APPENDIX

Nurse-Family Partnership programme – first year pilot sites in England

Pregnancy and the postpartum period

Report to the Department of Children, Schools and Families

From

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KEY MESSAGES

1. The Family Nurse Partnership (FNP) programme can be delivered effectively in England, in a variety of different areas, but further work needs to be done to understand and address the reasons for not meeting the fidelity targets for early recruitment, dosage, attrition and data collection. The findings of the evaluation highlight the following factors:
   - The conditions of being a test site, learning the programme and demands of the tight set up timetable i.e. birth clustered around same time;
   - There were wider demands on Family Nurses' time from organisation and multi-agency working;
   - There were challenges in providing this service within the UK context, with national healthcare, compared to the USA;
   - There was a lack of integration between maternity and child health services.

2. The FNP reached those who are likely to benefit most and the current eligibility criteria of all 19 years and under first time births should continue. Any further testing of the FNP with non-teenage mothers should focus on 20 to 22 year olds. Recruitment systems and processes have not always worked well and the evaluation indicates the following success factors:
   - Establishing clear, simple and consistent recruitment pathways and criteria;
   - Engaging midwifery leaders from the beginning and keeping them informed;
   - Family Nurses (FNs) are best placed to 'sell' the FNP to at risk clients;
   - Better data collection is needed at recruitment to understand the relationship between potential eligibility, referrals, eligibility and uptake.

3. The FNP is acceptable to first-time, young mothers but attrition during pregnancy exceeded the fidelity target in some sites. Further work is needed to understand why clients refuse or leave the programme and to factors associated with attrition such as dosage or client demographic characteristics. The evaluation found that:
   - Enrolment rates were high, on average 87% of those offered the FNP;
   - Enrolment was higher for under 20s (88%) than 20 to 23 year olds (81%);
   - Clients had very high regard for their Family Nurses;
   - Clients appreciated the difference between the FNP and other services;
   - Clients identified universal services as being judgemental;
   - Clients valued the learning aspects of the programme;
   - Some found the programme too demanding and did not wish to make a long term commitment;
   - Attrition rates were variable, with high mobility in some areas meaning that clients were know to have moved, or were not locatable.

4. The FNP seems acceptable to fathers. The evaluation found that fathers:
   - Participated in visits;
   - Used programme activities;
   - Valued the learning on prenatal development, diet and smoking, and preparation for labour and delivery;
   - FNs reported that many clients requested materials for fathers who could not be present, and conveyed questions that fathers had asked about the FNP programme.

5. The FNP is acceptable to the practitioners delivering the programme who, on the whole:
   - Valued the learning;
   - Considered that it differed substantially from their previous roles (as health visitors and midwives) with the emphasis on developing a supportive relationship with the client and her family;
   - Recognised the value of the FNP and the potential benefits for at risk clients;
   - Nonetheless they find the work demanding both emotionally and professionally and the workload heavy with significant levels of overtime.

6. Supervision is a core function of the FNP and vital to successful delivery to families but establishing this particular style of supervision was a challenge:
   - It proved difficult for first wave supervisors who were learning the programme at the same time as FNs;
   - Meeting the requirements for one-to-one supervision and group supervision added to perceived workload problems for the FNs;
   - On the whole supervisors were valued by the FNs but team functioning issues could get in the way of supervision;
   - Further work needs to be done to develop supervision in existing and future sites.

7. The evaluation identified best practice and barriers to effective working. FNs recognised the benefits of using a structured programme, developing a different kind of relationship with clients, using new skills and reaching real need. Barriers to effective working for further exploration are:
   - Caseload size;
   - Cancellation of visits by clients;
   - Lack of planning time;
   - Strategies for keeping clients engaged;
   - Wider family involvement;
   - Specific client needs (e.g. literacy, language);
   - Travel time and isolation from the team, particularly in rural areas.

8. Organisational infrastructure and support impacts on successful delivery of the FNP. Project Leads and Project Managers had key roles in setting up the FNP in the sites. Findings suggest that:
   - Midwifery leads need to be involved from the beginning;
   - There was a lack of clarity about responsibilities of supervisor and Project Manager;
   - The Project Manager and supervisor need to work collaboratively.

9. The integration of the FNP with wider services indicated that health colleagues were more familiar with the FNP but the evaluation identified concerns:
   - Some other professionals think that FNP teams are elitist and that they may take over existing roles;
   - Local Authorities had a lower level of understanding of the FNP;
   - Children's Centres in particular were not well informed and many did not understand the potential contribution of the FNP;
   - More needs to be done to promote and explain the FNP and raise its profile in Local Authorities.

10. The evaluation has looked at short term programme objectives, including:
    - Client views on their learning, changes in parenting and understanding of their infant. Many reported that they had gained confidence as parents and described aspirations for the future;
    - Most Family Nurses thought that clients were coping better with pregnancy, labour and becoming a parent;
    - Smoking in pregnancy showed a 17% relative reduction from 41% to 34%;
    - Breastfeeding rates appear better for this age group than national rates indicate, with more than two thirds initiating breastfeeding compared to just over half in a comparable national sample;
    - Engagement of fathers was good, with more than half attending visits;
    - There are limitations to these data such as the possibility that clients did not disclose alcohol and substance use, and some had not been questioned at two time points. In addition there is a lack of comparative data for this particular client group. However these early findings are promising.

11. Strengthening programme delivery. The evaluation has identified factors that support or hinder high quality programme delivery that require further discussion:
    - Should the FNP be protected at this early stage as a discrete programme or integrated within multi-agency children's services?
    - Clarity is needed about what the FNP is for parents. Much of the content is educational but presented with clinical expertise;
    - Appropriate caseload size, workloads and the feasibility of meeting fidelity requirements within English context need to be determined;
    - Time spent by FNs on non-programme activities needs better documentation
    - The nature of the therapeutic relationship is integral to the FNP and what this means for professional practice needs examination;
    - Family Nurses need guidance on dealing with scrutiny and data collection, which are inherent in the FNP, not only when it is piloted;
    - The level of central support has facilitated coping with local difficulties and allowed for shared learning between sites. The role of central team in the future will need to be discussed;
    - To determine the impact of the FNP for clients, their children and their families it is essential to conduct an RCT.

EXECUTIVE SUMMARY

1. Background

The Nurse-Family Partnership (NFP), developed in the USA by Professor David Olds, is an evidence-based nurse home-visiting programme designed to improve the health, well-being and self-sufficiency of young first-time parents and their children. It involves weekly or fortnightly structured home visits by a specially trained nurse from early pregnancy until children are 24 months old. The curriculum is well specified and detailed with a plan for the number, timing and content of visits. Supervision is ongoing and careful records of visits are maintained. The programme has strong theoretical underpinnings, with the formation of a strong therapeutic relationship between nurse and mother at its heart. The programme is designed for low-income mothers who have had no previous live births and starts in the second trimester of pregnancy.

The main goals are to improve the outcomes of pregnancy by helping women improve their prenatal health; to improve the child's health and development by helping parents to provide more sensitive and competent care of the child; to improve parental life course by helping parents plan future pregnancies, complete their education and find work. Research evidence from three randomised control trials in the USA has shown it to have positive effects from pregnancy through to the time children are 15 years old. The most pervasive effects are those relating to maternal life course (such as fewer and more widely spaced pregnancies) and better financial status. The likelihood of child abuse and accidents is reduced, the children are likely to have improved developmental outcomes as they reach school age and there is clear evidence for a reduction in antisocial behaviour in children when they reach their teens.

2. The evaluation of 10 pilot sites in England

In 2006 the UK government announced that 10 demonstration sites would test the NFP in England, where it is called the Family Nurse Partnership (FNP). Applications were invited from PCTs and local authorities, who were to be funded for one year; PCTs/LAs agreed to continue to support the service until the children involved were 24 months old. Selected sites, one from each Government Office region with two in London, provided some contrast in size and geography: County Durham and Darlington, Manchester, Barnsley, Derby City, Walsall, South East Essex, Slough, Somerset, Southwark and Tower Hamlets. The majority of those recruited to offer the FNP were extremely experienced. Most teams consisted of four Family Nurses and a supervisor, but some teams were a little larger.

The aims of the evaluation were: to document, analyse and interpret the feasibility of implementing the Nurse-Family Partnership (NFP) model of home visiting in 10 demonstration sites in England; to determine the most effective method of presenting the model; to estimate the cost of presenting the NFP model; to determine the short-term impact on practitioners, the wider service community and the children and families; and to set the groundwork for a possible longer term experimental assessment of the programme and its impacts.

The findings in this report are based on a number of information sources: forms completed by Family Nurses as part of the FNP programme; semi-structured interviews with approximately a 10% sample of the clients enrolled on the programme and with some of their partners or other family members – at two points

in time, during pregnancy and in the first month or two after their baby was born; semi-structured interviews with all the Family Nurses and supervisors, team administrators, local managers, stakeholders from other agencies in the areas, and members of the central government team responsible for establishing the programme. In addition researchers made visits to all the sites and observed some of the group supervision meetings. Training events were attended and their ratings of the different training experiences were analysed. Family Nurses and supervisors who wished to also contributed unstructured reflective thoughts on an ongoing basis.

It must be noted that this report contains early findings from test sites that were established with a tight, perhaps too tight time-scale. Setting up a new and very different programme such as FNP within the context of much larger systems of service provision is a complex task and the difficulties encountered would need to be addressed for the service to be delivered successfully.

3. Can the FNP be implemented with fidelity in England?

A number of fidelity targets are incorporated into FNP to allow the programme to be adjusted when used in new settings, and to promote ongoing performance, based on what has been shown to work in the USA. Collectively, the fidelity targets cover recruitment, attrition, and delivery of the programme and were assessed using forms completed by FNs after each home visit.

Recruitment targets

- 75% of eligible referrals are enrolled on the programme;
- 100% of enrolled women are first time mothers;
- 60% of pregnant women are enrolled by 16 weeks gestation;
- All full-time nurses have a caseload of 25 within 8-9 months.

The first two targets were achieved, the third was not achieved with recruitment taking place on average at 17 or 18 weeks and the fourth was close to being achieved.

Attrition target

- Attrition of 10% or less for pregnancy phase.

This was not achieved across the sites: one site attained less than 10% but others ranged from 11 – 24%. Attrition statistics include not only those clients who decide to stop receiving the service but also those who experience miscarriage or infant death, and those who move out of the area.

Delivery targets

- Percentage of visits completed is 80% of expected visits or greater in pregnancy;
- On average length of home visits with participants is 60 minutes;
- Content of home visits reflects variation in developmental needs of participants across programme phases. (Visit content is divided into domains, with a specification of the average time to be spent on each: personal health, 35-40%; maternal role 23-25%; life course development 10-15%; environmental health 5-7%).

The first of these was not achieved, it proved a challenge for most sites – the average proportion of expected visits received was 53%, and just over one in five clients (21%) received at least 80% of the expected number of visits. This fidelity target will be monitored closely so that future performance can be enhanced. The second was achieved with an average visit time of 73 minutes; the complex third target was close to being achieved.

Overall, while there were complications in sites in terms of identifying eligible pregnant women, once Family Nurses met with mothers there was a high rate of acceptance of the service. This suggests that the Family Nurses were well-prepared by their training to offer the service and that young first time mothers in England were open to the idea of this kind of help. The dosage being provided to clients is below that recommended by the USA, which may impact on expected outcomes. However attainment of this target was influenced by a number of external factors such as difficulties in establishing efficient recruitment pathways; the requirement to attend training during the period that recruitment took place; and a concentration of new clients, who require more frequent visits. These can be taken into account in future implementation plans.

Information collection
There is a substantial amount of record keeping integrated into the programme, using specially developed data forms from the USA. These cover a range of topics including demographic information about clients and document health related behaviour and relationships. Completion of the forms allows for monitoring of fidelity so that performance can be enhanced, and is also essential for the reflective learning aspect of the programme to operate. Teams were more successful in collecting forms about maternal health, less for forms about smoking, alcohol and drug use and changes in relationships.

4. Are the right people being reached?

Two categories of recruitment criteria were used in the ten sites. All sites offered the programme to first-time mothers under the age of twenty. Some sites also recruited mothers aged 20 to 23 if they had risk criteria relating to lack of income, education and/or employment or absence of a partner.

Using these inclusion criteria, the clients have many characteristics that make them potentially vulnerable to poor outcomes for themselves or their children. The majority are becoming parents at a young age, have low incomes, do not live with their partners and have few educational qualifications or steady employment. In addition they have identifiable vulnerabilities including physical health difficulties, mental health problems, experience of domestic violence and homelessness. They reflect the characteristics of the population in the US that has been shown to benefit most from this programme.

This suggests that a simple selection on the basis of being a first-time parent under the age of 20 will identify a group similar to those who were found to benefit most from the programme in the USA trials.

5. Is the FNP acceptable in England?

To young pregnant women, fathers and members of the extended family?
Clients and their families were positive about the programme and about the FNs. While it took a while for them to understand the full extent of the programme, they liked it in comparison with other services. They noted in particular the different way they were perceived by FNP staff, not judged and undermined but supported and strengthened. Some were not sure about it when they accepted, but most found the programme better than they had expected, particularly some of the young men interviewed. They felt more involved as fathers to be. Grandmothers were generally happy to let the Family Nurse provide up-to-date information to their daughters.

“I thought she was going to be really nosey and look down at me because I’m a teenage mum. But no she was really, really nice. Nothing like I expected her to be. I expected it to be really bad. I get on really well with her.”
“Every week she leaves stuff for me to read, to keep, so it’s nice to look back on them and go through them.”

To Family Nurses?
Many reported enjoying the job and the challenges it offered. On the whole they are very loyal to the programme, enthusiastic about its potential and have a sense of achievement. They feel satisfaction that their clients are well prepared for labour and have support from them when their babies are born. Many say it is the best job they have ever had. But a common theme throughout their interviews was the strain of seeing 25 clients and the number of visits required to them, relevant to the finding about dosage shortfall.

As well as the workload difficulties some Family Nurses had issues about the supervision, management or leadership of their team, and the majority made some comments about the burden of paperwork, which was exacerbated by additional requirements from their PCT to enter data in more than one place. However, they valued the high quality, extensive training and support they had received, and found working with a structured, prescribed programme more interesting and satisfying than they had expected. The descriptions of their growing familiarity with the programme and the materials indicated that Family Nurses' understanding of both increased as they used them.

To stakeholders?
Representatives of other services working with young parents in the pilot sites were aware of the programme but only superficially conversant with its approach and method. Some attended local boards or groups to oversee the development. In some areas Project Leads and Managers had been more successful in explaining the FNP than others, usually because they were personally well embedded in the area. The response to the FNP from health services was more welcoming and knowledgeable than that from other services. Here the idea that families were being offered intensive support was welcomed, but staff were afraid of overlap with their own work, felt they were already offering the support. They wanted FNs to be more involved with them on a multi-agency basis and to take clients who they felt would benefit from support. They worried about what would happen to the families once the children were two. It was clear that these stakeholders would have benefited from clearer information about the FNP and regular local feedback from it.

6. Management, existing structures and central team

The ten sites had Project Leads, in all but one based in the PCT, who mustered support for the programme from senior officers in the PCT, local authority and relevant agencies (including the midwifery service in acute trusts). A part-time Project Manager worked under the Lead, dealing with the practical needs of teams in order that they could operate in the English context and concentrate on delivering the programme. This meant looking after matters like accommodation, technology and communication, running steering and other support groups and explaining the programme locally.

Midwifery
The midwifery service was particularly important in this first year because midwives were central to the process of recruiting mothers to the programme. Midwifery managers had had some involvement in the original bid, but reported that they had ceased to have ongoing involvement and wished they could have more feedback about the local progress of the programme. In four sites midwives had not been targeted for recruitment as FNs, which had resulted in some resentment, and the programme could be seen as a threat by existing specialist workers like teenage pregnancy midwives.

To maintain partnership working between midwifery and FNP, midwifery managers needed to be involved in the planning of FNP services, and to be part of the strategic board guiding the programme. Referral systems needed to minimise additional work for midwives, and the latter needed to understand the programme its specific remit and its goals. Referrals needed to be written into the antenatal care pathway. FNP needed to make sure that the midwifery service knew whether clients had been accepted onto the programme. Guidance from the central team was required for all areas where FNP is operating, to clarify issues of consent and confidentiality for referrals.

Children's Centres
The plans for FNP in England had included integration of the programme into Children's Centres. Interviews with Children's Centre managers showed a low level of understanding of the precise nature of the FNP. It was difficult to see how managers could plan the integration of this programme with other services without that understanding. Family Nurses have been able to get some young clients to use Children's Centre services, often by accompanying them there. However this report deals primarily with FNP clients during early and late pregnancy and links between the FNP and Children's Centres may strengthen once infant are born.

Wider service structure
The implementation of the programme was managed by a central team based within the DCSF and in partnership with the DH. Their role initially focussed on learning in detail about NFP in the USA, and on managing programme implementation through the provision of training and support for FNs and supervisors, regular meetings with local leads and managers, troubleshooting when difficulties arose, such as in the establishment of effective recruitment pathways, and monitoring fidelity information. The open and full exchange between FNs, supervisors and managers and the central team is a strength in that it has allowed for ongoing support for the sites in this early phase, and has allowed for early difficulties to be addressed in a timely manner. The central team also have a wider role of linking FNP with the Every Child Matters and Child Health Promotion agendas and structures. They noted in interviews the tension between this new, innovative way of working and longstanding professional attitudes evident in some commissioners and local managers. However the profile of FNP is high and it has been noted as an important element in the new Child Health Promotion Programme.

7. Cost issues

An examination of how Family Nurses apportion their time, based on detailed diary-keeping by all but one of the FNP staff over a two week period, showed that in all sites Family Nurses were not able to deliver the requirements of the programme within their normal working hours; they were working 20% more than their standard hours. And this was happening at a time when many did not have a full caseload. Family Nurses who work part-time found it hard to keep their non-working days free of programme commitments. However, it was also the case that, at the same time as they were seeing clients, the FNs were also attending ongoing training sessions requiring substantial time-commitment. In addition the fast rate of recruitment meant that they had many new clients at one time, all requiring a high frequency of visits (weekly in the first month) making it a challenge to reach the dosage target. If recruitment had been phased more slowly this would not have been the case.

At present the babies born to clients of the FNs are only a few weeks or months old, so that lifetime outcomes are unknown. This means that it is not yet possible to compare the benefits of the programme with the costs. Further work will be done on this in year 2 of the evaluation.

8. Nature of the work and best practice

All those directly involved in the FNP in the pilot sites and centrally point out that while it may appear to be an intensive version of existing UK early years health services, the actual experience is of a very new way of doing things. FNs feel they are reaching real need, using their skills, standing shoulder to shoulder with clients and seeing change in them. They note how different it is to work in a structured programme, but found it extremely helpful in comparison with the professional approaches they had been used to (in health visiting and midwifery).
They valued the close relationship within the FNP team, the high quality of the training and the chance to work with the whole family.

Barriers to good practice included managing the workload, last minute cancellations of visits by clients, and insufficient planning time for visits. Evidence from a series of case studies with clients, some of whom presented with extra needs, showed that FNs were considered good listeners who gain access to clients because they are approachable and seen as different from other professionals – non-judgemental, non-threatening and able to spend time with clients. Once engaged the Family Nurse builds trust with the client, reinforcing confidentiality on every visit. FNs have had to be flexible in gaining and keeping clients interested in the programme, and have learnt to adapt programme content while trying to keep fidelity. FNs have liaised with other agencies on the client's behalf, and supported clients in tackling crises that occur in their lives, based on self-efficacy principles.

Clients prefer help which is seen as practical and which can quickly be proven to be effective. They appreciate the professional background of the FNs and want to take advantage of their health expertise. FNs have managed to engage and maintain relationships with clients with whom other professionals have not managed to engage. They have done so even where child safeguarding procedures has been put in place at the instigation of the FN. FNs have emphasised the strength of clients and encouraged them to re-engage with agencies they had previously stopped using or refused to use. They have been able to engage fathers, and have worked flexibly to keep fathers involved. FNs have found it difficult to maintain the engagement of some families where interpreters have been required and cultural perceptions have affected communication.

The skills of the Family Nurse and good practice in approaching clients can result in effective engagement, but progress can be strongly influenced by factors relating to the client, both current and historic.

9. Sites, teams and supervision

The organisation of FNs into dedicated teams is central to programme operations, with support from within the team and between team members acting as a consideration when FNs are finding the work difficult. The way FNP teams work is more intimate and mutually dependent than FNs had experienced in team-working in previous roles, where, for example, one of the prime functions of the team is to allow practitioners to cover for one another.

Team cohesion
Training has reinforced relationships within teams, partly because FNs have had to travel together to undertake training, and trainers have treated them as a group and also because they underwent team building exercises (though many disliked these at the time). Those who are not based with other members of their team feel isolated and can often lose some sense of the Family Nurse identity. Teams did not necessarily cohere from the outset, but relationships have improved over time, and are aided by the supervision process. It is therefore extremely important that group supervision is protected and experienced regularly.

Supervision
Supervisors help to make teams work, but at times their role is undermined, by local infrastructure deficits for instance. Ideally the team coheres and the supervisor helps this to happen. Supervisors, like the Family Nurses, feel frustrated that they do not have enough time to complete all elements of the job – but value the fact that they are visiting families and thus getting an insight into the day-to-day experience of team members. In the future it should be possible to ensure that a supervisor already has experience as a Family Nurse.

Support for supervisors from the central team psychologist and from the Implementation Lead has been helpful to them. They liked the direct link to the central team, and the opportunity to help one another. If the FNP develops in a wide number of sites, a system to allow links between supervisors, perhaps on a regional basis, would be helpful.

Supervisors have had a more extended local promotional role than might have been expected from their job descriptions. This may be because their insights into the FNP, based on their own visiting experience, have made them able to communicate what the programme is about in ways that are not open to Project Managers. Although most have enjoyed this part of the work, it can add considerably to their workload.

10. Can the FNP make a difference?

This implementation evaluation cannot say whether the clients who receive the programme changed in ways that are different to those who are not being supported in this manner. To answer that question a randomised trial is required but many of these clients believe that it is helping them. On a scale from 1 to 10, their average rating of the difference that the FNP was making to them was 8, with very few ratings below 6, suggesting that they think it has made a difference; both during pregnancy and once their infants had been born.
"She gives you that bit of extra support, confidence that you are doing things right with your child. She makes you feel better."

Client substance use
At the start of support 40% had smoked in the previous two days and this was reduced to 34% by 36 weeks gestation, with an average reduction in the number of cigarettes per day, for those who smoked, of 1.3 cigarettes per day. The reduction for those who smoked 5 or more cigarettes per day was 2.4 cigarettes.

Few clients reported any alcohol use at intake (14%) and at 36 weeks even fewer (8%) reported any alcohol consumption in the previous two weeks. A comparison of the daily consumption for those who had reported any use of alcohol at intake

indicated a significant reduction (down to 0.4 units) but this is based on a small number of clients. There were not sufficient clients using other drugs to make any sensible comparisons. It is likely that some clients were reluctant to disclose alcohol or other drug use to the Family Nurses and other methods may be required in a trial to gain accurate data.

Infant and maternal nutrition
At intake more than 50% of clients were either under or over-weight according to their BMI, estimated on the basis of their reported weight prior to pregnancy. Many recalled in interviews that Family Nurses had given them a lot of information about eating appropriately, with the use of diaries and information sheets, and this was said to have helped them to think about eating more fresh fruit and vegetables, and fewer fattening foods, which should contribute both to maternal and then infant health.

Many clients recalled that their Family Nurse had given them a great deal of support to enable them to think about breastfeeding, including knowledge about its benefits and practical activities such as using a special doll for practice. Two thirds had told their Family Nurse that they were planning to breastfeed and of those who had given birth two thirds had initiated breastfeeding, higher than the rate for mothers of that age in a national sample (52%). Data were available for 200 clients whose infants had reached 6 weeks and 21% were still breastfeeding, again higher than the national rate of 14%.

Father involvement
Many studies have shown that children do better academically and emotionally if their father is involved in their life, and families also gain financially if fathers, including non-resident ones, contribute financially. This study provides evidence about the involvement of fathers in the FNP programme, which should lead to closer involvement in their children's lives. The interviews with fathers revealed that many were interested in the FNP materials and activities, and that these had given them confidence, for example finding out how to communicate with the new baby.

Almost half the fathers and partners (49%) had been present for at least one FNP visit and for those who had attended at least one the average number of visits attended was 3.3, representing overall 23% of the visits made. Family Nurses judged that when they were present fathers were almost as involved as the mothers in the activities and that they appeared to understand and accept the materials. Family Nurses also reported that over half (58%) of clients asked for materials to be left so that they could be shown to partners. These were then shared with the Family Nurse, even if the fathers could not be present themselves, through work commitments or for other reasons.

Strengthening parenting
During interviews mothers and fathers indicated that they felt more confident about becoming parents. They also appreciated the positive approach of the Family Nurses who, instead of making them feel that they should not be having a child, gave them skills to be able to cope with the difficulties of the labour and delivery and then with their new infants. They were, in some instances, empowered in the hospital in the face of staff who were at times less than supportive, to ask the right questions or make requests related to pain relief or the progress of the labour.

They were also empowered in their interactions with their infants, expressing amazement and enjoyment in their learning and understanding about the complex ways that infants use to communicate. This should enable them to deal more effectively with stressful infant behaviour such as crying or sleeplessness.

11. Implications for the future

Cycles of disadvantage and social exclusion
Previous UK research has found that mothers who give birth for the first time before the age of 20 are later in their lives more likely to live in social housing, receive benefits, have no qualifications, a low household income, poor health, mental health problems and a low satisfaction with life. Explanations of the adverse consequences of early motherhood often make associations with low educational attainment, which limits later employment options available to women, and low income. Their children are also more likely to have children while still in their teens.

The FNP programme has the potential to mitigate against the adverse outcomes found in the past to be associated with young parenthood. Research from the USA has shown that in all three trials of the programme there was wider spacing between the first and subsequent births, less reliance on welfare, more take-up of education and more paid employment. There was also more paid employment of partners. Although recruited for the most part with a simple age criterion, the English client group reflects the earlier UK findings in that they are disproportionately from households with low income, they have few educational qualifications, and many vulnerabilities including mental health problems. Thus it is possible to offer a service that is not presented as stigmatizing with a simple age criterion, but that reached some of the most disadvantaged first-time mothers, likely to become even more disadvantaged in later life.

Selection based on additional risks for mothers giving birth aged 20 to 23 was less successful. Refusal of FNP was greater for the 23 and 24 year olds, and only small numbers were identified. Thus future sites may want either to recruit only under 20s – the simplest option since it requires less of the other services in terms of information sharing – or to offer routinely to under 20s and selectively from 20 to 22 years. Going above that age group may not be a good use of resources.

Many of the young parents reported that they feel and are excluded, judged or demeaned by many professionals that they come into contact with. The FNP programme could provide a way for this psychological aspect of their exclusion to be reduced. The FNs behaved in ways that were contrary to this, they accepted, supported and strengthened their clients. This can allow these young people to approach the rest of their lives with a sense or potential to be achieved rather than failure to be accepted.

Fitting the FNP into existing services for children and families
The FNP is best viewed as a discrete intervention: focussed, complete in itself and not so much a partner in a multi-agency approach as a prelude to it, with the potential to link clients efficiently with a wider range of services when this is warranted. When respondents referred to newly trained FNs as an ‘elite group’ in a concerned way, there may be no cause for concern.

This will not mean that the FNP should operate in a vacuum, divorced from other support services. There is every reason to suppose that helping clients participate in other services, introducing them to Children’s Centres, even helping Children’s Centres to set up services for them will work well, both for the clients and for the Children’s Centres. But there are risks in seeing FNs as new members of the Children’s Centre team, sharing family support work between them. Rather, this is a small focused resource, working with a small group of families in a very specific way, and FNs need to be able to concentrate on this.

FNs describe themselves as being in a changed alignment with their clients. They have reached this position as a result of the FNP training, the new skills they have developed like motivational interviewing, and by the experience of using the programme, the contents of which have succeeded in re-orienting them. This new position can be precarious, and the greater level of scrutiny and feedback about progress can start to feel intrusive and critical. Their time needs to be protected so that they can devote as much as possible to FNP activities, which is sometimes problematic when they are working within statutory agencies.

There is a tendency, as social programmes are rolled out from their early testing, to give the development and support role to regional and local agencies, which are already dealing with training and support for family services. The FNP does not lend itself to this approach. It may benefit, in the long-term, from being supported by a central unit, which is positioned outside the statutory sector and which acts as a contractor to those wishing to implement the intervention.

It has been suggested that one of the most important outcomes of the Head Start initiative in the USA or the Perry Preschool Project (Schweinhart et al., 1993) was not that they 'boosted child IQ' since this often faded over time, but the programmes gave the families an expectation that formal services could be helpful for their children, and that is what made the difference in the long term. The FNP has the potential to achieve this for young vulnerable parents and their children in England.