Parents’ experiences of Victoria’s Maternal and Child Health service during the transition to parenthood

Abstract

Raising happy and healthy children is important for not only the child, but their family, communities and future generations. In developed countries, it is considered that children have the right to develop to their full potential and their parents are expected to provide the necessary resources, experiences and environment to do so. However, most parents need information and/or support to achieve this, which is why family services like the Maternal and Child Health (MCH) service are beneficial and important. This qualitative research reports on the experiences and opinions of 30 parents who used the Victorian Maternal and Child Health service. Some parents conveyed their satisfaction and appreciation of the service, others felt that it was only useful for monitoring the health of their child, and a final group were more critical of the service or staff, and identified areas for improvement. The opinions expressed here provide useful insight into not only the MCH service, but the types of service and interactions that parents are seeking from their health professionals.

Keywords: Maternal and Child Health service, qualitative study, family wellbeing, child development, parenting.

Introduction

We have entered the new millennium with a well-developed understanding of child development, a reasonable understanding of parents' roles in shaping this, and of assessing children's developmental outcomes using a variety of measures. There are widely accepted principles of positive parenting practices with key concepts related to teaching, modelling, listening, providing safety and warmth, as well as clear and consistent discipline; the application of which is known to promote healthy child development (Sanson & Wise 2001; Seay et al. 2014). Children are more likely to experience positive developmental outcomes if raised within a context of quality parenting and an enriched home learning environment during the first five years of life (Council of Australian Governments [COAG] 2009; O'Connor & Scott 2007; Sanders 2008). It is for this reason that some experts think that parenting and parenting interventions should be considered a public health matter (Metzler et al. 2012; Zubrick et al. 2005) and advocate universal parenting training (Sanders 2008).

Because governments both here and abroad recognise the importance of adopting positive parenting principles for not only the wellbeing of this generation, but also of future generations (COAG 2009; Swain et al. 2007), a growing number of countries are implementing programmes that support parents during their transition to parenthood, such as Good Beginnings Australia, Sure Start, Head Start, and Early Years Plan (Department of Human Services [DHS] 2007; Spiteri, Borg Xuereb, Carrick-Sen, Kaner & Martin 2014). These services typically target ‘at risk’ or vulnerable groups by providing more intense parenting training. While not a parenting programme, per se, the only universal service available to all families in Victoria is the Maternal Child and Health (MCH) service. This service has traditionally focussed on the healthy development of children, but with the growing understanding of the link between family wellbeing and child wellbeing, the service espouses family-centred practice, offering a more holistic service. Given childhood outcomes are associated with parental wellbeing, this paper seeks to explore the ways in which parents engage and evaluate the usefulness and effectiveness of the MCH service during their transition to parenthood.

Transition to parenthood

For many people, parenthood is a new and complex stage of life that engenders a mixture of delight and tension (Senior 2014) and, despite efforts to prepare for the complexities of parenthood, new parents often remain underprepared for certain aspects of their new role (Borg Xuereb, Abela & Spiteri 2012; Condon, Boyce & Corkindale 2004; Cronin & McCarthy 2003; Sanders 2016). A concept analysis undertaken by Spiteri et al. (2014) found a paucity of research on the topic, but considered the transition to be stressful, with women in particular reporting significant changes to lifestyles and routines to which it can be difficult to adjust (Deave et al. 2008). Having children creates new daily demands requiring physical, psychological, social and sometimes
Parenting research has gained renewed momentum internationally, with recent studies exploring parents’ experiences of early parenthood (Borg Xuereb et al. 2012; Deave et al. 2008; Sanders, Lehmann & Gardner 2014; Spiteri et al. 2014) and books that examine the transition to parenthood more globally (Palkovitz & Sussman 2014; Roy et al. 2014). These studies have, for the most part, drawn the same conclusions as earlier research — modern parents are often underprepared for the challenges of early parenthood, which results in feelings of distress, isolation, and sometimes ill-considered parenting practices. This can be problematic when considering that the transition to parenthood is a major developmental period for the parent and has important implications for child development and outcomes (Deave, Johnson & Ingram 2008; Walker & Kirby 2010).

Parenting services for new parents

On the face of it, this evidence supports the appeal for universal parenting education to help better prepare and support parents, but there is limited understanding of how this would be accepted by the parenting community. Parenting and child development research has generated knowledge about characteristics associated with poor childhood outcomes, the efficacy of parenting programmes designed to avoid these outcomes and, more recently, parents’ experiences of early parenthood and how these might impact on the wellbeing of parent and child. What is lacking, however, is information about the intricacies of parents’ access to, and engagement with, parenting resources that aim to promote positive parenting practices and concomitant positive childhood outcomes.

Various parenting programmes have been developed to respond to parenting needs over time, but these have typically targeted ‘at risk’ groups, have often been dogged by poor attendance rates (Department of Education and Early Childhood Development [DEECD] 2011a; DHS, 2007; MCEECDYA, 2010) or, as with antenatal classes, are considered insufficient for addressing parents’ needs (Billingham 2011; Brixval, Axelsen, Andersen Due & Koushede 2014). Parenting information is well distributed through the Raising Children’s Network as a universal resource offered to all new parents in Victoria, Australia. It is a media-based (Internet and DVD) resource that provides information about child development and childhood illnesses and disorders. It offers parenting tips to help with day-to-day parenting decisions, and features other parents’ stories and experiences (http://raisingchildren.net.au/). In addition to these government-distributed resources, there are innumerable books, pamphlets, magazines and internet sites that parents can access independently. Some experts argue, however, that formal universal parenting training (for example Triple P™ or 123 Magic™ Parenting Program) is required if seeking to strengthen families and ameliorate poor childhood outcomes on a global scale (Hahlweg, Heinrichs, Kuschel, Bertram & Naumann 2010; Ulfsdotter et al. 2014; Winter, Morawska & Sanders 2012).

The Maternal and Child Health service

A universal family service offered to all new parents in Victoria is the MCH service. While not a parenting training programme as such, it aims to provide general and specific developmental and wellbeing education and support to all parents. This service is ideally placed to identify and support families experiencing hardship; and is particularly relevant for families living in rural and remote areas, where other face-to-face parenting resources are scarce or non-existent.

The MCH service is a state-based initiative usually delivered by local councils in conjunction with the Department of Education and Training (DET). It is a free and universal service aimed at supporting families with issues to do with parenting, health and wellbeing. Its core functions include education, support, monitoring and referrals to other community resources. The goal of the MCH service is to “promote healthy outcomes for children and their families, providing a comprehensive and focussed approach to managing the physical, emotional or social factors affecting families in contemporary communities” by “enhance[ing] family capacity to support young children and address[ing] physical, emotional, social and wellbeing issues affecting young children [and] enhance[ing] community capacity to support young children and their families ...” (DEECD 2009a, pp. 6 & 7).

The service consists of 10 key ages and stages (KAS) consultations with MCH nurses that begin at home one or two days after birth, and then at 2, 4, and 8 weeks, at 4, 8, 12 and 18 months, and 2 and 3½ years of age. Parents are encouraged to use these consultations as an interactive source of information and support, an opportunity to discuss their parenting experiences, and as a source of advice on how to optimise their child’s wellbeing. Nurses offer advice on the general day-to-day care of babies, with particular reference to feeding, sleeping, safety, language development, play and immunisations. They provide health checks in relation to growth, vision, hearing, language and general development. Parents are given a booklet to record their child’s development and immunisation at the first consultation, and brochures relevant to the child’s age and stage are provided at the first and subsequent consultations. They also address issues to do with mothers’ wellbeing, including postnatal depression (PND) and family violence. Some centres offer additional services like parenting education sessions, parent groups, playgroups and programmes that cater to the specific needs of families in their community. The delivery of these services depends on municipal funding and the attitudes of nurses in charge (DEECD 2011b).

The social context in which children are raised has changed dramatically since the inception of the MCH in 1917 and contemporary services have adjusted practice to accommodate these changes. With growing commitment to evidence-based practice, the service has moved beyond basic health, nutrition and developmental issues (which gained them the reputation of being a weights and measures service), and they now attempt to address issues of parenting and family support that cater to the changing nature of families and society as a whole. With greater diversity in family structure and functioning resulting from issues like sole parent households (Robinson 2008), mothers’ participation in the paid workforce (ABS 2006), less involvement by extended...
family (Vargas 2008), a noticeable socio-economic divide, cultural diversity (Ochiltree 1990; Sanson et al. 2002), mental illness, drug and alcohol problems and family violence, there is a greater level of social stratification that service providers need to take into account (Lexmond & Reeves 2009; O'Connor & Scott 2007). Over the course of its existence, the service has evolved to include an enhanced MCH service for parents in need of intensive support, a 24-hour MCH line for parents who have questions or concerns at any time of the day or night, and formal screening of risk factors like PND and family violence (DEECD 2009b). The service will no doubt continue to evolve as it adjusts to the changing needs of modern families; and it is important that parents contribute to this evolution.

The Victorian MCH service has been evaluated on three occasions. In 1990 and 1997 the opinions of service users were sought, with a further formal evaluation in 2005 with similar findings being reported at all three time points (DEECD 2011b; DHS 2006; Ochiltree 1990). The views and experiences of clients and other stakeholders were ascertained on matters of performance, implementation of new models, coordination and collaboration with other community services, and collection of outcome data. It was found to meet its objectives by providing a range of services that support, educate, refer and promote family health (DHS 2006); however, variability in service provision was found between municipalities. This was typically attributed to the individual nurse's personality or priorities of individuals in charge of the service. All three studies found that client engagement, or lack of engagement, was associated with particular demographic characteristics. Mothers of first-borns were more likely to use the service more often, and mothers from non-English-speaking homes and working mothers used the service less often. Ninety to ninety-five per cent of mothers found the service either helpful or very helpful, and particularly helpful for first-time mothers who lacked experience and sometimes confidence. Respondents said that it was a non-threatening support for mothers who might not have other sources of support, and they were content with the quality of staff and the advice they received. Mothers who did not find the service helpful reported personal qualities of the staff (like nurses who did not have their own children or were too bossy) that influenced their opinion. More recently, the DEECD undertook a review and consultation process as part of establishing its future direction. While the service will remain universal, the language is suggestive that it, too, is focussing on vulnerable and at-risk families (DEECD 2014).

While not a formal evaluation of the MCH service, this paper reports on one part of a larger doctoral study that explored parents' engagement with parenting resources. The information presented here provides a useful and independent account of parents' experiences of the MCH service and the ways the service impacted on their transition to parenthood. The results have implications for the provision of similar and related services, both in Victoria and at the national and international level in relation to what resources parents are seeking and how they want to engage with information. There are comparable services in all other states of Australia and indeed in most developed countries. Moreover, while developing countries have a need to prioritise the physical health of mother and child as a way of reducing mortality and morbidity rates, creating a supportive environment and continuum of care for mothers beyond the birth of their child is gaining momentum in developing countries (United Nations Children's Fund [UNICEF] 2008). While the participant views presented here are about contact with a specific service, they also provide useful insight and guidance for any professional interaction with new parents if wanting to provide a supportive and client-centred practice. Parents are affected by the expectations of them from their families, communities and the broader social structure (Borg Xuereb et al. 2012; Roy et al. 2014; Spiteri et al. 2014) and need their health service providers to understand the impact of these influences, particularly if they aim to provide a holistic service that works within a broader social context.

Methodology
The doctoral study mentioned above explored the nature of early parenthood and parents' engagement with parenting resources (Sanders 2016). The purpose of this paper is to present only those findings that relate to the MCH service. Earlier evaluations of the MCH service have reported extremely high service user satisfaction scores (90–95%) (DEECD 2011b; DHS 2006), but this is unsurprising, given most health service surveys report high client satisfaction (DHS 2006), and often only provide a partial indication of service user attitudes. The doctoral research provided parents with the opportunity to express opinions of any and all services freely, rather than attempt to evaluate any single resource. A constructivist Grounded Theory (GT) framework to data collection and analysis was employed (Charmaz 2006; Glaser & Strauss 1967; Strauss & Corbin 1990). However, the data presented in this paper resulted from a qualitative descriptive design (Sandelowski 2000) to represent parents' experiences of the MCH service during their transition to parenthood. There were some strong opinions about the MCH service and its impact on parents' transition to parenthood and so the authors thought it would be a missed opportunity not to share these views. While the data may be particularly relevant to the MCH service, it is also pertinent for other professionals who work with new parents as a useful guide about the type of support and interactions parents are seeking.

Purposive sampling methods were used to recruit participants who were parents of 0- to 10-year-olds. Recruitment took place in three rural and regional shires in Victoria and, while all participants were residing in rural and regional Victoria at the time of interview, experiences of early parenthood took place in metropolitan Melbourne for almost half of the sample. A multifaceted approach was taken to recruitment, including direct invitations sent by the researcher, articles published in three local newspapers, posters placed in sites where parents gather, and notifications lodged on selected Facebook sites. The researcher also attended a number of mothers' groups and neighbourhood house groups to speak with mothers directly about the study. Parents were interviewed about their experiences of parenthood and information-seeking behaviours using a semi-structured interview style (Galletta 2013). Questions changed from a narrow focus on parenting resources, to a broader understanding of parents' transition to parenthood. The interviews were audio-taped, and took between 30 and 60 minutes.

Interviews were transcribed and transferred to the qualitative software package NVivo (version 10) for a line by line inspection
of the data, which resulted in the identification of emergent codes and categories. These were systematically examined for interactional properties and core themes were identified as a way of representing the data (Strauss & Corbin 1990). One of the core concepts, namely “parents’ experiences of the MCH service”, is discussed here.

Ethical considerations, as outlined by the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council 2007), were met. A number of strategies were implemented to protect participants’ rights and wellbeing and these were approved by the La Trobe University Ethics Committee (FHEC12/190) prior to commencement of data collection. One of these included the participants’ right to self-select a pseudonym for the purpose of anonymity.

**Participants**

A total of 30 parents voluntarily participated in this study (26 women/4 men). Participants were aged between 25 and 51 years (mean =38) at the time of interview and 19 and 43 years (mean=30) when they had their first child. Seventeen were married or in a de facto relationship at the time of interview and the other 13 were single (either separated/divorced or never partnered). Two participants were stay-at-home parents, three worked full-time, eight worked part-time, seven were full-time tertiary students and 10 combined tertiary studies and part-time work. Participants were asked about their annual household income as a guide to their socio-economic status. Sixteen participants were in the two lowest income brackets and had an annual household income of up to $50,000, and the remaining 14 participants had an annual household income of $71–90,000 or over $90,000. The participants in the higher income brackets were mainly married or in de facto relationships, and the participants who had lower annual incomes were typically solo parents who were studying and often combined their studies with part-time work to supplement their sole-parent pensions. One participant was originally from Zimbabwe and settled in Australia at the age of 12 years of age and the remainder of the sample consisted of Indian originsettlers. Sixteen participants experienced early parenthood in metropolitan Melbourne, a further 12 resided in regional Victoria and the remaining four were from rural Victoria. One parent (Dave) was an adoptive parent, while the remaining 29 participants were the biological parents of their children.

**Findings**

The participants’ opinions and experiences of their interactions with the MCH service and how it impacted upon their transition to parenthood can be organised into four principal areas: the need for emotional support; the benefits and perceived need for practical advice and information; the importance of flexibility; and parents’ engagement with written material. For a number of parents, mothers in particular, parenthood was not as they had anticipated. They felt unsure about their ability to parent well, and they valued the support they gained from the MCH service. Some parents appreciated the practical support offered by nurses, particularly when they encountered problems or difficult situations. There were also some criticisms of the service, which, while not obstructing a successful transition, reveal ways that the service could improve to further support parents during their transition.

**Parents’ need for emotional support**

All parents experienced some form of emotional distress in relation to being a new parent. Emotional difficulties appeared to be part of the terrain, and probably more prominent than most parents had anticipated. Negative emotional responses predominantly consisted of disappointment, self-doubt, guilt, isolation and loneliness and mostly stemmed from unrealistic expectations of what parenthood would be like, perceptions of social judgement and doubt in their ability to parent well.

**Interviewer:** It sounds like the MCH nurse was a source of support.

**I absolutely had a picture of what parenthood would be like and it was almost the exact opposite to what it turned out to be ... I thought I was going to be able to do the traditional mother thing — I would bake and have a nice home, like my mum, but with a more modern twist, and probably a bit more funky. That was my plan, but it didn't go to plan ... I never thought it was going to be this hard. (Rose)**

**When he was crying I felt like they [people in the street] were thinking “why aren't you picking that baby up?”, so it was hard to feel like I could go out with him ... But it was isolating I think ... At the time we didn't have many answers to explain why he was unsettled, so my perception was that they would think that it's me. (Laura)**

It is because of these doubts and worries that some mothers saw their MCH nurse as a life-line and a source of comfort when they needed confirmation that their parenting was satisfactory and they were not going to harm their babies. Kim, for example, was happy with her nurse's more relaxed approach:

**We had one lovely lady. She was the first one I had. I remember her saying to me, “don't worry love, we have all burnt the kids or made the bath water too hot by accident, it's all a learning curve”. So she made me feel at ease straight away. (Kim)**

Like Kim, it wasn't the expert information that Sophie was after, but rather a comforting and supportive word:

**I went to all the scheduled appointments, and I remember I liked going to them. [Researcher: What did you like?] Well, I don't remember that I really got anything out of it except that they would tell me that I was doing fine and that I was doing a good job. And I remember that was all that I really took away, that I was doing fine and everything was fine. (Sophie)**

**I really liked to meet with the health nurse, she was calm and comforting. (Milly)**

The MCH nurse was an invaluable source of support for new parents who were feeling unsure about their parenting abilities. Nurses were sometimes used by the participants as a sounding board, or as someone to provide them with confirmation that they were “doing okay”.

**I needed to know that everything was fine. The MCH service was our check-in point to make sure that her growth and development was on track. (Mia)**
The role of the MCH service as an “emotional security blanket” was also evident in the reports by parents who found that it was missing or inadequate. Several mothers thought the service emphasised the health and wellbeing of their baby, while their own wellbeing was overlooked. These mothers wanted to discuss their emotional wellbeing, but appeared to want the nurse to initiate or invite the conversation.

I mainly used them as a weights and measures service, but I sometimes wished they would have checked how I was going, not just the baby. (Jessica)

I remember they did the PND screen and I was answering the questions thinking, “just ask me how I am feeling, I would have said I feel like rubbish”. They asked really specific questions related to PND [but] there was no general chat … there was no opportunity to talk about how I was doing or how his dad was doing because he was really struggling as well. (Hannah)

My MCH nurse wasn’t very helpful. She was very much about the baby. It was all about weighing the baby, rules and regulations, writing in the book, asking me yes/no questions … She was very businesslike … It was very much about the child. (Stephanie)

Benefits of practical advice and information

While the emotional transition to parenthood can be difficult, it can be alleviated when parents have tools which increase their confidence and, ultimately, reduce their self-doubt. The MCH service was a useful source of information and advice both generally and for those parents who were struggling with a particular issue.

I went to the MCH nurse and said “I’m not sleeping, she’s not sleeping, she’s using me as a dummy and I’m exhausted, what do I do? Please help!” She was so supportive [and gave me] very practical information that was quite lifesaving. (Rowena)

The MCH line was also a trusted service for some parents who required help with a particular issue or when they encountered a problem outside of normal working hours.

I remember when my son had been crying for 8 hours solid and I was beside myself. I didn’t know what to do … so I ended up calling the MCH line and they were great. They just talked me through and by some miracle he stopped crying during the phone call. They would not let me go until he had stopped crying … I remember they were really quite good and I called them quite a bit. (Hannah)

I used the helpline a few times when I wasn’t sure if I should take her to the hospital or not. I think they always gave me good advice and I trusted them. (Sandra)

Parents’ perceptions of need

It was apparent that parents had differing needs and experienced differing benefits from the service. A small number said they coped well with the transition to parenthood and had no need to engage with the MCH service beyond its function as surveillance of their children’s health and development. These parents had a fairly indifferent response to the service, but this might have been different if they had encountered problems or had cause for concern.

There has not been anything of concern so there hasn’t been a problem for them to help out with. (Dave)

The nurse was okay, but we didn’t really need to discuss parenting issues with her. We just went to get the girls checked-over. (Ben)

I did not really find them helpful beyond the weights and measures aspect of the service. (Michelle)

It is worth noting, however, that two of these participants were men and were not the primary carers, which may have influenced not only their perceived need of the services, but also what they felt they could gain from the service considering the name, MCH, infers that it’s primarily set up for children and mothers.

Moreover, it could be said that the mothers who said they had not needed the service may have thought differently had they realised that some of their parenting choices fell outside normative parenting practices (such as feeding solids at three months of age). In the main, younger mothers were more likely to have firm beliefs and were less likely to be swayed or even open to other people’s opinions about parenting and, as such, were perhaps less likely to consider the necessity or importance of a service to help with the transition to parenthood. In many ways, these mothers were able to avoid the negative consequences associated with self-doubt and guilt, but their lack of reflection also meant they may have made some flawed parenting decisions. One participant reflected on this when she was older:

I did not really look for information. Or if I did it was information on the packets of food. I just dealt with things as they came up … I was young and naive and it didn’t really occur to me to look for information. (Michelle)

The importance of flexibility and availability

While a number of parents said they greatly appreciated the support and advice provided by MCH nurses, and that this service helped with their transition, a fairly common criticism was some nurses’ approach to differences of opinion or parenting practices. Some of the participants did not appreciate what they perceived as an inflexible approach taken by some nurses. They would have preferred to engage in discussions about issues that they disagreed about as opposed to hiding their thoughts and actions in order to avoid being “told what to do” (Kim).

The problem you come up against is when you’re not on the same page with methods or theories. That’s when you realise that you’re just going to have to go this alone … The MCH nurse is helpful if you want to do things the way she does. She’s helpful if you agree with controlled crying or introducing solids at four months. She’s helpful until you go, “I don’t want to do that — I want to ….” (Susie)
I used the MCH service in the beginning, but I felt like she judged me for being a sole parent who used donor sperm. She tried to pressure me into choosing a surname for my baby (quickly) and it just felt really inflexible so I didn’t go anymore. (Sarah)

I asked the MCH nurse about giving my baby fruit in a jar, and she adamantly said “No, you should not feed your baby any fruit from a jar whatsoever. You should wait two months until your baby can eat real fruit, held in the hand, so that she gets the proper nutrition from a fresh piece of fruit.” When I spoke to my peer group of mothers they all said “That’s ridiculous; what a strange thing to say, of course you can feed your child puréed fruit.” I think the nurse had a problem with it being a processed food, but I had no idea how to cook and stew an apple or purée it … I would have considered options if I was given a proper reason. (Kate)

These are examples of what is, no doubt, a difficult line for nurses to tread. On some occasions, and with some families, they may need to engage in conversations in which the parents’ needs and views compete with the nurses’ and indeed the developmental needs of the child.

Moreover, the restricted hours of the service were problematic for a small number of families. As a sole parent who returned to work shortly after the birth of her son, Michelle wished she could have accessed an after-hours service because she lacked confidence in her parenting abilities and lacked adequate support. Two other participants said that their partners struggled in certain ways and would have liked an after-hours service so they could engage with the service as well.

Engagement with written material

As a supplement to face-to-face information, parents are provided with health promotion brochures known as “tip-sheets” at various KAS consultations (41 in total). These were recently amended and condensed to reduce the overwhelming volume of material, while still maintaining relevance (Department of Education and Training 2016). Two participants read these religiously, but the others were mostly underwhelmed by the nature of information or overwhelmed by the volume of information. The following statements represent the range of responses:

I read all the information they gave me — I wanted to know everything about everything. (Milly)

I didn’t really read the information unless it was relevant to my circumstances — like trouble with breastfeeding. (Sarah)

There was a lot of good information, but there were so many pamphlets. I think there was like 10 pamphlets each time … I flicked through them and if there was a really appropriate picture I would have a look. (Hannah)

There’s a lot of information in them. I’m talking A4 envelopes filled with 10 to 15 pieces of paper and pamphlets … There were some weeks where literally I opened it up and read the main document pages and shoved the rest back in the envelope and didn’t have a chance to read it for two weeks. I’d get around to it, but I’ll tell you right now, there must be a lot of people out there that don’t even get to read it. (Kate)

While it is important for the information contained in these pamphlets to be distributed in one form or other, it is important for nurses to be aware that the majority of parents do not read all the information. Pamphlets cannot be relied on, particularly when a problem or concerning behaviour has been identified.

Discussion

The purpose of the broader project from which this study is derived investigated the ways in which parents engage with parenting resources during the transition to parenthood. The purpose of this paper is to convey parents’ opinions and experiences of one resource in particular — the MCH service. While some parents were critical of the service or aspects of the service, there was general satisfaction, particularly as a weights and measures service, and as support for parents who doubted their abilities and struggled with certain parenting issues. While the overall feeling expressed by participants of the service was positive, there were also some specific criticisms. Some of these were particular to individual staff, and others related to the service as a whole. Most notably was mothers’ desires to be better supported. Evaluations of the MCH service are scarce, but independent client surveys undertaken in 1990, 1997 and 2006 reported criticisms similar to those expressed by participants of this study. Unlike the current study, however, prior evaluations also reported high parent satisfaction scores (approximating 90–95%) (DHS 2006; Ochiltree 1990). Much of this can be explained by methodological differences, and participants’ proclivity for overcompensating in health surveys (DHS 2006), but the evidence here suggests that a qualitative approach might yield more candid results when seeking client appraisals.

While this study was not an evaluation of the MCH service, participant views reflected some of the same limitations reported in earlier evaluations. Firstly, participants reported using the service more often for their first-born — when they lacked confidence and experience, but were less inclined to use the service with subsequent children. Secondly, working parents felt excluded because there was no after-hours service to help facilitate their engagement. An after-hours service might improve some of the non-attendance issues that have plagued the service for a long time (DHS 2006). Thirdly, participants of earlier evaluations reported dissatisfaction with the service based on personal qualities of the staff; a sentiment echoed by some participants in this study. The nature of these criticisms differs slightly, with early reports based on nurses not having their own children or being too bossy (DHS 2006; Ochiltree 1990), and current remarks related to a sometimes inflexible approach taken by nurses, a lack of perceived confidentiality in rural areas and a lack of connection between nurse and parent. A number of comments also related to systemic or service policy attributes. Even though the service changed its name and philosophy to include mothers a long time ago (Sanders 2014), participants believed that the focus remained on infant welfare. In recognition of social determinants of health, in particular the way that parent and family wellbeing impacts on childhood outcomes, MCH service policy guidelines promote the health and wellbeing of parents (DEECD 2009b). This is most evident in recent moves to implement PND and family violence screening into consultations. Without underlining the importance of these assessments, some participants suggested that the application of these assessments remains one of
monitoring as opposed to promotion and prevention. Screening for PND is found to be effective in ameliorating ongoing mental health problems for some women and their families (Leung et al. 2011), but some participants’ comments suggest that it might come at the expense of conversations about non-clinical distress. It appears that some parents do not feel the service is fully engaging with them and their needs. There is a perception that nurses are required to monitor and survey potential health risks, but this is sometimes done in a way that prevents rapport building and a connection between parent and worker. Perhaps this comes from remnants of old models of service provision based on economic rationalism and surveillance, as opposed to a holistic or ecological approach to family wellbeing (Maddocks & Maddocks 2000; Reiger 2001). Perhaps nurses are so time-pressured they do not have sufficient time to provide holistic family support. Whatever the reason, there are parents who feel they would benefit from more engaged conversations with MCH nurses (or some other professional) about their experiences of early parenthood.

Nurses are in a prime position to engage with families early and have a potentially enduring impact on child, parent and family wellbeing. Given the changing nature of families and the social problems experienced by many children, we need to ask if the current model of care is catering to the needs of today or addressing the needs of yesterday. If it remains essentially a service based on surveillance then it probably falls short of its potential. If, however, the service is able to engage with families and provide them with the necessary support as they transition to parenthood, there is great potential to build solid relationships of trust and respect that allow nurses to raise important health and social issues with parents that are in the best interests of their children.

There are lessons to be learned here for other professions as well. A key message is that mothers (and some fathers too), want to be able to talk about their concerns and require support and validation in their new role. These conversations can be had by other health and community professionals. GPs, playgroup coordinators, physiotherapists, childcare providers and the other services that new families engage with can play a role in supporting new parents. Moreover, professionals who work with parents engaged in specialised services such as drug and alcohol counselling, mental health support, and family violence programmes would benefit from a solid understanding of parents’ experiences and needs during the transition to parenthood and the ways it can impact and be impacted by these issues.

Conclusion

This study is limited by sample size, the homogeneity of the sample population, and a lack of intentional focus on the nature of parents’ experiences and engagement with this particular service, but the examples presented here provide incentive for further research into the MCH service and its future direction as a key contributor to children’s early development and families’ wellbeing. Of particular interest would be the identification of service provision that does not fulfil policy directives. When we consider that the MCH service is the bedrock of universal parenting support, an examination of why some parents are not feeling engaged with the service is essential to further enhance this important service. Also of interest might be the use of timely online resources that cater to the stages of development and individual needs of families. Not only are participants’ views relevant to the MCH service, but it provides a useful summary of parents’ needs for similar programmes, both here and abroad.

The Commonwealth and Victorian governments recognise the importance of social determinants of health on children’s immediate wellbeing and future outcomes. They have strong policy agendas aimed at reducing childhood vulnerability and disadvantage, and improving childhood outcomes. The MCH service is one component of the early years services that seek to promote this agenda. While many parents benefit from the service, some parents think the service could be improved with extended after-hours service, improved maternal support, and a more flexible approach taken by some nurses.

References


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