International Journal of Qualitative Studies on Health and Well-being

ISSN: 1748-2631 (Online) Journal homepage: www.tandfonline.com/journals/zqhw20

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To cite this article: Lene Nygaard, Deborah Lee Davis, Inge Olga Ibsen, Maiken Pontoppidan, Ellen Aagaard Nøhr & Dorthe Susanne Nielsen (2024) Care professionals' experiences within a multidisciplinary and cross-sectorial intervention for childbearing women and families in vulnerable positions: a focus group study, International Journal of Qualitative Studies on Health and Well-being, 19:1, 2410503, DOI: 10.1080/17482631.2024.2410503

To link to this article: https://doi.org/10.1080/17482631.2024.2410503

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Published online: 14 Oct 2024.

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INTERNATIONAL JOURNAL OF QUALITATIVE STUDIES ON HEALTH AND WELL-BEING
2024, VOL. 19, 2410503
https://doi.org/10.1080/17482631.2024.2410503

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Care professionals' experiences within a multidisciplinary and cross-sectorial intervention for childbearing women and families in vulnerable positions: a focus group study

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ABSTRACT

Inequality in health persists in childbearing families in socially or mentally vulnerable positions. The FACAM project was developed as an intervention aiming to enhance health outcomes for childbearing families.

Purpose: The aim of this study was to gain a deeper understanding of the experiences and perspectives of care professionals in multidisciplinary and cross-sectorial collaboration, and their experiences of interactions with childbearing families within the context of the FACAM project.

Methods: Eight focus groups were conducted with 32 multidisciplinary care professionals working with childbearing families in vulnerable positions. A thematic analysis was conducted, with positioning theory as the theoretical framework focusing on storylines, positioning and speech-acts.

Results: Two overall themes were constructed. Theme one: Cross-sectorial collaboration and the influence on the care provided. Theme two: Interaction with and assessment of women and families' care needs and their influence on the care provided, with three subthemes; a) Establishment of a trustful relationship, b) Assessments of vulnerable positions in relation to function in everyday life, c) Interactions with the woman or family depending on their needs.

Conclusion: Care professionals found needs-adapted and tailored care meaningful. Well-functioning multidisciplinary and cross-sectorial collaboration was important to support the families.

ARTICLE HISTORY
Received 18 May 2024
Accepted 25 September 2024

KEYWORDS
Qualitative; focus group; collaboration; integrated care; perinatal care; vulnerable groups

Introduction

Inequities in health persist among childbearing families in socially or mentally vulnerable positions, despite healthcare services focusing on developing initiatives to support the well-being of these families (Sundhedsstyrelsen, 2022).

Healthcare and social care professionals encounter pregnant women, mothers and families with complex social or mental health factors in the course of their professional duties (National Institute for Health and Care Excellence, 2010). Their focus is to support the families' individual needs during pregnancy and the first years of the child's life, to promote the development of the child, and wellbeing of the family (Sundhedsstyrelsen, 2019, 2022). Differentiation in the care provided, including the content, number, and length of consultations (Table III) (Sundhedsstyrelsen, 2022) can be important, as pregnant women in vulnerable positions due to social and/or mental health challenges are at risk of adverse health outcomes during pregnancy and the postnatal period (Harron et al., 2021; World Health Organization, 2022). Mothers and fathers who have an untreated psychiatric disease or severe social difficulties can have more difficulties in giving age-relevant stimulation to the child (Behrendt et al., 2019). Supporting parents to establish secure maternal-infant attachment, giving care, suitable emotional, and social stimulation is important to give the child a good start in life (Maggi et al., 2010).

There is a growing body of literature emphasizing the importance of a trustful relationship between care professionals and childbearing women or families in vulnerable positions (Ejlertsen et al., 2022; Frederiksen et al., 2021b; McElhinney et al., 2021). Good communication skills, being familiar with the women and her needs, and giving timely care is significant in maternity care (Korstjens et al., 2021). Several studies have highlighted both the importance of trustful collaboration with pregnant women and mothers and, addressed the

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need of a coordinated cross-sectorial collaboration because uncoordinated collaboration could be time-consuming, when structures for collaboration were not negotiated or planed (Anderzén Carlsson et al., 2021; Everitt et al., 2017; Weiber et al., 2016).

Integrated care and collaboration across professions and sectors often aim at improving health outcomes and reducing the use of inappropriate services (Leutz, 1999; Shortell, 2021). In Denmark, where the organization of health care and social care is separated, with the patient centred care located in hospitals, and the citizen centred care conducted by the municipalities (Rudkjøbing et al., 2012; Sundhedsstyrelsen, 2022) pregnant women and families can experience fragmented care in both relational and informational continuity (Schmied et al., 2010). When caring for people with complex challenges, the experience of continuity of care is significant (Fraser et al., 2007; Harmsen van der Vliet-Torij et al., 2022) because an unclear division of responsibilities, and lack of information can delay or leave out necessary care and preventive interventions to support the wellbeing of the family (Kompetencecenter for Patientoplevelser, 2019). A systematic review reveals that, despite good intentions, cross-professional collaboration faces challenges due to limited resources (Aquino et al., 2016).

While there is some literature on care professionals' experiences working in cross-sectorial collaboration with pregnant women and families in vulnerable positions (Anderzén Carlsson et al., 2021; Ejlertsen et al., 2022; Weiber et al., 2016) there is an urgent need to know more about how new collaboration models impact the participants and care professionals. Care professional's experiences can give insight into challenges, successes, facilitators, and barriers to sufficient collaboration. This knowledge can be used to develop more effective and supportive interventions to pregnant woman and families in vulnerable positions, and provide insight into cross-professional and cross-sectorial collaborations in healthcare more broadly. As a new intervention to reduce inequality in health, the FACAM project was developed for families in vulnerable positions.

The FACAM study

FACAM was an abbreviation for FAmily Center And Municipality, signalling a strengthened collaboration between the Family Center at a University Hospital and a large municipality in Denmark. The project was conducted as a multimethod study consisting of a Randomized Controlled Trial (RCT) and qualitative studies. The RCT investigated the impact of an early and coordinated intervention during pregnancy and the first year after birth on maternal mental health, mother-child attachment, and child development in families in vulnerable positions (Pontoppidan et al., 2022). Participants were women and families with severe psychiatric disease, psychological distress, social challenges, present or former substance use, indicating a need for extra support or increased multidisciplinary or cross-sectorial collaboration (Sundhedsstyrelsen, 2022). The FACAM intervention included standard care which included consultations with the general practitioner, midwife, health visitor, and if needed a psychologist or a social worker who could refer to further support by a family therapist. Furthermore the intervention consisted of assigning a support person (FACAM person), either a health visitor or family therapist, providing up to 47 hours of individual support during pregnancy and the child's first year. Additionally participants were offered a group based Circle of Security course with eight meetings (Marvin et al., 2002) or individual sessions to support parent-child attachment. An overall aim was also to strengthen the multidisciplinary- and cross-sectorial collaboration with joint meetings and regular interactions among care professionals from different sectors (Pontoppidan et al., 2022). Findings from the randomized controlled trial is reported elsewhere. This paper present a study of eight focus groups where the aim was to gain a deeper understanding of the experiences and perspectives of care professionals in multidisciplinary and cross-sectorial collaboration, as well as their experiences of interactions with childbearing families within the context of the FACAM project.

Materials and methods

Design

The epistemology of this study was social constructionism as we believed meaning was constructed and co-constructed during social interaction (Crotty, 1998). The design and conduct of the study were inspired by symbolic interactionism (Blumer, 1969). Through social interaction, we position others and ourselves, expressing our understanding of the situation and interpreting roles and social norms. Depending on the situation and social interaction in a group, meanings and understandings are defined and redefined (Blumer, 1969; Charon, 2010). During data analysis, positioning theory was used as a theoretical framework for a closer understanding of the social interaction during the conversations and discourses (Harré & van Langenhove, 1999). Positioning theory was used because we were interested in, not only *what* was said during the focus groups but also *how* meaning was constructed in group interactions.

Participants

Data were constructed through eight focus groups (Bloor et al., 2001; Morgan, 2019) with 3–5 participants in each group. Purposive sampling was used to ensure variation of the participants' perspectives. Permission to contact relevant care professionals for participation in the study was obtained from the leaders of the care professionals. Care professionals working with the mothers and families of the project were invited by an email to participate in a focus group. If the care professionals were interested in participating, further written and oral information about the study was provided. Written informed consent was obtained from all participants who accepted the invitation to participate in the study.

Ethical statement

The study was approved by the committee of Health Research in the Region of Southern Denmark (journal no. 18/48509, date of approval 29th of September 2018). The committee on Health Research Ethics in the Region of Southern Denmark assessed the study protocol and found no need for further approval (Case no. S-20182000-110, date of approval 27th of September 2018).

Focus groups

Seven focus groups were conducted during the months July and August 2020 and a final focus group in September 2021. This was 22 and 36 months after the FACAM project began, respectively. The first author moderated and initiated each focus group by presenting 4–7 cards with an agenda for discussion (Table II). The number of cards and wordings were adjusted to align with the focus group time frame and the participants' profession. The participants were encouraged to add to the agenda if needed. The moderator facilitated the focus group, but tried not to interrupt the interactions in the group. The focus groups lasted 77–131 minutes, with an average of 102 minutes. They were audio-recorded and transcribed verbatim.

Data analysis

Data were analysed using a six-phased inductive thematic analysis (Braun & Clarke, 2012, 2022). First, transcripts and audio-recordings were thoroughly reviewed. Second, the initial inductive coding was constructed based on descriptions of the data, interpretations, and single words used by the participants to ensure a close relation to the data. During the initial coding, we were looking for what was being said. The NVivo software for qualitative analysis was used during the coding process (Lumivero, 2020). Following this, we examined the data using positioning theory (Harré & van Langenhove, 1999). All the transcripts were re-read and coded using the three key elements of positioning theory (Harré & van Langenhove, 1999). The conversation structure included the triad of *positions*, *storylines* and *speech-acts* (Harré & van Langenhove, 1999). Conversations consisted of several storylines. Participants could intentionally or unintentionally position themselves and others depending on their moral, rights or duties, the content of the storyline, or the social context in which the conversation was situated. Speech-acts were the words used by participants to position themselves and others, with attention to not only what was said but also to the social force behind the words (Harré & van Langenhove, 1999). Third, we constructed themes by looking for relations between codes. Forth, we ensured that the themes were addressing the aim of the study and, related to the other theme without overlapping. Fifth, naming of the themes was discussed in the author group. Sixth, we drafted the final version of the findings. Preliminary findings were presented to participants, who found them meaningful.

Reflexivity

The study was conducted by the first author, a female PhD student and experienced midwife working with families in vulnerable positions. The co-authors, who contributed to data analysis and interpretation, were senior health science researchers, all but one with healthcare backgrounds. Insider positioning was both a strength and a weakness, as it facilitated recruitment and data collection while bringing a particular interpretative lens to the analysis, but at the same time, it potentially excluded other perspectives.

Findings

In total, 32 care professionals participated in the focus groups. Participants were specialist medical doctors, general practitioners, midwives, health visitors, social workers, family therapists, and care professionals working at the local alcohol and drug treatment centre. The health visitors and family therapists conducted the FACAM intervention as FACAM persons. The remaining participants were involved through their work with the project's target group and through professional network meetings in relation to the project. The care professionals had between 2½ to 23 years of working experience (Table I). Each of the focus groups consisted of participants from the same professional group.

During the analysis, two themes were constructed: one addressing how poor- and well-functioning

Table I. Demographic characteristics of study participants.

Variable	Number of participants (n = 32)
Gender	
Female	32
Male	0
Age group	Number of participants (*n* = 32)
20-29	1
30-39	9
40-49	10
50-59	10
60-69	1
70-79	1
Year of graduation	Number of participants (*n* = 32)
1990-1994	4
1995-1999	6
2000-2004	5
2005-2009	5
2010-2014	6
2015-2019	6

Care profession	Number of participants (*n* = 32)	Role during the FACAM project	Focus group number	ID number
Family therapist*,**	8	Conducting the FACAM intervention	1 4	F1, F2, F3, F4 F15, F16, F17, F18
Health visitor*, **	9	Conducting the FACAM intervention	2 3	S5, S6, S7, S8, S9 S10, S11, S12, S13
Health visitor student	1	Student	3	S14
Medical doctor	3	Having consultations with pregnant women and families if needed.	8	L30, L31, L32
Midwife*	4	Having consultations with pregnant women and families in relation to the FACAM project. Participating in minimum one joint consultation during pregnancy with the pregnant women, her partner and the FACAM person.	7	J26, J27, J28, J29
Practitioner at the alcohol- and drug-treatment center*	3	Having consultations with pregnant women and families if needed.	6	R23, R24, R25
Social worker*	4	Having consultations with pregnant women and families if needed.	5	So19, So20, So21, So22

*Participated in four cross-sectorial collaboration meetings per year.
**Participated in collaboration meetings with other FACAM persons and the project leaders each month.

Table II. Subject cards used during the focus groups.

Subject	Title
Understanding of collaboration	How do you experience the collaboration between professions and sectors?
Understanding of vulnerability	When I say "vulnerable pregnant women or families", what do you think then?
Understanding of the women and families participating in the FACAM project and the professional practice of the care professionals	Who are the pregnant women or families you have contact with as a part of the FACAM project? How do you work with pregnant women or families whom participate in the FACAM project?
Understanding of working with families outside the FACAM project	How do you work with vulnerable pregnant women or families as a health visitor/midwife/family therapist/doctor/social worker/practitioner?
Understanding of the impact of the FACAM project	Where does the FACAM project make a difference? Where does the FACAM project not make a difference?

multidisciplinary or cross-sectorial collaboration could influence the care provided to families, and the other addressing how care professionals' interaction with and assessment of care needs for (pregnant) women and families impact the care given. The findings presents information on how the care professionals position themselves and others in relation to the two themes. No significant differences were found between the professional groups in relation to the constructed themes.

Cross-sectorial collaboration and the influence on the care provided

Impact of a well-functioning multidisciplinary and cross-sectorial collaboration

The participants closely engaged in the FACAM intervention described that, their collaboration with their closest collaborators strengthened through the project. They discussed how this was achieved through joint consultations, fostering common knowledge and

Table III. Antenatal care in Denmark (Sundhedsstyrelsen, 2022).

In Denmark, antenatal care is divided into four different care-groups	
Group 1	Group 1 provide basic care for women and families with low risk during pregnancy and the perinatal period.
Group 2	Group 2 provide extra care for expectant parents with specific needs, paying attention to e.g., smoking, obesity, or previous traumas. Tailored consultations and referrals to specialized programs address individual concerns.
Group 3	Group 3 provide comprehensive support for expectant parents with diverse challenges, requiring collaboration with specialists like psychiatrists or social workers. Tailored services, addressing physical, mental, and social issues, should commence early in pregnancy for effective care and assistance.
Group 4	Group 4 provide collaboration with specialized institutions for complex issues like substance abuse and severe mental disorders. Expectant parents need inter and cross-departmental cooperation, ensuring child welfare amidst challenging circumstances.

understanding of families. They gained insight into shared core focuses on pregnancy, childcare and family development across professions and, they observed variations in how they approached the childbearing family. Experience from one joint consultation was utilized in another. The participants described trust and respect for the competence of their colleagues.

> S7: I would also say that it's the family therapists who make the difference in FACAM now. That they are involved so early on. It's nice that we both start together and hear the same thing from our different perspectives on the situation. It brings something good to the families and this thing about being involved early on [during pregnancy]. That they get to know the faces of who we are. Well, it also provides a sense of security for them. Now we do pregnancy visits for everyone. (Health visitor, focus group 2)

The health visitor presented a storyline that acknowledged the collaboration with the family therapists. She positioned their meetings during pregnancy and impact of the collaboration as a sense of security for the family.

As a part of the FACAM project, the care professionals from both sectors knew each other, knew who to contact and, how to reach out if a family needed support. They referenced colleagues' names when families were referred to new care professionals.

> F18: I haven't had any [mothers] who have been at the drug treatment centre for young people.
>
> F15: We have.
>
> F18: If I had, then I would know whom [of the care professionals] to contact, right.
>
> F15: Yes.
>
> F16: Earlier on, it was just "oh, who can we contact?" Then you call someone, "no, it is not me". "Oh, but who is it then?" Then you spend time on that. Now we know [name of care professional]. Bam!
>
> F18: Yes, and it's nice for us, but also for the mothers we are with.
>
> F15: Yes.
>
> F18: It just gets a little less daunting.
>
> F16: Yes.
>
> F18: Yes, let's call [name of care professional]. I'll help you. Come. Then we sit here and call her.
>
> F15: Exactly, exactly. (Family therapists, focus group 4)

F18 presented a storyline of how she as a part of the project, knew who to call if a woman needed support. F15 and F16 agreed. F18 positioning herself as a supporter for the women and positioning the situation as "a little less daunting" than normal practice, when referring the woman to a known colleague. This speech-act indicated that the care professionals felt, they could give better service, save time, and depressurize the situation for the woman, when knowing whom to contact.

Some participants discussed how they found reassurance in the FACAM person maintaining contact with the family during transitions between sectors, ensuring continuity of care. Others emphasized the significance of having a FACAM person, particularly when reporting to the social authorities. In most cases, a report would lead to increased support hours from the FACAM person, sometimes supported by a colleague. The extra support could be introduced immediately, and the situation was described as less disturbing or fearful for the family.

Impact of a poor-functioning multidisciplinary and cross-sectorial collaboration

Participants with limited contact with childbearing families in the project discussed how they felt distanced from their colleagues. They discussed the impact of organizational structures and interpersonal relations on collaboration across professions and sectors. They reflected on how it affected families when collaboration between care professionals was not sufficient.

Some of the care professionals deliberated on the consequences of being uninformed about the involvement of other care providers work within a family. They discussed situations where they were not formally invited to cross-disciplinary family meetings and how effective collaboration with colleagues helped them acquire information. One health visitor described it as

"*entering the process in reverse*" when not invited to an important network meeting concerning the action plan for a family.

> S10 This case was about a family where their child was removed. It wasn't necessarily that I disagreed with that decision, but it was more about the way it unfolded and leading up to it. I think that in that situation, I could have been a better support for them [the family] if I had been involved. (Health visitor, focus group 3)

This storyline illustrated that the health visitor would have liked to be more involved in the collaboration with other care professionals. She positioned herself as capable of supporting the family better if she had known what was to come.

Some participants discussed how uncoordinated interventions could influence the family. This could happen if information was not transferred during shifts between sectors or care professionals, or when parents faced numerous demands from different parts of the system. Practitioners from the alcohol and drug treatment centre elaborated on how their expertise and perspectives could be valuable if they were more involved in creating plans for newly admitted users.

> R25 The new man we just admitted [to the drug treatment centre], there is now a requirement [from other professionals] that he must have therapy sessions twice a week plus a urine test. Who says he can handle that? Given his level of substance abuse, is that realistic? (Practitioner from the alcohol and drug treatment centre, focus group 6)

The storyline illustrated that professionals outside the drug treatment centre set certain requirements for the treatment plan. R25 positioned herself as an expert in the field, questioning whether the level of substance use was adequately considered and whether the newly admitted individuals could manage the plan.

Across focus groups, participants elaborated on how their colleagues from other professions or sectors could have different perspectives or, more or less information about a family. This could affect their perception of a family's support needs.

Interaction with and assessment of women and families' care needs and the influence on the care provided

Establishment of a trustful relationship with women and families

All participants emphasized the importance of developing a strong relationship with the family as an essential part of caregiving. They expressed a genuine motivation to gain insight into and understand the challenges faced by women or families. Once a trusting and honest relationship was established, participants experienced that women and families actively sought their guidance and assistance.

In some focus groups, participants discussed the challenge of engaging families with previous interactions with the health or social care system, and reluctance towards accepting additional care. The participants discussed how they made an additional effort to make the families feel more comfortable.

> J29: I often think about vulnerable pregnant women where there can be some issue, where there is a lot of resistance to coming in here [to a midwifery consultation]. Especially there, I pay attention to the baby in the womb. I may sometimes have to compromise with things, and listen to things, that is of no concerns to a midwifery consultation, but it's the way I can maintain contact with the pregnant women, so I know she'll come.
>
> J26: Yes
>
> " . . . "
>
> J29: It's actually one of the greatest tasks working with the most burdened individuals. That they feel heard, and they feel welcome. Then I know they will come in here. It's the way I can keep an eye on them, that they are doing well, but also that the baby is doing well. (Midwives, focus group 7)

The speech-acts in the quote demonstrate the midwife's recognition that effective care for the woman and unborn child hinges on collaboration. This is embodied in her attentive listening and bypassing of the typical consultation structure to build trust. J26 concurs. When looking at the citation with a focus on positioning, the midwife was constructed as dedicated and caring, while initially portraying the woman as hesitant and burdened.

Assessments of vulnerable positions in relation to function in everyday life

Participants sensitively discussed women or families being in vulnerable positions, describing various types of vulnerability. These ranged from those linked to abrupt and severe events that could affect anyone, to vulnerabilities associated with diverse disorders, diseases, conditions, lifestyles, traumas, or neglect, significantly influencing the women and families. When addressing the families' vulnerable positions, participants assessed the family's function in everyday life, and their ability to meet their child's needs. They used words indicating their individual perspectives of being "worried" or "not worried" about a family's situation, or used terms that positioned women or families on a continuum from "well-functioning" or

labelled as "resourceful" to "challenged" (In Danish "Tung").

The social workers elaborated on whom they had contact with:

So22: Families or parents who grow up in difficult conditions and have been placed [in foster care]. Who actually just want a normal life but end up in the system because they themselves have been a case and perhaps had a turbulent upbringing. We have those too.

So20: Yes. Sparse network. A poor network.

So22: Where you say, "Do you have grandparents or someone who can help you?" "Well, they drink. That's why I was placed when I was little, right?" Well, maybe it's just them. So you might be lucky if the father maybe or someone has some network. But.

So20: Yes.

So19: Then you also see that. We also have very resourceful parents who maybe just can't figure it out. I mean, where everything is in order financially and a nice house. But maybe they are just not as good at the emotional aspect of their children. It's quite a mix.

So22: Yes, they are there too. (Social workers, focus group 5)

The social workers constructed a storyline depicting various forms of vulnerability. The first part illustrated attention to the parents' wish for a "normal life" despite being positioned as "a case" in their own childhood. In the storyline, the social worker tries to look for resources in the parents' network, to provide support. It emphasizes the intergenerational impact of social inequality and illustrate a perception of families trapped in unfavourable cycles due to past experiences. In the second part of the dialogue, they talked about "very resourceful parents" with visible resources who "maybe [.] are just not as good" regarding the emotional interaction with their children. The speech-act offers insight into the complexity of vulnerable positions where both past and present experiences and former and current challenges are significant.

Some participants discussed their understanding of mental health diagnoses and their connections to vulnerable positions, suggesting no clear link.

L31: A pregnant women with depression can indeed have good resources.

L32: Absolutely.

L31: And actually not be vulnerable in the way that I understand vulnerable pregnant women.

L32: Yes. But I'm just thinking that one can be… One can have many resources and still have depression.

L31: That's possible. Very easily.

L32: But it's clear that it's easier to seek help if you have good resources alongside.

L31: Yes.

L32: And a network. (Doctors, focus group 8)

The two doctors L31 and L32 agreed on the storyline that even though a woman experienced depression, she could still possess considerable resources, which did not necessarily correspond to the positioning of being vulnerable.

Interactions with the woman or family depending on their needs

In the focus groups, participants discussed how their interpretation of individual women or family situations influenced the care provided. Greater concern among care professionals led to increased attention and care for families, particularly if categorized as "challenging". Some participants emphasized how the "resourceful" women or families also might need additional care, if they experienced high levels of for instance anxiety. In most cases, "well-functioning" or "resourceful" women or families were positioned as good enough parents but facing other challenges.

S11: I also have one [woman] where I thought, when I started, "It's funny that she is participating in the FACAM project." She is a well-functioning healthcare professional and, good enough alone with the children. She previously had a husband who was SO dominant and physically and psychologically abusive. So, it was about rebuilding her self-esteem.

S13: mm

S11: She has been calling all the time asking, "Am I doing well enough? Am I doing well enough?" "Yes, it's good enough." "What do you think about this?" And now she's doing well. And there have been many phone calls.

S12: mm

S11: But in relation to the children, there hasn't been any issue because she could handle it. So, it was more about herself.

S10: Yes

S13: But the security you have provided her has also allowed her to provide for the children. (Health visitors, focus group 3)

The storyline highlighted how vulnerability could be concealed. S11 positioned herself as responsive to the woman's need for frequent contacts and acknowledged the woman's actions. S13 concluded that the

support provided could have positively impacted the woman's capacity to care for her children.

The participants illustrated how they during interaction with the women and family tailored care interventions and support to the family´s individual needs. Additional hours involved verbal and hands-on guidance, addressing topics such as baby interaction, daily routines, and practical tasks. The FACAM persons described it as meaningful to provide immediate care when the parents reached out, preventing issues from escalating. The family therapists described the impact of individual sessions on parent-child attachment, enhancing parental preparedness.

Some FACAM persons discussed that, if they or the family considered additional care unnecessary the FACAM person adjusted the intervention, for instance by transitioning from in-person visits to telephone support, thus avoiding overwhelming families.

The FACAM persons elaborated on the significance of voluntary participation in the project, suggesting that seeking support voluntarily might be more socially acceptable than receiving mandated care from the social authorities. However, there was a question about whether the project only appealed to families open to long-term contact with care professionals.

Discussion

This study approached the question of how care professionals experienced and positioned the multidisciplinary and cross-sectorial collaboration and, the collaboration with women and families in vulnerable positions in context of the FACAM project. The findings reveal different positions on how the multidisciplinary and cross-sectorial collaboration could influence the care provided to the women or families.

Axelsson and Axelsson (2006) defined collaboration as a form of integration between organizations that depend on a high degree of willingness to work together, involving intensive contacts, trust and respect. However, they addressed a potential obstacle if differences in culture or values between professions or organization were considerable (Axelsson & Axelsson, 2006). In our study, care professionals who worked closely with colleagues experienced a strengthened inter- and cross-sectorial collaboration, while those less involved reported the opposite. In line with our findings, van Minde et al. (2019) found in their study on inter-professional handover of information that, care professionals should be familiar with each other, and structures for collaboration should be arranged to provide high quality care (van Minde et al., 2019). When looking at the positioning of the collaboration and its impact on the provided family care, we identified experiences related to improving service, an elevated sense of security, and perceptions of giving better support when the collaboration was experienced as sufficient. Moreover, some participants' statements approached the impact of continuity of care regarding, care given over time to individual families in the elements of informational-, management-, and relational continuity (Haggerty et al., 2003). Many participants utilized the competences of multidisciplinary or cross-sectorial colleagues in new ways and adjusted the delivery of care to meet the changing needs of the families over time.

In our findings, the establishment of a trustful relationship was significant not only for the collaboration with other care-professionals but also for collaboration with women and families. This aligns with findings in previous studies (Ejlertsen et al., 2022; Frederiksen et al., 2021b; McElhinney et al., 2021).

Consistent with other studies, our finding regarding the assessment of vulnerable positions in relation to function in everyday life highlight the complexity of vulnerability. Previous research on childbearing women and families have found that care professionals assessed vulnerability as an individual perception addressing various definitions of vulnerability (Ejlertsen et al., 2022). A study on general practitioners assessment of vulnerability in pregnancy described both obvious and intangible indicators of vulnerability (Brygger Venø et al., 2021). Comparatively, our study found that care professionals, as a part of their individual perception of a vulnerable position, used words that could situate new categories of well-functioning, resourceful or challenged families as well as being worried or not worried for a family. This categorization might pose challenges from the parents' perspectives, as they may not agree with such classifications or could fear the potential consequences of such assessments (Frederiksen et al., 2021a). Spiers (2000) addressed the need for gaining insight from the individuals with lived experience, emphasizing their perspective on their own situation. Care professionals' assessment of vulnerability may be based on risk factors, whereas individuals with lived experience may experience vulnerability as a potential for growth (Spiers, 2000). Brown et al. (2017) have addressed various use and scope of the concept vulnerability depending on contextual context such as discipline and, empirical, theoretical or policy context (Brown et al., 2017). The Danish healthcare recommendations recommend differentiated antenatal care tailored the individual woman's need (Table III). Assessment of needs relies on a risk assessment of the woman, the unborn child and the overall family situation (Sundhedsstyrelsen, 2022). While women and families in the FACAM project were initially assessed to receive additional care during pregnancy, our findings suggested the necessity for flexible interventions as the families' situations might change over time. Our findings confirm that the assessment of vulnerable positions could relate to many

different aspects. Furthermore, it highlights the importance of recognizing how care professionals' positioning and assessment of families' vulnerable positions can influence the care provided. A clinical implication of the study's findings is the need for organizational focus on establishing and maintaining robust and appropriate collaboration among all care professionals, regardless of their level of contact with families in vulnerable positions. Ensuring that all voices and perspectives are considered when planning, adjusting, or coordinating care during the childbearing period is essential. Based on the study's findings, further research could be valuable for gaining insight into the perspectives of other professionals, such as psychologists and psychiatrists, on cross-sectorial collaboration and their work with women and families in vulnerable positions.

Strengths and limitations

The homogeneity of social backgrounds and attitudes among participants in the focus groups created a comfortable environment and consensus. However, involving professionals from diverse fields might have offered different perspectives and storylines (Harré & van Langenhove, 1999,) challenging tacit understandings (Morgan, 2019). The moderator's familiarity with the topic eased entry and the ability to ask focused questions but it may have hindered seeking further clarification on some concepts, which could have provided additional insight (Morgan, 2019). The use of terms as "vulnerable families" influenced discussions, aligning with policy language (Sundhedsstyrelsen, 2013) yet participants expressed varied views. While positioning theory provided valuable insights, different theoretical perspectives could yield distinct findings. The findings were contextualized within the FACAM project in Denmark, but the essence of insights into collaboration quality, professionals' assessments of vulnerable positions and family functioning is considered transferable to similar contexts in industrialized countries. This study focused on the care professionals' experiences, however further research on the families' lived experiences is recommended.

Conclusion

This research adds to our understanding of the importance of collaboration between professionals across different fields and sectors. Findings from the FACAM project illuminates the impact of such collaboration on the support provided to families. The study emphasizes the participants' experience of close engagement with families, based on trust and evaluation of their daily lives, providing valuable insights for customizing the care they receive.

Acknowledgments

We gratefully thank the women and families who participated in the project. Special thanks to the care professionals for generously sharing their valuable perspectives. We would like to acknowledge OPEN, Odense Patient data Explorative Network, Odense University Hospital, Odense, Denmark for providing a secure storage of data.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The study was funded by the PhD fund of Odense University Hospital and the A.P. Møllerske support fund [Den A.P. Møllerske støttefond, donation number 11678]. The funding sources were not involved in various aspects of the research process, including the collection, analysis, and interpretation of data, as well as the writing of the manuscript and the decision to submit the article for publication.

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Author contributions

The first author conducted the research and wrote the original draft of this manuscript. The first, second, fifth, and last authors participated in the analysis and interpretation of data. All authors contributed to the conceptualization and design phases, and have participated in reviewing and editing the manuscript. Additionally, all

authors have given their final approval of the submitted manuscript.

Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this manuscript, the authors used ChatGPT 3.5 in order to improve readability and language. After using this tool, the authors reviewed and edited the content as needed and the authors takes full responsibility for the content of the publication.

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References

Anderzén Carlsson, A., Bäccman, C., & Almqvist, K. (2021). The professional relationship forms the base: Swedish child health care nurses' experiences of encountering mothers exposed to intimate partner violence. *International Journal of Qualitative Studies on Health and Well-Being*, *16*(1). https://doi.org/10.1080/17482631.2021.1988043

Aquino, M. R. J. V., Olander, E. K., Needle, J. J., & Bryar, R. M. (2016). Midwives' and health visitors' collaborative relationships: A systematic review of qualitative and quantitative studies. *International Journal of Nursing Studies*, *62*, 193–206. https://doi.org/10.1016/j.ijnurstu.2016.08.002

Axelsson, R., & Axelsson, S. B. (2006). Integration and collaboration in public health—A conceptual framework. *The International Journal of Health Planning and Management*, *21*(1), 75–88. https://doi.org/10.1002/hpm.826

Behrendt, H. F., Scharke, W., Herpertz-Dahlmann, B., Konrad, K., & Firk, C. (2019). Like mother, like child? Maternal determinants of children's early social-emotional development. *Infant Mental Health Journal*, *40*(2), 234–247. https://doi.org/10.1002/imhj.21765

Bloor, M. F. J., Thomas, M., & Robson, K. (2001). *Focus groups in social research*. SAGE Publications Inc.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. University of California Press.

Braun, V., & Clarke, V. (2012). *Thematic analysis. APA handbook of research methods in psychology, vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association.

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE Publications Inc.

Brown, K., Ecclestone, K., & Emmel, N. (2017). The many faces of vulnerability. *Social Policy & Society*, *16*(3), 497–510. https://doi.org/10.1017/S1474746416000610

Brygger Venø, L., Jarbøl, D. E., Pedersen, L. B., Søndergaard, J., & Ertmann, R. K. (2021). General practitioners' perceived indicators of vulnerability in pregnancy: A qualitative interview study. *BMC Family Practice*, *22*(1), 135. https://doi.org/10.1186/s12875-021-01439-3

Charon, J. M. (2010). *Symbolic interactionism: An introduction, an interpretation, an integration* (10 ed.). Prentice Hall.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage Publications.

Ejlertsen, C., Rosenstrøm, S., Kristensen, I. H., & Brødsgaard, A. (2022). Engaging in partnerships is the key to preserving and creating a trustful collaboration with vulnerable families: A focus group study. *Midwifery*, *114*(103440), 1–8. https://doi.org/10.1016/j.midw.2022.103440

Everitt, L., Homer, C., & Fenwick, J. (2017). Working with vulnerable pregnant women who are at risk of having their babies removed by the child protection agency in New South Wales, Australia. *Child Abuse Review*, *26*(5), 351–363. https://doi.org/10.1002/car.2432

Fraser, J. A., Barnes, M., Biggs, H. C., & Kain, V. J. (2007). Caring, chaos and the vulnerable family: Experiences in caring for newborns of drug-dependent parents. *International Journal of Nursing Studies*, *44*(8), 1363–1370. https://doi.org/10.1016/j.ijnurstu.2006.06.004

Frederiksen, M. S., Schmied, V., & Overgaard, C. (2021a). Living with fear: Experiences of Danish parents in vulnerable positions during pregnancy and in the postnatal period. *Qualitative Health Research*, *31*(3), 564–577. https://doi.org/10.1177/1049732320978206

Frederiksen, M. S., Schmied, V., & Overgaard, C. (2021b). Supportive encounters during pregnancy and the postnatal period: An ethnographic study of care experiences of parents in a vulnerable position. *Journal of Clinical Nursing*, *30*(15–16), 2386–2398. https://doi.org/10.1111/jocn.15778

Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E., & McKendry, R. (2003). Continuity of care: A multidisciplinary review. *BMJ*, *327*(7425), 1219–1221. https://doi.org/10.1136/bmj.327.7425.1219

Harmsen van der Vliet-Torij, H. W., Venekamp, A. A., van Heijningen-Tousain, H. J. M., Wingelaar-Loomans, E., Scheele, J., de Graaf, J. P., Lambregtse van den Berg, M. P., Steegers, E. A. P., & Goumans, M. J. B. M. (2022). Development of a blueprint for integrated care for vulnerable pregnant women. *Maternal and Child Health Journal*, *26*(3), 451–460. https://doi.org/10.1007/s10995-021-03340-y

Harré, R., & van Langenhove, L. (1999). *Positioning theory: Moral contexts of intentional action* (1 ed.). Wiley Blackwell.

Harron, K., Gilbert, R., Fagg, J., Guttmann, A., & van der Meulen, J. (2021). Associations between pre-pregnancy psychosocial risk factors and infant outcomes: A population-based cohort study in England. *The Lancet Public Health*, *6*(2), e97–e105. https://doi.org/10.1016/S2468-2667(20)30210-3

Kompetencecenter for Patientoplevelser. (2019). *Hånd om sårbare gravide. Evaluering af tværsektorielle indsatsermålrettet sårbare gravide iomsorgsgruppe 3*. Region Hovedstaden.

Korstjens, I., Mesman, J., van Helmond, I., de Vries, R., & Nieuwenhuijze, M. (2021). The paradoxes of communication and collaboration in maternity care: A video-reflexivity study with professionals and parents. *Women & Birth*, *34*(2), 145–153. https://doi.org/10.1016/j.wombi.2020.01.014

Leutz, W. N. (1999). Five laws for integrating medical and social services: Lessons from the United States and the United Kingdom. *The Milbank Quarterly*, *77*(1), 77–110, iv–v. https://doi.org/10.1111/1468-0009.00125

Lumivero. (2020). *NVivo (version 13, 2020 R1)*.

Maggi, S., Irwin, L. J., Siddiqi, A., & Hertzman, C. (2010). The social determinants of early child development: An overview. *Journal of Paediatrics and Child Health*, *46*(11), 627–635. https://doi.org/10.1111/j.1440-1754.2010.01817.x

Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The circle of security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development*, *4*(1), 107–124. https://doi.org/10.1080/14616730252982491

McElhinney, H., Sinclair, M., & Taylor, B. (2021). Social Worker and midwife decision making regarding child protection risk and the unborn baby: A qualitative study. *Child Abuse Review*, *30*(2), 98–113. https://doi.org/10.1002/car.2661

Morgan, D. L. (2019). *Basic and advanced focus groups*. SAGE Publications Inc.

National Institute for Health and Care Excellence. (2010). *Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors*.

Pontoppidan, M., Nygaard, L., Thorsager, M., Friis-Hansen, M., Davis, D., & Nohr, E. A. (2022). The FACAM study: Protocol for a randomized controlled study of an early interdisciplinary intervention to support women in vulnerable positions through pregnancy and the first 5 years of motherhood. *Trials*, *23*(1), 73. https://doi.org/10.1186/s13063-022-06022-4

Rudkjøbing, A., Olejaz, M., Birk, H. O., Nielsen, A. J., Hernández-Quevedo, C., & Krasnik, A. (2012). Integrated care: A Danish perspective. *BMJ*, *345*(jul13 1), e4451. https://doi.org/10.1136/bmj.e4451

Schmied, V., Mills, A., Kruske, S., Kemp, L., Fowler, C., & Homer, C. (2010). The nature and impact of collaboration and integrated service delivery for pregnant women, children and families. *Journal of Clinical Nursing*, *19*(23–24), 3516–3526. https://doi.org/10.1111/j.1365-2702.2010.03321.x

Shortell, S. M. (2021). Reflections on the five Laws of integrating medical and social services-21 Years Later. *The Milbank Quarterly*, *99*(1), 91–98. https://doi.org/10.1111/1468-0009.12495

Spiers, J. (2000). New perspectives on vulnerability using emic and etic approaches. *Journal of Advanced Nursing*, *31*(3), 715–721. https://doi.org/10.1046/j.1365-2648.2000.01328.x

Sundhedsstyrelsen. (2013). *Anbefalinger for svangreomsorgen* (2 ed.).

Sundhedsstyrelsen. (2019). *Vejledning om forebyggende sundhedsydelser til børn og unge*.

Sundhedsstyrelsen. (2022). *Anbefalinger for svangreomsorgen* (4 ed.).

van Minde, M. R. C., van Veen-Belle, D. W., Ernst-Smelt, H. E., Rosman, A. N., Raat, H., Steegers, E. A. P., & de Kroon, M. L. A. (2019). Handover of care and of information by community midwives, maternity care assistants and preventive child healthcare professionals, a qualitative study. *Midwifery*, *78*, 25–31. https://doi.org/10.1016/j.midw.2019.07.012

Weiber, I., Eklund, M., & Tengland, P. A. (2016). The characteristics of local support systems, and the roles of professionals, in supporting families where a mother has an intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, *29*(3), 197–210. https://doi.org/10.1111/jar.12169

World Health Organization. (2022). *WHO guide for integration of perinatal mental health in maternal and child health services*.