Strategies for engaging young parents to improve outcomes for vulnerable children - USA, Canada, UK

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Catina Adams
15 September 2015
My nurse wanted to know my heart’s desire – I told her I want to be the best mum I can be, and I want an education and a job so I can provide by daughter with a better future.
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The Nurse-Family Partnership program is powerful because it works through partnership, building on strengths, and working towards goals that the young woman has identified as important to her. Most importantly, the young mother is supported in her pregnancy and parenting journey, to be the best mother she can be.

My name is Catina Adams. I am a Maternal and Child Health nurse, working for Hume City Council, on the north western fringe of Melbourne. Hume City is a socially diverse community with a rich culture, which includes some of the most vulnerable families in Victoria.

We have been working hard to increase the engagement of our more vulnerable families with services such as playgroups, Maternal and Child Health, and preschool. This is to improve outcomes for children, and to break the generational disadvantage which can occur in some of our communities.

My Churchill Fellowship has given me the opportunity to observe a program that has been running for more than thirty years in New York. It is called the Nurse-Family Partnership, where a family health nurse engages with the mother early in her first pregnancy, and through a program of sustained home visiting, maintains contact until her child is two years of age.

Evidence tells us that a supportive continuous relationship with an experienced, non-judgemental care-giver delivers the best outcomes for mothers and children. The key here is the continuity of the relationship (Fox et al, 2015).

The program in New York has a wealth of experience and a sound evidence base, with the first babies in the program now in their thirties. The Nurse Family Partnership program has demonstrated reductions in pre-term birth, drug and alcohol use, homelessness, family violence, crime, and repeat pregnancy. Proven benefits include higher employment and education rates for the mothers and children, and improved maternal and child health and wellbeing (Olds et al, 2007).

For the second half of my Fellowship, I travelled to the UK to observe the same program, but in an earlier stage of implementation. Comparing the experience of the mature, embedded program in the US with its younger sister in the UK has enabled me to return to Australia with rich knowledge and insight.
I gratefully acknowledge the support I have received from The Winston Churchill Memorial Trust of Australia. The staff have shared a wealth of knowledge and experience, for every stage of this long journey. The selection panels, the administrative staff, Campus Travel, previous Fellows, and even the insurers have all had a role to play.

I acknowledge the support of my two referees – Maria Axarlis-Coulter, Department of Human Services and Margarita Caddick, Director, City Communities, Hume City Council. I thank them for their support and encouragement. I thank Dominic Isola, CEO, Hume City Council, for his support and for providing a work place where innovation is encouraged. I am grateful to Lisa Letic, Ann McNair, and the outstanding team of nurses and family support workers at Hume City Council. Thank you to Anna Kruk, for outstanding graphic design, at short notice.

My Fellowship would not have been possible without the generous contribution from colleagues in the US, Canada and the United Kingdom. I met over one hundred and eighty committed and passionate workers in the Nurse Family Partnership program. We also made many new friends through Homestay and AirBnB.

I could not have done any of this without the unflinching support of my family and friends, who kept the home fires burning. I am forever grateful to my husband, David.

I dedicate this report to my mother, Ann Partridge, who taught me how to be a mother. And to my daughter, Verity, who was my photographer and teenage travelling companion.
Executive summary

Strategies for engaging young parents to improve outcomes for vulnerable children – USA, Canada, UK

There is a magic window during pregnancy – It’s a time when the desire to be a good mother and raise a healthy, happy child creates motivation to overcome incredible obstacles including poverty, instability or abuse with the help of a well-trained nurse.

David Olds, PhD, Founder, Nurse-Family Partnership

Studying the Nurse Family Partnership on both sides of the Atlantic has enabled me to see the same program but in very different contexts.

In the US, the Nurse Family Partnership is a mature program, with over thirty years of experience, with highly experienced nurses and supervisors. The first babies in this program are now fully adult, and this strong history has enabled longitudinal studies which have demonstrated the enormous short-term and long-term benefit to the mother and child.

In the US, the program is funded by philanthropic grants. The US do not have a universal maternal and child health service, so it is perhaps not surprising that coming from such a low baseline of support, women who are engaged with NFP do so well.

Conversely, in the UK, the program is just in the process of being rolled out. It is a NHS government-funded program, running alongside a well-established, but under-resourced Health Visitor program. An evaluation of the program in the UK is forthcoming, and it remains to be seen whether such a big impact on mothers and children can be observed, given the higher standard of universal care.

Nevertheless, I was struck by the similarities between the two programs, the main one being the passionate commitment of the nurses and nurse supervisors. It was inspiring to hear their stories, and between the two countries, the sentiment was echoed back and forth. I am proud to say that many Victorian Maternal and Child Health nurses have a similar passionate vocation.

Sustained nurse home visiting programs offer the most promising strategies for improving child development outcomes for young children. Nurse home visiting is a key strategy for providing coordinated care for vulnerable and at-risk families (Fox et al, 2015).

The resulting trusted relationship between the nurse and mother gives the mothers the support they need to have a healthy pregnancy, improve their child’s health and development, and become more economically self-sufficient (Olds, 2011).

Nurses can proactively engage and sensitively follow up vulnerable children and parents who are at risk of ‘dropping out’. Effective partnerships require a non-judgemental, non-threatening, non-expert approach, which includes cultural competence.

Fox et al (2015) have demonstrated that evidence-based prevention and early intervention can lead to “measurable and substantial reductions in the factors that place children and families at risk of poor outcomes” (p.6)

It’s even more important to understand that prevention and early intervention are more clinically effective than remedial responses, as well as more cost-effective.

The keys to delivering the Family Nurse Partnership program successfully are:

- Commitment from all stakeholders and a genuine desire to see the Family Nurse Partnership succeed
- Good preparation with dedicated support
- Strong leadership for the program locally

This report recommends Hume City Council’s active leadership in our region, to influence and collaborate with maternity services and other providers of care to pregnant women.

The Maternal and Child Health Service at State level is poised to consider how we can best connect with women during the antenatal phase, particularly the most vulnerable members of our community. I am very excited and optimistic about the future prospects for effectively supporting our families, to improve outcomes for our very precious children.

Catina Adams
Midwife and Maternal and Child Health Nurse
Hume City Council
0419 486 350
catinaa@hume.vic.gov.au
### United States

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<td>Kristen Misek, NFP Nurse</td>
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<td>Theresa Whitesel, Nurse Supervisor and Manager</td>
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<td>Roberta A. Holder-Mosley, Director Nurse-Family Partnership</td>
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<td>Brooklyn Team 2 Nurse, Family Partnership, New York</td>
<td>Hillary Fairbanks, Nurse Supervisor</td>
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<td>Mimi Ogawa-Spigland, Early Childhood Group Facilitator and Community Coordinator</td>
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<td>Dianne Busser, Family Health Manager, City of Hamilton</td>
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<td>McMaster University, Hamilton, Ontario</td>
<td>Professor Harriet MacMillan and Debbie Sheehan</td>
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<td>Institute for the Study of Children, Families &amp; Social Issues Birkbeck, University of London</td>
<td>Dr Jane Stuart, Trial Manager, First Steps Randomised Control Trial</td>
</tr>
<tr>
<td>Family Nurse Partnership National Unit, FNP National Unit Centre Heights, 137 Finchley Road, NW3 6JG, London</td>
<td>Mary Griffiths</td>
</tr>
<tr>
<td>Clyde Children’s Centre, Alverton Street, SE8 5NH, London</td>
<td>Kathleen Cruise, Supervisor Lewisham Family, Nurse Partnership</td>
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<tr>
<td>Family Nurse Partnership Enfield team, St Michael’s Hospital site, Enfield, Middlesex</td>
<td>Maxine Cull, Family Nurse Partnership Supervisor</td>
</tr>
<tr>
<td>Family Nurse Partnership Lambeth team, Gracefield Gardens Health and Socialcare centre, Streatham SW16 2ST, London</td>
<td>Dorothy Porter, Nurse Supervisor</td>
</tr>
<tr>
<td>Family Nurse Partnership National Unit, Department of Health, United Kingdom</td>
<td>Anne Rowe, Clinical Implementation Lead</td>
</tr>
<tr>
<td>Family Nurse Partnership Fulford Family Centre, Bristol BS13 9AQ</td>
<td>Nikki Lawrence, Nurse Supervisor</td>
</tr>
<tr>
<td>Family Nurse Partnership National Unit, Scotland</td>
<td>Gail Trotter, Clinical Director</td>
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<tr>
<td>NHS Lothian Team, Edinburgh</td>
<td>Pamela Murray, Nurse Supervisor</td>
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<td>NHS Greater Glasgow &amp; Clyde Team</td>
<td>Mhairi Cavanagh, Nurse Supervisor</td>
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<tr>
<td>FNP Highland team, Inverness</td>
<td>Anne Johnstone, Family Nurse</td>
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The Nurse-Family Partnership

The Nurse-Family Partnership is a program established over thirty years ago in New York to support vulnerable young mothers and their children.

The goals of the Nurse-Family Partnership Program are:

- To improve pregnancy outcomes
- To improve child health and development
- To improve parental life-course

(http://www.nursefamilypartnership.org/)

It is a voluntary home visiting program for first time young mothers, aged 19 or under. A family nurse visits the family regularly, from early in pregnancy until the child is two.

The resulting trusted relationship gives these mothers the support they need to have a healthy pregnancy, improve their child’s health and development, and become more economically self-sufficient.

The Family Nurse Partnership program is underpinned by a robust evidence base, which shows it can improve health, social and educational outcomes in the short, medium and long term, while also providing significant cost benefits, including:

- Improved prenatal health
- Fewer childhood injuries
- Fewer subsequent pregnancies
- Increased intervals between births
- Increased maternal employment
- Improved school readiness

The Nurse-Family Partnership has been carefully tested during nearly 30 years of ongoing, longitudinal, randomized trials in the United States. These scientifically controlled studies have found consistent and dramatic benefits for first-time, low-income mothers and their children (Olds et al, 2014).
David Olds

Outcomes

"Terrible things can be prevented and good things can be made to happen with the involvement of nurses with these families early in their lives."

– David Olds, PhD, University of Colorado Denver and Nurse-Family Partnership program founder

Nurse-Family Partnership is founded on the pioneering work of David Olds, professor of paediatrics, psychiatry, and preventive medicine at the University of Colorado Denver.

While working in an inner-city day care centre in the early 1970s, Olds was struck by the difficulties in the lives of low-income children. He realized the children needed help much earlier—at home, with their mothers, when they were infants, and before they were born. This led to the development of a nurse home visitation program for first-time, low-income mothers and their children.

Over the next 35 years, he tested the program in randomized controlled trials with three different populations: Elmira, New York, in 1977; Memphis, Tennessee, in 1988; and Denver, Colorado, in 1994. Results showed that the program improved pregnancy outcomes, improved the health and development of children, and helped parents create a positive life course for themselves.

Nurse-Family Partnership focuses on first-time mothers because it is during a first pregnancy when the best chance exists to promote positive health and development decisions, and to support the best parenting practice.

The Nurse-Family Partnership program is delivered by nurses who are perceived as trusted and competent professionals, which fosters a strong and effective bond between nurse and mother.

Data from the 15-year follow-up study to the Nurse-Family Partnership trial in Elmira, New York, shows positive effects for nurse-visited families more than 12 years after the visits ended. In addition, the following outcomes have been observed among participants in at least one of the three randomized, controlled trials:

**During pregnancy**
- 24% reduction in tobacco smoked
- 27% reduction in pregnancy-induced hypertension
- 18% reduction in births below 37 weeks gestation
- 12% increase in mothers who attempt to breastfeed

**Infant**
- 48% reduction in child abuse and neglect
- 56% reduction in emergency room visits for accidents and poisonings
- 67% reduction in behavioural and intellectual problems at age six

**Mother**
- 60% reduction in risk of infant death
- 38% reduction in injuries treated in emergency departments
- 39% reduction in language delay
- 72% fewer convictions of mothers
- 31% reduction in births within 2 years postpartum
- 24% reduction in births within 15 months postpartum

NFP Fact sheet
www.nursefamilypartnership.org
In Victoria

One of the five key action areas of the Victoria’s Vulnerable Children report is:

**Building effective and connected services**

Presently in Victoria, a young pregnant woman is often subjected to well-intentioned, but disconnected services.

Firstly, she books into a maternity hospital, and as a young mother she may be allocated to a “Young Mother’s Clinic”. She may also be allocated a case-worker from a specialist support service such as “Healthy Mothers Healthy Babies”. If there are significant concerns, an ante-natal notification to Child Protection may be made.

The Social Work department of the hospital may play a role with this new family, but resources are stretched and fragmented. The mother and baby is discharged a day or two after the birth. “Healthy Mothers Healthy Babies” may continue with the family for some time, but would generally discharge six weeks after the birth.

The Maternal and Child Health Service in Victoria offers a structured universal program of Key Age and Stage visits, and although excellent in most areas, is not sufficiently tailored to the needs of vulnerable families. They will work with the family until the child is in pre-school, but young mothers often disengage with a program that does not fill their needs. A referral might be made to the Enhanced Maternal and Child Health service but this is limited to 15 hours of additional support per family. A referral to Child First may also be made.

So this young mother and child will have passed through the hands of up to seven different agencies, let alone the individual workers. The only agency that bridges the gap between pregnancy and early childhood is Child Protection.
Young mothers

All parents need practical and accessible information and support about raising their child, on topics such as nutrition, health care and normal behavioural milestones. Through the provision of information and support, young parents can make informed decisions about the health and wellbeing of their children.

In recent years, researchers and practitioners in the field have emphasised the need to recognise the heterogeneity of the population of young mothers. Young mothers give birth in very different circumstances many of which will influence their ability to parent effectively and enjoy their lives as mothers. Differences in relation to pregnancy intention, socioeconomic situation, age and developmental stage, understandings of self, world views, life trajectories, and of course relationships, interconnect and contribute to the ways young women experience motherhood (Keys, 2008).

Hume has a rich diversity of young parents with varied culture, language, abilities, socioeconomic circumstances and household type – all potentially having different experiences and levels of support for their parenting.

Young parents often face substantial social stigma. For example, many young mothers report experiences of judgment or even hostility in their dealings with social service institutions, education providers, and health care facilities (Price-Robertson, 2010).

Young parents can be a socially excluded group and, in keeping with other socially excluded groups, outcomes for the children of young parents are poorer than average (Pogarsky et al., 2006). The children of teenage mothers experience poorer educational, health, economic, and developmental outcomes than do children of older mothers. This is the case even after controlling for the fact that teenage mothers are more likely to be from disadvantaged backgrounds (Pogarsky et al., 2006).

The young mothers have unique needs and represent a particularly vulnerable group within our community. Young mothers are over presented in Child Protection and Child First clients due to their lack of partner support, financial vulnerability and frequent homelessness.

With higher than average levels of disadvantage (SEISA 987.1), single parent households (17.7% vs 15.4% Melbourne Statistical Division), unemployment (7.1% vs 5.4% MSD) and AEDC vulnerability on two or more domains (16.5% vs 10% Victoria), it is important to ensure that young parents in Hume can access services and professional support, in order to provide them with the best start in parenthood.

While the experience of motherhood differs widely within the category ‘young mothers’, studies indicate that many young women parent in circumstances of poverty and isolation. This means that teenage parents and their children are not only facing disadvantage now, but are at risk of transmitting disadvantage down through their children to the next generation. Children of teenage parents are more likely to experience the risk factors for early parenthood and so become teenage parents themselves, creating a cycle of deprivation that is difficult to break.

Young mothers are three times more likely to suffer post-natal depression than older mothers and to suffer mental health problems for up to three years after the birth (Keys, 2008). Poor emotional health not only affects the wellbeing of the young mother but also affects her ability to be an attentive and nurturing parent, which can lead to an increased risk of accidents and behavioural difficulties for her child. Some young mothers may have pre-existing poor emotional health but this is exacerbated by the demands of parenthood, particularly when they lack family support, are in conflict with their partner, or are isolated in poor quality housing.

Support for young parents must be delivered in a way that is sensitive to their particular experiences and needs. The role of the service provider, then, is to understand the shared and individual needs of young parents and to develop services that are inclusive, welcoming and respond to these needs.
Strength in partnership

We work with families to recognise, draw from, and build their strengths, while facilitating and empowering change. All families have strengths and capabilities, and child and family wellbeing can be enhanced through the use of these strengths as tools and building blocks (Powell, cited in Fox et al, 2015).

This approach requires service providers to view families through a lens of possibilities and potential rather than incapacities and deficits, in order to facilitate necessary change (Fox et al, 2015).

Working in partnership with children and families relies on the quality of the relationship between families and service which incorporates continuity of care, attention to communication styles and strategies, and empowering families to recognise their own role in the therapeutic relationship (Fox et al, 2015).

Another key dimension of the strengths-based approach is the idea of capacity building. This means supporting families and children to build their skills, enabling them to set goals for themselves and the other members of their families.

This approach supports individuals to develop the necessary knowledge and abilities to find and apply solutions to their own lives. This in turn builds self-reliance, a sense of empowerment, control, and increased awareness of responsibility.

I look forward to seeing my nurse Kendra. I have so many questions, and I know that she has the right answers for me when I need them.

Lancaster, Pennsylvania
I spent three weeks in the United States, the majority of that time in New York.

New York City comprises five boroughs – Brooklyn, Queens, Manhattan, the Bronx, and Staten Island – which were consolidated into a single city in 1898.

The census-estimated 2014 population of 8,491,079 is distributed over a land area of just 790 km². Brooklyn has an area of 251 square km and an estimated population of 2.6 million people. As a comparison, the area of Hume City comprises 503 square km and a 2015 population forecast of 193,650.

New York City is going through one of the biggest baby booms in its history. The number of children under the age of 5 living in the city has increased by more than 32 percent.

- # of births in NYC in 2013: 120,457
- # of NYC Nurse Family Partnership sites: 7
- # of nurses employed (FTE): 88.5
- # of women served since program inception: 12,283
I met with the Staten Island Nurse Family Partnership (NFP) team, led by Jo-Ellen, and comprising Stephanie, Denise, Susan, Maria and Nora. The team of nurses is supported by an admin person, who I didn’t meet on the day.

The Staten Island NFP is an inspiring team of dedicated and skilled nurses, with over fifty years of combined experience working with families. It is a testament to the satisfaction these nurses get from the work they do, that they have all been working in this program for at least seven years.

The NFP program supports low income women having their first baby. Referrals come from the local maternity service, preferably at around 16 weeks, but can be accepted up to 28 weeks; women may also self-refer.

The nurses undertake regular home visits, during pregnancy up until the child is 2 years of age. These visits incorporate education and health promotion, related to the pregnancy and birth, as well as early child development and attachment. However, the program is client led, and aims to help the client achieve her heart’s desire.

The Wall of Wonderfulness is a reminder to nurses when such achievements occur: graduated from high school, got a job, gained citizenship, mother and child reunited.
**NFP supervisor’s meeting**

On Thursday, 16th April, I met with the Nurse Family Partnership supervisors of New York. We met in the New York City Department of Health & Mental Hygiene. I was intrigued by the name of the Department, and found a fascinating chronology of the Department, which has been serving the people of New York for over two hundred years. (for more info: http://www.nyc.gov/html/doh/html/about/bicentennial.shtml)

The nurse supervisors were interested to hear about the Maternal and Child health service in Victoria, and the comparatively straightforward funding model enjoyed by our service. In New York, NFP is funded by a number of agencies, including philanthropic, government, and the not-for-profit sectors. The funding is generally non-recurrent, however, the program is so well established in NYC that planning occurs on the basis that the programs will continue to be funded.

I was very happy to meet with Jo-Ellen again (from Staten Island) and also to meet Hilary Fairbanks, who kindly invited me to meet with the Brooklyn nurses, the following week.

**Brooklyn**

Brooklyn has two Nurse Family Partnership teams, each with eight nurses, a nurse-supervisor, and an administrative support person who deals with the large amount of data collection required by the program. The team I visited is in Brownsville and is co-located with a long day care centre. In the photo, you can see the children’s playground on the roof; open space is limited in Brooklyn.
The Projects

One of the NFP nurses, Kima, works and lives in Brownsville, and is a new grad nurse, who has gone directly into this program. I went out home visiting with her to see a young mother living in The Projects.

Brownsville contains the highest concentration of New York City Housing Authority developments in New York City, commonly known as The Projects. The population is approx 95% Black or Hispanic, low income, with high levels of unemployment, low educational attainment, and poor health.

I spoke to Kima about working in The Projects, and she told me that she had never felt unsafe. The role of the FNP nurse is generally respected and valued, so she is able to do her work without feeling harassed.

The young woman we visited was home with her 14 month old. Kima reviewed what had been discussed at the last appointment, which was largely about gross motor development and communication. The opportunity for the child to move around the tiny apartment is limited, as a number of people live there, with a lot of furniture and clothes crammed into the space. This was having an impact on his ability to toddle around. Kima encouraged the young woman to think of ways that he could have more floor time, and ways to make his space safer. I observed one of the central approaches to NFP practice – motivational interviewing. I will speak more about this later in the report, however, in this home visit I observed the – “elicit, observe, elicit” cycle in process.

• Elicit what the client already knows and wants to know.
• Provide information in a neutral manner.
• Elicit the client’s response to, interpretation of the information.
I was very interested to speak with Kirsten in Brooklyn about how birth preparation and support could fit in with the Nurse Family Partnership model. She confirmed that birth support is not part of the model, although she acknowledged that often clients asked NFP nurses to fulfil this role, and often nurses (particularly those who are also midwives) felt drawn to this work.

Kirsten spoke about how hard it would be to combine the work of a NFP nurse with being on-call for births, in terms of providing good service to all clients, and also spoke about the importance of maintaining boundaries and a clear perspective of the work to be done by the NFP nurse.

She told me about a client who had asked her to be her support person in labour, as she was completely isolated, and felt she had no-one else to ask. The nurse found it hard to resist this call, however, she worked with the client to find other sources of support. She told me that by the time the baby was one year old, the young women had a wide circle of friends and supporters, who helped to celebrate the baby’s first birthday. This may not have happened in quite the same way, if the nurse had taken the role of her “only” supporter.

Kirsten told me about the free Doula service in New York, which she referred many of her clients to. She also told me about BEBO, a volunteer group, matching mother mentors with clients seeking more support (see below for more information on both programs).

NA DOULA

The Doula Project works across the spectrum of choice to provide free doula care on a case-by-case basis to people who cannot otherwise afford it.
Brownsville

The next day I attended a playgroup in the Saratoga Street, Brownsville Children’s centre, facilitated by Mimi, a social worker. This group meets for a weekly two hour session for a 3 month series. Many of the participants are NFP clients.

The sessions are semi-structured, with the first half of the session in mother and child semi-free play. At the session I attended, Mimi also was supported by a Social work student, who assisted with supervising the children’s snack time, while the mothers participated in a group discussion in the second half of the session.

Today’s discussion was about toddler behaviour, and Mimi was very skilled at eliciting knowledge from the group that could be shared and built upon. The women were able to share their experiences, and later when I spoke to the women, they said this was a big part of the attraction of the group – that they didn’t feel so isolated in their parenting experience.
When I arrived in Lancaster County to speak with the nurses about the Nurse Family Partnership (NFP), Theresa Whitesel (nurse supervisor) asked me – Why Lancaster?

I replied that when I was planning my study tour, I came across a newspaper article that described President Obama’s administration as being the first to implement evidence-based health interventions, and named three of these, including the Nurse Family Partnership program in Lancaster County. So of course, I wanted to know more about what they were up to.

Therese and her husband Rick offered for us to stay with them for the duration of our visit. My first thrill of the trip was to be welcomed to the house by Rick in his traditional Scottish kilt. We learnt so much from Rick as he described the political and cultural scene, giving us a vivid understanding of the complexities of administering such a large country, both in population and size. We had just spent the weekend in Washington, so we were keen to know more about US politics.

While Verity attended two of the local schools, I had the pleasure of meeting the NFP team of nurses. I observed some individual nurse supervision sessions, and also attended some home visits, with Beth and Kendra.

The individual supervision is an intrinsic element of the program, with a nurse supervisor providing weekly supervision for up to 8-9 nurses, reviewing the client caseload, providing space for debriefing, and skill development. There is also a weekly team meeting.

A nurse working in the NFP program has a full-time caseload of up to 25 clients. The women are engaged prior to 28 weeks of pregnancy, but preferably around 16 weeks. The nurse offers home visits, initially weekly, and then every two to three weeks, as the child approaches two years of age. The family then graduates from the program.

Each visit is client-led, however, there is a series of topics to be covered. These include health promotion, child development and safety, maternal health and well-being, child attachment and play, and also support in achieving the mother’s employment and educational goals. The nurses have a wealth of resources, and they can be modified to suit the language and educational level of the mother.

I am constantly reminded that the aim of the program is for the mother to achieve her heart’s desire. The NFP nurse is the facilitator and coach.

I was struck by the similarities to our maternal and child health (MCH) program, the preoccupations of the families, the strength-based approach, and the curriculum which supports and nurtures the mother, so that she can support and nurture her child.

I was also struck by the potential to extend and improve our MCH program, tailoring the delivery and content for vulnerable families. I reflected on how satisfying this work would be for our MCH nurses, with the focus on the relationship between the nurse and mother as the key therapeutic intervention.

The nurses of the Nurse Family Partnership – Lancaster County are highly skilled, dedicated, and I could not have asked for a better opportunity to see this program in practice.
Hamilton, Ontario

I met with the Nurse Family Partnership team in Hamilton, Ontario, headed by NFP nurse supervisor Dianne Busser. She is also the Family Health Manager for the City of Hamilton. She has been in this role for over seven years, and prior to that worked in Public Health, Psychiatric nursing, and also the 24-hour nursing line. Her team of eight nurses come from a range of backgrounds prior to working in the Nurse Family Partnership – public health, labour and delivery, family health, and there was even an Australian nurse/midwife on the team.

Unlike the New York program, which admits pregnant women of any age on low incomes having their first baby, the Hamilton program adheres more closely to the original NFP program, admitting only women under 21, on low incomes, with “poor support”.

The City of Hamilton has nearly 6000 births per year, 21% of the population lives in poverty, and there are a higher number of young pregnant women than in Canada overall.

Canada has a similar universal health program to Australia, so I was interested to know more about the transition of the program. In order for the program to be introduced in a new health setting, there are three required steps for implementation:

• Adaptation & Feasibility (completed in Hamilton, Ontario)
• Randomized Controlled Trial and process evaluation (underway in British Columbia – 2014-2018)
• Expansion

The NFP unit in Denver Colorado, which is headed by Professor Olds, has strict oversight over the NFP programs offered at sites around the world. NFP is now being implemented in Canada, The Netherlands, England, Scotland, Northern Ireland and Australia.

The predominant maternal and child health program in Ontario is called Healthy Babies Healthy Children (HBHC), and is delivered in a blended way by nurses and paid parenting support peers. It was originally universal, but is now offered to women following a risk assessment during the pregnancy, and if the women are “identified with risk”, then they are offered the HBHC program.

For women under 21, they are offered NFP instead of HBHC. The NFP nurses are required to maintain records for both the NFP program (paper record) and the Ontario Health Record, which is electronic.

The major difference between NFP in Canada and the US is the reduced case-load for Canadian nurses. The US nurses have a caseload of 25 clients, however, this is not sustainable in Canada, as the working conditions are different between the two sectors. In the US, nurses get 2 weeks annual leave, whereas in Canada the nurses get 6 weeks annual leave and up to 10 public holidays (eight weeks in total). With six less working weeks per year, the case-load cannot be maintained at 25 clients, so it has been reduced to 20.
The next day I attended a home visit with Melissa, where we visited a young mother and her eight month old daughter. The young mother is living in supported accommodation, in a self-contained unit. In the unit, there is a resident youth worker, housing up to 12 young mothers. The apartments are next door to a secondary school, specifically catering for young pregnant women and young mothers. It offers modified programs and on-site childcare.

The Salvation Army Grace Haven was founded in 1896 to serve young women and their children. There are two major program streams for females between the ages of 13 and 21.

The residential program has a 12 bed capacity and provides prenatal and postnatal care, prenatal classes by a public health nurse, access to a public health clinic, high school education offered onsite by the Hamilton-Wentworth District School Board, life skills, preparation for independent living, counselling, parenting education, infant play, recreation, NFP home visiting, and respite care available to female non-pregnant teens when referred by selected agencies.

The community program is accessed on a weekly basis and offers high school credits offered on-site by the Hamilton-Wentworth District School Board, access to public health clinic and prenatal classes (day and evening), life skills, counselling, “Nobody’s Perfect” parenting program, breastfeeding peer support, twenty-four hour telephone support, NFP home visiting, New Choices Program for substance using pregnant and parenting teens/women offered onsite, and Chaplaincy services. Lunch is provided at no cost.

Today’s meeting was focussed on safety, with Melissa reviewing the measures the mother had put in place to accommodate an increasingly mobile crawler.

Her research focuses on the epidemiology of family violence, including prevention of child maltreatment and intimate partner violence. Along with colleagues from the US and Canada, she is evaluating the effectiveness of an intervention to reduce intimate partner violence within the context of an existing home visitation program – the Nurse Family Partnership.

Given our shared research interest in Intimate Partner Violence, we were able to talk about research projects in Australia, such as MOVE.

Professor McMaster’s colleague Dr Susan Jack, who was not available to meet with me when I was in Canada, has researched the role of the NFP program in reducing child abuse and Intimate Partner Violence. Dr Jack is leading the qualitative work to explore the transferability of the Nurse-Family Partnership program of nurse home visitation in the Canadian context.

Programs found to be successful among Americans have not always shown the same positive outcomes among Canadians. Canada’s uniquely vulnerable populations of Aboriginal and immigrant children, its challenging remote service settings and its more generous social services all may influence program effects. These are similar contextual considerations for Australia, with our large geographical area, indigenous and multi-cultural communities, and extensive universal health services.

Meeting with Professor MacMillan and Debbie Sheehan at McMaster University in Hamilton Ontario was such a pleasure. They have extensive experience of the NFP program and personal acquaintance with Professor Olds, the founder of the program.

"If you look at the opportunity to make a difference in the lives of children and young women, it’s very powerful and very fulfilling. As well, cost-benefit analysis shows the program is cost-effective in the short and long term. There are very few interventions that can make this kind of difference."

My conversation with Debbie Sheehan was a discussion around the roll-out of NFP internationally, including the Australian Nurse Family Partnership Program (ANFPP). She described the challenges of introducing the American program to other countries, including the staged introduction via pilot sites, the RCTs, the learning stage, and then full implementation.

We discussed the principle of “fidelity to the model”, and some of the terms associated with the program – dosage, which means the number of consultations; fidelity goals, which means adherence to the model; and also discussed the key intervention of the program, which is the therapeutic relationship.
My first appointment in London was with Dr Jane Stuart, Trial Manager, First Steps RCT Study, at Birkbeck, University of London. The RCT study is trialling the Family Nurse Partnership program, delivered in a group mode. Later in the week, I attended one of the group sessions and talked to nurses and clients about their experiences of the group approach.

Group FNP (gFNP) uses Family Nurse Partnership resources, materials and its approach to provide a structured learning program for groups of vulnerable women, incorporated with maternity care from early pregnancy until their child is 2 years old.

gFNP is provided by two Family Nurse Partnership nurses, one of whom is also a midwife. The group sessions last for 90 minutes, followed by or preceded by medical checks relevant to the pregnancy or to child development. Following the Centering Pregnancy model of working, many of the checks are completed by the clients themselves, guided by the FNP nurses.

Centering Pregnancy is a model of group antenatal care, which I first heard about in Pennsylvania. Women receive the same physical care and screening as in individual consultations, but in a group setting.

There are eight sessions during the antenatal period, at 16, 25, 28, 31, 34, 36, 38 and 40 weeks. In addition, there is a reunion one month after the birth. Additional appointments occur where needed.

The sessions are two hours long and each group consists of between eight and 12 women who have a similar expected date of delivery (EDD). The sessions comprise an initial 40 minutes when the women arrive, during which time they can socialise and get involved in self-care activities. They are also offered an abdominal palpation. The subsequent time is timetabled as discussion time. Women who require individual attention for physical, psychological or social reasons can be seen in private at the end of the session.

The room is set up with a circle of chairs, a mat and cushions at the edge of the room for the abdominal palpation, a refreshment area and a desk-height table for blood-pressure estimation. The room also has toilet and hand-washing facilities nearby. Prior to each session, the midwives familiarise themselves with the needs of the women, for example by obtaining the results of any screening tests.

An important part of Centering Pregnancy is the woman’s active involvement in the physical aspects of care and record-keeping. Women measure and record their own or each other’s blood pressure, test their urine for protein, estimate their gestation using an obstetric wheel and document the discussions in their maternity.
notes. These activities are overseen by one of the midwives.

The group discussions follow a set format of topics ranging from healthy eating, awareness of mental health and breastfeeding. There are also discussions about pregnancy, birth and beyond and accessing advice, support and information for a lifetime. Partners are invited to some, but not all, sessions to provide an opportunity for sensitive discussions such as domestic abuse.

According to Fox et al. (2015) the program has been trialled with a range of 'at-risk' women, including adolescents and those from culturally diverse backgrounds. Evaluation of the program has shown a significant improvement in the rates of preterm births and inadequate prenatal care, along with significant positive effects on breastfeeding initiation, antenatal knowledge, readiness for labour and delivery, and satisfaction with antenatal care (Ickovics, Kershaw et al., 2007). This evaluation also reported that the approach is cost-neutral when compared with individual antenatal care, in terms of the costs incurred for antenatal care and delivery care (Ickovics, Kershaw et al., 2007).

In Australia, group antenatal care has been trialled in a few locations with pregnant Indigenous women, showing promising outcomes related to birth weight, perinatal death and maternal health (DEECD, 2014).
Meeting with Mary Griffith at the FNP National Unit gave me an insight into the significant investment required to support the program.

Mary is the Service Development and New Projects Lead for the National Unit, and her work includes supporting the implementation of the program in the UK. The National Unit is located in North West London, near the quaintly named Tube station – Swiss Cottage.

She explained that the initial phase of the implementation was a test pilot site in 2007, with a formative evaluation. A Randomised Controlled Trial (RCT) commenced in 2009, and shortly afterwards the program was introduced across the National Health Service (NHS).

This quick uptake of the program, even before the results of the RCT were published, is a result of the very strong personal support offered by David Cameron, the Prime Minister.

The program comprises 135 teams with up to 800 nurses, nurse supervisors and admin staff. This enables 16000 places to be offered to young women in England, Ireland and Scotland. In some sites, 100% coverage has been achieved, with all young pregnant women being offered a place in the program. The program has not been implemented in Wales, as they have a pre-existing maternal and child health program.

The National Unit has a range of tools for provider organisations to use to ensure the right conditions for high quality preparation and delivery of the Family Nurse Partnership program. These include:

• A comprehensive ‘Management Manual’ which provides detailed and comprehensive guidance on preparing for and delivering the program
• Job descriptions for nurses and supervisors and guidance on practitioner recruitment and selection
• Provision of the Family Nurse Partnership learning program for nurses and supervisors
• Clear guidelines, content and materials for nurses to use in visits with clients
• A real-time information system and performance evaluation for individual nurses, the team and the site.
• A quality improvement process
• Learning days for provider managers, named nurses and others involved with delivery of the Family Nurse Partnership program

Every site also has a dedicated member of the National Unit, a Service Development Lead, to provide support and guidance to the local Family Nurse Partnership team, the site and local stakeholders. The Service Development Lead works with each site right from the beginning to support planning and preparation for program implementation.

At the outset this will involve:

• Gaining strategic commitment to the delivery of the Family Nurse Partnership program and its sustainability from the local authority and Clinical Commissioning Groups
• Working with NHS England Area Team to agree on a commissioning process, confirm service specification, choose a provider and agree on a budget
• Identifying a project manager to lead local strategy and implementation for the Family Nurse Partnership program
• Setting up a Family Nurse Partnership Advisory board
• Shaping and managing an implementation plan
• The keys to delivering the Family Nurse Partnership program successfully are:
• Commitment from all stakeholders and a genuine desire to see the Family Nurse Partnership succeed
• Good preparation with dedicated support
• Strong leadership for the program locally
The Service Development Lead continues to work with each site on the ongoing delivery of the Family Nurse Partnership, in particular with the process of continuous quality improvement. The focus of the Service Development Leads and the National Unit as a whole is on continually learning from and with sites in order to develop the program nationally and constantly improve the quality of program delivery.

(from the FNP website: http://fnp.nhs.uk/about/fnp-in-england/the-national-unit)

The next day, I spoke further with Mary Griffiths about the challenges in transferring a US program to a UK setting. The first and most obvious change was the name of the program – in the US it is the Nurse Family Partnership, and in the UK, it is the Family Nurse Partnership. This was a purposeful reframing of the relationship, putting the family first.

Mary described some of the other small changes to the program, such as changing the language of the materials used, but in essence the program has transferred well. Both programs speak in terms of fidelity goals, i.e. integrity to the model, such as enrolling the woman in the program by mid-pregnancy, retaining the clients until the child is 2 years of age and achieving prescribed “dosage", or the number of visits.

As she explained, the Family Nurse Partnership Program is based on the theories of human ecology, attachment and self-efficacy.

**Human ecology theory**

Bronfenbrenner’s theory of human ecology emphasises the importance of the social context as an influence on human development. Use of this theory means that nurses help their clients to consider the impact of their social context on their growing child, and to develop strong relationships with those who can play a supportive role.

**Attachment theory**

Bowlby’s attachment theory emphasises the importance of the security and safety that a primary relationship with a caregiver gives for a child’s healthy emotional development. Nurses use this theory to guide their work with FNP clients on sensitive and responsive caregiving.

**Self-efficacy theory**

Self-efficacy is seen by Bandura, in his social cognitive theory, as an individual’s belief in their ability to achieve their goals and that realising these will lead to a desired outcome. Nurses use this concept to guide their efforts in supporting positive change, enabling clients to understand why particular actions are important and to develop the confidence necessary to achieve these.

While Verity attended a local secondary school for the day, I met with the Streatham team of FNP nurses, led by nurse supervisor Dorothy Porter.

The baby dolls are a feature of the home visit, and are used as a teaching aide and ice-breaker.

In the morning, I attended their team meeting, and was able to share information about maternal and child health services in Australia. The meeting was predominantly a business meeting, but included a case presentation, with the team of nurses providing feedback on the case.

The case involved a young mother and infant who is “looked after” or in our context, under the protection of DHS. Another term used is “safeguarding” and in this case, the young mother herself is still under the care of Child Protection. There are a very limited number of foster care placements which can accommodate a young mother and her child. The involvement of a FNP nurse is considered a protective factor, and the nurse fulfils the dual roles of support and surveillance, a tension which we are also familiar with in Australia.

The local area has approximately 6000 births per year, and the team is well established and in a position to offer FNP place to 100% of eligible clients. Last year, the team had an acceptance rate of 50%. The nurses discussed the language used in offering the program to young women, and suggested that language such as “needing more support” could put off some young mothers, who feel they have enough support with family and partners. Instead the nurses describe the program as “working with” (walking with) and highlighting the partnership model, so that it is clear that the goals of the program are to enable her to fulfil “her heart’s desire".
My meeting with Maxine Cull, nurse supervisor of the Enfield team in Middlesex, enabled me to gain insight into the implementation of the FNP program in a local government area in the UK. With 5000 births a year, the size of the Borough is larger than, but comparable to Hume City. The social demographic of the Borough is similar to Hume City, with pockets of social advantage, and other areas with significant disadvantage and associated vulnerabilities.

The majority of referrals to the program come via the local maternity services, although as the program becomes more established, the number of self-referrals is increasing. The criteria for selection are that the woman must be under 20 years of age at her Last Menstrual Period (LMP), she must be a resident of the Borough, and it must be her first live birth. The team also worked closely with Child Protection Services (safeguarding) in identifying those families that needed to have priority access.

Maxine described some of the tools and work structures used to support the nurses. To enhance security while doing home visits, the nurses use the “What’s App” messaging tool, which enables group chat, and also enables nurses to check in and out.

The nurses have a weekly team meeting, in one week the focus will be on team education and skill development, for example “saying goodbye, letting go”, and in the other week, the meeting will have more of a business focus. The nurses have a monthly 2-hour case presentation, and a monthly 2-hour group supervision session with a psychologist. In addition, each nurse has a weekly supervision session with the nurse supervisor. This intensive support for nurses is an integral part of the program, and many nurses speak about how well supported they feel by the program. In addition, the National Office provides support via education and resources. As one nurse said “You never stop learning in FNP.”

Once recruited, the nurses undertake an intensive initial education comprising a one week residential program. In the journey from novice to competent practitioner, they have 40 prescribed competencies to achieve, and nurse supervisors an additional 40 competencies. The first 18 months of practice is a steep learning curve for most nurses, as they work through each of the facilitators for the first time.

I was interested in the recruitment of nurses, and Maxine explained that when a site is created, the nurse supervisor is appointed first with the Quality Support Officer. The nurses are then recruited via a two stage interview process, one panel comprising the nurse supervisor and staff from the National Office and the Local Health Authority, and another panel comprising teen clients of the service. Maxine said that almost always the two panels coincided in their choice.

We discussed the workload of the nurses, and Maxine spoke how difficult it was to achieve and maintain a caseload of 25 clients, as prescribed by the program. I shared with her my knowledge of the Canadian nurses working conditions, where because of their shorter working hours and additional weeks of annual leave compared to US nurses, they aimed to achieve a caseload of 20 clients. The working conditions of UK nurses is comparable to the Canadian nurses, which would make a caseload of 25 clients unsustainable.

Later in the day, I attended the weekly meeting, and met the team of FNP nurses. They spoke about the facilitators (resources for the home visits) and the adaptations required for the local context. For example, the women may not know the same nursery rhymes, and brand or store-names needed to be made local, such as Tesco instead of Walmart, or Farex instead of Gerbers.

As for other teams I have met, I was impressed by the passion and commitment expressed by the nurses. One of the nurses said “This is the hardest job I have ever loved.” Another described the learning process when she first started as FNP nurse, that she had to “learn, re-learn, and un-learn” in order to engage with the partnership model. She described it as “the gift of the program.”
On this day, I had the absolute pleasure of attending a Group Family Nurse Partnership (gFNP), facilitated by Anna and Emma, two FNP nurses, with five young mothers and their babies (all around five-six months of age).

The sessions are held in a Children’s Community Centre, which offers child care, pre-school, adult education courses, and other community services.

The sessions are held every two weeks, and today’s session was on emotional self-care. The format was structured but casual, and it was clear the young women had an easy relationship with the nurses and with each other. In the session, I spoke mainly with the young women, and heard about their experiences of the program.

They had all joined the group at around 18 weeks pregnancy, and were all due within a month of each other. The women talked about how positive it was to share the journey of pregnancy with other young women, and how the group setting reduced their feelings of isolation.
Bristol

The team at the Fulford Family Centre in Bristol comprises a nurse supervisor, Sarah, and four nurses. This is a team that is growing, which will build up to the full complement of eight nurses over time. The nurses have a caseload of 22 clients, the lower caseload reflecting the different working conditions to the nurses in the US program.

I attended the team meeting, and the topic for discussion was Supervision - who's it for, who benefits? I was very interested to hear the nurses’ views on this, as it is such an integral part of the FNP program, with weekly sessions for each nurse with her nurse supervisor.

The nurses recognise that supervision is not only for the benefit of the individual nurse, but also for the benefit of clients, the team and supervisors. It enables frequent reflection on the work, and provides a structure for Analysis, Reflection and Action.

According to the NFP model - Nurse supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings, and field supervision.

See more at: http://www.nursefamilypartnership.org/Communities/Model-elements

The program requirements for supervision are built into the licensing conditions for the program. Each nurse receives weekly, one-on-one supervision, fortnightly team meetings, and four-monthly accompanied home visits.

The relationship between supervisor and supervisee mirrors the relationship between nurse and client, and in turn mirrors the relationships the program fosters between the mother and child.
Boundaries

During this meeting, the topic of boundaries came up – one which is of interest to anyone working with families. The relationship between the mother and Family nurse is one of trust and this can lead to situations where a young person may develop some level of emotional dependence. Nurses often develop close relationships with clients and it is sometimes difficult to draw precise lines about where the boundary between professional and personal lies. As nurses, we are not effective if our relationship with clients is too cold or distant, neither can it overstep professional bounds.

In all our relationships we set limits. Each of us has a boundary around us that defines who we are as individuals. The strength of our boundary depends on our relationship with the other person and on the context of that relationship. We must be able to recognise when we may be crossing the invisible line which separates a client from a worker and which defines our relationship as professional and therefore workable (Dept of Health, 2004).

Decision tree

Sarah shared a useful tool, called the Decision tree, which she uses with the nurse in supervision.

**PROPOSED BEHAVIOUR**

Meets a clearly identified therapeutic need of the client rather than a need of the nurse, eg. is it part of the plan of care?

- **YES**
  - Proceed with the behaviour and document it.

- **NO**
  - Is the behaviour consistent with the role of nurse in the setting?

- **YES**
  - Abstain from the behaviour

- **NO**
  - Is this a behaviour you would want other people to know you had engaged in with the client?

- **YES**
  - Abstain from the behaviour

- **NO**
  - Abstain from the behaviour
Glasgow

I met with Mhairi Cavanagh, FNP Nurse Supervisor in Glasgow, who invited me to attend a meeting of the Glasgow City Community Health Partnership. The meeting was chaired by Lorna Dunipace, head of Primary Care and Community Services in Glasgow, and included representatives from the Family Nurse Partnership, the local Child Protection authority, the Health Visitor program, and other members from the local NHS and Local Government authority.

The group was originally set up to oversee the implementation of Family Nurse Partnership in Glasgow. Although the initial goals of the group had been fulfilled, the group has continued to meet because of the benefit gained from ongoing information sharing between senior health and children’s services managers, and also to oversee the next phase of implementation.

Two teams have been established in Glasgow, each with the prescribed staff profile of eight nurses, one nurse supervisor, and one administrative person. The nurses have a caseload of between 19-23 clients.

The goal is to offer the program to all young pregnant women under 20 years of age, so that FNP becomes universal care for young women. To achieve this, Glasgow City will need eight FNP teams, and a plan was tabled which showed a phased implementation over three years. A new team of nurses would be recruited every four-six months. This represents a significant financial commitment, both in staffing and infrastructure, however Glasgow City has confirmed its support for the program.

When a nurse starts in the FNP program, she is in her “learning phase” which means that she doesn’t start with a caseload of 25, but builds her caseload as she learns the program. By the time her first clients are graduating at age 2, she will have a full caseload.

There was a discussion about the career pathway for FNP nurses, and it was noted that this was lacking in the structure. FNP nurses may have the opportunity to become nurse supervisors, or to work in the National Unit in Clinical education or leadership, however, this is not an option for all. I observed that Maternal and Child health nurses in Victoria have a similar problem, with a very flat management structure, and few opportunities for career development and promotion.

Unlike Edinburgh, Glasgow does not have a centralised maternity intake, so recruitment of clients is less straightforward. The NFP teams have found more success if they are able to recruit the women directly, as leaving it with the midwives has been less successful, and potential clients have been overlooked. This may have been because of midwives not fully understanding the program, and having too many other things to cover at the first maternity appointment.

Working directly with the maternity hospitals, with the FNP nurses being able to contact the women directly, has helped overcome this. Also, with the full implementation of the program, it will be presented as universal care that women can “opt out” of, rather than a specialised program that they have to “opt in” to. This presents the Family Nurse Partnership as a universal program for young pregnant women, not just for those who need additional support, thereby removing any possible stigma attached to the program.
Edinburgh

I met with Pamela Murray, Nurse Supervisor of the Edinburgh team, the first site to start in Scotland with six nurses and one nurse supervisor.

Pamela described what she viewed as key elements of the program – the therapeutic nurse relationship, and also motivational interviewing.

She also spoke about how easily boundaries can be nudged, but this was well contained via supervision. One way of ensuring boundaries are maintained is to view contact with the nurse on an equity of service basis – all clients deserve equitable access to the nurse.

Pamela spoke about the work to define roles carefully – the Family nurse is one of a team with others playing their own roles, such as Social Workers, Midwives, Housing Office, and Child Protection. The role of Family nurse is big enough, without taking on the roles of others.

Because the Family nurses work exclusively with teen parents, there is often an overlap or crossing of boundaries between children’s and adult services, with the teen mother moving from one service to the next as she gets older.

Pamela described vividly the benefits of supervision, and said when it works best, there is a robust discussion that evokes a response from the nurse. Again I was reminded of the Nurse Family Partnership relationship between the nurse and mother, being strengths based and involving motivational interviewing, and the similarity to the relationship between supervisor and nurse.

She spoke about the recruitment and orientation of the new Family nurse. She starts working with clients after a 5-day residential program, and by the end of the first year, has worked up to her caseload of 25 clients. There are four teams in Edinburgh - in 2012 the second team commenced, in 2014 the third team, and in 2015 the fourth team started. All eligible young women are offered a place in the program with truly outstanding results - 84% acceptance, and 90% retention.
National Unit, Scotland

I spoke with Gail Trotter, Director of the National Unit in Scotland. She told me that 9 out of the 11 Health Boards in Scotland are offering the program, with 100 nurses, and 1600 clients. The Scottish government aspires to offer this program to every eligible young woman under 19. This will amount to up to 9000 women by 2018. The Health Minister Nicola Sturgeon is a strong supporter of the program, and is now also First Minister of the UK government.

Gail confirmed what I had already observed, the passionate commitment of the team, with a low attrition of nurses. She attributes this to the supportive structure of the program, with the built-in supervision elements for nurses and supervisors.

If you want a nurse to do a good job, give her a good job.
Inverness

My last visit for the Fellowship was to the Inverness team, who service rural and remote clients in the Highlands of Scotland. They have approximately 2200 births per year, and 180 teen births i.e. under 20 when they conceived.

There are four nurses in the team, all of whom are in the learning phase, i.e. building up to a full case-load. Of the 107 eligible clients, 91 commenced with the program and 14 refused. The reasons for refusal were given as “I have plenty of support” but it also appeared for some that it was controlling partners or parents who influenced the young pregnant woman in her rejection of the program.
What have I learnt?

Although caring for the young child is primarily the responsibility of the parents, both father and mother, it is the community’s responsibility to ensure that services are available to help them carry out their role competently and to make provisions for those with special needs, due to physical, mental, social or economic handicaps.

(Campbell and Wilmot, 1929)

On my travels I was impressed by the passion and commitment expressed by the nurses. One of the nurses said “This is the hardest job I have ever loved.” Another described the learning process when she first started as Family Nurse Partnership nurse - that she had to “learn, re-learn, and un-learn” in order to engage with the partnership model. She described it as “the gift of the program”.

It was inspiring to hear their stories, and between the two countries the sentiment was echoed back and forth. I am proud to say that many Victorian Maternal and Child Health nurses have a similar passionate vocation.

I was encouraged by the similarities to our maternal and child health (MCH) program, the familiar preoccupations of the families, the strength-based approach, working in partnership with families, and the curriculum which supports and nurtures the mother, so that she can support and nurture her child.

I was struck by the potential to extend and improve our MCH program, tailoring the delivery and content for vulnerable families. I reflected on how satisfying this work would be for our MCH nurses, with the focus on the relationship between the nurse and mother as the key therapeutic intervention. The trusted relationship between the nurse and mother gives the mothers the support they need to have a healthy pregnancy, improve their child’s health and development, and become more economically self-sufficient (Olds, 2011).

Studying the Nurse Family Partnership on both sides of the Atlantic has enabled me to see the same program but in very different contexts. The context is the most important factor in predicting the impact of the NFP intervention.

In a country such as the US with a relatively low baseline of maternal and child health support, it is not surprising that the women and babies who are engaged with Nurse Family Partnership do so much better. However, in countries with well-established universal services such as Canada, the UK and Australia, the impact of the Family Nurse Partnership program will be more subtle and more difficult to describe. That doesn’t mean that the program is not of great benefit to specific groups; it is just that the benefit needs to be evaluated and described in the different context.

Fox et al (2015) have strongly demonstrated that evidence-based prevention and early intervention can lead to “measurable and substantial reductions in the factors that place children and families at risk of poor outcomes” (p.6).
Recommendations

Hume City Council has strong potential to provide active leadership in our region, to influence and collaborate with maternity services and other providers of care to pregnant women, and young families.

The Maternal and Child Health Service in Victoria is poised to consider how we can best connect with women during the antenatal phase, particularly the most vulnerable members of our community.

At State level, the government is concerned with outcomes for Vulnerable Children, and at Federal level, a review is being undertaken around children experiencing Family Violence.

ARACY has published an excellent review of research and practice for prevention and early intervention - Better systems, better chances.

Strong evidence tells us that prevention and early intervention are more cost-effective and more clinically effective than remedial responses. With this in mind, I make the following recommendations.

Specifically, we can:

1. Initiate discussion with providers who work with pregnant women, to investigate scope to actively involve MCH nurses and Parent Support Workers during the antenatal period:
   - Strengthening families in the North
   - Local maternity services
   - Healthy Mothers Healthy Babies
   - Koori Maternity Services
   - Centrelink
   - AMES
   - Child Protection

2. Undertake a vulnerability analysis for Hume City, specifically looking at young parents, CALD groups, including refugees, Indigenous Australians, homeless parents and women experiencing family violence, mental illness and/or substance misuse.

3. Test the hypothesis that vulnerable clients are disengaged with early years services in Hume City. Undertake a review of the family’s journey through our service.

4. Investigate feasibility of jointly offering with The Northern Hospital, a Group Antenatal Clinic for Young Mothers, which would continue after birth to become a Young and a Mum Babies in Hume and/or the BUMP program.

5. Investigate feasibility of jointly offering with The Northern Hospital, a Group Antenatal Clinic for ATSI mothers, which would continue after birth to become a Boorais in Hume and/or the BUMP program.

6. Contribute to the forthcoming review of the Right at Home pilot in City of Whittlesea.

7. Undertake a business plan to support a New Initiative to offer sessions for pregnant women and partners in Maternal and Child Health centres, with a focus on breastfeeding and early parenting preparation (Pregnancy Conversations). Depending on the model proposed, some sessions would be targeted for vulnerable groups.


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In memory

To the memory of Vera Scantlebury Brown OBE, MD, the first Director of Maternal and Infant Welfare in Victoria. Her great vision, ability, dedication and personal qualities inspired all who were associated with her.