**Introduction**

Services for families play a critical role in supporting the early developmental years for children and parents identified at risk for health and wellbeing. Australian health policy mirrors international trends (OECD, 2012; UK Department for Education, 2013), in promoting partnership over expert-led models of care (Children Youth and Families Division, 2010; NSW Department of Health, 2009). Here, child and family health nurses (CFHNs) utilise the qualities and interpersonal communication skills required to work *with* families in a partnership relationship (Davis et al., 2002) as parents participate in decision-making to develop parenting capabilities, confidence and self-efficacy (Berry et al., 2015). Capacity-building is defined here as parents being able to recognise and act on issues that have a bearing on their wellbeing and that of their children. Capacity-building, in turn, contributes to resilience, which is about helping parents learn to create the conditions that positively affect their own and their children's wellbeing, changing trajectories that have negative consequences for wellbeing, educational achievement and social participation (Edwards and Apostolov, 2007). Partnership practices are a distinctive form of relation between families and CFHNs, in which learning is a key feature in bringing about change (Fowler and Lee, 2007).

Studies show that partnership practice enhances family outcomes (Fowler et al., 2012a; 2012b). However, CFHNs sometimes experience difficulties when using a partnership approach, which often requires challenging parents' beliefs and deciding together on alternative behaviours. CFHNs may become doubtful about using their expertise, or get 'stuck' in a relationship through fear of undermining trust.

The paper reports the outcomes of an ethnographic study shadowing CFHNs in home visiting and day-stay services in Sydney, which produced 52 sets of fieldnotes. The aim

of the study was to identify the most effective practices for seeding positive change in disadvantaged families with young children, in the context of Australian child and family health services that facilitate change through educating parents. It also aimed to discover how systemic features of such services enable and constrain CFHNs and parents working together to build resilience by learning about normal parameters of child development, behaviours and expectations.

The paper presents an original model comprising four distinct partnership activities showing how CFHNs use their expertise in capacity-building processes that foster resilience in families. It does this by briefly reviewing the partnership literature, outlining the theoretical framework, describing the analytical approach, exemplifying the four activities with qualitative data from one interaction, and discussing implications for practice.

**Literature on partnership**

Partnership is about professional expertise working in unison with families' strengths to enhance outcomes, including child development, parent-child interaction and psychological wellbeing (Davis and Meltzer, 2007). While there are different understandings of how it is enacted, calls to clarify the concept of partnership and the role parents might play (Lee, 1999; Taylor, 1998) necessitate documenting the complex practicalities (Kenyon and Barnett, 2001) involved in helping families without undermining the motives and integrity of professional practice. For example, a multidisciplinary team approach involving collaboration and partnership between health professionals supporting families with complex needs was recently used to assess the influence of an early parenting program on improved parenting capacity and self-efficacy (Berry et al., 2015).

Professional expertise in partnership is underpinned by CFHNs' qualities and interpersonal skills, yet studies show it can be difficult for CFHNs to know how and when to use their knowledge and skills to challenge families to change parenting behaviours (Rossiter et al., 2011). For change to occur, CFHNs must be explicit about their expertise, and understand how they expose families to new ways of thinking about and doing parenting (Fowler et al., 2012b), without overwhelming or alienating them. This paper shows how CFHNs accomplish this.

Taking a learning approach to understanding partnership practices enables a distinctive way of examining the importance of professional expertise. For example, Pelchat (2010) defines partnership in the context of interdisciplinary interventions for families adapting to having a child with a disability as a shared experience of 'support for and responsibilization of the families' (p. 212). Partnership leads to dialogue, extensive learning, reflection and transformation for all involved. However, with limited exceptions (Hopwood and Clerke, 2016; Lee et al., 2012), few studies systematically apply learning theory to the problem of how CFHNs productively use professional expertise in partnership work with families without threatening the relationship.

**Key concepts**

This paper uses Vygotskian (1978) concepts to build on previous studies investigating effective partnership (Hopwood and Clerke, 2012; 2016). Central to this is mediation, a process in which concepts are used as cultural tools with which to work on problems. Learning involves using cultural tools in increasingly informed ways to solve problems (Edwards, 2009). The role of mediation is to change the relation between the parent and that problem. Mediating *tools* are central to this change.

Relevant mediating tools here are what Vygotsky (1978) termed scientific and everyday concepts. Scientific concepts refer to interrelated abstract ideas underpinning professional knowledge and applied in practice; the specialist parenting knowledge and expertise CFHNs bring to partnership. Everyday concepts are concrete, particular ideas arising from families' everyday lives; the constructs in play when parents respond intuitively to their children. The former exist within an abstract systematic structure while the latter arise spontaneously through direct experience. Mediation also 'works back' on the parent to change their capabilities and self-beliefs. This reverse action is at the heart of a Vygotskian understanding of how capacity-building fosters resilience.

**Methods**

The study took an ethnographic approach to generate a detailed picture of the partnership work CFHNs undertook with families in the environments in which they interacted, rather than a large scale, quantitative study of clinical interventions. CFHNs are similar to United Kingdom health visitors (Cowley et al., 2007) and Scandinavian child health nurses (Fägerskiöld et al., 2000). Ethnography involves researchers immersing themselves in the day-to-day lives of the cultural groups they study to produce insider knowledge about these groups. The study employed the ethnographic method of shadowing, defined as involving 'a researcher closely following a member of an organization over an extended period of time' (McDonald, 2005, p. 456). Shadowing has recently emerged in management and organisational research (Cuncliffe, 2010; Czarniawska 2007), as a perspective-gathering mechanism for generating rich, thick descriptions (McDonald 2005) in diverse organizational settings and technolgocial domains.

Three organisations participated in the study in 2015: Karitane, Tresillian and Northern Sydney Local Health District. Approval was granted by South Western Sydney Local Health District Human Research Ethics Committee (HREC/15/LPOOL/77) and ratified by University of Technology Sydney HREC (no. 2015000284). Pseudonyms are used for organisations and participants.

Each organisation provides a range of services for families, including day stays and home visits, focusing on issues such as difficulties with feeding, sleeping and settling. Day-stay services operate like clinics, with families attending appointments with CFHNs and sometimes psychologists, for between four and seven hours, typically visiting two or three times. Home visiting involves a CFHN meeting families at home for one or two hours, with contact extending over weeks or months.

Qualitative data were generated through shadowing practitioners across the three organisations. This involved following, observing, and typing up handwritten fieldnotes about how CFHNs worked with families. Sixteen CFHNs were shadowed on 22 day-stay and 30 home visits with 43 families, producing 52 sets of fieldnotes.

Analysis followed Srivastava and Hopwood's (2009) iterative and reflexive approach to spark insight, develop meaning and identify patterns in how professionals used scientific concepts to mediate change in families by challenging everyday concepts to develop confidence and build resilience. Data were systematically coded by Hopwood and Clerke, using MacQueen et al.'s (1998) structured team-based process to enhance analytical validity and inter-coder agreement. This involved synthesising what was known about partnership interactions, defining inclusion/exclusion criteria, and learning how to recognise these in 'natural language' (p. 31). Each coded the text in separate Excel spreadsheets, tagging the four activities across the entire dataset for

retrieval and measurement, and highlighting the occurrence and duration of each activity. The criteria for each of the four activities were refined as the dataset was analysed by reading, retagging and rereading. Reliability and internal validity were confirmed through independent application by Hopwood and Clerke to a further data subset, from which the example that follows was selected. Face validity was established by presenting the model to CFHNs for discussion, and through consideration of the implications for practice by Chavasse, Fowler, Lee and Rogers.

**Results**

The study found that partnership between CFHNs and families was accomplished through four distinctive activities: locating and orienting change; creating new meaning for change; change through joint action; and planning for change. Each activity is defined according to a specific purpose and role of professional expertise. Illustrating how partnership works in this way is new, and builds on the Vygotskian concepts previously outlined. A table (insert link) documents the occurrence of these activities in all 52 visits, showing the prevalence of the activities and their validity across a range of challenges, goals and circumstances, and exemplifying content within each activity. The analysis shows that of the four activities, all except joint action were present in all interactions across the dataset. This is because in some home visits, either the child was already asleep or was not ready to feed, so no joint action was needed. Although seemingly linear, in many visits each activity unfolded around several foci, sometimes closely woven together, at other times cycling through separately and then revisiting activities.

To better explain each activity, their relationship, and their significance in practice, the discussion focuses on one interaction between CFHN Carol and first-time client Priscilla

during a day stay (visit 37), focusing on Priscilla's difficulties breastfeeding and settling her infant son George. The example illustrates each of the four activities, which are seen as sociomaterial interactions between CFHN, parent, child, objects (pram, dummy and chair) and the physical environment in the organisation or home that shaped the interaction, rather than conceptual ways of thinking. Tracking the relationships between the four activities illustrates the way they shift within this one interaction, yet the key points are representative of the broader dataset.

*Locating and orienting change*

This activity sets the scene for change in families' beliefs and behaviours. The interaction occurs at the start of the day stay, as Carol explores why and how Priscilla has come to the service, and identifies her goals, home environment, relationships, and relevant circumstances. The purpose is to retrospectively understand what is going on at home (the social context) and with what effects on her family, and to introduce the possibility for change. The activity begins with Carol asking about Priscilla's breastfeeding experiences.

Carol:     Is he feeding each time he wakes through the night?

Priscilla:  Yes, sometimes it's difficult, but it varies

Carol:     It's tricky in the early stages. Tired and hungry signs look the same. We look for a cluster of signs. Is he taking both breasts?

Priscilla:  He did at first, but he had reflux, and the GP suggested doing only one. He feeds for an hour, then comes off, and seems hungry or frustrated. I've got flat nipples but he has no problems latching on

Carol       For 50% of people it's like that. For everyone else, it's a big learning curve, and a big learning curve for the littlies.

Although the discussion is about breastfeeding, Carol's focus is on understanding the social context that potentially makes it possible for Priscilla to change. Carol's questions elicit responses from Priscilla that build a picture of her parenting concepts and experiences, how she feels about her capacity to parent, and her confidence in being able to provide a safe, nurturing environment for George. Carol positively acknowledges the difficulties Priscilla experiences and introduces the idea that breastfeeding is a learning process which does not always go smoothly, rather than something parents should instinctively know how to do.

*Creating new meaning for change*

In this activity, Carol introduces scientific concepts in the form of categories of milk supply and flow, to begin changing the relationship between parent and problem from my son won't feed properly to the idea that breastfeeding needs to be learned.

Priscilla:  His weight's not good, but he's feeding so much, one hour at a time, gulping but not gaining

Carol:      It looks like he's sucking a long time, but it's not nutritive sucking, it's comfort sucking

Priscilla:  Recently, he gets more agitated, it's painful and I can't do it anymore

Carol:      Sounds like you have good milk supply, so he quickly gets used to it pouring out. It's part of the learning process, to keep sucking and drawing down for more. If he gets fussy, it's because it's slowed down, he doesn't realize he

has to work harder for the let down. You have to reassure him, stay calm. From your tone, he will understand.

By listening to her responses, Carol places Priscilla into the category of having good milk supply. This category becomes a mediating tool that Carol uses to empathetically challenge Priscilla's anxiety about her capacity to nourish her child through breastfeeding. The interaction follows a path from Priscilla's everyday response—'he's gulping [milk] but not gaining [weight]'—to the idea that there are different kinds of sucking—comfort and nutritive—which have different meanings. The context for changing Priscilla's understanding of why her son is sucking a long time but not gaining weight is set up by the idea that breastfeeding involves learning on the child's part. Carol redirects the idea back to Priscilla to consider together how she might facilitate her son's learning.

*Change through joint live action*

This activity is distinguished by children's immediate needs and responses, which trigger joint action. The situation is now live, and learning occurs as the CFHN draws on different aspects of expertise to guide and support the parent, suggesting ways to navigate points at which their desire to change comes into conflict with their experience.

Carol:     Have you tried a football hold?

Priscilla:   In hospital, but I couldn't see as my breasts are so big

[she moves position]

Carol:     How's that feeling?

Priscilla: Better

Carol: It's good you stopped, moved and repositioned him. You can hear he's gulping. He's really going for it. The milk will quench his thirst in the first 25 drawing sucks, then he slows down, pausing longer and going well.

Carol suggests a different breastfeeding position, while positively reinforcing how Priscilla moves her body in response to her child's cues. Typically for this activity, new meanings continue to be made about differences between sucking and feeding in relation to milk flow.

*Planning for change*

The focus shifts to the conditions that enable parents to continue with new strategies, where their relationship to problems such as feeding is changed by the presence of new mediating tools. This activity is about setting parents up for success after contact with the service ends.

Carol: He's slowing down, I can hear him having nice little gulps, see the movement in the jaw line, nice alignment, esophagus straight. He looks comfortable, you got that happening. That squirting, it's coming pretty fast

Priscilla: I've not seen that before, it's never been a problem of milk

Carol: See him starting to lose it, talk to him in a calm voice, he'll know you're on the job and he'll get what he's wanting. He's really enjoying it.

The envisaged change requires Priscilla to recognise that her child is still hungry and stay calm so he can continue to feed. This redirects Priscilla's attention from a negative interpretation of her baby's responses to what can *she* do about it.

**Discussion and implications for practice**

The model presented here involves four distinctive partnership activities in which learning is central. It points to the diverse forms of expertise needed in effective partnership – core specialist expertise (the basis for scientific concepts), relationship-building expertise, and expertise in facilitating parents' learning, capturing previously overlooked partnership skills. All four activities contribute to parents' capacity to identify and build on their strengths, although they are not to be seen as stages on a linear trajectory.

In *locating and orienting change*, CFHNs use their expertise to understand a family's current context, recognising parents as experts. This involves questioning and listening to responses, a process through which parents may see their situation differently in relation to their goals and wellbeing, family and wider community. Listening without judgement and validating parents' difficulties and efforts can prompt spontaneous change. Initial child- and problem-focused goals ('why does my baby scream during breastfeeding') shift to self- and solution-focused goals ('what can I do differently so my child gets what he needs'). Shifting from what is wrong with the child to how can parents change their behaviour to support the child repositions parents as capable of creating the conditions of development for themselves and their child. In Vygotskian theory, capacity-building is a crucial foundation for developing resilience in the longer term.

*Creating new meanings for change* involves different specialist expertise as CFHNs listen and show respect for families' expertise, and sensitively introduce scientific concepts to challenge unhelpful constructs or beliefs. The CFHN's reframing of the problem through a mediating concept creates possibilities for new understanding and

solutions involving different parental behaviour. *Joint live action* activity may not always be present in an interaction, but when it does occur, meaning continues to be created, linked to immediate actions and responses.

*Planning for change* anticipates longer-term resilience by exploring what might preserve or threaten families' newly developed capacity and confidence, creating the conditions for future problem-solving.

The description of the model's four partnership activities has the potential to enhance development of professional expertise in child and family health nursing. It challenges practitioners to explicitly focus on advanced communication and clinical skills to provide the most effective intervention for families, particularly those with complex problems. The model offers guidance and reassurance by showing how and when CFHNs use their expertise without fear of endangering the partnership to help parents reframe problems from their children's perspectives, and guide outcomes towards what is best for both children and parents. Increased confidence fosters resilience as families cope with the changing demands of bringing up children.

The model makes outcomes visible by explicitly showing the power of mediation and its reverse action on vulnerable families. Expertise feeds into the partnership as scientific concepts that mediate parents' interpretations of their children, leading to different behaviours. This newly mediated activity works back on parents, building confidence and capacity for creating the conditions for future problem-solving. The process of parents' learning requires scientific concepts to be brought to bear on problems that matter to them. This paper provides a detailed picture of the partnership work undertaken by CFHNs with families in the environments in which they interact that is helpful for thinking about how partnership is successful in

achieving similar outcomes in other services. Rigour is evidenced through Shenton's (2004) four criteria for quality in qualitative research: credibility, through presentation of a realistic account of the phenomenon; transferability, through application of outcomes across a range of similar services; dependability, through rigorous documentation of data collection and analysis; and confirmability through feedback from CFHNs. The study is however, limited in its empirical generalizability.

**Conclusions**

This paper presents an original model of partnership work, based on concepts of learning. The four activities describe the process of change, by tracing relationships between parent, CFHN, learning, and expertise. The model provides conceptually rigorous and empirically-based ways of capturing different, complementary, aspects of partnership practice to address the challenge of effectively deploying specialist expertise without undermining its principles. It is important that CFHNs and policy-makers embrace the model to ensure that the four activities are embedded in practice and performance development.

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