealand public health nurses work with families. Gallaher (1997) suggests that further work is needed to describe how relationships with clients develop over time, the skills required for this process and how nurses cope with 'the dark side' of their work (p. 122). Hinder (1997) has emphasized the process of 'walking beside' families as intrinsic to public health nursing practice and recommends that this process be investigated in further studies (p. 112).

There is evidence that effective health interventions with vulnerable groups depend on building trusting relationships with individuals and

providing an intensive service (American Academy of Paediatrics, 1998; McNaughton, 2000; Olds et al., 1997). It has been identified that vulnerable individuals and clients require more rather than less involvement in order to facilitate change and provide the on going support necessary to ensure services are accessed (Ministry of Health, 1998; National Health Committee, 1998; The Royal New Zealand College of General Practitioners, 1999). This study provides insight into whether public health nurses are able to provide the level of input required by these clients.

The recent introduction of the 'Primary Health Care Strategy' (Ministry of Health, 2001) to the New Zealand health scene with its emphasis on community health and nurses taking a central role within primary health care, has significant implications for public health nursing in terms of how and where they will be utilised and employed in the future. Nurse leaders have recommended that community nursing roles be integrated under a generic primary health care nursing umbrella (Ministry of Health, 2002a). Thus it is important that the role of public health nurses is made visible so that its unique qualities are understood and valued.

The College of Nurses Aotearoa (2001) emphasises the value of a primary health care approach to working in a comprehensive way with families and the need to explore, describe, and affirm the practice of nurses within the community. This study provides an opportunity to make explicit processes such as relationship building, working in partnership and home-visiting, and how the principles of health promotion can be integrated into nursing practice with clients and families at a primary health care level. These factors contribute to the development of evidence based practice around family nursing within the community and have relevance for the allocation of health resources. If appropriate the processes used by public health nurses to work with vulnerable families could serve as a model for planning primary health care services in the future.

Summary

The contextual and client driven approach adopted by public health nurses when working with vulnerable families has traditionally aligned with a health promoting model of care as described by Hartrick (1997a) and Hartrick Doane and Varcoe (2005). It is possible that political and ideological reforms occurring within the health arena over the last fifteen years have had a constraining effect upon this area of public health nursing practice. The aim of this study therefore was to explore the perceptions of public health nurses within a New Zealand context in order to provide a contemporary description of how public health nurses work with vulnerable families and factors that enhance or constrain this process. The researcher was interested in whether this aspect of public health nursing practice continues to align with a health promoting model of care. The outcomes of the study may have implications for configuring effective services for vulnerable families and the place of public health nursing within the future primary health care nursing environment.

Structure of the thesis

This research study is presented in six chapters:

Chapter one has introduced the topic of the thesis and has outlined the background, purpose, aims and significance of the study.

Chapter two examines and critiques the literature relating to the work of public health nurses with vulnerable families. The way public health nurses define and refer to vulnerable families is explored, and literature pertaining to the process of working with vulnerable families as well as factors that enhance and constrain this practice is examined. The theory relating to a health promoting model of care is then outlined. This chapter highlights how 'vulnerable family' as a concept has significance for public heath nursing practice; the value of factors such as home visiting and having strong connections within the community for working

with vulnerable families; and the impact of recent health reforms upon this process.

Chapter three discusses the research methodology used in the study and a rationale is given as to the choice of research method. Justification for the use of a qualitative, descriptive, interpretative methodology is provided and a general inductive approach to data analysis is explained. The data collection process, participants, ethical considerations and strategies to address riguor are also outlined.

Chapter four presents the findings emerging from the study. The five main categories emerging from data analysis are described.

Chapter five discusses the relevance of each category in relation to the aims of the study and integrates this with the literature.

Chapter six presents the conclusions to this thesis and includes the outcomes, recommendations, limitations of the study and implications for future research.

This chapter has provided an introduction to this study by referring briefly to the historical context and present scope of public health nursing practice within New Zealand, and defining the concepts of 'vulnerable families' and 'a health promoting model of care'. The aims of the study and the researcher's interest in the research topic have then been presented and the significance of the study purpose in relation to past research and the contemporary health environment discussed. The chapter has concluded with an overview of this report. The following chapter provides further background information about public health nursing within New Zealand and presents an overview of literature relating to vulnerable families, a health promoting model of care, the work of public health nurses with families and factors constraining this area of public health nursing practice.

CHAPTER TWO

LITERATURE REVIEW

The purpose of the literature review is to provide a foundation to the study by presenting the current knowledge on the topic under investigation and bringing to light the significance of the present study (Polit-O'Hara, Beck, & Hungler, 2001). It thus provides a 'map of the territory' being covered, indicates the scope of the study and puts the research aims in the context of current research (Evans & Gruba, 2002, p. 6). The aim of this study was to describe how public health nurses work with vulnerable families and the factors that enhance or constrain this process. The researcher was interested in the relationship between this aspect of public health nursing practice and a health promoting model of care. The nature of vulnerable families as seen through the eyes of public health nurses was also of interest to the researcher, an objective endorsed by the literature which suggests that the way nurses refer to their clients can determine the approach taken in practice. This chapter presents background information and examines literature relevant to the aims stated above. The literature review reveals that although international research relating to the work of public health nurses with vulnerable families seems to be ongoing, there have been no recent studies of this nature within New Zealand. Thus in light of the considerable changes occurring in the health arena in the last fifteen years the present study is justified.

This literature review consists of two sections. Starting with an historical overview of public health nursing within New Zealand and a brief discussion of 'vulnerable family' as a concept, the first part of the review is concerned with how public health nurses define and work with vulnerable families, and the theoretical framework that underpins this process – a health promoting model of care. The second part focuses on

factors impacting on practice and centres around the health reforms of the 1980s and 1990s. The significance of the 'business model' and the 'New Public Health' in relation to public health nursing is discussed with reference to literature that highlights the impact of these forces upon work with vulnerable families. The chapter concludes with a short section explaining the relevance of the present study in light of the literature that has been reviewed.

The history of Public health nursing within New Zealand

Public health nursing and vulnerable families

Public health nursing as a distinct area of nursing practice within New Zealand emerged at the beginning of the twentieth century in response to the poor and declining health status of the Maori people. The Native Health Nursing Scheme was established in the early 1900s with the aim of assisting Maori to provide support for maternal and child health and to encourage improved living conditions in relation to hygiene, sanitation and the spread of communicable disease. This scheme was assimilated by the Public Health Department in 1911, and from then expanded to include the health concerns of the European settler population (McKegg, 1992). From 1917 the position of school health nurse was established to work alongside medical health officers and to work with families in response to health concerns referred by teachers. During the 1930s the Native Health Nurses and School Nurses combined into the role of a District Health Nurse. In the 1920s an occupational nursing role had emerged to attend to the health of employees within factories and other industries and in 1953 this service was amalgamated with the district nursing role to create the public health nurse (Burgess, 1984; Selby, 1996).

For the next three decades public health nurses continued to provide a comprehensive service in urban and rural areas which focused around the health concerns of infants, children, adolescents, mothers, workers and also the well elderly. Much of this work involved family centred care focused around infant welfare visits to families who were socially and

economically disadvantaged. Public health nurses would carry extensive case loads of families who would be visited on a regular basis. This enabled the nurse to build up a solid working relationship with families which would be the foundation for assisting the family to identify and address further health concerns. Families were able to choose between Plunket or the public health nurse for their infant welfare service. Those preferring the public health nurse were encouraged by ease of access due to the public health nurse tending to home visit rather than focus care around clinic appointments as was the case with Plunket. Also with some families (particularly within the Maori community) there was a history of being supported by the public health nurse over a number of generations, and consequently a sense of trust in the service had been established (Barham, 1984; McKegg, 1992).

The advent of Maori health initiatives in the 1980s and a 'for Maori by Maori' approach meant that public health nurses were becoming less focused on Maori families in some areas. However the vulnerable health status of the Maori population meant that in areas where there were not appropriate Maori providers of Well Child services, public health nurses remained the most accessible service and as such were responsible for reaching families with health needs and linking them with other primary health care services (Manchester, 2006a; Webby, 2004).

In latter years the work with vulnerable families has centred around the health of school-age children referred from schools, family doctors, hospital out patient clinics or other services within the community, and communicable disease case work (Manchester, 2003; Vause, 2006). These referrals provide access to vulnerable families. Within some of the larger urban / city areas, particularly in the North Island of New Zealand there are other vulnerable groups who are targeted by public health nursing . For example, public health nurses are reaching refugee and migrant groups through school referrals, communicable disease case work and collaborative community health initiatives (Anderson, 2006; Manchester, 2006b). Nurses have found that these groups can have significant unmet health needs which respond to support, health education, and assistance

to access other health and social services – processes facilitated by relationship building and fostering confidence and trust (Carryer, Dignam, Horsburgh, Hughes, & Martin, 1999).

Public health nursing and organizational change

Between 1953 (when industrial health nursing, native and school nursing services were amalgamated under the title 'public health nurse') and 1980, the organisational structure supporting the public health nurse role in New Zealand remained relatively unchanged (Selby, 1996). In 1980 public health nurses were employed under the State Services Commission and situated within the Department of Health. The public health nursing service was nationally organized with its own policies, programmes, provisions for education, and processes for workforce and career development. In each region the administrative structure leading and co-ordinating the service consisted of a Medical Officer of Health, a Principle Public Health Nurse and an Inspector of Health (Salmond, 1997).

In the 1980s as a result of the emerging 'new public health' ideology, Department of Health district services were reconfigured into Health Development Units (HDUs). Public health services in regions were now organized to align with the concept of health development, a programme focused, multidisciplinary approach to identifying and addressing health issues within communities (Brunton, Shaw, & Scuri, 1991). An emphasis on generic management emerged, traditional public health nursing leadership structures were dismantled and public health nurses were re-organised to work within multidisciplinary teams and programmes focused around identified health issues (Ewart, 1989). They were no longer expected to take on a generalist role but instead tended to take a specialist approach with an emphasis on one or two areas of work (Hansen, 2004). Sometimes this entailed a loss of a nursing title in favour of that of a generic health worker (Ewart). While these changes presented a considerable upheaval for public health nursing they also brought creative and exciting opportunities with nurses adapting to new roles in partnership with the community (Shaw, 1991). Some of these activities such as the Priority Area Programmes served to facilitate access

to and more intensive work with vulnerable populations (Richardson, 1998).

Further restructuring in the late 1980s resulted in Health Development Units being absorbed by newly established Area Health Boards which brought about the amalgamation of curative and preventative services within regions. As a result of this change an important aspect of the work of public health nurses with vulnerable families was redefined. Public health nurses had traditionally provided infant welfare and preschool child health and development assessments as an alternative service to Plunket and in particular had been accessible to and patronized by the Maori population. With the establishment of Area Health Boards Plunket was given primary responsibility for infant welfare and wellchild surveillance and public health nurses prioritized their involvement around 'hard to reach' and disadvantaged families (Blue, 1995). While public health nurses were able to retain access to the more vulnerable families within the population, this was to be considerably reduced following the advent of the more radical reforms of the 1990s.

With the formation of Area Health Boards the structure of the public health nursing service within New Zealand underwent a profound change. From now on the role of the public health nurse and the administrative structures in which they were placed would vary widely between regions which resulted in a loss of national focus to the service provided (Richardson, 1998; Shaw, 1991). This fragmentation was cemented by further health sector restructuring in 1991 with the abolition of the Area Health Boards and their replacement by Crown Health Enterprises. A radical change occurring with these reforms was the separation of the purchasing and provision of health services and with this, the emergence of a contract environment. For public health nurses the effect of these changes were exacerbated by a national 'unbundling' exercise undertaken by the government in 1992 which resulted in a division in funding between personal and population health services. There was some concern that this division did not reflect the complexity of their work within communities which could not be easily categorised as either

personal or population health (Richardson). The effect of the reforms upon public health nursing was compounded by the Employment Contracts Act in 1991 which brought restrictions to the employment conditions of public health nurses. The reforms had a dramatic effect on the number of public health nurses nationally which declined from 557 to 482 between 1990 and 1995 (Ministry of Health, 1995). By 2000 this number had only slightly increased to 487 (Health Workforce Advisory Committee, 2002).

Having provided an historical overview of public health nursing within New Zealand, this literature review will now examine the concept of 'vulnerable families' with reference to both the international and New Zealand literature. This will be followed by a section exploring the literature relating to the way public health nurses refer to and define this concept.

Vulnerable families

The literature reveals that the concept of family is defined in a variety of different ways by scholars, organizations and government agencies (Bomar, 2004). Within the nursing literature most of the definitions of family have similar elements relating to structure and function (Bomar; Friedman, Bowden, & Jones, 2003; Hanson, 2001; Wright & Leahey, 1994). Two definitions that have emerged recently are: 'the family is who they say they are' (Wright & Leahey, 1994, p. 40); and 'two or more individuals who depend on one another for emotional, physical and economic support ... the members of the family are self-defined' (Hanson, p. 6). Doane and Varcoe (2005) have critiqued current definitions of family as limiting the concept to a literal entity that does not allow for the notion of family as a 'complex relational experience' (p. 43). These writers suggest that the understanding of family be broadened to include a contextual view that encompasses a phenomenological, critical and spiritual lens. This approach will be expanded further in the section of this literature review relating to a health promoting model of care.

Vulnerability within the health care arena has been referred to in terms of increased relative risk or susceptibility to adverse health outcomes (Flaskerud & Winslow, 1998, p. 69). This risk can relate to a particular sensitivity to adverse effects, or involve a combination of multiple factors cumulating in a cycle of deprivation that can persist over an individual's lifetime or through generations within families (Flaskerud & Winslow; Koniak-Griffin, Anderson, Verzemnieks, & Brecht, 2000). Vulnerability may be related to limited physical /environmental, personal and bio-psychosocial resources due to factors such as poverty, insufficient social support, inadequate knowledge and skills, and the presence of illness or genetic predisposition (Aday, 2001). It also is associated with marginalization and disenfranchisement (Flaskerud & Winslow; Sebastian, 1999). Current public health documents within New Zealand acknowledge the above findings and consider vulnerability in relation to the issue of socio-economic inequalities and areas of deprivation. This data identifies that vulnerable groups within New Zealand belong to those who experience disadvantage and consequent ill health from factors such as being of Maori or Pacific Island ethnicity, low income, low level of education, substandard housing, unemployment, solo parent households, receiving a welfare benefit and reduced access to health care (Public Health Advisory Committee, 2004).

The nursing literature highlights family vulnerability when referring to those who are susceptible to disadvantage, deprivation and poor health outcomes (Appleton, 1994a; Mulcahy, 2004; Stanhope & Lancaster, 2004). Vulnerable families have been identified as those whose wellbeing and functioning are compromised by multiple and accumulating factors which limit environmental and economic resources and the ability to cope with stress (Boss, 2002; Friedman et al., 2003). References to family vulnerability from a nursing perspective emphasise factors such as indigenous and migrant status, adolescent pregnancy, sole parent families, mental health issues, substance abuse, domestic violence, child abuse and neglect (Bekemeier, 1995; Browne & Fiske, 2001; Browne, 1989; Cowen, 1999; Koniak-Griffin et al., 2000; Lutenbacher, 2002; Nester, 1998;Ryan & King, 1997; Souza, 2005; Williams, 1997). Recently

family vulnerability has also been considered in light of the family's capacity to be resilient and the notion that all families have strengths (Doane & Varcoe, 2005; McCubbin & McCubbin, 1993).

It is interesting to note that the tendency within the nursing literature is to reflect an epidemiological perspective rather than an 'emic' or insider view of vulnerability where the family's own experience is emphasized. Spiers (2000) contends that an epidemiological perspective is insufficient to understand human experience and that conceptualizations of vulnerability should include the perspective of the clients themselves. This argument is reflected in the tension between targeting health needs around predetermined notions of vulnerability or maintaining a flexible approach to the provision of services (Macfie, 2006). A recent New Zealand study involving Plunket nurses who used an epidemiologically based assessment tool to identify family risk factors, highlighted that using predetermined criteria for assessment can in fact result in some health needs not being recognized (Macfie). The recommendation emerging from this research is for a process that enables nurses to identify both articulated and unarticulated family needs with the suggestion that this should encourage ways of working with families that are empowering and capacity building.

How Public Health Nurses refer to and define vulnerable families

The participants involved in the present study were asked to self nominate their own definition of 'vulnerable families'. Not only was it anticipated that there might be some link between the way they define vulnerability and the approach they took in their practice, it was also hoped that this open perspective would encourage a rich spread of data. As the researcher was interested in how participants referred to and described the families they work with, it was considered important to seek out literature around this topic. This review will therefore explore literature relating to the way public health nurses define the families with which they work.

An examination of the literature reveals that there has been minimal research explicitly focusing on the way public health nurses refer and define their clients. Several studies in the United Kingdom have explored the way nurses working within a community context define vulnerability. Except for one study which involved public health nurses most of this research has targeted health visitors – a role that has some similarities to that of public health nursing thus indicating the research has some applicability to the current context.

Appleton (1994a) conducted a study in the United Kingdom to explore health visitors' perceptions of the concept of vulnerability and its relevance to child protection work. This study identified vulnerability as a complex, ambiguous and poorly defined term influenced by multiple interacting factors. The concepts of vulnerability and risk appeared to be referred to interchangeably by health visitors. Vulnerability was seen as a shifting state occurring along a continuum which families move in and out of at different stages of the life cycle. This experience is dependent on 'internal' and 'external' stress factors, coping ability and levels of support available (p. 1136). Stress factors emphasized by health visitors were: relationship and role conflict within the family; mother's health status; lack of support; the disability of a family member; parenting difficulties; financial difficulties and non use of health and social services. The study highlighted how assessing vulnerability tends to be influenced by the practitioner's personality, anxiety levels, knowledge and experience. The diverse meanings that the concept can have for different practitioners was emphasized. Thus the assessment of vulnerability is unique to each nurse and family involved.

Another United Kingdom study confirmed the above findings. Williams (1997) used a qualitative descriptive design to explore how health visitors organize their work in relation to the concept of vulnerability. This research also identified that vulnerability is a term that is difficult to define and that decisions relating to it require a flexible approach rather than rigid criteria. This study also highlighted the value of the

practitioner's past experience and intuition for the process of assessing vulnerability.

A more recent study from the United Kingdom, however, emerged with contrasting results to those above. Newland and Cowley (2003) explored how health visitors define vulnerability and how this influenced their work with families. Participants in this study were very clear about factors which constituted family vulnerability. Findings identified that practitioners considered family vulnerability to be a complex concept centred around social isolation and relating to factors such as: family size and composition; family dynamics; accommodation constraints; communication limitations; compromised health status; special needs; and an inability to maintain basic physical needs.

The only study to be found which specifically explored how public health nurses perceive the concept of 'vulnerable family' took place in Ireland (Mulcahy, 2004). Using a questionnaire this study showed that public health nurses describe vulnerable families in relation to factors that were similar to the earlier United Kingdom studies and supported the view of vulnerability as a dynamic and nebulous term that is difficult to define or measure. Despite the fact that the study relied heavily on mainly closed questions and an operational definition of vulnerability to guide respondents, the study concluded that vulnerability is multifaceted and determined by the confluence of personal and environmental factors.

To date there has been no New Zealand research that specifically explores public health nurse perceptions of family vulnerability. However there have been a number of studies focusing on public health nursing practice within a New Zealand context, and from these a picture of family vulnerability can be derived. Pybus (1993) makes reference to 'stressed families' in her study of the work of public health nurses with clients needing long term support. Vulnerability issues identified in this study are: families in a state of ongoing crisis; geographical mobility; issues relating to alcohol, financial constraint, violence and abuse; reduced coping skills, and compromised physical and mental wellbeing.

O'Sullivan's (1993) research project examining the work of public health nurses in relation to the health pf primary school children refers to the 'coal face realities' of : family hardship, families constantly moving, domestic stress, mothers not coping, housing and financial constraints, unemployment and parental illness or disability. Gallaher's (1997) phenomenological study of expert public health nursing practice highlights nurses' stories of families struggling to survive physically, emotionally and socially and of situations of despair, violence and abuse. Farrell's (2003) study exploring public health nurse experiences of clinical supervision refers to nurses descriptions of families with limited social support, mental health issues, drug and alcohol dependence, sole parenting, neglect and abuse.

The language used to define and refer to vulnerable families is a significant feature that was noted when exploring the literature for this review. A scan of both the international and New Zealand nursing literature reveals that families receiving focused care from health and social services have over the years, been referred to using terms such as: 'at risk', 'dysfunctional' , 'marginalized', 'hard to reach', 'multi problem' or 'high need' (Pybus, 1993; Stanhope & Lancaster, 2004; Zerwekh, 1992b). Doane and Varcoe (2005) contend that these labels reflect a deficit or problem focused world view and that this may limit the approach taken to the care nurses provide. This awareness has encouraged nurses to look for more affirming ways to describe their clients. For instance when public health nurses involved in a research project in Canada were asked how they would prefer to name their clients, there was a general consensus that even the word 'vulnerable' detracted from a strengths-based approach and that a more appropriate term would be 'high priority families' (McLeod, personal communication 2004).

There has been some suggestion within the nursing literature that the approach taken by nurses when referring to and defining the families they work with consequently shapes nursing practice (Doane & Varcoe, 2005; Koakinen, Hanson, & Birenbaum, 2004). However, research into public health nursing practice both overseas and within New Zealand shows that

while nurses may have adopted this deficit or problem focused terminology when referring to their clients, this has not been reflected in their practice. In fact the literature suggests that the approach taken by public health nurses when working with vulnerable families aligns more with identifying strengths and building capacity (Falk-Rafael, 2001; Gallaher, 1997; Pybus, 1993; Zerwekh, 1991b). This argument will be discussed more fully in chapter five of this report. To provide a context for this later discussion, the literature relating to public health nursing practice when working with vulnerable families will now be reviewed.

Approaches to working with vulnerable families

A review of the current international literature dating back to 1990 gives a comprehensive picture of how public health nurses work with families. Some of these studies are specifically pertinent for the present study as they were specifically designed to include families that were vulnerable.

A seminal study illuminating the work of public health nurses with vulnerable families was conducted in North America by Zerwekh (1990). Taking a phenomenological approach this study examined the expert practice of thirty public health nurses and focused upon their work with families consisting of high risk maternal /child clients. The family caregiving model of public health nursing which emerged from the findings highlighted processes such as locating families, building trust, building strength and encouraging self help. This study identified that working with vulnerable families is a complex and demanding process that requires a flexible, creative and client driven approach; knowledge of and links with a community; relationship building over time; an emphasis on empowerment and a contextual focus to the health issues involved.

Appleton's (1996) study in the United Kingdom of health visiting in relation to vulnerable families also identified the multifaceted nature of this work and suggested that the diversity of responses were a result of the complexity of the vulnerability experienced by families. Appleton identified that the work of health visitors with vulnerable families

involved four key roles; identification of vulnerability; being a support agent which included encouragement, education, advocacy, and empowering decision making; facilitating referral to other services; and a 'reluctant monitoring role' which related to the child protection component of the work (p. 917).

Two small North American studies which took place at this time and which also specifically centred around families identified to be 'at risk' emerge with similar findings. Mailer (1999) examined the expert practice of public health nurses working with families who had a high risk of problems with parenting. The four main competencies identified in this study as central to working with these families related to building trust, assessing needs and strengths, coaching to support self reliance and collaborating with other professionals. Langlois (1997) explored how public health nurses work with high risk families to prevent abuse and neglect. This study endorsed the applicability of Zerwekh's Family Care-giving model, in particular the importance of building trust and illuminated how public health nurses connect with these families by valuing them and acting in the community to assure their wellbeing. These findings are confirmed by other North American studies into public health nursing practice (Falk-Rafael, 2001; Kellogg, 1995; Leipert, 1999; Rafael, 1999a; Reutter & Ford, 1997; Schulte, 2000; SmithBattle & Diekemper, 2001; SmithBattle, Drake, & Diekemper, 1997). Although these further studies did not state specifically that vulnerable families were the target of the research undertaken, there is evidence that the majority of families who are clients of public nurses within this part of the world tend to be from the most impoverished and disadvantaged within the community (Schulte, 2000).

The findings from the small number of New Zealand research studies which focus on the practice of public health nurses with families are similar to the international studies in relation to the nature and complexity of the work. Three of these studies in particular each provide a rich picture of the complexity of working with families. Pybus (1993) used a case study approach involving three public health nurses and

fifteen families experiencing high levels of stress to identify features of the nurse family relationship that were effective for helping the families. This study highlighted the complexity of the public health nurse role when families are vulnerable and emphasised the importance of developing quality relationships involving trust, continuity, being available and working with client's own goals. Green (1993) utilized a grounded theory design to explore the perceptions of public health nurses of their work with children and their families and identified the process as one of 'enabling choice' (p. 119). The study identified how public health nurses assist clients to explore and act on possibilities through processes such as 'being accessible' (p. 122), 'framing their practice within a health and empowering model' (p. 123), 'seeing the whole picture' (p. 125), and 'making and using the relationship' (p. 126). This study emphasized the client centred and collaborative approach taken by public health nurses when working with families. The phenomenological study undertaken by Gallaher (1997) revealed an intricate picture of expert public health nursing practice. This study highlighted the complex nature of the work of public health nurses with families and illuminated how this process is contextual, flexible, client driven and focused on relationship building and continuity of care. While only one of the three studies above (the study conducted by Pybus) has specifically focused its aims around families who are particularly vulnerable, the remaining two studies make it clear that the families involved faced similar challenges.

Four other New Zealand studies though not directly concerned with exploring the dynamics of practice, also have relevance for the process of working with vulnerable families. O'Sullivan's (1993) small research project was conducted to ascertain if public health nurses make a difference to the health outcomes of primary school children and involved a survey of public health nurses as well as interviews that included parents, teachers and a child. This study illuminated the complexity of the work involved in responding to school referrals and highlighted the accessibility of the public health nurse, building trust, continuity of care, the collaborative nature of the work and the socio-political context of public health nursing practice within communities. Hinder's (2000) action

research study investigated the knowledge and skills required by an advanced public health nurses practitioner to work in a family centred clinic and identified that a collaborative, participatory and partnership approach emphasizing strengths and potential should be the foundation of this role. Clendon (1999) investigated the process of empowering 'at risk' clients by providing access to the public health nurse through a community clinic. A further study evaluating this initiative highlighted how strategies employed by the nurse to engage families were appropriately responsive and inviting and created a milieu that significantly influenced client perceptions of effectiveness and responsibility for personal health care (Krothe & Clendon, 2006).

Strategies supporting practice

The literature reveals that there are two key strategies that are significant for the way public health nurses are able to work with vulnerable families - building trusting relationships with clients through the process of home visiting and establishing credibility and working partnerships at a local level by building connections within the community (Gallaher, 1997; Green, 1993; Pybus, 1993; Schulte, 2000; SmithBattle et al., 1999; Zerwekh, 1991b). The next section of the review examines how these two key strategies are highlighted in the literature.

Home visiting

Studies into public health nursing practice have shown that home visiting has been a pivotal factor in relation to public health nursing practice with vulnerable families. The value of home visiting has been highlighted as an essential component of building trust, enabling the locus of control to remain with the client, understanding the context of people's lives and identifying need. It has been identified that this process allows nurses to build sustainable relationships with clients which in turn enables empowerment and change to occur. Being in the home facilitates the process of working in partnership and enables nurses to understand the reality of their client's lives, which then allows for ways of working that are acceptable to families (Byrd, 1998; Gallaher, 1997; Green, 1993;

Hanks & Smith, 1999; Kristjanson & Chalmers, 1991; McNaughton, 2000; O'Sullivan, 1993; Pybus, 1993; Rafael, 1999a; Zerwekh, 1991b).

The value of routine home visits by registered nurses to vulnerable families with infants and young children has been extensively studied and documented (McNaughton, 2000). Home visiting by registered nurses has been found to have positive outcomes in that it promotes the opportunity for vulnerable families who are experiencing crisis, health problems and child abuse to be identified (American Academy of Paediatrics, 1998; Appleton, 1996; McNaughton; Olds et al., 1997). An extensive study over fifteen years of the oral histories of public health nurses in Ontario confirms, from the perspective of public health nurses, the merit of this kind of intensive input into families (Rafael, 1999a).

Recent studies of working with vulnerable families confirm that home visiting is still a key strategy facilitating this work. A United Kingdom study focusing on the work of health visitors identified home visiting as an important vehicle for enabling the intensive approach required to work effectively with vulnerable families (Brocklehurst, Barlow, Kirkpatrick, Davis, & Stewart-Brown, 2004). The study illuminated how being in the home assisted health visitors to develop trusting relationships with clients, to understand the family's reality, to focus on the clients needs more fully, to be less directive and to facilitate change. These findings can be seen to have relevance for the work of public health nurses with vulnerable families.

Creating community connections

The literature also identifies how the process of working with vulnerable families is facilitated by the way public health nurses are embedded within communities. A North American study of the every day practice of public health nurses revealed how these nurses rely upon developing an 'organic relationship' with, and 'feeling the pulse' of the community to guide their practice and highlighted the importance of becoming engaged with and responsive to the community (SmithBattle et al, 1999 p. 219).

Reporting on findings from the same study SmithBattle et al.(1997) describe how public health nurses have a key role in integrating families with the community through processes such as 'mobilizing resources and fostering social connections' (p. 11). This intermediary role of assisting families to link with support and services that are relevant to their needs and at a time that is appropriate for them has been referred to in other literature (Green, 1993; Jakonen, Tossavainen, Tupala, & Turunen, 2002; O'Sullivan, 1993; Pybus, 1993; Rafael, 1999a; Zerwekh, 1990).

The theme of creating connections among communities emerged in a number of other North American studies. Schulte (2000) reports how public health nurses work within three interacting communities consisting of a geographically defined area, groups of people affiliated to each other by family bonds or similar links and a community of services and resources. Creating connections occurs through processes such as: 'forging working relationships, acting as a resource, detecting / asking the next question, making informed judgments, managing a sense of time, teaching, intervening with conditions influencing health, and using physical dexterity' (p. 7). Meagher Stewart's (2001) study of responding to the needs of women in high risk environments identified how the unique position of public health nurses within communities facilitates ways of working that are contextual, relational and empowering for clients. Rafael (1999a) identifies how the traditional focus of caring for the community, with the community, in the community is valued by public health nurses and is critical for assisting families to meet their health needs.

The processes outlined above reveal that public health nurses bring a contextual, client driven and empowering perspective to their work with families and communities (Falk-Rafael, 2001; Selby, 1996; SmithBattle et al., 1999; Zerwekh, 1991b, 1992b). The value of this approach in relation to the complex and demanding process of working with vulnerable families has been identified in the literature (Appleton, 1996; Pybus, 1993; Rafael, 1999a; SmithBattle & Diekemper, 2001). Studies of expert public health nursing practice confirm that this strategy of encouraging people to

recognise and enhance strengths persists as the essence of the way public health nurses work with vulnerable families (Gallaher, 1997; Zerwekh, 1992b). This approach aligns with the concept of a 'health promoting model of care' which has recently emerged in the nursing literature (Doane & Varcoe, 2005; Hartrick, 1997a; Hartrick et al., 1994).

A Health Promoting Model of Care

In 1994 Hartrick, Lindsey & Hills wrote a paper outlining a health promoting approach to family assessment which challenged nurses to reconsider their approach to family nursing practice. This model moved beyond a medical or behavioural view of health and health care to encompass a contextual world view, and the principles of phenomenological inquiry (Hartrick et al., 1994).

At this time nursing was identifying itself as a human science with an emphasis on caring as a science and an art, and humans as experiencing and contextual beings (Newman, 1986; Parse, 1992). The emergence of a socio-environmental view of health and the health promotion movement called for the notion of health promoting practice as a philosophy or an approach rather than a specific process (Labonte, 1989). This was mirrored within nursing with a shift from nursing knowledge as the primary focus to the nurse's way of being with families and clients (Hartrick et al., 1994). Rather than assessment as a means of diagnosis and treatment controlled by the nurse, the health promoting family nursing model highlighted an egalitarian relationship, families identifying their own health experience and shared responsibility (Hartrick et al., 1994, p. 87).

Based on a socio-environmental view of health a health promoting model of care draws on the tenets of the Ottawa Charter for health promotion (World Health Organisation, 1986) and the work of Freire (1993) and Labonte (1989). Health is seen to be embedded in the nature of human beings and the societal structures within which they live and related to the capacity of individuals to 'realise aspirations, satisfy needs, and to

change or cope with the environment' (World Health Organisation, 1986, p.1). A health promoting model of care builds upon the ethos of enabling personal choice and a process of mediating between people and their environment. The health professional relinquishes their power and control and people are encouraged to be recognized as experts of their own health situation. Thus health promoting practice involves an equal partnership between the nurse and the family in which families are encouraged to identify their own concerns and become 'an active participant in their own health care' (Hartrick et al., 1994, p. 87).

At the centre of this process is a relationship of 'genuineness, mutual respect, open communication and informality' between the nurse and the family (Gutierrez, 1990, cited in (Hartrick et al., 1994, p. 88). Hartrick (1997b, p. 525) refers to this as 'relational practice' – a process which moves beyond behavioural interpersonal models of relating to encompass a human-to human process as illuminated by Buber's (1958) I-thou relationship. Rather than a reciprocal relationship the emphasis becomes an ideal of care and responsiveness centred around a concern for others on their own terms (Lyons, 1988, cited inHartrick, 1997b). Relational practice focuses on the quality of the connection between the client and the nurse and the meanings arising from people's experiences of health and healing rather communication skills and problem solving.

Doane and Varcoe (2005) describe how a relational approach to knowing and working with families is informed by three philosophical lenses which enable a multidimensional view of families. A phenomenological lens which provides the perspective that people are interpreting beings who are continually engaged in the process of understanding their world, that this process is embedded within and emerges from the context within which they live and that there may be multiple versions or realities that relate to a particular situation (Hartrick & Lindsey, 1995). A critical lens which enables a deeper insight into how a family's experience of health and healing is shaped by contextual factors relating to power, social inequities and structural determinants of health (Doane & Varcoe, 2005). Also involved is a spiritual lens which extends beyond the physical,

psychological and social to encompass the 'life force' and ultimate concerns of families and which may include sources of faith, hope, trust, loyalty and inspiration (Doane & Varcoe, p.79).

The processes involved are about relating and understanding rather than assessment and intervention. Therefore rather than gathering information, recognizing problems and intervening, the emphasis of this model is upon understanding and working with the family's experience of health. Thus instead of putting emphasis upon identifying 'what is going on' within a family, the approach taken focuses upon understanding the multiple realities that might exist within that family (Hartrick, 1998, p. 82). Working with families becomes a process of inquiry to discover the lived experience of the family members. The emphasis is upon a way of being with families rather than a prescribed pathway. This approach guides practice toward an understanding of the 'depth and richness that family is', the 'possibilities that lie within family' and 'the meaning and experience of health and healing in the day to day lives of families' (Hartrick & Lindsey, 1995, p. 155).

Doane and Varcoe (2005) suggest that health promoting practice encompasses eleven key processes which are outlined below.

Entering Into Relation: Getting 'In Sync" with a Family
Conscious and intentional participation
Taking time to look, listen, and hear (small, taste, feel)
Unconditional positive regard
Walking alongside
Being in Collaborative relation: Staying 'In Sync'
Family collaborating with nurse
Family and nurse working together to assess and intervene
Respectful Inquiry into the Family Health and Healing Experience
Inquiring into what is meaningful and significant for the family
Keeping the family at the centre
Following the Lead of Families
Taking cues from the families
Taking a not-knowing stance
Using theoretical knowledge to enhance sensitivity to family experience
Scrutinizing theoretical and expert knowledge against family experience
Listening to and for
Through a phenomenological, critical, and spiritual lenses
Through a socio-environmental health –promotion lens
Through a capacity lens

Self-observation Participating consciously and intentionally Self knowing
Letting Be and Change To know who this family is and what is happening for them To create the opportunity for family to come to know more about their own experience, patterns, capacities, challenges, and contextual constraints. Letting be as the foundation for action and change
Collaborative Knowledge Development Drawing on family knowledge (experiential, historical, sociocultural) Drawing on nursing knowledge (experiential, scientific, biomedical, political, practical)
Pattern Recognition Of experience Of responses Of capacity Of capacity-adversity patterns
Naming and supporting capacity Seeking and recognizing capacity Looking beyond the surface Honouring the family's version of the story Working with the family to enhance capacity and address adversity
Emancipatory Action Recognizing and naming inequities Recognizing and naming structural conditions Drawing on and sharing contextual knowledge' Advocating with and on behalf of families Becoming politically active to address inequities

Table 1: Key processes for health promoting practice. Adapted from Doane & Varcoe (2005, p.228).

While there do not appear to be any studies that have explicitly explored the work of public health nurses in relation to a health promoting model of care, it is apparent from a survey of the literature that public health nursing practice within communities and with vulnerable families has traditionally aligned with this approach (Gallaher, 1997, Green, 1993, Rafael, 1999a; SmithBattle et al, 1997; Zerwekh, 1991b). There is evidence however, that the potential for public health nurses to work in this way, has in recent years been constrained by political and ideological changes within the health arena. It is possible that as a result of health reforms the practice of public health nurses may now tend toward a service model of care which emphasises a problem focused and prescribed approach to working with families (Hartrick, 1997a). The next section of this literature review outlines these changes with reference to the impact

of the business model and the 'new public health' upon public health nursing both internationally and within New Zealand.

The Health Reforms

There is some evidence that public health nursing practice in the western world has been significantly influenced by a constant and radical process of reform that has been occurring within the health arena in the last two decades (Falk-Rafael, Fox, & Bewick, 2005; Reutter & Ford, 1998; Richardson, 1998; Salmond & Bowers, 1997; SmithBattle et al., 1999). These changes have been driven by the need for cost containment and efficiency and the emergence of new health ideologies encouraging the reorientation of health services toward community empowerment and health promotion (Carryer, 2001; Rafael, 1999a; Twaddle, 2002). There have been two main strands to these reforms: the 'new public health' and the 'business model'. A move toward the values espoused by the 'new public health' and the adoption of a business approach to the funding and delivery of health services have significantly shaped and constrained public health nursing practice (Falk-Rafael et al., 2005; Reutter & Ford).

The New Public Health

The 'new public health' represented a major paradigm shift away from a bio-medical approach to a broader view of health and health care. This movement which gathered force in the 1970s emerged in response to the global burden of disease, health disparities, and the limits of medical technologies and was endorsed by the World Health Organisation vision of 'Health for All' and the philosophy of primary health care (World Health Organisation, 1978). The 'new public health' embodied an emphasis on health as a positive concept, prevention rather than cure, and the ideals of co-operation, social justice and participation (Talbot & Verrinder, 2005).

In developing countries this approach focused on empowering communities and providing essential services. In the developed world however, the emphasis was upon lifestyle factors influencing health status which resulted in some critique that this tended to blame the victim

(Lowenberg, 1995). This trend was modified in the mid 1980s with the Ottawa Charter (1986) which encouraged a move away from the rhetoric of individual responsibility toward a more comprehensive approach highlighting the notion that people's social and physical environments impact strongly on their health and health choices and that all public policies, not just health policies, have health consequences (Talbot & Verrinder, 2005). By the 1990s the 'new public health' had evolved into an approach that focused on both promotion and prevention; emphasised whole populations rather than individuals; highlighted a concern for underlying social-economic determinants rather than physical and behavioral risk factors; and encompassed collaborative strategies involving all sectors (Beaglehole & Bonita, 2004).

The philosophy encompassed by the 'new public health' resonated with nursing. Nurses recognized that the values enshrined in the Declaration of Alma-Ata (World Health Organisation, 1978) and the Ottawa Charter (World Health Organisation, 1986) were similar to the philosophy and approaches guiding their practice (Rafael, 1999b). Within New Zealand there were a number of innovative primary health care strategies initiated by public health nurses that emerged at this time (Richardson, 1998; Shaw, 1991). However in the 1990s the 'new public health' was refocused towards population health and health promotion which brought an emphasis on programme focused work and the role of the health promoter (Blue, 1995; Richardson). There is some evidence that this constrained the ability of public health nurses to respond to the needs of individuals and families at a grass roots level (Salmond & Bowers, 1997). This factor is highlighted in the international research which suggests that the health promotion and community development work traditionally a component of public health nursing practice has been devalued (Rafael). This will be explored further later in this chapter.

The Business Model

In the early 1990s in an effort to integrate and rationalize health spending governments through out the western world introduced a commercial business and competitive focus to the health arena (Davis & Ashton, 2001;

Fawcett-Henesey, 2000; Twaddle, 2002). These reforms were part of an overall reconfiguration of social policy occurring at this time in a number of industrialized countries which manifested as cuts to welfare benefits, a move away from universal subsidies for health, education and income support, and a business approach emerging in the delivery of social services (Davis & Ashton; Gauld, 2001). The changes were driven by a commitment to marketisation, manageralism and transparency in relation to the collection of information and financial management (Gauld, p 86). Governments proposed that introducing a market approach to the delivery of public health policy would enhance efficiency and effectiveness (Twaddle).

Within New Zealand these reforms were wide-reaching and profound, but were eventually blamed for continuing inefficiencies within the system (Ashton, 1999). By the end of the 1990s elements of the health reform model had been modified, and public service principles and those of collaboration and co-operation were re-introduced. The election of a Labour dominated government in 1999 embedded this shift away from the neo-liberal principles at the heart of the health reforms (Ryan, Carryer, & Patterson, 2003). This revision of the reforms was enhanced with the introduction of the Government's "Primary Health Care Strategy' in 2001 which in principle represented a further move away from a competitive and business focused model (Ryan et al).

The impact of one and a half decades of market liberalism has been to transform the public sector of New Zealand from a system centred around inputs and processes to one which focuses on outcomes and outputs (Davis & Ashton, 2001, p. 16). This significant change in philosophy has had a profound effect at an organizational level within the health system. The radical restructuring processes that occurred created major upheavals and stress for those working at the coal face which resulted in disillusionment, and loss of goodwill. A 'clash of cultures' occurring between non-clinical managers and health professionals resulted in further stress, loss of morale and attrition (Finlayson, 2001; Hornblow, 1997, p.1894).

The health reforms had a significant and pervasive effect upon nursing generally (Finlayson & Gower, 2002; Thomas, S., 2004). Changes occurring to health service delivery through out the western world were marked by a climate of anti-professionalism and accompanied by a cult of managerialism which resulted in professional and clinical nursing leadership disappearing (College of Nurses Aotearoa, 2001; Norman & Cowley, 1999). Within New Zealand the national nursing organization publication in the mid nineties carried repeated reports of senior supervisory nursing positions being eliminated, a leveling of the workforce, mediocrity within nursing structures and a deterioration of standards of practice (Manchester, 1999; Miles, 1997; Wilson, 1997; Woods, 1998). The depletion of experienced nurses from the workforce brought concerns about institutional and practice wisdom being lost and the quality and safety of nursing practice being compromised (O'Connor, 1995; Williams, 1996). Similar constraints were apparent internationally (Aiken et al., 2001; Thomas, S., 2004; Walsh & Gough, 2000). Questions were being asked about whether the holistic ethos fundamental to nursing was able to survive within a commercially driven and fragmented health care environment (O'Connor, 1996; Rafael, 1999a).

A survey of current literature shows that the impact of the reforms upon nursing generally can be translated to similar effects within public health nursing and subsequently to the work with vulnerable families. This next part of the review discusses the effects of the reforms on public health nursing and in particular the work with vulnerable families with reference firstly to the international literature and then to literature from a New Zealand context.

Impact of the reforms on public health nursing practice

The international context

International studies have identified how the combined effect of the business model and the 'new public health' has had a considerable impact on public health nursing practice and in particular the work with

vulnerable families (Falk-Rafael et al., 2005; May, Phillips, Ferketich, & Verran, 2003; Rafael, 1997, 1999a; Reutter & Ford, 1996, 1998; SmithBattle et al., 1999). These studies reveal that for public health nursing the health reforms brought continual reorganization, a focus on outputs and fragmented funding systems which gradually eroded the public health nurses scope of practice and eventually resulted in a distancing of public health nurses from their communities and reduced access to vulnerable families.

A number of studies identified how a fiscally driven system does not accommodate for the intense input required to work with vulnerable families (Appleton, 1996; May et al., 2003). Constraints identified were: philosophical differences between funders and practitioners as to the nature and identification of vulnerability, an incompatibility between an output driven system and processes such as family and community focused care, and as a consequence, the extent and quality of practice being invisible to and not valued by administrators. These factors were found to have a limiting effect on practice (Appleton; May et al.).

There were reports that the shift to focusing on whole populations brought by an emphasis on the 'new public health' also constrained the work with vulnerable families. Study findings revealed that routine activities such as child health surveillance, home visiting and services to schools had been reduced or eliminated, in favour of activity at a broader community level (Rafael, 1999a; Reutter & Ford, 1998). There was a concern that the 'new public health' was being used by bureaucracies to justify a decrease of services at a personal health level and that it tended to focus on those who were able to identify their health needs and self refer rather than those who were vulnerable and marginalized (Rafael; Reutter & Ford). Ulrich (2002) identified how this tension between the traditional public health and the health promotion paradigms was constantly being enacted in the everyday practice of public health nurses. This conflict centred around questions such as: Should the focus of practice be about improving the health of individuals or that of whole populations? Is public health nursing practice about the contribution made by the individual nurse to

health outcomes or about the effort of the combined public health nursing team? Is public health nursing practice confined to work which occurs within the public health sector or is it part of a collective societal endeavour to improve health?

Studies highlighted how due to the constraints referred to above, the work of public health nurses was becoming increasingly invisible and devalued (Rafael, 1999a; SmithBattle et al., 1999). Reference was made to the withdrawal of a whole nursing team from regular nursing activities to meet the deadlines of a measles immunization campaign where minimal public outcry was seen as an indicator of public health nursing's delicate profile in the eyes of politicians and within the community (Rafael). There was also evidence that the effect of continual reorganization, economic reform and a rigidly defined funding system had diluted the institutional wisdom and practice expertise within public health nursing which had consequences for resourcing the work with vulnerable families (SmithBattle et al.).

The New Zealand Context

There is no formal New Zealand research focusing specifically upon the impact of the reforms on public health nursing practice. However anecdotal accounts in the mid nineties tended to echo the international literature with reports of the contract environment inhibiting the ability of nurses to respond holistically within communities and to explore deeper health concerns with clients and their families (Carryer et al., 1999; Wilson, 1996). There were also stories of public health nurses being concerned by moral dilemmas relating to issues of social justice arising from the reforms. These related to reduced accessibility of services, increasing costs of health care, and a shift of responsibility for health status onto individuals rather than political and social structures (Kilday, 1999; Woods, 1998).

A nationwide review of the public health nursing workforce in the mid nineties referred to issues such as: components of the public health nursing role becoming fragmented ; other disciplines competing for work

previously the domain of public health nursing; community health workers capturing some of the traditional functions of public health nurses; the public health nursing career structure, salary awards and job security being dismantled; there no longer being a national focus to the service provided by public health nurses; and the risk that public health nursing was losing its identity (Salmond & Bowers, 1997).

These factors are also referred to in a number of New Zealand studies that relate to public health nursing (Blue, 1995; Clendon, 1999; Green, 1993; Hansen, 2004; Hinder, 2000; Richardson, 1998). These studies tended to highlight the incompatibility of the market philosophy with the holistic approach encompassed in nursing. Green's study in particular emphasises the complex and contextual nature of the work with families being incompatible with a system requiring defined outputs and quickly achieved outcomes and the concern that home visiting would be threatened in the health reform environment. This can be considered in the light of Pybus's study (1993) of stressed families which recognized the need for continuity of personnel and contexts for practice that enabled nurses to be available and accessible to families.

These studies also make reference to the erosion of the public health nurse role due to factors such as: the division of the service into personal and population health, the contract driven environment, managers not understanding the nature of public health nursing practice, variations in funding across New Zealand and a decline in public health nurses numbers (Blue, 1995; Clendon, 1999; Green, 1993; Hansen, 2004; Hinder, 2000; Richardson, 1998). The impact of constant restructuring on the profile of the public health nurse within the community was also highlighted (Clendon & McBride, 2001).

The debate between health promotion and personal health and their relevance for public health nursing has been a theme emerging in several studies (Blue, 1995; Hinder, 2000; Richardson, 1998). Blue's discussion of options for change within public health nursing questioned the continuation of the personal health aspects of the public heath nursing

role in favour of a 'new public health' model encompassing community development and multi-disciplinary action at a population level. Richardson explored public health nurse perceptions of the health promotion component of their role and advocated that public health nurses should have a key role within health promotion, but recognized the need for personal health activity to be on going due to rising levels of ill health, stress and poverty. Hinder identified the challenge of working with broad contracts that included both health promotion and personal health practice, and the tensions experienced by public health nurses when faced with the risk of the personal health needs of families being ignored if there was too much emphasis on a community focused health promotion.

Hinder's study also highlighted how restrictions imposed on the scope of public health nursing practice due to funding restraints and restructuring have limited the capacity of public health nurses to be available to and responsive within their communities. The relationship of this issue to the invisibility of the public health nurse was referred to in Clendon's (1999) study which identified that communities are unaware of much of the service provided by the public health nurse (Clendon & McBride, 2001).

The most recent New Zealand study by Hansen (2004) which explored the organisational attributes considered by public health nurses to be important to their practice, reveals that many of the issues emerging from the reforms persist within the contemporary public health nursing environment. The results of a survey sent to all public health nurses within New Zealand identified that the organisational context of public health nursing practice is 'far from ideal' (p.107). The qualitative data in particular revealed issues such as Ministry of Health contracts being a barrier to meeting the needs of the community; the invisibility of the public health nurse role within the health sector and the community; and resource constraints relating to access to cars, cellphones, computer technology, clerical support, safety policies and procedures, health promotion and education resources, relief time for isolated roles and clinical supervision.

A Service Model of Care

Rafael (1998) describes the changes to public health nursing practice due to the impact of economic and ideological reforms within the heath care environment in terms of the three levels of power and caring: – 'ordered caring, assimilated caring and empowered caring' (p.30). Rafael refers to 'ordered caring' to describe the way public health nursing has recently become more prescribed with explicit boundaries being placed around what is or what is not a service (p.31). Caring practiced by nurses that extends beyond what is ordered tends to become invisible and unvalued which has negative implications for nurses wellbeing, self confidence and ability to advocate for themselves and their clients. Doane and Varcoe (2005) argue that the business ethos dominating the health arena in the last fifteen years has served to reinforce a service rather than a health promoting model of care within nursing. A service model of care rests upon the assumption that it is the health professional, rather than the client, who possesses the knowledge and expertise necessary to manage the family's health situation (Hartrick, 1997a). Rather than health collaboration and health promotion the emphasis is upon problem identification, intervention and service provision. It has been suggested that rather than enabling capacity this approach tends to reinforce deficiency and to limit the possibility for nurses to work in ways that encourage people to be empowered and self reliant in relation to their health needs.

Summary

The purpose of this study was to describe how New Zealand public health nurses work with vulnerable families and factors that enhance and constrain this process with the aim of identifying how this particular aspect of public health nursing practice might align with a health promoting model of care. As the term 'vulnerable families' was to be self nominated by the participants themselves, the study also sought to identify how public health nurses define or refer to vulnerable families.

The first part of this chapter therefore has provided an historical overview of public health nursing within New Zealand and discussed literature relating to vulnerable families, a health promoting model of care and public health nursing practice. The second part of the review has examined the literature which focuses on the impact of recent political and ideological health reforms on the work of public health nurses with vulnerable families. A summary of the key points emerging from this review are as follows.

The literature reviewed for this study highlighted how public health nursing practice has traditionally focused on the needs of vulnerable families and that this emphasis has been sustained despite the continual changes to the structure of this service over the last century (Barham, 1984; Gallaher, 1997; McKegg, 1992; Pybus, 1993; Selby, 1996). It was apparent that concepts of vulnerable families within the health literature tend to be dominated by an epidemiological perspective, and that this trend has influenced the way public health nurses refer to the families in their care (Flaskerud & Winslow, 1998; Mulcahy, 2004). However it was also evident that there is a recent move within nursing to define families in terms of strengths and capacity (Doane & Varcoe, 2005; McCubbin & McCubbin, 1993). A suggestion within the literature that the way nurses define their clients influences the approach taken in practice was also noted (Doane & Varcoe).

There have been numerous studies internationally and a number from within New Zealand that have examined the nature of public health nursing in relation to families and it is apparent that home visiting and connecting with the community are two key strategies that are central to this work (Gallaher, 1997; McNaughton, 2000; Pybus, 1993; Reutter & Ford, 1998; Schulte, 2000). While there do not appear to be any studies that have explicitly explored the practice of public health nurses in relation to a health promoting model of care, a close examination of past international and New Zealand research reveals that the processes employed by public health nurses when working with vulnerable families resonate with the main features of this approach (Doane & Varcoe, 2005;

Falk-Rafael, 2001; Gallaher; Green, 1993; SmithBattle et al., 1997; Zerwekh, 1991b). There have however been no further studies exploring public health nursing practice within the New Zealand context since 1997 to confirm this finding from a contemporary perspective.

This review highlighted substantial evidence within the international literature that the health reforms of the last fifteen years have significantly constrained the ability of public health nurses to identify and respond to the needs of communities, particularly those who are vulnerable (Falk-Rafael et al., 2005; Rafael, 1997; Reutter & Ford, 1998; SmithBattle et al., 1999). However, while there is considerable literature verifying the impact of these changes within the New Zealand health arena generally (Davis & Ashton, 2001; Finlayson & Gower, 2002; Gauld, 2001), there is minimal evidence, and mostly anecdotal, to show the effect upon public health nursing within a New Zealand context (College of Nurses Aotearoa, 2001).

Given the profound changes that have taken place within the New Zealand health arena in the last two decades it thus seemed important to ascertain whether public health nurses are still able to work in a health promoting way with vulnerable families. Therefore the aim of this study was to provide a contemporary picture of how New Zealand public health nurses work with vulnerable families and to identify factors that enhance and constrain this process. The researcher was interested in how this aspect of public health nursing practice might align with a health promoting model of care. Because the literature suggests that the way nurses refer to their clients can determine the approach taken in practice, the researcher also sought to identify how public health nurses define or refer to vulnerable families.

The following chapter presents a discussion of the qualitative descriptive research methodology utilized for this study. The chapter will also include an account of the processes used for participant selection, data collection and analysis as well as strategies employed to address research rigour and the ethical factors involved.

CHAPTER THREE

THE RESEARCH PROCESS

The previous chapter provided a review of selected literature relating to the work of public health nurses with vulnerable families. This discussion revealed that this aspect of public health nursing has traditionally aligned with a health promoting model of care as defined by Hartrick (1997a) and Doane and Varcoe (2005), but that this may have been constrained by the effect of the health reforms over the last two decades. The literature review thus provided a context for the following research questions:

- How do public health nurses work with vulnerable families?
- What factors enhance or constrain this process?
- Does the way public health nurses work with vulnerable families align with a health promoting model of care as defined by Hartrick(1997a) and Doane and Varcoe (2005).

This chapter presents the research methodology utilized to explore these questions and will include an account of the processes used for participant selection, data collection and analysis, as well as strategies employed to address ethical factors and research rigour.

The methodology

This research has been positioned within a qualitative framework and has employed an interpretative descriptive design. Data collection involved semi-structured interviews, and a general inductive approach as recommended by David Thomas (2004) was used for data analysis. The following section provides an overview of the philosophical underpinnings of the methodological approach taken and links these to the purpose of the study.

A qualitative approach

A qualitative methodology provides a systematic and subjective approach that enables the researcher to identify and interpret aspects of human phenomena that are complex and do not lend themselves to measurement (Burns & Grove, 2001). The ontological assumptions underpinning a qualitative world view are that there are many versions of reality, that people create their own meanings from their experiences and that this interpretation is inextricably linked to how people are situated in relation to time, place and circumstances. This perspective also values that people and phenomena are constantly changing in response to these contextual factors and that this experience cannot thus be generalized (Roberts & Taylor, 1998). The aim of this study was to elicit the perceptions of public health nurses in relation to their experience of working with vulnerable families. The qualitative approach taken aligned with the relationship focused and context bound nature of this aspect of nursing practice. This enabled the unique aspects of each nurse's practice to emerge and the subtle and process related aspects of practice to be made visible.

A basic tenet of qualitative research is that knowledge which is real and trustworthy can emerge from people's experience and the meanings they derive from this (Roberts & Taylor, 1998). The emphasis is upon describing a phenomenon from an emic or insider point of view (Morse & Field, 1995). Narrative and subjective material is gathered with the aim of producing rich and indepth data that can elucidate the varied dimensions of a particular phenomenon (Polit-O'Hara & Beck, 2004). Thus qualitative research 'opens a window into the world of others' and facilitates an 'empathetic understanding' of this reality' (Morse & Field, 1995, p. 18). Because this study involved exploring the perceptions of public health nurses in relation to their practice, a qualitative methodology was considered necessary to allow for the subjective nature of the information and open approach required to gather this data.

Qualitative research involves processes that are 'inductive, interactive and holistic' and an approach that is 'flexible and reflexive' (Parahoo,

2006, p. 63). A flexible approach encompasses: 'a belief in multiple realities', approaching the phenomena in ways that support it, 'a commitment to the participant's viewpoint', limiting the 'disruption of the natural context of the phenomena of interest' and reporting data using rich description and participant exemplars (Streubert & Carpenter, 2003, p.16). A reflexive approach emphasizes the notion of the self as part of the research process and the importance of approaching the research in 'a genuine and authentic manner' (Streubert & Carpenter, p. 5). This requires that the researcher understand their own beliefs, values and assumptions, and recognizes these as intrinsic to the research process. Thus taking a stance that is both engaged and self aware is an essential component of qualitative research (Parahoo).

A qualitative approach has relevance for nursing in that it aligns with ways of knowing that have been emphasized within the discipline. Carper (1978) has identified the significance of personal knowing for nurses. This way of understanding oneself and others acknowledges the existential nature of human beings and values a commitment to being with and relating to others authentically (Streubert & Carpenter, 2003). Another dimension of knowledge valued by nurses is aesthetic knowing which refers to the art of nursing (Carper). Aesthetic knowing is about exploring and appreciating abstract processes that cannot be generalized or measured. Thus the study of phenomena such as how nurses perceive the care they provide supports a qualitative methodology that facilitates subjective expression and pattern recognition (Streubert & Carpenter).

A descriptive design

Descriptive research involves the study of phenomena in its natural state in order to present a complete and accurate picture of all its elements (Brink & Wood, 1998). The aim is to collect as much data as possible about an object, event or experience in order to provide a comprehensive summary which describes this phenomenon in everyday terms (Sandelowski, 2000). While a descriptive design can be referred to as 'basic' research, or the first step in the research process it can also be seen

to have value in and of itself (Sandelowski, p. 336). The advantages of a descriptive design are : the creation of a broad range of data which may present detail and richness not previously available, enabling an holistic view of patterns and processes to emerge, and the possibility of moving through observation, description, classification and conceptualization (Seaman, 1987, p.185). It has been affirmed that a good descriptive account of an important process never goes out of date, and can be a benchmark to refer back to in the future (Sandelowski; Seaman).

While there is a view that descriptive designs should combine both qualitative and quantitative methods, it is also appreciated that there is integrity in a purely qualitative approach to descriptive research (Sandelowski, 2000; Thorne, Kirkham, & MacDonald-Emes, 1997a). Qualitative description can be seen to differ from the other qualitative methodologies in that it does not emphasise a particular philosophical or conceptual framework, but rather draws upon the general tenets of naturalistic inquiry and stays closer to the data (Sandelowski). However, qualitative description still involves interpretation, and as such may encompass elements or the 'hues, tones and textures' of more complex approaches (Sandelowski, p. 337).

Brink and Wood (1998) state that a descriptive design is appropriate when there is little or no literature that describes the current phenomenon at the present time. As this was the case with the topic chosen for this research, it seemed appropriate to utilize a descriptive design in order to create a contemporary picture of public health nursing practice with vulnerable families within a New Zealand context. Thorne et al. (1997b) purport that a qualitative description has credibility as 'a quintessentially nursing form of science' and as such presents a straight forward interpretative approach to developing knowledge in ways that are relevant for nursing (p. 171). As the goal of this study was to provide a foundation of knowledge about the work of public health nurses with vulnerable families in order to raise questions and provide a building block for ongoing research in this area, a descriptive design seemed to be applicable. Brink and Wood suggest that a descriptive design can be

relevant when there are questions as to whether a particular theoretical or conceptual framework is applicable to a new population. One of the aims of the present study related to whether public health nursing practice aligned with a health promoting model of care as described by Hartrick (1997b) and Doane and Varcoe (2005). A qualitative descriptive design offered the opportunity to draw out themes from descriptions of public health nursing practice in order to create a conceptual picture that could be considered in the light of the model of care referred to above

A general inductive approach

An inductive approach to data analysis tends to be applied within qualitative research because it provides a framework for moving from the concrete to the abstract and of 'making the invisible obvious' (Morse & Field, 1995, p. 126). When qualitative research involves a descriptive design it has been advised that a straightforward method of analysis be chosen (Sandelowski, 2000; Seaman, 1987). However, Thorne et al. (1997b) caution that interpretation should not be short circuited when analysing qualitative descriptive data and recommend that best practice should involve continual immersion in and questioning of the data. A general inductive approach as described by David Thomas (2004) meets the requirements referred to above and was thus chosen to analyse the results of the present study.

General inductive analysis offers a straightforward yet comprehensive set of procedures which provide a convenient and efficient way of analyzing qualitative data. The aim of this approach is to allow 'findings to emerge ...without the restraints imposed by structured methodologies' (Thomas, ,D., 2004, p. 2). While the outcomes are identical to those emerging from a grounded theory approach, general inductive analysis does not involve processes such as saturation, theoretical sampling or constant comparative analysis (Thomas). A general inductive form of analysis has been termed generic because it does not sit within any of the specific traditional qualitative frameworks.

A principle of the general inductive approach is that the direction of the analysis is determined by the researcher's objectives together with multiple readings and interpretations of the data. The method is to create a brief summary of the data by identifying 'frequent, dominant, significant themes' embedded within it, and to link this with the research objectives in ways that are 'transparent and defensible' (Thomas, D., 2004. p. 2). This is achieved by reading and re-reading the text to identify themes and then placing coherent text samples into each theme. The researcher then develops a model or framework which encompasses these significant themes. The assumptions and experience of the researcher are significant in shaping the findings, and thus different researchers may derive different interpretations from the same findings (Thomas).

Research rigour

There is considerable discussion in the literature about the difference between the criteria needed to assess the rigour of qualitative studies and that used for quantitative research (Gillis & Jackson, 2002). Sandelowski (1986) highlights the artistic element present within qualitative research and emphasises that it is the 'meaningfulness' of the findings emerging from a study 'rather than control of the process' of the research that has significance when assessing rigour in relation to qualitative methodologies (p. 29). Mays and Pope (2000) suggest that because qualitative research is more about presenting perceived realities rather than accurate representations of the truth, an approach that focuses on subtle realism may be preferable when assessing the rigour of qualitative studies. There tends to be a consensus within much of the literature that care during the research process and the reporting of that process are vital to maintaining rigour (Mays & Pope; Morse & Field, 1995; Polit-O'Hara & Beck, 2004; Thorne et al., 1997b). Lincoln and Guba (1985) have referred to the concept of trustworthiness when assessing the quality of qualitative research. Trustworthiness or the degree of confidence that can be attributed to the research data can be assessed in terms of credibility, transferability, dependability and confirmability (Polit-O'Hara & Beck).

Credibility

Credibility relates to the question of whether the findings represent a faithful description or interpretation of the phenomenon studied (Sandelowski, 1986). This is determined by evidence that the research process has been conducted in such a way that there can be confidence in the meanings attributed to the data. In this study this was achieved by: ensuring that all the steps of the chosen methodology were closely followed, by describing the perspective of the participants as clearly as possible and by staying true to the experience of the participants when interpreting the data.

Credibility can also be affirmed through 'member checking,' a process in which participants are able to examine whether the researcher's account of the study findings aligns with their own experience (Lincoln & Guba, 1985 cited in Mays & Pope, 2000, p. 50). Sandelowski (1993) however, argues that the outcome of participants checking original data such as transcripts may be misleading as viewing data in retrospect cannot be decontextualised. Thorne et al. (1997b) suggest that rather than having participants review initial transcripts, it is preferable to take a sample of 'beginning conceptualizations' to individual research participants to be critically considered (p. 175). During the data analysis of this study the researcher presented a draft model of findings to several participants and was able to make some adjustments that reflected this shared interpretation. For instance two early themes that related to factors constraining practice were *being rebuffed by the organization* and *the ever changing public health nurse role*. One of the participants who viewed these initial themes confirmed that the essential factor here was *the impact of the business model* which enabled the former two themes to be combined into one category. Credibility is also about how context rich the descriptions are (Gillis & Jackson, 2002). The findings of this study were reported in a way that encompassed the contextual elements of public health nursing practice.

Transferability

Transferability refers to the potential for the findings to be transferred to other groups, settings or contexts and whether the reader recognizes these findings as applicable to their own experience (Polit-O'Hara & Beck, 2004). In order to assess transferability there needs to be sufficient detail included within the research report (Mays & Pope, 2000). Within this report the transferability of the study has been enhanced by providing a clear explanation of the historical and political context, and a full description of findings. Transferability can also relate to the diversity of the sample (Gillis & Jackson, 2002). In this study care was taken to ensure the sample included a range of public health nurses in relation to years of experience and both rural and urban contexts of practice.

Dependability

Dependability refers to the stability of the data over time, and in relation to varying conditions (Polit-O'Hara & Beck, 2004). With qualitative research issues of dependability need to reflect the inherently dynamic nature of the situations and people involved (Gillis & Jackson, 2002). Thus the emphasis is upon whether another researcher with comparable research experience, rapport with participants, and familiarity with the phenomenon and following the same research process, would make the same observations. The transparency or auditability of the research process and the decision trail are therefore required to assess dependability (Sandelowski, 1986). By providing within this report a clear audit trail of the steps taken during the conduct of this research the researcher has ensured that this assessment is possible.

Confirmability

Confirmability is associated with auditability and whether there is evidence in the research report of how interpretations have emerged from the research. In this study the research report has been written with the aim of enabling the reader to be sufficiently informed as to the decision

trail taken. Confirmability also refers to the researcher being explicit about personal biases, assumptions and values (Gillis & Jackson, 2002). These were outlined in the introductory chapter. It is acknowledged that the researcher's prior experience as a public heath nurse may have had a bearing on the interpretation of the data. The researcher endeavoured to overcome this possible bias by maintaining a neutral stance and not presenting her own perceptions during data collection (Appleton, 1995). However, there is a view that the subjective involvement of researcher and participants within the qualitative research process tends to contribute rather than detract from the quality of the research (Sandelowski, 1986). For instance the fact that the researcher was herself familiar with the study topic from her own practice experience was a factor enabling a contextual understanding of this phenomenon.

Guba and Lincoln (1989) assert that confirmability can be deemed established when credibility, transferability and dependability have been achieved. In reference to the criteria above, the researcher can have confidence in the trustworthiness of the study findings and conclude that the description of working with vulnerable families reflects the authentic experience of public health nurses.

Ethical Considerations

Prior to the commencement of this study ethical approval was received from the Massey University Human Ethics Committee (MUAHEC) and the branch of the Health & Disability Ethics Committee (HDEC) in the region where the study took place (see Appendix 1). Ethical issues during this research process were addressed with consideration given to processes aligning with fundamental ethical principles as identified by Polit-O'Hara and Beck (2004). The processes by which this study addressed the principles of beneficence, respect for human dignity and justice are discussed below.

Underpinning all research involving human participants is the principle of beneficence or ensuring freedom from harm (Polit-O'Hara & Beck, 2004,). During the data collection involved in this research it was important to be aware that as the participants were being asked about their personal views, sensitive personal information might be shared. Honouring the principle of beneficence meant ensuring freedom from exploitation by protecting participants from the risk of having any information they revealed being used against them. The possibility that confidential information about clients might be disclosed in the course of the interviews was also recognised. It was decided that this would be managed by requesting that participants not use names that could identify particular individuals and by exclusion from the data in the case that such disclosure occurred.

Another ethical principle guiding this research has been respect for human dignity which encompasses the right to self determination. This includes the right to decide voluntarily whether to participate, the right to withdraw without recrimination and the right to refuse to give information. Respect for human dignity also includes the right to full disclosure which refers to people's right to be fully informed about the nature, risks and benefits of the study and to make voluntary decisions about participation (Polit-O'Hara & Beck, 2004). Participation in this study was voluntary and there was no coercion in relation to participants agreeing to participate. Prior to deciding whether to be involved, prospective participants were given an information sheet with full details about the nature of the study and the contact details of the researcher for further clarification. The information sheet outlined participant rights such as declining to answer any question, asking for the audio tape to be turned off at any time during an interview, withdrawing from the study up until two weeks after the interview and having access to a summary of the project findings at the conclusion of the study (see Appendix 2).

The principle of justice is essentially about the right to fair treatment (Polit-O'Hara & Beck, 2004). Aligning the study with this principle included ensuring respect for cultural or other forms of diversity,

courteous and tactful treatment of participants, making sure participants had access to the researcher to clarify information arising from the study, non judgemental treatment of those who declined to participate or withdraw after the study commenced and honouring of all processes agreed to between the researcher and the participant. Cultural factors relating to respecting the needs of Maori participants were given special consideration when planning the study (refer page 54 of this report). Participants were informed that there would be no adverse consequences if they decided to withdraw prior to the conclusion of the study and it was particularly emphasized that withdrawal would not affect a participant's employment with the health organisation who had given permission for the study to be carried out.

The principle of justice also refers to the right to privacy (Polit-O'Hara & Beck, 2004). In this study privacy was protected by processes such as: keeping data provided by the participant in the strictest confidence; keeping all data in a locked file; ensuring computer files were protected by a password and deleted and transcripts destroyed after 10 years; destroying taped interviews at the completion of the study; ensuring the identity of the participant was not identifiable in the research report and using pseudonyms; and ensuring that all documents have only been seen by the researcher, her supervisor and the typist.

It was necessary that some factors relating to qualitative research and the participant's right to privacy were constantly considered by the researcher (Polit-O'Hara & Beck, 2004). For instance the small size of the sample required that the researcher take considerable care to safeguard the identity of the participants. This required more than not sharing names but also being careful not to reveal other characteristics that would allow participants to become known to others. The in depth nature of the data collection process meant a greater intrusion of privacy which necessitated special care in relation to taping and transcribing. Permission from participants was needed to allow interviews to be recorded and it was important that the system of coding used to identify participants and their tapes was known only to the researcher. The participant was informed

that transcription would be carried out by a reliable, trustworthy transcriber and made aware of the steps that would be made to maintain confidentiality during this process.

Protecting the rights of Maori participants

When planning this study the researcher ensured that there was special consideration given to the rights of Maori participants in relation to the principles of partnership, protection and participation endorsed in the Treaty of Waitangi. Prior to the study the researcher consulted with the Iwi advisor for the local Regional Ethics Committee and local Maori working in the health arena to ensure that the research process was safe and appropriate for Maori. There was in fact only one participant in this study who identified as Maori. However the researcher made special care to protect the Maori rights of this participant by inviting the participant to bring a support person or colleague to the interview, ensuring the interview occurred in a place and at a time that was safe and comfortable for the participant and having refreshments available. The researcher also ensured that she spent time introducing herself and her own background and that she gave the participant an opportunity to offer a karakia (a prayer) at the beginning and end of the interview. It was recognized that the families discussed by the participant might possibly be whanau (related to the participant by close or extended family ties), and thus the importance of confidentiality / privacy of identity. The fact that the vulnerable families described or referred to by the participant might be Maori and the issue of accessing and working safely with Maori families also required special consideration during the interview process

Participant Selection

A purposive sample was used for this study meaning that the participants were selected according to the needs of the study (Morse, 1991). This form of sampling involves purposely seeking participants from a pre-specified group of people (Procter & Allan, 2006). Because qualitative research is concerned with extracting the maximum amount from the minimum of

cases, sampling is concerned with selecting participants who are most likely to provide a depth of information about the study topic (Polit-O'Hara & Beck, 2004). A purposive sample suited the needs of this study in that it enabled the selection of participants who were most likely to produce the quality of data required to provide a description of how public health nurses work with vulnerable families. The potential for errors in judgment and reduced applicability have been identified as limitations of a purposive sampling method (Dempsey & Dempsey, 1999). Morse however states that the bias possible in purposive sampling is in fact a tool which facilitates the research process, and that controlling the sampling in this way enables the data to be both appropriate and adequate (Morse, 1991). Appropriate in terms of aligning with the purpose of the study, and adequate in relation to the sufficiency and quality of the data required (Morse, p. 134).

Thorne et al. (1997b) state that when seeking to generate nursing knowledge from descriptions of practice, purposeful selection should include targeting participants 'whose accounts reveal elements to some degree shared by others' (p. 174). Morse has identified that with purposive sampling, selection should be appropriate, in terms of certain criteria determined by the aims of the study, and adequate, in terms of the sufficiency and adequacy of the information collected (Morse, 1991). In order to provide the quality of data required to produce a picture of how public health nurses work with vulnerable families and the factors which enhance and constrain this, it was considered necessary to find participants with some experience in the role. Thus the criteria for participant selection included public health nurses in current practice with at least two years experience in the role, those with current experience of working with vulnerable families and those with the willingness and ability to articulate practice experience. It was also decided that if possible it would be preferable to have a mix of rural and urban public health nurses.

In qualitative research there are no rules about sample size which rather tends to emerge from the purpose of the inquiry, the depth of

understanding needed and the quality of the informants (Polit-O'Hara & Beck, 2004). In this study the sample size was consistent with the aim of the research which was to gather as much information as possible about the work of public health nurses with vulnerable families in order to capture all elements relating to this phenomenon. In line with research that uses a similar approach (Appleton, 1994; Green, 1993; Langlois, 1997; Mailer, 1997) between eight and twelve participants was considered appropriate to provide for the depth of data required, as well as to allow for the variety of contexts within which public health nurses work, and the possible differences between urban and rural settings. Finally, ten participants made up the sample for this study.

The initial recruitment process began with the researcher consulting with the community services manager and public health nurse clinical nurse leaders at the local district health board. The researcher then attended a regional public health nurse study day where information sheets were distributed to those interested. The study was explained to potential participants in simple lay language and care was taken to emphasise the voluntary nature of participation. The researcher explained the anticipated benefits of the study in relation to both the individual and society and how results would be shared. Assurances were given as to who would see the data, participant convenience during data collection and how confidentiality would be maintained (Polit-O'Hara & Beck, 2004). Those expressing an interest in taking part in the study were asked to contact the researcher by phone, e-mail or post. This was to ensure the confidentiality of potential participants, and to give people sufficient time to decide whether or not to participate. Those who expressed an interest were given further time to consider their decision whether or not to participate and were made aware that they had the right to withdraw at any time.

The participants

The participants in this study consisted of ten women ranging from thirty to fifty plus years. One of the participants identified as Maori and the

others as European. Their years of nursing experience ranged from fifteen to forty three years, while their time as a public health nurse ranged from five to twenty three years. Eight of the participants were based in small country towns from which their practice extended out into the wider rural communities linked to these settlements. Two of the participants worked solely within a large urban area.

The focus of the public health nurses' role within these communities consisted of responding to health concerns relating to the wellbeing of school age children and their families, communicable disease case work, immunisation campaigns, and health promotion activity. This work involved processes such as liaising with schools, home visiting, and collaborating with community agencies and other professionals. The role of two of the rural participants was centred around infant welfare activity only, which involved home visiting to monitor the health and development of infants and preschool children. Two other rurally based participants also included infant welfare in their work with families but this was as an additional component to the generic public health nurse role referred to above.

Data Collection

Semi structured interviews were used for the data collection in this study. This interview method is applicable when the researcher is familiar with the domain of the inquiry and so can frame the needed discussion in advance (Morse & Field, 1995). A semi structured interview process was appropriate for this study because it enabled participants to talk freely about their perception of vulnerable families and their practice in this area and to express their experiences in their own words (Polit-O'Hara & Beck, 2004). With this approach control over the interview process is facilitated by a set of guiding questions which provide direction for the interview (Roberts & Taylor, 1998). However because the answers cannot be predicted the process also requires some flexibility. In this study although the researcher had prepared a set of questions, these did not tend to be strictly followed. The challenge was to maintain a balance

between flexibility – encouraging participants to relate their experience without interruption - and consistency - ensuring that the detail included would be sufficient to facilitate interpretation (Morse, 1991).

One interview per participant took place at a time and in a setting of the participant's choice. Each interview was an hour to an hour and a half in duration. Questions were logically arranged from general to specific with additional probes ready as follow up questions. The aim was to use the questions in a way that provided rich and detailed data (Polit-O'Hara & Beck, 2004). The researcher was aware that because of her own background of professional experience in the area being explored it was important to take the stance of a novice and maintain a neutral approach, thus allowing participants to assume the role of expert and the research to become a process of discovery (Dempsey & Dempsey, 1999).

Interviews began by asking participants to describe their work history particularly in relation to public health nursing. Participants were then asked about their perceptions and experiences of working with vulnerable families. As the concept of 'vulnerable families ' was to be self identified by the respondents, this process began by asking participants to describe the families with which they work and how they determined a family to be vulnerable. Participants were then asked to describe the process of working with a vulnerable family, beginning with one example and then another. Further questions were asked about factors that assist them in their work with vulnerable families and what challenges their practice in this area. (See Appendix 5 for interview questions guide).

All interviews were tape recorded and later fully transcribed. The use of a tape recorder ensured that the attention of the researcher remained on the participant, that the flow of information from the participant was maximized and allowed the researcher to return to the raw data at a later date (Polit-O'Hara & Beck, 2004).

Data Analysis

Qualitative analysis requires that the researcher immerses themselves in the data through a process of reading, re-reading, intuiting, analysing, synthesizing and reporting (Gillis & Jackson, 2002). The approach taken by the researcher in this study encompassed the above process and involved the series of steps recommended by David Thomas (2004) when outlining the strategies for general inductive data analysis. These were preparation of raw files, close reading of the text, creation of categories, continuing revision and refinement and the development of a number of summary categories that capture the key themes in the text.

As is generally the case with qualitative research, the analysis process commenced with the collection of the data (Polit-O'Hara & Beck, 2004). The researcher recorded insights and reflection following each interview and following each interview the taped sessions were replayed a number of times to allow the researcher to engage with the content and the flow of the interview as a whole. The tapes were then transcribed by a professional transcriber. These were formatted with a large margin for notes to be recorded. Following transcription the researcher listened to the tapes while reading the transcripts to ensure that they were a verbatim record of the interviews. It is vital that transcripts are an accurate record of the interview and that they indicate features such as time lapses, emotional expression and emphasis (Polit-O'Hara & Beck). Copies of each transcript were then made as back up files and participants were coded from 1 to 10 so that they could be individually identified.

The process of listening to taped interviews, proofing and then re-reading the transcripts enabled the researcher to become thoroughly familiar with the data and to gain an understanding of the themes arising from the text. The expectation with the general inductive approach to data analysis is that the direction of analysis will be determined by both the research objectives and the interpretation of the raw data. The main research objectives were to describe how public health nurses work with vulnerable families and what facilitates and constrains this process. The study also

sought to identify how public health nurses define or refer to vulnerable families. Thus the data was examined with the view of uncovering the nature of vulnerable families as identified by public health nurses, the approach taken by public health nurses when working with vulnerable families and the factors impacting on this process. Themes encapsulating these features were sought when exploring the data.

Transcripts were examined line by line, and descriptive code names – i.e. words, phrases or sentences representing common concepts were written beside the text. Many of the categories tended to be coded using the actual words of the participants. For instance *'approaching gently'*, *'building a relationship'* and *'families trust you'* were phrases that emerged in reference to the care required to forge a connection with families. These were eventually grouped under the category **'building trust'**. At other times the categories represented a summary of what the participants appeared to be expressing (Morse & Field, 1995). For instance **'the vulnerability of the public health nurse'** emerged from participant accounts of threats to their personal wellbeing expressed by phrases such as *'feeling saturated'* *'being taken to the cleaners'* and *'being pushed out of your boundaries'*.

Through a process of cutting and pasting, segments of text were grouped by category. Memos containing the initial meaning for each category were developed, and further text segments were added to categories. Initially thirty two themes or categories were identified and coded. Then as a result of ongoing, multiple readings of the data these categories were revised and refined further, a process that included searching for contradictory points of view and new insights. Eventually fifteen specific categories emerged which the researcher believed captured the key themes embedded within the raw data. In the final phase of the analysis these categories were grouped into five summary, or upper level categories which were determined to be the most important themes in relation to the research objectives. As advised by Thomas the key features of the categories consist of: the label or name of the category, its meaning or description and text associated with it.

It is acknowledged that aspects of qualitative data can be overlapping and linked with several meaning units simultaneously (Thomas, D., 2004). It was challenging at times to identify text that could be assigned to a specific category, as much of the participants accounts occurred in the form of exemplars of practice that covered multiple facets of their practice experience. For instance one particular story encompassed the themes of *'being determined'*, *'knowing and being known by the community'*, *'making the child the priority'*, *'drawing on experience'*, and *'the vulnerability of the public health nurse'*. The multifaceted nature of qualitative data also arose when grouping the sub categories around the main categories. For example, *'having public health nurses' eyes'* was an initial category that seemed to fit well under of both **'working with families'**, and **'enhancing practice'** because it was described as both a process of assessing families, and a skill developed over time which facilitated effective practice. Eventually, after much reflection, it was decided that it would be subsumed into the subcategory of *'drawing on experience'* to support the main category of **'enhancing practice'**.

The network of categories finally emerging from analysis consisted of five upper level categories each supported by a number of lower level or sub categories. David Thomas (2004) states that 'when the research has several components or topics, there may be a separate set of categories for each component' (p. 9). The objectives of this study covered three main areas – namely how do public health nurses define vulnerable families, how do public health nurses work with vulnerable families, and what factors enhance and constrain this aspect of their practice. Thus these specific aims were reflected in four of the upper level categories as follows:

Vulnerable families
Working with families
Enhancing practice
Being constrained

The fifth upper level category represented the unexpected yet significant theme of:

Protecting the integrity of self

As this further main category refers to both the vulnerability of the public health nurse and the process of caring for self, it was recognized that there were links with the other main categories relating to either enhancing practice or constraints. However it was eventually decided that it should stand alone as a separate fifth main category because it was a new insight and an important theme emerging consistently through out the data.

Unsurprisingly, the subcategories are those identified in the intermediate phase of the analysis process. Having emerged directly from the data, these sub categories tend to be named using 'in vivo' phrases. These were then formatted into a diagram showing the links with other categories (Thomas, D., 2004). The final grouping of categories and sub categories is outlined in the following table:

Vulnerable families • *Only a season in their lives* • *Having multiple issues* • *Having a fear of trust being broken* • *All families are vulnerable*
Working with families • *Building trust* • *Encouraging strength* • *Making the child the priority*
Enhancing practice • *Knowing and being known by the community* • *Drawing on experience* • *Being determined to make a difference*
Being constrained • *Families unwilling or unable to respond* • *The impact of the business model* • *Dealing with the Child, Youth and Family Service*
Protecting the integrity of self • *The vulnerability of the public health nurse* • *Caring for self*

Table 2: Categories and sub categories

Summary

This chapter has outlined the research design for this study. A qualitative, descriptive research methodology was chosen as this was considered an appropriate means of gaining insight into the practice experience of public health nurses. A descriptive approach offered the opportunity to establish a picture of how public health nurses work with vulnerable families and to describe and explain this in every day terms. Ethical approval to undertake this study was granted and ten experienced public health nurses were selected as participants. Data collection consisted of one semi-structured interview per participant and the data was analysed using a general inductive approach (Thomas, D., 2004). Five main themes each with a number of categories were identified. These themes and sub categories will be described in the following chapter.

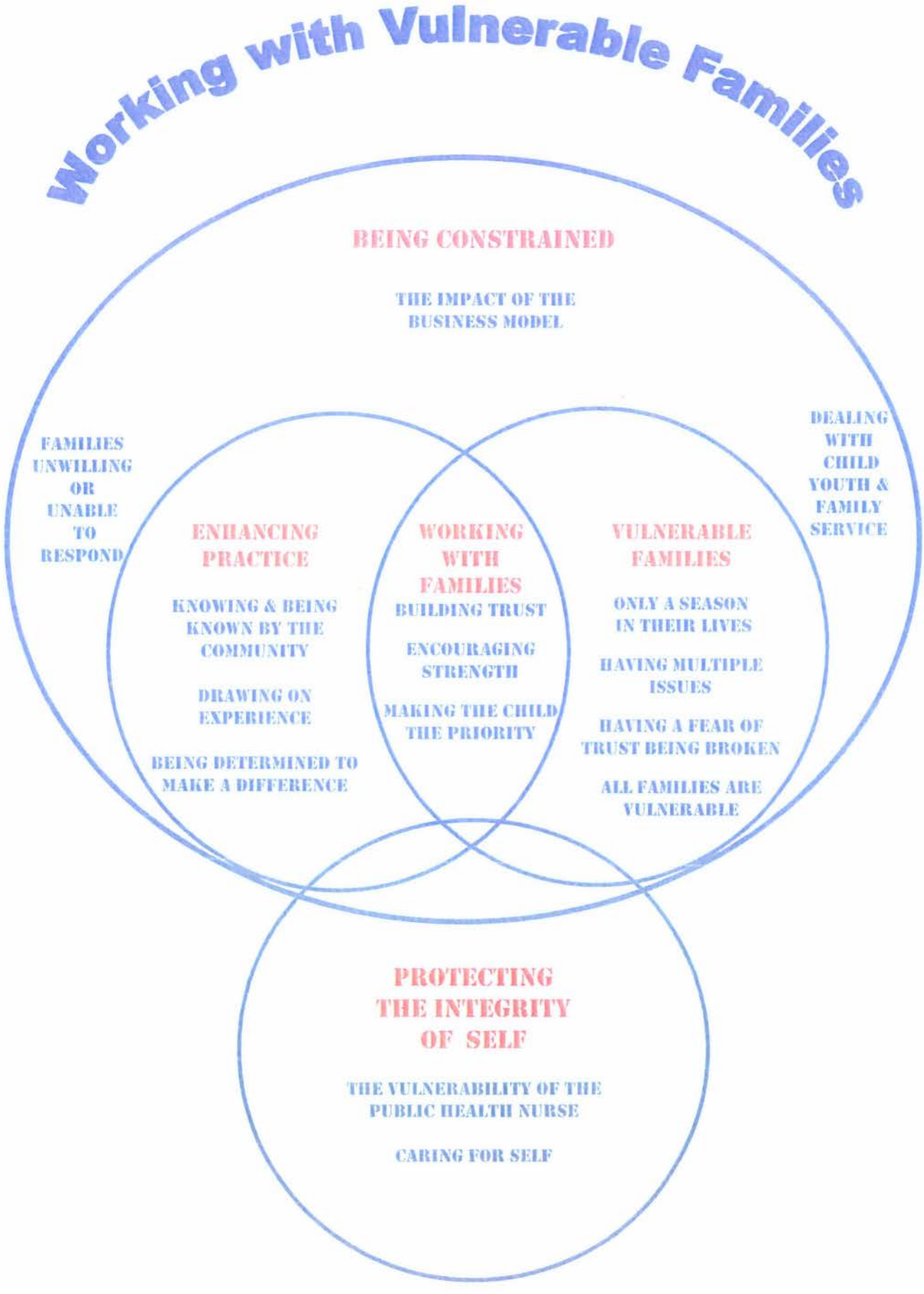

Diagram showing Categories and Sub Categories

CHAPTER FOUR

FINDINGS

The previous chapter presented the research methodology used in the study and outlined the processes involved in participant selection, data collection and analysis. Strategies employed to address ethical factors and ensure research rigour were also explained. The relational and contextual nature of public health nursing practice and the researcher's interest in the experience of participants were reflected in the qualitative and descriptive design chosen for the study. The data emerging from the semi structured interviews was analysed using a general inductive approach as recommended by David Thomas (2004). The following chapter presents the findings emerging from this process.

The purpose of this study was to describe how public health nurses work with vulnerable families and factors that enhance and constrain this process. As the term 'vulnerable families' was to be self nominated by the participants themselves, the study also sought to identify how public health nurses define or refer to vulnerable families. The findings presented here relate directly to these aims. It can be noted that the researcher was also interested in whether the approach taken by public health nurses when working with vulnerable families aligns with a health promoting model of care. This question will be explored in the discussion chapter.

Following the process advised by David Thomas (2004) the findings from this study are structured around four upper level or main categories (also referred to as themes) which relate directly to the aims of the research as stated above. These are:

Vulnerable families

Working with families

Enhancing practice

Being constrained

A further fifth upper level or main category represents an unexpected, yet significant theme which emerged from the data:

Protecting the integrity of the self

These five upper level categories are then supported by a number of sub categories which have emerged directly from the data (see diagram).

This chapter presents each upper level category and associated subcategories. The main headings refer to the upper level categories and are each identified by a brief description which is followed by smaller headings denoting the sub categories. Each sub category is supported by further description and participant excerpts from the data. Pseudonyms have been used when quoting the participants. As discussed in chapter three the emphasis with qualitative description is upon staying close to the data in order to provide a comprehensive summary that describes a phenomenon in everyday terms (Sandelowski, 2000). This chapter thus presents a straight forward account of the findings which will be discussed more fully and in relation to the literature in chapter five.

Vulnerable Families

The first main category: **vulnerable families** refers to the way the participants described the families with whom they work. This is supported by four subcategories: *only a season in their life: having multiple issues: having a fear of trust being broken:* and *all families can be vulnerable.*

Only a season in their life

The subcategory: *only a season in their life* refers to participants describing how for some families, being vulnerable relates to a specific period or situation in their life which disrupts the equilibrium of the family.

Lily, pg 3 ... I think too that it is only a season in their life. Some families don't stay in that vulnerable situation for ever. It is only because something has

happened or a change in the family dynamics ... or something. To me vulnerable is, when you are at a place where there is a like a crack like if you've got a vessel or a jar and it still holds water but because of the crack there, it has a weakness. And so it is like that where families have this deficit or this crack where it could snap it any time. So you know being vulnerable is actually where there is a weakness within the system.

When the wellbeing of one member of the family is compromised - for instance a child being ill – the whole family can become vulnerable for a period of time.

Stella, pg 3 ... Well it needn't necessarily just be the family, it can just be one member of the family. There is a child presenting at one of my schools with constant headaches. His schooling is being disrupted and the family life is being definitely disrupted because this child lies on the bed at home with headaches and he is a healthy boy apart from when the headaches come, a budding athlete. So that makes the child vulnerable and it also to some extent makes the family vulnerable because the family are spending a lot of money at the GP and seem to be going round in circles and getting nowhere.

Having multiple issues

The subcategory: *having multiple issues* refers to participant accounts of how some families can experience an ongoing state of vulnerability due to a number of persisting social and economic issues which are difficult to resolve. Participants identified that rather than one issue that can be easily resolved, these vulnerable families tend to be simultaneously confronted with numerous social factors that impact on their wellbeing and that these can be entrenched and on going.

Stella, pg 3 ...I do think that there are some stress factors that would make vulnerability for some families live longer than for others ...like unemployment, single parenthood, low education, high numbers of family, housing, health factors and may be any emotional or terminal illness within the family....

Amber, pg 3 ... They've got so many aspects of life that are working against them, that's the reason why they are in that position of being vulnerable, their unemployment, their lack of phone, lack of finance. So their whole socio

economic situation often is not wonderful. In some cases, they haven't got a lot of family support or don't choose to have family support ... the whole isolation factor

Participants explained how many of the vulnerable families referred to by participants in this study were from deprived areas – families disadvantaged by low socio-economic status and factors such as being Maori, lacking educational qualifications, not accessing employment and being transient. Families with deprivation experienced multiple social issues relating to poverty, isolation, crime, alcohol, drugs and violence.

Mavis, pg 3 ...The area I work and live in is a high deprivation area. We've got low decile schools, a larger percent of the population is sitting about 45% Maori and a lot of the families you are dealing with are vulnerable because they come from often a low socio economic, disadvantaged background. Some of them are not highly educated, transient, very needy, often will have worked the system quite well in the past and they are vulnerable because they are quite exposed cause the mum and dad may be haven't got formal qualifications, they find it hard seeking employment in a small rural area ... And being transient. Their needs are high.

The situation families experience because of the social factors they face can be so overwhelming that they are unable to prioritize ways to meet their health needs which can impact negatively on the wellbeing of the children.

Michelle, pg3 ...Being Maori, unemployment, single families, money has a lot to do with it, lifestyle, lots of smoking, alcohol, unable to get access to doctors services, ... the child has been born with runny ears, and still at school, 8 years old, and there has been no change.....

Lily, pg 7 ... I've got a little boy at the moment who is the eldest of 4 and he's just turned 6 and he's got a bad eye deficit, loss, and the mother is just so busy with these 4 little ones and she has got no transport and she can't get him glasses or get him tested. I'm having to do regular home visits. I have already been there for a whole year because he hasn't been going to school from 5. So there are lots of issues, social issues in that house....

Participants revealed how many of these factors are deeply embedded. They told stories of successive public health nurses working over the years with particular families where the children's health has continued to be compromised due to issues within the family that have persisted over generations.

Michelle, pg 8 ...I've known of this child's history, my previous colleagues had put lots of effort taking him to clinics and to doctors. That was 4 or 5 years ago and we are still at this point. What has changed in this family? Is this another generational thing that's going to continue?.

For some families there can be an ongoing history of drug and alcohol abuse and violence which impacts significantly on the wellbeing of the children.

Sarah, pg 29 ...I think it is dysfunctional families. They have got themselves caught up in this cycle of drug and alcohol and they are not able to function properly let alone look after their kids. There is not money for food, there is not money for rent and power. I've worked for many years with another family, a sister of the same family. They are both all the same and you are going to have another generation of them now because there has been no change, absolutely no change.

Gina, pg 5 ...I call them at risk families really and mainly the ones I have been dealing with recently have all been drug and alcohol related violence, lots of violence. These families have been referred to Child Youth and Family and in two cases the mother put into refuge. One of the families where there are two boys and a little girl, the boys have been so badly affected that they have chosen to stay with people they don't know, rather than with mum and the partner.

Factors relating to unemployment self esteem or poverty can become the norm for families becoming a role model for the next generation and setting up a cycle of deprivation from which it is hard to escape.

Mavis, pg 15 ...Often the families you work with their dad might have been unemployed or perhaps back in the railway days got laid off, hasn't wished to move out of the area because of family connections, but then the son is doing the same or the daughter and it is generational. Especially those deep

seated core, self esteem in families. That cycle of poverty, it's a vicious circle it's like a vacuum. You'd have to be a really really strong person to be able to break out of that because you are so conditioned to that. That's quite a normal existence for people, not that they would love to be able to have their own home or be able to support their kids to send them off to school camp ...even those little things in life that would make a lot of families who have got their backs against the wall who are probably trapped in that cycle of poverty, it's really really hard to break free out of that ... cycle of deprivation or the cycle of poverty and ...I think ... it will take a few generations for actual change to occur.

Having a fear of trust being broken

The subcategory: *having a fear of trust being broken* refers to participant reports that vulnerable families can tend to be wary of those in authority because of past experiences with professionals or the law in situations where they have felt they have been let down.

Mavis, pg4 ... those hard to reach families which are very vulnerable because they might have had may be a bad experience with a health care worker or an institution or hospital and they're really reluctant to go back down there ...

Marnie, pg2 ... that young lady had been knocked back so many times ...that's part of it too, that vulnerable families probably are often not very articulate may be, may be they say the wrong things at the wrong time and upset other people so things don't happen for them that normally should, ...

Because their experience with those in authority may have been upsetting in the past vulnerable families are cautious about allowing people to be in a position of power over them. Families also do not trust because they know that the public health nurse can report to the Child Youth and Family Service (CYFS).

Gina, pg 23 ... they don't trust you, they have had so much shit thrown at them usually, that they just expect something else is going to happen and unfortunately we carry that label of Child Youth and Family where they know a Public Health Nurse will actually report, so they are very very keen really not to have you involved often...

Mavis, 8 pg 20 ... they are very very cagey very edgy about CYFS. Have a morbid fear of their children being taken off them and whether that has actually officially occurred in the past or whether they've been threatened with that ... "You're not going to refer me to CYFS". ... It's amazing how many people will actually bring that up.

There is also a fear that confidentiality will be breached.

Mavis, pg 5 ... some people feel that their privacy is being encroached and also if they've got other family members in the town they don't always want them to know. I always stress to patients or clients that I'm working with that we are never going to break that code of confidentiality but they always have a fear that somebody's going to find out why I'm involved. ....

Participants recounted how the reluctance to trust and be open to others can also relate to the limited view vulnerable families can have of their sense of worth and their lack confidence in their ability to overcome issues.

Angela, pg 3 ...they are so sensitive they don't like to see anything as a criticism of what they are doing,.....

All families can be vulnerable

The subcategory '*all families are vulnerable*' refers to the recognition made by participants that all families are susceptible to the state of being vulnerable and that this vulnerability can occur in families from higher decile areas and as well as those families who face multiple factors relating to social and economic deprivation

Gina, pg 2 ...I see they are all at risk, it is not just the low decile areas and it is not just the people in the low socio economic group, it is all people ...

One participant pointed out that sometimes families from higher socio-economic backgrounds have more serious problems.

Stella, pg 4/5 ...you get different health issues for the children at private schools..., or upper echelon families, they have got sometimes even in some respects more serious problems. ...Body image problems, drinking problems,

Stella, pg 8 ... She lived up a back section, the police were going up there, I was going up there. The neighbours would be saying, "Why is the nurse coming up here? There is no-one sick and now the cops are coming up here". So it was like marking her. ... I've parked the Board car opposite and down the other sides of roads and walked to places at times.

Amber, pg 3 ...I've actually been quite gentle with families for a while until they build up that trust. They don't want people putting power on them. You cannot put yourself in a position of power with somebody who is vulnerable. ...

In an effort to approach families appropriately and avoid the impression of taking over in any way, participant's reported adopting strategies such as making a quick preliminary visit to introduce oneself or leaving encouraging notes in people's letter boxes to give families time to anticipate a later visit by the nurse and even text messaging. Participants described how engineering spontaneous and brief meetings with clients in ways that appear to be casual and to be happening by chance is an effective strategy for maintaining a non threatening approach to families.

Marnie, pg 14 / 15 ... Sometimes I've seen the principal and she might have made some comment and I think ... I'd better pop in and just see how things are. Or I'm driving past and I've actually got some spare time. And often I literally just stand on the door and just talk to her for 5 or 10 minutes and that might be all. But I just think it is quite important for her to have some point of contact with somebody whose just, low grade but there....not going to run off with things.

Angela, pg 5 ...I sometimes hang out at the school at 3 o'clock and then I'm just wandering out like I'm going out to my car and it's "Oh hello I've been meaning to catch up with you". Or whatever. ... It means that I don't feel like I'm harassing them in their homes and stuff. ... I know other places that I can catch up with them where it looks coincidental and I'm friendly ...

Participants explained how a good relationship with a family may take a number of years to develop. The trust that is necessary for this relationship to grow requires that public health nurses take care to interact with families in ways that are appropriate and acceptable to the

contraception or non contraception issues, those sort of issues so they still can become vulnerable families.

Gina, pg 3 ...most of my referrals came from decile 9, with lots of problems. In schools that are a higher decile the children get more, are probably left more, there is booze, they are often into drugs and I mean that is there in decile 1 too, but the children often don't get the attention from the parents and so they have lots of emotional and social issues that need addressing.

Working with Families

The second main category identified was that of **working with families**. This category refers to how public health nurses align their practice to meet the specific needs of vulnerable families. Subcategories relating to the main category of working with families are: *building trust; encouraging strength; maintaining a connection;* and *making the child a priority*.

Building trust

The subcategory *building trust* refers to the emphasis given by participants to the quality of the relationship which needs to be developed and sustained between the public health nurse and a family in order to facilitate a working partnership. Participants reported that this involves processes such as being non-threatening when approaching and interacting with families, being a friend yet being able to give a straight answer when necessary and ensuring that a connection is maintained with families.

When talking about building trust participants referred to finding non threatening ways of approaching and being with families. Participants explained how families can be sensitive to an official person arriving at the door in a government car, and the wariness families have about the power that professionals can wield.

client. An essential component of this trust relates to the care a nurse takes to respect a family's privacy.

Mavis, pg 5 ... if you've got a good relationship a family, ...it might take two years to have that trust between each other and it's respect you know, respecting their privacy.

Participants identified that families need to be reassured that the nurse is never going to break that code of confidentiality. The nurse's credibility as a health professional rests on this factor.

Mavis, pg 5 .... They always have a fear that somebody's going to find out why I'm ... involved. So it's reassurance there and I think it comes back to that trust again too. Its that credibility of you as a professional ... You just need to tarnish that and you might as well look for a job somewhere else...

The need for a respectful approach and to be careful to take the lead of the family was discussed by participants.

Marnie, pg 21 ... I think ... being respectful of where everybody, where anybody is. It's a bit like when you go into a different cultural situation. You are not quite sure what to do, but as long as you are respectful in your presentation of yourself then hopefully they will guide you with what to do and you're not going to upset people.

Participants emphasized the tendency for vulnerable families to be sensitive to anything they construe as criticism. Special care is required to initiate and maintain a relationship that will facilitate the process of working with these families.

Angela, pg 3 ... One of the schools has made a huge effort around head lice this year. They've developed policies and preclusion letters to the parents so that the children have to be treated before they can come back to school. They can refer to me and I will then visit and support families to treat their children. The families are sometimes not very happy, quite often they are not very happy at all. So for those ones you have to just be so careful and develop a relationship

Caroline, pg 21 .... This woman looked quite unwell actually and I made that comment. Well it grossly offended her. It was like the last straw for the

public health nurse to tell her that her children didn't look very well. And she said that she didn't want to see me again, she'd rather see the other nurse. ... It was a learning thing for me because I felt my gosh, yes that poor woman it was the last thing she needed to hear, she was totally burnt out looking after three children... And so I learnt from that. ....Well I just was careful how I said things you know.

Participant's descriptions of building trust with families centred around being a friend. Processes such as being with a client in their own home, having a cup of tea, spending more than just half an hour with them is a vital part of building trust. Families appear more comfortable, and are open to listening to and contacting the nurse later. An important aspect of this relationship building is about being able to communicate effectively with clients on a level that they are familiar with. As one participant explained, showing an interest in other aspects of a client's life facilitates this process.

Caroline, pg 19 ...It's really important to be able to relate to them on another level apart from the child with ear ache.... It is important to be able to talk about where they went for their holiday or something that happened to them. A lot of the women I see I can get on with quite well. If I see them in the street, we don't talk about little Johnny, we talk about something they've just done...

An emphasis on being a friend requires that the family is not overwhelmed by the nurse's professional status.

Amber, pg 10 ... You've got those skills to... sort of jolly them along ... to go along with the flow but it's in a flow that I want them to be happy about as well. ...I'm not pushing them down and saying you know come on... It's probably a whole sensitivity towards their natures. And I think that probably my age helps in that situation in some aspects too.... they probably look at me as a mother figure.

However participants explained that maintaining a friendship with a family can be challenging when faced with the need to report to the child protection service.

Mavis, pg 6 ...It's done on a professional level. It's not a personal friendship you're getting into. ...You've got to still keep those boundaries and you've still got to

be professional and not to get personally involved. That's the hardest thing I think ... reflecting on that. You think where is the point where you're becoming personally involved and does that obscure your judgment of where you are going within your practice.

Lily, pg 22 ...That's the hard part about the job. It's actually having enough skill and enough knowledge or knowing your boundaries and the rules and the mandatory reporting ...Because you may have to go back to the family on another issue. So you have to actually maintain a friendship.

Participants described how being direct with clients can sometimes be required when working with families and how giving a straight answer can foster trust in and respect for the public health nurse which facilitates the process of working with the family in the future.

Lily, page 22 ...She knew she could come to me because she would get a straight answer. She had trust and confidence in me. ... And I'd laid it on the line to her and I thought "Oh god I've lost a friend here". ... I thought "She'll never talk to me". But then when she rang up about another topic I thought "It always pays off to be up front and honest and say it how it is". ...

Sarah, pg 32 / 33 ...I wasn't getting anywhere with him and I thought "Right mate you're going to be speaking my language from now on" ...And that's when I got respect and that's when he listened. ... Taking him to and from clinic ...I used to have enormous conversations with him in the car. We talked about sexual health one day and how you got aids and Hepatitis B, so I gave him the whole gambit, a 20 minute drive from clinic to home he got the lot. In the finish he was listening to what I was saying and the family he was living with were also listening...And they'd come to me and say "Hey listen (name of adult male) is not doing so and so" ..., "Right, okay, we'll fix that". We'd address the issue.

Maintaining a connection with a family is an important aspect of ensuring the family continues to have trust and confidence in the public health nurse. Participants reported that there are many ways that public health nurses maintain links with families and that this process relates to the nature of vulnerable families – their hesitancy around trusting health professionals; their sensitivity about being approached; their embarrassment at not completing tasks they may have made a

commitment to; their tendency to move on and the reality that there are many issues that they are confronting in their lives. The mobility of the public health nurse facilitates the process of maintaining a connection with clients in that it allows a flexibility and availability that is appropriate for the needs of vulnerable families.

Marnie, pg 13 ...I feel we have got some sort of relationship and I'm the mobile one who can pop in. The others can't just by nature of their positions ... I think it's actually quite important that there is somebody who can physically just pop in without it being a big issue.....So I'm not on her back but I'm there if she needs me ....

This link with the public health nurse though brief and irregular can be important to the family.

Marnie, pg 14 ... I've got another lady I'm visiting around TB medication. She actually self medicates. Sometimes I just call on her just to see how things are going and it might be just a short visit. But I was away for a month and she said, " I haven't seen you for a long time so where've you been?".

Sometimes a nurse will use some innovative strategies to keep in touch with families.

Lily, pg 12 . .. So I had to be out there to remind them and I said to them, "What if you're not home and I need to tell you stuff?" Cause they've got no phone on. She said, "You just put a big note on my door". So I'd get a big envelope and I'd put a hole in it here and stick it through, and I'd write my message on it and she always obeyed. So we had that way of communication. If she came home and saw this big white envelope on her door she knew there was a message and she had to act. So we did this until we've now got that kiddy wearing glasses. So you do the strangest of things sometimes to actually communicate ...

Participant's accounts of building a trusting relationship with families included the need to maintain an on going connection with a family even after a particular episode of care is completed. Participants described ways that they have ensured that families remain connected to sources of assistance and support and are aware of the continued availability of the public health nurse.

Angela, pg 9 ... She moved out of the area and I got a phone call because I give them my card and say "Look if you've got any other health kind of things in the future ... if you need transport to appointments I know who to contact for that. If you've got any worries, if there is any hassles with the school, around health things or anything really" I say, "I probably know someone that can help." ... I've had lots of phone calls, quite a bit down the track from various people for things. Okay, nothing to do with their child necessarily but some other issue ...

Stella, pg 7 ... I went back to see her. ...I didn't want to be one of the people banging on her door, because the cops were there, all sorts of people were there and once I'd put in that lady (from a local support service), I knew that the situation was okay. I rang her to see if she was alright and she said yes it was alright. ... Three months later I called again, or just went round for a cup of tea and the horror of the situation had somewhat resolved....

Encouraging strength

The subcategory of *encouraging strength* refers to how public health nurses assist families to recognize and enhance their capacity to promote their own wellbeing. Participants talked about how encouraging strength involves processes such as working with the issue the family identifies, going at the family's pace, being encouraging, and involving others to support the family.

Participants explained that acknowledging and focusing action around issues of most concern to the family is an important starting point when working with families.

Sarah, pg 10 ...Well I asked mum what would be the best thing that could happen for her....after she'd poured it all out ... And she did. She was in tears the first two times I went she was just absolutely exhausted really. ... And then I said " ...next time I come I'd like you to say to me what would be the best way that you could relieve some of the stress for yourself. What would be some of the things that would be helpful to you". So then we looked at what the kids contributed, we looked at what dad contributed, we looked at what everyone contributed and when you looked at the whole thing, it was all

falling back on her really. So it was then that she started to make some changes and felt strong enough to confront them at work ...

Angela, pg 28 ... and that's part of that whole thing of identifying what they see as the issue not what we think needs to do fixed. ...like if they are really struggling to get food that hearing loss is really insignificant if they haven't got decent housing or food, you know that kind of thing.

Participants talked about the importance of going at the family's own pace when working in ways to encourage family strength. Allowing the family to determine the process and time required to work with their concerns builds trust and empowers families to take charge. Knowing when it is appropriate to be involved and when it is necessary to step back requires the public health nurse to be sensitive as to how often this family will be open to being visited; the level of urgency around the issue to be addressed; and whether there should be some pressure exerted to initiate action.

Amber, pg 8 / 9 ... I think the essence of working with families is actually working alongside a family and letting them direct the course of where they want to go and sometimes with some families that actually takes quite a bit of time. ... And you are still having to go along at the pace that the client wants to because if you don't, if you're going too quick or you might just say one thing out of tune or you might even appear a little bit impatient, you can turn them right off.

Lily, pg 11 / 12 ...The biggest change I've ever had to make is to wait and do things in peoples time. Unless it's a crucial thing, you know. ... working with a family sometimes I've had to step back and just wait till they were ready. ...you just sense it, you just know. You know when to push and when not to push.

One participant recounted the story of supporting a family through a complicated series of steps which would have been challenging for them to have to deal with on their own and how this process involved exerting some pressure.

Lily, pg 12 ... We've this little kiddy at the moment, ... he's got such a terrible eye condition and he has to have glasses and he has to go to the specialist but

he has to have his glasses on his face for a month. Well it's taken me about 6 months to even to get him to get the glasses ... but I had to really pressure the family and I was out there at say 8 o'clock most mornings and saying now you've got to do this, you've got to do this. Like they had to come in and they had to go for their appointment, they had to come in and pick a frame, they had to sort out with WINZ about the payment, ...and it was too much for them to think about the process. So I had to be out there to remind them....

In other situations the nurse will adopt a more gradual approach.

Mavis, pg 8 ...There is so much going on ...that's where often I'll suggest may be just ... taking it really slowly you just can't address everything all at once because some of this could be like historical, this could be ...years of baggage that has accumulated to where the breaking point is now. It's just sort of working out a plan with the family and nutting through the problems, the most urgent problems at that time and may be even looking at strengthening families ...to work out the solutions, the best outcomes for the family.

Angela, pg 11 ... Some of the ones that I know quite well ...they've often got lots of children, lots of ongoing complex issue. ... Sometimes it's best, if it's not the right time for them...to back off, wait till there's another crisis, get involved again and eventually, hopefully, something might happen.

As participants stated, much of this depends on how committed the family are and what help they may want.

Marnie, pg 28 ... Even though you think that you are making a difference, you presume to help them, at the end of the day it is the person themselves that makes the difference. It is whether or not they decide they want to change or they want to improve the situation they are in. You can't actually do it for them. They have got to do it themselves. You can offer what ever you like, you can offer advice, you can offer resources, you can offer support, but at the end of the day it is them. No-one else.

Mavis, pg 21 ... They've got to have some sort of accountability as well as we do as health professionals to make things work. ... I think sometimes people are ready at different times to be able to move on. Sometimes it's not that right time at that particular time. But you know 6 months down the track they might be ready, oh my goodness we have really got a problem here. You

might just sow that seed and it might just come to fruition further down the track.

Participants explained that the process of encouraging strength when working with vulnerable families requires adopting a positive and affirming approach, and being respectful of where people are on their journey.

Lily, pg 26 ...It is probably being positive and looking ahead and it is not looking at where they've been. ... Although you know where they've been and a lot of their history, ... but it's not looking at that as a huge thing.

Marnie, pg 9 ... When we originally met she was quite reticent about any sort of help or anything and more and more she's realised that it doesn't actually mean she's bad at this or bad at that. It's just that may be it's not a good place she's in at the moment, she needs a bit of a helping hand. I think she's opened up to that more. ... It's that thing about respecting people, I mean they may not be where you are up to, or where you are not up to which ever way you want to say it, but it's respecting what they are doing because you know amongst it all they are doing some really good things.... I think it's talking to them, but listening. I just have a big thing about it. It doesn't matter where people are, being respectful of where they are. ...

Participants believed that being encouraging is the optimum approach for effecting change although this approach can be challenging in terms of the time and effort involved.

Gina, pg 23 ... I believe there is always hope. I think there is hope that the right things said might possibly change even one person's life, you know that support, that unconditional support. ... That somewhere along the line there will be something that will trigger that person to have a turn around and just start having a better life somehow. ... I think the word is encouragement probably. To encourage the people that you visit to encourage them and say "Hey, you are doing okay We are there to support you but we can't do it for you because what will be will be, depending on what you do". If it is to be, it is up to me is the word really isn't it. If it's to be it is up to me ...

Angela, pg 3 ... If you can get them to the point where they can say, "Look, it's not working", and we can talk around until we get to something that they think they'd like to try or whatever. ... You have to do it so carefully. ... You can't

tell them what to do, but it's like getting them to the realisation that if they change how they treat their children, the children's behaviour will change. And that's quite time consuming and quite intense really.

By continuing to be encouraging while giving families the space and time to work through their issues participants believed that families will feel supported to make changes when the time is right for them.

Mavis, pg 4 ... I think you make a stamp in their life. My approach is very gentle. I am not forceful. I I think it's not up to me. I can't force things on people it's their choice at the end of the day so long as they've got all the information. And often I've found that's worked in my favour it will bounce back where people will contact me. Even if they've got no phone they'll just turn up at my door...

Lily, pg 19 / 20 ...I keep ringing the mother I keep encouraging her, ... I keep encouraging and ... anyway one day this lady rings me and she said, " I'm not ringing about the Head Lice I have another problem I want to ask you about". ...I thought woo I'm obviously her friend.

Participants reported that involving others to support the family is essential to the process of encouraging strength. The importance of collaboration with other professionals and services to strengthen the family rather than the public health nurse working alone was emphasized by participants.

Caroline, pg 14 ... If they are vulnerable, you can't really be the only person dealing with them. ... you would be calling in other agencies to help them. I don't think you can do it on your own.

Sarah, pg 22 ...It is imperative really because you are not able to do the work yourself and the agencies, the community agencies that are out there have the expertise,

Participants identified that the process of involving other services and agencies requires the family's consent. This participant described how the public health nurse facilitates the process of connecting the family with this support and then may step back when this is established.

Sarah, pg 13 / 14 ... And then I said to her "Is everything alright in your house?" And she wouldn't look at me or wouldn't speak. ...."Is everything okay between yourself and your husband?" She'd bow her head and say "umm". "Would you like some help? I can take you to a place where you can get some help if things aren't good between your husband and yourself. They are obviously not good between the children and this baby is getting the brunt of everything else that is going on in this house. This baby is not going to thrive". Well, it transpired she didn't even want the baby and she was hoping it would die. So what I did I got hold of Catholic Social Services, I said, "Would you like someone to come in and help you with your children?" "Yes please". Okay so I phoned them and they went round and they could see what I had seen and they were fearful for the baby and what was going on with the others, the two siblings. ... I took her down to (ethnic women's counselling service) and they interviewed her. ... So what happened in the finish was, I kept visiting for a wee while just to reassure her and let her gain some confidence and to make sure that baby was alright really. I alerted her GP as to what I had found and Catholic Social Services are really only allocated X number of times for visits but the lady that had started coming she said to me "I'm in there for the long haul"... So we got her down to (woman's counseling service) on a regular basis for English lessons, taking the baby with her and the woman from Catholic Social Services helped her with the baby and helped her learn to nurture it ...

Participants talked about the importance of knowing the most appropriate person with whom to consult or bring to the family. This was identified as relevant to working with Maori.

Michelle, pg 12 ...As a Maori health practitioner it's been brilliant having a Kaiwhina who could go into this family's home, allow mum to share how she was feeling at that particular time, having a karakia, ... asking the family to ensure that they felt safe and comfortable with what we were there for. It kind of gave us a sense of unity I suppose, mum wasn't tense or we weren't another organisation coming to tell mum off , and it seemed to help mum to understand really what it was we were coming in about. ... And that really helped us to develop that relationship of trust ... and mum was able to share a lot more...

Amber, pg 25 / 26 ...I might involve a Kaiawhina like our hospital Kaiawhina, ... if I feel or just get that underlying little bit of tichyness that I think I'm not really wanted here, so then I'll involve a Kaiawhina. ... I just say to them "Oh, I've

> got a lovely lady up at the hospital". ... Most of them know (name of adult female). So ... I just say "Would you like her to come back as your support? We'll work together, so you're actually also formulating that partnership with them.

Participants described how the public health nurse can be the key person to facilitate the process of bringing together relevant agencies and services to discuss ways to support the family. In particular, the team approach provided by a community initiative referred to as the Strengthening Families Process was identified as an effective vehicle for involving others to support a vulnerable family.

> Gina, pg 26 / 27 ...You need to know who else is involved and then you need to pull together a meeting. ... I did that just recently with another family. It was Mental Health we were working with, and we said "Have you called in all these services?" And they hadn't. So we called them all together. Called in Child Youth and Family, the support services, the social worker, WINZ, Housing New Zealand, ... we got the lawyer to come who was acting for the children, ... and had this meeting and we were able to sort out a huge amount, just by getting everyone together and discussing it.

> Marnie, pg 16 / 17 ...That's why I like the Strengthening Families thing because initially you bring in everybody involved. We did with this family with the 7 kids. We had one, and we involved everybody who was involved with it and it was quite a big meeting, about 13 people. And then ... you should be able to make sure that that's being looked after, that is done and that's not actually that person's thing it's somebody else's, and you should be able to get it down to just 2 or 3 people who are ongoing helping with the family ... You don't feel like you're on your own, you feel like you are part of a team. You mightn't be able to make a difference in this particular area, but somebody else might.

Making the child the priority

The subcategory making *the child the priority* refers to participant reports of working to ensure the child is at the centre of the care provided to a family. Participants described how they work to protect the safety and

wellbeing of the child so that this is not compromised by attempting to meet the needs of the whole family.

Participants recounted stories of public health nurses working with families to address their issues while ensuring that the needs of the child remain paramount. Making the child the priority involves continually assessing a vulnerable family's situation to identify factors that threaten a child's wellbeing and whether there is an issue of abuse or neglect.

Lily, pg 26 ...You work alongside the families you work with them. Like this little kiddy who needs glasses, now it might take me 6 months before she gets to the Optometrist. So what if that's her process. The end result is he will need to have them but whether it is tomorrow or 6 weeks or 6 months, who knows. You know sometimes you can't push the process. But then when does it become a neglect issue? So then you have to have all these thoughts in your head. How long doyou actually leave it for their process, how long do you try to make it a process for the child so he can actually learn and read. ... We have to look at their priorities, my priorities the priorities and the needs of the child. So you have to look at the whole big picture of what is going on.

Michelle, pg 5 ... But then at the end of the day, it's the health of that child or that child's hearing that ideally should be the ultimate thing. You know we seem to lose that picture and it is because of the vulnerability of this family that the child's hearing kind of takes a back seat. ... Initially it was like, "Oh this poor mother she needs all the support". But in giving that support to her we forgot the child. So we needed to change our focus and look at what's best for this kid, to help this child ...

Participants reported how sometimes the action required to protect a child's wellbeing is clear in that a referral to the child protection agency is necessary. Participants emphasised the public health nurse's responsibility in this respect.

Gina, pg 23 ...We carry that label of Child Youth and Family where they know a Public Health Nurse will actually report. So they are very very keen really not to have you involved often. ... I believe that in the name of the jigsaw and the puzzle and in child safety we should because at the end of the day if information comes in from anywhere, if they shift ... are transient, then it will be picked up and we won't have more children die.

Sarah, 4 pg 25 ....One was a little girl who has two holes in her heart. She has failed every dental appointment since 1998, ... she has 27 fillings to be done. The school asked me to take the consent form to get signed and mum refused to sign it. "Would you please go to the dental caravan tomorrow and talk this through with the girls because they need to be very clear about her health before they are able to do anything?". ... When I knew she hadn't been to the caravan the next day I said "Right this is a CYFS referral." ... If she gets an infection that means she loses all the valves in her heart. She ends up with endocarditis, pericarditis, the lot. ... And nothing was happening. So I made a referral. When we phoned the G.P. we found that she had not had an assessment since she was 2 years old. ... She had fallen right through the gaps.

In other situations the public health nurse may make the decision to work with a family before resorting to a referral to the child protection agency. Ensuring that this judgment is sound can require consultation with other professionals or colleagues.

Mavis, pg 17 / 18 ... Those children ... are the innocent component in the equation really. And they get caught up in the tangled web of the parental problems, and societal problems. It's a community responsibility it's just not always an individual responsibility ... Those parents need support from other community people to be able to manage that family effectively. ... and sometimes ... it's before it gets to CYFS, ... because I think we can probably diffuse a lot of the stuff before it gets to there and I think that's probably where your role is. ... And sometimes it's a judgment call ...

Participants explained how making the child the priority might necessitate being up front with families in order to ensure that the child's wellbeing was promoted and protected.

Lily, pg 12 / 13 ...They didn't see the need. No priority. ...I don't like the word threatened, but I said "If you don't keep this appointment you won't get another one for nearly 12 months so you've got to keep it ..., you've just got to keep it". ... So I gave her a week and then I went in ... I said, "Where is that script?" "Oh" she said "It's in the bedroom. We're not going to get it done because we can't afford it." And I had told and told them the importance. I said "Get me that script." So I took it. And she said "What are you going to do

with it?" I said, "You've got to have it you have got to have it". You see they just didn't understand. ...

Stella, pg 19 ...Well I mean I'd written little notes saying "Your child is itching a bit do you think you could possibly get some more medicine?" And this wasn't forthcoming. And I'd been into the GP who'd washed his hands of them. Then I went to the home and I said to her "You know it's not good enough something's got to happen to his medication".

Participants also told stories of how making the child the priority involved being an advocate - battling on behalf of the family or more specifically the child, to allow their concerns and needs to be attended to.

Stella, pg19 ...Well sometimes I find that the children don't get a good deal. The parents are so distracted and off on other tangents and sometimes I really don't think they care. Like a child I've got at the moment, the kid is 7, the mother is 22 at the most ... This child has got excruciating eczema, dreadful eczema. I've been to see her to try and get her to put the medication, ... she's gone to the GP she's got the script but she isn't going next-door to the chemist ... because she hasn't got any money. So therefore the child is still in the same vulnerable position. He arrives at school, he is scratching all over and the school ring me and say what can we do for this kid. So I feel may be if I can help to be the advocate for that child then I've helped that child somewhere along the line.

Sarah, pg 8 / 9 ...It's advocacy, and you bend over backwards when you see that some kids needs are not being met. You know that if they were in a better environment things would be better for them ... It's the king pin of all the work that you do with these families. Even if it's sitting up in WINZ or sitting in Housing NZ or sitting in CYFS where ever, it's your role really I feel.

Participants referred to the process of going beyond your role to describe the way public health nurses can extend their advocacy role beyond the usual boundaries of their job description in order to protect and promote the wellbeing of a child.

Stella, pg 22 ... I mean I have thrown in the towel at that People at Risk Meeting in front of CYFS and said "We are telling you about these children and you're

not following them up". ... I mean I've been to Parliament to get a letter from (member of Parliament) to make sure that someone (from CYFS) goes to that meeting because there was no-one going. ... So he sent a letter (to CYFS) and it said someone has to be at the (meeting), ... We actually invited the local MP to the People at Risk Meeting ... (CYFS) were told that the MP was going to come so they both fronted up. ... I think you have to know how the organisations run that you work with so that you can go to the very top if you don't get any satisfaction half way through. So to the top.

Sarah, pg 20 ... You go beyond your role really. You have to, to get the outcome. I mean mum needed every inch of support that she could get. And you stood by her the whole time. We pulled in someone from the Ministry of Education. ... You do some ferreting don't you. I said to myself, "Now there must be someone out there who supports parents when things aren't going well at schools for kids. They are not getting their needs met and they are not functioning in a good way, now who do I go to? I know, I go to the Ministry" There is this gentleman there, he's a former Principal. I went and had a talk to him. He said "You need to see (adult female) she's your lady she will help you with this". And that's what I did.

Enhancing Practice

The third main category identified was **enhancing practice** which refers to how factors relating to the context and quality of public health nursing practice enhance the way public health nurses work with vulnerable families. The subcategories related to this are: *knowing and being known by the community; drawing on experience ;* and *being determined to make a difference.*

Knowing and being known by the community

The subcategory *knowing and being known by the community* refers to factors that enable public health nurses to make connections and develop credibility and trust within the community. Participants reported that this involves factors such as being part of the local fraternity, knowing and feeling confident about agencies, gleaning the trust of the school and knowing family history.

Participants described how an important aspect of knowing and being known by the community involves being part of the local fraternity. This relates to having a history and a place in the community with which people can identify and being seen as someone who is sensitive to the needs of that community.

Mavis, pg 5 ... I was born and raised in the area so I do know a lot of how rural communities work. ... The advantage is that you know some of the old families there and even if you've only known them by name and not on a personal sort of basis, I think it actually makes it easier because they accept you, that you're part of the local sort of fraternity as such. So you're accepted as a person that is sensitive to their needs because you've lived in that rural community, you've been part of that right from a very young age.

Angela, pg 4 / 5 ...You see I've got a bit of history too because I used to be the plunket nurse here and I used to be a district nurse here, so I know a lot of people. And I'm from here and I've played a lot of sport here, so I've got good networks and stuff. ...Because of those things that I've done, or been involved in, I've got networks and usually ... if I give them a bit of time someone will usually say "Oh she's alright".

One of the ways that public health nurses build relationships that facilitate the process of knowing and being known by the community is through being involved in local initiatives within the community. One participant recalled how a referral came her way because of a connection brought about through her past participation in a community health promotion project.

Sarah, pg 18 ....It was quite interesting how I actually got the referral. ...All that health promotion stuff we did all those years in the late 90's, where we did all that work with Pacific communities and (iwi health organization). Now there's a young lady that worked at (iwi health organisation), ... Her sister was having problems with one of her daughters. She wasn't functioning at school at all. So this young lady who we had met during our health promotion said "Give Sarah a phone call, she's the public health nurse for that school and see what she can do". So this mum did phone me ....

Participants reported that a vital component of knowing and being known by the community relates to being familiar with and feeling confident

about community services and agencies. They emphasized the importance of being able to trust that they can make the right decision when referring families on to other organisations. This trust emerges from their past experience and knowledge of the services provided and nurses tend to go back to the agencies where there have been the best outcomes.

Sarah, pg 22 ...The community agencies have the expertise, and you have to have confidence in them, you have to know that they will do the best that they are able to do. If you didn't have confidence in them you wouldn't refer them. I mean I've come unstuck once or twice and I have never used those agencies again for the families' sake. But if you've got confidence and you know that you will get the best outcomes for the family, that is where you go back to each time.

Stella, pg 6 / 7 ...In one of my schools there was a horrific case of abuse. .... Now the mother and father were professional, well spoken people. They were totally and absolutely devastated, so distraught. .... So it really put me on the spot to get someone that wasn't inappropriate, that could speak to them on their level, and that would come straight away. ... I rang (local parent & child counseling service), I spoke to the manager. I told her the situation. I told her I wanted a mature, articulate, experienced counselor to come to speak to these parents who were distressed and distraught but I wanted them now and it must be an appropriate person. She sent her senior counselor who has been around for years, is a mature lady, dresses properly, speaks properly and she went the next day. ... I knew the right organisation to go to and I knew the head of that organisation was the right person who would understand ... and would have a vision of the need. ...Because of my experience of that organisation ...

Participants identified the process of gaining the trust of the school as paramount to establishing the credibility of the public health nurse within the community. Developing quality relationships with schools was considered important for working effectively in the community and ultimately with families. An effective relationship with a school community is built on a sound belief in the reliability, integrity and competence of the public health nurse. Participants saw this relationship as essentially a process of co-operation in terms of the nurse supporting and in turn being supported by the school. If the public health nurse gives

a good service then the school will facilitate ways for the nurse to access clients.

Gina, pg 3 / 4 ....If you are in and out of the schools, all schools all the time, that is when you get the referrals because you build that network, you build that rapport, you build that trust with the teachers, the Principal, the DP, the health worker, the office staff. Once they get to know you, and it takes at least three years to really gain that trust, then you start getting the referrals. .... Just the fact that you have gleaned the trust of the people in the school, you get to know the teachers, the Principal starts allowing you to spend time with the teachers and if you are trustworthy then you can see the children and the other thing is that you become known to the parents too.

Stella, pg 15 ...Because I am physically in the school, ... and printed on my chest are these words, "Oh I'm glad you're here I just wanted to see you"... Being in the school is absolutely the crunch, the pivot of the screw... You need to be there at lunch time, you need to be there at morning tea time, you need to know how the schools work.

Public health nurses establish trust and credibility by supporting the school with initiatives – for instance around the issue of head lice or in the classroom helping with the health curriculum or the school deal with stress.

Angela, pg 25 ...By doing stuff in the classroom you then see these kids down town and they're skipping around saying "Hello!" and then tapping their mother and saying " Angela came to school," ... So ...for a vulnerable family for their kid to be excited about seeing me, they might feel a bit more comfortable that ... I've obviously been at school and ... the child has ... related to me or something that I've done ... When you see them down the street and the kids do that, they smile. You think, "Oh well, ...at least if I need to go there for anything, then there's a little positive thing already".

Gina, pg 16 ...The Principal became really stressed, but then a lot of Principals have been stressed as the expectations are pretty high on these teachers. I have run stress information cluster days for them and we have sort of done health days for the teachers in the past

Participants identified that another vital aspect of knowing the community relates to the public health nurse's familiarity with a

family's history which enables the nurse to draw on relevant information and experience about and with a family to facilitate appropriate ways of responding to their needs.

Lily, pg 8 / 9 ...It makes my job easier because it helps me to understand perhaps why families don't do certain things knowing where their background is. ... Like truancy is a big thing in this area and knowing that the mother has been a truant all her life and has now got children helps me to encourage them in a different way. Perhaps if they've got that history you can take another tactic for how you are going to deal with that problem. ... The community know me, I know them. ... You can work without a lot of language and I can get quite a lot of co-operation because they know my history as much as I know theirs ...

Amber, pg 26 / 27 ....This particular mother, I knew that she could be difficult. The Dental Therapist had sent 3 or 4 lots of consents home to this mother and they just didn't get them returned. So I went around and saw the mother and she wanted to know what the properties were in the sealant which they use now as a filling. So I went back to (the Dental therapist) and photo copied all these pages and the woman was completely happy. She read everything. I said to her, "We're going to leave the consents here with you. If you wish to sign them you've got the opportunity to sign them and I'll collect them. If you don't choose to sign them, or sign the non consent, you can do that as well". ... I went there on the Tuesday, she had it all there. She said, "Everything's fine you were the only one that listened to me and provided access to that information"

The connections on the ground which the public health nurse builds with key people in the community can enable the nurse to gather valuable information about what is happening within families. Participants also emphasized how important it is for public health nurses to know the history and interplay of the community to ensure continuity of care and safe practice.

Gina, pg 18 / 19 ...I spoke to the kaiwhina at Plunket. ....The Protection Team at (named regional health organization) wanted to keep this kid safe. Well, it turned out one of the Aunt's drinks, her partner has raped a 12 year old, there is child abuse by the other one, while baby sitting. The grandmother has been in hospital and her daughter has now used money that wasn't hers and

so she is losing her house. ... The other partner: drugs and drinks, burglary, guns, ... and the other set that she could have gone to, massive arguments and beatings ... CYFS had none of this (information).... I gleaned that from just talking to the kaiwhina at Plunket. .. who knew the family, because I didn't know the family dynamics at all and so that is what that child would have been put with had she gone to anyone else. ....

Stella, pg 34 ...there's a family in town and there are two little girls and there is suspected child abuse from the father. Then there is another mother around the corner who has a daughter who plays with these two little girls. ... Now while I was away on leave a colleague came and stood in for me. The school called her and said the little girl around the corner has got incontinence of urine... My colleague not knowing the history went to the house and said "She'd got incontinence of urine and we've got to get her sorted out"..... Now I knew that woman and I knew that she would go and tell the father of those other two little girls and it would put him in alert situation. ...He has now become really aware and has closed ranks even more on the care of his own children. So because she didn't know she went to that family. I would not have gone to that family I would have gone a different way round and got an investigative interview at (name of social service) with that little girl cause that's what I was waiting for, any signs of urinary dysfunction so that that would alert me .... She also went round to the (other) house knocked and the door and said, "These children need looking after". Of course they do, but she didn't know that I'd been round there for a hundred years. .... She went with the best of intentions for professional reasons, but she didn't understand the dynamics of what was happening between those two families. That's why it is really important for continuity of care. .....

Drawing on experience

The subcategory '*drawing on experience*' refers to how public health nurses enhance their work with vulnerable families by drawing on their own life and practice experience, as well as the experience of colleagues and other professionals. Participants described how these factors resource the work with vulnerable families by enabling public health nurses to understand a family's situation and navigate the boundaries required for safe and effective practice.

Participants talked about how public health nurses draw on their past practice experience when using their senses and intuition to appraise a family's situation and how this enables them to quickly determine the multiple factors that may be involved. They described the skill involved in reading a family and how public health nurses draw on experiential knowledge to trust their gut feelings or intuition when responding to a family' situation. One participant referred to this as 'having public health nurse's eyes'.

Sarah, pg 16 ... After being in public health for a while you have what you call public health nurses eyes. And they are moving all the time picking up vibes, picking up clues, picking up feelings ... You've got your own gut feeling and 90% of the time are right. By going by your inner judgment, this is when you can help these families I think. ...

Amber, pg 8 / 9 ... I think its attempting to be in tune. It's actually reading them. It's seeing their body language, seeing what response they're giving you. ...They are acknowledging that they're happy with what's been said, you can sense it, it's like a gut feeling more than anything. ... You either know that you're doing the job right, or you know you're doing the job wrong, by looking at their body language, by their reactions ...

Participants described how reading a family involves the process of looking at the whole picture. This relates to taking a global all encompassing view of the factors influencing the situation experienced by a family.

Amber, 9 pg 3 ... When you get a child health referral from school, regarding a child, there's usually a whole heap of other issues that need to be dealt with. Its being involved with the whole family ....

Mavis, pg 8 ... Often when you are doing a nursing history or assessment the presenting problem is of that child. Over time, it could be over the next few weeks, there'll be other sort of social issues coming out about where the parents are at. Of course that's looking at the family as a whole so it does reflect on where that child is at. For example there was a young boy who had behavioral problems and so we went along the lines of why has he got these behavioral problems. But then when you get past the surface formalities as such. Mum is unemployed, there's been a marriage break up, there's children

that are attention deficit, she's moved, she's got no family support, she has no transport, she has a cellphone which often there is no money on the card. So there's quite a few problems there.

Drawing on experience also refers to the process of being clear about boundaries and how pubic health nurses ensure that decisions made and actions taken to promote a family's wellbeing are professionally appropriate and safe. Participants reported that the knowledge and skill required to maintain professional boundaries arises from personal attributes, beliefs and life experience as well as from the mastery of skills and practice wisdom from past 'hands on' participation in the field.

Stella, pg 17 ...Well it's life experience. It's never lost is it. Especially when they are very different, and very difficult sometimes. ... When you work for example as the only white midwife, in a very busy maternity ward and you are expected to run the show and they all speak in another language if they don't like what you are doing. ... Maori culture in (NZ rural settlement), ... the only multi tribal Pa in New Zealand. ...Life's experiences really. And having your own children growing up in a small rural community in New Zealand, I mean they all add part and parcel to who you are in the end....

Sarah, pg 41 ...But it's because I've been in the job a long time and I know it well. I know my limitations and I've got expectations and I know how far you can go before you have to do something else. You know your limits. ... Yes absolutely and you know what needs to be done. So you work the best way to get that done.

Participants described knowing how to navigate the challenges of practicing within their scope of practice. For instance participants referred to knowing the boundaries around working holistically with families to meet their needs while containing the nature and extent of their practice within the limits prescribed by professional and organizational guidelines.

Mavis, pg 22 ... I'm not an expert with counseling or social work or anything like that. You don't profess to be multi skilled like that because you can't be a maverick and be pushing people into different directions or assuming you're going to do some counseling with somebody when you've not actually got the training there. I think that's not kosher. You've got to know your boundaries.

Angela, pg 30 ... If they are vulnerable you've got to not make things any worse for them. ... And if I'm not the right person or if I'm the wrong one or whatever then that's fine. ... I don't hang onto things. ...If It doesn't feel right, I know that it's not right, it's not working, it's not right. I've found that quite reliable.

Participants also referred to knowing when it is time to step back from involvement with a family.

Sarah, pg 14 ...Well you can't keep on. You see, my role had finished. I had done all that I could do and I'd left them in the care of the Catholic Social Services who said they were in there for the long haul. I left her in (woman's counseling service) care and that was their responsibility, ... So that's as far as I could go really. ...

Michelle, pg 9 ...I've worked intensely with this family for a year and really it's the school's responsibility now and I have left it there. But I don't feel responsible for it. ... I just know that there is a cut off point you know and we are not always going to be there for this child. But this child will survive. ....

Participants described how they managed the challenge of balancing the community's expectations of their role and the professional parameters that determine their scope of practice.

Angela, pg 28 ...With schools too, I'm quite insistent ... It's their job if there's an issue, to raise it with the family and say "The public health nurse will be the person to help you with this. Are you happy for me to contact her?" or whatever, ... I won't just cold call, no. That's their responsibility.

Gina, pg 35 / 36 ...You can have a Tangi. ... You have your three days before when you can visit, and then you are expected to go to one of those days before to make it known that you acknowledge that they are dead and that you are there as part of your respect. They would like you to stay which of course you can't do because you are working and they accept that. But you are expected to go back for the burial day too. Now that may start at 10 but then often it starts at 11 or 12, and you are having lunch at 3 in the afternoon. Because you have been through the service, you are expected to stay and have kai as a mark of respect. You can go and then slip away. They notice and they say "Oh where were you?". And it is an ethical dilemma really because our service asks us to be culturally appropriate. But we are actually not able to be because we are paid ... and we are expected to do the work

... as in visiting babies ... visiting a school, following up on ... children or ....having family group conferences or whatever ..

Participants also referred to knowing the boundaries around the nature of the relationship that the public health nurse builds with the family.

Amber, pg 23 ...You also need to practice safely to yourself and to your client and to the community. ...I think it's knowing your boundaries. And I think from a professional point of view it's acknowledging all those codes, those rights of the client the Code of Rights. ... And the reality is if you're not practicing within those parameters and that scope of practice, you are leaving yourself wide open.

Mavis, pg 6 ... It's done on a professional level. It's not a personal friendship you're getting into. You've got to still keep those boundaries and I think you've still got to be professional and not to get personally involved and that's the hardest thing I think ... Where is the point where you're becoming sort of personally involved and does that obscure your judgment of where you are going within your practice.

Participants talked about how they drew on their experience to facilitate the flexibility required to work with vulnerable families and manage the boundaries imposed by contracts and guidelines. Participants referred to how this might mean working creatively around organizational and fiscal constraints and with best practice recommendations.

Sarah, pg 41 ...I work independently, I can't be bothered with the bureaucracy. Our manager comes to me every now and again and she will say "Are you behaving yourself Sarah?" ... And if things turn to custard and she might hear about it. I go to her and I say "I think you need to know about this" that's how I do it. ...

Lily, pg 4 ... We have practice pathways now where we do step A, B, C, D for everything whether it is for Head Lice down to Impetigo to visiting schools to everything else. It does help and it's good, but you have to adapt those guidelines to your community and to the specialty of the people. Because two schools are not the same. So you actually have to look at strategies within those policies and guidelines to make things work.

Another aspect of drawing on experience referred to by participants relates to the process of consulting with professional colleagues. Participants described how having good professional networks in the community and knowing with whom to confer, are important factors for drawing on the knowledge and expertise of others, and that this in turn enhances the work with vulnerable families.

Caroline, pg 12 / 13 ... It is really important to build your good relationship with the doctors and the practice nurses and work in with everybody. You have got to be with other people in this job, you have got to liaise you have got to share knowledge. It is really important for me to discuss something if you've got something unusual and you want to gain some more knowledge about something. If you are comfortable about talking to them you don't hesitate to gain further knowledge. I think it is particularly important in an isolated area to have that good relationship. It's the feeling that there is somebody else there who may be able to give you some advice. It is a good feeling actually.

Mavis, pg 18 ...And sometimes it's a judgment call. I might actually ring even the CYFS call centre and say look I've got this kid, completely confidential not making a notification or a social worker or other colleagues. You've got to bounce those ideas off and say, "Look I've done this, this and this. Have I done the right things, how could I've done it better?". Peer supervision, talking to somebody that you really respect, they're confidential and their knowledge is sound and I think they can totally understand where you are coming from ... I think it's supporting you in your practice that you are doing the right thing that you aren't sort of going over the boundary or have you lost your judgment.

Drawing on the experience of other public health nurses was valued by participants as a way of maintaining clarity around the boundaries required for safe and appropriate practice.

Sarah, pg 22 / 23 ... You've got your network of PHN's to refer to. So you've got that consultation within your own professional group. And you often go to another team mate to say "Look I've got this problem these are the issues...have you had a good experience with this agency?". Well it's normally the ones that have been around for a long time, like myself, and sometimes you take along a new public health nurse who is still learning on

the job, so that she can listen to what you are saying. This is the process that we use and that sort of stuff, and these are the agencies that we recommend.

Angela, pg 18 / 19 ...It's really helpful to have someone to talk it over with, to make sure that I'm on the right track. I mean I can go off in tangents sometimes, and think "Oh dear how did I get to here from there". But to have someone to run stuff past is quite reassuring. There's a public health nurse colleague in the next town, her and I talk usually without names or anything like that about clients or situation just to run it past someone. I actually try and get what I need from colleagues around the progress of my interventions and that sort of thing.

Participants recounted how formal processes of group peer support enabled public health nurses to share their experiences of case work and gain insights about their practice in a safe and confidential forum, and that this contributed to enhancing their understanding of and approach to, their work with vulnerable families.

Amber, pg 30 ... What we do now is peer supervision at each PHN meeting. We do it in a way that is building up, or adding to that situation that could make it better. I think it's that I know the girls that I'm working with, I trust them. It's been said right from the word go that it's a confidential situation and you then trust your colleagues enough to make sure that's confidential. I have actually worked with them all quite closely. It's a win/win situation.

Michelle, pg 12 / 13 ...What's really helped me this year this past year is also having Maori public health nurse colleagues. That has been a real breath of fresh air for me. To be able to discuss with my colleagues various families that we have been working with... And I think it's the Maori thing you know. We can joke as Maori colleagues and have a different understanding than what we would if we were to go to our Pakeha colleagues. I have been able to share incidents about our families, and you see it in a different light. And so I think that's what really enriched my public health nursing experience more so this year in dealing with vulnerable families. ... It's really changed our way how we work with families. ...

Being determined to make a difference

The subcategory being *determined to make a difference* refers to the tenacity that public health nurses describe when relating how they

persevere when assisting vulnerable families to deal with sometimes multiple and deeply entrenched issues. Participants talked about the personal and professional philosophies that underpin their practice and inspire their commitment to support the wellbeing of vulnerable families. Participants described this factor as an essential quality that enables their practice to be sustained through challenging situations.

Amber, pg 20 ... That's where your passion comes into it. You know you've made a difference for that mother and her child, ... You are passionate about wanting to make a positive difference for that family.

Michelle, pg 18 / 19 ... I suppose as a Maori nurse I have often asked those questions ... How can we help the Maori race increase and improve. Those are really big questions and I suppose I will be asking those questions for years to come, because I know I can't change the world in five minutes. But I want to be able to make a change and I know I do. You know, those little bite size things. It's that manageable practical stuff that makes the difference, That really makes the difference. ...

Sarah, pg 30 ...I was on the CYFS panel for 10 years and I used to have these head on arguments with Social Workers and head on arguments with the supervisors because they were 90% of the time they were looking at the parents' needs they were not looking at the children's' needs. And I'd come out angry, ... or else I'd come out with tears in my eyes from kids being beaten up. You know it was a horrific experience really but I needed to experience it to know what life was really like for a small proportion of our kids out there. And it made you even more determined to fight for those kids and be an even better advocate.

Being Constrained

The fourth main category identified was that of **being constrained** which refers to factors beyond the immediate control of the public health nurse which limit the scope and quality their work with vulnerable families. The subcategories supporting this category are: *families unwilling or unable to respond, the impact of the business model,* and *being frustrated by CYFS*.

Families unwilling or unable to respond

The subcategory '*families unwilling or unable to respond*' refers to how the nature of vulnerable families may mean that strategies to address the issues they face do not succeed. Participants reported how this may encompass factors such as families being wary, losing motivation or 'doing a runner'.

Participants talked about how efforts made by the public health nurse to support a family may not progress due to the family being wary, lacking in trust or not ready to accept help.

Sarah, pg 24 / 25 ...There are families that don't want to work with you. And they have a right there, they do. So that is quite difficult and they've probably already got a history, they've probably already been under CYFS, so they haven't got any trust in agencies themselves. They are often families who are into drug and alcohol and you know that the kids are not getting their basic needs met. They don't want other people working with them, they've had some bad experiences of agencies in the past. So those would be your barriers really. ... You've got to respect what they want and they've got a right to say we don't want you to work with us. Absolutely ... Well you monitor the situation through the school, make sure the child is still safe and still well and if it deteriorates and you haven't been able to make any inroads, well then it becomes a CYFS matter.

Mavis, pg 21 ... I think with ome of the families ... they want the help but they don't want the help ... it's a real two sided coin. And they are the ones that need the help the most. I think sometimes their barrier is they have been let down by health professionals before in the past and they've just slipped through the system and there's been no follow up. There's been no ... accountability. They've got to have some sort of accountability as well as we health professionals, to make things work. ... I think sometimes people are ready at different times to be able to move on. Sometimes it's not that right time at that particular time. But you know 6 months down the track they might be ready. "Oh my goodness we have really got a problem here". You might just sow that seed and it might just come to fruition further down the track

Families may lose motivation and put up a barrier because they are embarrassed about this or they may no longer be willing to continue the relationship with the public health nurse.

Marnie, pg 6 ... We've gone up and down quite a lot. The phone runs out of money or it runs out of power and an appointment is made but the car isn't working that time and all those sorts of things that keep coming out. . ... Part of Strengthening Families is that they have to do their bit too. But the motivation goes and I think it just seems that they never quite get on top of things. And they are supposed to go and look for another car and WINZ will help them to buy it because the car they are using at the moment gets too many fines because it's not registered and it's not got a warrant and all that sort of thing. But they won't get the motivation to actually walk to school. ... I find it really frustrating at the moment that we have these meetings, we try and set things up that suits them and they buy in and say, "Yes we'll do this we'll do that", and nothing happens.

Caroline, pg 18 ... You got the feeling that anything you did wasn't going to help. ... You felt like you'd done everything you could but you actually weren't going to make much difference. That's what happened in the end. ....

Michelle, pg 7 / 8 ...I've had to step, I've had to step back. ...I had the relationship in the beginning, then I'd made the notification to CYFS and it turned a bit sour as it would - the relationship with the mother. ... We've tried to put a few things in place for her, and she just wasn't in agreeance really. ... But once CYFS became involved things started to change and the relationship wasn't as good. ... So what's in place now is that the school takes charge really of the child's well being. ... so I work through the school with the child now.

Participants described how families can opt out by 'doing a runner', meaning that families can suddenly decide to close off, or decide to move to another town or area. There may be a number of reasons why families decide to move on and these may be unrelated to the assistance being provided by the public health nurse but in doing so families extricate themselves from this.

Amber, pg 9 ... It can actually change at any time. Sometimes people can just turn around and switch off to something and often you don't always know why it's happened. They might have other stuff that they're thinking about too.

Mavis, pg 9 ...I think back to other families where you've worked together collectively. It's been in consultation and with the consent of the family and there have been changes, the children have been doing well at school and they seem to be having help with budgeting, things are working out really well there's meals on the table, and they just decide to run and go somewhere else. It's really disappointing. You think "Oh gosh why did that happen?" May be it's the vulnerable family's way of coping. May be they've never had that security or that support before in the past. ....

The impact of the business model

The subcategory *the impact of the business model* refers to participants experiencing that the work of public health nurses with vulnerable families is undervalued and not adequately supported by the policy makers and by their own organisation. Participants talked about factors such as the constantly changing role of the public health nurse, and the work of public health nurses with vulnerable families being under valued and not supported by a formal process of clinical supervision.

Participants stated that the public health nurse role has been a roller coaster in recent years recounting how the public health nurse role has undergone persistent change and how this has impacted on the ability of nurses to provide an effective service to vulnerable families.

Mavis, pg 18 / 19 ... It's inconsistent for the schools and the families because our role is always changing. A couple of years ago we were doing health promotion and now suddenly that's taken out. I think people feel let down so it comes back to that credibility again. They say, "Well why aren't you doing that? We trusted you in that position." It's letting the community down and that's one of the biggest things, that consistency.

Gina, pg 33 ... I haven't been able to keep up with what is happening with those families and refer them on if they've shifted or if they are transient families. It is really important to keep tabs on where they go as those families get lost which is not good. It is not a good scene at all because that is how we get the deaths because we haven't been able to follow the families up. Well that is my belief because if we can keep a trail on the families that need

observing, then we should be able to stop any really serious violence on the children

Participants who had been working as public health nurses for many years identified that one significant change to the way public health nurses work with vulnerable families that has resulted from health restructuring has been the loss of infant welfare work. Participants talked about how the process of visiting families regularly for infant welfare assessments provided an opportunity to identify health issues early and facilitated the relationship building that created the context for encouraging the family to address other issues.

Lily, pg 5 / 6 ... I think the other big change is when Plunket got the contract for the 0-5 infant welfare. That was a huge deficit for us PHNs because then we didn't go in to work with families, in the home. It cut out a lot of the family work. We pick up the children now at 5 years and we are seeing them with more hearing and vision defects which could have been picked up at 3 and actually been actioned. But because we don't go into the homes we don't pick up those little ones, the pre-schoolers, even for being enrolled with Dental Clinics. So when we were out there monitoring a lot more in the homes we picked up a lot more perhaps abuse or violence, family dynamics. But we don't do that now. ... If there was a new baby there, you visited them regularly right up till they were 5. But you would start off with a new born by visiting every week and then it would go two weekly, then it would go monthly ... it all depended on their needs. Then of course if you did the baby, there would be say an 18 month old or a 2 year old so you would do that 18 months check and then you would do a 2 year check. So you were there for the whole family. ... There would be nutrition issues or there would be social issues, things like that. But we just work with children from 5 years now so you go into the schools and you get the referrals and you think, "Why was this speech or development not picked up?", or some sort of behaviour or whatever. And it has been sitting there for 5 years perhaps. I think that is a huge worry. There is always the children in the gap who never go to any pre-school centre or they choose not to go to Plunket and I don't think they get the same follow up.

Sarah, pg 4 ... When we were public health nurses doing home visits, we were into the families homes every week or fortnight. We did the immunizations at home, we ran clinics for the older kids, 3 4 5 year olds, before they went to

school. All of those processes were in place where now there is nothing. ... Occasionally now, you go into a home to do a home visit from a school related thing, "Oh nurse, nurse have you come to see my babies?" ... So there you go, those old families have not forgotten the service that we once provided. ...What's missing? They don't have a confidant, they don't have a nurse that they can trust. They found Plunket unacceptable as a service. They only do two visits, post midwife discharge, and then you are expected to go to a clinic, and possibly culturally it is not appropriate for them, I don't know. Although we were always accepted into their homes and we weren't Maori. I'm speaking specifically about Maori families now. But we were accepted in there and they trusted us and they knew when we were coming and 90% of the time they were there for you when you made the arrangements the week or fortnight before. It was someone taking a keen interest in that family. ...Guiding them. ... The only time you go into see these families now is from school referrals and you are looked upon as the policeman really.

Participants expressed their concern about the invisibility of their work with vulnerable families and how they feel that it is marginalized and not acknowledged by their organization.

Stella, pg 23 / 24 ... We had these auditors who came in and prior to them arriving someone came and looked at our charts to see whether we put our names on them and the dates. ... They didn't read the content, they only read the presentation. I said "Did you read what I'd written about these children?" They said, "No, we're not interested in the content we just need to know whether you signed it". That's saying you can see a kid for Head Lice and write a piece of paper, but no-one gives anyone any credibility for the fact that you actually have to sometimes go through really devious and difficult circumstances to get an achievement for the child. But there is no recognition in this management system to say that you've got from A to B ... It is not valued if you are doing stuff for children, if you're doing this sort of stuff for vulnerable families ....

Dealing with CYFS

The subcategory *dealing with CYFS* refers to participants stories of being disappointed with the service provided by the child protection agency or Child Youth and Family Service. Participants talked about how

dissatisfaction related to poor communication, referrals not being actioned and as a result of these factors public health nurses losing face within their communities.

Participants talked about how the Child Youth and Family Service's (CYFS) communication with public health nurses was poor. Public health nurses were concerned that they were not kept adequately informed by CYFS about the follow up being provided to families referred by the public heath nurses.

Gina, pg 19 ...Child Youth and Family have had no meetings with me. They have rung me to glean information, they never share information. It is very difficult, with the sharing of information. Then they have got an added problem, Child Youth and Family seem to only keep their staff for about 18 months before they get worn out and they move on and you've got someone new to deal with.

Caroline, pg 6 / 7 / 8 .... On one occasion she was removed by CYFS, unbeknown to me. And this is like amazing that CYFS do not notify you. Then they put her back into the community and they don't tell you. I mean it's absolutely astounding. You know the only reason we found out was the person who was normally helping her out every day said she was back. Although we tried to communicate with CYFS they didn't seem to follow the same protocols. We would arrange meetings and then they'd change, stuff like that. ... I actually wrote a complaint to them about things that happened on one particular occasion. It was just shoddy, shoddy, shoddy. You lose faith in the whole system really. These are the people that are supposed to be protecting our young children. They are not consistent. You know, over the top at other times. ... Well fortunately you don't have 100 cases like that. ... Unless of course you are in some areas like (NZ city) dealing with a lot. It would be extremely stressful

Participants also recounted their distress at referrals to CYFS not being actioned, and how this can impact negatively on their readiness to refer to this service.

Stella, pg 21 / 22 ... You give them information, you state that this child is vulnerable for whatever reason, they never contact you and they are so slow in following things through. That is the most difficult thing. ... It's a very

frustrating experience. ... The changing staff, they keep telling you they are so busy, they've got so many thousands upon thousands of referrals, but it is almost like they give you the criteria for urgency and you meet that criteria, you feel you've met it and you still hear nothing. So you wonder what their criteria is. ... Once they've been allocated then you can follow them up, but if you've just sent a referral through and it's unallocated, they'll just tell you it's unallocated so there is actually no-one that you can actually talk to that will know anything about it. So it's a frustrating experience. ... And I mean there is only so much that you can do ... I've got no statutory powers so therefore that becomes their responsibility, it's their responsibility not mine.

Mavis, pg 20 ...I do look at CYFS with quite a bit of thought before I even branch out there. ... With lack of resources they are so bogged down with work that the things that may be more social issues or may be a parent needing more support or something like that, its low priority. So it might be 2 to 3 months down the track when that actually occurs. ....

Participants described how the inability of CYFS to respond rapidly and to keep public health nurses informed affected the public health nurse's credibility and can result in the public health nurse losing face within the community.

Stella, pg 21 / 22 ...Well it affects you with the school too because you lose face really. ... The children I've referred, they were infested and I mean infested, head Lice I've never seen before or since in my life, feeding on sores in their heads, ... I took the clothing in and they wore it for three years, it was never washed. And ... there were all sorts of rumors rife in the community. ... I kept saying to the school, "I've referred it I can't do any more." I'm quite sure they think "Oh well, she comes in this school, she says she's done something, we see no evidence, the children are exactly the same". So you lose face as well. Seen as like non active when you're actually really done a lot of stuff behind the scenes and it's just not followed up by them.

Protecting the Integrity of Self

The fifth main category was **enhancing the integrity of self** which refers to how public health nurses describe being vulnerable and ways that they cope with this. The subcategories contributing to the main category of

protecting the integrity of self are: *the vulnerability of the public health nurse* and *caring for self.*

The vulnerability of the public health nurse

When referring to '*the vulnerability of the public health nurse*' participants reported how the process of working with vulnerable families can put the wellbeing of the public health nurse at risk. Participants described how public health nurses can be susceptible to factors threatening their physical safety, the emotional demands of the work and the challenge of maintaining personal and professional boundaries. Participants also described how the wellbeing of the public health nurse can be put at risk when families misjudge the actions of the nurse.

Accounts of practice highlighted how working with vulnerable families can present risks to the physical safety of the public health nurse due to being a lone practitioner, working in isolated neighbourhoods or rural communities and sometimes having to visit families after hours. Participants described arriving at people's homes sometimes unannounced, visiting to discuss issues about which families are reluctant to acknowledge or address, and feeling unsafe in relation to factors such as dogs, people taking drugs or alcohol, people unwell due to mental health conditions and encountering situations involving violence or other abuse.

Lily, pg 29 ...When you are working with families you've got dogs, you've got people on drugs, you've got angry relatives, you've got all sorts of people sometimes. And you have to go out there and do these home visits and what have you got?. ... So you know, we are more vulnerable I think sometimes than our community, than our families...

Participants described the emotional burden of working with vulnerable families, of feeling saturated from continually encountering families with ongoing complex issues, and the stress of being confronted by children who have been neglected or abused. They alluded to the depressive effect that this could have upon the public health nurse and recounted how

there are times when nurses can be reluctant to make contact with families because of few positive outcomes and progress being slow.

Caroline, pg 10 ... You know you are wasting your breath sometimes and you get ground down by it sometimes. I wouldn't like to be working in the areas where this is what you faced day in day out. ... one could easily become quite depressed at a continuous flow of families in need, I mean deprived families, or families or children that you can see being neglected.

Marnie, pg 17 / 18 ... There are times when I have to think " I must go and see that family now" and I have to sort of gather myself together to go. Bcause it's your job then you have to take that step and you go and see them. ... and it's not necessarily that you've got a bad relationship, it might just be that they're very hard work and you're not going anywhere fast. ... I guess it's just not seeing positive outcomes...

Participants reported how public health nurses working alone in isolated communities can face families experiencing extreme states of distress and how the action required in these situations may challenge both professional and personal boundaries. For instance, participants described how when living and working in the same community it may be difficult to ensure that issues relating to work with vulnerable families does not impinge on the personal life of oneself and one's family.

Lily, pg 28 ... I think that the vulnerability for nurses is that there is the potential that when you are working with vulnerable families you can't exclude the consequences coming back on you in the community. And it is not only to you but to your family or your children. Because you know in a small rural town there is a lot of gossip there is a lot of talk, there is a lot of misinterpretation. And so sometimes there is a lot of damage can be done to the public health nurse in retaliation. So that is an unpleasant side of the job. A hard part is how do you protect your family when you as an individual deal with these vulnerable families.

Participants also described how public health nurses can be pushed beyond their professional boundaries when faced with the demand of balancing loyalties within a small community. This might involve the expectations of the community extending beyond the scope of the public health nurse's job description. As reported earlier one participant

recounted how it was not possible to attend local tangis despite the fact that this did not align with community protocol. Another participant described being challenged by needing to maintain good will with a school while protecting the trust established with a family.

Angela, pg 12 / 13 ... It was like this huge team of people going to visit the home about this problem child. The idea of taking me was that I already had a relationship with her (the mother) and I might be able to be supportive, but ... it was sprung on me really quickly I didn't think it through. I said "Yes, I'm happy to be supportive." But she didn't see it that way at all. So I blew it big time there.... That's a very vulnerable family and so it wasn't funny. But she just said, " I hate that school you're always picking on him." Then she just turned away and because she's deaf she wouldn't lip read so it's no good talking anymore. ... The school then as a consequence of that, did write a letter saying that they had asked me to be involved because they thought I might be able to be a support person for her in accessing services that might help their family. ... So you know may be it's salvageable in the long run. I don't know. ... You get caught up in it. That wouldn't be how I would normally work. It felt really wrong afterwards ...

Participants talked about 'being taken to the cleaners' when recounting situations where the personal and professional integrity of the public health nurse has been put at risk by families challenging or misinterpreting the support they have been given. They reported how the nurse may unwittingly trigger a negative response from a family or be made a scapegoat for a family's distress and anger at the system generally. Accounts of practice revealed how families can blame the nurse and even take the step of making a complaint. Participants referred to the demands of situations such as these upon professional integrity and the challenge of maintaining codes of practice and respecting others while also protecting oneself.

Stella, pg 30 ...I just feel that we do become vulnerable working in the community through innocent actions sometimes and because people know we are nurses and they ask for advice or you can get embroiled in a situation where you don't intend to do anything. The code of ethics for nurses is that you do stuff with good intention but sometimes good intention by people who are mentally unstable can be twisted. Then we become vulnerable because they

are listened to and they are actually sick and it puts health professionals under great deals of stress. Because a lot of these people are very wiley and they know who to call in the system, they've written many letters and many complaints over the years and the know exactly how the system works and it is extremely stressful for health professionals.

Caring for self

The subcategory *caring for self* refers to participant discussions of the coping and survival strategies employed by public health nurses to deal with the threats to their wellbeing presented by working with vulnerable families. Participants revealed that these strategies relate to processes such as having an outlook on life that helps, recognizing rewards, cutting off at the end of the day and knowing who to talk to for support.

Participants talked about having a particular philosophy, belief or outlook on life that provided the enthusiasm needed to sustain their work with vulnerable families. Participants also referred to the value of maturity and of drawing nourishment from their personal life.

Amber, pg 32 ... Somebody actually said to me ages ago, "If you've got any baggage yourself, you will never cope with it." And I think they might be right because you're actually coping with a lot of baggage of other people. May be that's one of the reasons why a new practitioner might not be able to cope with it all. They might not have the maturity or the experience or they might be still growing emotionally through stuff.

Caroline, pg 18 / 19 .... You know how well you cope yourself with stress or excess workload. Everybody has got a personal life so everybody has got something else they do apart from their job. So it depends on how you cope, how you manage your own life. ...it depends on you as a person. If you are going to be the type of person that tires easily or stresses easily, you are going to be that person that burns out perhaps. ... Whereas another person is going to cope differently I suppose. And I suppose I am quite strong really...

Participants identified how caring for self involved finding a sense of achievement about and of feeling valued for their work with vulnerable

families. Recognizing work accomplished even small steps was considered important.

Sarah, pg 40 ... We don't get many bouquets in public health. Very little. Very few. But you can go home with a clear conscience I think that's the best thing, that you've done the very best that you are able, and if it turns to custard, well there is not another thing that you could have done. ...Not like the district nurses who come in with all this stuff from grateful clients. We never see that. ... Well it's the only reward and you have to have that otherwise you wouldn't survive in the job.

Participants described how it was vital to identify and appreciate rewards even if these might not be concrete or instantly apparent. For example, the gratification of having a previously wary client self refer to the public health nurse, or as one participant who had worked in her area for many years reported, the reward of seeing a once worrisome teenager as a now competent and successful adult.

Gina, pg 29 ...I had one kid many years ago, he was a glue sniffer and he came back to me just a few years ago and he is a handsome able young man now who has got a business of his own. I mean to me that was an absolute thrill. It is fabulous....It was great. ... Another one, I saw her the other day and she is now a school teacher, and that's great. Another one is shearing and I saw her in the queue at the Post Office the other day with her brother and I said "What are you doing?" "I'm making him open his bank account". I said "Good girl. Well done". ...What is good for them is good for me. I did okay.

Participants considered the process of sharing stories of practice as a vital for validating practice and acknowledging achievements. One participant described the experience of being able to recount practice experiences during a workshop with a visiting nursing scholar.

Stella, pg 28 / 29 ...And meeting her was just the pinnacle to me. I'll never ever forget that meeting we had with her. When she asked for stories, no-one had ever asked for stories ever before, it made you feel worthwhile. She listened, she was an academic who listened. She wanted to know your stories. If we'd had more time the flood gates could have opened and the others could have told. They've all got stories.

Participants also identified that processes such as cutting off at the end of the day are a vital aspect of caring for self. For instance knowing how to monitor involvement with a family to protect personal wellbeing, ensuring a clear boundary between one's private and working world by making a clean break from work at the end of each day and taking care not to entangle one's personal life with the dynamics of the community, particularly within rural areas.

Amber, pg 20 ... From a stress management point of view, that's actually a challenge in itself, keeping at an even keel, that you're not going to burn yourself out. I actually think that is a big part of public health nursing. Knowing when you need to back out, need time for yourself or you need to actually say "Look I need to have a really good long walk tonight to defuse." Or you might need to go and walk down by the river or you might need to go to church. You know you need to look after yourself. I think that's a challenge in public health nursing.

Angela, pg 27 ...Some of the stresses I believe are to do with working and living in a small community. And it can be an issue. I've developed some strategies for coping. I bought an answerphone at home, people mostly don't ring me at home but they can just look me up in the phone book you see and sometimes they do. Sometimes teachers do too ... so I've developed things like "Oh look, everything's at work ring my work phone and just leave me a message and I'll sort it when I get there tomorrow." ... Even going to the supermarket sometimes can be a bit of a trial but I know the quiet times to go there. I got to the stage where I felt like I couldn't go out and party or anything locally because people are watching. People comment on what's in my trolley at the supermarket, what does the public health nurse eat, which I find very invasive really. But anyway I've decided that I can be myself and they can like me or not ... since I've adopted that it's a bit more relaxed, ...

The value of knowing who to talk to for support was emphasized by participants as not only important for validating practice and professional guidance but also as an essential facet of self care. Participants described how public health nurses tend to find key people amongst their colleagues and within their communities with whom they can offload and consult and how the needs of each public health nurse in this respect can be different. For instance one participant who is Maori identified the value of finding

appropriate cultural supervision to deal with dilemmas that are unique to Maori.

Michelle, pg 18 ... I suppose about three years ago I just came to a stage in public health where I needed to go to somebody just for counseling really. And I totally believe that professional supervision but even more so cultural supervision has been something that I have been just so really in need of. ... with my colleagues. ... It's that working culturally with Maori, you know, because there are dilemmas that I face often as a Maori public health nurse.

Participants highlighted the need to feel safe within and not judged when seeking the support of others.

Stella, pg 30 ...Nurses need to know who to go to for their own safety and they shouldn't be made to feel that they are at fault. And may be even if they are at fault, none of us are perfect and all of us have done wrong things somewhere along the line or done regretful actions because we are humans. They need to be able to talk that through to someone who is understanding and experienced and not blaming

Participants were clear about the need for on going clinical supervision to provide a safe process of professional and personal support and were concerned that this had not been put in place by their organization.

Lily, pg 28 ...I wish that public health nurses could have supervision outside the agency they work for so that they could be able to talk about the frustration and the dynamics of community work. ... I think for new public health nurses we need to have supervision so people can actually take that to a supervisor and say "I'm feeling like this and I'm a bit scared about retaliation or I'm a bit scared about this, what'll I do?". ...

Gina, pg 25 / 26 ... At Mental Health, they have supervision every week. It is compulsory. They have as long as they need but it is usually a good two to three hours every week. But we just talk to each other. I think I would prefer to speak to a Psychiatrist, or someone within that field, or a psycho-analyst. Someone who would be able to turn it around, put something another way and look at it from a different point of view, but say what they say with knowledge.

Summary

The findings presented in this chapter emerged from qualitative data that was analysed using a general inductive approach. The aim of the study was to describe how public health nurses work with vulnerable families and factors enhancing and constraining this process. The researcher was also interested in how public health nurses define or refer to the vulnerable families in their care.

The findings identify that public health nurses view family vulnerability as a continuum that might involve a single episode or multiple issues which are continual and compounding. It was apparent that an important factor influencing this view of family vulnerability encompassed the fear that families have of those in authority and of their trust being broken. Participants were also clear that vulnerable families can come from all sections of the social strata.

It was revealed that working with vulnerable families encompasses processes such as building trust and encouraging strength, and that this is tempered by the need to prioritise the wellbeing and safety of the children involved. The findings revealed that the process of working with vulnerable families is enhanced when public health nurses are embedded within the community, are experienced and can draw on the experience of others and are determined to make a difference.

Factors constraining practice were identified as families being unwilling or unable to respond to the assistance provided by the public health nurse, the impact of the business model and the frustrations of dealing with the Child Youth and Family Service. The findings also highlighted how public health nurses may themselves become vulnerable as a result of working with vulnerable families and illuminated how nurses care for themselves and require support from others in the face of this challenge.

The following chapter discusses these findings in depth. Key outcomes are identified, and links made to the literature. The question of whether

the work of public health nurses with vulnerable families aligns with a health promoting model of care was of particular interest to the researcher. This question is also addressed in the next chapter.

CHAPTER FIVE

DISCUSSION

The previous chapter presented the findings from this study. The research process involved a qualitative descriptive design and the data was analysed using a general inductive approach as recommended by David Thomas (2004). This resulted in the development of five main categories or themes each supported by a number of sub categories which were presented in the previous chapter. The following chapter provides an overview of each of these categories with discussion that relates the findings to the literature.

The purpose of this research was to describe how public health nurses work with vulnerable families and factors that enhance and constrain this process. The researcher was interested in whether the way public health nurses work with vulnerable families aligns with a health promoting model of care as described by Hartrick (1997a) and Doane and Varcoe (2005). This question is referred to throughout the discussion and in particular in relation to the categories: **working with families** and **being constrained**. Another item of interest for the researcher related to how public health nurses define and refer to the families in their care. This meant that the term vulnerable families was not predefined prior to the study but was rather self nominated by the participants. **Vulnerable families** consequently became one of the main categories or themes in the findings.

This discussion of the findings begins with the main category of **vulnerable families** and the sub categories that support it. The discussion will then proceed through each main category and their related sub categories. The important findings relating to each category will be summarized, and key outcomes identified. This will be followed by a

discussion of significant points emerging from each category with links to the literature.

Vulnerable Families

Participants in this study revealed the meanings they attach to the concept of 'vulnerable family' through the rich descriptions they offered of families in their care. The four key ways of delineating the term **vulnerable families** that were identified in the findings illuminated an understanding of vulnerability as a complex and dynamic process. The findings also indicate that the way public health nurses name and define the families they work with has implications for the approach taken in practice.

Only a season in their lives

One way that participants in this study viewed the concept of 'vulnerable family' was as a temporary disruption to a family's equilibrium caused by a particular health or social situation. The wellbeing of the whole family may be challenged by an issue affecting one family member or an event may arise which directly impacts on each member of the family. Participants identified that every family can be vulnerable at certain stages of its lifecycle.

Reference in this study to vulnerability as a season in a family's lifecycle is endorsed by similar references in the nursing literature. The notion of vulnerability as a continuum has been identified by a number of authors and researchers (Copp, 1986; Lessick, Woodring, Naber, & Halstead, 1992; Rogers, 1997; Rose & Killien, 1983). The dynamic nature of this vulnerability which changes in response to the stressors emerging from the events, phases and transitions of the life cycle has also been recognized (Appleton, 1996; Rogers; Rose & Killien). The relevance of this approach for community nursing contexts has been well explored in the United Kingdom with studies focusing on the work of health visitors, a community nursing role that has similarities to the New Zealand public

health nurse (Appleton; Newland & Cowley, 2003). In a discussion of nursing research with vulnerable families Feetham and Deatrick (2002) confirm the current trend to consider vulnerability as a dynamic process that changes over time, and identify that this calls for an exploration of strategies that focus on strengthening families, and an understanding of vulnerability from the perspective of the families themselves in order to resource this approach to practice.

Sellman (2005), in a philosophical analysis of the concept of 'vulnerability' as it relates to nursing practice, also emphasizes vulnerability as a common human experience. Sellman however cautions that the inherent nature of vulnerability means that the term can be vague and ambiguous when applied to the recipients of nursing care. Appleton (1999) contends that due to its tendency to be abstract and even nebulous, the concept of vulnerability can have diverse meanings for different professionals; hence the need to temper the tendency to apply predetermined assessment tools to identify family needs. Spiers states that the notion of vulnerability as universal to all human beings, reflects an emic or subjective approach to this concept; that vulnerability is a lived experience that must be described from the person's perspective. This would appear to have relevance for including client or family derived definitions in contracts underpinning public health nursing practice.

The description of family vulnerability as a phase in the family life cycle indicates that public health nurses approach their clients with the understanding that families have resources and strengths that can buffer their experience of adversity. This notion of resilience has been well addressed in the literature (Hawley, 1996; McCubbin & McCubbin, 1993; Patterson, 2002; F. Walsh, 1996), and tends to reflect a strengths based approach to family nursing (Doane & Varcoe, 2005). However, Spiers (2000) emphasizes that there is a subtle difference between perceiving those who are vulnerable in terms of risk, and perceiving vulnerability in relation to quality of life and that this has an impact on whether practice is approached from a deficit or a capacity building perspective. Appleton highlights the negative associations attached to labeling families as

vulnerable and suggests 'families in need of support' as a more realistic and inclusive term. Alternatively there is evidence that a term such as 'high priority' families may be preferable as a more positive way of referring to families needing focused care within a community context (Mulcahy, 2004). It has been suggested that the way nurses define or refer to their clients determines the approach taken in practice (Doane & Varcoe; Koakinen et al., 2004). It would thus seem relevant to reconsider the use of the term 'vulnerable families' in the light of whether this is appropriate for encouraging health promoting practice.

Having multiple issues

Participants in this study identified that while family vulnerability may arise due to a particular situation that is eventually resolved, this vulnerability can also relate to an ongoing lack of cohesion due to multiple, chronic, compounding and unresolved issues. The complexity of this aspect of family vulnerability was made explicit through the stories participants provided of their practice. Pictures emerged of families coping with and being overwhelmed by the interplay of numerous factors in their lives. These issues may have been entrenched and have remained unresolved within families over generations. Terms such as 'at risk, 'high need' ' or 'dysfunctional' were used by some participants when referring to vulnerable families. This indicates the realistic view of families adopted by public health nurses and the need to consider the significance of these issues from the perspective of protecting children from existing or potential abuse and neglect. These findings as well as other research indicate that a relational practice approach needs to be balanced with a realistic consideration of context in terms of risk.

A number of studies of family nursing within a community context have identified family vulnerability in terms of multiple factors impacting on family wellbeing, and the complexity of the interrelationship between these factors (Appleton, 1996; Mulcahy, 2004; Newland & Cowley, 2003; Williams, 1997). This reflects an epidemiological perspective which focuses on the wider social determinants of health and centres around the

notion of 'risk' (Shaw, Blakely, Atkinson, & Crampton, 2005). An epidemiological approach to vulnerability involves an objective evaluation of demographic factors and their implications in terms of harm to the wellbeing of individuals or groups of people (Aday, 2001; Demi & Warren, 1995; Rose & Killien, 1983).

Spiers (2000) cautions that applying an epidemiological lens to vulnerability may carry certain assumptions and imply social norms about human functioning that influence how nurses approach their practice. This is endorsed by evidence that using screening tools and check lists to identify issues relating to vulnerability can over emphasise these factors and ignore the protective factors within families such as social support and cohesion (Barker, 1996; Cowley & Billings, 1999; Crompton, Davies, & Humphris, 1998; Hall & Elliman, 2003). Etic notions of vulnerability (those focusing on external factors) emphasise prescribed definitions of the level of harm or threat warranting intervention and require that those in authority decide whether intervention or assistance is valid (Spiers). This can be mirrored in the use of language which labels and imposes a negative frame of reference upon families, positioning clients as victims. There may be a tendency to adopt a deficit, problem focused approach to working with people rather than one that highlights strengths and values people's perceptions and realities (Doane & Varcoe, 2005).

Scott (2003) however has emphasized that it is necessary to have clear guidelines around definitions of vulnerability when considering risk in relation to child protection. As demonstrated in this study, public health nurses are constantly balancing the needs of the family with the needs of the child when determining priorities in relation to family vulnerability. The tendency to refer to families in terms of risk may in fact be a necessary aspect of maintaining a focus on the potential or actual vulnerability of the child within a family.

Having a fear of trust being broken

In this study participant descriptions of the nature of vulnerable families included the public health nurse's perceptions of the family's own

experience of this vulnerability. For instance, participants observed that vulnerable families may experience a fear of trust being broken, are wary of others putting power over them, can have a negative vision of themselves, and are reluctant to be identified by others to be in need of assistance. These descriptions of families highlighted how meanings attached to vulnerability are thus subjective and need to be defined by the family itself. Participants recognized that the full reality of a family's vulnerability may not be immediately apparent to an outsider such as the nurse, or revealed by a family. To understand the family's experience of their situation public health nurses were aware of the need to step inside the family's reality. In practice this is encompassed in the way public health nurses work in partnership with families and encourage them to identify their most pressing needs

However, as the participants in this study described their practice, they revealed how having an openness or accommodation to the family's sense of its own needs is tempered by the public health nurse's vigilance in terms of child safety and the risk of possible abuse and neglect. It was apparent that public health nurses are constantly balancing perceptions of vulnerability as defined by the family with predefined criteria that determine whether a child's safety is under threat. A continual interplay between these two factors means that family vulnerability is a dynamic concept for the public health nurse and one that is constantly changing.

The findings from this study illuminated how an understanding of the nature of a vulnerable family's lived experience is important for knowing how to approach and work with vulnerable families. This reflects an emic or subjective perspective in which vulnerability is conceptualised in terms of an individual's perception of challenges to self, and their capacity to protect themselves from this threat (Spiers, 2000). Fundamental to this lived experience is the assumption that being vulnerable is part of being human, and that this phenomenon is unique to each individual and not able to be quantified (Spiers). Sellman (2005) however cautions against a view of vulnerability that is purely subjective because this does not account for those who are unable to recognize, articulate or act in response

to this vulnerability. This has relevance for the challenge public health nurses face when balancing the vulnerability of the child with that of the family. Although the experience of the family is an important factor when determining family vulnerability, the risk to the wellbeing of the child is paramount. Spiers suggests that practice realities such as this can be accommodated by adopting a view of vulnerability that encompasses both an etic and an emic perspective which enables vulnerability to be considered both qualitatively and objectively. This has implications for enabling both the health promoting practice and child protection components of public health nursing practice with vulnerable families.

All families are vulnerable

Participants in this study were clear that vulnerable families can be found in all sections of the community. While the families referred to in this study were generally those facing deprivation in terms of income, housing, employment, education, and access to health services, participants emphasized that higher socio economic families can also be vulnerable, particularly in relation to factors such as substance abuse, emotional isolation and physical and sexual abuse. Descriptions of families encountered in practice showed that regardless of socio-economic background the primary focus when determining what constitutes family vulnerability is the safety and wellbeing of the child within the family.

The findings from this study revealed how public health nurse perceptions of vulnerability were not determined by predefined criteria but tended to emerge directly from their experience of working within communities. Descriptions of practice showed how family vulnerability is continually defined and redefined in partnership with the community: between the school and the nurse, the school and the family, the nurse and the family and more specifically by the family itself. Participant accounts illuminated how public health nurse perceptions of what constitutes a vulnerable family can differ in relation to the particular population and community context within which they work. Thus public heath nurses

draw on their experience of working in communities and with families to give meaning to the concept of 'vulnerable family'.

The way public health nurses conceptualize vulnerable families in relation to community need and draw on their network of connections to inform this process has been articulated in the literature (Gallaher, 1997; Green, 1993; Rafael, 1999a; Reutter & Ford, 1998; SmithBattle et al., 1997; Zerwekh, 1991b). Similarly nurse researchers involved in determining the nature of vulnerable populations advise that this process should encompass a dialogue that takes place within the context of family, culture and community (Feetham & Deatrick, 2002). This community driven, grass roots approach has been recognized as the essence of health promoting practice (Doane & Varcoe, 2005). Thus a significant outcome of this study is that public health nurses are positioned within communities in ways that enable a community driven approach to identifying family vulnerability.

The descriptions of family vulnerability reported by the participants in the present study reflect an openness to the unique reality of each community and each family. However these findings also illuminate that public health nurses are continually faced with the tension between aligning practice with predefined concepts of need as identified in the contracts or concepts of vulnerability as they emerge from the community. Studies from the United Kingdom reveal that Health Visitor perceptions of vulnerability had different meanings for practitioners depending on the socio-economic area in which they were practicing (Appleton, 1999; Williams, 1997). A New Zealand study which explored the needs of Plunket families in relation to predefined areas of deprivation established that nurses identify disadvantaged families within the whole spectrum of the community and confirmed that confining practice to predetermined criteria relating to deprivation and risk can limit the potential for nurses to identify and reach families in need (Macfie, 2006). It is thus important that concepts of vulnerability governing public health nursing practice reflect the reality of the communities within which they work. One of the recommendations of this study is that Ministry of Health and local

organizations work with public health nurses to define concepts of vulnerability that can then be incorporated into the policy and contracts underpinning public health nursing practice.

Working with Families

As outlined in the first part of this chapter, the participants in this study revealed that public health nurses are acutely aware of the reticence and sensitivity experienced by vulnerable families, of the multiple factors contributing to their vulnerability, and the ways that this vulnerability may compromise the wellbeing and safety of children. Accounts of working with vulnerable families illuminated how public health nurses accommodate for the susceptibility and risk inherent within this vulnerability by drawing upon the capacity of families to become empowered, through strategies such as building trust and encouraging strength. It is thus clear from these findings that public health nurses employ a health promoting approach when working with vulnerable families. However it was also apparent that this process is tempered by the need to prioritise the safety and wellbeing of the children involved.

A significant factor emerging from this study was that working with vulnerable families requires a process that is unique to the situation and experience of each family. When recounting how they work with vulnerable families, participants described a subjective and contextual approach which acknowledges the position of families as private citizens, the unique history and circumstances of each family, and the delicacy required to work with vulnerability. Descriptions provided by participants illuminated how public health nurses are constantly striving to understand and tailor their practice around the reality of each family and that working with families is essentially a family driven process. This finding reinforces a dominant theme emerging from this study: that the nature of the family determines the nature of the practice. Thus working with vulnerable families is essentially an unpredictable process unique to each family and as such cannot be predefined or prescribed.

When participants described their work with vulnerable families they emphasised how the way public health nurses have access to vulnerable families has a significant influence upon the potential to build trust and initiate strategies to address deeper issues faced by families. This factor will be introduced in this part of the chapter and then further discussed later when exploring factors that enhance and constrain practice.

This section of the chapter will now examine how public health nurses work with vulnerable families by building trust, encouraging strength, and making the child the priority and highlight how these processes align with a health promoting model of care and are facilitated by adopting a family centred approach and having regular and ongoing access to families.

Building trust

Participants in this study revealed that a considerable component of their work with vulnerable families relates to creating a trusting connection with families – a process which has been identified as the foundation of a health promoting model of care (Doane & Varcoe, 2005). That trust is crucial when families are vulnerable was apparent when participants described the persistence required to establish and maintain a connection with a family and the carefully considered and sometimes innovative strategies employed by public health nurses for approaching people on their own terms. Participants recounted how public health nurses continually work to be non threatening by positioning themselves alongside a family in a relationship something akin to being a friend – albeit with the boundaries of a professional friendship. Findings from this study highlighted the time and care involved in building trust and forging relationships with vulnerable families which is evidence of the unpredictable and indefinable nature of this work.

In this study, stories of working with families revealed that the way public health nurses have access to vulnerable families may impinge on the process of building trust. Accounts of practice showed that time is

required to develop and sustain relationships with vulnerable families. It was apparent that this involved visits of significant duration, and numerous visits sustained over an extended period of time. Participants described how with child health concerns in particular, the relationship with a family might consist of successive episodes of contact in response to a series of referrals over time. With each referral the nurse worked to build the connection with the family further so that the relationship gradually evolved. Participants recounted how the family might then feel confident about sharing underlying factors impacting on their wellbeing and be open to exploring their health experience further with the nurse.

However accounts of practice illuminated how contact with families resulting from referrals can tend to be incident focused and problem orientated. While two of the ten participants in this study still retained an infant welfare workload and were thus able to visit these families in a routine non threatening way on a regular basis, for most participants access to vulnerable families occurred mainly through referrals from schools and other professionals, or through factors such as communicable disease case work. Compared to the access provided by the regular nature of infant welfare visits, an incident focused approach can mean that there may be less opportunity to continue contact with a family once a particular episode of care is completed. Also stories shared by participants showed how when families have not been consulted by the referral agent as to the reason for a public health nurse visit (as with referrals from the dental therapist and outpatient clinics), or the public health nurse is unknown to the family, there is the risk of 'cold calling' carrying overtones of fault finding and enforcement that can intimidate families. While the participants in this study were all experienced practitioners with resources and skills to accommodate for this, it was apparent that at times the context within which vulnerable families were accessed presented major challenges in terms of being able to forge the relationships of trust required to assist vulnerable families to work through complex issues. Thus the way public health nurses have access to families may have implications for building trust and ultimately for the

potential to address the deeper factors contributing to family vulnerability.

This study resonates well with other New Zealand and international research into public health nursing practice which highlights that the connection public health nurses have with families *is* the work (Gallaher, 1997; Green, 1993; SmithBattle et al., 1997). These and other studies also emphasise the challenges inherent in approaching vulnerable families and the need to skillfully manage the transition into the family's world by understanding a family's reality and building trust (Gallaher; Green; O'Sullivan, 1993; Pybus, 1993; SmithBattle & Diekemper, 2001; Zerwekh, 1991c). The value of creating an equal partnership similarly features strongly in other research (Falk-Rafael, 2001; Gallaher; Green; Langlois, 1997; Leipert, 1999; Paavilainen & Astedt-Kurki, 1997; Pybus; Rafael, 1999b; SmithBattle et al.). These studies highlight the emphasis on respect, empathy and sharing of power that emerges in the present study. The need to connect with families over time in order to build trust and enable an effective working partnership and the value of this sustained connection working on deeper issues with a family, is also a common feature emerging from studies into public health nursing practice (Gallaher; Green; McNaughton, 2000; Pybus; SmithBattle et al.).

It is interesting to note how the pattern of contact with vulnerable families described in the present study compares with the other studies particularly in the area of child health. Research describing access to vulnerable families through routine maternal, infant and preschool child home visits identifies a non- threatening and sustained process of regular contact with families which facilitates an understanding between the nurse and the family of a relationship that is ongoing (American Academy of Paediatrics, 1998; McNaughton, 2000; Olds et al., 1997; Pybus, 1993). New Zealand studies describing contact with families emerging from school and other referral sources however, describe a less predictable relationship with contact constantly having to be negotiated with the family (Gallaher, 1997; Green, 1993). The more intermittent and unanticipated nature of the contact referred to in these studies mirrors

the findings of the present study and possibly reflects changes to the service provided by public health nurses within New Zealand over the last fifteen years. How this may have implications for working with vulnerable families will be further discussed later in this chapter.

Encouraging strength

Findings from this study reveal that the approach taken by public health nurses when working with vulnerable families is one of *encouraging strength* and that this process embodies a philosophy of respect and empowerment. Descriptions of practice showed how the process of encouraging strength encompassed a way of being with families that valued their privacy, autonomy and experience as well as their potential – factors which support a health promoting model of care (Doane & Varcoe, 2005). Participants constantly referred to the value of presenting oneself and responding in an encouraging way when working with vulnerable families. A positive, supportive and respectful approach was deemed necessary in order to work sensitively with the delicate aspects of family vulnerability and also as a vehicle to support change. Participants explained how being encouraging enabled a family to gain confidence not only in the nurse but also in themselves. For instance stories of practice revealed that as well as easing factors that might be threatening for families and assisting the public health nurse to enter the family's world physically and socially, *encouraging strength* was also a way of motivating a family to connect with their needs and capacities. Accounts of practice illuminated how by striving to be positive, reassuring and convey a sense of hope and possibility, public health nurses were able to foster a family's ability to help themselves. Participants described how this might involve recognizing and validating the family's resources and achievements no matter how small or it might involve spending time with families listening, empathising, reflecting back and affirming possibilities. By allowing space for the family to become aware of their needs and determine viable options for the future, public health nurses encouraged families to connect with their capacity to overcome obstacles. These findings show that when public health nurses adopt a constructive and

supportive stance toward families they are working in a health promoting way, and that not only is this approach vital for creating a working partnership, it is instrumental for empowering families to identify their strengths.

Findings from the present study have however illuminated how the extent to which public health nurses were able to engage a family in the process of encouraging strength tended to depend on the level of involvement with the family. Numerous studies illuminate how it is a trusting relationship which provides a safe container within which this process of empowerment can take place (Gallaher, 1997; Green, 1993; Jakonen et al., 2002)j(Langlois, 1997; Leipert, 1999; O'Sullivan, 1993; Pybus, 1993; SmithBattle et al., 1997; Zerwekh, 1991b, 1992a, 1992b). In this study examples of practice situations reveal that because contact with families is mostly referral focused, it tends to be erratic and not necessarily sustained. Public health nurses are thus drawn to find innovative ways to build a working partnership with families, often capturing moments as they arise, even if this is on the door step, in the school grounds or in the shopping centre. It is interesting to note how public health nurses in this study were able to adapt their practice in this way, a factor which reveals how intrinsic this approach is in their work with families. However, although these findings demonstrate that *encouraging strength* is a flexible process that nurses can bring to every situation or context in which they interact with families, there are limits and obstacles that emerge when access to families is constrained. This will be further explored later in this chapter.

In this study a health promoting approach was evident in the way nurses positioned themselves in relation to 'working with' rather than 'doing for' vulnerable families. Participants in this study described how the public health nurse works beside a family, taking the role of an ally, bolstering the family and supporting their journey. While the family's perceptions and experience direct the process, the nurse gently steers the course of events. Participants explained how *encouraging strength* involves a flexible approach with both parties taking the lead at certain times. For

instance sometimes when families were overwhelmed, in crisis, or there were issues of safety or urgency, public health nurses became more directive in their role with families. This partnership approach also encompassed the process of involving others: assisting families to access the support of appropriate agencies and services. Participants referred to the brokerage role of the public health nurse and the value of being part of a team supporting a family; that this is an essential component of working with the multiple issues faced by vulnerable families. Accounts of practice illuminated how at best, the partnership approach adopted by public health nurses when working with vulnerable families enabled families to take ownership of the process involved, a strategy that resonates with the philosophy of health promotion (Doane & Varcoe, 2005).

Findings from this study revealed how the process of *encouraging strength* is driven by the needs and circumstances of the family and as such is a process that cannot be forced and thus predetermined. For instance participants described the importance of beginning with the issues the family believes to be the most pressing, and of encouraging the family to be the decision maker. Participants also described working at a pace determined by the family. Accounts of practice highlighted situations where it was necessary to stand back and wait until the time was right from the family's perspective, and be ready to capture moments when a family was open to respond, such as when a crisis precipitated a way out of a situation that had been overwhelming a family. These findings illuminate how practice is determined by the family and that flexibility around time frames and outcomes is required when working with vulnerable families.

These findings resonate with previous New Zealand and overseas studies which refer to how public health nurses use similar processes to focus on encouraging strength and empowering a sense of control when working with vulnerable families (Gallaher, 1997; Green, 1993; Jakonen et al., 2002; Pybus, 1993; Rafael, 1999a; Reutter & Ford, 1997; SmithBattle et al., 1997; Zerwekh, 1992b). The way public health nurses shape their practice around the realities of people's lives rather than preconceived

solutions is also a dominant theme in the public health nursing literature (Gallaher; Green; Pybus; Reutter & Ford; SmithBattle & Diekemper, 2001; Zerwekh, 1991b).

An emphasis on partnership and collaboration which emerged as a significant aspect of encouraging strength in the present study, is a common theme in the literature (Green, 1993; Jakonen et al., 2002; O'Sullivan, 1993; Pybus, 1993; SmithBattle et al., 1997; Zerwekh, 1991b, 1992b). These studies also refer to the intermediary role taken by public health nurses when negotiating multiple forms of support and services to assist families. While some authors have emphasised the case management aspect of this work (Kellogg, 1995), the findings from the present study tend to highlight a team approach, with shared goals and responsibilities. The Strengthening Families process which is now common within New Zealand emphasizes a collaborative approach with the family being encouraged to take responsibility and become empowered (Ministry of Health, 1996). The family, the public health nurse, other services and professionals are all involved, with the family positioned at the centre of this process as the key decision maker.

The relational and capacity building approach referred to in the present study and the literature above, aligns with a health promoting approach. Doane and Varcoe (2005) identify processes such as 'entering into relation, being in collaborative relation', 'inquiring into the health experience of the family', 'following the lead of families', 'listening to and for', 'letting be', 'pattern recognition', and 'naming and supporting capacity' as encompassing a health promoting model of care (p. 228). Similar processes are clearly evident in the findings of the present research.

Making the child the priority

The findings from this study revealed that while the process of *encouraging strength* involves supporting the family to become empowered, the paramount concern is with the wellbeing and safety of the children involved. Participants emphasized the goal of *making the child*

the priority as an ethical principle guiding safe practice and as the source of the determination required to sustain their commitment to the work with vulnerable families.

Descriptions of practice showed how public health nurses continually strive to keep the child's wellbeing at the forefront of their work with vulnerable families. Stories from participants highlighted the public health nurse as a vigilant observer on high alert to ensure that the child's health and safety was not threatened by giving primacy to other issues faced by the family. Accounts of practice also illuminated how working to protect children is a complex and delicate process. Participants identified that often the best strategy is not clear, particularly in cases where the issue is one of neglect (rather than physical and sexual abuse which have a clearer decision pathway). Participants described how public health nurses are continually evaluating strategies as to the best outcome: whether it may be necessary to step forward and be directive rather than working at a pace the family desires; whether reporting to the child protection agency is required; or whether finding other support and ways to strengthen the family is a preferable strategy. Thus working in a health promoting way with vulnerable families is not straightforward but requires constant vigilance to prevent dangerous practice (Morrison, 1995,).

Participants referred to being an advocate as the most important aspect of this work – that this involves working on behalf of the family or the child to further the interests of the child. The term 'battling' was repeatedly used by participants which provided an image of the public health nurse as a crusader, fighting battles for the cause of the child and sometimes going beyond their role to do so. Participants recounted how this might involve carrying an issue forward to community or government agencies or even further to politicians, or negotiating with a family to ensure a child's wellbeing. Stories of practice illuminated how protecting the child could involve being prepared to be up front with families and how this might even require jeopardizing the relationship with the family which could be a demanding experience for public health nurses. Participants

illuminated how working to protect the rights and wellbeing of children within vulnerable families carries significant tensions and challenges and thus requires support, determination and clinical expertise.

These findings align with literature that highlights the vigilance needed to prioritise the needs of the child when working with vulnerable families (Appleton, 1994b; Dale, 1986; Gallaher, 1997; Green, 1993; Langlois, 1997; Ling & Luker, 2000; O'Sullivan, 1993; Pybus, 1993; Taylor & Tilley, 1989; Zerwekh, 1991b). These and other studies emphasise the advocacy role involved and the political and ethical dimensions that this can encompass (Langlois, 1997; Pybus; SmithBattle et al., 1997; Zerwekh, 1992b). The challenges inherent in the child protection work are also referred to in the literature: the difficulty of assessing neglect; the decision making around supporting the family yet prioritizing the child; and the possibility of having to betray trust built up with the family when referring to the child protection agency (Appleton; Brocklehurst et al., 2004; Browne, 1995; Langlois; Liaschenko, 1994; Marcellus, 2005; Peckover, 2002; Taylor & Tilley, 1989; Zerwekh). These findings are endorsed by recent research by Doane (2002) who has identified how moral decision making for nurses is complicated by the contextual and relational nature of their every day practice.

The cautions encompassed in integrating child protection accountabilities with the relational and family centred approach encompassed in a health promoting model of care has been linked to the concept of 'professional dangerousness' (Morrison, 1995, p. 16). This phenomenon refers to situations whereby individual workers are unwittingly drawn into the powerful process of abuse that may be present in a vulnerable family as the relationship is fostered with the people who are the perpetrators of the abuse and not the victims (Dale, 1986; Morrison; Taylor & Tilley, 1989). This situation may involve nurses desperately attempting to meet the parent's needs for dependency by providing material resources, encouraging parenting skills and building self esteem; but in the process ignoring the needs of the children (Children and Young Persons' Service, 1995). The nursing literature highlights the challenges encompassed in

the split loyalties that can be involved when balancing a supporting and surveillance role, and the issue of becoming torn between an obligation to the relationship with the parents, and the need to protect the rights of the child (Gallaher, 1997; Marcellus, 2005; Oberle & Tenove, 2000; Peckover, 2002; Pybus, 1993; Zerwekh, 1992b, p. 104). The literature also outlines how this challenge is further complicated by the fact that in these situations the nurse has had time to build up a relationship of trust with the family and is faced with the possibility of having to betray this trust and appear to abandon this relationship, if he or she decides to refer on to the child protection agency (Appleton, 1994b; Brocklehurst et al., 2004; Dale, 1986; Liaschenko, 1994; Peckover; Taylor & Tilley).

Morrison (1995, p. 16) emphasizes the need for clinical supervision to prevent dangerous practice. Support for nurses in the face of the moral distress that can result from the ethical challenges of child protection work has also been recognized (Marcellus, 2005; Oberle & Tenove, 2000). This recommendation is endorsed by the nursing literature which highlights the risks for safe practice and personal wellbeing inherent in the isolated and often disturbing nature of child protection work (Butterworth, 1988; Farrell, 2003; Zerwekh, 1991a). A strong message emerging from the literature is that nurses working with vulnerable families should be supported by 'high quality, regular and frequent clinical supervision' (Brocklehurst et al., 2004, p. 178; Butterworth; Farrell; Oberle & Tenove).

The findings from this study reveal that while a relational and family centred approach is optimal when working with vulnerable families, this must be tempered by ensuring the needs of the children involved are a priority. The findings also illuminated the ethical challenge of maintaining health promoting practice while ensuring that the needs of the child remain paramount. Therefore when considering these findings in the light of the literature discussed above, it is recommended that public health nurses are provided with a formal process of clinical supervision to resource and support the child protection component of

their work with vulnerable families. This will be discussed further on pages 142 and 143.

Enhancing Practice

Participants in this study referred to *knowing and being known by the community*, *drawing on experience* and *being determined to make a difference* as essential to enhancing the quality of their work with vulnerable families. These factors had implications for accessing families, building trust, recognizing and responding to family concerns, and for sustaining a commitment to the demanding and often disturbing nature of the work. It was apparent that time in the role of public health nurse and within a particular community is required to build the connections, credibility, knowledge, skills and commitment that facilitate the process of working with vulnerable families.

Knowing and being known by the community

Participants revealed how *knowing and being known by the community* encompasses the process of creating networks and building trust at a grass roots level within a particular community. Descriptions of practice illuminated how this encouraged a relational, family centred and empowering approach to working with vulnerable families. Knowledge of family history, community dynamics, local services and support networks heightened the ability of the nurse to respond to families more promptly, appropriately and sometimes more safely. The public health nurse's familiarity with, and visibility within the community, facilitated referrals to nurse, the readiness of families to trust, access to agencies and services, and the potential to extend practice to address deeper issues with families. These findings illuminated how the connections and credibility that a public health nurse establishes within a particular community provide a foundation for adopting a health promoting approach when working with vulnerable families.

It was apparent that the process of becoming embedded within a community could not be fast tracked. Participants revealed how it can

take two years to become known and valued within a community and that this involves strategies such as being visible, particularly in the schools; being available to reciprocate and participate in ways deemed appropriate by the community; and proving oneself dependable and trustworthy. The process of 'knowing and being known by the community' was enhanced when nurses had a history within their practice area.

For instance the majority of participants in this study came from rural areas where they had created strong connections community wide and with particular families, which extended back many years. They believed that this familiarity carried them across the threshold of homes and eased links with local support networks and services. Participants talked about feeling confident about services and agencies through past experience and how this enhanced the process of being able to support families effectively. It was clear that *knowing and being known by the community* is an organic process that requires availability, flexibility and above all time within the particular area.

It is possible that being well established within a community may accommodate for the decreased scope of practice brought about by constant changes to the public health nurse role during the last fifteen years. For instance having strong links within a community may compensate for the loss of infant welfare work which traditionally has served as a routine and non threatening passport to vulnerable families and a way of facilitating in-depth and preventative work with families. However, while this may be possible in rural areas where public health nurses have often lived and worked for many years, and where communities are smaller and more contained, it may be less feasible within urban areas where community boundaries are more fluid and the infrastructure more complex.

This evidence aligns with numerous studies from the nursing literature that highlight the unique position that public health nurses have within communities and the value of this for enhancing the work with vulnerable families (Gallaher, 1997; Green, 1993; Jakonen et al., 2002; Leipert, 1999;

Meagher-Stewart, 2001; Rafael, 1999a; Schulte, 2000; SmithBattle et al., 1999; SmithBattle et al., 1997; Zerwekh, 1991b, 1992a). These studies emphasise the time required to become trusted by and familiar with a community, and the significance of this connection for developing the relational and contextual knowledge required to access and respond appropriately to vulnerable families.

Thus one of the key outcomes from this study is that the process of working with vulnerable families is facilitated when each public health nurse is situated within and responsible for a particular defined geographical community, and that public health nurses require time within this community in order establish and draw upon the infrastructure required to work effectively with vulnerable families.

Drawing on experience

The findings from this study illuminated that public health nurses draw on their own life and practice experience and the experience of other professionals to resource their work with vulnerable families. Accounts of practice showed how drawing on experience in this way facilitated the processes of recognizing and responding to family vulnerability, navigating practice boundaries and identifying appropriate strategies to assist families. This supports one of the key findings emerging from this study: that time spent working within a community gaining first hand clinical experience as a public health nurse enhances the potential to work in a health promoting way with vulnerable families.

Participant accounts from this study illuminated how working with vulnerable families is enhanced by past professional and life experience, and in particular time spent 'in the field' as a public health nurse. Stories of practice revealed how public health nurses use relational and intuitive skills to identify signs and patterns and draw on both their personal and past clinical experience to confirm and understand their perceptions. One participant referred to this process of reading a family as 'having public health nurses eyes'. Participants recounted how, over time, public health

nurses develop confidence in their ability to acknowledge and trust these insights. Descriptions of practice also illuminated how public health nurses drew on past experience to manage the boundaries of practice. For instance: ensuring safe practice around working with the family and protecting the child, knowing the limits of the service a public health nurse can provide to a family, balancing the expectations of the community with the constraints and responsibilities of the job description or working creatively with contracts and practice pathways. Participants were clear that dealing with the tension relating to these boundaries requires prior experience as a public health nurse and of working with vulnerable families.

Accounts of practice revealed how public health nurses also draw on the experience of others to enhance their work with vulnerable families. Participants highlighted the value of consultation with colleagues, other trusted professionals and community members to ensure safe practice, share knowledge and resources. The support of the nursing team was considered crucial. Participants emphasised the importance of drawing on one's nursing peers to explore practice strategies and ensure safe decision making and described consciously choosing experienced colleagues when requiring this assistance. The value of formal processes of peer support for encouraging the sharing of this expertise was affirmed. Participants stressed the need for depth of experience (team members with years and time spent in the field as a public health nurse) within the public health nursing workforce to sustain the quality of practice within the team and to mentor fledging practitioners. Thus a key recommendation emerging from this study is that experienced public health nurses are valued, retained and provided with training to facilitate the process of providing peer support to their colleagues.

Participants also recognized that drawing on experience to support their work with vulnerable families encompassed accessing professional supervision from outside the nursing team. Participants shared how peer support could at times be limited by colleagues not being available, being burdened by their own stressful case loads, or by not having the expertise

to advise another about complex cases. The need for access to individual clinical supervision sessions facilitated by a professionally trained supervisor to assist with decision making with complex case work was thus clearly identified.

The findings from this study align with previous research which has revealed how the process of working with vulnerable families requires a unique blend of relational skills and clinical judgment (Appleton, 1996; Brocklehurst et al., 2004; Gallaher, 1997; Pybus, 1993; Reutter & Ford, 1997; Taylor & Tilley, 1989; Zerwekh, 1992a). The present findings also resonate with previous research that has identified that the art of sensing and intuiting situations and of managing practice boundaries is vital to the work with vulnerable families and that this expertise is developed over time and refined through practice experience (Gallaher; Jakonen et al., 2002; Paavilainen & Astedt-Kurki, 1997; Reutter & Ford; SmithBattle & Diekemper, 2001; SmithBattle, Diekemper, & Leander, 2004a, 2004b; SmithBattle et al., 1997; Zerwekh, 1991b). These findings can thus also be considered in the light of literature which highlights the significance of embodied knowing and expert practice (Arbon, 2004; Benner, 1983, 1999). This evidence thus supports a significant outcome arising from the present study: the importance of 'hands on' experience and time in the field for developing the practice skills and knowledge required to work effectively with vulnerable families

The need for public health nurses to be supported by the expertise of colleagues when grappling with the complexity of working with vulnerable families has been identified in the literature (Appleton, 1994b; Brocklehurst et al., 2004; Farrell, 2003; Gallaher, 1997; Oberle & Tenove, 2000; SmithBattle et al., 1999). The value of experienced colleagues for resourcing this process and for consequently promoting a culture of excellent practice within public health nursing teams has also been articulated (SmithBattle et al., 1999; SmithBattle et al., 2004a, 2004b; Zerwekh, 1992c). A recent New Zealand study has highlighted the benefits of providing public health nurses with a skills development programme to enhance the peer support process (Farrell, 2003). Thus a

key recommendation arising from this study is that public health nurses receive the training required to resource the provision of peer support to colleagues.

The recognition that formal processes of clinical supervision are needed to resource complex work with families has also been identified (Brocklehurst et al., 2004; Farrell, 2003; Oberle & Tenove, 2000). The value of clinical supervision within the helping professions allied to health, such as psychotherapy, counselling and social work has been well documented (Butterworth, Faugier, & Burnard, 1998; Farrell; Hawkins & Shohet, 2000). However, it is only recently that this process has been recognised within nursing (Barton-Wright, 1994; Butterworth, 1988; Farrell; Irvine, 1998). In the United Kingdom clinical supervision is seen as fundamental to safe guarding standards, developing professional expertise, and ensuring the delivery of quality care (Bishop, 1994; Butterworth et al., 1998). However within New Zealand supervision has still to become part of the culture of nursing. While mental health nurses have for some time benefited from the support of this process, nurses in other fields may have embraced the concept but have not implemented it (Farrell; Irvine).

A New Zealand study exploring the value of clinical supervision for public health nurses revealed that this process needs to be more fully understood by nurses in order to be accepted and embraced as a routine component of practice (Farrell, 2003). A process of peer reciprocal supervision involving 'in-depth reflection-on-practice' shared with colleagues is suggested by Farrell as a model suited to the New Zealand public health nursing context (p. 99). However as findings from the present study caution, peer support while valuable and rewarding, may be limited by the availability and capability of one's colleagues and issues relating to confidentiality. Thus participants in this study suggested that the option of formal clinical supervision provided by a professionally trained supervisor be readily available to public health nurses as an additional and complementary process to peer support.

Being determined to make a difference

In this study stories of practice revealed how working with vulnerable families required a particular persistence and tenacity which participants referred to as *being determined to make a difference*. Participants described how this commitment was fueled by personal beliefs and the experience of working with vulnerable families over time. Emerging from participant accounts was a keen sense of social justice and a desire to protect the vulnerable, particularly the children within vulnerable families. The frustration or outrage fueling this determination was often palpable in participant accounts. It was evident that this inspired public health nurses to persevere with a family or take on a cause on their behalf, even if this involved taking steps beyond their role, through advocacy or even politically. While participants referred to being driven by a personal philosophy or vision, it was apparent that this commitment also emerged from and was strengthened by the experience of working alongside vulnerable families, identifying with their realities and taking on their concerns. This evidence further supports one of the key findings from this study: that public health nurses draw on their past experience 'in the field' to enhance the way they work with vulnerable families.

Previous studies, both from within New Zealand and internationally, have identified how working alongside vulnerable families encourages public health nurses to develop a special commitment to emancipation and justice which sustains and enhances their practice in this area (Gallaher, 1999; Langlois, 1997; Meagher-Stewart, 2001; Pybus, 1993; Rafael, 1999a; Reutter & Ford, 1998; SmithBattle et al., 1999; Zerwekh, 1992b). The way public health nurses can go beyond their role to battle on behalf of individual families and the children involved has also been highlighted in the nursing literature (Brown, 2003; Green, 1993; SmithBattle & Diekemper, 2001; SmithBattle et al.; Zerwekh). Evidence from the present study endorses these findings.

Being Constrained

In this study participant perceptions of factors constraining the way public health nurses work with vulnerable families emerged constantly in their descriptions of practice with particular reference to: *families being unable or unwilling to respond, the impact of the business model* and its misalignment with the holistic and relational nature of nursing practice; and the challenges of *dealing with the Child Youth and Family Service.* Participant perceptions of these factors and their impact on the scope and quality of public health nursing practice with vulnerable families will be discussed in the following section.

Families unable or unwilling to respond

This study has identified that for public health nurses, the process of working with vulnerable families and the extent to which this is possible is determined by the nature of each family involved. Evidence gathered from participants showed that sometimes this process can be constrained due to a family's circumstances or experience which may limit their ability or willingness to respond. Participants described how families might be wary about trusting, or distracted by other factors in their lives; or might withdraw because of embarrassment at not completing tasks and deadlines, or a sudden decision to move to another town or region. Participants explained how sometimes a vulnerable family might not have the capacity, or will to move beyond their present situation, or simply might not be ready for change. Participants emphasised how for public health nurses, working with vulnerable families is dependent upon the family's co-operation, and how because the work takes place in the family's territory the nurse must always wait to be invited into the family's world. Participant accounts of their practice illuminated how the nurse is not in control and must respect the family's autonomy and freedom of choice as to whether to be involved. This evidence illuminates the realities encompassed in engaging and sustaining the participation of vulnerable families and highlights the need for public health nurse

contracts, staffing levels and practice timeframes that reflect the complexity and challenges of this work.

The complexities of engaging with vulnerable families when they are unable to trust, are overwhelmed, in a state of paralysis, or in constant crisis has been documented in the literature (Gallaher, 1997; Pybus, 1993; Reutter & Ford, 1996; Zerwekh, 1991b, 1992a). Previous studies have also illuminated the commitment needed to persevere with vulnerable families and the unpredictable nature of this work in terms of timeframes and outcomes (Appleton, 1996; Gallaher; Langlois, 1997; O'Sullivan, 1993; Pybus; SmithBattle et al., 1997; Zerwekh, 1992a). This evidence supports one of the key outcomes emerging from this study: that working with vulnerable families is a complex process which cannot be predicted or prescribed, and as such requires flexible timeframes and outcomes.

The impact of the business model

Participants in this study repeatedly reported that the complexity and challenges of their work with vulnerable families were not understood by their organization. They felt that their work was not valued, and regarded this as a constraining factor. They described an emphasis on outputs rather than on the substance of their work, a reduction in numbers of public health nurses and constant changes to the public health nursing role. They cited the recent withdrawal of the whole public health nursing workforce from family work for an extended period of time to deliver a national immunisation campaign as an example of the way in which their work could be changed at the whim of politicians or management. Participants also referred to the lack of support available to ensure the professional and personal safety of public health nurses when working with vulnerable families. They instanced the absence of clinical supervision, relevant in-service education, and practical resources such as a cell-phone for each nurse. To participants this lack of support was further evidence that the risks and challenges inherent in the work were not acknowledged by management. Participants found this lack of awareness and support frustrating and demeaning. One described it as

being 'rebuffed' by the organization. These findings suggest that the business model is inconsistent with the philosophy which underpins the work of public health nurses with vulnerable families.

Participants referred to the 'ever changing public health nurse role' during the last fifteen years as significantly constraining the quality of service provided to vulnerable families. They reported communities being confused and let down by this constant change, and explained that this had eroded the trust and community infrastructure needed to support the work with vulnerable families. Participants also reported how these changes had impacted on capture and continuity of care. Those who had been public health nurses for many years, cited the withdrawal (except in a few rural areas) of the infant welfare component of their work in the mid 1990s as a significant example. Participants recalled how public health nurses had traditionally been responsible for monitoring the growth and development of infants and children within vulnerable families. This had facilitated access to families and the opportunity to address other health related issues within the family. In principle this service is now provided by Plunket, however participants reported that many vulnerable families did not continue to access Plunket because of the emphasis on attending a clinic rather than home visits. Also a heavy caseload and exclusive focus on the infant or child means that the Plunket nurse has minimal opportunity to address wider family issues. Participants believed that the withdrawal of public health nurse infant welfare work had implications for nurses being unable to identify health concerns early, the number and severity of health issues increasing, and vulnerable families being lost within the system.

Stories from participants illuminated how the infant welfare component of public health nursing work in the past had provided a non threatening way to reach vulnerable families and a structure around which to form a working partnership. However further evidence from this study reveals that more recent configurations of public health nursing practice may mean that the service to families is more fragmented than in the past. Descriptions of practice provided by participants in this study reveal how

the involvement of public health nurses with vulnerable families now tends to be incident focused with an emphasis on taking a brokerage approach and closing cases rather than sustaining an ongoing partnership. These accounts illuminated how public health nurses are now more likely to connect with families intermittently, focusing contact on a particular referral or episode of care. The nurse may successfully work with the family to address a presenting health issue but this may not provide the context or opportunity for continued contact with the family or for developing the trust required to address wider issues. Participants described how the relationship might even take on authoritarian overtones, with for instance, the nurse arriving as a stranger, unannounced, to follow up non attended dental therapist or outpatient clinic appointments. As one participant stated –'the public heath nurse is now like a policeman'. This suggests that the way public health nursing is structured today constrains the process of working with vulnerable families.

The issue of the public health nursing role constantly changing to fit with the latest ideology or trend considered a priority by government or management resonates with literature highlighting the issue of nurses being treated as a commodity. Walsh and Gough (2000) refer to community nursing being shaped and driven by the contract culture of the market, how this has fragmented continuity of care and marginalized nursing within the primary care environment. These are concerns reiterated in the present study.

Evidence that the quality of public health nursing work with vulnerable families has been constrained by health restructuring and the business model is consistent with the literature (Clendon, 1999; Falk-Rafael et al., 2005; Gallaher, 1997; Rafael, 1999a; Reutter & Ford, 1998;Salmond & Bowers, 1997; SmithBattle et al., 1999). The impact of these forces upon access to and relationship building with vulnerable families can be understood in the light of international research exploring the value of routine home visits by registered nurses to families with infants and young children (American Academy of Paediatrics, 1998; McNaughton,

2000; Olds et al., 1997). Outcomes from this research showed that accessing families in this way provides a non-threatening context within which to establish an effective working relationship with clients, a factor affirmed as vital to achieving positive outcomes. Families who received regular contact with a public health nurse or similar over a sustained period of time emerged with significant benefits to their physical, psychological and social wellbeing. The international and New Zealand literature reveals that the provision of infant welfare and child health home visits has traditionally been a major component of the way public health nurses have accessed and sustained relationships with vulnerable families (Pybus, 1993; Rafael; Zerwekh, 1991b). The quality of the connection established with families through the process of regular home visiting over time was seen to be ideal for prevention, promotion, early intervention, and ultimately the wellbeing of the whole community.

Recent evidence however shows that the reduction of infant welfare visits by public health nurses in North America due to health restructuring has significantly constrained the benefits referred to above as well as contributed to a general distancing of public health nurses from the community (Rafael, 1999a; Reutter & Ford, 1998; SmithBattle et al., 1999). The present study suggests these findings could be applied to the New Zealand context. Certainly in the last decade there have been a number of studies within New Zealand that have made reference to the impact of the changing health arena upon the service provided by public health nurses to families (Blue, 1995; Hansen, 2004; Hinder, 2000; Richardson, 1998). Concern as to the invisibility of public health nurses within New Zealand communities and how this related to families having difficulty accessing their care has been highlighted (Clendon & McBride, 2001; Richardson).

The literature demonstrates that the business model is inconsistent with the holistic and relational philosophy of nursing (Doane & Varcoe, 2005; Rafael, 1998). The present study substantiates these findings. It would thus appear that the contracts underpinning the delivery of public health nursing reflect a lack of understanding of the holistic way that public

health nurses function within communities, and the complex input required to work with vulnerable families. Rafael describes how the health restructuring has limited the quality of the service provided by public health nurses to a form of prescribed or 'ordered caring'. Similarly Hartrick (1997a) describes how family nursing can become constrained by a service model of care, a process of intervening and problem solving dominated by the health professional rather than facilitating health promoting practice. Thus a key finding emerging from the present study is that the contracts framing the delivery of public health nursing have significantly reduced the opportunities for sustained contact with vulnerable families and hence the potential to align practice with a health promoting model of care.

Dealing with the Child Youth and Family Service

Participants in this study identified the process of *dealing with the Child Youth and Family Service* (CYFS) as a significant constraint to their work with vulnerable families. The findings revealed a lack of confidence in the capacity of the service to respond to referrals promptly, dissatisfaction with the level of communication from social workers and disappointment with the organisation's inability to work in partnership. Some participants expressed a sense of distrust as to whether the service would be effective, appropriate or even safe for families, citing factors such as social workers unfamiliar with local communities and constant changes to and insufficient numbers of personnel. This study identified that dealing with CYFS is a frustrating and disillusioning process for public health nurses.

The participants believed these constraints created a significant barrier to the process of working with vulnerable families and ultimately undermined the welfare of the children involved. They described situations becoming more unsafe for children due to a slow response to referrals and already marginalized families losing faith in the system. Anger was expressed about the system letting the process down when public health nurses worked hard on the ground to bring a referral

through to CYFS. Participants revealed how because of these barriers some public health nurses were tentative about and even reluctant to refer cases on to CYFS. There was a sense of disbelief that a service charged with protecting children could actually collude in undermining their welfare further.

The findings illuminated how dealing with CYFS had implications for the professional and personal integrity of the public health nurse. Participants described the negative impact upon a nurse's safety and credibility within the community. For instance, not being informed about progress with a case could mean a public health nurse feeling unsafe if a relationship with a family had been jeopardised in order to refer to CYFS. This could delay or obstruct the ability of the nurse to work with the family further. Also the community's belief in the professional integrity of the public health nurse could be affected by the nurse being unable to reassure people that a situation threatening a child's wellbeing was being addressed. Participants believed that these factors eroded the ability of public health nurses to work effectively with vulnerable families

Participants shared how the process of dealing with CYFS is professionally demeaning as well as personally disturbing. They described how public health nurses feel that their child protection role, in particular the intense effort made behind the scenes to identify concerns and present a referral, was ignored and misunderstood. Participants also described the emotional burden of child protection work being exacerbated by the challenge of dealing with CYFS. Because of a lack of confidence in the service, participants described continuing to feel accountable about families and children even after referring to CYFS and being powerless to change the situation.

One positive finding relating to this issue was the recent establishment of a Child Protection Advisory and Support Service at the local district health board. Participants reported how this was proving to be a valuable and effective resource for consultation about child protection cases and for liaising with CYFS. They believed that this related to the nurse co-

ordinator being an ex public health nurse with inside knowledge of the intricacies of working with vulnerable families and the demands of the public health nurse role.

The participant's sense that their contribution to the child protection process was ignored and devalued reflects the incongruity between the values espoused by the business model such as efficiency, competition, and productivity and the holistic and ethical values of nursing (Davis, Aroskar, Liaschenko, & Drought, 1997; Kilday, 1999). The implications of the business model in relation nursing practice being invisible has been discussed in the literature (Clendon & McBride, 2001; Rafael, 1999a; Reutter & Ford, 1996, 1998; Richardson, 1998).

Participants in this study shared how public health nurses may intellectually transfer responsibility when they refer to CYFS, but because of the inadequate service, nurses cannot emotionally divest themselves of this burden. This sense of impotence when faced by the moral dilemma of not being able to provide a service believed to be needed by the community is referred to by Wilkinson (1987) as moral distress: feelings of guilt, frustration and a sense of moral alienation from not aligning one's actions with one's beliefs. Research has suggested that ethical or moral distress amongst nurses can be a source of burn out, and staff turnover (Cameron, 1997; Martin, 1990). Thus the public health nurse is rendered both personally and professionally vulnerable by the experience of dealing with the challenges presented by CYFS.

Protecting the Integrity of Self

A significant finding emerging from this study was that public health nurses themselves can be vulnerable as a result of the process of working with vulnerable families. Participants emphasized the importance of maintaining both personal and professional integrity in the face of the challenges experienced from this work and that this can be exacerbated by factors within the organizational context of public health nursing. While it was apparent that public health nurses are resourceful at caring for

themselves, it was also evident that organizations have a responsibility to provide the resources and support processes necessary to promote and protect the wellbeing of public health nurses.

The vulnerability of the public health nurse

The findings from this study reveal that the process of working with vulnerable families can threaten the physical and emotional wellbeing as well as the professional integrity of the public health nurse. Accounts from participants highlighted how this vulnerability emerges from factors such as: the solitary status of the role, the community context of practice and the nature of the vulnerable families themselves. Participants recounted how the vulnerability of the public health nurse is intensified by organisational constraints limiting the support available to nurses and devaluing the substance of their work with families and within communities.

It was apparent from the findings of this study that working with vulnerable families can pose numerous risks which have implications for the vulnerability of the public health nurse. Accounts of practice revealed how working alone without immediate access to the support of colleagues or the protection of an institutional setting can mean that public health nurses are susceptible to situations that challenge their physical safety and their personal and professional integrity. Participants referred to working in isolated communities, providing a service that sometimes is not welcomed by families and visiting some of the most vulnerable and troubled families in the community. They described how on a daily basis public health nurses can face situations involving dogs, alcohol, drugs, violence or the mentally ill and at times can be confronted by the resentment and anger of families. Participants were acutely aware that public health nurses are susceptible to being blamed and or made a scapegoat by families who feel they have been let down by the system and told stories of the distress they experienced when this had occurred. These findings illuminate how practising alone within a community context, the unpredictable nature of the work, and the tendency for vulnerable families

to distrust those in authority, can mean that public health nurses become vulnerable themselves.

It was obvious from these accounts that continually encountering families with long term, unresolved and often disturbing issues is emotionally and psychologically demanding. Accounts of practice illuminated how being physically present in a family's home can mean that the public health nurse is more susceptible to being overwhelmed by the complexity and sometimes distressing nature of the situations presenting. The public health nurse becomes immersed in the world of the family – more intensely so than within the setting of a hospital or clinic – and nurses can find themselves being drawn into the cycle of helplessness and despair experienced by some families. It was evident from the findings that for public health nurses the emotional impact of working with vulnerable families was compounded by their distress at the increasing plight of vulnerable families. There appeared to be gnawing at a deep level, a sense of anger and helplessness at not being able to adequately attend to these needs. In fact it was the experienced nurses who conveyed the most anguish when describing how situations in which they found their clients were more complex and disturbing than in the past. Much of this angst was frustration and disillusionment as to the impact upon vulnerable families of services disappearing and changing in the last decade due to government reforms and constantly encountering in their practice evidence of needs not being identified and addressed. There was also anger that the infrastructure supporting their work with vulnerable families has been constantly undermined by continual restructuring of the public health nurse's role. The moral distress experienced by participants as to the above concerns was palpable in the accounts of practice they provided.

It was apparent that the vulnerability already experienced by public health nurses was intensified by the stress of being undervalued and unsupported by the organization. Factors such as the lack of provision of a cell phone for each nurse and not having access to a regular and professional process of clinical supervision were for public health nurses

tangible evidence of this lack of support. It was obvious that public health nurses felt neglected and ignored by their organization and there was a sense of outrage at these needs not being recognized when they were clearly essential to the safety and wellbeing of staff. Participants also described how their vulnerability was exacerbated by constant changes to the public health nurse role and the feeling that there was no control as to how this might be further restructured in the future. Of particular significance was a recent configuration withdrawing public health nurses from health promotion activity, a component of their work which public health nurses considered provided a healthy balance to their involvement with vulnerable families. That public health nurses could at any time become victims of the capricious designs of politicians, health bureaucrats, or their own management, and the impotence that this engendered, were seen as crucial factors intensifying the vulnerability of the public health nurse.

The vulnerability of the public health nurse as an issue has been referred to but not fully explored in the literature (Farrell, 2003; Pybus, 1993; Rafael, 1999a; Reutter & Ford, 1996, 1997, 1998). An exception to this can be found in studies exploring expert practice which have explicated more extensively the experience of nurses when faced with responding to and dealing with the stress and risks encompassed in the work (Gallaher, 1997; Zerwekh, 1991a). The North American study by Zerwekh referred to public health nurses having to 'struggle with adversity' when coping with the hardship and complexity faced by families (p. 58). Gallaher's study from a New Zealand context refers to the 'dark side' of public health nursing practice in relation to the stress inherent within this work and the personal toll it can take on the wellbeing of nurses (Gallaher, 1999, p.22). The issues highlighted by Zerwekh and Gallaher resonate with the findings from the present study.

The stress experienced by the public health nurses in the present study as a result of constant restructuring of their role reiterates findings emerging from North American studies reported by Rafael (1999a), Falk- Rafael et al. (2005) and Reutter and Ford (1996). References were made by these

writers to the impact of constant restructuring upon the morale of public health nurses, the stress of living in a climate of uncertainty and how feeling devalued and powerless can undermine the wellbeing of nurses. Constant restructuring has been identified in the literature as a factor causing burnout (Maslach & Leiter, 1997). Research has revealed that this phenomenon is closely connected to a lack of control experienced by workers (Long, 1998; Matthews, Hertzman, Ostry, & Power, 1998). For public health nurses this effect may be buffered by autonomy of the role, being able to maintain a certain amount of independence or control and being able to divorce self from organisational issues due to the community context of their practice (even though conversely there are factors to do with the community context that mean public health nurses can be more vulnerable). However nurses in the present study were nevertheless angry and referred to a number of colleagues who in the previous few years had been on stress leave because of burn out caused by persistent changes to the public health nurse role and workload.

Literature associated with burnout in the human service occupations asserts that there are five main factors implicated with this phenomenon: strong professional motivation, the emotional demands of the job, the uncertain nature of the work, pressures created by society, and an unsupportive organizational environment (Maslach & Leiter, 1997; Schaufeli & Enzmann, 1998). Sandra Thomas (2004) reporting on American research into the frustration stress and anger of nurses in the face of the rapid changes of the 1990s within health care organizations has identified themes underpinning the distress of nurses. Four of these themes – feeling powerless, not being heard, moral distress and not being supported by management - are particularly relevant to the experience of the public health nurses in the present study.

Caring for self

The findings from this study highlighted how public health nurses develop practical strategies and draw upon inner resources to cope with the vulnerability they face when working with vulnerable families.

Participants referred to the careful ways that public health nurses approach families in order to protect their physical safety and how they learn to skillfully intuit situations to gauge potential threat. Stories from practice illuminated how processes such as monitoring involvement with families, identifying achievements and separating one's personal and working life are considered important for maintaining emotional and psychological wellbeing when working with vulnerable families. Factors such as being mature, having an optimistic outlook and being able to draw upon a personal philosophy or belief to find meaning in the work, were also considered vital for sustaining one's wellbeing. It was clear that public health nurses relied upon their own capacity to protect and nurture themselves when faced with the stresses and challenges of working with vulnerable families.

Participants also emphasized that an essential component of caring for self involves knowing who to talk to when support is required. However, while participants clearly valued the informal support public health nurses receive from colleagues, the need for formal processes of consultation was considered an urgent requirement to assist with both the professional demands of practice and the process of caring for self. Participants identified the requirement for privacy, skilled guidance and time to attend to their issues without concerns about confidentiality or the demand of having to provide a reciprocal service as with the peer support process. Thus the need for public health nurses to have access to regular clinical supervision sessions provided by a professionally trained facilitator emerges as a significant outcome of this study. This highlights the necessity for organisations employing public health nurses to acknowledge the challenges encompassed in working with vulnerable families and to take responsibility for supporting those who provide this service.

Zerwekh (1991a, p.58) refers to the 'nurse preserving sphere' of expert practice and Gallaher (1999, p.22) to 'coping with the dark side' to describe how public health nurses deal with threats to their emotional and physical wellbeing. Both these studies have identified how public health

nurses adopt strategies and skillfully adapt their practice to deal with threats to their emotional and physical safety when working with vulnerable families. For instance, processes such as establishing a level of involvement with families that is safe for the nurse, maintaining a clear separation between one's personal and working worlds and drawing on the support of colleagues were strategies emerging from these studies that are identified in the present research. While this provides evidence that public health nurses are skilful and resourceful at looking after themselves there were clear recommendations in both of these studies: firstly that organisational policy include procedures to protect the physical safety of public health nurses; secondly that strategies such as formal processes of peer support and clinical supervision to support practice and the personal well being of nurses are implemented.

An examination of a selection of the literature discussing stress and nursing, reveals an emphasis on nurses finding ways to care for themselves, rather than encouraging nurses seek solutions at a structural level (Andrica, 1996; Lachman, 1996; Lempp, 1995; Strickland, 1998). Wilkinson (2001) however, emphasizes the contextual factors surrounding the issue of nurse vulnerability. Wilkinson's study examined the physical safety of district nurses in New Zealand and raised questions about the part the institution plays in contributing to the compromised safety of nurses working in the community. Citing an Australian study by Fisher et al. (1995) and the work of Freire (1972), Wilkinson refers to the reticence of nurses to articulate concerns and to take action in response to the issue and identifies that this 'culture of silence' is indicative of the complex power relationships shaping practice. Issues such as health organizations contracting to provide a level of service which is not sufficiently resourced to protect the safety of staff, the stigma of not coping that might be attributed to a nurse's concern about feeling at risk, and the unrealistic expectation that expert practice encompasses the skills and knowledge to cope with and prevent threats to safety were highlighted in this study. Wilkinson recommends a culture of safety with policies that reflect the needs of the nurses themselves and not just those of the institution. An emphasis upon employer responsibility for the

provision of cellphones to all staff, processes for accessing an appropriate buddy for risk related home visits (colleague, community psychiatric nurse or police) and appropriate external clinical supervision for nurses were of particular relevance to the present study.

The need for formal processes of supervision to support nurses faced with the emotional impact of front line work with families has been identified in the literature (Farrell, 2003; Gallaher, 1997; Pybus, 1993; Zerwekh, 1991a). While there has been much discussion within nursing generally as to the value of clinical supervision, a body of research identifying outcomes has yet to be developed (Fowler, 1996). Much of the debate surrounding this topic has centred around which model is appropriate for which area of nursing (Fowler; Lyth, 2000). A recent New Zealand study undertaken by Farrell examined the perceptions of public health nurses in relation to a model of reciprocal peer supervision, an approach which has been considered relevant to nurses working within a community context. This model involves a supervisory and supportive relationship between two colleagues where the roles of supervisor and supervisee are alternated between the two people involved (Farrell; Hawken & Worrall, 2002). Outcomes of Farrell's research showed that peer supervision has benefits in terms of sharing, exploring and validating clinical practice and that this can in turn enhance the wellbeing of the nurses participating. However reservations were expressed by participants in Farrell's study as to the expediency of the peer reciprocal model when a safe forum is required to address personal issues arising from practice. The present study endorses this finding and asserts that being exposed to the scrutiny and judgment of colleagues, while relevant when exploring clinical situations, may not be appropriate when nurses are seeking support for emotional issues relating to their work. Thus a significant outcome to emerge from the present study is that as well as the support of peers, public health nurses have access to individual professional supervision which is safe, private and confidential and facilitated by a professionally trained supervisor from outside the public health nurse team and line of management.

Summary

A discussion of the findings emerging from this study has identified a number of key points. The findings revealed how public health nurses view family vulnerability as a dynamic interplay between risks to the wellbeing of the child and the family's experience of their situation. This has implications for tempering a client driven and family centred approach to practice with an emphasis on prioritising the needs of the children involved. It was also apparent that public health nurses draw upon their experience of working with families and within communities to give meaning to the concept of 'vulnerable family' and that this can consequently cause tensions for them when striving to balance contract boundaries with the realities of working with community need.

It is evident that that the relational and contextual way that public health nurses approach their work with vulnerable families encompasses a health promoting model of care. However it is clear that this requires flexible contracts and practice contexts that enable routine, regular contact with vulnerable families that can be sustained over time and continuity of personnel. It is also apparent that time in the field and within a particular community are vital to developing the practice expertise, community infrastructure and commitment which enhance the potential to work in a health promoting way. The study findings also highlighted the importance of peer support, although there was evidence that this can limited by the availability and capacity of colleagues and that it is crucial that this is supplemented by formal processes of individual clinical supervision.

The ever-changing public health nurse role and the incompatibility of the business model with the holistic and relational focus of health promoting practice were cited in the study as significantly constraining the work with vulnerable families. It was evident that the withdrawal in the 1990s of the infant welfare service provided by public health nurses had negatively impacted on the capture and continuity of care to vulnerable families. It was also apparent that the contract environment encourages

an incident-focused and brokerage approach to working with vulnerable families and that there is consequently a risk of practice becoming problem-focused and authoritarian while families become disempowered and alienated.

The incapacity of the Child Youth and Family Service to respond rapidly to referrals and work in partnership with public health nurses was considered a major barrier to the work with vulnerable families. While it appeared that this situation had been somewhat moderated by the provision of a child protection liaison unit within the local district health board, there was a sense of impotence and moral outrage at the welfare of vulnerable children being further undermined by chronic inefficiencies within the system.

An unanticipated yet important finding emerging from this study was that the personal and professional integrity of the public heath nurse can be significantly compromised in the face of supporting some of the most troubled families in the community. It was apparent that this was exacerbated by organizational constraints limiting the support available to nurses and devaluing the substance of their work with families. The need for organizational strategies to promote and protect the wellbeing of those working with vulnerable families was emphasised and the need for ready access to a confidential process of clinical supervision reinforced.

The next chapter will conclude this research report. The outcomes from this study will be discussed with reference to practice, education, research and policy. The final chapter will also refer to the limitations of the study and present a number of recommendations.

CHAPTER SIX

CONCLUSION

The purpose of this study was to explore how New Zealand public health nurses work with vulnerable families, what factors enhance or constrain this process, and whether this aspect of public health nursing practice aligns with a health promoting model of care. The research process involved a qualitative approach, a descriptive design, semi-structured interviews and utilized a general inductive approach for analysis of the data. The participants consisted of ten public health nurses from a district health board within New Zealand. The criteria for selection required current practice, at least two years experience as a public health nurse and a present caseload of vulnerable families.

The findings identified that New Zealand public health nurses continue to align their practice with a health promoting model of care when working with vulnerable families, particularly if nurses are experienced, embedded within a community and determined to make a difference. It was evident, however, that the ability of public health nurses to work in this way is significantly constrained by factors relating to the nature of the families themselves, the business model framing the delivery of public health nursing services and the challenges involved in dealing with the Child Youth and Family Service. This study also highlighted the vulnerability of the public health nurse which may occur as a result of working with vulnerable families and dealing with the constraints referred to above.

Vulnerable Families

Public health nurses participating in this study viewed family vulnerability as a continuum which can fluctuate in response to stressors in the family life cycle and also as a cumulative state that can become

entrenched. Participants were clear that vulnerable families also have strengths which can buffer their experience of adversity. This reflects a move within nursing to refer to clients in relation to capacity rather than deficits (Doane & Varcoe, 2005), and a preference for using terms such as 'high priority families' (Browns et al, 2000, cited in Mulcahy, 2004, p. 258). It has been suggested that the way nurses define and refer to their clients determines the approach taken in practice. It may be timely for public health nurses to reconsider the terminology used to refer to the families in their care and the implications this has for their practice.

Although the study tended to highlight families facing deprivation and disadvantage, participants also emphasized that vulnerable families can come from all social strata. This indicated that the present focus of public health nurse contracts on school decile ratings or areas of deprivation may exclude a significant number of vulnerable families. It was also apparent that public health nurses view family vulnerability as a dynamic interplay between the risks to the wellbeing and safety of the child and the family's experience of their situation. It is important therefore that the policies and contracts determining public health nursing practice encompass both these perspectives. A key recommendation emerging from this study is therefore that organizations work with public health nurses to develop appropriate terminology and definitions relating to family vulnerability, that this is informed by research identifying the experience of the families themselves, and that these are incorporated into public health nursing policy and contracts.

Participants identified 'being Maori' as a factor contributing to family vulnerability. It was also apparent that the public health nurse tended to be the first point of access to the health system for the Maori families referred to in the study. This raises questions as to the availability of culturally appropriate services within the rural areas where the majority of participants were placed, the preferences of families as to which local service is acceptable and the ability of other services to reach vulnerable families. The fact that only one of the ten participants in this study identified as Maori reflected the composition of the public health nursing

team from which the participants were drawn. This has implications for addressing Maori health concerns in ways that facilitate adequate and meaningful participation by Maori and the numbers of Maori nurses (Barwick, 2000; Ministry of Health, 2002a, 2004).

Working with families

Public health nurses in this study showed that their practice with vulnerable families encompassed a health promoting model of care. This was embodied in the client driven, relational and collaborative processes adopted by public health nurses and the respectful and empowering way families were encouraged to take ownership of factors affecting their wellbeing. This process was not however, a prescribed modus operandi imposed on practice but rather, arose from the realities of practice and the need to find sensitive and compatible ways of responding to the needs of vulnerable families.

Descriptions provided by participants illuminated how the nature of the family determined the nature of practice. The need to proceed in ways that are unique for each family and the time and care required to forge relationships when families are vulnerable was highlighted. It was thus apparent that working with vulnerable families is an unpredictable process which cannot be predefined or prescribed and one which requires flexibility around contractual boundaries, timeframes and outcomes. This has implications for the policy and organizational guidelines configuring and supporting public health nursing practice.

Of significance also, is the finding that the essence of public health nursing practice with vulnerable families is essentially relational. While public health nurses assist vulnerable families in numerous practical ways such as connecting families with services and resources, the substance of their work consists of encouraging families to recognize and build upon their strengths. This is not possible without a relationship of trust. Because vulnerable families do not tend to self refer to the public health nurse and in fact may not even welcome being approached by the

nurse, the forging of this relationship is different to other nursing situations were the service is sought or desired by the client. Thus the way that public health nurses have access to families has implications for building trust and ultimately for the potential to address deeper factors. This highlights the importance of contexts for practice that facilitate access to families and the continuity of contact necessary for building trust such as the infant welfare visits traditionally provided by public health nurses.

The ethic of protecting the child which underpins the work of public health nurses with vulnerable families was particularly emphasized in this study. A relational and family centred approach carries the risk of focusing on the concerns of the parents and family at the expense of the needs of the children or dangerous practice (Morrison, 1995). It was thus clear that a health promoting approach to working with vulnerable families is tempered by the goal of prioritizing the wellbeing and safety of the children involved.

This study revealed how working with vulnerable families is ideally a collaborative process and emphasized the value of the Strengthening Families strategy which has been adopted in many parts of New Zealand. This process involves a team approach with the family positioned as the key decision maker, while supported by a team of professionals and agencies. It was clear from these findings that public health nurses play a vital role in initiating and sustaining this process due to their mobility and availability within communities, and the quality of the connection they develop with families.

There has been some suggestion that the historical specialities within nursing are a barrier to an integrated primary health care nursing service and that this is perpetuated by present funding and contracting arrangements (Carryer, 2004; Minto & Hansen, 2005). The present study demonstrates that working with vulnerable families requires a health promoting approach and that this process has traditionally been enabled by the unique position and function of public health nurses within their

communities. One of the key goals of the Primary Health Care Strategy is to align practice with community need (Ministry of Health, 2001). It is thus important that the new primary health care environment is configured to ensure that nursing practice continues to interface with families and communities in ways that facilitate a health promoting model of care.

Enhancing practice

It is evident that the connections and credibility that public health nurses establish within a community provide the foundation for working in a health promoting way with vulnerable families. Being situated within, known and trusted by a particular community over time (years), and continuing to be visible and available within this community, facilitates access to vulnerable families and the opportunity to address complex issues. Thus public health nurses require time within a particular community in order to establish and draw upon the infrastructure required to work effectively with vulnerable families. A key recommendation emerging from this study is that each public health nurse be responsible for and situated within, a defined, geographically cohesive community.

This study affirmed that time in the role of public health nurse is necessary to build the skills, knowledge and commitment required to work effectively with vulnerable families. 'Hands on' experience in the field develops the expertise needed to assess families and manage complex practice boundaries. This practice experience also fosters the determination needed to sustain involvement with vulnerable families and to advocate for their wellbeing. Also highlighted was the importance of drawing upon the experience of colleagues through processes such as peer support, in order to enhance practice and ensure safe clinical decision making when working with vulnerable families. This evidence emphasises the need for depth of experience within the public health nurse team workforce to support and enhance work with vulnerable families.

While the value of peer support was identified in this study the need for this to be supplemented by a formal process of clinical supervision was also highlighted. Participants shared how peer support can be limited by the availability and capability of colleagues and issues relating to confidentiality. It is therefore important that the option of a confidential process of clinical supervision is readily available to all public health nurses to support practice and ensure safe ethical decision making as is the case with social workers, counsellors and mental health nurses. Within these professions one's practice is not considered ethically safe unless it is supported by ongoing regular clinical supervision that involves: a supervisor professionally trained in clinical supervision who is personally chosen by the professional seeking the guidance; a process that values the confidentiality and safety of the clinician; a process that allows the clinical, professional, and personal issues related to particular cases to be addressed; and a process that has as its goal the achievement of competent safe practice (Butterworth, 1988).

The significance of experience 'in the field' and expertise within teams for enhancing the work with vulnerable families has implications for the future direction of nursing education. The recent development of primary health care pathways at an undergraduate level have been seen as a way to promote primary health care as a discrete area of practice within nursing (Wright & MacDonald, 2003). There has also been a move to promote the transition of new graduates directly into primary health care positions (Pinnacle, 2004). There is evidence however that the opportunity for undergraduate students to gain experience in family nursing is limited by the availability of clinical placements and the nature of community practice which may mean that students are observing rather than interacting with clients (Ministry of Health, 2002a, p. 37). Given the complex relational and community knowledge required to work effectively with vulnerable families it is vital that new graduates within primary health care (particularly those working within a public health nursing context) are well supported. New practitioner internship programmes within primary health care settings have been recommended (Pinnacle, 2004). It is important therefore that there is a body of

experienced practitioners to resource this process. A model of preceptorship training that is recognized as a professional development activity and is appropriately rewarded has been identified as an essential component of this development (Pinnacle).

Being constrained

This study provided copious evidence that working with vulnerable families is a demanding and challenging process due to the complex nature of family vulnerability. It was clear that the potential for public health nurses to engage with families can be constrained by the very vulnerability the nurses are seeking to support. Families may be unable or unwilling to respond because they are in crisis, overwhelmed, itinerant or wary of trusting those in authority. This can be compounded by the community context of practice and the need to value the privacy and autonomy of the family. Thus the realities encompassed in engaging and sustaining the participation of vulnerable families can have implications for the unpredictability of the work, the timeframes involved and expected outcomes.

Participants in this study highlighted how constant changes to the public health nurse role and a reduction of public health nurse numbers in recent years had resulted in a distancing of public health nurses from their communities with negative repercussions for the quality of the service to vulnerable families. Of significance was the withdrawal of the infant welfare component of public health nursing practice in the mid nineties and the recent removal of the whole public health nurse workforce from family work for an extended period of time to focus on a national immunisation campaign. Also cited was the elimination of the community development and health promotion dimension of the public health nurse role. These factors were considered to have impacted negatively on the capture and continuity of care to vulnerable families and the process of building the community infrastructure needed to sustain this work. Participants urged that the public health nurse workforce

capacity and contracts be configured to reflect the continuity and complexity of input required to work effectively with vulnerable families.

It was evident that a significant factor constraining the work with vulnerable families related to an incompatibility between the business model and the relational and holistic focus of nursing. The study illuminated how contracts that emphasise outputs rather than processes tend to fragment service provision, and ignore the complex way that public health nurses function within communities. While public health nurses in this study still managed to align their practice with a health promoting model of care, it was apparent that this was becoming an increasing struggle in the face of the constraints referred to above. The effort of extending practice beyond contract boundaries to facilitate effective work with vulnerable families requires a special determination and professional wisdom. However the challenge of working in ways not authorized at a contractual level can be stressful and alienating. It is possible that this commitment to retain a health promoting approach to working with vulnerable families cannot be sustained. There is now a risk that the business model will encourage a problem focused, authoritarian approach to the work with vulnerable families which may disempower and alienate families (Hartrick, 1997a). It is thus clear that the business model limits the potential for public health nurses to effectively work with and address the health needs of vulnerable families. Therefore an important outcome of this study is that the relational and contextual nature of this work must be reflected when determining public health nurse workforce capacity, and contractual timeframes and outputs.

It was apparent that contracts needed to be reconfigured to include strategies for accessing vulnerable families on a regular, routine and non-threatening basis to provide the ongoing and sustained contact required to identify health concerns early and to address deeper issues. One possibility is for public health nurses to resume responsibility for the delivery of a wellchild home visiting service to vulnerable families not accessing an iwi health provider and requiring a more intensive service than that provided by Plunket. Vulnerable families could be identified by

the lead maternity carer in the first six weeks following birth and the option of public health nursing well child visits could be offered to these families at this time. Additionally regular access by public health nurses to vulnerable families on an accepted basis could be facilitated via surveillance of children beyond five years of age (as part of the well child schedule). A further strategy to encourage vulnerable families to self refer to the public health nurse could involve community based clinics within the school setting.

Public health nurses within this study expressed deep concern about the needs of vulnerable families remaining unidentified until the issues they face emerge as extreme cases of neglect, abuse or more serious crime statistics. Participants cited vulnerable families not accessing well child nursing services during the pre school years. This suggests that the political rhetoric around the value of early intervention and the urgent need to address issues of child neglect and abuse should be examined in relation to research that identifies the real picture relating to the uptake of well child services within New Zealand (Ministry of Health, 2002b, 2002c). Who are the families accessing which services? Which families are not being reached, why, and what impact is this having on the health status and safety of children within vulnerable families? The need for these questions to be considered in the light of research that emphasises the value of early, intensive, long term services to vulnerable families by registered nurses is highlighted by the findings of the present study (American Academy of Paediatrics, 1998; Olds et al., 1997).

This study revealed how dealing with the Child Youth and Family Service (CYFS) significantly constrained the work with vulnerable families. Participants clearly identified that relating to this organization is a frustrating and disillusioning process that has negative consequences for their practice with vulnerable families. Factors such as inadequate communication from CYFS and the inability of this organization to follow up child protection work rapidly, impacts on the credibility of the public health nurse within the community, which in turn inhibits their ability to work effectively with vulnerable families. Evidence from this study

revealed how the establishment of a child protection liaison role within the local district health board has recently provided an effective bridge between public health nurses and CYFS which has served to moderate some of the issues referred to above.

It has been suggested that the New Zealand Primary Health Care Strategy (2001) offers an opportunity to address the constraints presented by the factors referred to above (Ministry of Health, 2002a). The concept of a generic primary health care nurse, and the notion of an integrated comprehensive primary health care nursing service have been proposed as possibilities for future change (Ministry of Health). A number of collaborative practice initiatives recently funded by the Ministry of Health have been promoted as emerging models of primary health care nursing (Ministry of Health, 2005). There has also been an emphasis upon advanced practitioner roles, and nurses assisting with the delivery of primary medical care (Ministry of Health, 2002a). It is however important that the rush to embrace the primary health care vision does not further constrain practice by marginalizing the holistic and relational approach required to work effectively with vulnerable populations. Thus the new primary health care nursing environment should be configured to ensure a practice context that supports and sustains a health promoting approach to working with vulnerable families.

This study was interested in whether public health nursing practice with vulnerable families has changed in the face of the profound changes occurring within the health arena during last fifteen years. When considering this question in the light of the language used to describe the work of public health nurses it might appear that their practice today is more evolved. For instance Green's (1993) description of 'enabling choice' infers that this is something the nurse is doing to the family (p. 119). Today we might refer to how the public health nurse engages with the family to assist them to identify strengths. Are these differences the subtle nuances of language use or is practice today more empowering? This study suggests that conditions prior to the 1990s offered a more favourable context for encouraging a strengths-based approach to practice

and that public health nurses were in fact able to work in a more health promoting way with vulnerable families. This indicates that it is important to maintain a realistic view of the power of language when we are comparing present interpretations of practice with those from the past. Alternatively it can be valuable to consider how the power of language may transform our practice. Thus the influence of language upon the way public health nursing practice is articulated and the impact this has on the development of practice is suggested as an option for future research

Protecting the integrity of self

An unanticipated, yet significant, theme emerging from this study was that the personal and professional integrity of the public health nurse can be challenged when working with vulnerable families. It was clear that public health nurses experienced themselves to be physically, emotionally and professionally vulnerable in the face of the risks associated with working with some of the most troubled families in the community. The emotional toll of supporting families in disturbing and often unresolving situations was exacerbated by a sense of moral distress at services to vulnerable families being reduced or obstructed by health restructuring and bureaucracy. It was also apparent that the vulnerability public health nurses experience can be intensified by organizational constraints limiting the support available to nurses and devaluing the substance of their work with families and within communities.

While public health nurses are resourceful at finding ways to protect and nurture themselves in the face of the stresses and challenges relating to their work it is necessary for organisations to recognize the contextual factors involved. Responsibility should be taken to provide the resources and support necessary to promote and protect the wellbeing of those working with vulnerable families. Practical factors, such as a cell phone for each public health nurse and processes to ensure physical safety when home visiting, were identified as particularly necessary. This study has identified that for public health nurses the support of colleagues is a vital

factor for preserving wellbeing, however the limitations of this process for addressing emotional issues arising from practice has also been acknowledged. This reinforces the recommendation referred to earlier in this chapter - that public health nurses have ready access to a formal process of individual clinical supervision.

Limitations and strengths of the study

There are a number of limitations relating to this study that need to be acknowledged. The participants consisted of public health nurses from only one of the district health board regions within New Zealand. However the way public health nursing is configured can differ between each district health board throughout the country. The participants involved were all experienced public health nurses, each with over five years of practice 'in the field'. It is possible that having some novice practitioners as participants would have provided a unique perspective to the findings particularly in relation to constraints and the vulnerability of the public health nurse. The majority of participants worked in rural areas within which they had lived and / or worked for many years. Given that the community infrastructure supporting practice is a vital factor influencing the work with vulnerable families, there may have been some differences to the outcomes of the study if the majority of the participants had worked in urban areas.

The subjectivity of the researcher in relation to her past experience as a public health nurse and familiarity with a number of the participants in the study was also a particular feature of this research project. While it is recognized that this familiarity with both context and participants may contribute to bias it is also recognized that with qualitative research the researcher is an integral part of the the research process and the experience of the participants (Gillis & Jackson, 2002). The researcher believes that these factors enabled a depth of understanding of issues explored and a level of trust between the researcher and the participants which contributed to the depth of data collected. In order to address

issues of bias arising from the factors above the researcher ensured that her personal experiences and assumptions relating to the research topic were clarified prior to the study commencing and continued to be articulated in a research journal as the study progressed. This report also contains a description of the audit trail taken during the research and statements with rationale about the decisions made.

Recommendations

As a result of the findings a number of recommendations have been made:

1. That organisations work with public health nurses to define vulnerability and that these definitions are incorporated into the contracts and policy determining public health nursing practice.
2. That experienced public health nurses are valued, retained and supported and are provided with training to facilitate the process of providing peer support to their colleagues.
3. That staffing levels and the contracts governing the work of public health nurses reflect the complexity of input and flexible time frames required by public health nurses to work effectively with vulnerable families and to build the community infrastructure involved.
4. That public health nurses continue to be situated within and have responsibility for a specific geographically coherent community.
5. That public heath nurses explore different approaches to working with vulnerable families to encourage families to take the initiative of self referral.
6. That public health nurses resume responsibility for the infant welfare and preschool wellchild services to vulnerable families who require a more intensive service than that provided by Plunket and who are not accessing the services of iwi health providers.
7. That the wellchild schedule is extended beyond 5 years of age for children from vulnerable families as a way of enabling public health nurses to establish regular interaction on an accepted basis with vulnerable families

8. That the local district health board child protection liaison role is continued as this appears to be effective in establishing links between public health nurses and CYFS
9. That organisational policy include procedures to protect the physical safety of the nurse such as a cellphone for each public health nurse and processes for accessing assistance for risk related home visits.
10. That clinical supervision be readily available to all public health nurses. That this takes the form of a regular (fortnightly or monthly) process which is safe, private, confidential, facilitated by a professionally trained supervisor from outside the public health nurse team and line of management and is fully funded by the organization.
11. That local district health boards establish primary health care nursing initiatives to enable public health nurses to consolidate and expand their work with vulnerable families
12. That a public health nurse practitioner role is established within each District Health Board to support and expand practice with vulnerable families

Future research

Recommendations for future research are:

- Research into the process and outcomes of infant and preschool child health home visits to vulnerable families by registered nurses within a New Zealand context
- Research which explores from the perspective of the families themselves the optimum approaches and contexts for working with vulnerable families
- Further research into clinical supervision focusing on outcomes for the practice and wellbeing of public health nurses
- Research to explore the language used to describe public health nursing practice. The aim of this research could be to ascertain how changes to the language describing public health nursing

practice over the last three decades has impacted upon our understanding of the way public health nurses work with families, whether it is the language or the practice itself that has changed and if the language used to describe practice subtly influences and transforms this practice

Personal Reflection

The public health nurses participating in the study demonstrated how working with vulnerable families requires not only expertise that is honed over time, but also compassion and a determination to make a difference. This study revealed their tenacity, perseverance and dedication as they strove to assist vulnerable families to transform their lives. These qualities were evident in the often extreme efforts made by nurses to advocate for children and their families, sometimes in situations which required nurses to challenge the status quo or take political action. This work often remained invisible and unacknowledged because it did not fit neatly into contracts and practice guidelines. It thus seemed important when naming this study that this special commitment, which inspires and sustains the work of public health nurses with vulnerable families, was made visible.

Concluding statement

There is evidence that intensive input, facilitated by an ongoing relationship with a trusted health professional (particularly a registered nurse), encourages effective health outcomes for vulnerable families (Olds et al., 1997). It is also apparent that working with vulnerable families requires an approach that is client driven, relational and collaborative, a process that has been referred to as a health promoting model of care (Appleton, 1994b; Doane & Varcoe, 2005; Gallaher, 1997; Zerwekh, 1991b). Over the last century public health nurses have been uniquely positioned within communities to offer this service and to facilitate this way of working. However since the 1990s public health nursing has been buffeted by an era of political and ideological reform. This study has

identified that while contemporary public health nurses endeavour to work in a health promoting way with vulnerable families, the process of reaching and sustaining contact with families is now significantly constrained. The Primary Health Care Strategy (2001) has been promoted as an opportunity for innovation and expansion for nursing. It is vital, however, that the valuable service public health nurses have traditionally provided at a grassroots level within communities continues to be part of this picture. It is thus important that in looking to the future we do not disregard ways of working and contexts for practice that have historically been of value.

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31 August 2004

Alison Garlick
C/o Dr Denise Dignam
College of Humanities and Social Sciences
Massey University
Albany

Dear Alison

HUMAN ETHICS APPROVAL APPLICATION – MUAHEC 04/075
"Working with vulnerable families: an exploratory study of public health nursing practice"

Thank you for your application. It has been fully considered, and approved by the Massey University, Albany Campus, Human Ethics Committee to proceed to the Health and Disability Ethics Committee, Auckland.

Could you please forward to us a copy of the letter of response from HDEC, once that committee has considered your application?

If you make any significant departure from the Application as approved then you should return this project to the Human Ethics Committee, Albany Campus, for further consideration and approval

Yours sincerely

Associate-Professor Kerry Chamberlain
Chairperson,
Human Ethics Committee
Albany Campus

cc Dr Denise Dignam
College of Humanities and Social Sciences

19 October 2004

Waikato Ethics Ref No: WAI 04/09 079
Please include the reference number and study title in all correspondence

Waikato
Ethics Committee

[redacted]

Dear Alison

Working with vulnerable families - an exploratory study of public health nursing practice.

Investigator:	**Alison Garlick**
Supervisor	Assoc Prof Denise Dignam, School of Health Sciences, College of Humanities & Social Sciences, Massey University.
Reference:	**WAI/04/09/079**

Thank you for submitting this proposal for ethical review. It was considered by the Waikato Ethics Committee at its meeting on 15 September 2004. Thank you for your emailed letter of 13 October 2004 and the attached documents and Part V declaration in response to our letter to you dated 17 September 2004.

The above study has been given ethical approval by the Waikato Ethics Committee.

Approved Documents
- Information Sheet; October 2004
- Participant Consent Form; September 2004
- Possible questions to be asked in a guided qualitative interview
- Authority for release of tape transcripts
- Transcriber's confidentiality agreement

Certification
The Committee is satisfied that this study is not being conducted principally for the benefit of a manufacturer or distributor of a medicine or item in respect of which the trial is being carried out. This certification is for the purposes of the Injury Prevention, Rehabilitation and Compensation Act 2001.

Accreditation
This Committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

Progress Reports
The study is approved for its duration (15 months). An annual progress report is due in October 2005. A final report is required upon completion of the study. Please note that failure to complete and return this form may result in the withdrawal of ethical approval. A report form is available for this purpose and is enclosed with this letter. A Word document version is also available should you prefer to complete it in this way.

Amendments
All amendments to the study must be advised to and approved by the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

Further use of data
Please note that if the data collected in this study is to be used in another study at some time in the future, then further ethics approval must be obtained for that study at that stage.

General
It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your study.

Yours sincerely

pp Juliana Smillie

Peter D Allan
Chairperson

cc Assoc Prof Denise Dignam, School of Health Sciences, College of Humanities & Social Sciences, Massey University

Working with vulnerable families: An exploratory study of public health nursing practice

INFORMATION SHEET

My name is Alison Garlick. I am presently working as an educator for the Bachelor of Nursing programme at the Waikato Institute of Technology and as part of my Master of Arts (Nursing) degree at Massey University I plan to conduct a research study to form the basis of my Masters thesis. My supervisors for this project are Dr Denise Dignam Associate Professor and Jill Clendon Lecturer, Massey University.

I would like to invite you to take part in this research study. The information below outlines the research project and what would be expected of you as a participant.

The Manager for the Community Health Service, Waikato District Health Board has given permission for this study to be carried out. Participation in this study is voluntary, and refusal to participate or withdrawal from participation after consenting, will not affect a potential participant's employment with the Waikato District Health Board. All responses will be confidential and individuals will not be identifiable in the final report.

The Study

The purpose of this research is to explore how public health nurses work with vulnerable families. My interest in this topic has been generated from many years of working as a public health nurse in Wellington, Auckland and the Waikato. During this time I became aware of the complexity and challenges of working with vulnerable families and I am interested in how public health nurses describe their practice in this area.

The approach taken in this study will be qualitative as I wish to gather first hand descriptive accounts from public health nurses about their experience of this aspect of their practice. The aim of this research is to provide a picture of contemporary public health nursing practice in relation to vulnerable families and to identify what factors might facilitate or constrain this process.

It is hoped that this research will illuminate the scope of public health nursing practice in relation to maintaining and promoting the health of vulnerable families and the factors required to support and enhance this work. This information may have significant implications in relation to the establishment of Primary Health Care Organisations, the visibility of the public health nursing role and the planning of future primary health nursing services.

If you have had at least two years experience in the public health nurse role, are currently working with vulnerable families and are willing to talk about your practice you are invited to be one of the eight to ten public health nurse participants in this study.

The Process

Participation in this study will involve one interview taking 1-2 hours with me (the researcher) at a time and in a location of your choice and outside your working hours. The interview will be informal and fairly unstructured. I will have some questions to guide the process and you will be asked to talk about your practice using every day language and including as much detail as you are able to give.

With your consent the interview will be audio-taped and later transcribed by a transcriber who will be asked to sign a confidentiality agreement. The information given during the interviews will be confidential and seen only by myself, my thesis supervisors and the transcriber.

You may wish to edit the initial transcription or have the data that is likely to be used in the study returned to you to enable you to make any changes or to request withdrawal of anything you do not wish to be made public. The information given during the interviews is confidential and will be used only for the purpose of the research report and any publications or presentations arising from the research.

To ensure your anonymity and privacy transcripts of interviews will be coded and no identifying names of participants, institutions or third parties will be used. I will ask you to choose a pseudonym for the transcript and written report which is known only to me and yourself. Your name will not be used

during the interview unless you ask otherwise. No material which could personally identify you or any other individual will be used in any reports on this study.

Storage of Information
During the research the tapes and transcriptions will be kept in a locked filing cabinet in the researcher's home. Computer files will be protected by a password. I am the only person who will hold the key and the password. You will have the option of having the audio-tapes returned to you or destroyed on completion of the research. The data gathered from the tapes will be destroyed after ten years.

Your rights
You are under no obligation to accept this invitation. If you decide to participate you have the right to:

- decline to answer any particular question
- withdraw from the study up until two weeks after the interview
- ask any questions about the study at any time during participation
- provide information on the understanding that your name will not be used unless you give permission to the researcher
- be given access to a summary of the project findings when it is concluded
- ask for the audio/video tape to be turned off at any time during the interview.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact the New Zealand Nurses Association. You may also wish to contact the Health Advocacy Service phone: 0-800 42 36 38 {4 ADNET}

Other Information
If you choose to be involved in this study you can contact me either by phone, email or in writing to the contact details below. If you need further clarification my supervisors Denise Dignam or Jill Clendon or
I would be happy to discuss any issues with you.

Alison Garlick
16 Waterford Estate
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Hamilton07 8396631
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Dr Denise Dignam
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Jill Clendon
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Ethical Approval
This project has been reviewed and approved by the Massey University Human Ethics Committee, ALB Application 04/075 If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x9078, email humanethicsalb@massey.ac.nz

This project has also been reviewed and approved by the Waikato Ethics Committee.

Thank you for taking the time to read this document.

Alison Garlick

Working with vulnerable families: an exploratory study of public health nursing practice

PARTICIPANT CONSENT FORM

This consent from will be held for a period of ten (10) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I wish/do not wish to have my tapes returned to me.

I understand that I have the right to decline to answer any particular questions and to ask for the audio tape to be turned off at any time during the interview.
I understand that I will not be identified by name on the audiotapes or any written documentation.
I understand that I may withdraw from the project at any time and that, if I do, I will not be affected in any way.

I agree to participate in this study under the conditions set out in the Information Sheet.

Date:

Signature: .....

Full Name - printed .....

I wish/do not wish to have a summary of the study findings

Address .....

.....

Working with vulnerable families: An exploratory study of public health nursing practice

TYPIST CONFIDENTIALITY AGREEMENT

This form will be held for a period of ten (10) years

I ..... (Full Name - printed)

agree to keep confidential all information concerning the project:

Working with vulnerable families: An exploratory study of public health nursing practice.

I will not retain or copy any information involving the project.

Signature: ..... **Date:** .....

Working with vulnerable families: An exploratory study of public health nursing practice

Possible questions to be asked in a guided qualitative interview

Years in practice:

Self identified ethnicity:

Age:

How do you determine a family to be vulnerable?

Thinking about a vulnerable family you have worked with tell me about that experience.

What about another vulnerable family you have worked with?

How do you get to know which vulnerable families need your input?

If the family is of a different ethnic group or culture to yourself is there anything in particular that you do when approaching and working with them?

What enhances your ability to work with vulnerable families?

What assists you to work effectively with vulnerable families?

What is challenging about working with vulnerable families?

Is there a particular philosophy or model of care that guides your practice with vulnerable families?